OFFICE OF THE GOVERNOR
STATE OF MONTANA

Steve Bullock
GOVERNOR

Mike Cooney
LT. GOVERNOR

August 26, 2019

The Honorable Alex Azar II
U.S. Department of Health and Human Services
200 Independence Avenue SW, Sixth Floor
Washington, DC 20201

Dear Secretary Azar:

Thank you for your on-going collaboration with the State of Montana and our efforts to expand Medicaid coverage to over 95,000 adults. I am pleased to submit the Montana Department of Public Health and Human Services' Section 1115 Medicaid Demonstration Amendment and Extension Application, "Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program," (Project Number 11-W-00300/8).

Montana seeks to amend and extend the State's current Demonstration to maintain existing Demonstration features while testing new and amended Medicaid program features, as required by HB 658, 2019 Mont. Laws ch. 415[1], which include the following:

- **Work/Community Engagement.** The State seeks waiver authority to condition Medicaid coverage on compliance with work/community engagement requirements for non-exempt expansion adults with incomes up to 138 percent of the FPL.
- **Premium Increase Structure Based on Coverage Duration.** The State seeks to amend its Demonstration approach to premiums by applying a premium structure that gradually increases monthly premiums based on the length of time an individual is enrolled in coverage under the Demonstration.

Montana also seeks to extend 12-month continuous eligibility which we believe is critical to improving continuity of coverage and care.

Medicaid expansion has improved access to quality, affordable health care for low-income Montanans, and supported Montana's economy. It provides health insurance for 95,246 adults, or 9.3% of our population, and has increased access to primary and preventive care. Medicaid expansion has created 5,300 new jobs between 2016 and 2018. What's more, Medicaid expansion and Montana's innovative HELP-Link program have contributed to a 6 percent increase in Medicaid-expansion-eligible adults joining the workforce, and 57% of Montana businesses have workers enrolled in Medicaid expansion.

[1] https://leg.mt.gov/content/Publications/sales/2019SessionLaws_VOL2.pdf

All in all, we estimate that between 2018 and 2020, Medicaid expansion will generate more than $270 million in Montanans' personal income. Medicaid is also essential to our rural hospitals and providers to keep their doors open. Hospitals have seen a 49% decrease in uncompensated care, and community health centers have seen an $11.7 million increase in revenue.

Montana looks forward to its ongoing work and partnership with the Center for Medicare and Medicaid Services to ensure Montanans continue to have access to quality health care.

Sincerely,

STEVE BULLOCK
Governor

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Montana Department of Public Health and Human Services

Section 1115 Demonstration Amendment and Extension Application

Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program

Updated August 30, 2019

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Section I. Historical Narrative Summary of the Demonstration

A. Introduction

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

On May 9, 2019, Governor Steve Bullock signed House Bill 658, the Medicaid Reform and Integrity Act, that directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal waiver approval for new Medicaid expansion program features including those that condition Medicaid eligibility on participation in work/community engagement.

B. Summary of the Current HELP Demonstration Program

The HELP Demonstration Program was initially designed to meet the following policy objectives:

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

The State has made significant progress in meeting the policy objectives of the HELP Demonstration Program. As of June 2019, Montana's Medicaid enrollment under the HELP Demonstration Program reached 92,548 adults.[1] The rate of uninsurance in Montana has declined to 8.6 percent.[2] Medicaid expansion in Montana has afforded unprecedented access to primary and preventive care, cancer treatment, and mental health and substance use treatment, among other essential health care services. As of June 24, 2019, 101,309 adults who gained coverage under Medicaid expansion received preventive health care services, including:[3]

[1] For the most up-to-date enrollment numbers, see the Montana Medicaid Expansion Dashboard, available at https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.
[2] Montana Healthcare Foundation, 2019 Report on Health Coverage and Montana's Uninsured, June 2019, available at https://mthcf.org/resources/2019-report-on-health-coverage-and-montanas-uninsured/.
[3] Montana Department of Public Health and Human Services, Montana Medicaid Expansion Dashboard, Services Summary, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard, accessed on July 14, 2019. For additional information on the

- 8,172 adults received a colon cancer screening, resulting in 2,941 possible cases of colon cancer averted;
- 9,257 women received a breast cancer screening, resulting in 136 women diagnosed with breast cancer as a result of screening;
- 2,492 adults were newly diagnosed with and treated for hypertension;
- 1,156 adults were newly diagnosed with and treated for diabetes;
- 35,152 adults received outpatient mental health services and 3,484 adults received inpatient mental health services; and
- 3,610 adults received substance use outpatient services and 2,337 adults received substance use residential services.

Medicaid expansion has also enabled rural hospitals and health care providers to keep their doors open, preserving access for rural Montanans of all incomes. Following the HELP Demonstration Program's implementation, Montana hospitals witnessed a 49 percent decrease in uncompensated care and Montana's community health centers saw an increase of $11.7 million in Medicaid revenue.[4]

Medicaid expansion led to the creation of approximately 5,300 new jobs between 2016 and 2018.[5] These are healthcare jobs – which are among the highest paying in the State – as well as jobs in retail, trade, construction, services industry, real estate, and technology. In addition, the Demonstration contributed to more low-income adults joining the workforce in Montana; from 2015-2016, Montana witnessed a 9 percent increase in non-disabled adults working and a 6 percent increase in people with disabilities working. The State estimates that Medicaid expansion resulted in more than $270 million in new income for Montanans each year.[6]

C. Summary of Montana's New Proposed HELP Demonstration Program Features

House Bill 658, the Medicaid Reform and Integrity Act,[7] directs DPHHS to request federal waiver approvals for new Medicaid program features. Montana seeks to amend and extend the State's current Demonstration to maintain current Demonstration features while testing new and amended Medicaid program features which include the following:

- **Work/Community Engagement.** The State seeks waiver authority to condition Medicaid coverage on compliance with work/community engagement requirements for non-exempt expansion adults with incomes up to 138 percent of the FPL.
- **Premium Increase Structure Based on Coverage Duration.** The State seeks to amend its Demonstration approach to premiums by applying a premium structure that gradually increases monthly premiums based on the length of time an individual is enrolled in

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demonstration see "Montana HELP Demonstration Section 1115 Waiver Annual Report, Demonstration Year 3" attached to this report.

[4] HELP Act Oversight Committee, 2018 Report to the Governor and Legislative Finance Committee, August 2018, available at https://dphhs.mt.gov/Portals/85/Documents/healthcare/HELP-ActOversightCommitteeReport2018.pdf.

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

[6] Ibid.

[7] Montana State Legislature, House Bill 658, available at https://leg.mt.gov/bills/2019/billpdf/HB0658.pdf.

coverage under the Demonstration. In the first two years of coverage, Demonstration enrollees with income greater than 50 percent of the FPL will pay premiums in the amount equal to two percent of their aggregate household income. The enrollee's premium obligation would gradually increase by 0.5 percent in each subsequent year of coverage under the Demonstration with a maximum premium amount not to exceed 4 percent of the enrollee's aggregate household income. Medicaid enrollees will not be subject to co-payments under this premium payment structure.

Populations eligible for the Demonstration are not changing, but eligibility requirements are changing as described in Section II, A. Work/Community Engagement Requirements. As described above and in greater detail in Section II, B. Premiums, the State proposes changes to the premium structure for Demonstration enrollees.

The State does not propose any changes to the Medicaid health care delivery system. Demonstration enrollees will continue to receive services through the State's fee-for-service delivery system. Demonstration enrollees will also continue to receive benefits through the Alternative Benefit Plan; the State does not propose any changes to benefits for Demonstration enrollees.

D. Summary of Current Demonstration Features to be Continued Under the 1115 Demonstration Amendment and Extension

Under this amendment and extension application, Montana seeks approval to extend the following current Demonstration features:

- **Twelve-Month Continuous Eligibility Period.** Enrollees will receive continued benefits during any periods within a twelve month eligibility period.
- **Premiums.** The State will continue, and amend its approach to, charging premiums to non-exempt individuals with incomes greater than 50 percent of the FPL, as described in greater detail in Section II, B. Premiums.

Enrollees excluded from the current Demonstration will continue to be excluded in this amendment and extension request. These enrollees include those who:

- Are medically frail;
- The State determines have exceptional health care needs, as identified through the application process or by an individual notifying the State at any time, including but not limited to medical, mental health, or developmental conditions;
- Live in a region (that may include all or part of an Indian reservation), that would not be effectively or efficiently served through the Demonstration, including where the State is unable to contract with sufficient providers;
- The State determines, in accordance with objective standards approved by CMS, require continuity of coverage that is not available or cost-effective through the Demonstration; or
- Individuals exempted by federal law from premium or cost sharing obligations, whose exemption is not waived by CMS, including all individuals with incomes up to 50 percent of the FPL.

These enrollees hereinafter referred to as "Excluded Populations" will be served under the Medicaid State Plan and subject to the terms and conditions therein.

E. Future Additional Goals of the HELP Demonstration Program

Through this Demonstration amendment and extension, Montana seeks to further the goals and policy objectives of the underlying HELP Demonstration Program described above, as well as:

- Improve the health, well-being, and financial stability of Montanans through participation in work/community engagement requirements;
- Encourage HELP Demonstration Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions, and ultimately improve their health through changes to the premium structure; and
- Improve continuity of coverage and care through 12 month continuous eligibility.

Section II. Changes Requested to the Demonstration

A. Work/Community Engagement Requirements

As directed by State legislation, and consistent with CMS's State Medicaid Director Letter encouraging Medicaid programs to test the intersection of work/community engagement and health and well-being,[8] Montana seeks to implement work/community engagement requirements as a condition of Medicaid eligibility. Montana has designed a work/community engagement initiative to promote the health, wellness, and financial stability of enrollees.

1. Populations Subject to Work/Community Engagement Requirements

Montana will make participation in work/community engagement a condition of ongoing eligibility for all Demonstration enrollees between ages 19 and 55 with incomes up to 138 percent FPL who do not otherwise qualify for an exemption, as further defined below. Enrollees will be required to participate in 80 hours of work/community engagement activities each month.

2. Qualifying Activities

Qualifying work/community engagement activities shall include:

- Employment;
- Work readiness and workforce training activities;
- Secondary, postsecondary, or vocational education;
- Substance abuse education or substance use disorder treatment;
- Other work or work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program;
- A community service or volunteer opportunity; and
- Any other activity required by CMS for the purpose of obtaining necessary waivers.

3. Exemptions

Montana will exempt enrollees who meet the standard and hardship/good cause exemptions described in this section. The specific length of time for which an exemption applies will depend on the exemption. Some exemptions may be permanent, including, for example, enrollees who are blind; other exemptions will be time-limited including, for example, exemptions for women who are pregnant.

- ***Standard Exemptions.*** Enrollees who qualify for an exemption from work/community engagement requirements include those who are:
    - Medically frail enrollees as defined in 42 CFR 440.315;
    - Blind or disabled;
    - Pregnant;
    - Experiencing an acute medical condition requiring immediate medical treatment;
    - Mentally or physically unable to work;
    - A primary caregiver for a person who is unable to provide self-care;

[8] Centers for Medicare and Medicaid Services State Medicaid Director Letter, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 11, 2018, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

- A foster parent;
- A full-time student in a secondary school;
- A student enrolled in the equivalent of at least six credits in a postsecondary or vocational institution;
- Participating in or exempt from the work requirements of the Temporary Assistance for Needy Families (TANF) program or the Supplemental Nutrition Assistance Program (SNAP);
- Under supervision of the Department of Corrections, a county jail, or another entity as directed by a court, the Department of Corrections, or the Board of Pardons and Parole;
- Experiencing chronic homelessness;
- A victim of domestic violence as defined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. 601, et seq.;
- Living in an area with a high-poverty designation;
- A member of an entity subject to the fee provided for in 15-30-2660(3);
- An enrollee whose income exceeds an amount equal to the average of 80 hours per month multiplied by the minimum wage; or
- Otherwise exempt under federal law.

- ***Hardship/Good Cause Exemptions.*** To address life circumstances that affect an enrollee's ability to engage in work/community engagement, Montana will also exempt individuals who:
  - Are hospitalized or caring for an immediate family member who has been hospitalized;
  - Have a documented serious illness or incapacity or are caring for an immediate family member with a documented serious illness or incapacity; or
  - Are impacted by a catastrophic event or hardship, as defined by DPHHS, which prevents enrollees from complying with the work/community engagement requirements.

  The duration of these exemptions will be dependent on the enrollee's circumstances.

4. Process for Determining Standard and Good Cause/Hardship Exemptions and Compliance with Work/Community Engagement Hours

Montana will use a variety of methods to identify individuals who qualify for standard and good cause/hardship exemptions as well as those who are already complying with work/community engagement hours for enrollees who are not exempt, using a multi-pronged process that includes but is not limited to using available data (within DPHHS and other State agencies) to identify enrollees who should be exempt from or are already complying with work hours (e.g., exemption from or compliance with SNAP requirements, employment-based income that equates to required work hours assuming Montana minimum wage, and claims experience indicating medical frailty).

For enrollees for whom the Department is unable to use data to determine their exemption or compliance, the Department will provide multiple ways for enrollees to self-report an exemption or their compliance with work/community engagement requirements, including online, through a call center, by mail, and in person.

5. Notices

A description of the work/community engagement requirements will be outlined in supplemental information provided to applicants and enrollees in the Medicaid application, redetermination, and change reporting processes. All Medicaid enrollees subject to work/community engagement requirements will receive consumer notices at application and renewal that describe the program, qualifying work/community engagement activities, exemptions, required hours, compliance reporting processes, and who they can contact with questions. This information will also be available at county eligibility offices, online, and through the call center.

6. Penalties for Non-Compliance

DPHHS will notify a program enrollee who is not in compliance with the work/community engagement requirements that the enrollee has 180 days to come into compliance, and failure to comply within the 180-day period will result in suspension from the program, unless the enrollee attests and the Department confirms that the enrollee is exempt from the work/community engagement requirements.

7. Reactivation of Coverage

An enrollee who is suspended from the program for noncompliance may be reinstated 180 days after the date of suspension or upon a determination by the Department that the program enrollee: (a) is exempt from the work/community engagement requirements; (b) has been in compliance with the requirements for 30 days; or (c) meets an Medicaid eligibility group that is not subject to the Demonstration.

8. Audit Trigger

Per State legislation, if suspensions for noncompliance with work/community engagement requirements exceed 5 percent of program enrollees, the Department will notify the Legislative Audit Committee. The Legislative Audit Committee shall select an independent third-party auditor to conduct an audit of the enrollees who were subject to suspension. If the audit finds that more than 10 percent of the enrollees in the audit sample were suspended erroneously as defined by the Department, the Department will cease further suspensions until the conclusion of the next general legislative session. The audit must be completed within 90 days or the Department will cease suspensions until the audit is complete and the Legislative Audit Committee has received the audit report.

9. Employment Assessment and Supports for Montana HELP Demonstration Program Enrollees

As it does currently, the Department will continue to provide enrollees the option to participate in an employment assessment to identify barriers to employment. The Department of Labor and Industry will contact each interested program enrollee subject to the work/community engagement requirements and assist them with completion of an employment or reemployment assessment. Based on the results of the assessment, the Department of Labor and Industry shall identify services to help the enrollee address barriers to employment.

Enrollees will also have the option of participating in HELP-Link, the workforce development program operated by the Department of Labor and Industry. Services offered through HELP-Link include:

- Assistance with resume and cover letters, job applications and interview skills;
- Resource center for job seekers including the Montana Career Information System;

- Labor market information and skills testing;
- Assistance for veterans of the military and eligible spouses;
- Workforce and educational training; and
- Referrals to other service providers (e.g., childcare, housing supports, and financial counseling).

To date, more than 25,244 HELP enrollees have received workforce services through HELP-Link.[9] The Montana Bureau of Business and Economic Research (BBER) found that since the implementation of the HELP Demonstration Program, including HELP-Link, more low-income adults are joining the workforce, including a 9 percent increase in employment among non-disabled adults.[10]

Additionally, pursuant to legislation, the Department of Labor and Industry will award grants to employers to hire or train enrollees in skills to help them obtain new or improved employment, obtain employment with healthcare benefits, earn a wage that allows them to purchase their own health insurance, and improve their long-term financial security.

B. Premiums

Montana is amending its Demonstration approach to premiums by requiring Demonstration enrollees to pay monthly premiums that increase based on the length of time they are enrolled in the HELP Demonstration Program. Specifically, enrollees who are not otherwise exempt from paying premiums will continue to be required to pay monthly premiums equal to 2 percent of their modified adjusted gross income for the first two years of participation. Per State legislation, the premium will increase 0.5 percent in each subsequent year of Demonstration coverage, up to a maximum of 4 percent of the enrollee's aggregate household income. The proposed premium structure will encourage HELP Demonstration Program enrollees to be discerning health care purchasers, to take personal responsibility for their health care decisions, and ultimately to improve their health.

The figure below depicts the premium schedule for enrollees in the HELP Demonstration Program for six years or more.

Figure 1. **Premiums**

Year of Participation in HELP Demonstration Program	Premium Amount
Year 1	2 percent of an enrollee's household income
Year 2	2 percent of an enrollee's household income
Year 3	2.5 percent of an enrollee's

[9] HELP Act Oversight Committee, 2018 Report to the Governor and Legislative Finance Committee, August 2018, available at https://dphhs.mt.gov/Portals/85/Documents/healthcare/HELP-ActOversightCommitteeReport2018.pdf.

[10] The Economic Impact of Medicaid Expansion in Montana, University of Montana Bureau of Business and Economic Research, commissioned by the Montana Healthcare Foundation and the Headwaters Community Foundation, April 2018, available at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid ExpansionReport_4.11.18.pdf.

Year of Participation in HELP Demonstration Program	Premium Amount
	household income
Year 4	3 percent of an enrollee's household income
Year 5	3.5 percent of an enrollee's household income
Year 6 and beyond	4 percent of an enrollee's household income

1. Premium Exemptions

Pursuant to State statute, program enrollees who are exempt from the work/community engagement requirement are also exempt from premium increases.

2. Consequences for Unpaid Premiums

Within 30 days of an enrollee's failure to make a required premium payment, the Department shall notify the enrollee that payment is overdue and must be paid within 90 days from when the notification was sent.

If an enrollee with an income of 100 percent FPL or less fails to make payment for overdue premiums, DPHHS will provide notice to the Department of Revenue of the enrollee's failure to pay. The Department of Revenue will collect the amount due for nonpayment by assessing the amount against the enrollee's annual income tax. The enrollee will not be disenrolled from the program.

If an enrollee with income of more than 100 percent FPL and up to 138 percent FPL fails to make the overdue payments within 90 days of being notified, DPHHS will:

- Follow the same collection procedures described above for enrollees with an income of 100 percent FPL or less; and
- Suspend the enrollee from coverage.

The Department will unsuspend an enrollee from coverage upon: (a) payment or assessment of the total amount of overdue premium payments; (b) demonstrating a standard or good cause exemption; or (c) meeting a Medicaid eligibility group not subject to the Demonstration.

Enrollees who meet two of the following criteria are not subject to suspension for failure to pay overdue premiums:

- Discharge from United States military service within the previous 12 months;
- Enrollment for credit in any Montana university system unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- Participation in a workforce program or activity; and
- Participation in any of the following healthy behavior plans:
    - Medicaid health home
    - Patient-centered medical home
    - Cardiovascular disease, obesity, or diabetes prevention program

- Program restricting the enrollee to obtaining primary care services from a designated provider and obtaining prescriptions from a designated pharmacy
- Medicaid primary care case management program established by the department
- Tobacco use prevention or cessation program
- Substance abuse treatment program
- Care coordination or health improvement plan administered by a third-party administrator

3. Co-Payments

Demonstration enrollees are currently subject to co-payments. Under this amendment and extension application, Demonstration enrollees will not be subject to co-payments.

Section III. Implementation of Amendment and Extension

Specific implementation target dates depend on policy negotiations with and waiver approval by CMS. New Demonstration initiatives under this application require large and complex business processes development, infrastructure planning and deployment, and information systems modifications. Montana is also cognizant of reporting from states with similar work/community engagement requirements that suggests loss of coverage may result from inadequate systems or a lack of consumer information regarding work/community engagement and/or premium requirements. As such, Montana proposes to implement new HELP Demonstration Program features once the operational infrastructure is in place to support these Demonstration features. This implementation approach will promote continuity of coverage, minimize confusion and complexity for enrollees, and better position the State to achieve the goals of the Demonstration.

Section IV. Requested Waivers and Expenditure Authorities

Montana is seeking to extend the waivers and expenditure authorities currently approved under the Demonstration except as indicated below. In addition, the State is seeking additional waiver authorities to implement its proposed work/community engagement and premium policies. Montana is not requesting any new federal expenditure authority as part of its Demonstration amendment and extension application.

Figure 2. **Montana Waiver Authority Requests**

Waiver Authority	Use of Waiver	Currently Approved Waiver Request?
§ 1902(a)(8)	To waive the reasonable promptness requirement to permit suspension or termination of eligibility for Demonstration enrollees who fail to comply with certain Demonstration requirements.	No
§ 1902(a)(14) **§ 1916**	To impose monthly premiums not to exceed 4 percent of household income.	No

Demonstration enrollees are currently subject to co-payments. Under this amendment and extension application, Demonstration enrollees will not be subject to co-payments and therefore the State is no longer requesting waiver authority of § 1902(a)(17).

The State is seeking § 1115(a)(2) expenditure authority to apply 12 month continuous eligibility to Medicaid eligible adults. This expenditure authority was approved under the current demonstration.

Section V. Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

The following reports, attached to this application, provide information on quality of and access to care provided under the HELP Demonstration Program:

- Federal Evaluation of HELP: Draft Interim Evaluation Report
- Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration: Section 1115 Annual Report, Demonstration Year: 3 (01/01/18 – 12/31/18)
- Montana Help Oversight Committee's 2018 Report to the Governor and Legislative Finance Committee and 2016 Report to the Governor and Legislative Finance Committee[11]

As discussed in these reports, the HELP Demonstration Program has increased Montanans' access to high quality health care, strengthening care delivery across the state and helping enrollees prevent health problems before they occur, and prevent chronic conditions and other health problems from worsening. Please see Section VII. Evaluation & Demonstration Hypotheses for a summary of findings from the federal evaluation of the HELP Demonstration Program.

Montana has a fee-for-service delivery system and therefore does not have managed care organization (MCOs) quality or monitoring reports.

Access to Preventive Services
Throughout the HELP Demonstration Program, the State has monitored and reported on covered adults' access to preventive services. As of June 2019, more than 101,309 covered adults have received preventive services through the HELP Demonstration Program. The table below summarizes the services accessed to date based on paid claims.

Figure 3. **Preventive Services Accessed by HELP Program Demonstration Enrollees through June 2019**[12]

Number of Adults Accessing Service	Preventive Service
101,309	Adults have received preventive services
8,172	Adults have received a colon cancer screening
9,257	Women have received a breast cancer screening
136	Women diagnosed with breast cancer as a result of screening
2,492	Adults newly diagnosed and treated for hypertension
1,156	Adults newly diagnosed and treated for diabetes
35,152	Adults have received outpatient mental health services
3,610	Adults have received inpatient mental health services
9,083	Adults have received substance use outpatient services
2,512	Adults have received substance use residential services

The top 10 Medicaid preventive services accessed through June 30, 2018 are summarized below.[13]

[11] The legislature, in separate legislation, eliminated the HELP Oversight Committee in the 2019 session.
[12] Montana Department of Health and Human Services, Montana Medicaid Expansion Dashboard, Accessed on July 11, 2019, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

Figure 4. **Top Preventive Services Accessed by HELP Program Demonstration Enrollees through June 2018**

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

Medicaid Payment and Delivery System Reform to Strengthen Primary Care
HELP Demonstration Program enrollees have also benefited from Montana's investments in Medicaid payment and delivery system reforms through the state's participation in Comprehensive Primary Care Plus (CPC+), 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. As of June 2018, 61,065 Medicaid members were seeing primary care providers participating in CPC+.

The Montana Medicaid program also encourages providers to become certified patient centered medical homes (PCMHs). PCMHs are designed to provide Montana Medicaid members with a comprehensive coordinated approach to primary care where the member is at the forefront. For each member enrolled in a PCMH, the primary care provider receives additional reimbursement for providing enhanced services, reporting quality measures, and supporting comprehensive infrastructure.

[13] HELP Act Oversight Committee, 2018 Report to the Governor and Legislative Finance Committee, Submitted August 2018, https://dphhs.mt.gov/Portals/85/Documents/healthcare/HELP-ActOversightCommitteeReport2018.pdf.

Section VI. Financial Data

A. Historical Enrollment and Expenditures

Historical enrollment figures since the launch of the program and corresponding program year expenditures for full coverage years are summarized below.

Figure 5. **HELP Demonstration Program Historical Enrollment**

Program Month and Year	Point in Time Enrollment
December 2016	59,501
December 2017	89,605
December 2018	94,967

Figure 6. **HELP Demonstration Program Historical Total Expenditures**

Total Expenditures	
Program Year (Calendar Year)	**Expenditures (for full year)**
2016	291,856,023
2017	647,168,966
2018	699,573,205
Total (2016 – 2018)	1,638,598,194

Figure 7. **Historical Information – PMPM Based by Program Year**

Program Year (Calendar Year)	Count of Enrollees	Member Months	PMPM[14]
2016	88,720	667,526	416.45
2017	114,565	1,017,744	621.88
2018	125,666	1,198,211	570.34

B. Projected Enrollment and Expenditures for the Demonstration Amendment and Extension

Enrollment and expenditure projections under the proposed Demonstration amendment and extension are described below, as are assumptions and data used to develop these estimates. To predict future costs, adjustments to reflect enrollment trends based on the proposed work/community engagement activities and premium changes were predicted based on available administrative data related to work requirement exemptions and compliance requirements and the State's recent experience with premium disenrollment. We have broken out the analysis of the projected impact of work/community engagement requirements and premium collections to more clearly reflect assumptions related to each

[14] PMPM reflects health care services only and excludes administrative expenses.

requirement, and note that some beneficiaries will be subject to both requirements. Finally, in providing these estimates, the State notes that because the work/community engagement requirements policy is new, and one with little precedent nationally, it is impossible to predict future enrollment effects of the Demonstration with certainty, and that coverage losses could be greater.

Figure 8. **Estimated Compliance and Exemptions by Administrative and Self-Report Status for Montana Medicaid Expansion Beneficiaries Subject to Work/Community Engagement Requirements**

	Number	Percent of Total
Subject to requirement (average during year)	100,000[15]	100%
No reporting obligation; State determines through available administrative data that the enrollee is either exempt from or compliant with work/community engagement requirements*	74,030	74%
Has reporting obligation	25,970	26%
Does not report or fails to meet the work requirement**	4,000 – 12,000	4 – 12%

Notes: Sums of components may not equal totals due to rounding. Figures reflect Montana Department of Health and Human Services administrative data and the application of assumptions developed from a variety of sources (e.g., available SNAP data and survey data on characteristics of the HELP population).
* SNAP/TANF is the largest component at 55.85% (includes beneficiaries either meeting or exempt from work requirements for those programs); primary caregiver is 13.52%; age 56 or older is 2.05%. Figures are adjusted to account for overlap between the groups. Percent of total for each exemption type ranges from less than 3% to approximately 56%.
** These estimates assume a disenrollment rate of 4 to 12%. We estimated our range from a low based on the final Fiscal Note prepared by the Governor's Office of Budget and Program Planning for House Bill 658, which assumed that 4% of enrollees would lose coverage due to penalties associated with work/community engagement requirements,[16] and a high based on a review of emerging literature about compliance with work requirements in other states and the extent to which beneficiaries will be aware of, and comply with new reporting requirements. Our current range estimates reflect reasonable assumptions, but we acknowledge that coverage losses could be higher. Notably, a recent study from the Center on Budget and Policy Priorities found that implementation of work/community engagement requirements in Arkansas resulted in 23% of program enrollees subject to the requirements losing coverage.[17]

Evaluations of Montana's current premium requirement indicate that in 2018, 2.9 percent of beneficiaries subject to premiums with income above 100 percent of the FPL, the group subject to

[15] The State estimates that in 2019 programmatic saturation is expected to occur which will result in 100,000 estimated covered lives per month.
[16] The fiscal Note required a single point in time analysis and not a range for the purposes of estimating fiscal impact. Montana Governor's Office of Budget and Program Planning, HB 658 Fiscal Note, May 10, 2019. Available at: https://leg.mt.gov/bills/2019/FNPDF/HB0658_3.pdf.
[17] Center on Budget and Policy Priorities, Commentary: As Predicted, Arkansas' Medicaid Waiver is Taking Coverage Away from Eligible People, June 28, 2019. Available at: https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people.

disenrollment for failing to pay premiums, were disenrolled for non-payment. The proposed Demonstration Amendment and Extension would increase premium obligations from 2 percent of income to 4 percent of income based on the duration of beneficiaries' enrollment and continue the State's authority to suspend individuals over 100 percent FPL who fail to pay their premiums. There is overlap across beneficiaries who could lose coverage for non-payment of premiums and non-compliance with work/community engagement requirements and thus there are limitations with the estimates of the projected coverage losses.

Pursuant to State statute, program enrollees who are exempt from the work/community engagement requirement are also exempt from premium increase. Given that the populations projected to lose coverage overlap, and that the exemptions for premiums under the current demonstration are intended to continue, the State expects that the disenrollment rate for non-payment of premiums will continue at 2.9 percent. In providing these estimates, the State notes that that the evaluation also found that "half of the surveyed enrollees reported some degree of concern about their ability to make the monthly premiums." Because the premium increases based on coverage duration is a new policy it is impossible to predict future enrollment effects of the Demonstration with certainty, and that coverage losses as a result of premium non-payment could be greater.

Based on the assumptions above, the table below depicts Montana's enrollment projections, by total member months, taking into account the proposed changes to the HELP Demonstration Program. The table also includes the State's budget projections for Demonstration spending.

Figure 9. **Projected Enrollment and Expenditures for HELP Demonstration Expansion Population, Assuming Adoption of Work/Community Engagement Requirements and Premium Payment Requirements**[18]

	DY1	DY2	DY3	DY4	DY5
Estimated Number of Member Months	1,200,000	1,212,000	1,224,120	1,236,361	1,248,725
Estimated Number of Member Months For Enrollees Determined Exempt or Compliant via Administrative Data	888,360	897,243	906,216	915,278	924,430
Member Months Subject to Work/Community Engagement	311,640	314,756	317,903	321,083	324,294

[18] Estimated enrollment is expected to grow in proportion to Montana's population growth which is estimated at 1 percent per year. This growth assumption is applied to all member month rows in Figure 5.

	DY1	DY2	DY3	DY4	DY5
Requirements And Not Determined Exempt or Compliant Via Administrative Data					
Member Months Noncompliant with Work/Community Engagement Reporting or Participation Requirements (Disenrolled)	48,000 – 144,000	48,480 – 145,440	48,965 – 146,894	49,454 – 148,363	49,949 – 149,847
Member Months over 100% FPL Subject to Premium Requirements	97,416	98,390	99,374	100,368	101,371
Member Months over 100% FPL Noncompliant with Premium Requirements (Disenrolled)	2,825	2,853	2,882	2,911	2,940
Total Member Months Less Member Months Removed	1,053,175 – 1,149,175	1,063,707 – 1,161,667	1,074,344 – 1,172,273	1,085,087 – 1,183,996	1,095,938 – 1,195,836
PMPM	$660.60	$662.80	$666.22	$669.74	$673.27
Total Costs	$695,724,593 – $759,141,941	$705,027,502 – $769,292,837	$715,755,966 – $780,999,232	$726,723,053 – $792,966,001	$737,858,181 – $805,116,129

DPHHS is unable to estimate the number of individuals who will gain employer-sponsored coverage, or other coverage, as a result of the work/community engagement requirement. Per the Federal Interim Evaluation Report of the current Demonstration, evaluators noted a limitation in their ability to estimate the number of people who were disenrolled from Medicaid and were either uninsured or gained alternative coverage.[19] A recent study in the New England Journal of Medicine found that Arkansas's work and community engagement requirements resulted in significant losses in Medicaid coverage, without significant changes to the rates of employment among the population subject to the new

[19] N.Kowlessar, A.Bernstien, N.Odaka, et. al., "Federal Evaluation of Help: Interim Evaluation Report," July 2019.

requirements. If Montana's experience is similar, it is expected that Montana's proposed policies will result in an increase in the number of uninsured individuals in the State.

Section VII. Evaluation & Demonstration Hypotheses

To meet the federal 1115 waiver evaluation requirement, Montana participated in the multi-state 1115 Demonstration Federal Evaluation and Meta-Analysis.[20] The evaluation of Montana's HELP Demonstration Program was conducted by Social & Scientific Systems (SSS) and the Urban Institute ("federal evaluation.") A summary of the draft interim federal evaluation report is included below.

Summary of Draft Interim Federal Evaluation Report

As described in Section V and in the Federal Evaluation of HELP: Draft Interim Evaluation Report, Social & Scientific Systems (SSS) and the Urban Institute conducted the federal evaluation of Montana's HELP Demonstration Program. The evaluation had four principle objectives:[21]

- Understand the design, implementation, and administrative costs of the HELP Demonstration Program;
- Document enrollee understanding of and experiences with the HELP Demonstration Program, including experiences with premiums, copayments, enrollment, and disenrollment;
- Estimate the impacts of Montana's Medicaid expansion, including the third-party administrator (TPA) plan, on health insurance coverage, access to and use of health care, quality of health care, health care affordability, and health behaviors; and
- Provide timely information on the HELP Demonstration Program that can inform CMS, Montana, and other states as they consider ways to improve the Medicaid program

To achieve these objectives, the federal evaluation of HELP has three components that rely on qualitative and quantitate analyses:

- Qualitative analyses entailing document review and two rounds of site visits (September 2017 and September 2018), including conducting informational interviews with HELP stakeholders and focus groups with HELP enrollees;
- HELP beneficiary surveys (2017 and 2018) and descriptive analyses based on Medicaid administrative data; and
- Impact analyses using both Medicaid administrative data (through 2018) and national survey data (through 2017).[22]

[20] Centers for Medicare & Medicaid Services, 1115 Demonstration Federal Evaluation & Meta-Analysis, accessible at https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/federal-evaluation-and-meta-analysis/index.html.

[21] "Evaluation Design Report for Montana HELP Federal Evaluation," Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2017), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf.

[22] Because the national survey data to be used for the impact analysis are released in the fall of the year after the survey is fielded (e.g., data for 2017 are released in fall 2018), the final year of survey data available to the HELP evaluation is 2017.

The goals of the qualitative analyses were to provide careful documentation of HELP Demonstration Program implementation and operations, as well as successes and challenges Montana faced in managing the demonstration. The qualitative analyses were also to provide an in-depth assessment of consumer experiences with the HELP Demonstration Program through the enrollee focus groups and the beneficiary surveys. The goals of the impact analyses were to assess the extent to which the HELP Demonstration Program led to changes in health insurance coverage, as well as changes in health care access and affordability, health care quality, health behaviors, and health status.

The draft interim evaluation report, summarized here, covers findings from the 2017 and 2018 site visits, which includes information obtained from key informant interviews and enrollee focus groups; beneficiary surveys from 2017; and impact estimates.

Findings from the Evaluation

Findings from all three components of this HELP evaluation show that the program had significant and positive effects, although, as with any program, implementation and administration faced some challenges. Overall, there were substantial gains in health insurance coverage; beneficiaries for the most part expressed satisfaction with the program; and stakeholders believed it had positive economic impacts by decreasing hospital uncompensated care costs and stimulating economic growth in the state.

Allowing Montana to use a section 1115 demonstration resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage. As of September 2018, nearly 100,000 Montanans were enrolled in HELP. Moreover, based on results from the impact analysis, the expansion in health insurance coverage exceeded the gains that would have been expected if the state had expanded Medicaid without a demonstration or with a demonstration more similar to those of Michigan or New Hampshire. Apart from increases in health insurance coverage, the three components of the assessment of HELP provide results that may be informative to other states considering designing and implementing section 1115 Medicaid demonstrations.

Findings from the key stakeholder interviews

Strong stakeholder engagement and collaboration with the state expedites system change. While state officials and stakeholders acknowledged that it took time and compromise to pass the Medicaid expansion in Montana, once HELP legislation was enacted, the deep collaboration between the state and stakeholders in implementing HELP created a win-win situation for hospitals, the broader health care system, and the uninsured in Montana.

Changing patterns of health care use. While findings from stakeholder interviews and focus groups indicate continued gaps in enrollee understanding of HELP, there were evidence of changes in health care behaviors in response to program changes, as more enrollees were reported to be obtaining preventive care over time. These changes were noted by state officials and other interviewees, and also appeared to be supported by the early impact estimates.

Flexibility in program design is important. State officials and other interviewees highlighted the importance of periodically revisiting the HELP demonstration design based on actual program experience. Their findings that the 2 percent premium credit as well as copayments for non-emergent use of the emergency room were difficult to track and administer resulted in the elimination of both these program features.

Findings from the Survey and focus group

Satisfaction with the HELP program was high among current enrollees. A majority of enrollees reported being somewhat to very satisfied with individual features of HELP, such as monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of needed health care services. Among the disenrollee respondents, nearly 50 percent indicated that they would choose to re-enroll in HELP.

HELP enrollees' and disenrollees' had limited understanding of the individual features of HELP. Enrollees and disenrollees in focus groups in focus groups expressed confusion about some of the basic components of HELP such as what is coverage by the program as well as some of the more complex features of HELP such as premium credits. This was consistent with findings from the surveys of HELP enrollees and disenrollees.

Access to health care improved for many beneficiaries. Focus group and stakeholder interviews showed that access to needed healthcare services was viewed favorably by both beneficiaries and stakeholders. Survey results indicated that most beneficiaries reported receiving needed services and that cost was a barrier to receiving services for fewer than 20 percent of enrollees. With gains in health insurance coverage, beneficiaries perceived increases in access relative to their prior coverage status. However, even with HELP coverage, access barriers were more prevalent for dental and vision services than for other services, based on both focus group and survey results.

Findings from the impact analyses

Health insurance coverage increased in Montana. We find strong evidence that Montana's HELP demonstration expanded health insurance coverage for adults beyond what would have been expected if Montana had not expanded Medicaid, a view echoed by site visit interviewees. Health insurance coverage also increased in Montana relative to similar states that expanded Medicaid, without a demonstration or with a different demonstration.

Early evidence suggests that the use of preventive care increased in Montana relative to similar states, regardless of Medicaid expansion status. Given that the post-implementation period for this analysis only extends through 2017, it is still early to see changes in access and affordability measures under Montana's 2016 demonstration. Even so, we do see some evidence of increases in the use of preventive care relative to similar states, with gains in routine check-ups and receipt of a flu vaccine in Montana for all adults and low-income adults, although only few of the estimates for low-income adults are statistically significant.

Policy Implications

Based on results from this evaluation, Montana's HELP program provided coverage and access to care for about 100,000 Montanans, and was viewed positively by the majority of stakeholders and beneficiaries we interviewed or surveyed. While the design of HELP was intended to encourage enrollees to take responsibility for their health care through premiums, copayments, and strategies to promote healthy behaviors, these features produced administrative complexity that sometimes confused beneficiaries, or were administratively difficult to implement (such as copayments for emergency room visits). In addition, programs are not implemented in a vacuum, and state infrastructure and budget affect both implementation and program administration. States contemplating implementing or revising their Medicaid programs may wish to learn from Montana's experiences with specific program features, such as use of a third-party administration (TPA), or with their experiences with beneficiary outreach and education, which appears to be necessary for many beneficiaries in order to use the program effectively.

1115 Waiver Amendment and Extension Evaluation Plans

Montana plans to continue participation in the federal evaluation through federal fiscal year 2019. The State intends to contract with an independent third party to evaluate: the objectives and hypotheses that are approved under the current Demonstration that the State is seeking to extend; and the objectives and hypotheses for the new authorities requested for this Demonstration including those related to work/community engagement and premiums.

Evaluation Hypotheses for New Requested Authorities

The hypotheses under consideration for the new authorities requested for this Demonstration amendment and extension period are below.

Figure 10. **Evaluation Hypotheses under Consideration**

Hypothesis	Selected Outcome Measures & Analytic Approaches	Data Sources
Work/Community Engagement		
Enrollees enrolled in the Demonstration will secure sustained employment.	Analyze enrollee employment outcomes	• Eligibility and enrollment data • Enrollee survey data • State and national survey data • Other state administrative data sources
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Analyze coverage outcomes	• Eligibility and enrollment data • Enrollee survey data • State and national survey data
The Demonstration's work/community engagement requirements will not deter eligible enrollees from applying for or renewing Medicaid coverage.	Analyze coverage trends pre/post implementation	• State and national survey data • Eligibility and enrollment data • Enrollee survey data
Participation in the Demonstration's work/community engagement requirements will improve current and former enrollee health and well-being, compared to Medicaid beneficiaries not subject to the requirements.	Analyze enrollee utilization, diagnoses, and self-reported health	• Utilization and diagnoses data, including preventive services • Enrollee survey data • State and national survey data • Health outcomes

Hypothesis	Selected Outcome Measures & Analytic Approaches	Data Sources
		data
Work/community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	Analyze enrollee income	• Enrollee survey data • State and national survey data
Premium Increase Structure Based on Coverage Duration		
Conditioning coverage among enrollees with incomes above 100 percent FPL on payment of gradually increasing premiums will promote continuous coverage and continuity of care.	Analyze coverage gaps and utilization trends	• Eligibility and enrollment data • Enrollee survey data
Premiums will not deter eligible enrollees from applying for, enrolling in or renewing Medicaid coverage.	Analyze coverage trends pre/post implementation and within and inside/outside Medicaid	• Enrollee survey data • State and national survey data • Eligibility and enrollment data
Enrollees who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.	Analyze familiarity with premiums pre/post implementation	• Enrollee survey data • State and national survey data

Upon approval of this extension, Montana will work with CMS to develop an evaluation design plan consistent with the Standard Terms and Conditions (STCs) and CMS policy.

Section VIII. Compliance with Public Notice Process

Public Notice Process

Montana has undertaken a robust public notice process in compliance with State and federal requirements, and made clarifying edits to the application to reflect feedback received throughout the public comment process. The State notified the public of its intent to submit the amendment and extension application on June 14, 2019, publishing the application and public notice on the State's website. The State also announced dates and locations for two public hearings and the tribal consultation meeting.[23] On June 18th, the State published the abbreviated public notice in the State's three largest newspapers: Missoulian, (Missoula, MT); Billings Gazette, (Billings, MT); and the Independent Record, (Helena, MT). The State also emailed an interested parties listserv and the Montana Health Coalition, the State's Medical Care Advisory Committee, to inform them of the application's posting, public comment period, public hearings, and process for public comment submission.[24]

In late June, CMS notified the State that the amendment and extension application must include the interim federal evaluation of the current HELP Program. The interim federal evaluation was made publicly available on July 22, 2019. On July 23, 2019, the State posted an updated amendment and extension application and full and abbreviated public notices that included the interim federal evaluation findings and updated information on projected enrollment, disenrollment estimates due to work/community engagement and premium requirements, and projected program costs.[25] The abbreviated public notice was also re-published in the State's three largest newspapers; affidavits from the newspapers are included in Appendix B.

The State certifies that it held two public hearings to present the details of the amendment and extension application and to take public comment. The first hearing was held on July 31, 2019 from 11:30 am to 1:30 pm at the Billing Clinic Conference Center, 2800 10th Avenue North, Billings, Montana. The second hearing was held on August 1, 2019 from 11:00 am to 1:00 pm at the Sanders Auditorium, 111 North Sanders, Helena, Montana. Telephone and webinar participation was available for both public hearings for those who were unable to participate in person.

In addition to the two public hearings, the amendment and extension application was presented to the Legislative Interim Committee on Children, Families, Health and Human Services during their meeting on July 30, 2019 and to the Montana Health Coalition, consistent with federal requirements, on August 15, 2019. There were opportunities for public comments at both meetings.

Please refer to the public notice schedule on the State's website for a full calendar of public notice activities related to the amendment and extension application.

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[23] On July 10, 2019, the State announced it would reschedule the public hearings in Billings and Helena, and on July 15, 2019 the State published notice of the rescheduled public hearings in the State's three largest newspapers: Missoulian, (Missoula, MT); Billings Gazette, (Billings, MT); and the Independent Record, (Helena, MT)

[24] Department of Public Health and Human Services Letter to Interested Parties, "Montana Medicaid 1115 Waiver Amendment and Extension Application, June 14, 2019, available at https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/06142019InterestedPartiesMemo.pdf.

[25] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application, updated July 23, 2019, available at https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf.

Public Comment

The State-required 60-day public comment period ran from June 15, 2019 through August 23, 2019. The CMS-required 30-day public comment period ran from July 24, 2019 through August 23, 2019.

The State received 309 public comments on the amendment and extension demonstration application, including comments submitted via email and regular mail as well as comments provided orally during the public hearings and other meetings.

The State thanks the public for its robust review of the amendment and extension demonstration application and for their comments. The State reviewed and considered all public comments; a summary of the comments and the State's responses are in Appendix C.

The majority of commenters supported the continuation of Medicaid expansion under the HELP Program and recognized the benefits it has afforded to enrollees with respect to enabling access to affordable, high quality health care. The majority of commenters were concerned with the proposed changes to the HELP Program as required by State legislation, HB 658, which reauthorized the HELP Program. Specifically, commenters were largely opposed to the implementation of work/community engagement requirements and the premium increase structure, and expressed concerns that these changes would lead to coverage losses and would not increase employment among enrollees.

Tribal Consultation

In accordance with the Montana Medicaid State Plan and federal regulations at 42 CFR §431.408(b), the State conducted tribal consultation for the amendment and extension application through an in-person meeting as well as a written consultation. On June 5, 2019 the State sent an invitation and agenda to Indian Health Services, Tribes and Urban Indian Health Centers (ITUs) for the tribal consultation meeting to be held on July 16, 2019.[26] On June 14, 2019, the State sent tribal consultation letters to ITUs inviting their input at the public hearings to be held in Helena and Billings; this information was subsequently revised and emailed on July 12th to inform ITUs of the changes to public hearing dates.

On July 16, 2019, Medicaid Director Marie Matthews held the tribal consultation meeting to present the amendment and extension application and discuss with Tribes the potential impact of changes to the HELP Program. During the meeting, participants raised concerns that unemployment is high on Montana's Indian reservations and that state employment data likely does not capture actual tribal employment rates. They also expressed concern that enrollees with mental health challenges will slip through the cracks and fail to report to meet work/community engagement requirements. Participants also recognized that Medicaid expansion has enabled Indian Health Services to be able to purchase services that would have otherwise been unaffordable and suggested that it will be important to extend the program beyond the current sunset date of June 30, 2025. Finally, participants asked questions about how work/community engagement requirements and the associated reporting process

[26] Montana Department of Public Health and Human Services, "Invitation to Attend Formal Medicaid State-Tribal Consultation on Tuesday, July 16, 2019 in Helena," June 5, 2019, available at https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/6-5-19TribalConsultationFormalInvitation.pdf. Montana Department of Public Health and Human Services, "Medicaid Tribal Consultation Agenda," available at https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/6-5-19TribalConsultationAgenda.pdf.

will be implemented. The State thanked the Tribes for the operational questions and responded that implementation details will be finalized after the approval of the amendment and extension application.

On July 23, 2019, the State issued a second round of written formal tribal consultation letters to ITUs inviting their input on the updated amendment and extension application.[27]

Summary of Changes to Demonstration Amendment and Extension Application
In response to the comments received, the State made the following changes to its application:

- Added language to *Section II, Changes Requested to the Demonstration* to clarify that the State will exempt enrollees from work/community engagement requirements if the State determines an enrollee's income exceeds an amount equal to the average of 80 hours per month multiplied by the minimum wage
- Corrected the number of jobs Medicaid expansion has helped to create to approximately 5,300 between 2016 and 2018

Compliance with Post-Award Public Input Process
Following approval of the HELP Demonstration Program waiver, DPHHS held an initial post-award public forum within 6 months of the implementation date of the waiver and then annually thereafter, using the Medical Care Advisory Committee. Over the course of the Demonstration, the State has continued to update the Medical Care Advisory Committee regularly; these meetings are open to the public. The dates of all public forums were published to the DPHHS website at least 30 days prior to each forum. A list of the forums held to date and their dates are below.

- August 15, 2019 in Helena, Montana
- December 4 and 5, 2018 in Helena, Montana
- December 5, 2017 in Helena, Montana
- November 28, 2016 in Helena, Montana
- August 20, 2015 in Helena, Montana

[27] Montana Department of Public Health and Human Services, "Revised Tribal Consultation Notice Pertaining to Montana Medicaid Expansion Waiver Amendment and Extension," July 23, 2019, available at https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/6-5-19TribalConsultationFormalInvitation.pdf.

Section IX. Public Notice

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION
Public Notice – Updated July 23, 2019

The Montana Department of Public Health and Human Services (DPHHS) is providing a revised public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application.

This notice revises a prior notice issued on June 15, 2019. The revisions to this public notice include additional detail related to the 1115 Demonstration amendment and extension's goals and objectives, enrollment projections and expenditures, waiver authorities, interim federal evaluation findings, and hypotheses that will be tested through the Demonstration.

I. Overview

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

House Bill 658, the Medicaid Reform and Integrity Act, continues the state's Medicaid expansion and directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to implement new Medicaid expansion program features. Therefore, the Department is seeking to amend and extend its current Medicaid Section 1115 Waiver, Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program, to: (1) condition Medicaid coverage on compliance with work/community engagement requirements; and (2) apply a premium structure that gradually increases enrollee premiums based on coverage duration. The HELP Demonstration Program will continue to apply to most Medicaid expansion enrollees eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, as now incorporated into Montana's Medicaid State Plan.

Through the 1115 Demonstration amendment and extension, Montana will continue to provide quality and affordable coverage for the nearly 100,000 low-income Montanans who gained coverage under expansion. The goals and objectives of the demonstration are described in more detail below.

II. Goals and Objectives

Through this Demonstration amendment and extension, Montana seeks to accomplish the following goals and objectives:

- Improve the health, well-being, and financial stability of Montanans through participation in work/community engagement requirements;
- Encourage HELP Demonstration Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions, and ultimately improve their health through changes to the premium structure;
- Improve continuity of coverage and care through 12 month continuous eligibility;
- Increase the availability of high quality health care to Montanans;*
- Provide greater value for the tax dollars spent on the Montana Medicaid program;*
- Reduce health care costs;*
- Boost Montana's economy;* and
- Reduce the costs of uncompensated care and the resulting cost-shifting to patients with health insurance.*

**Indicates original policy objectives of the HELP Demonstration Program.*

II. Program Description

A. Work/Community Engagement Requirements

Montana will condition Medicaid coverage on compliance with work/community engagement requirements for new adult enrollees ages 19 to 55 with incomes up to 138 percent of the federal poverty level (FPL). Non-exempt Demonstration enrollees will be required to participate in 80 hours of work/community engagement activities each month. Qualifying work/community engagement activities include: employment; work readiness and workforce training activities; secondary, postsecondary, or vocational education; substance abuse education or substance use disorder treatment; other work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program; a community service or volunteer opportunity; and any other activity required by the Centers for Medicare and Medicaid Services (CMS) for the purpose of obtaining necessary waivers.

Leveraging available administrative data sources as well as information collection and retention tools, Montana will identify and exempt from work/community engagement requirements enrollees who meet work/community engagement requirements or qualify for certain standard or hardship/good cause exemptions. Demonstration enrollees will also have multiple ways to self-report an exemption or their compliance with work/community engagement requirements, including online, through a call center, by mail, and in person. The Department will notify an enrollee who is not in compliance with the work/community engagement requirements that they have 180 days to come into compliance, and failure to comply within the 180-day period will result in suspension from the program. A suspended enrollee may be reinstated 180 days after the date of suspension or upon a determination by the Department that they are: (a) exempt from the work/community engagement requirements; (b) in compliance with the requirements for 30 days; or (c) meet a Medicaid eligibility category that is not subject to the Demonstration.

B. Cost Sharing: Premium Increase Structure Based on Coverage Duration

Montana intends to extend its waiver authority to require premium payment as a condition of eligibility for Medicaid for new adults enrolled in the Demonstration. Montana is seeking to modify the current Demonstration premium structure to increase premiums based on coverage duration in the HELP Demonstration Program. Enrollees will continue to be required to pay monthly premiums equal to 2 percent of their modified adjusted gross income for the first two years of participation. The premium will increase 0.5 percent in each subsequent year of coverage, up to a maximum of 4 percent of the enrollee's aggregate household income.

As is the case under the current demonstration, enrollees who fail to make payment for overdue premiums will have premium debt assessed against their income taxes by the Department of Revenue. Enrollees with incomes above 100 percent FPL and up to 138 percent FPL who fail to pay premiums will be suspended from coverage until they pay overdue premiums or until the Department of Revenue assesses the premium debt against their income taxes.

Pursuant to State statute, program enrollees who are exempt from the work/community engagement requirement are also exempt from premium increases based on duration of HELP Demonstration Program enrollment.

Demonstration enrollees are currently subject to co-payments. Under this amendment and extension application, Demonstration enrollees will not be subject to co-payments.

C. Eligibility Requirements

Populations eligible for the Demonstration are not changing, but eligibility requirements are changing as described in the Work/Community Engagement Requirements section above.

D. Health Care Delivery System and Benefits

The State does not propose any changes to the Medicaid health care delivery system. Demonstration enrollees will continue to receive services through the State's fee-for-service delivery system.

Demonstration enrollees will also continue to receive benefits through the Alternative Benefit Plan; the State does not propose any changes to benefits for Demonstration enrollees.

III. Enrollment Projections and Annual Expenditures

To predict future costs, adjustments to reflect enrollment trends based on the proposed work/community engagement activities and premium changes were predicted based on available administrative data related to work requirement exemptions and compliance requirements and the State's recent experience with premium disenrollment. We have broken out the analysis of the projected impact of work/community engagement requirements and premium collections to more clearly reflect assumptions related to each requirement, and note that some beneficiaries will be subject to both requirements. Finally, in providing these estimates, the State notes that because work/community engagement requirements is a new policy, and one with little precedent nationally, it

is impossible to predict future enrollment effects of the Demonstration with certainty, and that coverage losses could be greater.

The State estimates that, on average, 100,000 adults will be enrolled in the HELP Demonstration Program and be subject to work/community engagement requirements. The State estimates that through the review of available administrative data, 74 percent of enrollees will be exempt from or compliant with work/community engagement requirements. Of the remaining 26 percent of enrollees, the State predicts that between 4 percent and 12 percent of enrollees will not report or fail to meet the work/community engagement requirement.

Evaluations of Montana's current premium requirement indicate that in 2018, 2.9 percent of beneficiaries subject to premiums with income above 100 percent of the FPL, the group subject to disenrollment for failing to pay premiums, were disenrolled for non-payment. The proposed Demonstration amendment and extension would increase premium obligations from 2 percent of income to 4 percent of income based on the duration of beneficiaries' enrollment and continue the State's authority to suspend individuals over 100 percent FPL who fail to pay their premiums. There is overlap across beneficiaries who could lose coverage for non-payment of premiums and non-compliance with work/community engagement requirements and thus there are limitations with the estimates of the projected coverage losses.

Pursuant to State statute, program enrollees who are exempt from the work/community engagement requirement are also exempt from premium increase. Given that the populations projected to lose coverage overlap, and that the exemptions for premiums under the current demonstration are intended to continue, the State expects that the disenrollment rate for non-payment of premiums will continue at 2.9 percent. In providing these estimates, the State notes that because the premium increases based on coverage duration is a new policy it is impossible to predict future enrollment effects of the Demonstration with certainty, and that coverage losses as a result of premium non-payment could be greater.

Based on the assumptions above, the table below depicts Montana's enrollment projections, by total member months, taking into account the proposed changes to the HELP Demonstration Program. The table also includes the State's budget projections for Demonstration spending.

Figure 1. **Projected Enrollment and Expenditures for HELP Demonstration Expansion Population, Assuming Adoption of Work/Community Engagement Requirements and Premium Payment Requirements**[28]

	DY1	DY2	DY3	DY4	DY5
Estimated Number of Member Months	1,200,000	1,212,000	1,224,120	1,236,361	1,248,725
Estimated	888,360	897,243	906,216	915,278	924,430

[28] Estimated enrollment is expected to grow in proportion to Montana's population growth which is estimated at 1 percent per year. This growth assumption is applied to all member month rows in Figure 5.

	DY1	DY2	DY3	DY4	DY5
Number of Member Months For Enrollees Determined Exempt or Compliant via Administrative Data					
Member Months Subject to Work/Community Engagement Requirements And Not Determined Exempt or Compliant Via Administrative Data	311,640	314,756	317,903	321,083	324,294
Member Months Noncompliant with Work/Community Engagement Reporting or Participation Requirements (Disenrolled)	48,000 – 144,000	48,480 – 145,440	48,965 – 146,894	49,454 – 148,363	49,949 – 149,847
Member Months over 100% FPL Subject to Premium Requirements	97,416	98,390	99,374	100,368	101,371
Member Months over 100% FPL Noncompliant with Premium Requirements (Disenrolled)	2,825	2,853	2,882	2,911	2,940
Total Member Months Less Member Months Removed	1,053,175 – 1,149,175	1,063,707 – 1,161,667	1,074,344 – 1,172,273	1,085,087 – 1,183,996	1,095,938 – 1,195,836
PMPM	$660.60	$662.80	$666.22	$669.74	$673.27

	DY1	DY2	DY3	DY4	DY5
Total Costs	$695,724,593 – $759,141,941	$705,027,502 – $769,292,837	$715,755,966 – $780,999,232	$726,723,053 – $792,966,001	$737,858,181 - $805,116,129

IV. Waiver and Expenditure Authorities

The State will request to continue the waivers and expenditure authorities currently approved under the demonstration except as indicated below. In addition, the State is seeking the following new waivers and expenditure authorities in the 1115 Demonstration amendment and extension application.

Figure 2. **Waiver Authority Requests**

Waiver Authority	Use of Waiver	Currently Approved Waiver Request?
§ 1902(a)(8)	To waive the reasonable promptness requirement to permit suspension or termination of eligibility for Demonstration enrollees who fail to comply with certain Demonstration requirements.	No
§ 1902(a)(14) **§ 1916**	To impose monthly premiums not to exceed 4 percent of household income.	No

Demonstration enrollees are currently subject to co-payments. Under this amendment and extension application, Demonstration enrollees will not be subject to co-payments and therefore the State is no longer requesting waiver authority of § 1902(a)(17).

The State is seeking § 1115(a)(2) expenditure authority to apply 12 month continuous eligibility to Medicaid eligible adults. This expenditure authority was approved under the current demonstration.

V. Demonstration Hypotheses and Evaluation Parameters

Montana plans to continue participation in the federal evaluation through federal fiscal year 2019; the federal evaluators released a Draft Interim Evaluation Report in July 2019. The State intends to contract with an independent third party to evaluate: the objectives and hypotheses that are approved under the current Demonstration that the State is seeking to extend; and the objectives and hypotheses for the new authorities requested for this Demonstration including those related to work/community engagement and the premiums.

The hypotheses under consideration for the new authorities requested for this Demonstration amendment and extension period are below.

Figure 3. **Evaluation Hypotheses Under Consideration**

Hypothesis	Selected Outcome Measures & Analytic Approaches	Data Sources
Work/Community Engagement		
Enrollees enrolled in the Demonstration will secure sustained employment.	Analyze enrollee employment outcomes	• Eligibility and enrollment data • Enrollee survey data • State and national survey data • Other state administrative data sources
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Analyze coverage outcomes	• Eligibility and enrollment data • Enrollee survey data • State and national survey data
The Demonstration's work/community engagement requirements will not deter eligible enrollees from applying for or renewing Medicaid coverage.	Analyze coverage trends pre/post implementation	• State and national survey data • Eligibility and enrollment data • Enrollee survey data
Participation in the Demonstration's work/community engagement requirements will improve current and former enrollee health and well-being, compared to Medicaid beneficiaries not subject to the requirements.	Analyze enrollee utilization, diagnoses, and self-reported health	• Utilization and diagnoses data, including preventive services • Enrollee survey data • State and national survey data • Health outcomes data
Work/community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	Analyze enrollee income	• Enrollee survey data • State and national survey data
Premium Increase Structure Based on Coverage Duration		
Conditioning coverage among enrollees with incomes above 100 percent FPL on payment of gradually increasing premiums will promote continuous coverage and continuity	Analyze coverage gaps and utilization trends	• Eligibility and enrollment data • Enrollee survey data

Hypothesis	Selected Outcome Measures & Analytic Approaches	Data Sources
of care.		
Premiums will not deter eligible enrollees from applying for, enrolling in or renewing Medicaid coverage.	Analyze coverage trends pre/post implementation and within and inside/outside Medicaid	• Enrollee survey data • State and national survey data • Eligibility and enrollment data
Enrollees who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.	Analyze familiarity with premiums pre/post implementation	• Enrollee survey data • State and national survey data

VI. Public Review and Comment Process

The complete version of the updated draft of the Demonstration amendment and extension application is available for public review at https://dphhs.mt.gov/MedicaidExpExt. Paper copies are available to be picked up in person at DPHHS offices located at 111 North Sanders Street, Helena, Montana 59601.

Two public meetings will be held regarding the Demonstration amendment and extension application:
(1) July 31, 2019 from 11:30 am to 1:30 pm MT at the Billings Clinic, Conference Center, 2800 10th Avenue North, Billings, Montana.
(2) August 1, 2019 from 11:00 am to 1:00 pm MT at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

To register for one or both meetings, use the following link, https://dphhs.mt.gov/MedicaidExpExt. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact (406) 444-2584.

Public comments may be submitted until midnight on August 23, 2019. Questions or public comments may be addressed care of Medicaid Expansion Extension, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov.

After Montana reviews comments submitted during this state public comment period, we will submit a revised application to CMS. Interested parties will also have opportunity to officially comment during the federal public comment period; the submitted application will be available for comment on the CMS website at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

Appendices

A. Monitoring and Evaluation Reports

a. Federal Evaluation of HELP: Interim Evaluation Report, July 2019 *or see Appendix E for a copy of the Report.*

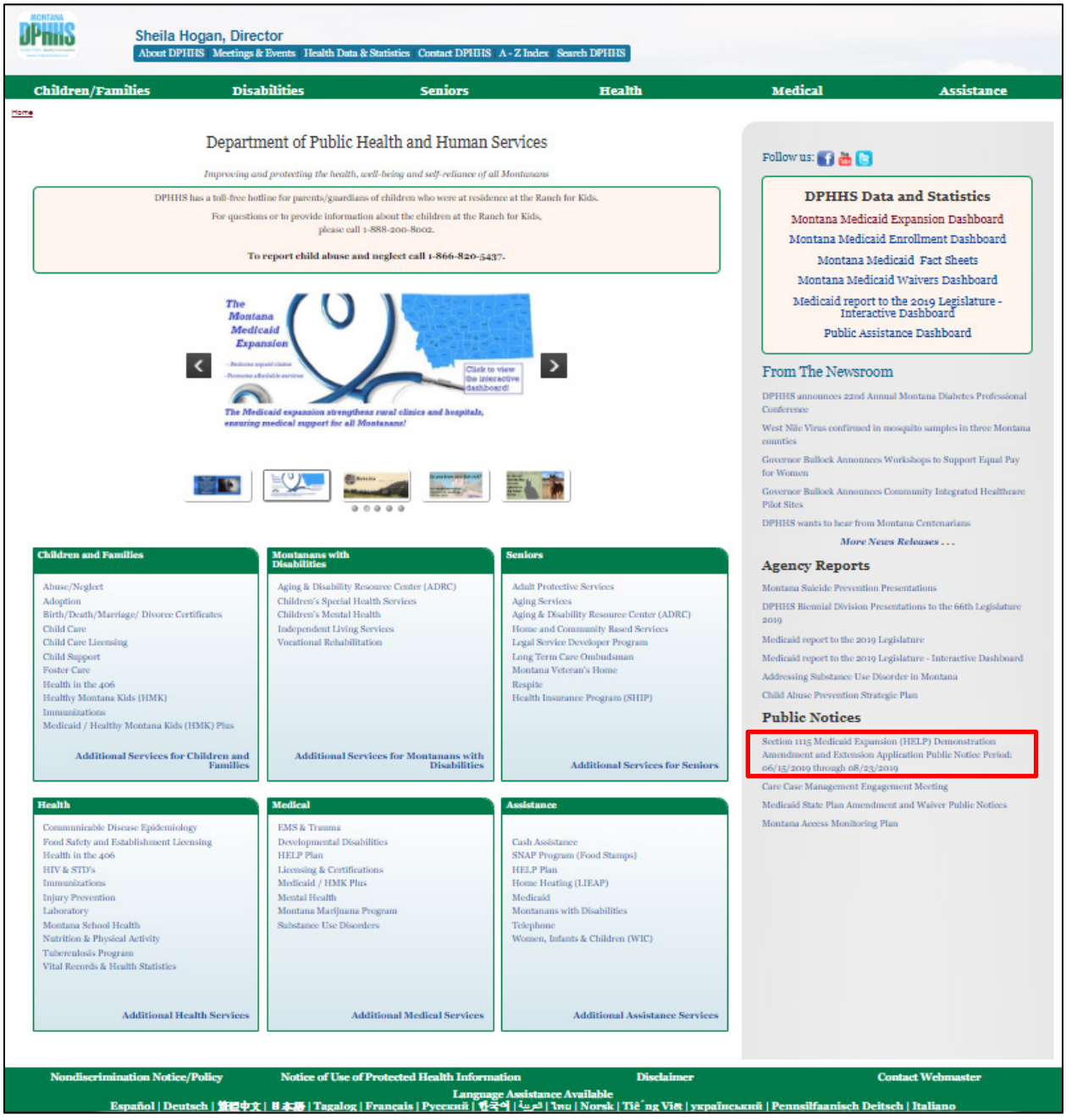
b. Federal Evaluation: Montana Health and Economic Livelihood Partnership Plan, A Look at the Program A Year and a Half into Implementation, December 2018

c. Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration: Section 1115 Annual Report, Demonstration Year: 3 (01/01/18 – 12/31/18)

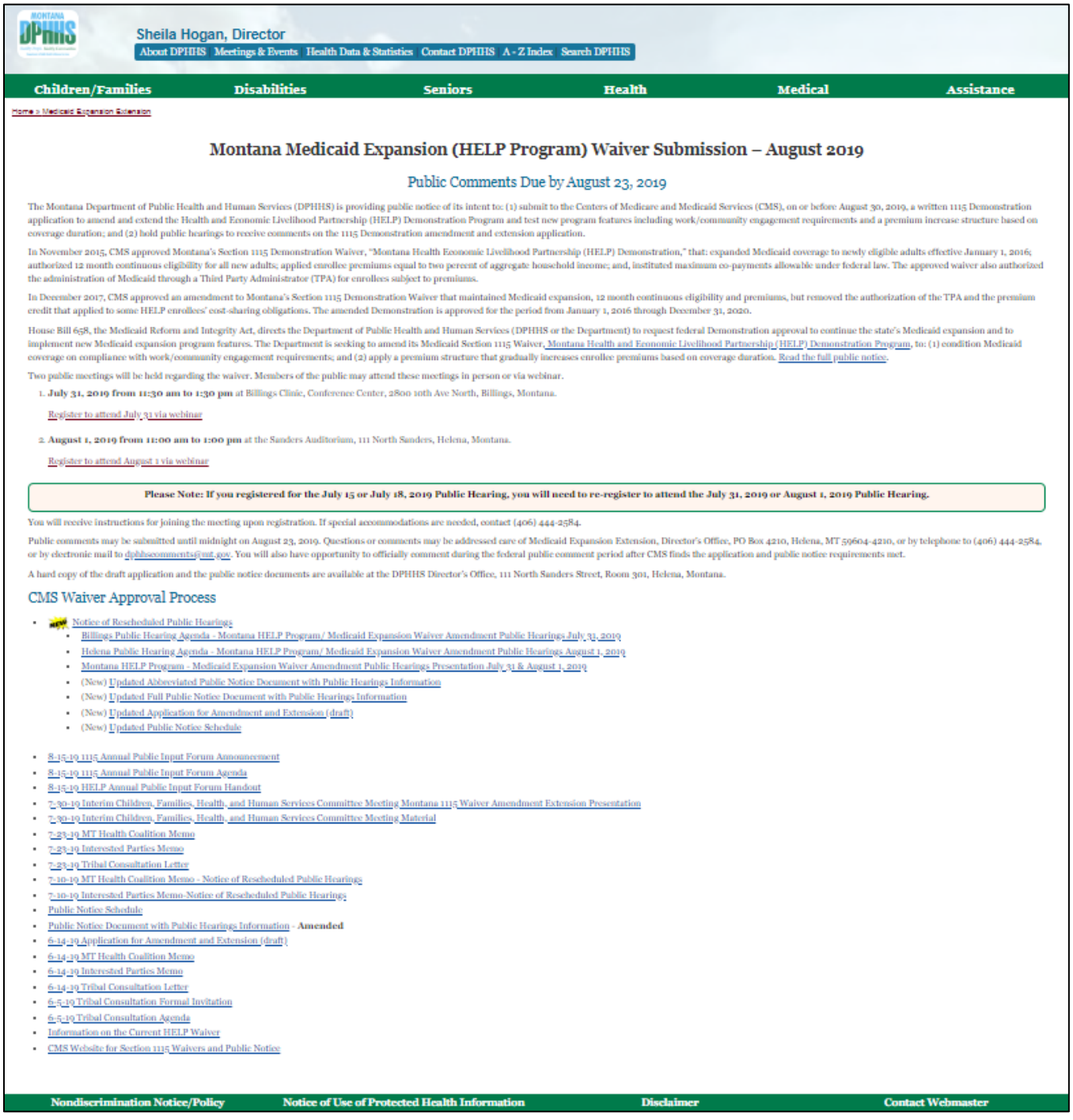
d. Montana Help Oversight Committee's 2018 Report to the Governor and Legislative Finance Committee and 2016 Report to the Governor and Legislative Finance Committee

B. Documentation of Compliance with Public Notice Process

Montana DPHHS Main Webpage
https://dphhs.mt.gov/



HELP Program Waiver Submission Webpage
https://dphhs.mt.gov/medicaidexpext



Sheila Hogan, Director

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Children/Families | Disabilities | Seniors | Health | Medical Assistance

Home » Medicaid Expansion Extension

Montana Medicaid Expansion (HELP Program) Waiver Submission – August 2019

Public Comments Due by August 23, 2019

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium increase structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application.

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

House Bill 658, the Medicaid Reform and Integrity Act, directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to continue the state's Medicaid expansion and to implement new Medicaid expansion program features. The Department is seeking to amend its Medicaid Section 1115 Waiver, Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program, to: (1) condition Medicaid coverage on compliance with work/community engagement requirements; and (2) apply a premium structure that gradually increases enrollee premiums based on coverage duration. Read the full public notice.

Two public meetings will be held regarding the waiver. Members of the public may attend these meetings in person or via webinar.

1. **July 31, 2019 from 11:30 am to 1:30 pm** at Billings Clinic, Conference Center, 2800 10th Ave North, Billings, Montana.

   Register to attend July 31 via webinar

2. **August 1, 2019 from 11:00 am to 1:00 pm** at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

   Register to attend August 1 via webinar

Please Note: If you registered for the July 15 or July 18, 2019 Public Hearing, you will need to re-register to attend the July 31, 2019 or August 1, 2019 Public Hearing.

You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact (406) 444-2584.

Public comments may be submitted until midnight on August 23, 2019. Questions or comments may be addressed care of Medicaid Expansion Extension, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov. You will also have opportunity to officially comment during the federal public comment period after CMS finds the application and public notice requirements met.

A hard copy of the draft application and the public notice documents are available at the DPHHS Director's Office, 111 North Sanders Street, Room 301, Helena, Montana.

CMS Waiver Approval Process

- NEW! Notice of Rescheduled Public Hearings
  - Billings Public Hearing Agenda - Montana HELP Program/ Medicaid Expansion Waiver Amendment Public Hearings July 31, 2019
  - Helena Public Hearing Agenda - Montana HELP Program/ Medicaid Expansion Waiver Amendment Public Hearings August 1, 2019
  - Montana HELP Program - Medicaid Expansion Waiver Amendment Public Hearings Presentation July 31 & August 1, 2019
  - (New) Updated Abbreviated Public Notice Document with Public Hearings Information
  - (New) Updated Full Public Notice Document with Public Hearings Information
  - (New) Updated Application for Amendment and Extension (draft)
  - (New) Updated Public Notice Schedule

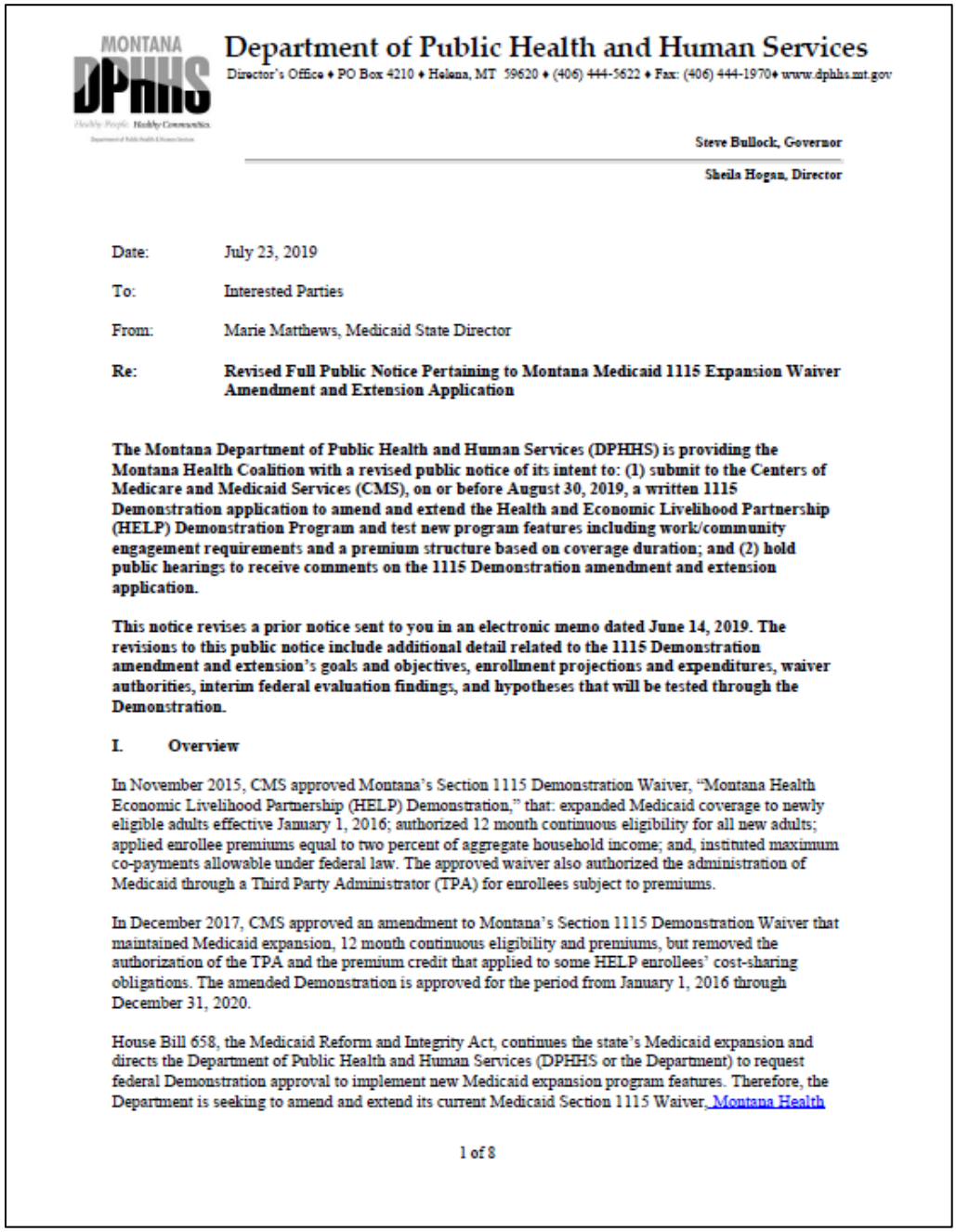
- 8-15-19 1115 Annual Public Input Forum Announcement
- 8-15-19 1115 Annual Public Input Forum Agenda
- 8-15-19 HELP Annual Public Input Forum Handout
- 7-30-19 Interim Children, Families, Health, and Human Services Committee Meeting Montana 1115 Waiver Amendment Extension Presentation
- 7-30-19 Interim Children, Families, Health, and Human Services Committee Meeting Material
- 7-23-19 MT Health Coalition Memo
- 7-23-19 Interested Parties Memo
- 7-23-19 Tribal Consultation Letter
- 7-10-19 MT Health Coalition Memo - Notice of Rescheduled Public Hearings
- 7-10-19 Interested Parties Memo-Notice of Rescheduled Public Hearings
- Public Notice Schedule
- Public Notice Document with Public Hearings Information - **Amended**
- 6-14-19 Application for Amendment and Extension (draft)
- 6-14-19 MT Health Coalition Memo
- 6-14-19 Interested Parties Memo
- 6-14-19 Tribal Consultation Letter
- 6-5-19 Tribal Consultation Formal Invitation
- 6-5-19 Tribal Consultation Agenda
- Information on the Current HELP Waiver
- CMS Website for Section 1115 Waivers and Public Notice

Nondiscrimination Notice/Policy | Notice of Use of Protected Health Information | Disclaimer | Contact Webmaster

Interested Parties Email, Revised Public Notice

https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/072319InterestedPartiesMemo.pdf

Please visit the URL above to view the full memo.



MONTANA DPHHS

Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Steve Bullock, Governor

Sheila Hogan, Director

Date: July 23, 2019

To: Interested Parties

From: Marie Matthews, Medicaid State Director

Re: Revised Full Public Notice Pertaining to Montana Medicaid 1115 Expansion Waiver Amendment and Extension Application

The Montana Department of Public Health and Human Services (DPHHS) is providing the Montana Health Coalition with a revised public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application.

This notice revises a prior notice sent to you in an electronic memo dated June 14, 2019. The revisions to this public notice include additional detail related to the 1115 Demonstration amendment and extension's goals and objectives, enrollment projections and expenditures, waiver authorities, interim federal evaluation findings, and hypotheses that will be tested through the Demonstration.

I. Overview

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

House Bill 658, the Medicaid Reform and Integrity Act, continues the state's Medicaid expansion and directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to implement new Medicaid expansion program features. Therefore, the Department is seeking to amend and extend its current Medicaid Section 1115 Waiver, Montana Health

1 of 8

Montana Health Coalition Memo, Revised Public Notice
https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/072319MTHealthCoalitionMemo.pdf
Please visit the URL above to view the full memo.

MONTANA DPHHS
Healthy People. Healthy Communities.

Department of Public Health and Human Services
Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Steve Bullock, Governor

Sheila Hogan, Director

Date: July 23, 2019

To: Montana Health Coalition Members, Ad Hoc Members, and Interested Parties

From: Marie Matthews, Medicaid State Director

Re: Revised Full Public Notice Pertaining to Montana Medicaid 1115 Expansion Waiver Amendment and Extension Application

The Montana Department of Public Health and Human Services (DPHHS) is providing the Montana Health Coalition with a revised public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application.

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

House Bill 658, the Medicaid Reform and Integrity Act, continues the state's Medicaid expansion and directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to implement new Medicaid expansion program features. Therefore, the Department is seeking to amend and extend its current Medicaid Section 1115 Waiver, Montana Health

Revised Tribal Consultation Notice

https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/072319TribalConsultationLetter.pdf

Please visit the URL above to view the full notice.

MONTANA DPHHS
Department of Public Health and Human Services
Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970 ♦ www.dphhs.mt.gov

Steve Bullock, Governor
Sheila Hogan, Director

The Honorable [First Name] [Last Name]
[Title]
[Organization]
[Address]
[City], [State] [Zip]

July 23, 2019

Re: Revised Tribal Consultation Notice Pertaining to Montana Medicaid Expansion Waiver Amendment and Extension

Dear [Title] [Last Name]:

The Montana Department of Public Health and Human Services (DPHHS) is providing Tribal Chairs, Tribal Presidents, Urban Indian Health Center Executive Directors and Indian Health Service (IHS) with a revised notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application. This notice revises a prior notice sent to you in a letter dated June 14, 2019.

The revisions to this public notice include additional detail related to the 1115 Demonstration amendment and extension's goals and objectives, enrollment projections and expenditures, waiver authorities, interim federal evaluation findings, and hypotheses that will be tested through the Demonstration.

I. Overview

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

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Tribal Consultation Invitation

https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/6-5-19TribalConsultationFormalInvitation.pdf

Please visit the URL above to view the full invitation.

MONTANA DPHHS Healthy People. Healthy Communities.

Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Steve Bullock, Governor

Sheila Hogan, Director

June 5, 2019

The Honorable [First Name] [Last Name]
[Title]
[Company Name]
[Address Line 1]
[City], [State] [Zip Code]

Re: **Invitation to Attend Formal Medicaid State-Tribal Consultation on Tuesday, July 16, 2019, in Helena**

Dear [Title] [Last Name]:

The Montana Department of Public Health and Human Services (DPHHS) would like to request your presence and participation in a formal Medicaid Tribal Consultation in Helena. This consultation is being conducted with representatives from Tribal Governments, Urban Indian Health Centers and the Indian Health Service.

This important Medicaid Tribal Consultation is scheduled for **Tuesday, July 16, 2019, from 8:30 am to 4:00 pm in Helena**. It will be held at the DPHHS Cogswell Building, 1400 Broadway Street, in the combined meeting rooms C205, C207 and C209. Lunch will be provided.

The attached draft agenda focuses on: a) the changes to the Montana Medicaid Expansion program; and b) implementation of House Bill 658 from the 66th Montana Legislative Session. Consultation topics will include:

- Revised Medicaid eligibility verification.
- New community engagement requirements and exemptions.
- Changes in premium structure and copayments.
- American Indian/Alaska Native cost sharing protections.

In addition to the consultation topics, we will discuss the Department's timeline for submission, negotiation and implementation of the new Montana Medicaid Expansion provisions.

1

Notice of Rescheduled Public Hearings

https://dphhs.mt.gov/Portals/85/MedicaidWaivers/expansionextension/NoticeofRescheduledPublicHearings.pdf

Notice of Rescheduled Public Hearings

The Department of Public Health and Human Services is rescheduling the Medicaid Expansion Hearings in order to provide additional information in the notice of waiver application, as requested by the Centers for Medicare and Medicaid Services. The rescheduled hearings will give interested parties additional time to review materials prior to the public hearings.

Therefore, the Medicaid Expansion hearings previously set for Monday, July 15, 2019, in Helena, and Thursday, July 18, 2019, in Billings, will not take place.

The rescheduled hearings will take place:

(1) July 31, 2019, from 11:30 am to 1:30 pm, at Billings Clinic, Conference Center, 2800 10th Avenue North, Billings, Montana.

(2) August 1, 2019, from 11:00 am to 1:00 pm, at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

To register for one or both hearings, use the following link, https://dphhs.mt.gov/MedicaidExpExt. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact (406) 444-2584.

Newspaper Affidavits

AFFIDAVIT OF PUBLICATION
THE BILLINGS GAZETTE

401 N 28th St
Billings, MT 59101
Phone: (406) 657-1212 Fax: (406) 657-1345

Received
JUN 20 2019
Director's Office
DPHHS

Ad Number: 20892808

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION
Public Notice

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, written amendment and extension application for an 1115 Waiver to amend and extend the Health and Economic Livelihood Partnership (HELP) Program and test new program features including work/ community engagement requirements and a premium increase structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Waiver amendment and extension application.

On 5/9/19, Governor Steve Bullock signed into law House Bill 658, the Medicaid Reform and Integrity Act, that directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to continue the state's Medicaid expansion and to implement new Medicaid expansion program features. The Department is seeking to amend its Medicaid Section 1115 Waiver, Montana Health and Economic Livelihood Partnership (HELP) Program, to: (1) condition Medicaid coverage on compliance with work/community engagement requirements; and (2) apply a premium structure that gradually increases enrollee premiums based on coverage duration.

Through the 1115 Waiver amendment and extension, Montana will continue to provide quality and affordable coverage for the nearly 100,000 low-income Montanans who gained coverage under expansion.

Work/Community Engagement Requirements
Montana will condition Medicaid coverage on compliance with work/ community engagement requirements for Demonstration enrollees enrolled in HELP with incomes up to 138% of the federal poverty level (FPL). Non-exempt Demonstration enrollees will be required to participate in 80 hours of work/community engagement activities each month. Qualifying work/community engagement activities include: employment; work readiness and workforce training activities; secondary, postsecondary, or vocational education; substance abuse education or substance use disorder treatment; other work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program; a community service or volunteer opportunity; and any other activity required by the Centers for Medicare and Medicaid Services (CMS) for the purpose of obtaining necessary waivers.

Jessica Bledsoe, being first duly sworn, deposes and says. That she is the principal clerk of The Billings Gazette, a newspaper of general circulation published daily in the City of Billings, in the County of Yellowstone, State of Montana, and has charge of the Advertisements thereof.

That the: 13 Folio legal regarding:
a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

6/18/19

Making all 1 publication(s)

Mark below if certification for the State of Montana

I hereby certify that I have read sec. 18-7-204 and 18-7-205, MCA, and subsequent revisions, and declare that the price or rate charged the State of Montana for the publication for which claim is made in the attached papers in the amount of $169.00 is not in excess of the minimum rate charged any other advertiser for publication of advertisement, set in the same size type and published for the same number of insertions, further certify that this claim is correct and just in all respects, and that payment or credit has not been received

STATE OF MONTANA
County of Yellowstone

On this day of June 18, 2019 before me, the undersigned, a Notary Public for the State of Montana, personally appeared Jessica Bledsoe known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed same. IN WITNESS WHERFOF, I have hereunto set my hand and affixed my notarial seal the day and year first above written.

NOTARY PUBLIC for the State of Montana
Residing at Billings, MT

My commission expires: June 25, 2019

TAMMY WARD NOTARIAL SEAL STATE OF MONTANA
TAMMY WARD
NOTARY PUBLIC for the
State of Montana
Residing at Billings, Montana
My Commission Expires
June 25, 2019

Leveraging available administrative data sources as well as information collection and retention tools, Montana will identify and exempt enrollees who meet work/community engagement requirements or qualify for certain standard or hardship/good cause exemptions. Demonstration enrollees will also have multiple ways to self-report an exemption or their compliance with work/community engagement requirements, including online, through a call center, by mail, and in person. The Department will notify an enrollee who is not in compliance with the work/community engagement requirements that they have 180 days to come into compliance, and failure to comply within the 180-day period will result in suspension from the program. A suspended enrollee may be reinstated 180 days after the date of suspension or upon a determination by the Department that they are: (a) exempt from the work/community engagement requirements; (b) in compliance with the requirements for 30 days; or (c) meet a Medicaid eligibility category that is not subject to the Demonstration.

Premium Increase Structure Based on Coverage Duration

Montana will also require enrollees to pay monthly premiums that increase based on duration of enrollment in the HELP program. Enrollees will be required to pay monthly premiums equal to 2% of their modified adjusted gross income for the first 2 years of participation. The premium will increase 0.5% in each subsequent year of coverage, up to a maximum of 4% of the enrollee's aggregate household income. Enrollees who fail to make payment for overdue premiums will have premium debt assessed against their income taxes by the Department of Revenue. Enrollees with incomes above 100% FPL and up to 138 FPL who fail to pay premiums will be suspended from coverage until they pay overdue premiums or until the Department of Revenue assess the premium debt against their income taxes.

The State will request the following waivers in the 1115 Demonstration Waiver:

- § 1902(a)(8): To waive the reasonable promptness requirement to permit suspension of eligibility for Demonstration enrollees who fail to comply with work/community engagement requirements.
- § 1902(a)(8): To waive the reasonable promptness requirement and permit disenrollment of Demonstration enrollees with incomes above 100% of the FPL who fail to pay required premiums.
- § 1902(a)(14): To impose monthly premiums not to exceed 4 percent of household income.
- § 1902(a)(17)*: To waive Medicaid comparability requirements to enable the State to vary cost-sharing requirements for enrollees who would otherwise be subject to the State Plan and to enable the State to charge targeted cost sharing to non-exempt individuals with income greater than 50 percent of the FPL.
- § 1902(e)(12)*: To apply 12 month continuous eligibility to Medicaid eligible adults.

**Waivers being requested are the same as those approved in the current demonstration*

The Demonstration will be Statewide and will operate for 5 years following Demonstration approval. Montana estimates that 88,019 individuals (92%) will either meet or be exempt from the work/community engagement requirements. The remaining 8,163 individuals (8%) would be required to participate in and report on work/community engagement activities to remain eligible for Medicaid; based on the experience of other states requiring work activities to remain eligible for healthcare coverage, the Department estimates 50% of these individuals will be unable to meet the community engagement activities, exemptions, or reporting requirements. This will result in the projected disenrollment of 4,081 enrollees from health coverage.[1]

The Demonstration will test the following hypotheses related to promoting continuous coverage and continuity of care, securing employment, promoting financial stability, and improving health and well-being.

- Enrollees in the Demonstration will secure sustained employment.
- Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.
- The Demonstration's work/community engagement requirements will not deter eligible enrollees from applying for or renewing Medicaid coverage.
- Participation in the Demonstration's work/community engagement requirements will improve current and former enrollee health and well-being, compared to Medicaid beneficiaries not subject to the requirements.
- Work/community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.
- Conditioning coverage among enrollees with incomes above 100% FPL on payment of gradually increasing premiums will promote continuous coverage and continuity of care.
- Premiums will not deter eligible enrollees from applying for, enrolling in or renewing Medicaid coverage.
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Two public meetings will be held regarding the waiver:
(1) 7/15/19 from 10:00 am to 12:00 pm in the Sanders Auditorium, 111 North Sanders, Helena, Montana.
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Published June 18, 2019

GREAT FALLS TRIBUNE
PART OF THE USA TODAY NETWORK

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THE GREAT FALLS TRIBUNE
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GREAT FALLS, MT 59405
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Toll Free (800) 438-6600

FAL-6COL Legal

MT DEPT PHHS/MEDICAID
ROOM 301
HELENA, MT 59601

REFERENCE: FAL-015602 **CASE NO:**
0003629330 √ 1115 DEMONSTRATION AMEI

I, being first duly sworn deposes and says that GREAT FALLS TRIBUNE COMPANY is a corporation duly incorporated under the laws of the State of Delaware, that the said GREAT FALLS TRIBUNE COMPANY is the printer and publisher of the GREAT FALLS TRIBUNE, a daily newspaper of general circulation of the County of Cascade, State of Montana, and that the deponent is the principal clerk of said GREAT FALLS TRIBUNE COMPANY, printer of the GREAT FALLS TRIBUNE, and that the advertisement here to annexed...

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION Public Notice The Montana Department of Public He

Has been correctly published 1 times in the regular and entire issue of said paper on the following dates:

06/18/19

LEGAL CLERK

7/12/19
DATE

known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

In witness whereof, I have hereunto set my hand and affixed my Notarial Seal of the day and year first above written.

State of Wisconsin, County of Brown Notary Public

4-19-21
Notary Expires

# of Affidavits 1

VICKY FELTY NOTARY PUBLIC STATE OF WISCONSIN

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION

Public Notice

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On 5/9/19, Governor Steve Bullock signed into law House Bill 658, the Medicaid Reform and Integrity Act, that directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to continue the state's Medicaid expansion and to implement new Medicaid expansion program features. The Department is seeking to amend its Medicaid Section 1115 Waiver, Montana Health and Economic Livelihood Partnership (HELP) Program, to: (1) condition Medicaid coverage on compliance with work/community engagement requirements; and (2) apply a premium structure that gradually increases enrollee premiums based on coverage duration.

Through the 1115 Waiver amendment and extension, Montana will continue to provide quality and affordable coverage for the nearly 100,000 low-income Montanans who gained coverage under expansion.

Work/Community Engagement Requirements

Montana will condition Medicaid coverage on compliance with work/community engagement requirements for Demonstration enrollees enrolled in HELP with incomes up to 138 percent of the federal poverty level (FPL). Non-exempt Demonstration enrollees will be required to participate in 80 hours of work/community engagement activities each month. Qualifying work/community engagement activities include: employment; work readiness and workforce training activities; secondary, postsecondary, or vocational education; substance abuse education or substance use disorder treatment; other work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program; a community service or volunteer opportunity; and any other activity required by the Centers for Medicare and Medicaid Services (CMS) for the purpose of obtaining necessary waivers.

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(3629330) 6/18/2019.

MNAXLP

AFFIDAVIT OF PUBLICATION
THE MISSOULIAN

500 S. Higgins Ave.
Missoula, MT 59801
Phone: (406) 523-5236 Fax: (406) 523-5221

Ad Number: 0057373714

Chris Arvish, being first duly sworn, deposes and says that he is a Classified Advertising Representative of The Missoulian, a newspaper of general circulation published daily in the City of Missoula, in the County of Missoula, State of Montana, and has charge of the Advertisements thereof.

That the legal regarding:

Public Notice

a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

June 18, 2019

Making all 1 publication(s)

Signed: Chris Arvish

Chris Arvish

Received
JUL 01 2019
Director's Office
DPHHS

State of Montana
County of Missoula

Subscribed & sworn before me this 27th day of June 2019 by Chris Arvish.

Barbara L Garrison

Notary Public for the State of Montana

BARBARA L GARRISON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 02, 2020.

BARBARA L GARRISON NOTARIAL SEAL STATE OF MONTANA

Order Number	:	20573714	Ad Number	:	11452589
PO Number	:		Ad Key	:	
Customer	:	60075826 DPHHS - Medicaid Expansion	Salesperson	:	DF01 - Default Transient DF01
Contact	:	Director's Office, Mary Eve Ku	Publication	:	Online Liners
Address1	:	PO Box 4210	Section	:	Classified
Address2	:		Sub Section	:	Legals
City St Zip	:	Helena MT 59604	Category	:	399 Legals
Phone	:	(406) 444-2584	Dates Run	:	06/18/2019-06/18/2019
Fax	:		Days	:	1
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Printed By	:	misarvic	Words	:	1238
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			Ad Price	:	174.00
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Keywords	:	MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND E			
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Contact	:	Director's Office, Mary Eve Ku	Publication	:	Online Liners
Address1	:	PO Box 4210	Section	:	Classified
Address2	:		Sub Section	:	Legals
City St Zip	:	Helena MT 59604	Category	:	399 Legals
Phone	:	(406) 444-2584	Dates Run	:	06/18/2019-06/18/2019
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Address1	:	PO Box 4210	**Section**	:	Classified
Address2	:		**Sub Section**	:	Legals
City St Zip	:	Helena MT 59604	**Category**	:	399 Legals
Phone	:	(406) 444-2584	**Dates Run**	:	06/18/2019-06/18/2019
Fax	:		**Days**	:	1
	:		**Size**	:	2 x 14.60, 156 lines
Printed By	:	misarvic	**Words**	:	1238
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Notes	:				
Zones	:				

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#20573714 June 18, 2019

AFFIDAVIT OF PUBLICATION
THE BILLINGS GAZETTE

401 N 28th St
Billings, MT 59101
Phone: (406) 657-1212 Fax: (406) 657-1345

Ad Number: 20995508

Notice of Rescheduled Public Hearings

The Department of Public Health and Human Services is rescheduling the Medicaid Expansion Hearings in order to provide additional information in the notice of waiver application, as requested by the Centers for Medicare and Medicaid Services. The rescheduled hearings will give interested parties additional time to review materials prior to the public hearings.

Therefore, the Medicaid Expansion hearings previously set for Monday, July 15, 2019, in Helena, and Thursday, July 18, 2019, in Billings, will not take place.

The rescheduled hearings will take place:

(1) July 31, 2019, from 11:30 am to 1:30 pm, at Billings Clinic, Conference Center, 2800 10th Avenue North, Billings, Montana.

(2) August 1, 2019, from 11:00 am to 1:00 pm, at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

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Published July 15, 2019

Jessica Bledsoe, being first duly sworn, deposes and says. That she is the principal clerk of The Billings Gazette, a newspaper of general circulation published daily in the City of Billings, in the County of Yellowstone, State of Montana, and has charge of the Advertisements thereof.

That the: 2501.0 legal regarding:
a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

7/15/19

Making all 1 publication(s)

Mark below if certification for the State of Montana

X I hereby certify that I have read sec. 18-7-204 and 18-7-205, MCA, and subsequent revisions, and declare that the price or rate charged the State of Montana for the publication for which claim is made in the attached papers in the amount of $ 26.00 is not in excess of the minimum rate charged any other advertiser for publication of advertisement, set in the same size type and published for the same number of insertions, further certify that this claim is correct and just in all respects, and that payment or credit has not been received

Jessica Bledsoe

STATE OF MONTANA
County of Yellowstone

On this day of July 15 20 19 before me, the undersigned, a Notary Public for the State of Montana, personally appeared Jessica Bledsoe known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed same. IN WITNESS WHERFOF, I have hereunto set my hand and affixed my notarial seal the day and year first above written.

Tammy Ward

NOTARY PUBLIC for the State of Montana
Residing at **Billings, MT**

My commission expires: June 25, 2023

TAMMY WARD NOTARIAL SEAL STATE OF MONTANA

TAMMY WARD
NOTARY PUBLIC for the
State of Montana
Residing at Billings, Montana
My Commission Expires
June 25, 2023

Page	:	1 of 1 07/11/2019 13:10:09	**Ad Number**	:	11010648
			Ad Key	:	
Order Number	:	20455768	**Salesperson**	:	IR02 - Cathyann Christian IR02
PO Number	:		**Publication**	:	Independent Record On-Line
Customer	:	60013893 MT ST DPHHS Disability Servi	**Section**	:	Class Section
Contact	:	Mary Eve Kulawik	**Sub Section**	:	Legal
Address1	:	P.O. Box 4210	**Category**	:	9999 Legals
Address2	:		**Dates Run**	:	07/15/2019-07/15/2019
City St Zip	:	Helena MT 59604	**Days**	:	1
Phone	:	(406) 444-5647	**Size**	:	2 x 2.33, 21 lines
Fax	:		**Words**	:	163
	:		**Ad Rate**	:	Legal2019
Printed By	:	Cathyann Christian	**Ad Price**	:	21.19
Entered By	:	Cathyann Christian	**Amount Paid**	:	0.00
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Received
JUL 17 2019
Director's
DPHH...

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(2) August 1, 2019, from 11:00 am to 1:00 pm, at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

To register for one or both hearings, use the following link, https://dphhs.mt.gov/MedicaidExpExt. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact (406) 444-2584.

July 15, 2019 **MNAXLP**

AFFIDAVIT OF PUBLICATION

STATE OF MONTANA,

County of Lewis & Clark

Cathyann Christian

Being duly sworn, deposes and says;

That she is the principal clerk of the Independent Record, a newspaper of general circulation published daily in the City of Helena, in the County of Lewis & Clark, State of Montana, and has charge of the advertisement thereof:

That the Public Notice

a true copy of which is hearto annexed, was published in said newspaper on the following dates: viz.:

July 15, 2019

making in all_1_ publication(s)

Cathyann Christian

Subscribed and sworn to me this _15_ day of _July_, 2019.

Billie Jo Williams

Notary Public for the State of Montana
Printed Name: Billie Jo Williams
Residing at Clancy, Montana 59634
My commission expires August 31, 2022

(Notary Seal)

BILLIE JO WILLIAMS NOTARIAL SEAL STATE OF MONTANA

BILLIE JO WILLIAMS
NOTARY PUBLIC for the
State of Montana
Residing at Clancy, Montana
My Commission Expires
August 31, 2022

AFFIDAVIT OF PUBLICATION
THE MISSOULIAN

500 S. Higgins Ave.
Missoula, MT 59801
Phone: (406) 523-5236 Fax: (406) 523-5221

Ad Number: 20576096

Received
JUL 17 2019
Director's Office
DPHHS

Chris Arvish, being first duly sworn, deposes and says that he is a Classified Advertising Representative of The Missoulian, a newspaper of general circulation published daily in the City of Missoula, in the County of Missoula, State of Montana, and has charge of the Advertisements thereof.

That the legal regarding:

Rescheduled Public Hearings

a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

July 15, 2019

Making all 1 publication(s)

Signed: Chris Arvish

State of Montana
County of Missoula

Subscribed & sworn before me this 15th day of July 2019 by Chris Arvish.

Barbara L Garrison

Notary Public for the State of Montana

BARBARA L GARRISON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 02, 2020.

BARBARA L GARRISON NOTARIAL SEAL STATE OF MONTANA

Page	:	1 of 1 07/12/2019 17:01:28	**Ad Number**	:	11456482
			Ad Key	:	
Order Number	:	20576096	**Salesperson**	:	DF01 - Default Transient DF01
PO Number	:		**Publication**	:	Online Liners
Customer	:	60075826 DPHHS - Medicaid Expansion	**Section**	:	Classified
Contact	:	Director's Office, Mary Eve Ku	**Sub Section**	:	Legals
Address1	:	PO Box 4210	**Category**	:	399 Legals
Address2	:		**Dates Run**	:	07/15/2019-07/15/2019
City St Zip	:	Helena MT 59604	**Days**	:	1
Phone	:	(406) 444-2584	**Size**	:	2 x 2.47, 27 lines
Fax	:		**Words**	:	163
	:		**Ad Rate**	:	Legal Govt
Printed By	:	misarvic	**Ad Price**	:	31.00
Entered By	:	misarvic	**Amount Paid**	:	0.00
			Amount Due	:	31.00
Keywords	:	Notice of Rescheduled Public Hearings The Departme			
Notes	:				
Zones	:				

Notice of Rescheduled Public Hearings

The Department of Public Health and Human Services is rescheduling the Medicaid Expansion Hearings in order to provide additional information in the notice of waiver application, as requested by the Centers for Medicare and Medicaid Services. The rescheduled hearings will give interested parties additional time to review materials prior to the public hearings.

Therefore, the Medicaid Expansion hearings previously set for Monday, July 15, 2019, in Helena, and Thursday, July 18, 2019, in Billings, will not take place.

The rescheduled hearings will take place:

(1) July 31, 2019, from 11:30 am to 1:30 pm, at Billings Clinic, Conference Center, 2800 10th Avenue North, Billings, Montana.

(2) August 1, 2019, from 11:00 am to 1:00 pm, at the Sanders Auditorium, 111 North Sanders, Helena, Montana.

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#20576096 July 15, 2019

AFFIDAVIT OF PUBLICATION
THE BILLINGS GAZETTE

401 N 28th St
Billings, MT 59101
Phone: (406) 657-1212 Fax: (406) 657-1345

Ad Number: 20896455

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION
Abbreviated Public Notice - Updated July 23, 2019

The Montana Department of Public Health and Human Services (DPHHS) is providing an abbreviated public notice of its intent to: (1) submit to the Centers of Medicare and Medicaid Services (CMS), on or before August 30, 2019, a written 1115 Demonstration application to amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program and test new program features including work/community engagement requirements and a premium increase structure based on coverage duration; and (2) hold public hearings to receive comments on the 1115 Demonstration amendment and extension application.

In November 2015, CMS approved Montana's Section 1115 Demonstration Waiver, "Montana Health Economic Livelihood Partnership (HELP) Demonstration," that: expanded Medicaid coverage to newly eligible adults effective January 1, 2016; authorized 12 month continuous eligibility for all new adults; applied enrollee premiums equal to two percent of aggregate household income; and, instituted maximum co-payments allowable under federal law. The approved waiver also authorized the administration of Medicaid through a Third Party Administrator (TPA) for enrollees subject to premiums.

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

House Bill 658, the Medicaid Reform and Integrity Act, directs the Department of Public Health and Human Services (DPHHS or the Department) to request federal Demonstration approval to continue the state's Medicaid expansion and to implement new Medicaid expansion program features. The Department is seeking to amend its Medicaid Section 1115 Waiver, Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program, to: (1) condition Medicaid coverage on compliance with work/community engagement requirements; and (2) apply a premium structure that gradually increases enrollee premiums based on coverage duration. A complete summary of the proposed Demonstration Amendment and Extension is available here: https://dphhs.mt.gov/MedicaidExpExt/pubnotice.

Through the 1115 Demonstration amendment and extension, Montana will continue to provide quality and affordable coverage for the nearly 100,000 low-income Montanans who gained coverage under expansion.

Summary of New Proposed HELP Demonstration Program Features
Montana seeks to amend and extend the State's current Demonstration to

Jessica Bledsoe, being first duly sworn, deposes and says. That she is the principal clerk of The Billings Gazette, a newspaper of general circulation published daily in the City of Billings, in the County of Yellowstone, State of Montana, and has charge of the Advertisements thereof.

That the: 9 Folio legal regarding:
a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

7/23/19

Making all 1 publication(s)

Mark below if certification for the State of Montana
X I hereby certify that I have read sec. 18-7-204 and 18-7-205, MCA, and subsequent revisions, and declare that the price or rate charged the State of Montana for the publication for which claim is made in the attached papers in the amount of $_____ is not in excess of the minimum rate charged any other advertiser for publication of advertisement, set in the same size type and published for the same number of insertions, further certify that this claim is correct and just in all respects, and that payment or credit has not been received

Jessica Bledsoe

STATE OF MONTANA
County of Yellowstone

On this day of July 23, 2019 before me, the undersigned, a Notary Public for the State of Montana, personally appeared Jessica Bledsoe known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed same. IN WITNESS WHERFOF, I have hereunto set my hand and affixed my notarial seal the day and year first above written.

Tammy Ward

NOTARY PUBLIC for the State of Montana
Residing at **Billings, MT**

My commission expires: June 25, 2023

TAMMY WARD NOTARIAL SEAL STATE OF MONTANA

TAMMY WARD
NOTARY PUBLIC for the
State of Montana
Residing at Billings, Montana
My Commission Expires
June 25, 2023

Medicaid program features which include the following:

- **Work/Community Engagement**. The State seeks waiver authority to condition Medicaid coverage on compliance with work/community engagement requirements for non-exempt expansion adults with incomes up to 138 percent of the FPL.
- **Premium Increase Structure Based on Coverage Duration**. The State seeks to amend its Demonstration approach to premiums by applying a premium structure that gradually increases monthly premiums based on the length of time an individual is enrolled in coverage under the Demonstration. In the first two years of coverage, Demonstration enrollees with income greater than 50 percent of the FPL will pay premiums in the amount equal to two percent of their aggregate household income. The enrollee's premium obligation would gradually increase by 0.5 percent in each subsequent year of coverage under the Demonstration with a maximum premium amount not to exceed 4 percent of the enrollee's aggregate household income. Medicaid enrollees will not be subject to co-payments under this premium payment structure.

Populations eligible for the Demonstration are not changing, but eligibility requirements are changing as described above.

The State does not propose any changes to the Medicaid health care delivery system. Demonstration enrollees will continue to receive services through the State's fee-for-service delivery system. Demonstration enrollees will also continue to receive benefits through the Alternative Benefit Plan; the State does not propose any changes to benefits for Demonstration enrollees.

Public Meetings and Comment Process

The full public notice statement and complete version of the updated draft of the Demonstration amendment and extension application is available for public review at https://dphhs.mt.gov/MedicaidExpExt. Paper copies are available to be picked up in person at DPHHS offices located at 111 North Sanders Street, Helena, Montana 59601.

Two public meetings will be held regarding the Demonstration amendment and extension application:
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Public comments may be submitted until midnight on August 23, 2019. Questions or comments may be addressed care of Medicaid Expansion Extension, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov.

After Montana reviews comments submitted during this state public comment period, the Department will submit a revised application to CMS. Interested parties will also have opportunity to officially comment during the federal public comment period after CMS finds the application and public notice requirements met.

Published July 23, 2019

Order Number	:	20456799	**Ad Number**	:	11012180
PO Number	:		**Ad Key**	:	
Customer	:	60013893 MT ST DPHHS Disability Servi	**Salesperson**	:	04 - Lynn Hencley - 04
Contact	:	Mary Eve Kulawik	**Publication**	:	Independent Record
Address1	:	P.O. Box 4210	**Section**	:	Class Section
Address2	:		**Sub Section**	:	Legal
City St Zip	:	Helena MT 59604	**Category**	:	9999 Legals
Phone	:	(406) 444-5647	**Dates Run**	:	07/23/2019-07/23/2019
Fax	:		**Days**	:	1
	:		**Size**	:	2 x 12.21, 110 lines
Printed By	:	Cathyann Christian	**Words**	:	852
Entered By	:	Cathyann Christian	**Ad Rate**	:	Legal2019
			Ad Price	:	110.76
			Amount Paid	:	0.00
			Amount Due	:	110.76
Keywords	:	MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND E			
Notes	:				
Zones	:				

MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND EXTENSION APPLICATION

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Through the 1115 Demonstration amendment and extension, Montana will continue to provide quality and affordable coverage for the nearly 100,000 low-income Montanans who gained coverage under expansion.

Summary of New Proposed HELP Demonstration Program Features

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			Ad Key	:	
Order Number	:	20456799	**Salesperson**	:	04 - Lynn Hencley - 04
PO Number	:		**Publication**	:	Independent Record
Customer	:	60013893 MT ST DPHHS Disability Servi	**Section**	:	Class Section
Contact	:	Mary Eve Kulawik	**Sub Section**	:	Legal
Address1	:	P.O. Box 4210	**Category**	:	9999 Legals
Address2	:		**Dates Run**	:	07/23/2019-07/23/2019
City St Zip	:	Helena MT 59604	**Days**	:	1
Phone	:	(406) 444-5647	**Size**	:	2 x 12.21, 110 lines
Fax	:		**Words**	:	852
	:		**Ad Rate**	:	Legal2019
Printed By	:	Cathyann Christian	**Ad Price**	:	110.76
Entered By	:	Cathyann Christian	**Amount Paid**	:	0.00
			Amount Due	:	110.76
Keywords	:	MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND E			
Notes	:				
Zones	:				

Montana seeks to amend and extend the State's current Demonstration to maintain current Demonstration features while testing new and amended Medicaid program features which include the following:

Work/Community Engagement. The State seeks waiver authority to condition Medicaid coverage on compliance with work/community engagement requirements for non-exempt expansion adults with incomes up to 138 percent of the FPL.

Premium Increase Structure Based on Coverage Duration. The State seeks to amend its Demonstration approach to premiums by applying a premium structure that gradually increases monthly premiums based on the length of time an individual is enrolled in coverage under the Demonstration. In the first two years of coverage, Demonstration enrollees with income greater than 50 percent of the FPL will pay premiums in the amount equal to two percent of their aggregate household income. The enrollee's premium obligation would gradually increase by 0.5 percent in each subsequent year of coverage under the Demonstration with a maximum premium amount not to exceed 4 percent of the enrollee's aggregate household income. Medicaid enrollees will not be subject to co-payments under this premium payment structure.

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Address1	P.O. Box 4210	**Section**	Class Section
Address2		**Sub Section**	Legal
City St Zip	Helena MT 59604	**Category**	9999 Legals
Phone	(406) 444-5647	**Dates Run**	07/23/2019-07/23/2019
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July 23, 2019 **MNAXLP**

AFFIDAVIT OF PUBLICATION

STATE OF MONTANA,

County of Lewis & Clark

Cathyann Christian

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That the Amendment and Extension Application

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making in all_1_ publication(s)

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Billie Jo Williams

Notary Public for the State of Montana

Printed Name: Billie Jo Williams

Residing at Clancy, Montana 59634

My commission expires August 31, 2022

(Notary Seal)

BILLIE JO WILLIAMS NOTARIAL SEAL STATE OF MONTANA

BILLIE JO WILLIAMS
NOTARY PUBLIC for the
State of Montana
Residing at Clancy, Montana
My Commission Expires
August 31, 2022

AFFIDAVIT OF PUBLICATION
THE MISSOULIAN

500 S. Higgins Ave.
Missoula, MT 59801
Phone: (406) 523-5236 Fax: (406) 523-5221

Ad Number: 20576933

Chris Arvish, being first duly sworn, deposes and says that he is a Classified Advertising Representative of The Missoulian, a newspaper of general circulation published daily in the City of Missoula, in the County of Missoula, State of Montana, and has charge of the Advertisements thereof.

That the legal regarding:

Public Notice

a true copy of which is hereto annexed, was published in said newspaper on the following dates: via:

July 23, 2019

Making all 1 publication(s)

Signed: Chris Arvish

Received
JUL 31 2019
Director's Office
DPHHS

State of Montana
County of Missoula

Subscribed & sworn before me this 29th day of July 2019 by Chris Arvish.

Barbara L Garrison

Notary Public for the State of Montana

BARBARA L GARRISON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 02, 2020.

BARBARA L GARRISON NOTARIAL SEAL STATE OF MONTANA

Order Number	:	20576933	Ad Number	: 11457890
PO Number	:		Ad Key	:
Customer	:	60075826 DPHHS - Medicaid Expansion	Salesperson	: DF01 - Default Transient DF01
Contact	:	Director's Office, Mary Eve Ku	Publication	: Online Liners
Address1	:	PO Box 4210	Section	: Classified
Address2	:		Sub Section	: Legals
City St Zip	:	Helena MT 59604	Category	: 399 Legals
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Fax	:		Days	: 1
	:		Size	: 2 x 10.56, 113 lines
Printed By	:	misarvic	Words	: 854
Entered By	:	misarvic	Ad Rate	: Legal Govt
			Ad Price	: 122.00
			Amount Paid	: 0.00
			Amount Due	: 122.00
Keywords	:	MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND E		
Notes	:			
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			Ad Number	:	11457890
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Contact	:	Director's Office, Mary Eve Ku	**Sub Section**	:	Legals
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			Amount Due	:	122.00
Keywords	:	MONTANA SECTION 1115 DEMONSTRATION AMENDMENT AND E			
Notes	:				
Zones	:				

up to 138 percent of the FPL.

• **Premium Increase Structure Based on Coverage Duration.** The State seeks to amend its Demonstration approach to premiums by applying a premium structure that gradually increases monthly premiums based on the length of time an individual is enrolled in coverage under the Demonstration. In the first two years of coverage, Demonstration enrollees with income greater than 50 percent of the FPL will pay premiums in the amount equal to two percent of their aggregate household income. The enrollee's premium obligation would gradually increase by 0.5 percent in each subsequent year of coverage under the Demonstration with a maximum premium amount not to exceed 4 percent of the enrollee's aggregate household income. Medicaid enrollees will not be subject to co-payments under this premium payment structure.

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#20576933 July 23, 2019

C. Responses to Public Comments

The State received 309 comments during the public comment period. Two hundred and eighty four comments were received via email and mail, and 25 comments were provided during the State's two public hearings on July 31st and August 1st, a tribal consultation meeting on July 16th, and a meeting of the Legislative Interim Committee on Children, Families, Health and Human Services on July 30th. All written and transcribed comments are included in Appendix D.

The majority of the comments support the continuation of Medicaid expansion in Montana, but oppose the new features that Montana state legislation requires to be implemented with this amendment and extension. Specifically, commenters largely opposed work/community engagement requirements and the premium increase structure, while voicing support for the underlying demonstration and availability of Medicaid coverage and preventive services to new adults.

Continuation of Montana's Medicaid Expansion

Comment: **The majority of commenters expressed support for the continuation of Medicaid expansion, citing the program's benefits to enrollees as well as the state's economy.**

Response: The State thanks the commenters for their support of the continuation of Medicaid expansion under the HELP Program. The State looks forward to continuing to provide access to health coverage and services for Montanans.

Comment: **A commenter representing a health service corporation expressed support for the continuation of the HELP Program and the access to preventive services the Program has given Montanans. The commenter noted its support for the assessment on health service corporations to fund the HELP Program.**

Response: The State thanks the commenter for their support of Medicaid expansion.

Comment: **Four commenters were opposed to the extension of the HELP Program, citing concerns about government run programs and funding. One commenter who opposed the extension of the HELP Program expressed strong support for work/community engagement requirements for enrollees.**

Response: The State thanks the commenters for sharing their concerns. Pursuant to HB 658, the State of Montana will continue the HELP Program through June 30, 2025. Extension of the HELP Program beyond June 30, 2025 will require legislative action.

Work/Community Engagement Requirements and Premium Increase Structure

Comment: **Multiple commenters expressed concerns with work/community engagement requirements, specifically that enrollees who are not currently working face significant barriers to employment and that the work/community engagement requirements will create a barrier to coverage for low-income Montanans. The commenters stated that the work/community engagement requirements will likely decrease coverage without increasing work. The commenters also expressed concern with the proposed premium increase structure, noting that it may lead to disenrollment and loss of coverage.**

Response: The State thanks the commenters for sharing these important concerns and is committed to mitigating coverage loss to the maximum extent possible. As required by HB 658 and described in *Section II, Changes Requested to the Demonstration*, Montana will make participation in work/community engagement a condition of ongoing eligibility for all Demonstration enrollees between ages 19 and 55 with incomes up to 138 percent FPL who do not otherwise qualify for an exemption. Enrollees will be required to participate in 80 hours of work/community engagement activities each month.

Qualifying work/community engagement activities. Qualifying work/community engagement activities include:

- Employment;
- Work readiness and workforce training activities;
- Secondary, postsecondary, or vocational education;
- Substance abuse education or substance use disorder treatment;
- Other work or work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program;
- A community service or volunteer opportunity; and
- Any other activity required by CMS for the purpose of obtaining necessary waivers.

Work/community engagement exemptions. Montana will exempt enrollees for whom it determines the enrollee's income exceeds an amount equal to the average of 80 hours per month multiplied by the minimum wage. Montana will also exempt enrollees who meet standard and hardship/good cause exemptions, listed below.

- *Standard Exemptions.* Enrollees who qualify for an exemption from work/community engagement requirements include those who are:
    - Medically frail enrollees as defined in 42 CFR 440.315;
    - Blind or disabled;
    - Pregnant;
    - Experiencing an acute medical condition requiring immediate medical treatment;
    - Mentally or physically unable to work;
    - A primary caregiver for a person who is unable to provide self-care;
    - A foster parent;
    - A full-time student in a secondary school;
    - A student enrolled in the equivalent of at least six credits in a postsecondary or vocational institution;
    - Participating in or exempt from the work requirements of the Temporary Assistance for Needy Families (TANF) program or the Supplemental Nutrition Assistance Program (SNAP);
    - Under supervision of the Department of Corrections, a county jail, or another entity as directed by a court, the Department of Corrections, or the Board of Pardons and Parole;
    - Experiencing chronic homelessness;
    - A victim of domestic violence as defined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. 601, et seq.;
    - Living in an area with a high-poverty designation;
    - A member of an entity subject to the fee provided for in 15-30-2660(3);
    - Otherwise exempt under federal law; or,

  - An enrollee whose income exceeds an amount equal to the average of 80 hours per month multiplied by the minimum wage.

- *Hardship/Good Cause Exemptions.* To address life circumstances that affect an enrollee's ability to engage in work/community engagement, Montana will also exempt individuals who:
  - Are hospitalized or caring for an immediate family member who has been hospitalized;
  - Have a documented serious illness or incapacity or are caring for an immediate family member with a documented serious illness or incapacity; or
  - Are impacted by a catastrophic event or hardship, as defined by DPHHS, which prevents enrollees from complying with the work/community engagement requirements.

Administering work/community engagement exemptions. Pursuant to HB 658, the State will use a variety of methods to identify individuals who qualify for standard and good cause/hardship exemptions as well as those who are already complying with work/community engagement requirements for enrollees who are not exempt. The State will use a multi-pronged process that includes, but is not limited to, using available data (within DPHHS and other State agencies) to identify enrollees who should be exempt from or are already complying with work hours (e.g., exemption from or compliance with SNAP requirements, employment-based income that equates to 80 work hours assuming Montana minimum wage, and claims experience indicating medical frailty). Also pursuant to State statute, enrollees who are exempt from the work/community engagement requirement will also be exempt from premium increases.

For those enrollees who the Department is unable to use data to determine their exemption or compliance, the Department will provide multiple ways for enrollees to self-report an exemption or their compliance with work/community engagement requirements, including online, through a call center, by mail, and in person.

Workforce development and supports. The State will also continue to provide enrollees the option to participate in an employment assessment to identify barriers to employment. The Department of Labor and Industry will contact each interested program enrollee subject to the work/community engagement requirements and assist them with completion of an employment or reemployment assessment. Based on the results of the assessment, the Department of Labor and Industry shall identify services to help the enrollee address barriers to employment.

Enrollees will have the option of participating in HELP-Link, the workforce development program operated by the Department of Labor and Industry. Services offered through HELP-Link include:

- Assistance with resume and cover letters, job applications and interview skills;
- Resource center for job seekers including the Montana Career Information System;
- Labor market information and skills testing;
- Assistance for veterans of the military and eligible spouses;
- Workforce and educational training; and
- Referrals to other service providers (e.g., childcare, housing supports, and financial counseling).

Additionally, pursuant to legislation, the Department of Labor and Industry will award grants to employers to hire or train enrollees in skills to help them obtain new or improved employment, obtain employment with healthcare benefits, earn a wage that allows them to purchase their own health insurance, and improve their long-term financial security.

Premium exemptions. With respect to the premium increase structure, as noted above, enrollees who are exempt from the work/community engagement requirement will also be exempt from premium increases. In addition, enrollees with incomes of 100 percent FPL or less will not be disenrolled for failure to pay premiums. Enrollees with incomes between 101 and 138 percent FPL who fail to make premium payments will be notified of their overdue payments and required to pay within 90 days of being notified; if enrollees fail to make overdue payments they will be suspended from coverage. Enrollees who meet two of the following criteria will not be suspended from coverage due to their failure to pay overdue premiums:

- Discharge from United States military service within the previous 12 months;
- Enrollment for credit in any Montana university system unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- Participation in a workforce program or activity; and
- Participation in any of the following healthy behavior plans:
    - Medicaid health home
    - Patient-centered medical home
    - Cardiovascular disease, obesity, or diabetes prevention program
    - Program restricting the enrollee to obtaining primary care services from a designated provider and obtaining prescriptions from a designated pharmacy
    - Medicaid primary care case management program established by the department
    - Tobacco use prevention or cessation program
    - Substance abuse treatment program
    - Care coordination or health improvement plan administered by a third-party administrator

Comment: **The State received many comments in opposition to the proposed changes to the HELP program, specifically work/community engagement requirements and increased premiums. Commenters expressed concern that the work/community engagement requirements and premium increase structure will disproportionately affect women, especially those who are primary caregivers to children and may not have paid time off following pregnancy and during child rearing years. The commenters stated that no Montanans should live at risk of becoming jobless and without health care. One commenter also stated that the lack of affordable childcare is a significant barrier to employment for low-income parents.**

Response: The State thanks the commenters for sharing their concerns and is committed to working to ensure women are not disproportionately affected by the proposed changes to the HELP Program. The State is implementing work/community engagement requirements and premium increases consistent with HB 658, including a series of exemptions that will help ensure women (and men) with caregiving responsibilities do not lose coverage. Specifically, the following enrollees will be exempt from work/community engagement requirements; enrollees who are:

- Pregnant;
- A primary caregiver for a person who is unable to provide self-care;
- A foster parent; or,
- A victim of domestic violence as defined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. 601, et seq.

In addition to the exemptions listed above, the State will also exempt individuals based on life circumstances that affect their ability to meet work/community engagement requirements. There are

several exemptions that will help women (and men) with caregiving responsibilities retain coverage. Specifically, the State will exempt individuals who:

- Are hospitalized or caring for an immediate family member who has been hospitalized;
- Have a documented serious illness or incapacity or are caring for an immediate family member with a documented serious illness or incapacity; or,
- Are impacted by a catastrophic event or hardship, as defined by DPHHS, which prevents enrollees from complying with the work/community engagement requirements.

Pursuant to State statute, program enrollees who are exempt from the work/community engagement requirement are also exempt from premium increases.

As described above, the State will implement a variety of approaches to identify and authorize exemptions to mitigate coverage losses such as those that the commenters express concern about.

Comment: **One commenter stated that work/community engagement requirements will have a disproportionate impact on communities of color, noting that these communities are overrepresented in the Montana Medicaid program and are more likely to live in neighborhoods with poor access to jobs and be affected by a reporting requirement due to systemic challenges in employment.**

Response: The State thanks the commenter for their feedback. As described above, the State will implement a variety of approaches to identify and authorize exemptions to mitigate coverage losses as well as minimize the reporting burden on enrollees. As described in the application, the State will exempt individuals who live in an area with a high-poverty designation, which could signal a lack of work opportunities. For individuals who do not qualify for any exemptions, we note that participation in a broad array of activities can satisfy the work/community engagement requirement, not just paid employment. For a full list of qualifying activities and exemptions, please see *Section II, Changes Requested to the Demonstration.* Finally, our monitoring plan will actively monitor disenrollment, which will allow the State to identify – and address – any disenrollment trends among communities of color.

Comment: **One commenter stated their opposition to all changes to the HELP Program that will result in a loss of coverage, risk of Montanans being disenrolled or suspended from their care, and any changes that would make the program more difficult to access.** (71)

Response: The State thanks the commenter for their feedback. As the Department works to implement program changes pursuant to HB 658, it is committed to doing so in ways that minimizes coverage loss and barriers to access. (For example, see *Section II, Changes Requested to the Demonstration* for a list of exemptions.) Even with the steps the Department is taking, we recognize that the proposed changes will likely lead to coverage loss based on the experiences of other states that have implemented work/community engagement requirements and Montana's previous experience with premiums in the HELP Program. Pursuant to HB 658, if more than 5 percent of program enrollees have their coverage suspended for noncompliance with work/community engagement requirements, an independent third party audit take place. If the audit finds that more than 10 percent of enrollees were suspended erroneously, all suspensions will cease until the conclusion of the next legislative session.

Comment: **Nineteen commenters asked the State to keep hard working Montanans, caregivers, and caregivers' clients in mind when implementing changes to the HELP Program, specifically work/community engagement requirements and the premium increase structure. Some of these**

commenters are concerned caregivers may not meet the 80 hour monthly work/community engagement requirement due to the scarcity of work across the state and ever-changing nature of their jobs.

Response: The State thanks the commenters for their feedback. Under the Demonstration amendment and extension application, the State is seeking to further the goals and policy objectives of the HELP Program, including increasing the availability of high quality health care to Montanans. As the Department implements changes to the HELP Program required by HB 658, it will do so with the goal of minimizing coverage losses. For example, we have defined a broad list of qualifying work activities as well as a broad list of exemptions to both work/community engagement requirement and premiums. An enrollee who is a primary caregiver for a person who is unable to provide self-care will be exempt from work/community engagement requirements and, pursuant to State statute, enrollees who are exempt from the work/community engagement requirement are also exempt from premium increases. Caregivers with fluctuating hours could meet the work and community engagement requirements by engaging in other qualifying activities, such as work readiness and workforce training activities; secondary, postsecondary, or vocational education; other work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program; and community service or volunteer opportunities.

Comment: **Several commenters requested that the State automatically exempt people with serious, acute, and chronic diseases, such as cystic fibrosis, cardiovascular disease, bleeding disorders, other rare disorders, cancer patients and survivors, individuals and populations with elevated risk of morbidity and mortality, and people living with human immunodeficiency virus (HIV) from work/community engagement requirements and premiums. The commenters recognized Medicaid's important role in helping people with chronic diseases in accessing the specialized care and treatment they need to lead healthy and fulfilling lives, and the potential for these individuals to experience lapses in employment due to their health. These commenters also expressed support for the State's request to extend 12-month continuous eligibility.**

Response: The State thanks the commenters for their request. Enrollees who meet the medically frail definition, to be defined by the Department, will be exempt from work/community engagement and premium payment requirements. The State will provide a more detailed definition of medically frail as part of its Implementation Plan to be developed after the Demonstration amendment and extension is approved by CMS. The State looks forward to working with stakeholders as it further develops its medically frail definition. Consistent with CMS guidance and HB 658, the Department will also ensure that all enrollees with a disability are exempt from work requirements.

The State also notes that enrollees who are hospitalized or have a documented serious illness or incapacity will be exempt from work/community engagement requirements. Please see S*ection II, Changes Requested to the Demonstration* for a full list of standard and hardship/good cause exemptions.

Comment: **Multiple commenters stated that work/community engagement requirements and the premium increase structure will increase barriers to coverage and treatment for Montanans struggling with substance use disorder (SUD), addiction, and mental health conditions.**

Response: The State thanks the commenters for their concerns. The State is committed to ensuring Montanans struggling with SUD, addiction, and mental health conditions have access to treatment,

including adults enrolled in the HELP program. We recognize the importance of continuity of care for beneficiaries in need of SUD and mental health treatment and the proposed waiver includes several provisions that will safeguard access for Montanans struggling with addiction and receiving mental health treatment. First, enrollees with chronic substance use disorders are considered medically frail as defined in 42 CFR 440.315, and will be exempt from work/community engagement requirements. Others struggling with addiction may be exempt if they are experiencing an acute medical condition requiring immediate medical treatment or are mentally or physically unable to work. Second, if an enrollees is not exempt, participation in substance abuse education or SUD treatment for 80 hours per month will meet the work/community engagement requirement.

Comment: **One commenter expressed concern that low-income parents and families will be negatively impacted by work/community engagement requirements and the premium increase structure. The commenter states as parents lose coverage their children will be directly affected and that premiums will be a barrier to access to healthcare for many families.**

Response: The State thanks the commenter for their concerns. The State is committed to ensuring low-income parents and their families have access to quality health care through the HELP program. Enrollees who are primary caregivers for a person who is unable to provide self-care will be exempt from work/community engagement requirements. The State will further define this and the exemptions detailed in *Section II, Changes Requested to the Demonstration* in the Implementation Plan. Finally, our monitoring plan will actively monitor disenrollment, which will allow the State to identify – and address – any disenrollment trends among parents.

Comment: **One commenter believes that the program changes proposed in the Waiver, including work/community engagement requirements and the premium increase structure are reasonable, common-sense measures to ensure Medicaid Expansion's long-term sustainability.**

Response: The State thanks the commenter for their support of the Demonstration and of the provisions required by HB 658.

Work/Community Engagement Requirements

Comment: **Several commenters asked the Department not to implement work/community engagement requirements due to the anticipated negative impact on enrollees and potential for coverage loss.**

Response: The State thanks the commenters for their input. HB 658, which authorizes the continuation of the HELP Program, provides that the State must implement work/community engagement requirements. As the Department implements changes to the HELP Program required by HB 658, it will do so with the goal of minimizing coverage losses, such as by administering a broad range of standard and good cause/hardship exemptions. As described above, if suspensions for noncompliance with work/community engagement requirements exceed 5 percent of program enrollees, an independent third-party auditor will conduct an audit of the enrollees who were subject to suspension. If the audit finds that more than 10 percent of the enrollees were suspended erroneously, the Department will cease further suspensions until the conclusion of the next general legislative session. The audit must be completed within 90 days or the Department will cease suspensions until the audit is complete.

Comment: **Multiple commenters requested that Indian Health Services (IHS) beneficiaries be exempt from work/community engagement requirements. The commenters cited the importance of Medicaid**

to Montana's tribal population, noting that Medicaid expansion has been critical to addressing health disparities in Indian Country, and allowed for federal funding and reimbursement for IHS and Tribal Health organizations' health care services. The commenters also noted that many IHS beneficiaries live in areas of chronic unemployment and without any form of coverage other than Medicare or Medicaid, and that tribal members are among the most vulnerable with respect to poverty, health disparities, and mental and behavioral health disorders.

Response: The State thanks the commenters for their feedback and for sharing their concerns. The Department will seek to exempt American Indians/Alaskan Natives from work/community engagement requirements to the maximum extent permissible under federal law. The Department looks forward to continuing its partnership with IHS and Tribal Health organizations to further design the HELP program to ensure IHS beneficiaries have access to high quality healthcare.

***Comment:* One commenter who is a small business owner expressed support for Medicaid expansion, but is opposed to work/community engagement requirements. The commenter noted that many of her employees are subject to irregular hours and seasonal employment and therefore expressed concerns that the proposed work requirements and premium changes could result in her workers losing coverage. Another commenter shared concerns about Montanans working in industries with seasonal and volatile markets, such as agriculture, construction, and health care, citing that one in four Montana Medicaid enrollees works part-time and could be subject to losing coverage.[29]**

Response: The State thanks the commenters for their support of Medicaid expansion. The State is committed to mitigating coverage losses to the maximum extent possible. Pursuant to HB 658, enrollees ages 19 to 55 who are not exempt will be required to participate in 80 hours of work/community engagement activities each month. For employees with irregular hours or fluctuating hours due to seasonal employment, there are a wide variety of activities that can satisfy the 80-hour per week requirement, including work readiness and workforce training activities; secondary, postsecondary, or vocational education; other work/community engagement activities that promote work or work readiness or advance the health purpose of the Medicaid program; and community service or volunteer opportunities.

***Comment:* One commenter was concerned that reporting would be difficult for rural program beneficiaries, noting that Montana ranks 48th in the nation for access to broadband internet.**

Response: With respect to reporting, the State will provide multiple ways for enrollees to self-report an exemption or their compliance with work/community engagement requirements, including online as well as through a call center, by mail, and in person. As described in the application, the Department will also work proactively to identify enrollees who are exempt or already compliant with work/community engagement requirements through the use of administrative data.

***Comment:* One commenter stated that many families would like to be employed or have access to better paying jobs, yet jobs and volunteer opportunities are hard to find in rural communities. He and**

[29] Garfield, R., Rudowitz, R., and Damico, A., Kaiser Family Foundation, "Understanding the Intersection of Medicaid and Work," January 2018, accessible at http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

other commenters expressed particular concern that Montanans living in rural communities will be at risk of losing coverage due to work/community engagement requirements.

Response: We appreciate the commenters' concern that in some parts of the state it could be difficult for beneficiaries to find work or volunteer activities to satisfy the new work/community engagement requirements. As described in the application, the State intends to exempt enrollees who meet standard and/or hardship/good cause exemptions from work/community engagement requirements. One such exemption is for individuals who live in an area with a high-poverty designation, which will be further defined by the Department. For individuals who do not qualify for any exemptions, we again note that participation in a broad array of activities can satisfy the work/community engagement requirement, not just paid employment. For a full list of qualifying activities and exemptions, please see *Section II, Changes Requested to the Demonstration.*

Comment: **One commenter stated that access to medical care should not be contingent on job status.**

Response: The State thanks the commenter for sharing her concerns. Pursuant to HB 658, the State is required to seek authority to implement work/community engagement requirements, but the legislation also provides for a number of qualifying activities that are not tied to job status. For example, qualifying work/community engagement activities include: secondary, postsecondary, or vocational education; and community service or volunteer opportunities. As described in *Section II, Changes Requested to the Demonstration,* the application also includes a list of standard and good cause/hardship exemptions for individuals who may have difficulties securing or maintaining participation in work/community engagement qualifying activities.

Comment: **A few commenters were concerned that individuals with disabilities would lose Medicaid coverage because they are not able to work.**

Response: The State thanks the commenters for their concerns. The new work requirements apply only to adults enrolled in the new adult expansion group; many individuals with disabilities are enrolled in Medicaid through disability-related eligibility categories and will be exempt from work/community engagement requirements. Individuals with disabilities who have not secured a disability determination and are enrolled in the new adult group will also be exempt from work/community engagement requirements. The State will use available data to proactively identify individuals with disabilities who will be exempt from work/community engagement requirements, as well as provide multiple ways for enrollees to self-report an exemption. For a full list of exemptions, please see *Section II, Changes Requested to the Demonstration.*

Comment: **Multiple commenters flagged that due to medical issues they may not be able to work sufficient hours to comply with work/community engagement requirements.**
Response: As described in the Demonstration amendment and extension application, enrollees will be exempt from work/community engagement requirements if they are mentally or physically unable to work, disabled, or experiencing an acute medical condition requiring immediate medical treatment. Other exemptions as well as qualifying activities to meet the work/community engagement requirements are described in *Section II, Changes Requested to the Demonstration*.

Comment: **One commenter asked about the State's plan to notify and work with enrollees who are not compliant with work/community engagement requirements before they are disenrolled; the**

commenter was concerned that there was an estimated 4,000 – 12,000 families that could be negatively impacted and lose health coverage. One commenter applauded the State's plan for exemptions based on administrative data as well as the ability for enrollees to self-report exemptions through multiple platforms.

Response: The State thanks the commenter for their question. DPHHS will notify a program enrollee who is not in compliance with the work/community engagement requirements that the enrollee has 180 days to come into compliance, and failure to comply within the 180-day period will result in suspension from the program, unless the enrollee attests and the Department confirms that the enrollee is exempt from the work/community engagement requirements. Pursuant to HB 658, an enrollee who is suspended from the program for noncompliance may be reinstated 180 days after the date of suspension or upon a determination by the Department that the program enrollee: (a) is exempt from the work/community engagement requirements; (b) has been in compliance with the requirements for 30 days; or (c) meets an Medicaid eligibility group that is not subject to the Demonstration. As described above, the State will actively monitor disenrollment and if more than 5 percent of enrollees are suspended from coverage due to noncompliance with work/community engagement requirements, the State will undertake an independent third party audit.

Additional detail about enrollee notification and outreach activities will be detailed in the forthcoming Implementation Plan.

Comment: **Multiple commenters were concerned that older adults will face obstacles to meeting work/community engagement requirements, noting that employment rates are lower at older ages for a variety of reasons, including chronic health conditions and ageism.**

Response: The State thanks the commenters for their feedback. Work/community engagement requirements will apply to new adult enrollees, ages 19 to 55; Medicaid expansion adults over age 55 will not be subject to the work/CE requirements. Nonetheless, we appreciate the commenter's concern that some older adults may have difficulty complying with the requirements. We note that some older adults – including individuals with certain serious chronic health conditions – will qualify for exemptions and will not be subject to the requirements. Other standard and good cause/hardship exemptions could apply; for a full list, please see *Section II, Changes Requested to the Demonstration.* To minimize the reporting burden on enrollees, the State will utilize available administrative data to confirm enrollees' exemptions or compliance with work/community engagement requirements.

For non-exempt enrollees who are subject to work/community engagement requirements, we also note that enrollees can satisfy the requirements through secondary, postsecondary, or vocational education and community service or volunteer opportunities. Finally, our monitoring plan will actively monitor disenrollment, which will allow the State to identify – and address – any disenrollment trends among older adults.

Comment: **Several commenters disagreed that the implementation of work/community engagement requirements promotes the objectives of the Medicaid program consistent with 42 USC 1315(a). The commenters cited coverage losses from Arkansas's implementation of work/community engagement requirements as evidence that "work requirements do not help to furnish medical coverage consistent with Medicaid program objectives." The commenters also pointed to the additional costs the State will bear by implementing work/community engagement requirements, thereby diverting resources that could be otherwise used to furnish coverage and care. One commenter called for additional clarity around standard and good cause/hardship exemptions.**

Response: The State thanks the commenters for their feedback. The Department intends to implement program changes pursuant to HB 658 in a way that mitigates coverage losses, to the maximum extent possible. The Department acknowledges that implementation of work/community engagement requirements will require development of new business processes, infrastructure, and modifications to information systems. The Department will leverage existing systems and resources to the extent possible and will only implement program changes once the required operational infrastructure is in place. The State will provide additional detail and definition of the proposed standard and good cause/hardship exemptions through the development of an Implementation Plan following CMS's approval of the amendment and extension application.

Comment: **A commenter asked whether individuals who are disenrolled for non-compliance with work/community engagement requirements will be automatically reinstated after 180 days of disenrollment or will be required to proactively re-apply for coverage. One commenter opposed the proposed 180-day suspension of benefits for non-compliance with work/community engagement requirements and stated it is unclear how the Department will determine the length of time an exemption applies.**

Response: The Department is committed to minimizing the burden on enrollees to the greatest extent possible and will evaluate opportunities for automatic reinstatement of enrollees disenrolled for non-compliance as it prepares to implement work/community engagement requirements. The Department will seek to expeditiously reinstate the enrollee if it determines the enrollee (a) is exempt from the work/community engagement requirements; (b) has been in compliance with the requirements for 30 days; or (c) is enrolled in a Medicaid eligibility group that is not subject to the Demonstration.

Pursuant to the provisions of HB 658, the Department is obligated to implement the 180-day suspension when an enrollee does not comply with work/community engagement requirements. The Department will provide more information on definitions of and the process for determining the length of a good cause/hardship exemption in the Implementation Plan.

Comment: **Multiple commenters expressed concern over the work/community engagement reporting requirement, citing recent coverage losses in Arkansas's Medicaid program which had similar requirements as well as the administrative burden and expense on the State associated with implementing the reporting requirement.**

Response: The State thanks the commenters for their feedback. The Department intends to implement program changes pursuant to HB 658 in a way that mitigates coverage losses, to the maximum extent possible. The State is aware of coverage losses associated with work/community engagement requirements in Arkansas and other states, and is seeking to learn from those states' experiences as it implements work/community engagement requirements in Montana and corresponding reporting obligations for enrollees. Upon approval of the amendment and extension application, the Department will begin designing the systems, processes, and technical requirements that will support new program features; these will be detailed in forthcoming documentation such as the Implementation Plan and Monitoring Protocol.

***Comment*: Multiple commenters asked for assurances that Medicaid enrollees will be afforded adequate notice, protections, due process, and a meaningful opportunity to seek appeals of decisions impacting their coverage as a result of noncompliance with work/community engagement requirements**. **One commenter suggested that the Department support a robust consumer education program in collaboration with the health care industry to provide information to enrollees affected by work/community engagement requirements. One commenter stated that the increased administrative burden on enrollees subject to work/community engagement requirements will likely decrease the number of Montanans with Medicaid coverage.**

Response: The State thanks the commenter for their concern and commits to ensuring that subject enrollees will receive the assistance they need to comply with work/community engagement requirements. The Special Terms and Conditions that CMS will issue as part of a Demonstration approval will outline applicable federal Medicaid requirements that we anticipate developing in greater detail as part of the Demonstration Implementation Plan and Monitoring Protocol. Those enrollees who fail to meet these requirements will receive appropriate notice and due process during administrative appeals and coverage will be maintained while appeals are pending. All enrollees subject to work/community engagement requirements will receive consumer notices at application, renewal, and change reporting stages that describe the program requirements, qualifying activities, exemptions, required hours, compliance reporting processes, and who they can contact with questions. Staff in Offices of Public Assistance will be available to assist in person or over the phone, and additional resources will be available online. In addition, the Department will also work with stakeholders—especially those that serve enrollees such as enrollment assisters, community health centers, hospitals and other providers—to support enrollee outreach and education and ultimately mitigate coverage loss due to non-compliance with reporting to the maximum extent possible.

***Comment:* Three commenters expressed support for work requirements, citing concerns about Medicaid recipients and their inability or unwillingness to hold paid jobs. Commenters feel that by urging program recipients to find job opportunities and advancement, enrollees will be better served and encouraged to be productive citizens, while offering healthcare coverage without work/community engagement requirements would not have the same impact.**

Response: The State thanks the commenters for their support of the Demonstration and of the provisions required by HB 658.

Premium Increase Structure

Comment: **One commenter expressed concerns about the premium increase structure, suggesting that providers reduce their charges to lower medical expenses.**

Response: The State thanks the commenter for their input. The state is implementing premium increases consistent with HB 658. The premiums are designed to encourage enrollees to be discerning health care purchasers, to take personal responsibility for their health care decisions, and ultimately to improve their health, and are not directly tied to provider charges.

Comment: **One commenter suggested that DPHHS's interpretation of the premium increase structure is inconsistent with the plain language of HB 658 and requested the Department consider amending the premium increase structure proposed in the Demonstration amendment and extension application. Specifically, the commenter suggested that the Department interpret "increase by 0.5% in each subsequent year" to mean an enrollee's premium would increase by 2% + (2%*0.5%) or 2.1% in year three of enrollment, rather than to 2.5% in year three as proposed by the State.** (69, 116)

Response: The State thanks the commenter for their request. The Department reviewed HB 658 and continues to interpret the legislation's premium increase provision as directing a 0.5% increase "of a participant's income" after the first two years of enrollment, up to a maximum of 4% of the participant's income. If the annual premium were to increase by 0.5% of 2%, an enrollee would not reach a premium equal to 4% of their modified adjusted gross income until year 16 of their enrollment, which is inconsistent with the legislature's intent for this provision.

Comment: **Two commenters disagreed with the hypotheses specific to premiums in the Demonstration amendment and extension application. The commenter stated that contrary to the premium hypotheses in the application (i.e., premiums will not deter enrollment; increasing premiums will promote continuous coverage and continuity of care; and enrollees will gain familiarity with a common feature of health insurance), premiums will likely deter eligible individuals from applying for, enrolling in, or renewing coverage. Multiple commenters also expressed concern that one of the hypotheses – helping enrollees gain familiarity with the features of commercial health insurance – infers that public tax dollars are being used to prepare people to be consumers of private industry.**

Response: The State thanks the commenter for their feedback on the hypotheses included in the Demonstration amendment and extension application. The Department developed these hypotheses in compliance with 1115 transparency requirements and informed by CMS guidance – *Appendix to Evaluation Design Guidance for Section 1115 Eligibility & Coverage Demonstrations: Premiums or Account Payments* – which encourages states to include the hypotheses in the amendment and extension application. The State will contract with an independent third party evaluator to refine these hypotheses and conduct the evaluation of the HELP Program. The evaluator will use a variety of methods, including but not limited to interviews, focus groups, and data analysis. Based on the outcomes of the evaluation, the State may work with CMS to amend the Demonstration.

Comment: **Multiple commenters opposed the premium increase structure, stating that individuals participating in the HELP program are low-income and struggling to afford basic necessities (e.g., housing, utilities, and food) on limited incomes and that premiums will jeopardize their access to care.**

Response: The State thanks the commenters for their input. Enrollees who are not exempt from paying premiums will be required to pay monthly premiums equal to 2 percent of their monthly income for the first two years of participation; per HB 658, the premium will increase 0.5 percent in each subsequent year of coverage up to a maximum of 4 percent. As described in previous responses, enrollees who are exempt from work/community engagement requirements will also be exempt from paying premiums. In addition, enrollees with incomes of 100 percent FPL or less will not be disenrolled for failure to pay premiums. Enrollees with incomes between 101 and 138 percent FPL who fail to make premium payments will be notified of their overdue payments and required to pay within 90 days of being notified. Enrollees that meet two criteria from the list *Section II, Changes Requested to the Demonstration* will not be subject to suspension for failure to pay overdue premiums.

Comment: **One commenter expressed concern over the lock-out period for non-payment of premiums for enrollees making over 100 percent FPL and urged the State not to move forward with mandating any premiums for HELP enrollees.**

Response: The State thanks the commenter for their feedback. Pursuant to the provisions of HB 658, individuals above 100 percent FPL who fail to make premium payments will be suspended from coverage if overdue premiums are not paid within 90 days of notification from the Department. The Department will unsuspend an enrollee's coverage upon (a) payment or assessment of the total amount of overdue premium payments; (b) demonstrating a standard or good cause exemption; or (c) meeting a Medicaid eligibility group not subject to the Demonstration.

Comment: **One commenter requested additional clarity regarding the definition of a year for purposes of the premium increase structure and recommended that the Department define a year as 12 continuous months.**

Response: The State thanks the commenter for their input. The Department will further define the premium increase structure in the Implementation Plan that will be developed following CMS's approval of the amendment and extension application.

Medically Needy Spend Down

Comment: **One commenter expressed frustration with the medically needy spend down process. He explained that he is a senior citizen with disabilities and that his medically needy spend down will prohibit him from enrolling in the Medicaid program. He expressed concern that the Demonstration could require him to go back to work to qualify for Medicaid.**

Response: The HELP Demonstration offers coverage to enrollees ages 19 to 64, and work/community engagement requirements are applicable to individuals ages 19 to age 55. The Demonstration amendment and extension does not affect Montana's Medically Needy Pathway, also referred to as a Spend-Down Program, which allows those who are categorically aged, blind, and disabled and would otherwise be over the income limit to qualify for Medicaid if they have high medical expenses. An enrollee must "spend down" their income above the medically needy income limit before becoming eligible for Medicaid. The State understands the commenter's frustration and recommends that he reach out to the Department for assistance.

Behavioral Health

Comment: **One commenter requested that Applied Behavior Analysis be included in the HELP Program benefit package; it is currently excluded. Applied Behavior Analysis is an evidence-based intervention for adults with autism.** (57, 68, 74)

Response: The amendment and extension application does not address HELP Program benefits, which are not changing. The State thanks the commenter for their suggestion and information regarding Applied Behavior Analysis and will take this feedback under consideration.

Continuous Eligibility

Comment: **Many commenters support the extension of 12-month continuous eligibility.**

Response: The State thanks the commenters for their support of 12-month continuous eligibility for new adults enrolled in the HELP program.

Health Service Corporation Fee

Comment: One commenter expressed concern that the health service corporation fee authorized in Section 6 of HB 658 is not compliant with federal requirements that require that any tax revenues as the state share of Medicaid costs must be broadly based, uniformly imposed throughout a jurisdiction, and not designed to hold providers harmless from the burden of the tax.

Response: Section 6 of HB 658 imposes a one percent tax on the net premium income of health service corporations. Under federal requirements, a healthcare-related tax must be "broad-based" and "uniformly imposed" within a class of providers, or the state must obtain a waiver from the Centers for Medicare & Medicaid Services (CMS).The State plans to apply to CMS for a waiver of the requirements that the tax be "broad-based" and "uniformly imposed" because the tax is "generally redistributive;" that is, the tax shifts money from non-Medicaid to Medicaid providers by exclusively taxing revenue from non-Medicaid providers to support the state's share of Medicaid expenditures.

Tribal Consultation

The Department held two tribal consultations; one in person and one in writing. During the first tribal consultation meeting on July 16th, participants raised concerns that unemployment is high on Montana's Indian reservations and that state employment data likely does not capture actual tribal employment rates. They also expressed concern that enrollees with mental health challenges will slip through the cracks and fail to report to meet work/community engagement requirements. Participants also recognized that Medicaid expansion has enabled Indian Health Services to be able to purchase services that would have otherwise been affordable and suggested that it will be important to extend the program beyond the current sunset date of June 30, 2025. Finally, participants asked questions about how work/community engagement requirements and the associated reporting process will be implemented. The State acknowledged these questions, but responded that implementation details will be finalized after the approval of the amendment and extension application.

Comments received as a result of the second tribal consultation, completed via formal letter on July 23, 2019, are incorporated throughout this document with all other comments received.

Other

Commenter: **One commenter identified an error in the PowerPoint presentation used during the public hearings. Specifically, the presentation incorrectly cited the number of new jobs Medicaid expansion helped create.** (54)

Response: The State thanks the commenter for identifying the error. The statement was revised to read "Medicaid expansion led to the creation of approximately 5,300 new jobs between 2016 and 2018." The source for the statistic is the Montana Bureau of Business and Economic Research (BBER), *The Economic Impact of Medicaid Expansion in Montana,* April 2018. The statistic can be found on page 2 in Table 1: Summary of Economic Impacts of Medicaid Expansion in Montana/Year and Cumulative.

The State has updated the Demonstration amendment and extension application to accurately reflect the BBER report.

D. Public Comments

I am for helping people who really need it. But expanding programs is not the answer, just an easy way out. I am very much for having able people on assistance work. Instead what we have is a give-me program run by government. Show me one program that the government is in charge of that has worked. And remember, the government might pay for these programs but it is actually the working people that are trying to make a living for themselves and their family and the retired people who have worked their whole life just for a comfortable retirement that the funds are coming from. Having run several small businesses over 40 years, I have seen and hired many different people. They have run from people down and out that we have given hope and an opportunity to. The majority of our jobs are not life long jobs with advancement. But we have given our employees skills and self-esteem so that they can go on to a better opportunity. Let's not expand these programs. Let's end the give-me attitude that these programs promote. Instead we need to prop up everyone. A job does that. I have experienced too many able people who are glad to get the handouts so that they can play, party every weekend, buy the latest truck, the latest big screen TV, etc. We need all people to be responsible for themselves. Let us end the give-me programs!

I see the information on the next move toward Soviet style insurance, towards socialist medicine. You know very well we can not afford it. You know you must rob "Peter" to pay Paul, you know this is not health care but merely a "balagan" insurance. Why are you doing this? You don't care about us, about the foundation of our nation, about paying the bills. Shame!
Want to read how this is working in real life? A friend who has multiple health issues, many stemming from obesity, has a husband who is the same. He has figured out he can't get fired from his job if he claims he is homosexual and being discriminated against. Now he finds this program taking him to the next level as it pays for a sex change operation. Insanity.
Please!

Do not amend and extend the Health and Economic Livelihood Partnership (HELP) Demonstration Program!

Thank you for taking my comments.

Please reply to my Hotmail account.

[redacted]

I fully support Bullock's Medicaid expansion however gradually increasing enrollee premiums is misguided. What we thinking Americans are looking for is to lower all medical expenses by demanding the providers reduce their charges. Doctors and hospitals are going to have to accept lower pay. Doctors should not be making more than 150,000 to 200,000 /yr, as they do in western Europe. Hospitals making over 800/night for a bed is outrageous. If doctors want to get rich they should quit and go to Wall Street or become corporate CEOs. Continuing to make huge profits off of other people's misfortune is no longer acceptable.

Re: House Bill 658

July 20, 2019

[redacted]

To whom it may concern,

I was not in favor of taxpayers having to pay for Medicaid Expansion. I believe we need to encourage able body citizens to work and be productive citizens. I was sadden when HB 658 passed. Now that it is here, I strongly believe that people should have to work if they are able. My brother is a good example of working event though he had bipolar issues. The state of Minnesota worked with him to find a job he could do and the hours he could handle and he was so proud of his accomplishments on that job.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

My sister is a seasonal worker who relies on Medicaid expansion for her healthcare. She works infrequent hours, and work requirements would likely cause her to lose access to healthcare. All Montanans deserve access to quality affordable healthcare!

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

July 24, 2019

My name is [redacted]. I live in [redacted]. I am a Senior Citizen with disabilities. I am now seventy one and retired. I do support Medicaid Expansion and its programs. Medicaid Expansion has helped many Montanans. Because I need personal assistance and home care very much at this time, I have gone down to my local OPA office to apply for Medicaid Expansion and Medicaid Waiver funded services. I cannot and will not utilize these programs at this time because my medically needy spend down is very steep approximately $1500 due to my father's military pension . Because I am retired, I do not want to reenter the work force just to become Medicaid eligible I know people who are younger and are thirty years my junior who are eligible and use Medicaid. I hope my issues can be fixed and addressed.

[redacted]

Below is Benefis Health System's official public comment in support of the approval of the 1115 Waiver application for the extension and amendment of the Montana Health and Economic Livelihood Partnership (HELP) Program:

Benefis Health System fully supports the approval of the 1115 Waiver application aimed at amending and extending the Health and Economic Livelihood Partnership (HELP) Program, Montana's version of Medicaid Expansion.

Benefis has been a very vocal proponent of the continuation of Medicaid Expansion and believes that the program amendments proposed in the Waiver (including work/community engagement requirements and a premium increase structure based on coverage duration) are reasonable, common-sense measures to ensure Medicaid Expansion's long-term sustainability.

Numerous studies, data points, and personal stories offer undeniable evidence that Medicaid Expansion benefits not only the nearly 100,000 Montanans who receive coverage from the program, but also the sate's economy as a whole. The discontinuation of the program would be devastating to current program enrollees and would be a major step backwards for Montana. Extending the program with amendments will not only protect the coverage of current enrollees but will allow future Montanans in need of healthcare coverage a viable alternative to living uninsured.

Benefis Health System is strongly committed to ensuring the long-term success of Medicaid Expansion in Montana and plans to implement programs to help Cascade County residents fulfill their community engagement requirements, making the amended program requirements easier for enrollees to meet.

Good afternoon.

This comment is not specific to the waiver but rather to the PowerPoint presentation used during the waiver public hearing meeting.

On page 6 under Economic Effects, the slide says “Medicaid expansion led to the creation of 15,000 new jobs between 2016 and 2018.” The citation for that statistic was noted as the BBER “The Economic Impact of Medicaid Expansion in Montana” report issued in April 2018. Per that report it seems the provided statistic is incorrectly reflected in the slide.

The Abstract section of the BBER report projects *“… generating approximately 5,000 jobs and $270 million in personal income in each year between 2018 and 2020.”*

Additionally, the Summary section at the bottom of page 1 of the BBER report (somewhat confusingly) states “As a result, Medicaid expansion stimulates economic activity. We estimate that, between 2018 and 2020, it will generate approximately 5,000 jobs and $270 million in personal income annually…” However, the footnote at the bottom of that same page provides clarification stating *“1 It is useful to note that our analysis does not say that the expansion creates 5,000 in one year and then a different additional 5,000 new jobs the next year. Many of the jobs are created in one year and then persist. For instance, a nursing position created as a result of expansion in 2017 that persists through 2020 would be part of the (approximately) 5,000 in 2020.”*

I submit it today because that specific stat was cited by an individual during their public comments at the Helena meeting.

Thank you.

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

Having had two children, a great job and a very supportive spouse, I can especially relate to how this would affect women with children or those who are expecting children. I can't imagine what I would do without all the resources I have. Please don't take away some of these resources, especially from women at such a crucial time in life.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]
The proposed changes are regressive for all the reasons cited above!

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
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These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
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[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,
[redacted]

Dear Medicaid Expansion Extension Director's Office,

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[insert personal comments here]

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Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

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These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

I testified numerous times to keep Medicaid in Montana. I testified because everyone should have access to healthcare. That access should not be contingent on hoops one has to go through.

Work requirements hurt the already vulnerable people of Montana that use Medicaid.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

My students are at high risk of developing greater health needs without adequate care.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

Our part of the state strongly favors jobs that are not amenable to pregnancy or caring for newborns, whether outdoor work with high physical hazards or tourism-associated service work with unpredictable schedules and strong seasonal fluctuations. Penalizing women in particular for being unable to find work in these conditions will leave our community worse off.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here] As a woman, I am aware that EVERYONE needs health care whatever our gender, our race, our age.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,
[redacted]

Dear Medicaid Expansion Extension Director's Office,

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[insert personal comments here]

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Thank you for your time.

Sincerely,
[redacted]

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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]

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Thank you for your time.

Sincerely,
[redacted]

Dear Medicaid Expansion Extension Director's Office,

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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]As a physcian, I see even more clearly the devastating effects of how this will negatively effect Montana citizens, especially women. Please investigate further and leave any preconceived notions of how those in poverty should act and truly see how devastating this could be for ALL Montantans.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
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[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

As someone who is a beneficiary of Montana Medicaid, I find this expansion troublesome. Healthcare in America is not at its best. I am one of many who cannot afford healthcare from any other provider besides you. Be here for the people who need you most.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

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These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here] It is time for health coverage to be a right not a privilege and for health costs to be kept affordable for all. Programs like medicaid are filling in the gaps, imperfectly, while private insurance companies are raising copays and looking for any reason to deny coverage. Please don't make Montana's medicaid expansion waiver more burdensome and expensive for the poorest among us. Please start taking action to create a universal health care system that provides all Americans with decent, affordable healthcare. Yes, the transition will be painful for those whose livelihood is based on the current system but new opportunities will open up if we have the courage to do what is right for our country and its people.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

As a Montanan and a Licensed Clinical Social Worker (LCSW) I support having Medicaid expansion easily accessible and available to all Montanans. Work requirements should not be included in expansion. Please protect the more vulnerable populations in Montana by expanding Medicaid without adding work requirements and premiums.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

These changes seem to be aimed at the most vulnerable parts of our society. No one should have to worry first about the cost of getting well or being taken care of.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

When we invest in health insurance for our low income population our health costs actually go DOWN over time, because people don't have to use the ER for basic care, nor do they leave large health bills unpaid.

Health care isn't a luxury. There should not be complicated bureaucratic hoops limiting people's access to Montana's Medicaid.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

A year and a half ago I had a baby and experienced some complications afterward that required hospitalization. It was a really scary time, even for someone with health insurance and enough accumulated sick leave that I would have income during my maternity leave (like most, my employer did not offer paid maternity leave). I can't imagine how traumatizing that would be if our family had been incurring debt and financial insecurity on top of dealing with a life or death situation. If Montana's elected officials actually care about families, they will support ALL families. Not just ones with oodles of money in the bank.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

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In my experience as a female, OBGYN medical issues are very common and sometimes beyond our control without medical attention. Many young, low income women suffer from OBGYN issues. Removing basic coverage for simple medical care in this area can only result in more frequent ER visits, which are costly and would take resources away from our already exhausted ER. Cutting back healthcare is not what's right from Montanans.

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I got really sick two years ago and was unable to keep working the minimum hours to get health insurance through my work. I was able to enroll in Montana Medicaid and get the care that I needed because there were no work requirements. After a year of focusing on my health and getting treatments I couldn't have afforded otherwise I was back to work full time and off Medicaid. I wouldn't be as healthy and productive as I am today if I hadn't been able to get Medicaid or had to fulfill work requirements to stay on the program.

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Health care is a right that should be available to every citizen of our great nation, not only to those who work for the right companies or who can afford it.

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There are big problems with this. People who receive Medicaid and are able to work generally work at low-wage jobs with no paid time off, like housekeeping at a hotel. Work shifts may be intermittent, depending for example on how booked the hotel is, and if you work fewer hours than mandated you lose your Medicaid. If you strain your back cleaning rooms, or just get a bad flu, or your beat-up old car stops working, or you need to take care of your sick child or elderly parent, you may miss work and get fired; you lose your Medicaid. If you were already struggling financially and now have to pay higher premiums for Medicaid, you may have to choose between food and heat in the winter, or paying the rent vs. paying for car repairs so you can get to your job. If you lose your Medicaid, you can easily rack up medical debt and fall even further into poverty and perhaps homelessness.

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[insert personal comments here]
The possible loss of employmant as a consequence of medical issues and work eligibility changes is a terrible outcome. Please respect people who already have challenges they must deal with. Make a positive and human decision.

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Wage labor isn't the only socially valuable labor. Taking care of a child is as much a contribution to society, as working in retail or a restaurant.

Work requirement don't exactly increase workers' bargaining power, in your attempt to keep some people off Medicaid, you might be keeping more people on it.

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Please vote against adding work requirements and increase premiums for Montana!! Women are essential to raising the next generation and need to be available to their kids when needed, especially when they are young. They need to be able to spend this time with their children, rather than having to rush out and find a job to meet work requirements, and send their children to child care.

My mother stayed home to raise us and to be there every day until we were school age. There were times that funds were very tight, but my parents decided that having a parent at home was most important.

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I can't imagine why we would want to make people's lives even harder than they already are by instituting work requirements for medicaid. Stop punishing people for being poor and in need. Our country has been great because we have committed to helping each other when we need it. Let's continue to trust and support our fellow Montanans and give them the help they need without burdensome work requirements.

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You could give up your golden parachute benefits to fund the needy, you know. Or you can continue to abuse the poor and needy as is typical of our legislature and the other non-empathetics in this state.

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MT Medicaid has been massively important to my low-income family. Me (25) and my sister (19) have both benefited immensely from Medicaid, as I've been working low-paid in human rights and advocacy since college, and couldn't afford health care coverage otherwise. My sister has been even more deeply impacted, since Healthy MT Kids and now Medicaid have covered her through very, very costly treatment and medication for serious asthma, anxiety, and clinical depression.
Please don't make changes to our Medicaid that would make it harder for my family and other Montanans to qualify for health care! It is such an important support system for those who most need it, and it makes our state healthier and stronger.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,
[redacted]

Hello,

I was wondering, would the work requirements apply to someone who was disabled, but still in the process of applying for SSI/SSDI? For example, let's say you had someone with autism who was high-functioning enough that they could take care of themselves and maybe work on a sporadic basis, but not regularly, and who was in the process of applying for SSI for that reason. Would they be exempt?

Thanks,

[redacted]

Dear Ms. Sheila Hogan,

As a resident of Montana and someone personally affected by cystic fibrosis, I'm writing to share my support for continuing Medicaid expansion and the 12-month continuous eligibility period. However, I am concerned about how proposed barriers to Medicaid eligibility may impact enrollees and ask you to automatically exempt people with CF from the work requirements and premiums in Montana's Health and Economic Livelihood Partnership (HELP) program amendment and extension application.

Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that

can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

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Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid

enrollees, including those with CF and other complex medical needs, from gaps in coverage that can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

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Sincerely,

[redacted].

I am so grateful Medicaid Expansion in Montana was protected and preserved. Having affordable health insurance is a big part of what us working Montanans need. So many of us who work hard but still can't afford other coverage. Increased premiums and work requirements need to be implemented in a way that makes sure our families can still get healthcare. Thanks for your work on this and thinking of us when rules get made.

[redacted]

[redacted]

[redacted]

Working Montanans need healthcare we can afford. Rules about Medicaid coverage still need to be fair to all of us. Remember us when you're making rules about things like premiums and work requirements. Healthcare is a human right. Thank you.

[redacted]

My family relies on much-needed Medicaid coverage to stay healthy. I already work, like so many people whose families rely in some way on Medicaid do. The clients I care for are on Medicaid because they can't work. As you make rules about continued Medicaid Expansion in Montana, please do that in a way that is fair to all of us. Thanks so much.

[redacted]

I worked hard with so many others to make sure Medicaid Expansion was protected in Montana. Now, we also need to make sure the program stays affordable and available for all Montana families who need it, just like mine. As rules get made, please remember – Premiums have to be affordable, and work requirements can really hurt, instead of help. Let's make sure they don't. Thank you.

[redacted]

As you make rules for Medicaid Expansion in Montana, please remember Montanans like my clients. I am a caregiver, and my clients need access to Medicaid. So do a lot of my coworkers. Let's make sure the rules stay fair for everyone. Thank you.

[redacted]

Medicaid insurance is important to us in Montana. As a retired caregiver, I know how much it is needed. Please remember that healthcare is a human right when you are making rules about things like work requirements and premiums. Health insurance needs to stay accessible.

[redacted]

[redacted]

I am so glad we still have Medicaid Expansion in Montana! I have relied on it for my healthcare and still need it so much. As someone who can't work anymore because of disability, I need you to please remember me and people like me as rules for our healthcare get made. Thank you for your time.

[redacted]

[redacted]

[redacted]

I am a Montana caregiver. Unfortunately, I do not access Medicaid for my own healthcare, though I wish I could. Many of my coworkers, friends and others in our communities do use Medicaid to get affordable insurance. So do my clients. Please keep all of us in mind as you are working on rules to keep healthcare available to all Montanans. Thank you for your time.

[redacted]

[redacted]

[redacted]

Most people who use Medicaid for health insurance are working hard, like me, or are unable to work through no fault of their own, like my clients. We need to be remembered while rules about things like premium costs and work requirements are being decided. Thanks.

[redacted]

[redacted]

[redacted]

When rules for Medicaid get made, it is Montanans like my clients and coworkers – and so many other Montana families – that feel the impact. As a caregiver, I know how much my clients need Medicaid. Also as a caregiver, I know that there are all kinds of families working hard in important jobs that still don't make enough to afford healthcare. Medicaid rules about things like premiums and work requirements need to take us all into account. Thanks.

[redacted]

[redacted]

[redacted]

My granddaughter, [redacted], is five now and was born without the ability to hear. Both of [redacted]'s parents work full-time but do not have access to other, affordable healthcare options at work. Rules about things like premiums and work requirements sometimes forget about families like mine. Please keep them in mind throughout this process. Thank you.

[redacted]

[redacted]

[redacted]

Continued Medicaid Expansion is a very good thing for Montana. Please make sure that the rule-making process around work requirements, premiums and other issues remain fair and equitable. Healthcare is a fiscal good and a human right. Thank you so much for your time.

[redacted]

[redacted]

[redacted]

I am a working Montanan that benefits from Medicaid Expansion. Even though I work, this coverage is the only affordable option for me. There are thousands of Montanans in the same boat. When making rules about premiums and work requirements, please remember us. Thank you for your time.

[redacted]

[redacted]

[redacted]

My name is [redacted]. I've been working in homecare for over 20 years, and right now work 18 hours a week. I'm also a cancer survivor, and August will be my 4th anniversary since my diagnosis. I'm doing well but not out of the woods yet. Medicaid Expansion has allowed me to get the treatments I need to beat cancer. It's also helped me get new glasses and teeth cleanings. Adding work requirements will make it harder for me to keep my insurance and continue working as a caregiver.

[redacted]

[redacted]

[redacted]

My name is [redacted], I live in [redacted] Mt. I have worked in health care for 27 years through the local nursing home, hospital and homecare. I'm opposed to changes in the Medicaid Expansion waver because many people in rural communities simply cannot afford or unable to meet the requirements. It's important that healthcare and other workers have access to healthcare because it means less sick days, less stress to co-workers and better care for clients. Medicaid Expansion also supports local economies through funding to rural hospitals, nursing homes and homecare.

[redacted]

[redacted]

[redacted]

My name is [redacted], I've been a caregiver for roughly 26 years serving families in the Billings area. I'm writing to express my concerns about adding work requirements to Medicaid Expansion. I was lucky to have healthcare through my employer 2 years ago when I was diagnosed with cancer, but I know many Montanans that are not that fortunate. Work requirements are a bad idea especially for people caring for family members and are practically unable to get a second job or work more hours. I also know a number of older caregivers that are still working because they can't afford to retire, but don't have the energy to work the required 80 hours a month. I'm glad that Medicaid Expansion did pass and was reauthorized by the Legislature, but more needs to be done to help working people afford healthcare.

[redacted]

[redacted]

[redacted]

I am one of nearly 100,000 Montanan's who have Medicaid Expansion and if I lose it I will be in serious trouble. For years I have struggled with a bad knee, and my doctor has said it will eventually need to be replaced, which Medicaid Expansion will cover. Medicaid also pays for physical therapy and medication for a thyroid condition, which costs over $2000 a month.

Right now, I'm working 7-12 hours a week as an in-home healthcare worker and it's a challenge to even work that much because of the pain. Copays to see a surgeon and lab work cost $4 each visit. With the limited hours I am able to work I would have no money to pay premiums if they were implemented. The only wiggle room I have in my budget is for fuel, which I need to get to my clients' homes. Work requirements will make it nearly impossible to keep my insurance and continue working.

[redacted]

[redacted]

[redacted]

Hello. My name is [redacted]en, I am [redacted] years old and live in [redacted] where I work as caregiver. I'm opposed to any changes to the Medicaid Expansion program that would make it more difficult for working Montanan's to get healthcare. Throughout most of my life I have battled Krone's disease, which is very expensive to treat and can be fatal. Thankfully I haven't had any flare ups in the last year, but I have had to see my GI doctor several times which was only possible because of Medicaid Expansion. Work requirements are a bad idea, especially for caregivers, because we don't always get to work the number of hours that we are scheduled. Right now I am scheduled for 26 hours a week, but may end up working less due to changes to client cancellations, family visits or hospitalizations. There is no guarantee we are able to pick up clients when we are short. If I lose my coverage I would have no way to afford my medications, and even a slight increase to my premiums would me cutting costs elsewhere that I simply don't have.

[redacted]

[redacted]

[redacted]

My name is [redacted]. I work with adults with developmental disabilities in [redacted]. I'm writing to you as someone who benefits from Medicaid Expansion. This is the first time I've been able to afford health insurance, aside from a short period of time in my early 20's. Without it I would have no teeth, and not be able to work due to chronic neck pain from 3 herniated discs. I get a cervical spine epideral a couple times a year, and without it I wouldn't be able to work. I wouldn't be able to stand for long periods of time, couldn't sleep and would be in constant pain. Medicaid Expansion has been a miracle to me and my family. Additional restrictions like work requirements will only make it harder for people like me to get the help I need.

[redacted]

[redacted]

[redacted]

My name is [redacted]. My wife and I are both direct care workers in [redacted] MT, where we provide care and job coaching for adults with developmental disabilities. We are also both covered under Medicaid Expansion. We don't qualify for any other kind of assistance. We don't get food stamps, rent assistance or anything else. This is the only public aid that we qualify for and it's critical that we are able to keep it. Working people in Montana need to have access to healthcare. It's too expensive to purchase on your own, and it's too important to go without it. Our employer does offer health coverage but it is so expensive and with 3 kids we wouldn't have anything left over the pay rent or other bills. Please don't take away this vital lifeline for people like us.

[redacted]

[redacted]

My name is [redacted]. I'm a caregiver from [redacted]. I'm writing to oppose work requirements and other restrictions to the Medicaid Expansion program that would make it harder for people to get the care they need. Right now I'm working 2 jobs – one to pay the bills and the other to keep my healthcare insurance. It's a constant struggle to maintain hours and I'm always on the edge of losing it. Requiring caregivers to work 80 hours a week doesn't make a lot of sense because our hours can vary so much. Also its important that caregivers have healthcare because of the kind of clients we care for and their potential to get sick and spread illness to others.

[redacted]

[redacted]

[redacted]

I'm [redacted], and I live in [redacted], where I work as a caregiver for our seniors and people with disabilities. The Medicaid Expansion program has helped over 100,000 Montanan's including myself, and other caregivers I know, live a better life than we could afford on our own. I was disturbed when I heard about restrictions passed by the Legislature earlier this year, because this program was set up to help low-income workers, Native Americans and our vets. Now those same people are at risk for losing their healthcare.

Most caregivers don't get full time or even part time hours. We pick up shifts when new clients are enrolled in the program and we are constantly losing clients when they get sick and have to go to a nursing home, like the Libby Care Center. They could be there for a few days to a couple weeks, and there are not always other shifts available for us to pick up. We are working and working hard. Please don't make our lives any more difficult than they already are.

[redacted]

[redacted]

[redacted]

My name is [redacted], I am a grandmother, a tribal member and a home healthcare worker in [redacted]. Medicaid Expansion has been a lifeline to people in rural eastern Montana, especially in Indian Country. Prior to the HELP Act the only option that most folks had was to go to IHS. Now because of Medicaid Expansion we can see a doctor of our choice, and we're able to live healthier lives.

I'm opposed to adding work requirements to this program. Politicians like to talk about how people need to have skin in the game, as if we aren't working already. In small towns on the High Line there aren't a lot of job options, and those that are available require more education than most people have. Also if you are caring for a loved one, like my disabled daughter, you don't have the option of getting a second job. I don't think it's right that people who have so little should be made to jump through hoops to keep their healthcare. This proposal may have sounded good on paper, but it will end up hurting hard working Montanans.

[redacted]

[redacted]

[redacted]

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana’s Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

Medical care through Medicaid should not have more barriers to accessibility.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

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Everyone deserves to have equal access to quality healthcare, and shame on you for trying to swindle that away from working class individuals and people who really need healthcare. Can't we go just one month without our government trying to deprive us from basic human rights? You were elected to serve the people, and I am asking you to do your job. Do the right thing, and don't turn your back on the constituents that need you.

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,
[redacted]

From: [redacted]
Sent: Monday, August 12, 2019 1:08 PM
To: HHS DIR Public Comments <dphhscomments@mt.gov>
Subject: Public comment - Montana Medicaid Expansion waiver

The following is a public comment on proposed work/community engagement requirements to the Montana Medicaid Expansion waiver:

Medicaid work requirements are not logical or sustainable, as other states have learned. For Americans with pre-existing conditions, medical treatment obtained through the Medicaid program may be the reason they can work in the first place.

Many Montanans with disabilities can work and support families, provided they have consistent access to health care. Making health care contingent on work hours means that, if an employer changes schedule temporarily, their employee may permanently lose the health care that enabled them to perform the job at all.

Medicaid work requirements are an irrational idea that should be consigned to the dustbin of history.

AUTISM LEGAL RESOURCE CENTER

Medicaid Coverage of ABA for Adults

Adult ABA services are coverable under Medicaid and should be provided when medically necessary. Failing to provide these services may contravene the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), Section 1557 of the Affordable Care Act (ACA), various Medicaid provisions of the Social Security Act (SSA), the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

Applied Behavior Analysis (ABA) treatments for Autism Spectrum Disorder (ASD) are "services for a mental health condition" and, therefore, covered by MHPAEA.[1] Medicaid coverage of mental health services for adults is subject to MHPAEA as long as some portion of services is delivered through MCOs. Thus even if states carve out some mental health services from an MCO contract and deliver those services through PIHP, PAHP or FFS, parity requirements apply to the entire benefit package.[2] Parity requirements apply regardless of the authority a state employs for its Medicaid program and are fully applicable to section 115 demonstrations and other waiver authorities.[3] Parity requirements are intended to track those imposed on commercial insurers.[4] Services in excess of the state plan will be allowed and

[1] Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans: Final Rule, 81 Fed. Reg, 18390, 18436 (March 30, 2016); 42 CFR §438.900 (mental health benefits); American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013, p. 20 (Definition of a Mental Disorder) and 50-59 (Autism Spectrum Disorder).

[2] 81 Fed. Reg, 18411; 80 Fed. Reg. 19418, 19420 (April 10, 2015).

[3] 81 Fed. Reg. 18414.

[4] Medicaid Fact Sheet: Mental Health Parity Proposed Rule for Medicaid and CHIP (April 6, 2015), p.1 ("[S]tates that have contracts with managed care organizations will be required to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers" this "prevents inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market (including the state and federal marketplace) and Medicaid."). In some instances, the Final Rule accords beneficiaries greater protections than the commercial market. See 81 Fed. Reg. 18417 (declining to extend MHPAEA cost exemption to Medicaid MCOs); 81 Fed. Reg. 18392-3 (applying MHPAEA to long term care services in part to prevent state from avoiding MHPAEA by classifying care as exempt from MHPAEA protections).

must be provided when necessary to comply with MHPAEA.[5] Under the Final Rule, even when services are delivered solely through FFS, states are encouraged to apply MHPAEA.[6]

It is well established that age caps and other discriminatory age-based treatment limitations on mental health benefit coverage not imposed on medical/surgical benefits violate MHPAEA. (see attached guidance from departments of insurance in Oregon and New Jersey that age limitations violate MHPAEA).[7] This analysis applies to state Medicaid programs as well. Following a report by its Legislative Counsel Service that New Mexico's Medicaid program was likely in violation of MHPAEA by limiting ABA coverage to persons below 21 years old,[8] New Mexico is now in the process of extending coverage of ABA services to Medicaid eligible adults.

In addition to MHPAEA, state Medicaid programs must also comply with the nondiscrimination provisions of ACA Section 1557 which prohibits discrimination in the provision of healthcare, including discrimination in benefit design. Construing the requirements of Section 1557 and MHPAEA, the Idaho Department of Insurance recently determined that "an exclusion of treatments for autism spectrum disorder [i]s discriminatory and prohibited when a plan includes coverage of rehabilitative or habilitative services, such as coverage of occupational therapy or speech therapy."[9]

Indeed, for many persons with ASD, ABA treatment is the only effective behavioral health treatment to address their medical needs.[10] Failing to cover this treatment where the state covers behavioral health treatment and rehabilitative or habilitative services that are effective for other conditions is manifestly discriminatory under MHPAEA and Section 1557 and implicates other Medicaid requirements as well. In *K.G. ex rel. Garrido v. Dudek,* the Court

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[5] See 81 Fed. Reg. 18434 (Medicaid MHPAEA rules was necessary because otherwise state would not have to remove or align limits on services in State Plan for beneficiaries in MCOs and individuals could still be subject to treatment limits not in compliance with parity requirements); 81 Fed. Reg. 18418 (where service beyond what is included in state plan are necessary to comply with MHPAEA, states may include in MCO benefit packages and adjust capitation rates or add them to state plan by state plan amendment). 81 Fed. Reg. 18417 (discussing contract review and rate setting where services in excess of service and/or treatment limits specified in state plan are necessary to comply with parity requirements); Medicaid Fact Sheet, supra n. 5 at p.1 ("States will be required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements . . . states that have contracts with managed care organizations will be required to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers. States will have the flexibility to include the cost of providing additional services or removing treatment limitations in their capitation rate methodology.").

[6] 81 Fed. Reg. 18411.

[7] New Jersey Department of Banking and Insurance, PRN-2014, p. 3; Oregon Insurance Division Bulletin INS 2014-2, p. 4.

[8] Reconciling Autism Spectrum Disorder Coverage in Federal and State Law, New Mexico Legislative Counsel Service (October 2016), p.17, available at https://www.nmlegis.gov/handouts/DISC%20100716%20Item%206%20Michael%20Hely,%20LCS%20Reconciling%20Autism%20Spectrum%20Disorder%20Coverage%20in%20Federal%20and%20State%20Law.pdf

[9] Idaho Department of Insurance Bulletin, 18-02 (April 2, 2018), attached and available at https://doi.idaho.gov/DisplayPDF?Id=4924.

[10] See National Autism Center, National Standards Project, Phase 2 (2015), p. 73, available at http://www.nationalautismcenter.org/national-standards-project/phase-2.

considered the plaintiffs' comparability claim for ABA services in addition to their EPSDT claim.[11] In considering the comparability claim, the Court found that under Florida's Medicaid rules, those "with certain DSM/ICD diagnoses (e.g., depression, schizophrenia) can get behavioral health services that are medically necessary to treat their condition while categorically needy children with ASD cannot get medically necessary behavioral services to treat their condition."[12] The Court held that this violated Medicaid's amount, duration and scope requirements at 42 U.S.C. § 1396a(a)(10)(B)(i), and 42 C.F.R. § 440.240(b)(1) as well as the nondiscrimination provision at 42 C.F.R. § 440.230(c).[13] Refusing to provide the type of behavioral health treatment needed by persons with autism is particularly devastating where the treatment is necessary to prevent a likelihood of segregation or institutionalization in violation of *Olmstead*[14] and the integration mandate of Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act.[15]

[11] 981 F. Supp. 2d 1275 (S.D. Fla. 2013), a*ff'd in part and modified in part,* 731 F. 3d 1152 (11th Cir. 2013).
[12] 981 F. Supp. 2d at 1292.
[13] *Id* at 1293.
[14] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[15] 42 U.S.C. §12132; 28 C.F.R. § 35.130; 28 C.F.R. § 4151(b)(3)(i); 45 C.F.R. § 84.4(b)(4).

Comments on Montana DPHHS Section 1115 Demonstration Amendment and Extension Application

August 15, 2019

Marie Matthews, Montana Medicaid Director
c/o
The Department of Public Health and Human Services
P.O. Box 202951
Helena, Montana 59620-2951

RE: Montana Budget and Policy Center Comments on Montana Department of Public Health and Human Services (DPHHS) Section 1115 Demonstration Amendment and Extension Application

Dear Director Matthews:

The Montana Budget and Policy Center submits this comment in support of the Montana Department of Public Health and Human Services' (DPHHS) proposed amendment and extension to the state's demonstration waiver pursuant to sections 1115 of the Social Security Act of 1965 (herein "the waiver"), to continue health care coverage to individuals in Montana with incomes below 138% of the federal poverty line.

The Montana Budget & Policy Center (MBPC) is a nonprofit organization founded in 2008. MBPC's mission is to advance responsible tax, budget, and economic policies through credible research and analysis in order to promote opportunity and fairness for all Montanans. MBPC fulfills this mission by providing credible and timely research and analysis on state fiscal issues to legislators, tribal leaders, advocates, the public, and the media.

As one of several organizations working to expand Medicaid in Montana, MBPC supported the Health and Economic Livelihood Partnership (HELP) Act, passed by the Montana Legislature during the 64th Legislative Session. As of January 1, 2019, 92,548 low-income Montanans are enrolled in affordable health care coverage.[1] This effort has moved Montana closer toward closing the coverage gap, has reduced uncompensated care, and has injected billions in taxpayer dollars into our local economies.

Montana's expansion of Medicaid has had many economic, health, and employment benefits for the state and its participants. While expansion covers individuals with incomes at or below 138% of the federal poverty level (FPL), nine out of ten enrollees are living below poverty. As of December 2018, 101,309 Montanans have accessed preventative health care services.[2] HELP has also transformed access to health care for many American Indians. Medicaid supports Indian Health Service (IHS) and tribal facilities by paying 100 percent of the costs of care for American Indians who are enrolled in Medicaid and receive care at these facilities. That helps ensure that IHS and tribal facilities have the resources needed to maintain and increase their capacity to provide care.

As part of the HELP Act, the Montana Legislature enacted the HELP-Link program, an innovative, voluntary work-support program to help people on Medicaid gain access to stable employment. These services include job seeker workshops, assistance for training in high-demand sectors, credit history counseling, and on-the-job-training programs. The program also connects people to other services such as home health aides, childcare, and housing. By addressing actual barriers to work, HELP-Link has been effective at raising employment as well as earnings. The HELP-Link program has connected 25,244 people who are enrolled in Medicaid to Department of Labor and Industry (DLI) employment services.[3] HELP-Link provides intensive one-on-one support that has helped over 3,000 receive employment training services.[4]

The results for participants have been significant. Of the 3,150 Medicaid clients that completed the DLI workforce training programs in 2016, 70 percent were employed after finishing their training. Over half of those employed had higher wages after completing the program, with an $8,057 wage gain over the previous year.[5]

Medicaid expansion and the HELP-Link program may have raised employment rates among Montanans living on low-incomes, according to the Bureau of Business and Economic Research at the University of Montana.[6] Montana saw labor force participation for low-income individuals rise by three to six percentage points more than other states. Montana did not see similar employment gains among those with higher income levels.[7]

MBPC Comments on Montana's Proposed Waiver

MBPC strongly supports the continuation of Montana's successful Medicaid expansion. While MBPC supported HB 658 to continue Medicaid expansion beyond the current termination date of June 30, 2019, we remain concerned about new provisions that will result in the loss of coverage for thousands of Montana enrollees. MBPC submits the following comments on Montana's updated draft waiver, released on July 23, 2019.

Work/Community Engagements Will Result in Taking Away Health Coverage from Eligible Low-Income Families. Montana's draft extension proposes new requirements for Demonstration enrollees to work or participate in certain allowable activities totaling 80 hours per month. MBPC is concerned about the likely impact of these requirements and the loss of coverage for many enrollees.

The vast majority of Medicaid beneficiaries who can work, do work. In Montana, the vast majority of Medicaid enrollees already work. More than two-thirds of all non-elderly adult Medicaid enrollees work.[8] Only one in six live in a household with no worker present. Nationally, of those *not* working, 29 percent are ill or disabled, 32 percent are caretaking, and 18 percent are attending school.[9]

National studies show that, of those enrollees not employed, virtually all are facing either health-related barriers to employment or labor-force barriers.[10] A Brookings Institute analysis of 2013-2014 Census Bureau survey data found that for Medicaid enrollees aged 18-49 with no dependents under age six, only 1.1 percent do not work because they are not interested in working. For those aged 50-64, only 1.4 percent are not interested in working for pay. For those who are actively participating in the labor force yet not working for pay, the most common reasons cited are work-related (e.g. cannot find a job, recently laid off). For those who are not actively participating in the labor force, the most common reasons cited are health or disability related. Health or disability reasons are cited significantly more among Americans aged 50-64.[11]

The draft waiver's provisions to impose work/community engagements requirements will result in the loss of coverage for certain enrollees. The state's own estimates project that 25,970 enrollees will be subject to the new requirements. Of these roughly 4,000 – 12,000 will not report or fail to meet the requirements and face suspended coverage.

National studies and evidence from other states indicate the state's projections of loss of coverage are likely accurate or even understated. Arkansas was the first state to implement a federal Medicaid waiver requiring enrollees meet monthly work and reporting requirements. As of February 2019, nearly 17,000 Arkansans have lost health insurance, and the state continues to face serious difficulties administering the burdensome requirements.[12] Nearly 22 percent of all beneficiaries subject to the new policy have lost coverage so far - significantly higher than the 6 to 17 percent coverage loss that Kaiser Family Foundation researchers forecasted could result from implementing work requirements nationwide. Confusion over the new system, a lack of awareness, or difficulty accessing internet caused difficulty in complying with the reporting requirements. Without health insurance, many Arkansans face unmet physical and mental health care needs.

Montana workers with low-incomes are especially subject to the volatility of the labor market. National studies

show 22 percent of working Medicaid participants worked over 20 hours in at least one month within a two-year time span but did not do so in other months.[13] This volatility is especially common in rural areas where jobs like farming, manufacturing, and retail commonly feature variable hours, involuntary part-time work, and irregular scheduling.[14]

Many hardworking Montanans who work in vital Montana industries like agriculture, construction, and health care could lose their health care coverage if they fail to meet the set hourly requirements one month. One in four Montana Medicaid enrollees work part-time and could be subject to losing coverage.[15] More than half (53 percent) of Medicaid enrollees in Montana work in the agriculture or service industry, namely restaurant and food service industry. Fifteen percent work in education or health, fields with many part-time and variable hours.[16]

Older Montanans will encounter additional obstacles. Older workers often face barriers maintaining steady employment due to health conditions that make it difficult to consistently meet hourly work requirements. Age discrimination also makes it more difficult for older people to find new employment or maintain their current position.[17]

Frequent reporting is also more difficult for rural program beneficiaries. Montana ranks 48th in the nation for access to broadband internet.[18] A lack of internet connection could mean working individuals lose their health care coverage if they are unable to report their hours worked on time even if they have worked enough to qualify for coverage.

Not only do work requirements hinder Medicaid's goal of providing health care access, work requirements do not achieve the stated goals of increasing work or decreasing poverty. When work requirements have been imposed, research shows that the requirements did not have significant long-term effects. Those not subject to the requirements were found to reach similar employment levels after five years, compared to those subject to the requirements. Stable employment among beneficiaries subject to requirements was the exception, not the norm, and most enrollees with significant barriers to employment never found work.[19]

Montana's Current Premium Requirements and Proposed New Premium Increase Structure Will Result in Taking Away Coverage from Eligible Low-Income Families. The draft demonstration amendment and extension reflects new requirements within HB 658 on premiums. For individuals subject to premiums and subject to work community engagement, premiums will increase gradually based on coverage duration. The demonstration amendment maintains the current disenrollment procedures for certain demonstration enrollees that fail to pay premiums.

Montana has clear evidence that imposing premiums on enrollees has resulted in the loss of health care coverage for thousands. Under Montana's current premium requirements, the state has disenrolled over 5,400 enrollees for failure to pay premiums.[20] This loss of coverage represents roughly one-third of those subject to premiums and disenrollment for failure to pay (ie., those above 100% FPL).

As provided for in the waiver, DPHHS proposes a 0.5 percentage point increase each year where an enrollee subject to premiums is enrolled for more than two years. For an enrollee who is enrolled in a third year, this increase would represent a 25 percent increase in premiums, inconsistent with HB 658. We believe this premium increase structure, as proposed by DPHHS, is inconsistent the plain language of HB 658, and we urge the Department consider amending the waiver to reflect the 0.5 *percent increase* as articulated in HB 658.

If DPHHS chooses to move forward with the 25 percent increase in premiums in year three, the state will continue to see loss of coverage, likely at even higher rates. A previous analysis shows that raising premiums from two percent of income to three percent, as the waiver indicates would happen in demonstration year four, could result in a 24% percent decline in enrollment among those subject to premiums.[21]

Studies show that premiums result in eligible individuals struggling to access or maintain health care coverage.[22] This effect is greatest on those living on low income and living in poverty. For many families living on low wages and struggling to afford food, housing, and other necessities, the requirement to pay even modest premiums can result in fewer individuals accessing health care services. Those that are able to maintain coverage still face greater financial burdens. Further research shows that the impact of premiums can have an even greater negative effect on families of color.[23]

Maintaining Continuous Eligibility Will Reduce Churn and Provide Continuity of Coverage. MBPC strongly supports the state's waiver provisions to continue 12-month continuous eligibility. Providing 12-month continuous eligibility will help reduce churn and provide greater continuity of coverage. This is particularly important for those accessing medication or treatment and those experiencing a chronic illness.

Conclusion

Medicaid expansion has had tremendous benefits in Montana and for individuals accessing health care coverage. We strong support the continuation of Montana's successful Medicaid expansion, but we remain concerned about the likely loss of coverage as a result of new features of the demonstration.

MBPC appreciates the opportunity to submit this comment.

Sincerely,

[redacted]

[1] Montana Department of Health and Human Services, "Montana Medicaid Expansion Dashboard," December 2018.
[2] Montana Department of Health and Human Services, "Montana Medicaid Expansion Dashboard."
[3] HELP Act Oversight Committee, "2018 Report to the Governor and Legislative Finance Committee."
[4] Montana Department of Labor and Industry, "HELP-Link Program 2018 Fiscal Year End Report," accessed December 2018.
[5] Median wage increased to $16,784. Montana Department of Labor and Industry, "HELP-Link Program 2018 Fiscal Year End Report."
[6] Ward, B., and Bridge, B., "The Economic Impact of Medicaid Expansion in Montana: Updated Findings," University of Montana Bureau of Business and Economic Research, January 2019.
[7] Ward, B., and Bridge, B., "The Economic Impact of Medicaid Expansion in Montana: Updated Findings."
[8] Garfield, R., Rudowitz, R., and Damico, A., "Understanding the Intersection of Medicaid and Work," Henry J. Kaiser Family Foundation, Jan. 5, 2018.
[9] Garfield, R., Rudowitz, R., and Damico, A., "Understanding the Intersection of Medicaid and Work."
[10] Work-related reasons for not working include not being able to find work, losing a job, working 15 or more hours for no pay at a family business or farm. Health or disability includes being unable to work due to injury, illness, chronic condition, or disability. Caregiving includes pregnancy, recent childbirth, taking care of children or elderly. Students include those who did not report they were enrolled full or part time but reported not working because they were going to school.
Bauer, L., Whitmore Schanzenbach, D., and Shambaugh, J., "Work Requirements and Safety Net Programs," The Hamilton Project, Oct. 2018.
[11] Bauer, L., Whitmore Schanzenbach, D., and Shambaugh, J., "Work Requirements and Safety Net Programs."
[12] Wagner, J., "As Predicted, Arkansas' Medicaid Requirement Is Taking Coverage Away From Eligible People," Center for Budget and Policy Priorities, December 18, 2018.
[13] Bauer, L., Whitmore Schanzenbach, D., and Shambaugh, J., "Work Requirements and Safety Net Programs."
[14] Center on Budget and Policy Priorities, "How Medicaid Work Requirements Will Harm Rural Residents – And Communities."
[15] Garfield, R., Rudowitz, R., and Damico, A., "Understanding the Intersection of Medicaid and Work."
[16] Garfield, R., Rudowitz, R., and Damico, A., "Understanding the Intersection of Medicaid and Work."
[17] Justice in Aging, "How Medicaid Work Requirements Will Harm Older Adults & Family Caregivers," accessed June 2019.
[18] BroadbandNow, "Broadband Service in Montana," accessed on July 2019.

[19] Pavetti, L., "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 7, 2016.
[20] Department of Public Health and Human Services, "Montana Medicaid Expansion Dashboard," accessed June 2019.
[21] While this report was not updated after legislative amendments to HB 658, the analysis of the premiums is still relevant as that section of the legislation did not substantially change during the legislative process. Ku, L., and Brantley, E., "Potential Effects of Work Requirements in Montana's Medicaid Program," Milken Institute School of Public Health, George Washington University, February 13, 2019.
[22] Artiga, S., et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017.
[23] Artiga, S., et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings."

August 15, 2019

Sheila Hogan, Director
Montana Department of Health and Human Services
111 Sanders St.
Helena, MT 59601

Re: Section 1115 Demonstration Amendment and Expansion Application, Montana Health and Economic Livelihood Partnership (HELP) Program

Dear Director Hogan,

The American Heart Association (AHA) appreciates the opportunity to submit comments on the Montana's 1115 Demonstration Amendment and Expansion application for the Montana Health and Economic Livelihood Partnership (HELP) program. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we appreciate the state's efforts to ensure that the Medicaid program continues to serve low-income Montanans but continue to have concerns about new policies included in the waiver that create barriers to care for patients.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.[1] In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease.[2] Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Low-income populations are disproportionately affected by CVD with adults reporting higher rates of heart disease, hypertension, and stroke. For millions of Americans with CVD, Medicaid is the coverage backbone for the healthcare services individuals need to maintain or improve their health.

The connection between health coverage and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance or are underinsured, have higher mortality rates[3] and poorer blood pressure control[4] than their insured counterparts. Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,[5] and a higher risk of death[6] than similar patients covered by health insurance. In 2015, heart disease and stroke were the number two and number five killers of Montanans.[7] Restricting access to Medicaid would harm South Carolinians who are already facing troubling health outcomes.

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[1] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

[2] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

[3] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.

[4] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.

[5] Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.

[6] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886 –2894.

[7] http://www.heart.org/idc/groups/public/@wcm/@adv/documents/downloadable/ucm_492449.pdf

Montana's Medicaid Reauthorization, Work & Community Engagement Requirements
The AHA is pleased that the legislature, in partnership with the Governor, were able to craft legislation that secured the continuation of the state's Medicaid expansion. While we applaud this action, the AHA continues to express its deep concerns over the inclusion of work and community engagement requirements – as we did during the legislative process. While the state estimates that 88,019 (or 92 percent) of individuals currently enrolled in Medicaid will meet or be exempt from the work and community engagement requirements, the AHA is concerned that unnecessary losses in coverage for the remaining 8 percent of enrollees is unnecessary and could result in negative health outcomes. Nobody should lose access to health care services as a result of administrative barriers or reporting requirements.

The purpose of the Medicaid program is to provide affordable healthcare coverage for low-income individuals and families, which aligns with AHA's commitment to ensuring adequate, affordable and accessible healthcare coverage for all Americans. However, several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have jeopardized patients' access to such quality and affordable healthcare coverage.[8] A recent federal court ruling support this view. On March 27th, U.S. District Judge James Boasberg ruled against the U.S. Department of Health and Human Services (HHS) finding that work and community engagement requirements in Arkansas' and Kentucky's were not in keeping with the aims of the Medicaid program.[9] We continue to urge the state to withdraw this application given both its negative impact on enrollees and questionable legal footing.

Under the amended application, individuals between the age 19 and 55 would be required to either demonstrate that they work at least 80 hours per month or meet exemptions. One significant consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Individuals will need to demonstrate that they meet certain exemptions or have worked the required number of hours, and the proposal does not specify how often individuals would need to this information in order to remain in compliance. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not.

Many individuals with cardiovascular disease experience lapses in employment due to their condition or may have been directed by a physician to take time away from work as part of their treatment and recovery. Therefore, participation in work or work searches as a condition of Medicaid eligibility could discriminate against these individuals and create inappropriate and unwarranted barriers to medical care.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[10] A study published in *JAMA Internal*

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[8] American Lung Association, A Coordinated Attack: Reducing Access to Care in State Medicaid Programs, July 2018. Accessed at http://www.lung.org/assets/documents/become-an-advocate/a-coordinated-attack.pdf.
[9] NEED COURT RULING REFERENCE
[10] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

Medicine, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[11] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

Coverage Losses as a Result of Work Requirements

Until recently, Arkansas was implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption, and also attempted to exempt certain enrollees through data matching as Montana proposes in its application. Still, during the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[12] In another case, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[13] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Reporting & Exemptions

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, like heart disease and stroke. If the state finds that individuals have failed to comply with the new requirements for 180 days, their coverage could be suspended. People who are in treatment for a life-threatening condition such as cardiovascular disease rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

While the American Heart Association acknowledges that the state has attempted to provide exemption criteria for enrollees, these efforts cannot reasonably assure all individuals with, or at risk of, serious and chronic health conditions that prevent them from working, including those with CVD, will have access to the program. In short, the outlined exemptions are not sufficient to protect patients. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[14] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administrative Burden

Regardless of system integration, administering these requirements will be expensive for Montana and burden MDHHS staff as well as Medicaid beneficiaries. States such as Michigan, Pennsylvania, Kentucky and Tennessee have estimated that setting up the administrative systems to track and verify exemptions

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[11] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[12] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Accessed at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[13] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[14] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

and work activities will cost tens of millions of dollars.[15] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Premiums

The AHA is also concerned that the amendment would impose new premium requirements on enrollees. Montana will now require enrollees with income greater that 50 percent of the federal poverty level (FPL) to pay monthly premiums equal to 2 percent of the enrollee's modified adjusted gross income (MAGI) for the first to years of participation. Afterwards, the premiums will increase at 0.5 percent each subsequent year that the enrollee receives coverage, up to a maximum of 4 percent of the enrollee's income.

Research suggests that premiums and cost sharing may not result in the intended cost-savings for programs. What research does show, is that low-income individuals served by Medicaid are more sensitive to costs compared to others, more likely to go without needed care, and more likely to experience longer-term adverse outcomes.[16] A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a co-pay on emergency services resulted in decreased utilization of such services, but did not result in the intended cost savings because of subsequent use of more intensive and expensive services. The results of the study suggest this policy may cause inappropriate delays in needed care.[17] Therefore this proposal will likely fail to meet its intended goal while harming patients at the same time.

Conclusion

The American Heart Association believes all Montanans and all Americans should have access to quality and affordable healthcare coverage. We applaud the unique efforts in Montana to make this a reality. While we support the Montana HELP Amendment in its effort to continue Medicaid Expansion in the state for the next 6 years, we do so with great concern regarding the inclusion of premiums and work and community engagement requirements. These requirements do not meet the AHA's standards for access to high quality and affordable care. The American Heart Association is ready to work with the state to improve access to high-quality, affordable health insurance and appreciates the opportunity to provide comments. If you have any questions about these comments, please contact [redacted]

Sincerely,

[redacted]

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[15]Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[16] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." *Center on Budget and Policy Priorities* (July 2005), available at http://www.cbpp.org/5-31-05health2.htm.

[17] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

My concern is as follows. The work requirement is more of a social experiment this is not acceptable as a taxpayer I object. They are listed as “community engagement” in the bill and include volunteering, work force training (taxpayer paid), drug rehab(taxpayer paid), school (taxpayer paid), probation(taxpayer paid).

This is not what I would call WORK. It’s another vehicle for taking advantage of the taxpayer.

Whomever is in charge of this program must look at the fact that taxpayers are paying for this it’s a waste of money and an abuse of a broken system that has NO value. I was not in favor of this when the bill was proposed originally and not in favor of just more give a ways and no solutions. A feel good program as it is presented does not work it keeps people dependent on a system that will fail.. I have seen many ABLE bodies people unwilling to work and somehow can afford tattoos and cigarettes with beer in their baskets in grocery stores how do you justify this behavior, simply put you can’t.

Thank you,

[redacted]

[redacted]

[redacted]

MHA Montana Hospital Association

August 9, 2019

Sheila Hogan, Director
Department of Public Health and Human Services
Medicaid Expansion Extension
PO Box 4210, Helena, MT 59604-4210

Delivered via email to dphhscomments@mt.gov

RE: Montana Medicaid Expansion (HELP Program) Waiver Submission

Dear Director Hogan:

The Montana Hospital Association appreciates this opportunity to comment on the Department's proposal to seek an extension for the existing waivers supporting expanded eligibility for Medicaid, and the request for 2 waivers to implement new requirements approved by the 2019 Montana legislature and Governor Steve Bullock.

MHA is the principal spokesperson for the collective interests of our 86 institutional members. MHA established a goal to make Montana a top 10 healthy state. Among the initiatives adopted by MHA is achieving increased insurance coverage for Montanans, including Medicaid coverage for low income Montanans.

MHA believes that health care coverage:

- Is key to providing access to health care services that allows the correct care to be delivered at the right time and in the most appropriate and cost effective manner,
- That access to quality health care, especially to routine primary care, serves to establish and maintain a healthy lifestyle and thus reduce health care costs, and
- That Medicaid is the most cost-effective way to provide coverage to low income citizens that are not eligible for subsidized coverage under the Affordable Care Act or who can ill afford private insurance coverage on the individual market.

MHA supported the enactment of the 2015 HELP Act that expanded Medicaid coverage to low income Montanans. We worked with a bipartisan group of legislators and the Governor's office to extend the HELP Act and to establish the new requirements for community engagement in the 2019 session. As part of the extension of Medicaid coverage hospitals agreed to a new tax on outpatient hospital revenue to help fund the state share of Medicaid benefits.

MHA supports the Department's request for the continuation of the Medicaid HELP Act and the request for 2 new waivers aimed at implementing community engagement

requirements and the elimination of cost sharing requirements in favor of increased premiums for longer term Medicaid eligibility.

MHA believes that a great number of persons covered under Medicaid expansion already meet the community engagement requirements, or are exempt from those requirements as articulated in current Montana statutes.

MHA recommends that as CMS and the Department consider the waiver requests that any final community engagement program is implemented in such fashion so as not to end coverage for any Medicaid beneficiary due to bureaucratic design. For example, a person who meets an exemption from community engagement should be provided a reliable route to determine that an exemption exists, that the exemption is documented and that the member not face any considerable or unreasonable barriers to communicate their status to the Department.

The Department notes in its waiver documentation that it expects between 4,000 and 12,000 persons to lose their coverage due to a failure to participate in community engagement activities, failure to demonstrate an exemption or failure to complete required reports. The Department intends to mostly rely upon existing administrative data and resources to administer the new requirements. MHA is concerned that this approach may result in beneficiaries losing coverage due solely to these administrative limitations.

MHA recommends that the Department include a robust program to provide information and consumer education to those persons who are affected by the new reporting requirements. We are prepared to enter into a collaborative effort with the Department to disseminate information and support consumer awareness campaigns.

MHA intends to provide more detailed comment at a future time when more specific details about administration of the new waivers is available for review.

Thank you again for this opportunity to comment on the waiver request. We look forward to CMS approval and the opportunity to work with the Department to implement the new requirements.

Sincerely

[redacted]

[redacted]

Dear Ms. Sheila Hogan,

As a resident of Montana and someone personally affected by cystic fibrosis, I'm writing to share my support for continuing Medicaid expansion and the 12-month continuous eligibility period. However, I am concerned about how proposed barriers to Medicaid eligibility may impact enrollees and ask you to automatically exempt people with CF from the work requirements and premiums in Montana's Health and Economic Livelihood Partnership (HELP) program amendment and extension application.

Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that

can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

MONTANA ACADEMY
OF FAMILY PHYSICIANS

8 CLOVERVIEW, HELENA, MONTANA 59601 • PHONE (406) 431-9384

August 12, 2019

Sheila Hogan, Director
Montana Department of Public Health and Human Services
C/o Medicaid Expansion Extension, Director's Office
PO Box 4210
Helena, MT 59604-2410

Re: Amending and Extending the Montana Health Economic Livelihood Partnership (HELP) Demonstration Program

Dear Director Hogan:

On behalf of the Montana Academy of Family Physicians (MAFP), which represents 570 family physicians, residents, and medical students across our state, I write in response to Montana's proposed Medicaid Section 1115 Demonstration to amend and extend the existing Montana Health Economic Livelihood Partnership (HELP) Demonstration Program.

In November 2015, Montana received federal approval to expand Medicaid to newly eligible adults, including low-income individuals with incomes up to 138 percent of the poverty line, for the first time. As a result of the Montana HELP Demonstration Program (the Demonstration), nearly 100,000 Montanans gained coverage and our state's uninsured rate dropped from 20 percent in 2012 to 7.8 percent in 2018. At the same time, our state's newly established Health and Economic Livelihood Partnership Link (HELP-Link) voluntary employment assistance program – targeted at the newly eligible Medicaid population – has allowed 25,000 Montanans to gain critical job training and career counseling experience since 2016.

To avoid termination of Medicaid expansion in Montana this year, the Montana legislature passed and the Governor signed the Medicaid Reform and Integrity Act (HB 658) to renew and amend the existing Demonstration and permanently expand Medicaid. We are pleased our state legislature came together to ensure the future of this critical program, which has expanded coverage to individuals, improved health outcomes for patients, and benefitted our economy.

Included in this proposed Demonstration are new community engagement and cost-sharing requirements for beneficiaries enrolled in the Medicaid expansion population. While we appreciate the certainty for our physicians and their patients that comes with permanent Medicaid expansion, we are concerned that several aspects of the proposed Demonstration could limit patients' access to care and pose excessive administrative burden to both physicians

and patients. Unlike HELP-Link, a voluntary program to assist Montanans gain employment and self-sufficiency, the proposal's mandatory community engagement and reporting requirements could lead to significant declines in health insurance coverage if not implemented correctly, especially amongst our state's most vulnerable.

According to the Department of Public Health and Human Services, an estimated 4,000-12,000 Medicaid enrollees could lose coverage under the new community engagement requirements. A similar initiative in Arkansas led to more than 18,000 Medicaid enrollees losing their insurance before a federal judge halted further disenrollment. We worry excessive barriers to care, including some of those contained in this proposed Demonstration, could force Medicaid enrollees to avoid seeking care entirely.

It is imperative that all reporting requirements be communicated individually to all enrollees before the work requirement goes into effect. Notification of any changes to enrollees' coverage should be done through multiple means, must be easily comprehensible, and in relevant languages, and must be done more than once in order to mitigate any potential coverage losses.

Furthermore, we urge that any reporting requirements not contribute to any additional burden, financial, administrative, or otherwise, to the physician. Unfortunately, the proposed Demonstration is likely to add to our physicians' workloads and force them to take time away from their patients through the need to verify that enrollees met their community engagement requirements. Effective implementation would be burdensome and costly at the practice level, requiring new procedures, system changes, and considerable time with back office staff. These requirements would only add to the list of needless regulatory complexities doctors face within and beyond the Medicaid program. We fear the new requirements under the proposed Demonstration will further dissuade physicians from treating Medicaid populations.

Potential concerns of what this will mean for family physicians' practices with the proposed Demonstration include the following:

- How will we be able to verify that our patients still have Medicaid?
- Will there be an online database? If so, will this be updated in real time?
- What if our patients had Medicaid coverage months before a visit, had services rendered, but then cannot pay?
- Will family physicians be required to initiate collection proceedings against the Medicaid population?

The proposed Demonstration also increases the cost-sharing requirements for which Medicaid enrollees are responsible from no more than two percent of household income for individuals with incomes greater than 50 percent of the federal poverty level (FPL) to up to four percent FPL – if approved, the highest such beneficiary contribution in the nation. A family of four with a combined household income of $12,550, half the FPL or just $1,045.83 per month, could face a monthly premium of nearly $42 per month, not including other forms of cost-sharing. A literature review compiled by the Kaiser Family Foundation found that premiums and other forms of cost-sharing within Medicaid serve as a barrier to care and may lead some to become uninsured. The review also found that any state savings attributed to premiums and other cost-sharing are offset by increased Medicaid disenrollment and greater utilization of more expensive services in place of primary care. As family physicians, we worry that additional enrollee cost-sharing in the form of increased premiums could disrupt a patient's continuity of care and increase overall uncompensated care costs.

We appreciate the opportunity to comment on Montana's proposed Medicaid Section 1115 Demonstration to amend and extend the HELP Demonstration Program. The MAFP is eager to work with regulators and policymakers to identify innovative strategies to allay our concerns and strengthen Medicaid in Montana. Please contact [redacted] with any questions.

Sincerely,

[redacted]

My name is [redacted] I am a parent of a 27 year old woman with Autism, and is non verbal. [redacted]'s additional disabilities are, Auditory Processing Disorder, Sensory Processing Disorder and a Seizure Disorder.

Each disorder comes with it's own difficulties. Her ability to enjoy going to a job, going out for coffee, swimming with friends, or eating dinner out are very limited given her anxiety.

Anxiety is a condition of Autism and is not easily managed. The only thing that has increased her ability to be part of this world is ABA. Before ABA [redacted] would spend hours in her bedroom perseverating on many strange items. She would get stuck in her world of Autism and we could not help her come out. She had become very reclused and depressed. We had no way to get inside her and pull her back to life.

We have spent years seeking help from many experts.
Nothing has helped [redacted] come out from inside herself except for ABA.

Her bedroom routine was a 3 hour ordeal. Thanks to ABA programming we have reduced it to 30 minutes. Now she has time to go to work. Invite friends for breakfast etc.

[redacted]'s swim routine was torturous, we would spend an enormous amount of time trying to retrieve her from the pool. Now thanks to the programming it literally takes her a few minutes.

[redacted] lives only 2 blocks from her job. She refused each time we tried to walk to work. With the ABA programming [redacted] is now successful walking to work and enjoying the walking mall in Helena.

We are now able to expose [redacted] to new places and activities with out difficulties.

Our lives are very different now after learning how to support our daughter with ABA programming. We have been limited to what we can do together as a family all her life. But now we can include her in most all things.

August 1, 2019

Regarding: Public Comment for Montana Section 1115 Demonstration Amendment and Extension Application

I appreciate the opportunity to submit public comment about Montana's Health and Economic Livelihood Partnership Program (HELP). This program has greatly increased the health and wellbeing of many living in Montana.

I speak today to request the removal of the exclusion of Applied Behavior Analysis for habilitation and rehabilitation benefits within the HELP plan. Applied Behavior Analysis is the only intervention identified as established for individuals with autism over the age of 22 according the National Autism Center report in 2016. Excluding the only evidence based intervention for adults with autism need to change. Back in 2015 when the benchmark definition of habilitation and rehabilitation was set, licensure for behavior analysts in the state of Montana was not established. However, currently licensure for behavior analyst is under the Board of Psychologist.

Please change exclusion to inclusion and allow adults with autism to receive evidence based intervention for treatment of autism.

In Kind Regards,

[redacted]

HELP Plan Services Described

may be individual, group, or family therapy.

Specialty Care

Specialty care is any health care your primary care provider advises but cannot provide. Examples are X-Rays, therapy, or tests to spot a health issue. It is best if all of your health care services are managed by your primary care doctor. If you need specialty care, your primary care provider will refer you to a HELP Plan specialist. Referrals are not required for specialty care, including obstetrical and gynecological care, as long as you see a HELP Plan participating provider. However, treatment received from a provider who is not in the HELP Plan network will not be covered without preauthorization.

If specialty care is needed and a HELP Plan participating provider is not available in your area, contact BCBSMT at **1-877-233-7055**. We will give you information on how to obtain specialty care.

Speech Therapy

(see Therapies, pg. 25)

Supplies

(See Durable Medical Equipment (DME) and Medical Supplies, pg 19)

Surgery

Most medically necessary surgeries are covered, whether done in a hospital or surgery center. Some surgeries must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Telemedicine Services

Telemedicine services are covered when they are provided by HELP Plan providers. The services must be for covered benefits. Telemedicine services are provided through a secure electronic connection. The provider and the participant are not at the same site. There must be both an audio and video portion to the visit. Both the provider and participant must take part in the discussion.

Therapies

Covered therapies are:

- Occupational therapy (requires preauthorization),
- Physical therapy (requires preauthorization),
- Respiratory therapy,
- Speech therapy (requires preauthorization),
- Cardiac therapy, and
- Pulmonary therapy.

Occupational therapy, physical therapy, and speech therapy must be ordered or referred by a HELP Plan provider.

Coverage is provided for habilitative care services when the participant requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

HELP Plan Services Described

Applied behavior analysis for adults is excluded.

Habilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Coverage is provided for rehabilitative care services when the participant needs help to keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled. Rehabilitative services will include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

Applied behavior analysis for adults is excluded.

Rehabilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Therapy services must be preauthorized by your HELP Plan provider; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Tobacco Cessation

Tobacco cessation drugs and counseling are covered by the HELP Plan. You can also get help to stop smoking or chewing by calling the Montana Tobacco Quit Line at **1-800-QUIT-NOW** or **1-800-784-8669**.

Transplants

Organ and tissue transplants are covered. Transplant benefits include:

- Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants.
- For organ and tissue transplants involving a living donor, transplant organ/tissue procurement, and transplant-related medical care for the living donor are covered.
- Transplants of a nonhuman organ or artificial organ implant are not covered.
- Donor searches are not covered.

For certain transplants, BCBSMT contracts with a number of Centers of Excellence that provide transplant services. BCBSMT highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Participants being considered for a transplant procedure are encouraged to contact BCBSMT Participant Services to discuss the possible benefits of utilizing the Centers of Excellence.

Inpatient services must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Research Findings for Adults (22+ Years)

Established Interventions for Adults

The only intervention to be identified as Established for individuals ages 22 years and older is Behavioral Interventions. The Behavioral Intervention category consists of applied behavior analytic interventions to increase adaptive behaviors and decrease challenging behaviors. Examples of specific strategies identified in the 17 articles supporting Behavioral Interventions are provided in the table on the following page.

Emerging Interventions for Adults

Emerging Interventions are those for which one or more studies suggest they may produce favorable outcomes. However, before we can be fully confident that the interventions are effective, additional high quality studies are needed that consistently show these interventions to be effective for individuals with ASD. Based on the available evidence, we are not yet in a position to rule out the possibility that Emerging Interventions are, in fact, not effective.

The following intervention has been identified as falling into the Emerging level of evidence:

- Vocational Training Package

Unestablished Interventions for Adults

Unestablished Interventions are those for which there is little or no evidence in the scientific literature that allows us to draw firm conclusions about their effectiveness with individuals with ASD. There is no reason to assume these interventions are effective. Further, there is no way to rule out the possibility these interventions are ineffective or harmful.

The following interventions have been identified as falling into the Unestablished level of evidence:

- Cognitive Behavioral Intervention Package
- Modeling
- Music Therapy
- Sensory Integration Package

Behavioral Interventions

Established Intervention & Detailed Description

The Behavioral Intervention category is comprised of interventions typically described as antecedent interventions and consequent interventions. Antecedent interventions involve the modification of situational events that typically precede the occurrence of a target behavior. These alterations are made to increase the likelihood of success or reduce the likelihood of problems occurring. Consequent interventions involve making changes to the environment following the occurrence of a targeted behavior. Many of the consequent interventions are designed to reduce problem behavior and teach functional alternative behaviors or skills through the application of basic principles of behavior change.

Basic Facts

Number of articles reviewed:

NSP2 = 17

Ages of participants: Adults 22+ years

Skills increased:

- communication
- personal responsibility
- self-regulation

Behaviors decreased:

- problem behaviors

Example

Examples of Behavioral Interventions consisting of one identified component:

- Prompting
- Extinction (sensory and escape)
- Differential Reinforcement of Incompatible Behavior (DRI)
- Choice
- Functional Communication Training

Examples of Behavioral Interventions consisting of two identified components:

- Prompting + Error Correction
- Prompting + Blocking
- Escape Extinction + Sensory Extinction
- Differential Reinforcement of Alternative Behavior (DRA) + Extinction
- DRI + Response Interruption

Example *(cont.)*

Examples of Behavioral Interventions consisting of three or more identified components:

- Prompting + Blocking + DRA
- DRI + Reprimand + Overcorrection
- Rapport Building + Choice Making + Embedding + Functional Communication Training

Recommended Readings

Danya International, Inc., Organization for Autism Research & Southwest Autism Research & Resource Center. (2006). *Life journey through autism: A guide for transition to adulthood*. Arlington, VA: Organization for Autism Research, Inc. Retrieved from http://www.researchautism.org/resources/reading/index.asp#Transition

Luiselli, J. K. (Ed.) (2011). *Teaching and behavior support for children and adults with autism spectrum disorder: A practitioner's guide*. New York, NY: Oxford University Press.

Wehman, P. (2011). *Essentials of transition planning*. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Wehman, P., Smith, M. D., & Schall, C. (2009). *Autism and the transition to adulthood*. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

HHS.gov U.S. Department of Health & Human Services

Civil Rights

Discrimination on the Basis of Disability

As they apply to entities under the jurisdiction of the Office for Civil Rights (OCR), OCR enforces:

- Section 504 of the Rehabilitation Act of 1973, including programs and activities that are conducted by HHS or receiving Federal financial assistance from HHS
- Section 508 of the Rehabilitation Act of 1973, covering access to electronic and information technology provided by HHS
- Title II of the Americans with Disabilities Act (ADA) of 1990, covering all health care and social services programs and activities of public entities
- Section 1557 of the Patient Protection and Affordable Care Act (ACA), ensuring that an individual is not excluded from participating in, denied benefits because of, or subjected to discrimination as prohibited under Section 504 of the Rehabilitation Act of 1973 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.

Rights and Responsibilities under Section 504 and the ADA

Section 504 and the ADA protect qualified individuals with disabilities from discrimination on the basis of disability in the provision of benefits and services. See the Facts Sheet and the Regulations for an explanation of who is a qualified individual with a disability and more detailed information about rights and responsibilities.

Covered entities must not, on the basis of disability:

- Exclude a person with a disability from a program or activity;
- Deny a person with a disability the benefits of a program or activity;
- Afford a person with a disability an opportunity to participate in or benefit from a benefit or service that is not equal to what is afforded others;
- Provide a benefit or service to a person with a disability that is not as effective as what is provided others;

August 20, 2019

Marie Matthews
Medicaid State Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604

Re: Montana Health and Economic Livelihood (HELP) Demonstration Program

Dear Director Matthews:

The National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on Montana's proposal to extend and amend its existing Health and Economic Livelihood (HELP) Demonstration Program.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. We are committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. NORD is committed to ensuring that Montana's Medicaid program provides adequate, affordable and accessible healthcare coverage.

In Montana, over 92,000 low-income adults currently receive healthcare coverage through the state's Medicaid expansion. This means that thousands of enrollees are receiving prevention, early detection and diagnostic services as well as disease management and treatment for their conditions.[i] 1-in-10 individuals in Montana have one of the approximately 7,000 known rare diseases.[ii] Medicaid expansion is beneficial for patients with rare, serious, and chronic health conditions.

Montana's application to continue the HELP Demonstration Program includes policies that threaten access to healthcare by creating new financial and administrative barriers that could lead patients with rare diseases to lose their healthcare coverage. NORD is concerned about these policies and offers the following comments on Montana's proposal.

Premiums
Montana's Medicaid program currently charges premiums equal to two percent of modified adjusted gross income to adults with incomes above 50 percent of the federal poverty level ($889 for a family of three). Individuals with incomes above 100 percent of the federal poverty level ($1,778 per month for a family of three) can lose their coverage for failing to pay these

premiums. The state proposes to increase premiums by 0.5 percent each year, up to a maximum of four percent, after individuals have been covered by the program for two years. This policy would likely both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program, as research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[iii] For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] For individuals with rare diseases, maintaining access to comprehensive coverage is vital to ensure they have access to needed treatment and therapies. Based on an evaluation of the state's current premium requirement, the state's application estimates that 2.9 percent of individuals will lose coverage as a result of this coverage, likely an underestimate given the increase in premiums under the proposed policy. NORD believes that these premiums create significant financial barriers for patients that jeopardize their access to needed care.

Work Reporting Requirements

Under the application, individuals in the expansion population between the ages of 19 and 55 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[v] Montana's own application includes an estimate that between 4,000 and 12,000 individuals could lose coverage as a result of the work reporting requirements alone but acknowledges that coverage losses could be even higher.[vi]

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements after 180 days, their coverage would be suspended for 180 days unless they are able to demonstrate compliance or qualification for an exemption.

NORD is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to self-report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[vii] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will also be expensive for the state of Montana. States such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[viii] This

would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care – and compromise the fiscal health of Montana's Medicaid program.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[ix] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[x] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[xi] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment.

Additionally, as Montana itself notes in its application, recent research shows that the work reporting requirement in Arkansas did not lead to increased employment among the Medicaid population. A study in *The New England Journal of Medicine* found that the implementation of Arkansas's work requirement was associated with a significant loss of Medicaid coverage and significant increase in the number of uninsured individuals.[xii] The study found no corresponding increase in employment, which negates the argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage. The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so.

Montana's Medicaid program already connects enrollees with Montana's Health and Economic Livelihood Partnership Link (HELP-Link), which provides workforce training to unemployed enrollees who face barriers to work such as limited skills and lack of access to support such as childcare and transportation. This program has reached 25,000 low-income adults since its launch, 70 percent of whom found jobs within a year after completing the program.[xiii] HELP-Link provides low-income adults a pathway to the labor market and employment opportunities that have increased Montanans earning potential without imposing administrative barriers that jeopardize patients' access to care.

Continuous Eligibility

Finally, Montana's application would continue its current policy providing 12 months of continuous eligibility to the Medicaid expansion population. This policy helps to reduce churn in the Medicaid program and minimize the administrative burden to both the state and enrollees. NORD supports Montana's request to continue this policy.

NORD believes that healthcare coverage should be affordable, accessible and adequate for patients with rare diseases. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[redacted]

[redacted]

[i] Montana Department of Public Health and Human Services, Montana Medicaid Expansion Dashboard January 28, 2019. Available at: https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard

[ii] Id.

[iii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iv] Id.

[v] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[vi] Montana Department of Public Health and Human Services, Section 1115 Demonstration Amendment and Extension Application, July 23, 2019. Available at: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf.

[vii] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[viii] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[ix] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[x] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[xi] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[xii] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019. Available at: https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B.

[xiii] Hannah Katch, "Proposed Restrictions Could Undermine Montana's Successful Medicaid Expansion," Center for Budget and Policy Priorities, February 13, 2019, https://www.cbpp.org/research/health/proposed-restrictions-could-undermine-montanas-successful-medicaid-expansion#_ftn1

Public Comment from [redacted]
Submitted to the Montana Department of Public Health and Human Services
August 20, 2019

As Montana's statewide food bank, we are writing to express our concerns with the proposed changes in Montana's Medicaid expansion waiver. Ensuring access to affordable healthcare is a critical step towards reducing hunger in Montana, and our existing Medicaid expansion program has made significant progress in this direction by providing health coverage to nearly 1 in 10 Montanans.

We are concerned that the proposed changes to Montana's Medicaid expansion waiver will weaken our existing program and put vulnerable Montanans at risk of losing health coverage. We oppose the new community engagement/work requirement and the increased premiums. The community engagement/work requirement puts those facing barriers to work, as well as those currently working, at risk of losing coverage due to a failure to secure a necessary exemption or for a failure to complete reporting requirements. We are particularly concerned with this new requirement given the revised analysis of how many individuals will be impacted – nearly 26,000 people, three times the number initially estimated.

We also oppose the increased premiums. Individuals participating in Medicaid expansion are living on very limited incomes and already struggle to afford housing, utilities, food, and other necessities. An additional expense will only further strain limited incomes, increasing their risk of food insecurity.

Montana's existing Medicaid expansion program has helped people get and stay healthy by providing basic access to healthcare for tens of thousands of individuals. Services such as preventative care, mental healthcare, and addiction treatment are essential in creating strong, productive communities and reducing hunger in the long term. The proposed changes to our Medicaid expansion waiver put the success of Montana's program at risk. We urge the state to consider these concerns and recognize our strong opposition to both the community engagement/work requirement and to the increased premiums when drafting the waiver.

[redacted]

MONTANA FOOD BANK NETWORK
Our mission is to end hunger in Montana.

ADDRESS 5625 Expressway | Missoula | 59808
PHONE (406) 721.3825
ONLINE mfbn.org

August 20, 2019

Medicaid Expansion Extension
Director's Office
P.O. Box 4210
Helena, MT 59604-4210

Dear Director Hogan,

The Montana Chapter of the American Academy of Pediatrics (MTAAP), a nonprofit organization representing 120 pediatricians from across the state, dedicated to the health, safety and well-being of all Montana infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the Montana Section 1115 Demonstration Amendment and Extension Application.

We write today to express our concerns with this proposed waiver application, which would create significant barriers to affordable health care coverage for low-income individuals, particularly parents. Montana seeks waiver authority to add work as a condition of Medicaid coverage for all newly eligible adults under the current Demonstration, all of whom are at significantly low incomes. The proposed waiver would also increase premium costs for this population of Medicaid beneficiaries by basing increases not on income levels, but on the length of time individuals are enrolled. Currently, the income eligibility for the parent/caregiver relative group is 24% of the federal poverty level (FPL), which means many parents and caregivers living in poverty are currently receiving Medicaid benefits as part of the current Demonstration.[1] This newly proposed work reporting requirement would put that vital coverage at risk.

While Montana rightfully touts its reduced uninsured rate and new access to preventive care, cancer treatment, and mental health and substance use treatment as a result of its Medicaid expansion, the state is now putting those gains at risk in order to implement new work reporting requirements and increased premiums for individuals earning very low incomes. Additionally, there does not appear to be a need for the work reporting requirement, as the current employment assessment and supports the state already has in place appear to be working to increase employment level among beneficiaries. According to the state's own application, more low-income adults are joining the workforce, including a 9% increase in employment among non-disabled adults. The programs already in place appear to be fulfilling the goals this proposed waiver claims to be setting.

Moreover, as the recent federal court decisions *Gresham v. Azar*, *Stewart v. Azar*, and *Philbrick v. Azar* demonstrate in blocking similar waivers in Arkansas, Kentucky, and New Hampshire, it is not clear that this waiver furthers the clear objective of the Medicaid program to furnish medical assistance to low income residents in Montana.

[1] https://www.medicaid.gov/state-overviews/stateprofile.html?state=Montana

Specifically, we are concerned with the following issues:

- **The potential for significant coverage losses and treatment delays.** As currently written, newly eligible adults, including parents and caregivers, would be required to participate in and report their work and community engagement hours to the state. As we have seen in Arkansas, the first state to implement its work reporting requirement, there have been extreme coverage losses, with more than 18,000 people losing coverage in 2018. Additional data also show that more people would be likely to lose coverage in 2019, had its proposal not been blocked by federal court.[2] While we appreciate the provisions the state has included which would trigger an audit of the program if more than 5% of enrollees have their eligibility suspended, this does not prevent parents and caregivers from losing access to valuable coverage.

  While the state's proposal technically does not disenroll people from coverage, but "suspends" coverage, this does not solve the problem of low-income individuals being unable to seek care. Coverage suspended for 6 months will still result in parents not having access to health care during that time. If individuals are faced with an emerging health issue, care could be significantly delayed or not received at all. Additionally, there does not appear to be a provision protecting those who may be receiving an ongoing course of treatment for a condition which would not deem them exempt from the requirements. While the state would reinstate coverage after 6 months or when beneficiaries are found to be in compliance for 30 days, the proposed waiver does not indicate whether services received during the suspended period would be retroactively covered. This could leave low-income families responsible for medical bills incurred during this time and/or result in uncompensated care costs for providers and hospitals.

  Low-income parents losing or having their Medicaid coverage suspended will have an impact on the health of Montana children as well. As pediatricians, we know that parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain their children's coverage over time. Research shows the positive effects that Medicaid coverage of adults is having in other states in terms of coverage, access to care, utilization, affordability, health outcomes, and many economic measures.[3] New research also demonstrates that coverage of parents has spillover effects in terms of increased use of preventive services by children.[4] The loss of parental coverage because of this new proposal will directly affect children.

  Montana claims that being employed improves health outcomes while simultaneously proposing to take health care away from individuals who are unable to work or fail to properly document their work activities. This runs counter to what is known about access to health care and the ability to work. A report evaluating the impact of Medicaid expansion in Ohio revealed that of new Medicaid enrollees who were employed, 52% stated that having Medicaid made it easier for them to continue working, while of those who were not employed, 74.8% said having

[2] https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/
[3] https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/
[4] http://pediatrics.aappublications.org/content/early/2017/11/09/peds.2017-0953

coverage made it easier for them to look for employment.[5] As shown in this Ohio evaluation, Medicaid plays a critical role in supporting the abilities of individuals to look for employment and once employed, continue working.

- **Impact of increased premiums on low income individuals and families.** We also have concerns about premium increases for low-income individuals based on their length of enrollment rather than income levels. This change will disproportionately impact lower income families. While we appreciate the state's proposal to not disenroll beneficiaries with incomes below 100% of FPL for not paying the increased premiums, the additional cost to families could still result in coverage losses. Research demonstrates that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. Premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling.[6] This proposal is punitively punishing low-income families for needing health care services for longer periods of time, in spite of the fact working alone does not always eliminate the need for Medicaid.

  Even if those families with income below 100% of FPL retain their Medicaid coverage, the increase in premium costs will still be deducted from beneficiaries' income through Department of Revenue collections and will have a large impact on their ability to meet their basic needs. A 2015 report shows that "families living in poverty, and particularly in deep poverty, have few resources available after they pay for the most basic necessities, even before other critical expenditures such as health care, childcare, and transportation are taken into account." It concludes that low-income individuals are particularly sensitive to modest or nominal increases in medical out-of-pocket costs, including premiums.[7]

  While we do commend the state for removing the requirement that Demonstration enrollees be subject to co-payments, we remain concerned that the premium cost increases will be a barrier for access to health care for many families.

- **Transitioning to private coverage**. This proposal hypothesizes that individuals who meet the work requirement will transition to other health insurance. However, simply being employed does not guarantee an individual will be able to obtain health insurance. A 2014 study showed that only 28% of employees of private firms with low average wages obtain health insurance through their jobs, and 42% are not even eligible for employer sponsored coverage.[8]

  Another proposal hypothesis is that this waiver will result in more people gaining sustained employment. However, a recent study of the implemented Arkansas waiver reveals "the nation's first work requirements in Medicaid in 2018 was associated with significant losses in health insurance coverage in the policy's initial six months but no significant change in

[5] http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf
[6] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
[7] https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty
[8] https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

employment." The authors found commensurate increases in the uninsured rate in the state.[9] This study provides evidence that Arkansas' work requirement left people uninsured and did not promote employment.

- **Beneficiary notification of requirements.** We also remain concerned as to how Medicaid beneficiaries will receive notice that they are now required to report work hours and the means by which they will do so. While Montana indicates beneficiaries will receive supplemental information on new work reporting requirements with Medicaid applications, redeterminations, and change reporting, we remain concerned that beneficiaries will not clearly understand these new requirements and how to fulfill them. In Arkansas, there have been many issues with effective outreach and beneficiary reporting. It has been noted that a majority of enrollees subject to the new requirement were simply unaware of it.[10] Written notices have been confusing and may not account for lower levels of literacy or a lack of English proficiency. Social media and other online outreach had limited impact in Arkansas due to lack of access to computers and/or the internet.[11] Without assuring meaningful methods of reporting compliance, parents and caregivers may lose coverage or have it suspended because they are simply unaware of the new requirement or do not have the means to report their hours to the state.

- **Additional state costs.** Montana is likely to see additional financial burdens because of the administrative costs of implementing a work requirement. As an example, when one state implemented a work requirement in its Temporary Assistance for Needy Families (TANF) program, it cost $70 million to implement.[12] And reports from Kentucky indicate administrative costs in Medicaid have jumped by as much as 40% in part due to implementation of its work requirement.[13] An increase in costs for uncompensated care is also likely if this waiver is approved and implemented. As more individuals lose access to their health coverage, they will begin to visit emergency departments, a much more expensive source of care. And as that coverage would be provided regardless of the patient's ability to pay, the state would see increased uncompensated care costs, while also putting a greater strain on our safety-net hospitals and clinics.

This waiver proposal creates unnecessary additional complexity to the Medicaid program and puts the gains the state has already seen at risk. The intent of the Medicaid program is to provide needed coverage to low-income residents—most of whom already work—who cannot afford private insurance. Adding an onerous work reporting requirement and increasing premiums based on length on

[9] https://www.nejm.org/doi/full/10.1056/NEJMsr1901772
[10] https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/
[11] http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Implementation-of-Medicaid-Work-Requirements-in-Arkansas
[12] http://www.governing.com/topics/health-human-services/gov-medicaid-work-requirements-states-cost-implement.html
[13] https://www.forbes.com/sites/brucejapsen/2018/07/22/trumps-medicaid-work-rules-hit-states-with-costs-and-bureaucracy/#6879ebdd66f5

enrollments as proposed contradicts the very nature of Medicaid as a health care lifeline for those most in need.

We hope the state takes the thoughts of Montana's pediatricians into consideration as it contemplates this waiver amendment. Thank you for the opportunity to provide comments on this application. If you have questions regarding our concerns, please contact Kylee Bodley, Executive Director of the Montana Chapter of the American Academy of Pediatrics.

Sincerely,

Rocky Mountain Hemophilia
& Bleeding Disorders Association
a 501(c)(3) nonprofit Montana corporation

HFA
Hemophilia Federation of America

National Hemophilia Foundation
for all bleeding disorders

August 19, 2019

Marie Matthews
Medicaid State Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604

Re: Montana Health and Economic Livelihood (HELP) Demonstration Program

Dear Director Matthews:

Rocky Mountain Hemophilia and Bleeding Disorders Association (RMHBDA) is a non-profit organization based in Bozeman that serves the bleeding disorders community of Montana and Wyoming. RMHBDA's mission is to improve the quality of care and life for persons with inherited bleeding disorders, including hemophilia and von Willebrand Disease, through education, peer support, resources, and referral. Hemophilia national non-profit organizations that represent individuals with bleeding disorders across the United States. Our missions are to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence. Together, RMHBDA, HFA, and NHF appreciate the opportunity to submit comments on the Montana Health and Economic Livelihood (HELP) Demonstration Program.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. Our organizations support Medicaid expansion in Montana. Over 92,000 low-income adults currently receive healthcare coverage through the state's Medicaid expansion. This means that thousands of enrollees are receiving prevention, early detection and diagnostic services as well as disease management and treatment for their conditions.[i] Medicaid expansion is clearly beneficial for patients with serious and chronic health conditions such as hemophilia and other inherited bleeding disorders.

Montana's application to continue the HELP Demonstration Program also includes policies that threaten access to healthcare by creating new financial and administrative barriers that could lead patients with bleeding disorders to lose their healthcare coverage. RMHBDA, HFA, and NHF therefore offer the following comments on Montana's proposal.

Premiums

Montana's Medicaid program currently charges premiums equal to two percent of modified adjusted gross income to adults with incomes above 50 percent of the federal poverty level ($889 for a family of three), and individuals with incomes above 100 percent of the federal poverty level ($1,778 per month for a family of three) can lose their coverage for failing to pay these premiums. The state proposes to increase premiums by 0.5 percent each year, up to a maximum of four percent, after individuals have been covered by the program for two years. This policy would likely both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program, as research has shown that even relatively low levels of

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cost-sharing for low-income populations limit the use of necessary healthcare services.[ii] For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iii] For individuals with bleeding disorders, maintaining access to comprehensive coverage is vital to ensure effective prevention and/or treatment of bleeding episodes. Based on an evaluation of the state's current premium requirement, the state's application estimates that 2.9 percent of individuals will lose coverage as a result of this coverage, likely an underestimate given the increase in premiums under the proposed policy. RMHBDA, HFA, and NHF believe that these premiums create significant financial barriers for patients that jeopardize their access to needed care.

Work Reporting Requirements

Under the application, individuals in the expansion population between the ages of 19 and 55 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[iv] Montana's own application includes an estimate that between 4,000 and 12,000 individuals could lose coverage as a result of the work reporting requirements alone but acknowledges that coverage losses could be even higher.[v]

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with bleeding disorders. If the state finds that individuals have failed to comply with the new requirements after 180 days, their coverage would be suspended for 180 days unless they are able to demonstrate compliance or qualification for an exemption. This would be devastating for people with bleeding disorders, who rely on essential medications and care to manage their condition: to prevent bleeding, and to treat acute breakthrough bleeding episodes which could lead to cumulative, irreversible joint damage or worse. Individuals with a bleeding disorder cannot afford to experience sudden gaps in their care which cut them off from timely access to their treatment.

RMHBDA, HFA, and NHF are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working Regardless, even exempt enrollees may have to self-report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[vi] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will also be expensive for the state of Montana. States such as Kentucky, Tennessee, and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[vii] Spending money on tracking systems would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care – and compromise the fiscal health of Montana's Medicaid program.

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a 501(c)(3) nonprofit Montana corporation

HFA Hemophilia Federation of America

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Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[viii] A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.[ix] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two-thirds reported having a chronic physical condition and one quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it *easier* to work or look for work (83.5 percent and 60 percent, respectively).[x] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with work and reporting requirements will hurt rather than help people search for and obtain employment.

Additionally, as Montana itself notes in its application, recent research shows that the work reporting requirement in Arkansas did not lead to increased employment among the Medicaid population. A study in *The New England Journal of Medicine* found that the implementation of Arkansas's work requirement was associated with a significant loss of Medicaid coverage and significant increase in the number of uninsured individuals.[xi] The study found no corresponding increase in employment, which negates the argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage. The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so – and that coverage losses are likely to be widespread among people who comply with the substance if not the reporting requirements of the rule.

Montana's Medicaid program already connects enrollees with Montana's Health and Economic Livelihood Partnership Link (HELP-Link), which provides workforce training to unemployed enrollees who face barriers to work such as limited skills and lack of access to support such as childcare and transportation. This program has reached 25,000 low-income adults since its launch, 70 percent of whom found jobs within a year after completing the program.[xii] HELP-Link provides low-income adults a pathway to the labor market and employment opportunities that have increased Montanans earning potential without imposing administrative barriers that jeopardize patients' access to care.

Continuous Eligibility

Finally, Montana's application would continue its current policy providing 12 months of continuous eligibility to the Medicaid expansion population. This policy helps to reduce churn in the Medicaid program and minimize the administrative burden to both the state and enrollees. RMHBDA, HFA, and NHF support Montana's request to continue this policy.

RMHBDA, HFA, and NHF believe that healthcare coverage should be affordable, accessible and adequate for patients with hemophilia and other inherited bleeding

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disorders. We urge Montana to craft its Medicaid policies accordingly. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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[i] Montana Department of Public Health and Human Services, Montana Medicaid Expansion Dashboard January 28, 2019. Available at: https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard

[ii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iii] Id.

[iv] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[v] Montana Department of Public Health and Human Services, Section 1115 Demonstration Amendment and Extension Application, July 23, 2019. Available at: https://dphhs.mt.gov/Portals/85/Documents/Medicaid Expansion/UpdatedApplicationforAmendmentandExtension-draft.pdf.

[vi] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[vii] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[viii] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

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[ix] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[x] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[xi] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019. Available at: https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B.

[xii] Hannah Katch, "Proposed Restrictions Could Undermine Montana's Successful Medicaid Expansion," Center for Budget and Policy Priorities, February 13, 2019, https://www.cbpp.org/research/health/proposed-restrictions-could-undermine-montanas-successful-medicaid-expansion#_ftn1

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LEUKEMIA & LYMPHOMA SOCIETY®

August 22, 2019

Marie Matthews, Medicaid State Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604

Re: Montana Health and Economic Livelihood (HELP) Demonstration Program

Dear Director Matthews,

The Leukemia & Lymphoma Society (LLS) writes to express serious concerns regarding the HELP demonstration project waiver application. If implemented, this waiver would impede access to health care by imposing undue burden on individuals enrolled in Medicaid. Recognizing that work requirements and premium increases will create barriers to care, we urge you not to advance this waiver application.

As the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities, Medicaid covers 1 in 5 Americans.[i] In Montana, 92,000 Montanans were covered when Medicaid was initially expanded. Many of them have complex and costly health care needs, making Medicaid a critical access point for disease management and care for many of the poorest and sickest people in the state. Maintaining Medicaid expansion in Montana is of critical importance to ensuring access to coverage. Medicaid expansion is also beneficial to Montana's economy as Medicaid expansion has been associated with a reduced risk of hospital closures, especially in rural areas.[ii]

While LLS strongly supported last year's effort to lift the sunset on Medicaid expansion in Montana, we strongly oppose restricting eligibility and enrollment by imposing barriers to access on Medicaid beneficiaries.

Requiring beneficiaries to work will result in loss of coverage

LLS opposes so-called "work requirements" because they are likely to trigger significant reductions in the number of low-income patients who are able to access Medicaid coverage. Consider Arkansas, where such requirements have been implemented through a program called Arkansas Works. Arkansas Works requires Medicaid enrollees either to report their hours worked or to secure an exemption from having to comply with the program's requirements. During the initial six months of implementation, Arkansas terminated Medicaid coverage for over 18,000 individuals who purportedly did not meet the program requirements, however research demonstrated that the overwhelming majority of those who lost coverage were working and simply failed to meet reporting requirements[iii] and thus were eligible to continue enrollment in Medicaid .[iv] In April of 2019, Judge James E. Boasberg of the Federal District Court for the District of Columbia ruled that the Arkansas work requirements program was unlawful on the grounds that it failed to provide medical assistance to its citizens, a "central objective of Medicaid".[v]

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Exemptions do not provide adequate protection to intended populations

The loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. For example, people in the midst of cancer treatment rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols. While this waiver includes provisions to exempt those "experiencing an acute medical condition requiring immediate medical treatment," it is unclear how those exemptions will be tracked. In some cases, the administrative burden of proving an exemption can result in a loss of coverage. For example, in the Temporary Assistance for Needy Families (TANF) program, many people who were working or should have qualified for exemptions from work requirements lost benefits because they did not complete required paperwork or were unable to document their eligibility for exemptions.[vi]

Premium requirements pose barriers to access and have limited impact on savings to the state

Increases in premiums and cost-sharing are likely to cause Medicaid enrollees to either lose access to coverage and/or decrease their adherence to treatment.[vii] Cancer patients often require strict treatment protocols and any disruption to that treatment can result in serious, adverse health consequences. Additionally, studies project that increasing enrollees' premiums and cost-sharing would generate only limited savings for states and that, in some cases, those savings would be eliminated by increases in uncompensated care (e.g. increased use of the emergency department by individuals who now lack coverage) and increased administrative expenses.[viii]

LLS strongly supports Medicaid expansion, but believes that additional restrictions proposed in the waiver application will result in Montanans losing coverage. We hope that you will support the 92,000 Montanans covered by Medicaid expansion who rely on Medicaid as their only source of affordable, meaningful coverage and ensure they are not subject to additional barriers to care.

Sincerely,

[redacted]

[i] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[ii] Richard Lindrooth, Marcelo Perraillon, Rose Hardy, and Gregory Tung, "Understanding the Relationship Between Medicaid Expansions and Hospital Closures," Health Affairs 27, no. 1 (January 2018): pp. 111-120. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976.

[iii] Benjamin D Sommers et al, "Medicaid Work Requirements – Results from the First Year in Arkansas," NEJM, June 19, 2019. Available at: https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[iv] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018, https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/

[v] Goodnough, Abby. (March 27, 2019). Judge Blocks Medicaid Work Requirements in Arkansas and Kentucky. *The New York Times.* Retrieved from: https://www.nytimes.com/2019/03/27/health/medicaid-work-requirement.html

[vi] Solomon, Judith. Kentucky Waiver Will Harm Medicaid Beneficiaries. (January 16, 2018). *Center on Budget and Policy Priorities*. Retrieved from: https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries.

[vii] Artiga, S., Ubri, P., Zur, J. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. (June 1, 2017). *Kaiser Family Foundation.* Retrieved from: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[viii] Ibid.

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BEATING CANCER IS IN OUR BLOOD.

*Submitted electronically via **dphhscomments@mt.gov**.*

August 22, 2019

Medicaid Expansion Extension
Director's Office
PO Box 4210, Helena, MT 59604-4210

Re: Section 1115 Demonstration Amendment and Extension Application: Montana Health and Economic Livelihood Partnership (HELP) Program

Dear Director,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP submits the following comments in response to Montana's Section 1115 Demonstration Amendment and Extension Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Montana.

These comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. In fact, only 16 percent of poor adults receive health insurance through their jobs[1] and, according to recent a recent survey by the Bureau of Labor Statistics, low-wage workers pay more for employer-provided medical care benefits than higher-wage workers.[2] Others may have

health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.
The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.[3] A waiver that does not promote the provision of health care would not be permissible.

This proposal's attempt to transform Medicaid and reverse its core function will result in individuals losing needed coverage, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[4] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected.

Losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. Montana writes that one of the future goals of the HELP program is to "improve the health, well-being, and financial stability of Montanans by implementing a work/community engagement program." The proposed approach to condition Medicaid on participating in work reporting requirements would take away – not contribute to – progress the state has made to improve health and financial outcomes for Montanans. By expanding Medicaid, the state has seen a 9 percent increase in non-disabled adults working and a 6 percent increase in people with disabilities working. In fact, Montana already supports work without taking people's health coverage away, providing workforce training on a volunteer basis to a small share of enrollees who can work, but aren't working find or hold jobs.[5] This proposal would take Montanans off their path towards improved health and economic outcomes and wipe out the gains made since expanding Medicaid.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Montana's proposal to take away health coverage from individuals who do not meet new work reporting requirements. Our comments that follow focus on the harmful impact the proposed work requirements will have on low-income Montanans and the state.

Montana is proposing to implement a work reporting requirement. The directly impacted population would be all Demonstration enrollees between 19 and 55 with income up to 138 percent FPL who do not otherwise qualify for an exemption. Montana notes that some populations, such as individuals meeting the work reporting requirement or already determined exempt under TANF, will be exempt from the work reporting requirement. The penalty for not complying with the work requirement is suspension from Medicaid.

CLASP strongly opposes work reporting requirements for Medicaid beneficiaries and urges Montana

to withdraw this request. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Promote Employment

Creating a work requirement for Medicaid is misguided and short-sighted. Lessons learned from other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.[6] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[7] Medicaid expansion enrollees from Ohio[8] and Michigan[9] reported that having Medicaid made it easier to look for employment and stay employed. Additionally, as referenced above, more adults in low-income households have been able to join the workforce in Montana since expanding Medicaid. Further, recent analysis by the New York Times finds that young single mothers' participation in the labor force increased four percentage points more in states that expanded Medicaid in 2014 compared to those that didn't, providing evidence that if people don't lose their health insurance when they go to work, they are more likely to work.[10] Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Lead to Employer-Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition to affordable employer-sponsored insurance (ESI). Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs—and only 16 percent of poor adults do so.[11] The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not offer ESI, and when they do, it is not affordable.[12] In fact, in 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under in their employer offered insurance.[13] People working multiple part-time jobs or in the gig economy are particularly

unlikely to have access to ESI.

A recent study by the Urban Institute provides additional evidence in New Hampshire – a state that was recently approved to move forward with their work reporting requirement. The paper found that New Hampshire residents who could lose Medicaid under work reporting requirements will likely face limited and costly employer-sponsored insurance options. In particular, researchers found that less than one in tend part-time private-sector employees in New Hampshire were eligible for employer-sponsored coverage and just over half of full-time employees at firms with fewer than 50 employees were eligible for employer-sponsored coverage in 2017. Additionally, annual employee contributions for a single-coverage plan would represent 12.5 percent of annual income for a minimum-wage, full-time worker and 25.0 percent of annual income for a minimum-wage, part-time worker— more than ten times the percentage premium limit in the Marketplace for individuals earning 100 percent of the federal poverty level.[14]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away health coverage from Medicaid enrollees who do not meet new work requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems.

One of the key lessons of the Work Support Strategies initiative is that every time a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements.

Lessons from the WSS initiative is that the result of Montana's new administrative complexity and red tape is that eligible people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome. Recent evidence from Arkansas' implementation of work reporting requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 18,000 beneficiaries lost coverage before the program was suspended by a federal judge, likely becoming uninsured because they didn't report their work or work-related activities.[15] As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[16] The recent study looking at the Arkansas program found that "work requirements have substantially exacerbated administrative hurdles to maintaining coverage". The study found a reduction in Medicaid of 12 percent, even though more than 95% of those who were

subject to the policy already met the requirement or should have been exempt.[17]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take health coverage away from Medicaid enrollees who do not work a set number of hours do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum number of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[18] This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Montana's proposal to implement work reporting requirements of 80 hours per month is incredibly blind to the reality of low-wage work. An analysis by the Urban Institute found that Kentucky's proposal to take away health care from individuals who do not work a set number of hours – which is similar to Montana's - does not align with the reality of some working enrollees' lives. Urban found that an estimated 13 percent of nondisabled, nonelderly working Medicaid enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky's Medicaid program could be at risk of losing Medicaid coverage at some point in the year under the work requirements because, despite working 960 hours a year, they may not work consistently enough throughout the year to comply with the waiver.[19] Additional analysis from the Urban Institute shows that Medicaid enrollees who would potentially be subject to work reporting requirements are more likely to face barriers to employment, compared with privately insured adults. The analysis found that half of nonexempt Medicaid enrollees reported issues related to the labor market or nature of employment, such as difficulty finding work and restricted work schedules, as reasons for not working more, and over one-quarter reported health reasons.[20]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose coverage because of the work requirement. Although Montana is proposing to exempt people who are medically frail or have exceptional health care need in reality, many people are not able to work due to disability or disease are likely to not receive an exemption due to the complexity of paperwork. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. In Montana, this rate increases to 37 percent.[21] Additional research from the Kaiser Family Foundation shows that people with disabilities were particularly vulnerable to losing coverage under the Arkansas work reporting requirements, despite remaining eligible.[22]

And, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[23] and nearly 20 percent had filed for Disability/SSI within the previous two years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement. The result is that many people with disabilities will, in fact, be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Montana's proposal to take away health coverage from Medicaid enrollees who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek re-enrollment once they need healthcare, and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

When the beneficiary re-enrolls in Medicaid after their suspension, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[24] Public programs will end up spending more to bring these beneficiaries back to health.

Support services will be inadequate

Child care is a significant barrier to employment for low-income parents. Many low-income jobs have variable hours from week to week and evening and weekend hours, creating additional challenges to finding affordable and safe child care. Finding affordable and safe child care for children is difficult and a barrier to employment, including for those who are not single parents. Requiring employment in order to maintain health care, but not providing adequate support services such as child care, sets a family up for a no-win situation. Even with the recent increase in federal child care funding, Montana does not have enough funding to ensure all eligible families can access child care assistance.[25]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Have a Disparate Impact on Communities of Color

We strongly oppose the proposal due to its disproportionate impact on communities of color. Many people of color face employment challenges and, under the proposed policy, would be disadvantaged in being able to maintain their Medicaid eligibility.

Persons of color are overrepresented in the Montana Medicaid program, meaning that policies such as a work reporting requirement will disproportionately affect this population and contribute to

furthering racial disparities in health care access. Persons of color are more likely to be affected by a work reporting requirement due to systemic challenges they face in employment.

Employment discrimination limits access to the workforce for many people of color: Studies show that racial discrimination remains a key force in the labor market.[26] In a 2004 study, "Are Emily and Greg more employable than Lakisha and Jamal: A Field Experiment on Labor Market Discrimination," researchers randomly assigned names and quality to resumes and sent them to over 1,300 employment advertisements. Their results revealed significant differences in the number of callbacks each resume received based on whether the name sounded white or African American. More recent research indicates that this bias persists. A study from 2013 submitted fake resumes of nonexistent recent college graduates through online job applications for positions based in Atlanta, Baltimore, Portland, Oregon, Los Angeles, Boston, and Minneapolis. African-Americans were 16% less likely to get called in for an interview.[27] Similarly, a 2017 meta-analysis of field experiments on employment discrimination since 1989 found that white Americans applying for jobs receive on average 36% more callbacks than African Americans and 24% more callbacks than Latinos.[28]

Hispanic and Black workers have been hardest hit by the structural shift toward involuntary part-time work: Despite wanting to work more, many low-wage workers struggle to receive enough hours from their employer to make ends meet. A report from the Economic Policy Institute found that 6.1 million workers were involuntary part-time; they preferred to work full-time but were only offered part-time hours. According to the report, "involuntary part-time work is increasing almost five times faster than part-time work and about 18 times faster than all work."[29] Hispanic and Black workers are much more likely to be involuntarily part-time (6.8 percent and 6.3 percent, respectively) than their White counterparts, of whom 3.7 percent work part time involuntarily. And Black and Latino workers are a higher proportion of involuntary part-time workers, together representing 41.1 percent of all involuntary part-time workers. The greater amount of involuntary part-time employment among Black and Hispanic workers is primarily due to their having greater difficulty finding full-time work and more often facing work conditions in which hours are variable and can be reduced without notice.[30]

People of color are more likely to live in neighborhoods with poor access to jobs: In recent years, majority-minority neighborhoods have experienced particularly pronounced declines in job proximity. Proximity to jobs can affect the employment outcomes of residents and studies show that people who live closer to jobs are more likely to work.[31] They also face shorter job searches and fewer spells of joblessness.[32] As residents from households with low-incomes and communities of color shifted toward suburbs in the 2000s, their proximity to jobs decreased. Between 2000 and 2012, the number of jobs near the typical Hispanic and Black resident in major metropolitan areas declined much more steeply than for white residents.[33]

Due to overcriminalization of neighborhoods of color, people of color are more likely to have previous histories of incarceration, which in turn limit their opportunities: People of color, particularly African Americans and Latinos, are unfairly targeted by the police and face harsher prison sentences than their white counterparts.[34] After release, formerly incarcerated individuals fare poorly in the labor market, with most experiencing difficulty finding a job after release. Research shows that

roughly half of people formerly incarcerated are still unemployed one year after release.[35] For those who do find work, it's common to have annual earnings of less than $500.[36] Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.[37] People who have been involved in the justice system struggle to obtain a driver's license, own a reliable means of transportation, acquire relatively stable housing, and maintain proper identification documents. These obstacles often prevent them from successfully re-entering the job market and are compounded by criminal background checks, which further limit access to employment.[38] A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[39]

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. For decades these narratives have played a role in discussions around public assistance benefits and have been employed to garner support from working-class whites.[40] Below are a few examples of the relationship between poverty, racial bias, and access to basic needs programs.

- When the "Mother's Pension" program was first implemented in the early 1900s, it primarily served white women and allowed mothers to meet their basic needs without working outside of the home. Only when more African American women began to participate were work reporting requirements implemented.[41]
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans flowed north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.[42]
- As civil rights struggles intensified, the media's portrayal of poverty became increasingly racialized. In 1964, only 27 percent of the photos accompanying stories about poverty in three of the country's top weekly news magazines featured Black subjects; by 1967, 72 percent of photos accompanying stories about poverty featured Black Americans.[43]
- Many of Ronald Reagan's presidential campaign speech anecdotes centered around a Black woman from Chicago who had defrauded the government. These speeches further embedded the idea of the Black "welfare queen" as a staple of dog whistle politics, suggesting that people of color are unwilling to work.[44]
- In 2018, prominent sociologists released a study looking at racial attitudes on welfare. They noted that white opposition to public assistance programs has increased since 2008 — the year that Barack Obama was elected. The researchers also found that showing white Americans data suggesting that white privilege is diminishing led them to express more opposition to spending on basic needs programs. They concluded that the "relationship between racial resentment and welfare opposition remains robust."[45]

Premium increase would harm families in low-income households

Medicaid has strong affordability protections to ensure that beneficiaries have access to a

comprehensive service package and protects beneficiaries from out-of-pocket costs, particularly those due to an illness.[46] Medicaid generally prohibits premiums for Medicaid beneficiaries with income below 150% of the Federal Poverty Level (FPL). Under Montana's current waiver they received unique permission from CMS to impose premiums on persons earning as little as 50% FPL. Some states, including Montana, have received approval to apply mandatory premiums for individuals with incomes between 100-150% FPL.

CLASP does not support Montana's proposal to increase premiums for enrollees with income greater than 50 percent of the FPL who are not otherwise exempt to pay monthly premiums. Montana's proposal to require program enrollees to pay monthly premiums equal to 2 percent of the enrollee's modified adjusted gross income for the first two years and increasing premiums by 0.5 percent in each subsequent year up to a maximum of 4 percent of the enrollee's income would considerably harm families in low-income households.

Failure for not paying with the premium – collection of amount due in annual tax returns, if enrollee has an income of 100 percent FPL or less, or suspension from Medicaid, if enrollee has an income greater than 100 percent FPL – is cruel and runs counter to Montana's stated goal of improving health, well-being, and financial stability of residents. Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138% of FPL to pay a premium[47] or face disenrollment or lockout,[48] have found that it deters enrollment. About one-third of individuals who applied and were found eligible were not enrolled because they did not pay the premium.[49] It is safe to assume that as premiums increase people will face increased difficulty paying the premium and more people will either not enroll due to the premiums or lose coverage (if over 100% FPL) for non-payment of premiums.

A large body of research shows that even modest premiums keep people from enrolling in coverage.[50] Individuals, particularly during period of unemployment or other financial hardship, may be unable to afford to make the payments. Low-income consumers have very little disposable income and often must make choices and stretch limited funds across many critical purchases. While Medicaid is designed to protect consumers against costs, this proposal adds another cost to their monthly budget.

Moreover, simply the burden of understanding the premium requirements and submitting payments on a regular basis may be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[51] Finally, states or insurance companies may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.[52]

Unlike private health insurance, the reality of this proposal is that individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with private insurance receive it through their employers, and have their share of the premiums automatically withheld from their paychecks, without having to take any positive action. Moreover, one-quarter of households with

incomes under $15,000 reported being "unbanked,"[53] which may create additional barriers to making regular payments.

Twelve-Month Continuous Eligibility Period

CLASP supports Montana's proposal to extend their waiver authority to allow enrollees to receive continued benefits during any period within a twelve-month eligibility period.

Conclusion

For all the reasons laid out above, the state should reconsider their approach to encouraging work and withdraw their waiver application. If Montana is serious about encouraging work, helping people move into jobs that allow for self-sufficiency, the state would be committed to ensuring that all adults have access to health insurance in order to ensure they are healthy enough to work.

Thank you for considering CLASP's comments. Contact [redacted]) or [redacted] with any questions.

All sources accessed August 2019.

[1] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2017, **https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel= percent7B percent22colId percent22: percent22Location percent22, percent22sort percent22: percent22asc percent22 percent7D**;, "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100 percent FPL)," 2017, **https://www.kff.org/other/state-indicator/poor-adults**.
[2] Bureau of Labor Statistics, "Lower-wage Workers Pay More Than Higher-wage Workers for Employer-provided Medical Care Benefits," U.S. Department of Labor, January 2019, **https://www.bls.gov/opub/ted/2019/lower-wage-workers-pay-more-than-higher-wage-workers-for-employer-provided-medical-care-benefits.htm**.
[3] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU**.
[4] Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, New England Journal of Medicine, July 2017, **http://www.nejm.org/doi/full/10.1056/NEJMsb1706645**.
[5] Hannah Katch, "Montana Program Supports Work Without Causing Harm," Center on Budget and Policy Priorities, December 2018, **https://www.cbpp.org/blog/montana-program-supports-work-without-causing-harm**.
[6] Jessica Gehr, "Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers," Center for Law and Social Policy, June 2017, **https://www.clasp.org/sites/default/files/publications/2017/08/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf**.
[7] Jessica Gehr and Suzanne Wikle, "The Evidence Builds: Access to Medicaid Helps People Work," December 2017, Center for Law and Social Policy, **https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work**.
[8] "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," The Ohio Department of Medicaid, January 2017, **http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf**.
[9] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, et al., "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, **http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches**.
[10] Claire Cain Miller and Ernie Tedeschi, "Single Mothers Are Surging into the Work Force," *The New York Times*, May 2019, **https://www.nytimes.com/2019/05/29/upshot/single-mothers-surge-employment.html**.
[11] Ibid., 1a; Ibid., 1b.
[12] Brynne Keith-Jennings and Vincent Palacios, *SNAP Helps Millions of Low-Wage Workers*, Center on Budget and Policy Priorities, May 2017, **http://www.cbpp.org/research/food-assistance/snap-helps-millions-of-low-wage-workers**.
[13] U.S. Department of Labor, "Table 2. Medical care benefits: Access, participation, and take-up rates," Bureau of Labor Statistics, July 2018, **https://www.bls.gov/news.release/ebs2.t02.htm**.
[14] Emily M. Johnston, Anuj Gangopadhyaya, Genevieve M. Kenney, et al., "New Hampshire Residents Who Lose Medicaid under Work Requirements Will Likely Face Limited Employer-Sponsored Insurance Options," The Urban Institute, May 2019, **https://www.urban.org/urban-wire/new-hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options?cm_ven=ExactTarget&cm_cat=HPC+-+05.30.2019&cm_pla=All+Subscribers&cm_ite=https%3a%2f%2fwww.urban.org%2furban-wire%2fnew-hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options&cm_lm=swikle@clasp.org&cm_ainfo=&&utm_source=%20urban_newsletters&&utm_medium=news-HPC&&utm_term=HPC&&**.
[15] Jennifer Wagner, "Commentary: As Predicted, Arkansas' Medicaid Waiver Is Taking Coverage Away from People," *Center on Budget and Policy Priorities*, June 2019, **https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people**.
[16] Jennifer Wagner, "Commentary: As Predicted, Eligible Arkansas Medicaid Beneficiaries Struggling to Meet Rigid Work Requirements," *Center on Budget and Policy Priorities*, July 2018, **https://www.cbpp.org/health/commentary-as-predicted-eligible-arkansas-medicaid-beneficiaries-struggling-to-meet-rigid**.
[17] Ibid., 10.
[18] Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits," *Center for Law and Social Policy*, September 2015, **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf**.
[19] Anuj Gangopadhyaya, Emily M. Johnston, Genevieve M. Kenney, et al., "Kentucky Medicaid Work Requirements: What are the Coverage Risks for Working Enrollees," The Urban Institute, August 2018, **https://www.urban.org/research/publication/kentucky-medicaid-work-requirements-what-are-coverage-risks-working-**

enrollees.
[20] Michael Karpman, *Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment*, The Urban Institute, May 2019, **https://www.urban.org/research/publication/many-adults-targeted-medicaid-work-requirements-face-barriers-sustained-employment**.
[21] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, **http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/**.
[22] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," Kaiser Family Foundation, June 2019, **https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/**.
[23] *Comprehensive Report: Able-Bodied Adults Without Dependents*, Ohio Association of Foodbanks, 2015, **http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf**.
[24] Ibid.
[25] "Child Care in the FY 2018 Omnibus Spending Bill," Center for Law and Social Policy, March 2018, **https://www.clasp.org/sites/default/files/publications/2018/03/Child%20Care%20in%20the%20FY%202018%20Omnibus.pdf**.
[26] Robert Manduca, *Income Inequality and the Persistence of Racial Economic Disparities*, Sociological Science, March 2018, **https://www.sociologicalscience.com/download/vol-5/march/SocSci_v5_182to205.pdf**.
[27] Brett Arends, "In Hiring, Racial Bias is Still a Problem. But Not Always for Reasons You Think," *Fortune*, November 2014, **http://fortune.com/2014/11/04/hiring-racial-bias/**.
[28] Lincoln Quillian, Devah Pager, Ole Hexel, et al., "Meta-Analysis of Field Experiments Shows No Change in Racial Discrimination in Hiring Over Time," *Proceedings of the National Academy of Sciences of the United States of America*, September 2017, **https://doi.org/10.1073/pnas.1706255114**.
[29] Lonnie Golden, *Still Falling Short on Hours and Pay*, Economic Policy Institute, December 2016, **http://www.epi.org/publication/still-falling-short-on-hours-and-pay-part-time-work-becoming-new-normal/**.
[30] Ibid.
[31] Scott W. Allard and Sheldon Danziger, "Proximity and Opportunity: How Residence and Race Affect the Employment of Welfare Recipients," *Housing Policy Debate*, September 2000, **http://fordschool.umich.edu/research/poverty/pdf/ProximityandOpportunity.pdf**.
[32] Elizabeth Kneebone and Natalie Holmes, "The Growing Distance Between People and Jobs in Metropolitan America," *The Brookings Institution*, March 2015, **https://www.brookings.edu/research/the-growing-distance-between-people-and-jobs-in-metropolitan-america/**.
[33] Ibid.
[34] Jamal Hagler, "8 Facts You Should Know About the Criminal Justice System and People of Color," *Center for American Progress*, May 2015, **https://www.americanprogress.org/issues/race/news/2015/05/28/113436/8-facts-you-should-know-about-the-criminal-justice-system-and-people-of-color/**.
[35] Adam Looney and Nicholas Turner, *Work and Opportunity Before and After Incarceration*, The Brookings Institution, March 2018, **https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/**; Joan Petersilia, *When Prisoners Come Home: Parole and Prisoner Reentry,* Chicago, Ill: University of Chicago Press, 2003, **https://www.amazon.com/When-Prisoners-Come-Home-Prisoner/dp/0195386124**; Jeremy Travis, *But They All Come Back: Facing the Challenges of Prisoner Reentry,* Washington, D.C.: Urban Institute Press, 2005, **https://www.amazon.com/But-They-All-Come-Back/dp/0877667500**.
[36] Rachel Black and Aleta Sprague, "Republicans' Fixation on Work Requirements is Fueled by White Racial Resentment," *Slate*, June 2018, **https://slate.com/human-interest/2018/06/trump-administrations-fixation-on-work-requirements-for-snap-benefits-is-part-of-a-long-racist-policy-history.html**.
[37] Christy Visher, Sara Debus, and Jennifer Yahner, *Employment after Prison: A Longitudinal Study of Releasees in Three States*, The Urban Institute, October 2008, **https://www.urban.org/sites/default/files/publication/32106/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF**.
[38] Marina Duane, Nancy La Vigne, Mathew Lynch, et al., *Criminal Background Checks: Impact on Employment and Recidivism*, The Urban Institute, March 2017, **https://www.urban.org/sites/default/files/publication/88621/2017.02.28_criminal_background_checks_report_finalized_blue_dots_1.pdf**.
[39] Thomas Ahearn, " Survey Finds 96 Percent of Employers Conduct Background Screening," *Employment Screening*

Resources, August 2017, **http://www.esrcheck.com/wordpress/2017/08/03/survey-finds-96-percent-of-employers-conduct-background-screening/**.

[40] Josh Levin, "She Used 80 Names: The Real Story of Linda Taylor, America's Original Welfare Queen," *Slate*, December 2013, **http://www.slate.com/articles/news_and_politics/history/2013/12/linda_taylor_welfare_queen_ronald_reagan_made_her_a_notorious_american_villain.html**.

[41] Ibid., 36.

[42] Kali Grant, Funke Aderonmu, Sophie Khan, et al., *Unworkable and Unwise: Conditioning Access to Programs that Ensure a Basic Foundation for Families on Work Requirements*, Economic Security and Opportunity Initiative at Georgetown Law, February 2019, **http://www.georgetownpoverty.org/issues/tax-benefits/unworkable-unwise/**.

[43] Rachel Black and Aleta Sprague, "The Rise and Reign of the Welfare Queen," *New America*, September 2016, **https://www.newamerica.org/weekly/edition-135/rise-and-reign-welfare-queen/**.

[44] Gene Demby, "The Truth Behind the Lies of the Original 'Welfare Queen'," *NPR*, December 2013, **https://www.npr.org/sections/codeswitch/2013/12/20/255819681/the-truth-behind-the-lies-of-the-original-welfare-queen**.

[45] Rachel Wetts and Robb Willer, "Privilege on the Precipice: Perceived Racial Status Threats Lead White Americans to Oppose Welfare Programs," *Social Forces*, Volume 97, Issue 2, December 2018, Pages 793–822, **https://doi.org/10.1093/sf/soy046**.

[46] David Blumenthal, Petra W. Rasmussen, Sara R. Collins, et al., "Does Medicaid Make a Difference," *The Commonwealth Fund*, June 2015, **http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/does-medicaid-make-a-difference**.

[47] MaryBeth Musumeci, Robin Rudowitz, Petry Ubri, et al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, Kaiser Family Foundation, January 2017, **http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana**. Lower-income recipients could opt to pay a premium in order to receive an enhanced package of benefits.

[48] Dee Mahan, "Indiana's Medicaid Expansion Waiver: Arguments to Counter Problematic Elements," *FamiliesUSA*, February 2015, **http://familiesusa.org/product/indiana-medicaid-expansion-waiver-arguments-counter-problematic-elements**.

[49] Judith Solomon, "Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved," *Center on Budget and Policy Priorities*, August 2016, **http://www.cbpp.org/research/health/indiana-medicaid-waiver-evaluation-shows-why-kentuckys-medicaid-proposal-shouldnt-be**.

[50] David Machledt, *What Makes Medicaid, Medicaid? Affordability*, National Health Law Program, March 2017, **https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/03/WhatMakesMedicaidMedicaid-Affordability-3.9.17.pdf**.

[51] *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, The Lewin Group, Inc., July 2016, **https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf**.

[52] Alison Kodjak, "The Future Of Medicaid May Be Found In Indiana, Where The Poor Pay," *NPR*, December 2016, **http://www.npr.org/sections/health-shots/2016/12/27/506348147/the-future-of-medicaid-may-be-found-in-indiana-where-the-poor-pay**.

[53] "2015 National Survey of Unbanked and Underbanked Households," *Federal Deposit Insurance Corporation*, **https://www.economicinclusion.gov/surveys/2015household/banking-status-findings/**.

Dear Ms. Sheila Hogan,

As a resident of Montana and someone personally affected by cystic fibrosis, I'm writing to share my support for continuing Medicaid expansion and the 12-month continuous eligibility period. However, I am concerned about how proposed barriers to Medicaid eligibility may impact enrollees and ask you to automatically exempt people with CF from the work requirements and premiums in Montana's Health and Economic Livelihood Partnership (HELP) program amendment and extension application.

Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that

can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

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Sincerely,

[redacted].

August 21, 2019

Via: dphhscomments@mt.gov

Ms. Sheila Hogan, Director
Montana Department of Public Health and Human Services
111 North Sanders, Room 301, Helena MT 59620
PO Box 4210, Helena MT 59604-4210

Re: Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application - Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program

Dear Director Hogan;

ViiV Healthcare appreciates the opportunity to submit comments to the Montana Department of Public Health and Human Services regarding the proposed Section 1115 Demonstration Amendment and Extension Application for the Montana Health and Economic Livelihood Partnership (HELP).

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people living with HIV (PLWH). From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As a manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people living with HIV (PLWH) to live longer, healthier lives, and has been shown

to reduce HIV-related morbidity and mortality at all stages of HIV infection.[1, 2] Furthermore, effective HIV treatment can also prevent the transmission of the disease.[3]

Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of PLWH are retained in medical care, according to the Centers for Disease Control and Prevention (CDC).[4] More than 1.1 million people in the United States are living with HIV, and fifteen percent are unaware that they are have the virus.[5] Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for people living with HIV.[6] It is imperative to preserve continuous access to comprehensive health care, including antiretroviral therapy (ART) for people with HIV in order to improve health outcomes and reduce new transmissions.

Effective HIV Treatment

HIV treatment is a dynamic area of scientific discovery, and treatment protocols are constantly changed and updated to reflect advances in medical science. PLWH often face a variety of medical challenges that impede access to, retention in, and adherence to HIV care and treatment.

Strict adherence to antiretroviral therapy (ART) – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.[7] The Health Resources and Services Administration (HRSA) stated in its *Guide for HIV/AIDS Clinical Care* that "adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival."[8] Nonadherence – or skipping HIV medicines – may lead to drug-resistant strains of the virus for which HIV medicines are less effective.[9] In fact, the World Health Organization (WHO) recently reported that resistance among people retained on ART ranged from

[1] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201

[2] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714

[3] Roger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0.

[4] Understanding the HIV Care Continuum, CDC, https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf Accessed June 19, 2019

[5] HIV in the United States: At a Glance, CDC, https://www.cdc.gov/hiv/statistics/overview/ataglance.html. Accessed June, 19, 2019.

[6] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[7] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.

[8] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.

[9] AIDS Info, HIV Treatment Fact Sheet (March 2, 2017), https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance. Last accessed October 13, 2017.

four to 28 percent, while among people with unsuppressed viral load on first-line ART regimens, resistance ranged from 47 to 90 percent.[10]

Federal HIV clinical treatment guidelines (DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents[11]) emphasize the importance of adherence to ensure long-term treatment success.[12] The effective treatment of HIV is highly individualized and accounts for a patient's size, gender, treatment history, viral resistance, comorbid conditions, drug interactions, immune status, and side effects.[13] Aging beneficiaries who are living with HIV often experience non-HIV related comorbidities.[14] Clinically significant drug interactions have been reported in 27 to 40 percent of HIV patients taking antiretroviral therapy requiring regimen changes or dose modifications.[15] Medical challenges for PLWH also include an increased risk for, and prevalence of, comorbidities such as depression and substance use disorders,[16] as well as cardiovascular disease, hepatic and renal disease, osteoporosis, metabolic disorders, and several non–AIDS-defining cancers.[17,18] The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.[19]

Prevention

Effective treatment of HIV also helps to prevent new transmissions of the virus. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy,[20] there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection.

Reduced transmissions not only improve public health, but also save money. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[21] Other studies estimate that each HIV positive patient may approach $338,400 in additional

[10] WHO, HIV Drug Resistance Report 2017, http://apps.who.int/iris/bitstream/10665/255896/1/9789241512831-eng.pdf?ua=1. Accessed October 13, 2017.
[11] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH.gov https://aidsinfo.nih.gov/guidelines Accessed on 6/26/2019
[12] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH.gov https://aidsinfo.nih.gov/guidelines Accessed on 6/26/2019
[13] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, p. 183, https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0. Accessed October 13, 2017.
[14] Schouten J, et al. Clin Infect Dis. 2014 Dec 15;59(12):1787-97.
[15] Evans-Jones JG et al. Clin Infect Dis 2010;50:1419–1421; Marzolini C et al. Antivir Ther 2010;15:413–423.
[16] CDC, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014)
[17] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518
[18] Rodriguez-Penney, Alan T. et al. "Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life." AIDS Patient Care and STDs 27.1 (2013): 5–16. PMC. Web. 21 June 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3545369/
[19] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518
[20] Roger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0 .
[21] Skarbinski, et al. *JAMA Intern Med*. 2015;175(4):588-596.

costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.[22] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $1.79 million by preventing[23] further transmission to others. These savings can only occur, however, if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

Proposed Waiver

ViiV applauds the state for expanding Medicaid, and for the impressive list of health accomplishments that have resulted from this expansion, including expanded access to healthcare, increased screenings, and increased primary care treatments in the state.[24]

As Montana seeks to renew this demonstration, ViiV respectfully comments on several of the proposals that are likely to impact the health and wellbeing of PLWH in Montana Medicaid.

1. Continuous Coverage / Eligibility

ViiV applauds the state's proposal to extend twelve months of continuous coverage to all enrollees.[25] Continuous insurance coverage and access to lifesaving treatments are essential for PLWH to reach viral load suppression and lower transmission rates. HTPN052, a clinical study from the National Institutes of Health (NIH), found that treating HIV-positive people with ART reduces the risk of transmitting the virus to HIV-negative sexual partners by 93 percent.[26] This can only occur, however, if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy. According to the Centers for Disease Control and Prevention (CDC), however, only about half of PLWH are virally suppressed.[27]

In a study, PLWH who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound,

[22] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/
[23] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/
[24] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019 Page 3-4: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf
[25] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019 Page 5: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf
[26] Cohen et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839 DOI: 10.1056/NEJMoa1600693.
[27] Understanding the HIV Care Continuum, CDC, https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf Accessed June 19, 2019

drug resistance, and increased morbidity and mortality.[28] Drug benefits for PLWH and other complex medical conditions should be given special consideration within system efforts that may create potential disruptions in access to necessary medications. Data from the Ryan White HIV/AIDS Program shows that in 2016, more than 28,000 ADAP clients nationwide were also Medicaid-eligible at some point of the calendar year as a result of changes in income.[29] Given the tendencies for fluctuations in eligibility for the Medicaid population, we encourage policies that promote continuity of coverage for PLWH in order to prevent potential disruptions in care and treatment.

2. Suspension Penalty for Work/Community Engagement

The waiver proposes to create a work/community engagement requirement, with a penalty of suspension from the program for noncompliance, and therefore the loss of covered benefits such as medical care and treatment.[30] Even though the state allows for reinstatement in the program 180 days after disenrollment, this penalty could have catastrophic effects on the health and wellness of PLWH affected by it.

For PLWH, adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities.[31] [32] PLWH who are subject to this penalty are vulnerable to medication treatment disruptions that could negatively impact their health, and potentially result in resistance, as well as the development of HIV-related co-morbidities. In addition, access to qualified medical care providers is important for PLWH in order to monitor disease progression and ensure viral suppression is maintained.[33] [34] Disruptions in benefits and loss of access to coverage may lead to increased overall health costs and may result in increased HIV transmission.[35]

[28] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1

[29] 2018 Annual Report- National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report. NASTAD https://www.nastad.org/sites/default/files/Uploads/2018/2018-national-rwhap-partb-adap-monitoring-project-annual-report.pdf Accessed August 2, 2018. Page 8.

[30] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019 Page 9: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf

[31] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.

[32] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.

[33] Kitahata MM, Koepsell TD, Deyo RA, Maxwell CL, Dodge WT, Wagner EH. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. New Engl J Med. 1996;334:701–7. [PubMed]

[34] Gallant, Joel E. et al. "Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition." Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America53.11 (2011): 1043–1050. PMC. Web. 20 Dec. 2017.

[35] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

3. Categorical Exemption of People Living With HIV

ViiV encourages the state to protect PLWH from potential disruptions in care and treatment through exemption from demonstration waiver proposals and recommends that states automatically designate exempted populations, as a means of ensuring they are protected from penalties that might cause interruptions in care and treatment.

Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. For this reason, ViiV recommends that PLWH be exempted from penalties that create potential disruptions in access to necessary medications or care, similar to other complex medical conditions or medically frail populations. As such, ViiV encourages the state to exempt all PLWH, categorically, and not on a case-by-case basis, or by other designations. This is due to the necessity of uninterrupted access to medical care and HIV treatment for all PLWH within the program.

One way to protect HIV patients from potential disruptions in care and treatment is through designation of all PLWH as "medically frail." In the proposal, the state proposes to exempt medically frail individuals but did not specify that PLWH would be included in that definition or exempt from these penalties. The state makes reference to "Medically frail enrollees as defined in 42 CFR 440.315." [36] The definition of 42 CFR 440.315 says, *"… the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those … with serious and complex medical conditions…"*[37] According to one analysis, this means that CMS has left it up to the states to establish their own definition.[38] For this reason, we encourage the state to specifically include PLWH as a population that will be exempted under this designation, and from this demonstration.

In its proposal, the state also lists those who*, "The state determines have exceptional health care needs…,"* among those who will be exempted, and further states, "*Montana will also exempt individuals who…. Have a documented serious illness or incapacity…"*[39] We encourage the state to specifically include PLWH in defining populations who require uninterrupted access to medical care and treatment.

[36] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019, Page 7: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf
[37] Government Publishing Office, "42 CFR § 440.315 - Exempt individuals," https://www.govinfo.gov/content/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec440-315.pdf
[38] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40
[39] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019 Page 8: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf

Many states have defined populations that should be exempted from proposals due to their health and medical needs using terms such as "medically complex populations" or those with "high medical need," "serious medical conditions," "chronic conditions" and/or "special medical needs." As an alternative, the state of Oklahoma simply included a list of populations exempt from their proposed SoonerCare "Community Engagement" 1115 waiver amendment, without any further designations.[40] Several states, including Kentucky, Michigan, Virginia and Indiana have included HIV in their definition of "medical frailty" when designing work requirements.[41]

Another example to model was seen in Arizona's 2018 Health Care Cost Containment System 1115 waiver request, which also specifically exempts PLWH from the requirements through automatic designation, as medically frail:

> *"AHCCCS will work with [Center for Medicare and Medicaid Services] CMS to develop a comprehensive definition of what members would be considered medically frail. This list will include, but is not limited to, members with cancer, HIV/AIDS, chronic substance abuse disorder, hemophilia, and end-stage renal disease (ESRD). Members will be identified through claims and encounter data, which is lagged, as well as a process by which members or providers can notify AHCCCS of the diagnosis to ensure timely application of their exemption."*[42]

Whatever designation of terminology, ViiV applauds policies that seek to protect PLWH from potential disruptions in care and treatment.

4. Automatic Exemption Process

In its waiver application, the department indicates the method it will use to determine exemptions as:

> *"Montana will use a variety of methods to identify individuals who qualify for standard and good cause/hardship exemptions as well as those who are already complying with work/community engagement hours for enrollees who are not exempt, using a multi-pronged process that includes but is not limited to using available data (within DPHHS and other State agencies) to identify enrollees who should be exempt … For enrollees for whom the Department is unable to use data to determine their exemption or compliance, the Department will provide multiple ways for*

[40] CMS, Medicaid Waivers, Oklahoma https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8258
[41] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40
[42] Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 2017 https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf

enrollees to self-report an exemption or their compliance with work/community engagement requirements, including online, through a call center, by mail, and in person…."[43]

ViiV applauds the state for this proposal. Automatic designation of exempted populations is an additional step which can protect vulnerable patients from penalties that might cause interruptions in care and treatment. For example, in 2018 the State of Michigan submitted a Medicaid demonstration waiver (Healthy Michigan Plan §1115 Demonstration Waiver Extension Application / Project No. 11-W-00245/5)[44] to CMS, implementing a work requirement for the Michigan Medicaid expansion program. In the proposal submitted to CMS[45], the state exempted medically frail individuals from the demonstration, including PLWH and determined to identify PLWH through self-attestation and/or using claim analysis codes specific to HIV *(ICD-10 category codes for HIV: B20 – Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases; Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status[46])*. This more automated process for identifying exempt individuals is notable because most PLWH were automatically identified and exempted without need for further action on their part.

ViiV also supports the state's proposal to allow patients to self-report an exemption, through multiple platforms and access points, such as online, in person, or by phone.

5. Informing Eligible Populations

ViiV encourages the state to take all possible measures to make sure the population covered by this waiver is aware of the new requirements before instituting penalties that can negatively impact the health of those in the program.

Recently in the state of Georgia, 17,000 elderly and disabled individuals fell out of care because the state claims the individuals did not respond to their renewal notices, yet eligible individuals said they were never contacted by the state.[47] This confirms the importance of having a verified and accurate system for outreach, and making sure patient options are simple to understand.

[43] Montana Department of Public Health and Human Services, "Section 1115 Demonstration Amendment and Extension Application," Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program Updated July 23, 2019 Page8: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf

[44] Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf

[45] Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf

[46] ICD-10 codes for HIV https://www.ncbi.nlm.nih.gov/books/NBK236995/bin/annex2-m1.pdf

[47] Governing.com, "17,000 Medicaid Patients Are Losing Their Health Care in Georgia" By Tribune News Service, JUNE 10, 2019, Author: Ariel Hart; https://www.governing.com/topics/health-human-services/tns-georgia-cuts-medicaid-for-17000-patients.html Accessed June, 26, 2019

Conclusion

ViiV Healthcare looks forward to working with the state and other stakeholders to ensure that Montana's public programs continue to ensure that PLWH have access to quality care and to improved health outcomes.

Please feel free to contact me at [redacted] should you have any questions.

Sincerely,

[redacted]

PUBLIC COMMENT FROM
CHILDREN, FAMILIES, HEALTH AND HUMAN SERVICES COMMITTEE

[redacted]	Good morning Madam Chair, members of the committee. My name is [redacted]. Today representing Pacific Source Health Plans. One moment please. I'm here to comment on the departments thorough work and the waiver application. I needed to loop this committee in on correspondence we had had with the department and the executive regarding the application and our desires therein. I need to open up by saying that Pacific Source Health Plan as the largest non-profit health insurer in the state appreciates the hard work that everyone involved in the process gave this last session. I think a lot of minds were at the table, both in the public sphere and countless hours behind the scenes. So I would like to thank committee members, members of the public, the executive team, all the experts that were consulted for that hard work. It's critical to Montana's healthcare industry as a whole. That expansion stand solid. And so we really, really enjoy that that's there and is going to continue at least for another five years. We are going to be submitting comments to CMS, however, because we have requested that the administration and the department submit two separate state plan amendments, SPAs, I'm going to refer to them as SPAs, state plan amendments. One for the policy and one for the financing portion. A lot of conversation has been had today, especially, and for months-and-months about work requirements versus community enhancement versus those sorts of meaty policy issues that a lot of people are divided on, quite frankly. And our concern is not in the policy section of the bill, however, it's in the financing section. Specifically section 6 of House Bill 658. It's the health service corporation fee. So what the legislature has effectively done is laid a 1% tax on non-profit insurers in the state. So that means the one insurer that is for profit, Blue Cross Blue Shield of Montana, they are doing business as Blue Cross Blue Shield of Montana—they are actually owned by HCSC of Illinois—they are for profit and they have the majority of the market share and they are not paying anything for the Medicaid expansion program as HB 658 is written, right. So what we've done is we were concerned that three basic requirements defined by 42 CFR 4th section 433.68 and I'll get you these specific details in an email to the whole committee so you don't have to take notes. Big take away is that any tax revenues as the state's share of Medicaid cost must be broadly based, uniformly imposed throughout a jurisdiction and not designed to hold providers harmless from the burden of the tax. So that language, as we all know, sways depending on where the definitions lie and where case law lies and what CMS has done in the past and so we asked these experts—it's a leading independent national research and consulting firm in the healthcare industry—they are called Health Management Associates, I'll get you their thorough report. It is there unqualified opinion that

	there are significant concerns with HB 658 when it comes to purely this 1% tax under Section 6 because it only applies to non-profit insurers. The reason this is sticky widget is because Montana is unique in our classification of health service corporations. Members of this committee have heard this in the past, right. So health service corporations in Montana must be non-profit and if you are a for-profit insurance company, it must be a different classification. When Blue Cross Blue Shield of Montana sold in 2012 to HCSC of Illinois, they signed an agreement, voluntarily, that they would classify as a for-profit corporation registered as such at the Secretary of State's office. So the health—what our consultants determined, and this is quoting, "the most likely scenario is that the tax would automatically fail," meaning, the most likely scenario is that CMS would reject that section of our waiver application. Again, I am not asking this committee to take an action on it because our audience right now is CMS and I'm informing the committee in case there's information out there that you need some clarification on that I am available to answer questions. I will be copying this committee on the letter that we had sent to the administration and the executive on this topic as well as the attachment from our consulting firm. Thank you.
[redacted]	Hello members of the committee. I'm [redacted]. I'm [redacted] for the Montana Association for Behavior Analysists. I want to say that Medicaid expansion has done huge things for our state as representative Cafaro said earlier. It's been a huge lift and we appreciate the legislative lift and the departments lift in getting this up and going and this waiver moving quickly too, as well. What I wanted speak to is within the first help service plan. There is ten essential healthcare benefits. When I spoke at that time back in 2015, the definition of habilitative services, we worked on that definition through public comment at that time and the definition is quite well. It says coverage is provided for habilitative care services when participants require help to maintain, learn or improve skills and functioning of daily living or to prevent loss of skills. These services include, but are not limited to, physical therapy, occupational therapy, speech language pathology, behavioral health professional treatment. But then it goes on to say that applied behavior analysis for adults is excluded from the benefit. Applied behavior analysis is the only evidence based treatment for adults with Autism. The National Autism Center in 2016 did a review of the literature. They've done reviews before for children's services and in 2016 they reviewed for adult services. And what they found is the only intervention to be identified as established for individuals age 22 or older is behavioral interventions. The behavioral intervention category consists of applied behavior analytic services. So to exclude the only evidenced-based intervention for adults with autism through Medicaid expansion, I just think is a huge fault. And I'll

	present this as well at the public hearings, but just any help to get that exclusion removed as we move forward with waiver will be greatly appreciated. I also have some handouts with the information to give out. And I have a family testimony to read as well too. [redacted] wasn't able to attend today. She talks about being a parent of her 27-year-old daughter with autism—non-verbal as well too. She's been receiving assistance through [Brooks?] rehab. And [Brooks?] rehab has purchased AVA services for her daughter—dealt with her rigid behaviors. And I'll just give a couple of the examples within what she's given. Her bedroom routine at night is a real torture for the family—it's about three hours. And so, and also, like some of the expectations of [redacted] has within her routine is that dad comes home and gives her a kiss goodnight. And so, like if every night you have to be there, and as a family you can't go out to a movie—you know, because eight o'clock you have be there to do this part of the routine, is really difficult for their routine as well too. So having AVA in the home has helped [redacted] be more flexible and accept different changes within her routine, and helped her be able to go to work too. She had lots of problems with rigidity with leaving her home and leaving at the right times and leaving even from work. And so AVA has been able to help her to be more flexible around those things and flow with routines as well too. So it's helped the family every day of the routine and it's helped her keep with employment as well too. So, AVA is just hugely beneficial. And it's the only evidenced-based practice for adults as well too. So, that's what I have and I'll hand out some fliers too as well.
[redacted]	I'm representing Synergetics today—Synergetics Mental Health. As I'm looking at the percentages, I agree with the other representatives that people do need to be empowered and they do need to go back to work. And I really—when I read this program and the updates I was enthralled by the progress that we're making in this state to empower people to get back to work. My concern is the 4 to 12,000 people. There is going to very different reasons why they are not compliant, and I was just kind of wondering if there was any kind of a contingency plan to address this once we do start to notify them of their reporting obligation. I don't see 4 to 12,000 individuals, I see 4 to 12,000 families that without this kind of care could lose their homes, could lose what work they are trying to do. So I was just kind of—that was my question for today. Thanks.
[redacted]	Good morning—it's still morning—Chair [Sands?] Senator Caferro, staff, other members of the committee on the phone. [redacted]. First of all I do want to give a big shout out to the Department for its continued work on this waiver and everything else you do to protect the public health of Montanans . Interestingly, I just came from an event

	sponsored by Big Sky 55 Plus. It was an event commemorating the 54th anniversary of Medicare in this country. And there's a connection here. Some of the handouts that we were given gave me pause. There's one here from the Center on Budget and Policy Priorities taking away Medicaid, not needing work requirements harms older Americans. Older adults face obstacles to meeting work requirements. Across age groups, about 60% of non-elderly adult Medicaid enrollees not receiving SSI work. Of the rest, about half live in working families. You've heard all of this, but employment rates are lower at older ages for a number of reasons, whereas nearly two-thirds of enrollees under age 50 work. Work rates begin to fall off for those over 50 for a number of reasons—ageism—only a minority of 60 to 64-year-olds work. In addition, some working enrollees of all ages work part time—meaning they may not meet the monthly hourly requirements. People in their 50s and 60s are also much more likely than younger people to have serious chronic health conditions, including heart disease, diabetes or back pain conditions that limit their ability to work to work full time. So, state waivers generally propose limited exemptions for people who are medically frail, and I believe ours does too, and for those diagnosed with acute medical conditions. But as AARP and other advocacy groups for older people and people with disabilities have explained, the exemptions won't keep older enrollees with serious health conditions from falling through the cracks. So I guess just to sum it up, I too am concerned about that 4,000 to 12,000 number of people who may not be compliant in reporting. So, I know you're cognizant and many people are cognizant. As we move forward, we don't want to deny access to health and wellness, which I believe is a human right to any of our Montana neighbors, friends, family members. Thank you.

PUBLIC COMMENT ON MEDICAID WAIVER
HELENA, MT, 8-1-19

Man (No name given)	Medicaid has helped me by making it easier to get treatment for my addiction. Without Medicaid I would not have been able to afford the treatment and medication that helped me properly detox from the drugs that I was using. Since I've gotten on medical-assisted treatment, my life has changed drastically. I have a full-time job, I have remained sober for eight months, and I'm a whole new person. Without help from medically-assisted treatment, I would not have been able to wean myself off the drugs that I was using because I would been too sick to help myself and I would have resorted back to using. When I was in my active addiction I was also jobless and I did not have a lot of money because I had to support my addiction. Without Medicaid, I would not have been able to afford help, and work requirements would have caused me to lose my healthcare. Higher premiums and work requirements will increase barriers for Montanans struggling with addiction. Everyone deserves the healthcare that could allow them to get the help they need. I appreciate your consideration of the harm these requirements pose for the most vulnerable Montanans.
[redacted]	Good afternoon, my name is [redacted]. So, um, in addition to my continued opposition of unaffordable expansion of government, I'm a peer support specialist and a life-long Montanan living and working here in [redacted]. Medicaid expansion helped me to tackle my opioid addiction and become a resource in the recovery community and to others. When I had enrolled in Medicaid, I had not yet to become my recovery process and was working irregular hours. [Ordering?] requirements and continued increasing premiums will cause people such as me to lose their healthcare coverage, piling burdens on the backs of those who need to focus on their recovery. Medicaid expansion has altered my life and played a major role in my current success. Adding work requirements and raising premiums will mean fewer success stories. We should not take healthcare away from people when they need it the most. So, thank you for listening to my comments and concerns.
[redacted]	[redacted] I'm a Montana primary care association. We support the waiver, as you all, bear some uncertainties, and will be submitting written comment.
[redacted]	Hello, my name is [redacted]. I am in full support of the Medicaid expansion. I'm a mother of a child with very severe asthma and potentially life-threatening food allergies. Preventative care is absolutely imperative to help offset more costly emergency treatments, hospitalizations, etc. Also, my husband and I are small business

	owners. We don't have healthcare coverage available through employers. In the process in building our business it was absolutely necessary. We would have drowned with out-of-pocket costs. Many of our employees are also subject to irregular work hours, seasonal employment, etc. Implementing work requirements and increased premiums would force them to be kicked off their health insurance, and we certainly don't need more hiccups in the road for a lot of Montana families. For these reasons I oppose the proposed changes to the waiver. Thank you for your consideration
[redacted]	My name is [redacted]. I live in [redacted] and work in [redacted] schools as a speech pathologist. I serve many children and parents who get their healthcare through Montana's Medicaid program. Those parents who are employed are, for the most part, working menial jobs that pay minimum wage. Many are not guaranteed a steady work schedule or paycheck. Others are unemployed with health issues of their own. I am certain that every parent that I work with would like a job or a better paying one. Furthermore, volunteer opportunities are scant to nonexistent in these communities. When they or their children need Medicare, they have to come up with the gas money, transportation and time off from an hourly job, if they have one, to get to Conrad or Cut Bank—a good 35 minutes to an hour away, many times in very adverse weather conditions—or, even further, to Great Falls for specialized care. From my point of view, adding the work requirements and increased premiums are punitive. Let's not make it even harder for them to take care of their families. Thank you.
[redacted]	Hi, my name is [redacted] I live here in [redacted]. I have a master's degree and I've been working since I was 15 years old, and I don't seem like a typical Medicaid recipient. I was on Medicaid in 2017. I had just moved to Missoula, fresh out of grad school. I've worked all kinds of jobs, from at the Forest Service to cleaning tables in college cafeterias, and I never had any trouble finding work. But I spent five humiliating jobless months in Missoula, despite all my best efforts and multiple interviews. Medicaid made it possible for me to get out of bed every morning. I knew that Medical debt in the number one reason Americans file for bankruptcy. I knew that one person not paying attention in hitting me their car, one freak accident can land me with the sort of debt that would destroy every plan I had ever made. The security that having Medicaid gave me, even while I was feeling so ashamed of my inability to find a job, made it possible for me to feel safe living my life—doing basic things like walking to pass out resumes or going to the store to get groceries or driving home to see my parents. I would have not been able to qualify for Medicaid during that time had work requirements been in place. Financially unstable Montanans have been dealing with housing and rent price increases, decades long wage

	stagnation, chronic underemployment, student debt, and many more issues. Some of us are highly-educated people, like me, who have had seemingly every opportunity in life and long education and job histories. But if even people like me need help, can you imagine how hard it must be for others. Access to medical care should not be contingent on your job status. In Montana we take care of each other when we need it, not punish each other for dealing with the curve balls of life that are often out of our control. Adding work requirements to Montana Medicaid will serve no purpose except taking healthcare away from people who need it. Thank you for considering my comments.
[redacted]	Hello, my name is [redacted], and I'm here because I oppose the proposed changes to Montana's Medicaid program. My oldest son is on Medicaid. He's a brilliant young man with an intellectual disability, and right now he is homebound most days due to his disability. I think my son would love to work if he could, it's just that his chronic illness disables him to where he has trouble functioning at the level that a job would require. His ability to work is irregular. My son is dependent on his access to healthcare to help stabilize his illness. Currently my son's disability makes work or volunteer requirements unreasonable, but he needs Medicaid to manage his chronic illness or intellectual disability. You must realize that some people struggle with their intellectual abilities to a point where they find paperwork, or the task to understand program requirements, so difficult that they walk away. They jeopardize their critical medical care, which helps stabilize their illness. The financial gap in our state between those who can afford health insurance and those who do not have access to health coverage is vast. Montana needs to provide healthcare to all of its resident so that vulnerable Montanans have resources when they need them most. No one should live at risk of becoming jobless and without healthcare. I won't give up on my son ever and neither should you. Thank you for considering my comments.
[redacted]	Good morning. My name is [redacted] with the Behavioral Health Alliance of Montana— [redacted]. We stand in support of the waiver but, as we all know, the devil is in the details of the rulemaking, so we will submit comments addressing many of the issues people had today with the waiver specifically. And also today I just want to say that rather than wait until the rules are out and we get up and complain about them, we want to offer our help as the rules are being written so that we can help address some of the issues people have with some of the rules, and we're happy to do that as providers for the mentally ill and substance use providers. Because we do see in the Help Act, many many substance use disorder people were treated through the Help Act. Thank you.

Woman	Thank you for the opportunity to comment on the proposed 1115 waiver to amend and continue Montana's Medicaid expansion program. Montana Women Vote is a statewide organization of low income women and families. For the last 20 years we've worked alongside low income communities on a variety of issues including access to healthcare. And since 2013, we've been one of several organizations working to ensure that Montana expands and invests in our Medicaid program. In 2015, we supported the passage of the Help Act and have been pleased with the success of Medicaid expansion in the year since. Over 97,000 Montanans have gained access to affordable quality healthcare since Medicaid expansion was implemented. This access to care has not just led to better health outcomes, it has also meant parents are able to take better care of their kids, people are better able to go back to work, and folks are getting access to the mental healthcare and substance use disorder treatment that they need, among many other things. For these reasons, and others, Montana Women Vote continues to strongly support the state's expanded Medicaid program. We do, however, remain concerned about several aspects of the proposed waiver. First and foremost, we're concerned with the work and community engagement requirements. We know that the vast majority of Medicaid expansion recipients are working, and those who aren't working face significant barriers to employment—health-related, job market barriers, etc. Requiring Medicaid recipients to meet work or community engagement requirements and comply with reporting mandates would create a barrier to coverage for thousands of low-income Montanans. Furthermore, as we know that work requirements do not achieve the goal of increasing workforce participation, this new program element would decrease coverage without increasing work. We do not believe that this meets the stated goal of Medicaid in increasing healthcare coverage. We are also concerned with the proposal to increase premiums based on the length of enrollment. For many low-income enrollees this could also lead to disenrollment and loss of coverage. There are many reasons why a Medicaid recipient might be enrolled for two or more years, including accessing multi-year treatment for cancer, mental health needs, or receiving coverage while a caretaker for a disabled relative. We thank you so much for considering out comments today.
[redacted]	Hello, I'm [redacted]. I'm here on behalf of Montana Association for Behavior Analysts. I really do appreciate all the Department's effort in getting this rolled out in such a timely manner and the legislative effort that's been put into this as well, too, to continue all this health benefits for Montana as well. What I want to speak to you today is part of Medicaid expansion. There's the ten essential healthcare benefits, and one of those healthcare benefits is habilitative services and rehabilitative services. When I stood in this

	room back in 2015, when this was rolling out the first time, we worked on those definitions as well back then. At that time the definition for habilitation was defined as coverage is provided for habilitative care services when participants require help to maintain, learn or improve skills and function of daily living or to prevent loss of skills. These services include, but are not limited to, physical occupational speech language, behavioral health professional treatments. It also goes on to say applied behavioral analysis for adults is excluded for habilitative services and rehabilitative services as well. Habilitative services for adults, applied behavioral analysis, the Autism Center back in 2016 went back to the literature and looked at what was evidence-based at this time, and behavioral interventions under applied behavioral analysis is the only evidence-based intervention for those over 22. And so I'm just asking for the removal of that exclusion for the only evidence-based intervention for adults with autism within the waiver for habilitative care and rehabilitative care as well too. Thank you very much.
[redacted]	Thank you Director Mathews and Department staff. My name is [redacted] I'm the [redacted]. Montana Budget and Policy Center strongly supports the continuation of Medicaid expansion. However, we remain concerned about new work or community-engagement requirements and increased premiums for some enrollees that will result in taking away healthcare coverage for thousands of Montana enrollees. National studies show that of those enrollees not employed, virtually all are facing either health-related or labor force-related barriers to employment. By the state's own estimates, upwards of 12,000 Montanans could not report or failed to meet the requirements and face suspended coverage. Montana workers with low incomes are especially subject to the volatility of labor markets. Many face irregular hours, struggle to find more than just part-time work, seasonal work or are temporarily caring for a child or family member. This volatility is especially common in rural areas. Older Montanans will encounter additional obstacles in complying with these new work reporting requirements. Older workers often face greater barriers in maintaining steady employment, often due to health conditions or age discrimination. Not only do work requirements hinder Medicaid's core objective of providing healthcare access, work requirements do not achieve the stated goals of increasing work or decreasing poverty. Second, we have some concerns about the new premium structure as proposed in the waiver. Montana has clear evidence that premiums result in the loss of healthcare coverage. Under Montana's current program the state has disenrolled over 5,400 individuals for failure to pay premiums. This waiver proposes a new premium structure which imposes a .5 percentage point increase per year after the second year of enrollment. For an enrollee in their third year, this increase would

	represent a 25 percent increase in premiums. We believe this premium increase structure, as proposed by DPHHS in the waiver, is inconsistent with the plain language of House Bill 658, and we urge the Department to consider amending the waiver to reflect a .5 percent increase, as articulate in House Bill 658. We know that premiums are already having a disparate impact on access to healthcare coverage, and the state is likely to see even higher rates of loss of coverage under the proposed waiver. We appreciate the opportunity to comment on the proposed waiver and will submit lengthier written comments, and thank the Department for all their work to continue Montana's successful Medicaid program.
[redacted]	My name is [redacted]. I'm here in [redacted]. I live here. I'm here today to ask you not to include work requirements on Medicaid expansion program. I personally am on Medicaid expansion. I personally benefitted from this program by having a life-changing surgery, including the opportunity to stay on top of many other medical needs. These proposed changes will have a negative effect on Medicaid and people like me. In some personal medical issues I could be out of work and _____, and that is just not an option for me. Thank you.
[redacted]	Hello, my name is [redacted]. I'm here on behalf of the Montana Human Rights Network. Thank you for having this public hearing today. We've submitted full written comments, but I wanted to touch on a couple of things today. We strongly oppose any and all changes to the Medicaid expansion program that will result in a loss of coverage, a risk of Montanans being disenrolled or suspended from their care, and any changes that would make the program more difficult to access. We believe that the proposed changes, specifically the work requirements and the premiums, will result in these things. Thank you.
[redacted]	My name is [redacted]. I'm speaking as a private person, and I'm a lifelong Montana resident—lifelong taxpayer. I don't qualify for Medicaid, but I don't mind my taxpaying money going to help people to have better health coverage—I know it's better for our communities. This proposal, I believe, will decrease preventative care, which will potentially decrease healthcare jobs—they said there were 15,000 new jobs created. I believe we would lose jobs in Montana. Also, if there are thousands who would probably lose their care, we would increase emergency room care again, because they wouldn't be getting preventative care. This would be increased costs for the hospitals, once again. There is in your slides, it said employees have failed to make payments for overdue premiums. We'll have their premium debt assessed against their income taxes. Those with incomes above 100% of the federal poverty level who fail to pay premiums, will be suspended from coverage until they pay overdue premiums or until their premium

	debt is assessed against their taxes. Now this is what was happening with the Affordable Care Act with people with insurance if you were fined for not having coverage, and that came out of your taxes. This was stopped in 2019, federally, for the Affordable Care Act for people with insurance. Now, this seems to me you're going to do the same thing to people with Medicaid. If they cannot pay, they lose coverage and they're fined through their taxes. So, it doesn't seem that right. That's right. Okay. In the hypothesis, which is really what's being submitted, I disagree with the hypothesis that conditioning coverage among enrollees with incomes about 100 percent of the federal poverty level will gradually increase premiums. Gradually increasing premiums will promote continuous coverage and continuity of care. Many people have stopped getting Affordable Care Act coverage and insurance, the premium tax credit, because the premiums increased—they dropped coverage. And I believe Medicaid people will be the same. As the premiums increase, more people will drop their coverage. I disagree with the hypothesis that premiums will not deter eligible individuals from applying for, enrolling in, or renewing medical coverage. I believe premiums are a deterrent. Lastly, it says employees who are required to make premiums—this is a hypothesis—payments will gain familiarity, it's a common feature of commercial healthcare insurance. Are we using public money to groom people to become private industry paid customers? I do not believe that should be the goal of using public funds to groom them to become private insurance customers. Thank you.

My name is [redacted]. I reside at [redacted].
I have utilized Montana and Pennsylvania Medicaid throughout my adult life due to Cerebral Palsy and glaucoma suspect visual disabilities. I am really happy that Medicaid Expansion passed 2015 because it has helped bridge the insurance gap for Montanans with chronic disease and disabilities . I currently am eligible under Montana Medicaid For Workers with Disabilities. Because of this funding stream and past state plan amendment, I am able to pay a cost increment and keep working at North Central Independent Living Services, Inc. a center for independent living in Black Eagle, Montana . Medicaid and Medicare often set the payment and benefit standard packages which private insurers follow and cover. I need Home Health and Community First Choice services, but I advocate for north central Montanans with disabilities. I have concerns that if CMS adopts stringent work plans as part of Medicaid Expansion throughout the nation. including Montana, it will cause consumers and families more stress a in other areas . I am afraid the way CMS will view more stringent work requirements will become the norm with no grace periods for serious issues, Yes, there are community engagement requirements,but many on Medicaid already work. If the Federal government, state, and DPHHS were truly concerned about self sufficiency rather than reliance on needed benefits, the State of Montana as well as other states, would truly adopt a benefits planning system similar to what was in place during the WIPA or Work incentives Planning and Assistance grant time period. After participating in the Medicaid Expansion hearing, I found out that the Medicaid policy developers weren't working with our State Vocational Rehabilitation Services offices s so they could assist people who do identify as having disabilities to return or explore returning to work with the proper supports and accommodations

Benefit Packages and eligibility aren’t seamless or linear . To me as a citizen, what services are offered where and how throughout the Medicaid system should be seamless . Montana and other states need to design our Medicaid system so that we can live and use Medicaid Services TO LIVE in our homes NOT NURSING HOMES. . Consumers want services to match needs yet we as a state and nation only look at Medicaid in an incremental way.

Thanks for accepting comments,

August 22, 2019

Marie Matthews
Medicaid State Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604

Re: Montana Health and Economic Livelihood (HELP) Demonstration Program

Dear Director Matthews:

The Arthritis Foundation appreciates the opportunity to submit comments on the Montana Health and Economic Livelihood (HELP) Demonstration Program.

The Arthritis Foundation is the Champion of Yes. Leading the fight for the arthritis community, the Foundation helps conquer everyday battles through life-changing information and resources, access to optimal care, advancements in science and community connections. We work on behalf of the over 200,000 people in Montana who live with the chronic pain of arthritis every day.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. The Arthritis Foundation is committed to ensuring that Montana's Medicaid program provides adequate, affordable and accessible healthcare coverage.

The Arthritis Foundation strongly supports Medicaid expansion in Montana. Over 92,000 low-income adults currently receive healthcare coverage through the state's Medicaid expansion. This means that thousands of enrollees are receiving prevention, early detection and diagnostic services as well as disease management and treatment for their conditions.[1] Medicaid expansion is clearly beneficial for patients with serious and chronic health conditions like arthritis.

Montana's application to continue the HELP Demonstration Program also includes policies that could threaten access to healthcare by creating new financial and administrative barriers that could lead patients with arthritis to lose their healthcare coverage. The Arthritis Foundation therefore offers the following comments on Montana's proposal.

Premiums
Montana's Medicaid program currently charges premiums equal to two percent of modified adjusted gross income to adults with incomes above 50 percent of the federal poverty level ($889 for a family of three), and individuals with incomes above 100 percent of the federal poverty level ($1,778 per month for a family of three) can lose their coverage for failing to pay these premiums. The state proposes to increase premiums by 0.5 percent each year, up to a maximum of four percent, after individuals have been covered by the program for two years. This policy would likely both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program, as research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[2] For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[3] For individuals with arthritis, maintaining access to comprehensive coverage is vital to ensure clinical

stability and avoid costly hospitalizations or surgeries. Based on an evaluation of the state's current premium requirement, the state's application estimates that 2.9 percent of individuals will lose coverage as a result of this coverage, likely an underestimate given the increase in premiums under the proposed policy. The Arthritis Foundation believes that these premiums create significant financial barriers for patients that jeopardize their access to needed care.

Work Reporting Requirements

Under the application, individuals in the expansion population between the ages of 19 and 55 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[4] Montana's own application includes an estimate that between 4,000 and 12,000 individuals could lose coverage as a result of the work reporting requirements alone but acknowledges that coverage losses could be even higher.[5]

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements after 180 days, their coverage would be suspended for 180 days unless they are able to demonstrate compliance or qualification for an exemption.

The Arthritis Foundation is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working Regardless, even exempt enrollees may have to self-report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[6] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will also be expensive for the state of Montana. States such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[7] This would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care – and compromise the fiscal health of Montana's Medicaid program.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[8] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[9] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[10] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier.

Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment.

Additionally, as Montana itself notes in its application, recent research shows that the work reporting requirement in Arkansas did not lead to increased employment among the Medicaid population. A study in *The New England Journal of Medicine* found that the implementation of Arkansas's work requirement was associated with a significant loss of Medicaid coverage and significant increase in the number of uninsured individuals.[11] The study found no corresponding increase in employment, which negates the argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage. The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so.

Montana's Medicaid program already connects enrollees with Montana's Health and Economic Livelihood Partnership Link (HELP-Link), which provides workforce training to unemployed enrollees who face barriers to work such as limited skills and lack of access to support such as childcare and transportation. This program has reached 25,000 low-income adults since its launch, 70 percent of whom found jobs within a year after completing the program.[12] HELP-Link provides low-income adults a pathway to the labor market and employment opportunities that have increased Montanans earning potential without imposing administrative barriers that jeopardize patients' access to care.

Continuous Eligibility

Finally, Montana's application would continue its current policy providing 12 months of continuous eligibility to the Medicaid expansion population. This policy helps to reduce churn in the Medicaid program and minimize the administrative burden to both the state and enrollees. The Arthritis Foundation supports Montana's request to continue this policy.

The Arthritis Foundation believes that healthcare coverage should be affordable, accessible and adequate for patients with arthritis. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

[1] Montana Department of Public Health and Human Services, Montana Medicaid Expansion Dashboard January 28, 2019. Available at: https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard

[2] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[3] Id.

[4] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-

arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[5] Montana Department of Public Health and Human Services, Section 1115 Demonstration Amendment and Extension Application, July 23, 2019. Available at: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf.

[6] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[7] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[8] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[9] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[10] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[11] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019. Available at: https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B.

[12] Hannah Katch, "Proposed Restrictions Could Undermine Montana's Successful Medicaid Expansion," Center for Budget and Policy Priorities, February 13, 2019, https://www.cbpp.org/research/health/proposed-restrictions-could-undermine-montanas-successful-medicaid-expansion#_ftn1

Hello

I would like to offer a few comments regarding the Medicaid Expansion work documentation requirements:

Montana has many small Independent Contractors/self employed people operating as sole proprietors or partnerships. They may be on call full time, work long or odd hours. Income can vary month to month, or may be seasonal.

How would these individuals document their time?

August 22, 2019

Ms. Sheila Hogan
Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604-4210

Dear Ms. Hogan,

Thank you for the opportunity to comment on the Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program amendment and extension application. On behalf of people with cystic fibrosis (CF), we write to support Montana's request to extend Medicaid expansion and the twelve-month continuous eligibility period, but also to express our concern that work and community engagement requirements, as well as increased premiums, are barriers to accessing the high-quality care that people with CF need. As such, we ask the state to specifically and automatically exempt people with cystic fibrosis from these requirements.

Cystic fibrosis is a life-threatening genetic disease that affects 120 adults in Montana, more than 30 percent of whom rely on Medicaid for all or some of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. For those with CF, health care coverage is a necessity and interruptions in coverage can lead to lapses in care, irreversible lung damage, and costly hospitalizations—compromising the health and well-being of those with the disease. Removing an individual from Medicaid coverage if they are unable to comply with work or premium requirements, or during the determination of whether an individual is eligible for an exemption, will leave these patients without coverage they depend upon to maintain their health. Explicitly exempting cystic fibrosis will minimize the number of individuals who are disenrolled from coverage due to these new requirements.

Medicaid Expansion and Continuous Eligibility

We strongly support the state's request to continue Medicaid expansion, which currently provides coverage to 93,000 people, or 9 percent, of Montana's population.[1] Medicaid is a crucial source of coverage for patients with serious and chronic health care needs – often serving as a payer of last resort, filling important gaps in coverage left by private health plans. For people with CF, Medicaid helps them afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing people with CF to maintain their health and well-being. Extending Medicaid expansion will continue to increase access to affordable, high-quality health care and ensure a safety net for those who might otherwise be left without access to coverage.

[1] https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard

We also appreciate the state's extension of its twelve-month continuous eligibility period, which helps enrollees maintain their coverage throughout the year, regardless of fluctuations in income that may otherwise impact eligibility and interrupt coverage. Continuous eligibility protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that can lead to decreased access to care and high out of pocket costs.

Work and Community Engagement Requirements

Continuous access to high-quality, specialized CF care is essential to the health and well-being of people with cystic fibrosis. Making work a condition of Medicaid eligibility threatens access to care for people with CF, as their ability to work can vary with changes in health status. The Cystic Fibrosis Foundation appreciates Montana's decision to exempt from community engagement and work requirements individuals who are medically frail; this reflects the important reality that health status can significantly affect an individual's ability to search for and sustain employment. Likewise, we are pleased to see the state plans to leverage existing resources to determine both standard and good cause exemptions. As the state works to define these categories, we strongly urge you to further clarify the exemption list to specifically include cystic fibrosis as an automatic exemption to the requirements.

Nonetheless, even considering exemptions listed above, we still have serious concerns about the administrative challenges someone with CF could face in understanding and navigating these requirements and the exemption process. Arkansas' program is a prime example of how administrative burdens can jeopardize coverage. The November 2018 Arkansas Works program report shows an overwhelming majority – nearly 80 percent – of those required to log-in and report compliance with the work requirements failed to do so, putting these individuals at risk for loss of coverage.[2]

Moreover, as this application notes, Arkansas' experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. Within six months of Arkansas implementing work requirements, more than 18,000 people lost Medicaid coverage in the state. If work requirements are implemented in Montana, the state estimates that between 4-12 percent of enrollees will lose coverage due to work requirements.

Audit Trigger

We support the state's proposal to initiate a third-party audit should suspensions due to Medicaid work requirements surpass 5 percent of program enrollees. If auditors find that more than 10 percent of enrollees in the sample were erroneously suspended, the Department will stop coverage suspensions until the end of the next general legislative session. This stopgap measure is a step in the right direction to prevent against massive coverage losses for Medicaid enrollees but in no way fully ameliorates the harmful effects of work requirements.

Increased premiums

In addition to above concerns, we worry the proposal to increase premium payments for some enrollees may impose unmanageable health care costs on financially vulnerable and medically complex adults if they are unable to obtain an exemption. Our research shows that while 99 percent of people with CF have insurance, one-quarter delay or skip care due to cost concerns. Such actions seriously jeopardize the health of people with CF and lead to costly hospitalizations and fatal lung infections.

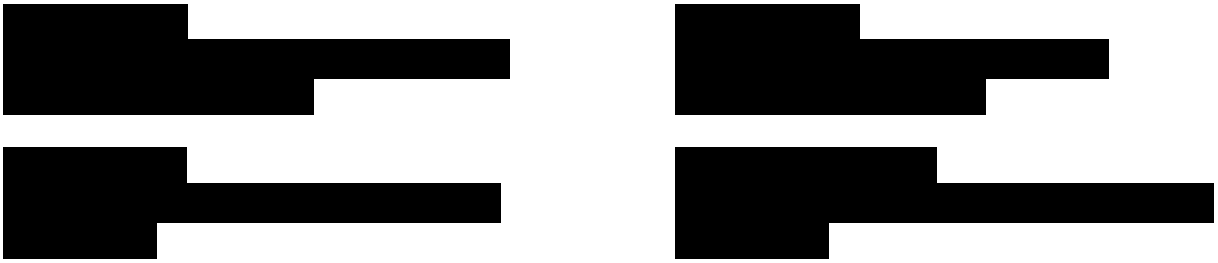
[2]https://humanservices.arkansas.gov/images/uploads/newsroom/181217_AWreport.pdf

The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals, as this waiver acknowledges that Montanans have already begun to lose their coverage due to premium requirements. Montana's current premium requirements for enrollees with incomes above 100 percent of the federal poverty level (FPL) led to 2.9 percent of enrollees subject to the requirements losing coverage for non-payment in 2018.

Not only are nominal premiums often unaffordable for low income beneficiaries, but the process of making a premium payment can create barriers to care for a population that may not have bank accounts or credit cards. For instance, an analysis of Indiana's Medicaid program found that nearly 30 percent of enrollees never enrolled in coverage or were disenrolled from coverage because they failed to make premium payments during the study period. The analysis found 22 percent of individuals who never enrolled because they did not make the first month's payment cited affordability concerns, and 22 percent said they were confused about the payment process. Additionally, researchers found that many beneficiaries in Michigan used money orders to pay their premiums, as money orders are a common form of payment for individuals without a bank account or credit card, and beneficiary advocates and enrollment assisters noted that money order fees could sometimes equal or exceed the amount of premiums or copayments owed. For these reasons, we again ask for CF to be included on a list of explicit exemptions.

The Cystic Fibrosis Foundation appreciates the opportunity to provide input on these important policy changes. As the health care landscape continues to evolve, we look forward to working with Montana to ensure access to high-quality, specialized CF care and improve the lives of all people with cystic fibrosis. Please consider us a resource moving forward.

Sincerely,



Rocky Mountain Tribal Leaders Council

711 Central Avenue, Suite 220, Billings, Montana 59102
Ph: (406) 252-2550 Fax: (406) 254-6355 Web: www.rmtlc.org

August 21, 2018

Via Electronic Mail: dphhscomments@mt.gov

Medicaid Expansion Extension
Director's Office
P.O. Box 4210
Helena, MT 59604-4210

RE: Request for Exemption from Work Requirements for IHS Beneficiaries

Dear Director's Office;

The Rocky Mountain Tribal Leaders Council is writing on behalf of its member Tribes in Montana to request an exemption to the work requirements currently contained in the Montana Department of Public Health and Human Services (DPHHS) proposed Montana Medicaid Expansion Waiver Amendment and Extension for Indian Health Services (IHS) Beneficiaries.

Montana proposed to condition Medicaid Coverage on compliance with work/community engagement requirements for new adult enrollees ages 19 to 55 with incomes up to 138 percent of the federal poverty level.

Medicaid is uniquely important to the Tribal population in Montana. American Indians are among the most vulnerable population in Montana. The U.S. Census Bureau estimates that 37% of tribal members in Montana are below poverty, not including people who are considered mixed-blood. The median age at death is nearly 18 years shorter for American Indian people than for white people in Montana. Leading causes of death include injury, heart disease, diabetes, and cirrhosis. DPHHS has determined that mental and behavioral disorders ranks 8 for cause of death for tribal members in Montana.

Many of the IHS eligible population live in areas of chronic unemployment, which leaves them without any form of coverage other than Medicare and Medicaid. According to the Montana Department of Labor and Industry, every single reservation has an unemployment rate higher than the State of Montana overall unemployment rate of 4.2%; these rates range from Flathead Reservation with a rate of 6.5% to Northern Cheyenne with a 15.5% unemployment rate.

Unlike other Medicaid enrollees, American Indians have access to IHS services to fall back on at no cost to them. However, IHS is currently funded at around 60% of need and the average per capita spending for IHS patients is only $3,688 compared with $9,223 nationally.

If eligibility is tied to state-imposed work requirements, many IHS eligible Medicaid enrollees will simply elect not to participate in Medicaid. Thus, work requirements will have a unique effect of Montana IHS eligible Medicaid enrollees alone that will in turn deny the Indian Health system Medicaid funding Congress intended it to receive through Section 1911 of the Social Security Act.

Medicaid expansion in Montana has allowed a total of $51.1 million dollars in 100% federal reimbursement for health care services into IHS and Tribal Health organizations located in Montana Indian Country.

CMS has ample legal authority to make accommodations to ensure that work and community engagement requirements do not pose a barrier to access to Medicaid for IHS beneficiaries given the Federal Government's unique legal and political government-to-government relationship with Tribal governments, and the special obligation to provide services for American Indians and Alaska Natives.

The money that has come to IHS and Tribal Health Organizations in Montana through expanded Medicaid has been critical in addressing the health disparities in Indian Country in Montana. The inclusion of a work exemption for IHS eligible participants in Montana's Waiver Application is necessary in the on-going fight to reduce the health disparities of the Tribal population in Montana. Montana's Waiver cannot effectively and efficiently serve IHS eligible beneficiaries without an exception to work/community engagement requirement.

Sincerely,

[redacted]

Dear Ms. Sheila Hogan,

As a resident of Montana and someone personally affected by cystic fibrosis, I'm writing to share my support for continuing Medicaid expansion and the 12-month continuous eligibility period. However, I am concerned about how proposed barriers to Medicaid eligibility may impact enrollees and ask you to automatically exempt people with CF from the work requirements and premiums in Montana's Health and Economic Livelihood Partnership (HELP) program amendment and extension application.

Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that

can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted].

Dear Ms. Hogan,

The changes to Montana Medicaid requiring work requirements and increased premiums will negatively impact so many people who rely on Medicaid but are unable to work for various reasons. It will particularly impact women and mothers. Please re-consider this legislation. There are better + more effective ways to track and support effective use of Medicaid resources.

Thank you-

[redacted]

August 23, 2019

Sheila Hogan
Director
MT Department of Public Health and Human Services
111 North Sanders St
Helena, MT 59601

RE: Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application: Montana Health and Economic Livelihood (HELP) Demonstration Program

Submitted via email to dphhscomments@mt.gov

Dear Ms. Hogan,

The Montana Primary Care Association is grateful for the opportunity to comment on the Section 1115 Demonstration Amendment and Extension Application for the Montana Health and Economic Livelihood Partnership (HELP) Act. As you know, in its final form, MPCA supported HB 658, the legislation to renew and amend Montana's Medicaid expansion program during the 2019 legislative session and we appreciate the bipartisan commitment to reauthorize the program. MPCA supported HB 658 because we saw it as the only path forward for continuation and expansion. We do, however, continue to have concerns about loss of coverage and the scope of exclusions and exemptions.

The Montana Primary Care Association (MPCA) is the statewide membership organization for all the state's federally qualified health centers (FQHCs) and four of Montana's Urban Indian Clinics (UICs). Combined, MPCA's members serve as the health home for over 110,000 medically-underserved Montanans, the majority of whom live below the Federal Poverty Level and face multiple social and environmental factors which impact their need for health care and their ability to access care appropriately. With over 80 sites in a frontier state, Montana's FQHCs and UICs provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services.

As noted through public testimony during HB 658's legislative process, MPCA is concerned about loss of coverage. Primarily, MPCA's concern largely rests with the legislation's proposed work and community engagement requirements. Given the state's own reports and research, we know that the majority of Medicaid enrollees and/or families already participate in the workforce.[1] National research clearly shows that for those Medicaid enrollees not working, the primary reasons include either health-related barriers or labor force barriers.[2]

Fundamentally, MPCA believes that the draft waiver's amendment to impose work/community engagement requirements will result in the loss of coverage for thousands of Montanans. At the time of

[1] Ward, B., and Bridge, B., "The Economic Impact of Medicaid Expansion in Montana: Updated Findings."
[2] Bauer, L., Whitmore Schanzenbach, D., and Shambaugh, J., "Work Requirements and Safety Net Programs," The Hamilton Project, Oct. 2018.

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its passage, HB 658 estimated loss of coverage at approximately four thousand Montanans.[3] However, new numbers included in the state's draft waiver application now estimate that the original loss of coverage number is at the low end of possible loss of coverage.[4]

MPCA is concerned that the increased estimate for loss of coverage stems from several issues, all of which reside in the ambiguity of the underlying legislation and the state's subsequent waiver application. MPCA urges DPHHS to refine through rules its definitions of exclusions and exemptions to clearly define those Montanans who are best served through continuous Medicaid eligibility without the burden of work and community engagement reporting requirements. MPCA anticipates weighing in during the state's rule-making process for this reason.

In addition to MPCA's concerns regarding the proposed work/community engagements, we have the following comments:

- Section I, subsection C, second bullet: *"Premium Increase Structure Based on Coverage Duration."* MPCA requests clarity on this section and asks that DPHHS define a year as twelve continuous months to trigger premium increases. As a healthcare entity, MPCA is well-versed in the "churn" experienced for its Medicaid enrollees. Many individuals do not remain on Medicaid for a continuous 24 months, perhaps because of changed employment, relocation to another state, or personal crisis. Someone who is on the program intermittently for two years ought not be subject to the premium increase structure; someone on the program for twenty-four continuous months may be subject. Because Montana has already documented a significant loss of coverage due to its current premium structure, MPCA's concern is that people will drop Medicaid in even greater numbers due to the inability to afford increasing premiums without this modification.[5]
- Section I, subsection D: *"Summary of Current Demonstration Features to Continue Under the 1115 Demonstration Amendment and Extension."* MPCA supports the 12- month continuous eligibility period listed in this section.
- Section I, subsection D: *"Summary of Current Demonstration Features to be Continued Under the 1115 Demonstration Amendment and Extension."* This section identifies the list of those enrollees excluded in the current Demonstration who will not only continue to be excluded from the extension, but will also be excluded from the proposed amendments in this application. This list is critical and reflects the Department's recognition that some populations health needs will not be improved by testing one of the application's hypothesis – "Participation in the Demonstration's work/community engagement requirements will improve current and former enrollee health and well-being, compared to Medicaid beneficiaries not subject to these requirements." MPCA believes that this list of exclusions recognizes that for certain populations, the physical and economic cost to the individual and the health care system is better served by unrestricted inclusion in the program and that possible exclusion due to work/community requirements will cause significant harm. Furthermore, through its agreement with CMS and its

[3] Fiscal Note 2021 Biennium. HB 0658.03. Generally revise healthcare laws and permanently expand Medicaid. Fiscal Analysis: Assumptions 1. Enrollment (e.). April 10, 2019.
[4] Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application. Figure 8. Estimated Compliance and Exemptions by Administrative and Self-Report Status for Montana Medicaid Expansion Beneficiaries Subject to Work/Community Engagement Requirements. Page. 18.
[5] Department of Public Healthy and Human Services, "Montana Medicaid Expansion Dashboard," July 2019.

subsequent rule-making process, DPHHS should exercise its authority under this section to include individuals and populations with demonstrated risk of elevated morbidity and mortality. These groups may be identified by any number of factors including claims data for known significant chronic health conditions (i.e. diabetes, hypertension, obesity, etc.), geographic area due to evidence-based research identifying elevated risk, and/or identified health risks not otherwise listed in the demonstration. The benefits for keeping these populations on Medicaid, regardless of their employment or community engagement status, outweighs testing the proposed hypothesis.

- Section II, subsection A, subpoint 2: *"Changes Requested to the Demonstration: Work/Community Engagement Requirements: Qualifying Activities."* MPCA urges DPHHS to utilize its existing claims system to verify participation and define any substance abuse education or treatment, regardless of intensity, as meeting the demonstration's requirements. Again, the continuous benefits for an individual seeking and receiving these services outweighs testing the demonstration's proposed hypothesis that work/community engagements improve the health and well-being of enrollees.
- Section II, subsection A, subpoint 3: *"Changes Requested to the Demonstration: Work/Community Engagement Requirements: Exemptions."* In general, assuming the state will enact some level of work/community engagement requirements despite considerable concerns that people will lose coverage, MPCA hopes the list of standard exemptions listed in this section will be sufficient to identify and protect access for many vulnerable populations. Specifically, MPCA supports the TANF and SNAP exemptions and high poverty exemptions. In addition, MPCA requests that the definition of a "primary caregiver for a person who is unable to provide self-care" should be sufficiently broad to include parents and caregivers to not only children below the age of majority, but also include family members with disabilities, significant chronic illnesses, or age-related complications.

Thank you for the opportunity to comment. If you have any questions, you may contact me at [redacted].

Sincerely,

[redacted]

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August 22, 2019

Sheila Hogan
Director
Montana Department of Public Health and Human Services
Director's Office
PO Box 4210
Helena, MT 59604-4210

Re: Montana Health and Economic Livelihood Partnership Program Section 1115 Demonstration Amendment and Extension Application

Dear Director Hogan:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Montana's Medicaid Section 1115 demonstration amendment and extension application. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

We strongly support the extension of Montana's Medicaid expansion, which covers over 92,000 Montanans.[1] We are particularly pleased to see that 101,309 adults who gained coverage under the expansion received preventive health care services, including 8,172 adults receiving a colorectal cancer screening (resulting in 2,941 possible cases of colorectal cancer averted) and 9,257 women receiving a breast cancer screening (resulting in the diagnosis of 136 breast cancers).[2] The prevention and early detection of cancer is critical to the fight for a world without cancer. Research has shown that individuals in expansion states are more frequently diagnosed with cancer at earlier stages than those in non-expansion states.[3,4] Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.[5]

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[1] Montana Department of Public Health and Human Services. *Montana Medicaid Expansion Dashboard*. June 2019 enrollment. Accessed July 26, 2019. https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.
[2] Ibid.
[3] Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among non-elderly patients with cancer after the Affordable Care Act. *J Clin Oncol*. 2017; 35:2906-15.
[4] Soni A, Simon K, Cawley J, Sabik L. Effect of Medicaid Expansion of 2014 on overall and early-stage cancer diagnoses. *Am J Public Health*. 2018; 108:216-18.
[5] Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* 2009; 115(6):1300-9.

Over 5,920 Montanans are expected to be diagnosed with cancer in 2019[6] and there are nearly 60,000 cancer survivors in the state[7] – many of whom are receiving health care coverage through Montana Health and Economic Livelihood Partnership (HELP) Program. ACS CAN wants to ensure that cancer patients and survivors in Montana will have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

The proposed Medicaid work/community engagement requirement and premium increase structure could limit eligibility and access to care for some of the most vulnerable Montanans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. We strongly urge the Montana Department of Public Health and Human Services (DPHHS) to address the concerns that we and other stakeholders have before moving forward with the waiver process.

The following are our specific recommendations for the Montana Health and Economic Livelihood Partnership Program section 1115 demonstration amendment and extension application:

Montana Work/Community Engagement Requirements

Montana's waiver application would require all demonstration enrollees between ages 19 and 55 with incomes up to 138 percent of the federal poverty level (FPL) to be employed or volunteer 80 hours per month or meet an exemption in order to maintain eligibility or enrollment in the Medicaid program. This policy could unintentionally disadvantage Medicaid enrollees with complex chronic conditions, including cancer patients, recent survivors, and those facing a cancer diagnosis. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[8,9,10]

ACS CAN opposes tying access to affordable health care for lower income persons to work or community engagement requirements, because cancer patients, survivors, and those who will be diagnosed with the disease – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage because they are physically unable to comply. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[11] Recent cancer survivors often require frequent follow-up visits and maintenance medications to prevent

[6] American Cancer Society. *Cancer Facts & Figures 2019*. Atlanta, GA: American Cancer Society; 2019.
[7] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.
[8] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.
[9] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.
[10] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.
[11] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

recurrence,[12] and suffer from multiple comorbidities linked to their cancer treatments.[13,14] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.[15,16,17,18] If work and community engagement is required as a condition of eligibility, many recent cancer survivors and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the State's Medicaid program. We also note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to preventive care, including cancer screenings.

We appreciate the State's acknowledgement that not all people are able to work and the decision to include several exemption categories and hardship/good cause exemptions from the community engagement requirement and associated suspension period, including individuals considered to be medically frail. However, the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors and other serious chronic diseases often linked to cancer treatments.[19,20] The State anticipates in the waiver application that 4,081 enrollees will be disenrolled from health coverage. The increase in administrative requirements for enrollees to attest to their working or exemption status on an unspecified basis would likely decrease the number of individuals with Medicaid coverage even more, regardless of whether they are exempt.[21,22] While we appreciate the Department using as many automated tools as possible to determine compliance and exemptions for the work/community engagement requirements, the Department cannot ensure without a doubt that automated tools will catch all eligible enrollees; therefore, individuals will likely fall through the cracks.

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[12] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed July 2019. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[13] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[14] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[15] Ibid.

[16] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268.

[17] Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382.

[18] Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol*. 2018; 36(3):287-303.

[19] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[20] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[21] Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirements: National estimates of potential coverage losses. Kaiser Family Foundation. Published June 2018. Accessed July 2019. http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses.

[22] Sommers BD, Goldman AL, Blendon RJ, et al. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019. DOI: 10.1056/NEJMsr1901772.

Given the recent experience with Arkansas' work requirement, where uninsured rates were driven up and employment actually declined in the state since the work requirement went into effect,[23] Montana must consider the number of Montanans whose health could be negatively impacted, and coverage lost due to this proposal. Additionally, it is clear from this preliminary data from Arkansas that the work requirements are not meeting the state's goal of incentivizing employment and increasing the number of employed Arkansas Works beneficiaries. A goal that Montana also states in their waiver.

Suspension of Benefits
We oppose the proposed 180-day suspension of benefits period for non-compliance with the work or community engagement requirement or suspension of coverage until the work requirement has been met for 30 days. According to the Department's estimates, approximately 8,163 Montanans would be required to either provide additional evidence of a qualifying exemption or comply with the community engagement program.

It is also unclear how the Department will determine the length of time an exemption applies, only stating that the time frame is "dependent on the enrollee's circumstances." For medical exemptions, will this be determined by the patient's physician? Or will the Department use some other arbitrary time frame to determine how long a person can be exempt?

Those with acute and chronic health care conditions who apply for an exemption to avoid the suspension period will still have to verify their exemption and undertake a burdensome documentation process. This could lead to instances where those who should be able to maintain coverage are disenrolled, jeopardizing access to life-saving treatment. If individuals are locked out of coverage they will likely have no access to affordable health care coverage, making it difficult or impossible for a cancer patient or recent survivor to continue treatment or pay for their maintenance medication until they come into compliance with the requirement or they are determined to be exempt. This is particularly problematic for cancer survivors who require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence[24] and who suffer from multiple comorbidities linked to their cancer treatments.[25] It may also be a problem for individuals in active cancer treatment who may not realize they are exempt. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the lock-out would have on individuals and their families could be devastating.

Premium Increase Structure Based on Coverage Duration
Montana seeks to amend its demonstration approach to premiums by applying a premium structure for demonstration enrollees with an income greater than 50 percent of the FPL that gradually increases based on coverage duration. Monthly premiums would be required equal to 2 percent of the enrollee's modified adjusted gross income for the first two years of participation, with premiums increasing 0.5 percent in each subsequent year the enrollee receives coverage up to a maximum of 4 percent of the enrollee's income. ACS CAN strongly opposes mandated monthly premiums – particularly for enrollees

[23] Ibid.
[24] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed July 2019. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.
[25] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

under 100 percent FPL. Cost-sharing and related penalties for non-payment have been shown to create administrative burdens for enrollees,[26] deter enrollment or result in a high number of disenrollment,[27] and could potentially cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid program.[28,29,30] Proposals that place greater financial burden on the lowest income residents, especially those under 100 percent FPL, create barriers to care and could negatively impact Montana HELP enrollees – particularly those individuals who are high service utilizers with complex medical conditions. This undermines a stated goal of the Montana HELP Program, namely – to improve the health and well-being of Montanans.

Low-income populations are more likely to have an inconsistent income throughout the calendar year. Therefore, if Montana were to move forward with this proposal, we urge the Department to base the premium contribution on monthly household income (rather than the proposed aggregate income), as it is a more accurate indicator of an individual's income and ability to consistently meet cost sharing requirements – particularly for seasonal workers or individuals who must spend down before meeting the Medicaid eligibility criteria.

Lock-Out Period

We are deeply concerned about the proposed lock-out period for non-payment of premiums until the enrollee making over 100 percent of FPL (a) pays the total amount of overdue premium payments; (b) demonstrates a standard or good cause exemption; or (c) meets a Medicaid eligibility group not subject to the Demonstration. The State reports that in 2018, 2.9 percent of beneficiaries' subject to premiums of up to 2 percent of income were disenrolled for non-payment. Increasing the premium obligation to 4 percent of income would likely cause even more individuals to lose coverage. Subjecting enrollees to the proposed lock-out, even with exemptions, could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for cancer survivors (who require frequent follow-up visits) and individuals in active cancer treatment. During the proposed lock-out period, low-income cancer patients or survivors will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until they can pay all outstanding premiums. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team, even

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[26] The Lewin Group. *Health Indiana Plan 2.0: POWER Account Contribution Assessment*. Published March 31, 2017. Accessed August 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

[27] Artiga S, Ubri P, Zur J. *The effects of premiums and cost sharing on low-income populations: Updated review of research findings*. Kaiser Family Foundation. Published June 1, 2017. Accessed August 2019. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[28] Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86.

[29] Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.

[30] Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. Published July 16, 2015. Accessed April 21, 2016. http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

for a short period of time, could have a significant impact on an individual's cancer prognosis and the financial toll that the lock-out would have on individuals and their families could be devastating.

We urge Montana not to move forward with mandating premiums for individuals on HELP, whether gradually increasing or not, particularly for enrollees below 100 percent of the FPL. This will ensure the HELP beneficiaries will not be denied access to services due to an inability to pay their monthly premium.

Conclusion

We appreciate the opportunity to provide comments on Montana's 1115 waiver demonstration amendment and extension application. The preservation of eligibility and coverage through Medicaid remains critically important for many low-income Montanans who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Department to weigh the potential impact this proposal could have on low-income Montanans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Department to ensure that all Montanans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at [redacted].

Sincerely,

[redacted]

AMERICAN LUNG ASSOCIATION.
IN MONTANA

August 22, 2019

Marie Matthews
Medicaid State Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604

Re: Montana Health and Economic Livelihood (HELP) Demonstration Program

Dear Director Matthews:

The American Lung Association in Montana appreciates the opportunity to submit comments on the Montana Health and Economic Livelihood (HELP) Demonstration Program.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 35 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 130,000 Montana residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. The Lung Association is committed to ensuring that Montana's Medicaid program provides adequate, affordable and accessible healthcare coverage.

The Lung Association strongly supports Medicaid expansion in Montana. Over 92,000 low-income adults currently receive healthcare coverage through the state's Medicaid expansion. This means that thousands of enrollees are receiving prevention, early detection and diagnostic services as well as disease management and treatment for their conditions.[i] For example, nearly 2,500 adults have been diagnosed and treated for hypertension, 136 women have been diagnosed with breast cancer as a result of screening and over 35,000 adults have received outpatient mental health services.[ii] Medicaid expansion is clearly beneficial for patients with serious and chronic health conditions.

Montana's application to continue the HELP Demonstration Program also includes policies that threaten access to healthcare by creating new financial and administrative barriers that could lead patients with lung disease to lose their healthcare coverage. The Lung Association therefore offers the following comments on Montana's proposal.

Premiums
Montana's Medicaid program currently charges premiums equal to two percent of modified adjusted gross income to adults with incomes above 50 percent of the federal poverty level ($889 for a family of three), and individuals with incomes above 100 percent of the federal poverty level ($1,778 per month for a family of three) can lose their coverage for failing to pay these premiums. The state proposes to increase premiums by 0.5

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percent each year, up to a maximum of four percent, after individuals have been covered by the program for two years. This policy would likely both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program, as research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[iii] For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] For individuals with lung disease, maintaining access to comprehensive coverage is vital to ensure they continue to maintain access to their physicians, medications and other treatments and services they need. Based on an evaluation of the state's current premium requirement, the state's application estimates that 2.9 percent of individuals will lose coverage as a result of this coverage, likely an underestimate given the increase in premiums under the proposed policy. The Lung Association believes that these premiums create significant financial barriers for patients that jeopardize their access to needed care.

Work Reporting Requirements

Under the application, individuals in the expansion population between the ages of 19 and 55 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[v] Montana's own application includes an estimate that between 4,000 and 12,000 individuals could lose coverage as a result of the work reporting requirements alone but acknowledges that coverage losses could be even higher.[vi]

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements after 180 days, their coverage would be suspended for 180 days unless they are able to demonstrate compliance or qualification for an exemption. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The Lung Association is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to self-report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[vii] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will also be expensive for the state of Montana. States such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[viii] This would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care – and compromise the fiscal health of Montana's Medicaid program.

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Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[ix] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[x] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[xi] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment.

Additionally, as Montana itself notes in its application, recent research shows that the work reporting requirement in Arkansas did not lead to increased employment among the Medicaid population. A study in *The New England Journal of Medicine* found that the implementation of Arkansas's work requirement was associated with a significant loss of Medicaid coverage and significant increase in the number of uninsured individuals.[xii] The study found no corresponding increase in employment, which negates the argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage. The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so.

Montana's Medicaid program already connects enrollees with Montana's Health and Economic Livelihood Partnership Link (HELP-Link), which provides workforce training to unemployed enrollees who face barriers to work such as limited skills and lack of access to support such as childcare and transportation. This program has reached 25,000 low-income adults since its launch, 70 percent of whom found jobs within a year after completing the program.[xiii] HELP-Link provides low-income adults a pathway to the labor market and employment opportunities that have increased Montanans earning potential without imposing administrative barriers that jeopardize patients' access to care.

Continuous Eligibility

Finally, Montana's application would continue its current policy providing 12 months of continuous eligibility to the Medicaid expansion population. This policy helps to reduce churn in the Medicaid program and minimize the administrative burden to both the state and enrollees. The Lung Association supports Montana's request to continue this policy.

The American Lung Association in Montana believes that healthcare coverage should be affordable, accessible and adequate for patients with lung disease. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

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[i] Montana Department of Public Health and Human Services, Montana Medicaid Expansion Dashboard January 28, 2019. Available at: https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard

[ii] Id.

[iii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iv] Id.

[v] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[vi] Montana Department of Public Health and Human Services, Section 1115 Demonstration Amendment and Extension Application, July 23, 2019. Available at: https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/UpdatedApplicationforAmendmentandExtension-draft.pdf.

[vii] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[viii] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[ix] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[x] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[xi] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[xii] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019. Available at: https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B.

[xiii] Hannah Katch, "Proposed Restrictions Could Undermine Montana's Successful Medicaid Expansion," Center for Budget and Policy Priorities, February 13, 2019, https://www.cbpp.org/research/health/proposed-restrictions-could-undermine-montanas-successful-medicaid-expansion#_ftn1

Rocky Mountain Tribal Leaders Council

711 Central Avenue, Suite 220, Billings, Montana 59102
Ph: (406) 252-2550 Fax: (406) 254-6355 Web: www.rmtlc.org

Resolution # 14-August-2019-3

A RESOLUTION TO PROTECT MONTANA MEDICAID EXPANSION AND OPPOSE WORK REQUIREMENTS ON AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS IN MONTANA

WHEREAS, the Rocky Mountain Tribal Leaders Council (TLC) has been created for the express purpose of providing its member Tribes with a unified voice and collective organization to address issues of concern to the Tribes and Indian people; and

WHEREAS, the Board of Directors of the Tribal Leaders Council consists of duly elected Tribal Chairs, Presidents and Council Members who are fully authorized to represent their respective Tribes; and

WHEREAS, as a manifestation of their solemn duty, the Tribal governments actively engage in policy formation on any matters that affect the Tribes and reservations; and

WHEREAS, Tribal Leaders Council is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the health status of American Indians is far below the general population, the unmet health needs are significant, and an unacceptable health disparity exists in Montana where American Indians die 20 years earlier than the white population; and

WHEREAS, those covered under Montana's Medicaid Expansion includes 95,000 individuals of which over 15,000 are American Indians; and

WHEREAS, Medicaid Expansion has infused crucial funds into local communities, hospitals, tribal and urban Indian health organizations and American Indians have benefitted from improved access to quality medical care, including prevention programs; and

WHEREAS, job opportunities are severely limited and chronic unemployment exists in most Montana reservation communities; and

WHEREAS, Montana DPHHS will be submitting its written 1115 Demonstration application to amend and extend its Expanded Medicaid Plan with the inclusion of work/community engagement requirements by August 31, 2019, and is accepting comments on the proposed application until August 23, 2019.

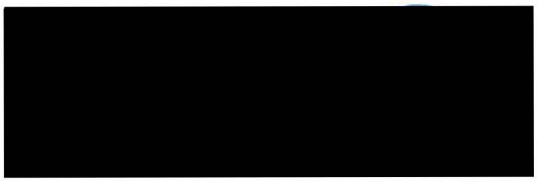
WHEREAS, Work requirements erect barriers for American Indians and a Medicaid community service hour quota reporting requirement not only creates the same costly administrative barriers

to health care as work hour quota reporting requirements, it would also force low-income people to work for a non-monetary benefit; and

NOW, THEREFORE, BE IT RESOLVED that the Rocky Mountain Tribal Leaders Council authorizes a comment on behalf of RMTLC to be submitted to the State requesting that an exemption the Work/Community Engagement requirement for Tribal citizens be included in the State of Montana's application to CMS.

CERTIFICATION

We, the undersigned, as the Chair and Secretary of the Tribal Leaders Council, do hereby certify that the foregoing Resolution was duly presented and approved unanimously at an official Board Meeting of the Rocky Mountain Tribal Leaders Council, which was held on August 15, 2019, with 6 member Tribes present to constitute a Quorum.



FORT PECK TRIBES
Assiniboine & Sioux

August 23, 2018

Via Electronic Mail: dphhscomments@mt.gov

Medicaid Expansion Extension
Director's Office
P.O. Box 4210
Helena, MT 59604-4210

RE: Request for Exemption from Work Requirements for IHS Beneficiaries

Dear Director's Office:

The Fort Peck Assiniboine and Sioux Tribes request an exemption to the work requirements currently contained in the Montana Department of Public Health and Human Services (DPHHS) proposed Montana Medicaid Expansion Waiver Amendment and Extension for Indian Health Services (IHS) Beneficiaries.

Montana proposed to condition Medicaid Coverage on compliance with work/community engagement requirements for new adult enrollees ages 19 to 55 with incomes up to 138 percent of the federal poverty level.

Medicaid is uniquely important to the Fort Peck Tribes. American Indians are among the most vulnerable population in Montana. The poverty rate on the Fort Peck Indian Reservation was estimated to be 30.6% in 2015.[1] The median age at death is nearly 18 years shorter for American Indian people than for white people in Montana. Leading causes of death include injury, heart disease, diabetes, and cirrhosis. DPHHS has determined that mental and behavioral disorders ranks 8 for cause of death for tribal members in Montana.

Fort Peck's IHS eligible population current lives in an area of significant and chronic unemployment, which leaves these individuals without any form of coverage other than Medicare and Medicaid. According to the Montana Department of Labor and Industry, every single reservation has an unemployment rate higher than the State of Montana overall unemployment rate of 3.4%, with a rate of 5.2% unemployment on the Fort Peck Tribes in the

[1] http://www.montana.edu/extensionecon/countydata/FortPeck.pdf (August 2017)

month of July, 2019, for example.[2] The labor force participation rate for the Fort Peck reservation in 2015 was estimated at 48%.[3]

Unlike other Medicaid enrollees, American Indians have access to IHS services to fall back on at no cost to them. However, IHS is currently funded at around 60% of need and the average per capita spending for IHS patients is only $3,688 compared with $9,223 nationally.

If eligibility is tied to state-imposed work requirements, this added burden will discourage many Fort Peck IHS eligible Medicaid enrollees from participation in Medicaid and instead they will likely rely solely on the woefully underfunded health services provided through IHS. Thus, work requirements will have a significant and specific effect on Fort Peck IHS eligible Medicaid enrollees that will in turn deny the Indian Health Services and Fort Peck Tribal Health Programs critical Medicaid funding.

Medicaid expansion in Montana has allowed a total of $7.5 million dollars in 100% federal reimbursement for health care services on the Fort Peck Reservation.

CMS has ample legal authority to make accommodations to ensure that work and community engagement requirements do not pose a barrier to access to Medicaid for IHS beneficiaries given the Federal Government's unique legal and political government-to-government relationship with Tribal governments, and the special obligation to provide services for American Indians and Alaska Natives.

The money that has come to Fort Peck Tribes in Montana through expanded Medicaid has been critical in addressing the health disparities on the Fort Peck Reservation in Montana. The inclusion of a work exemption for IHS eligible participants in Montana's Waiver Application is necessary in the on-going fight to reduce the health disparities of the Tribal population in Montana. Montana's Waiver as currently written cannot effectively and efficiently serve IHS eligible beneficiaries on the Fort Peck Reservation without the inclusion of an exception to the work/community engagement requirement.

Since[redacted]

[2] http://lmi.mt.gov/ Source: Local Area Unemployment Statistics (LAUS) Program
[3] See Footnote 1.

Dear Ms. Sheila Hogan,

As a resident of Montana and someone personally affected by cystic fibrosis, I'm writing to share my support for continuing Medicaid expansion and the 12-month continuous eligibility period. However, I am concerned about how proposed barriers to Medicaid eligibility may impact enrollees and ask you to automatically exempt people with CF from the work requirements and premiums in Montana's Health and Economic Livelihood Partnership (HELP) program amendment and extension application.

Cystic fibrosis (or "CF") is a life-threatening, genetic disease that causes persistent lung infections and progressively limits the ability to breathe over time, often leading to respiratory failure. Approximately 120 Montanans live with CF. As a complex, multi-system disease, CF requires targeted, highly specialized treatment and medications, which must be taken regularly throughout the patient's entire life. This strict regimen can result in significant medical costs for people with CF and their families. There is no known cure for CF, which means a person will live with cystic fibrosis for the entirety of their life.

Medicaid plays an important role in helping people with CF afford the specialized care and treatments they need to lead a healthy, fulfilling life. It often serves as a payer of last resort, filling important gaps in coverage left by private health plans. Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing them to maintain their health and well-being. Medicaid expansion can provide a safety net for these Montanans who otherwise might be left without access to critical health care.

I also support Montana's request to extend its 12-month continuous eligibility period, which allows Medicaid enrollees to maintain their coverage throughout the year, even if they have changes in income that would otherwise impact their eligibility. This protects Medicaid enrollees, including those with CF and other complex medical needs, from gaps in coverage that

can lead to decreased access to care and high out of pocket costs.

While I am pleased the state is continuing Medicaid expansion, I am very concerned that employment reporting requirements and premium increases could introduce barriers to care, leading to interruptions and delays in treatment. Although many Medicaid recipients work, people with CF may be unable to do so depending on their health status or the amount of time they need to spend on the treatment regimen needed to maintain or improve their health. Their ability to work can also vary over time and complications from CF can take someone out of the workforce for significant periods. As such, I ask the state to specifically include people with cystic fibrosis in the definition of those who are automatically exempt.

Moreover, as Montana's application notes, Arkansas's experience with work requirements shows that this policy causes people to lose Medicaid coverage and does not lead to significant gains in employment. If work requirements are implemented in Montana, the state estimates that between 4-12% of enrollees will lose coverage due to work requirements.

I am also concerned about this waiver's proposal to increase premiums for some enrollees. The state says that the goal of increasing premiums is to encourage enrollees to be discerning health care purchasers, to take personal responsibility for health care decisions, and to improve their health. However, increasing premiums will prevent Medicaid enrollees from achieving these goals. Not only are nominal premiums often unaffordable for low income beneficiaries, but studies have shown that the addition or increase of premiums leads to a reduction in Medicaid enrollment. Montana estimates that nearly 3% of enrollees will lose coverage due to premium increases.

Again, I urge you to expand Medicaid and continue the 12-month continuous eligibility period but ask that you exempt people with CF from the work requirements and premiums. Your attention to this matter will help people with CF continue to have access to the quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted].

Dear Medicaid Expansion Extension Director's Office,

I am opposed to the changes in Montana's Medicaid expansion waiver.
Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana’s Medicaid program.
These work requirements disproportionately affect women because they are the ones who may get pregnant, give birth, and tend to care for newborns, and they are more likely to have no paid time off or lose a job during this time - especially lower-wage workers.
These changes will increase health care barriers for low-income Montanans, kick working Montanans off their health coverage, and make it harder for people with chronic illnesses to visit their doctors.

[insert personal comments here]

No Montanan should live at risk of becoming jobless and without health care.
Thank you for your time.

Sincerely,

[redacted]

montana
HUMAN RIGHTS NETWORK

August 22, 2019

Marie Matthews, Montana Medicaid Director
The Department of Public Health and Human Services
P.O. Box 202951
Helena, Montana 59620-2951

RE: Montana Human Rights Network's Comments on Montana Department of Public Health and Human Services (DPHHS) Section 1115 Demonstration Amendment and Extension Application

Director Matthews,

The Montana Human Rights Network (MHRN) is writing in support of DPHHS' proposed amendment and extension to the state's 1115 Medicaid demonstration waiver (Waiver) to continue health coverage for Montanans up to 138% of the federal poverty level (FPL).

MHRN is a non-profit organization based in Helena, Montana, representing individual members and affiliate groups across the state. MHRN is a multi-issue organization that works to achieve equitable healthcare policies at the local, state, and federal level. Our organization has been involved in the issue of Medicaid expansion since 2012, when the US Supreme Court ruled that the decision to expand Medicaid coverage to adults living below 138% of FPL was to be made by individual states. Since then, we have been active in public education, legislative advocacy, and administrative implementation.

MHRN fully supported the 1115 demonstration waiver submitted by this department in 2015 in order to implement the Health and Economic Livelihood Partnership (HELP) Act. The HELP Act has been an incredibly successful program that has ensured that over 92,000 Montanans have health coverage, reduced our state's uninsured rate, offered fiscal security to rural hospitals, and pumped millions of dollars into local economies all across the state. The HELP Act allowed primary care visits that resulted in early detection of cancer, opened up access to substance abuse disorder treatment, and generally resulted in healthier individuals and reduced healthcare system costs. The HELP Act also had enormous and critical results in Indian Country. Because Medicaid covers 100% of the costs of care accessed by American Indians at Indian Health Service (IHS) and tribal facilities, IHS and Tribal facilities have been able to not only maintain care, but to expand it in their communities.

Additionally, the HELP Act offered an innovative job training and career support program called HELP Link, that tens of thousands of Montanans utilized in order to find a job or improve skills to advance their careers or job prospects.

The proposed amendment and extension to the Waiver and the legislative changes to the HELP Act that the waiver will approve are concerning to MHRN. Our organization supported this legislation during the 2019 Montana Legislative Session but continue to articulate serious concerns about the work requirement, how it would be implemented, and the harm that it might cause vulnerable Montanans. This state estimates that the changes contained in the amendment to this Waiver will result in between 4,000 and 12,000 Montanans facing the suspension of health coverage. MHRN finds this an unacceptable result of the needless bureaucracy surrounding a work requirement that has no role in a program which has the explicit purpose of providing access to healthcare for low income people.

Medicaid expansion has been an incredibly positive force in Montana, and MHRN supports continuing the program. However, we remain deeply concerned about projected coverage loss for individuals and the cost that coverage loss will have to individuals, families, health care providers, and our overall health system.

Sincerely,

[redacted]
[redacted]
[redacted]

PacificSource
HEALTH PLANS

August 23, 2019

Medicaid Expansion Extension
Director's Office
PO Box 4210
Helena, MT 59604-4210

Re: Montana Health and Economic Livelihood Partnership Extension Application

Dear Director Hogan:

Thank you for the opportunity to provide public comment on the waiver extension application that the Department of Public Health and Human Services (DPHHS) intends to submit to the Centers for Medicare and Medicaid. PacificSource Health Plans insures nearly 50,000 individuals in Montana through commercial fully insured products and through services provided as a Third Party Administrator for self-funded plans. On behalf of our members, we respectfully request that you accept and consider this comment.

We write today to address Section 6 of HB 658, the Health Service Corporation fee. We believe that this section does not comply with the three basic requirements defined by 42 CFR § 433.68, which states that any tax revenues as the state share of Medicaid costs must be broadly based, uniformly imposed throughout a jurisdiction, and not designed to hold providers harmless from the burden of the tax.

I have attached for your review an analysis of the bill commissioned from Health Management Associates, a leading independent national research and consulting firm on Medicaid and governmental healthcare. We encourage your teams to review this report, paying special attention to the first paragraph of the Summary on Page 6, which recaps the expected CMS review and analysis of Montana's unique provider tax, and states in part, "The most likely scenario is that the tax would automatically fail."

We support DPHHS's goal of providing quality health coverage to Montanans. We look forward to working with DPHHS as a partner to implement the changes that arise as a result of this waiver extension application.

If you have any questions, please advise. You can reach me at [redacted] or [redacted].

Sincerely,

[redacted]

828 Great Northern Boulevard • Suite 101 • Helena, MT 59601 • 406.422.1008

PacificSource.com

Assessment of Montana's Proposed Health-Care-Related Provider Tax

Executive Summary

Provider taxes can be used to fund the state's portion of the Medicaid program, however there are three tests that it must meet to achieve federal approval. HB658.02's tax may not meet these tests as it is currently constructed. These criteria and their interpretation are described below.

Given that provider taxes are generally unpopular with the current administration at HHS, it is unlikely they will be open to considering a new version of provider taxes if it is not considered broad-based and uniformly imposed. HMA recommends that Montana reach out to Federal authorities immediately, if it has not done so already, to discuss the tax structure plan and be prepared to revise the proposal.

Background

Montana's Medicaid program for the expansion population covers childless adults (19-64) who make less than 138% of the federal poverty level. Montana has been operating this program under a Section 1115 waiver called the Montana Health and Economic Livelihood Partnership (HELP) Act since January 1, 2016. This program is funded with 90% federal Medicaid funds, with the state required to provide the remaining 10% through various state mechanisms.

The 2019 Montana Legislature has proposed House Bill 658, which would enact a fee on health services corporations operating in the state. Health services corporations can be either tax-paying or tax-exempt non-profit managed care organizations (MCOs). The funds to be collected would be deposited in the Montana HELP Act special revenue account. Targeting the fee to fund state Medicaid expenditures makes federal matching payments available.

Montana's current insurance Premium Tax is limited to for-profit and 'Mutual Legal Reserve' MCOs operating in the state. These other MCOs are not 'health service corporations' and would not be subject to the proposed fee as described in HB 658.02. The revenue generated by the current Premium Tax goes into the State general fund, not the HELP Act revenue account.

Permissible Health-Care-Related Provider Taxes

Under Federal Medicaid rules, a state may impose a provider tax (sometimes called an assessment or fee) on one or more classes of health care organizations, including MCOs, hospitals, nursing facilities and others. Provider taxes that are spent on Medicaid-eligible items and services are eligible for federal matching payments but must be federally reviewed and approved.

Provider taxes are any mandatory payment, including licensing fees or assessments, in which at least 85 percent of the burden falls on health care providers. To use provider tax revenues as the state share of Medicaid costs, the tax must meet three basic requirements as defined by 42 CFR § 433.68. The tax must be:

- ✓ Broad based;
- ✓ Uniformly imposed; and
- ✓ Not designed to hold providers harmless from the burden of the tax

The Centers for Medicare & Medicaid Services (CMS) is responsible for determining whether these requirements are met.

- **Taxes Must Be Broad-Based**. To be considered broad-based, a provider tax must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state. For example, in the case of a tax on MCOs, a tax would not be considered broad-based if it exempted the MCOs operating in the eastern half of the state. The state can waive the broad-based requirement to exclude certain providers so long as this does not reduce the portion of tax falling on Medicaid revenues overall.

- **Taxes Must Be Uniformly Imposed**. In general, a provider tax is uniformly imposed if it is the same amount or rate for each provider in the class. For example, a licensure fee imposed on a facility would have to be the same amount for each facility; a licensure fee based on the number of beds in a facility would have to be the same for each bed in each facility. Similarly, a tax imposed on MCO revenues or covered lives would have to be imposed at a uniform rate for all MCOs in the class. A uniformly imposed tax may exclude some or all Medicaid or Medicare payments or revenues so long as all taxpayers get this exception.

- **Taxes Cannot Hold Providers Harmless**. A provider tax is considered to hold the provider harmless if the tax payer directly or indirectly receives a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the payer harmless for all or a portion of the tax. A provider tax is also considered to directly hold the payer harmless if Medicaid payments to the payer vary based only on the amount of the taxes paid by the payer. A provider tax is also considered to indirectly hold the payer harmless if the tax or taxes levied on a class of providers produces revenues greater than 6.0 percent of the revenues received by the tax payer and 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid or other state payments.

The Secretary of HHS is authorized to waive the broad-based and uniform tax requirements (but not the hold-harmless requirement). Thus, a tax might not apply to all providers in a class, or it might not be applied uniformly to the providers to which it does apply (rural and sole community providers are expressly cited as allowable exemptions). The Secretary may waive the broad-based and uniformity

requirements, however, only if the net impact of the tax is "generally redistributive" (as determined by quantitative tests set forth in regulations) and not directly correlated with Medicaid payments to the providers subject to the tax.

Evaluation of HB658.02 Provisions

The legislation, as currently written, may be considered to violate either the broad-based requirement (i.e., some plans are excluded) or the uniform requirement (levying varying rates on plans) or both. If Montana chooses to go forward with the provider tax as written, the state should expect a Federal review, and must be prepared to request consideration for a waiver.

In order to obtain an automatic waiver of the broad-based requirement, the state must submit to a statistical test called the P1/P2 test. If the violation is for the uniform requirement, the state must submit to a statistical test called the B1/B2 test, in order to obtain an automatic waiver.

Broad-Based P1/P2 Test: The P1/P2 test measures how the proposed tax structure changes the amount of tax collected attributable to Medicaid. P1 = the proportion of tax attributable to Medicaid under a uniform tax (e.g., a tax in which all MCOs are included) and P2 = the proportion of the tax attributable to Medicaid under the proposed tax structure. To allow a waiver of the broad-based requirement, P1/P2 must be equal to 1 or more.

Following is a hypothetical example of the P1/P2 test based on a tax on hospital discharges where all hospitals have some level of Medicaid utilization, and Hospital B is proposed for exemption from the tax.

	Medicaid Discharges as a Percentage of Taxable Discharges	Uniform Tax on All Hospitals	Proposed Tax on Hospitals	P1 – Tax Attributable to Medicaid Discharges Under Uniform Tax	P2 – Tax Attributable to Medicaid Discharges Under Proposed Tax
Hospital A	10%	$10,000,000	$15,000,000	$1,000,000	$1,500,000
Hospital B	15%	$8,000,000	$0	$1,200,000	$0
Hospital C	25%	$5,000,000	$8,000,000	$1,250,000	$2,000,000
Total		$23,000,000	$23,000,000	***$3,450,000***	***$3,500,000***

Under this example, P1=$3,450,000 and P2=$3,500,000, so P1 divided by P2 results in a number less than 1 and the test fails. The test shows that by exempting Hospital B, more of the tax burden falls on Medicaid utilization.

Because no Medicaid MCOs currently operate in Montana, the statistical tests become less clear. If the only MCO excluded is the MCO that is not tax exempt, then that would trigger the P1/P2 test of the broad-based requirement.

Following is a similar chart based on hypothetical premium and tax amounts for the three Montana MCOs.

	Medicaid Premiums as a Percentage of Taxable Premiums	Uniform Tax on All MCOs	Proposed Tax on MCOs	P1 – Tax Attributable to Medicaid Discharges Under Uniform Tax	P2 – Tax Attributable to Medicaid Discharges Under Proposed Tax
MCO A	0%	$1,000,000	$2,500,000	$0	$0
MCO B	0%	$3,000,000	$7,500,000	$0	$0
MCO C	0%	$6,000,000	$0	$0	$0
Total		$10,000,000	$10,000,000	***$0***	***$0***

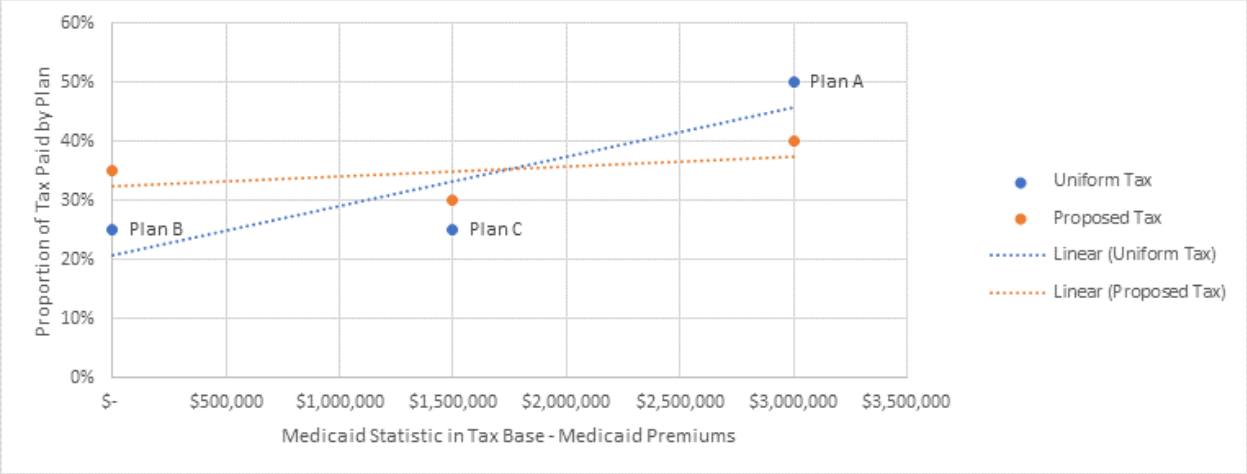
Based on this chart, P1=0 and P2=0, so P1 divided by P2 is undefined because a number cannot be divided by 0.

Uniformly Imposed B1/B2 Test: If the Centers for Medicare & Medicaid Services (CMS) review of the legislation finds that it violates the uniformity requirement, then the agency will apply the B1/B2 statistical test, which will also result in an undefined calculation. The B1/B2 test measures the slope of a line of best fit drawn across a chart of the Medicaid statistic within the tax (e.g., if a tax on premiums then Medicaid premiums) vs. the percentage of tax each plan pays.

Following is a hypothetical example of the B1/B2 test based on what we typically see where there are both Medicaid and commercial plans in a state.

	Medicaid Premiums*	Proportion of Tax Paid - Uniform Tax	Proportion of Tax Paid - Proposed Tax
Plan A	$3,000,000	50%	40%
Plan B	$0	25%	35%
Plan C	$1,500,000	25%	30%

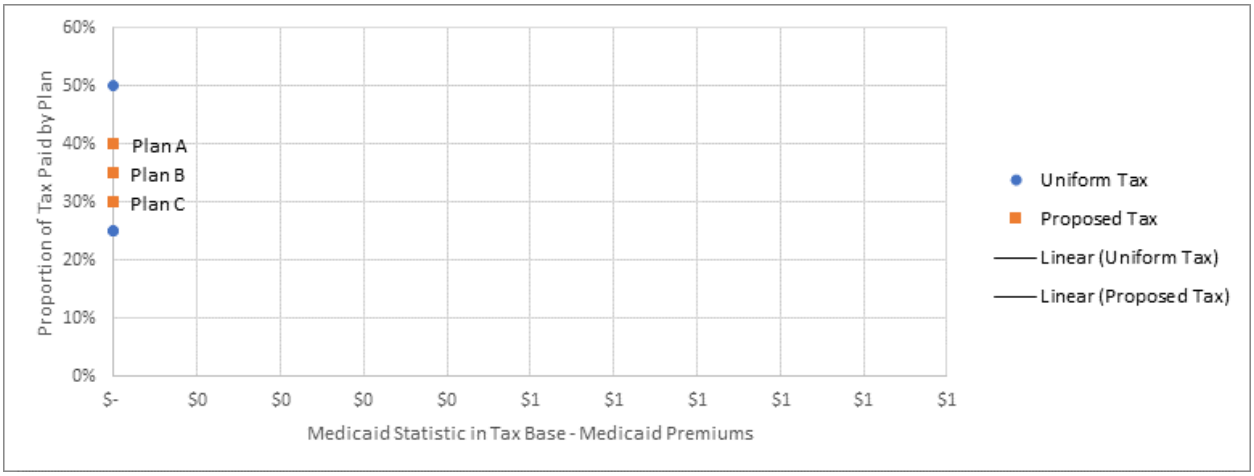
*NOTE: This example differs from Montana, where there are no Medicaid managed care organizations



The B1/B2 test for the example would show that the slope of the line (B1) through the points on the chart related to the uniform tax (the blue line) is larger than the slope of the orange line (B2) which shows the proposed tax. This is meant to prove that as Medicaid revenues increase, plans are not paying a higher tax under this proposal than they would have under a uniform tax.

Since there are no Medicaid plans in Montana to include in the tax base, the chart would like this:

	Medicaid Premiums	Proportion of Tax Paid - Uniform Tax	Proportion of Tax Paid - Proposed Tax
Plan A	$0	50%	40%
Plan B	$0	25%	35%
Plan C	$0	25%	30%



The points are clustered at $0 in Medicaid premiums so the lines through the points are vertical lines for which the slope is undefined.

Summary

The situation of a tax levied on some but not all managed care organizations, none of which has Medicaid revenue, is unique and not one our provider tax experts have seen before. Because of the indeterminate test results in both the broad-based P1/P2 and the uniformly applied B1/B2, it is not clear how CMS would apply the usual tax tests. The most likely scenario is that the tax would automatically fail. The provider tax experts at HMA are not aware of clear example from other states of CMS either determining that the tax automatically passes or that it does not apply.

How CMS will respond to the proposed tax structure will depend on several additional factors including federal program goals, the state's overall relationship with the federal administration, and potentially a state willingness to make other changes to the Medicaid program in line with federal priorities. The Secretary of HHS has waived certain tax requirements as outlined earlier, but our experience is that is usually a specific type of provider, such as a teaching hospital. We have not seen a provider tax waiver by the Secretary of HHS based on tax-exempt status of an MCO. Given that provider taxes are generally unpopular with the current administration at HHS, it is unlikely they will be open to considering a new version of provider taxes. A straight-forward solution might be to amend the legislation to apply the new Medicaid tax uniformly to all types of MCOs operating in Montana.

Because it is not clear how CMS will view the proposed tax structure in the House Bill, HMA suggests that the Montana Department of Public Health and Human Services, if it has not done so already, discuss this concept with CMS. Discussion between a state and CMS ahead of formalizing proposed changes are the norm and are beneficial to states seeking to make changes that have not been implemented elsewhere.

Background on HMA Staff

Janet Meyer, MHA – Principal, Portland

Janet, the project director is a leader in not-for-profit healthcare. As a seasoned and results-oriented professional experienced in integrated delivery systems, community-driven transformation and publicly funded healthcare she will ensure this project is successful and completed on time. During her career she has served Medicaid enrollees at the highest level as a health plan chief executive (CEO) and chief operating officer (COO). Most recently, she was the CEO of Health Share of Oregon, the Portland area's Medicaid coordinated care organization. Janet led Health Share since its inception and as it blended multiple partners, multiple funding streams and expanded enrollment.

Janet has a strong background in finance, Medicaid rate setting and alternate payment methodologies. She has extensive experience with health care taxing approaches as Oregon has examined them for funding its Medicaid program over the last sixteen years. With a focus on data and analytics, she has led the development of community based, cross-sector collaboratives and developed strategies to build and maintain strong, cross-functional teams, mutually-beneficial partnerships and products and services to reach a diverse audience.

Mary Goddeeris, MA - Senior Consultant, Chicago

Since joining HMA in 2009, Mary Goddeeris has centered her work on provider reimbursement for the Medicaid and uninsured populations, with a strong focus on the hospital community. Working with hospital providers in over 15 states, Mary has contributed to the modeling and implementation of Medicaid and disproportionate share financing structures largely funded through provider assessments, intergovernmental transfers and certified public expenditures. Most recently, her efforts have centered on working with hospitals to ensure access to care for the Medicaid and uninsured populations as the health care landscape changes in the face of health care reform.

In addition to her work with hospitals, Mary has also contributed to numerous projects for community health centers by analyzing the health care needs of a population. These needs assessments play a key role in the federal approval process for Federally Qualified Health Center (FQHC) and FQHC Look-Alike designations, and for New Access Point awards, which are determined based on the provision of care to some of the nation's most underserved populations.

Nora Leibowitz, MPH - Principal, Portland

Nora Leibowitz has extensive Medicaid, Marketplace and Affordable Care Act experience and supports client efforts to innovate to meet state goals and full program requirements. At HMA, Ms. Leibowitz has worked with local and national health plans, assisted Oklahoma and New Hampshire with Section 1332 waiver development, assessed and developed Medicaid reforms for Alaska, and helped Hawaii transition from SBM to federal marketplace technology.

Prior to joining HMA, Ms. Leibowitz served as chief policy officer for Oregon's Marketplace, where she led policy development and implementation, including overseeing individual market eligibility,

enrollment policy, managed corporate policies and procedures, compliance, and evaluation activities. Ms. Leibowitz planned and implemented resolutions to high-priority, public challenges facing the organization and actively engaged in strategic and project planning, risk management, and resource allocation. Ms. Leibowitz also gained Medicaid operations and policy experience at the Oregon Health Authority and Department of Human Services (DHS) and Rhode Island DHS. She joined Oregon DHS as a provider tax analyst, where she wrote state regulations and implemented three provider tax collection programs. As an evaluator with the federal Department of Health and Human Services Office of Inspector General, she gained a deep understanding of federal regulation and state implementation while researching the impacts of federally funded state programs.

Jeanene Smith MD, MPH - Principal, Portland

Dr. Smith has led the development and implementation of major health policy initiatives, including two 1115 Medicaid waivers, for three Oregon governors. Dr. Smith served as chief medical officer for the Oregon Health Authority (OHA) and administrator of the Office for Oregon Health Policy and Research (OHPR). She has provided Medicaid technical and policy support to the Oregon Health Plan, as well as legislative and executive branch decision-making on statewide health policy. Providing leadership and alignment of medical policy across the OHA which includes the Medicaid program, Public Employees Benefit Board, Addictions and Mental Health Services, Public Health Division and the Transformation Center, Dr. Smith's clinical advice and guidance played a key role in a range of OHA and statewide efforts to support Governor Kitzhaber's coordinated care model. She also served as the principal investigator for Oregon's State Innovation Model (SIM) grant.

She has practiced family medicine in both private practice and community clinics for over 20 years and continues to see patients at a federally-qualified community health center.

Kathleen Nolan, Vice President - Washington DC

Kathleen joined HMA following several years as division director of health for the National Governors Association (NGA), and then as director of state policy for the National Association of Medicaid Directors (NAMD), Kathleen has earned a unique perspective on state policy making. In both roles, she was a respected and persuasive voice for governors and Medicaid directors in health policy discussions, industry forums and the media. She convened national and state leaders to foster collaboration, find common ground, share promising practices and lessons learned, and advance implementation of health care reform. She will review the brief for the team for an input to enhance content and voice for the expected audience of the document.

Rebecca Kellenberg, MPP – Principal, Denver

Rebecca Kellenberg specializes in assisting public and private health care organizations with Medicaid and CHIP policy analysis and implementation. With 18 years of experience working as a senior state Medicaid official and consultant, she brings a comprehensive understanding of the publicly financed healthcare system to her work with state agencies, health plans and providers. She has specialties in women's health care, oral health care, and behavioral health care in rural and tribal communities.

Rebecca's work focuses on Medicaid delivery system approaches as well as state and federal fiscal and policy trends. Rebecca lives in Missoula, Montana with her husband and two kids.

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August 23, 2019

Sheila Hogan, Director
Montana Department of Public Health and Human Services
c/o Medicaid Expansion Extension, Director's Office
PO Box 4210
Helena, MT 59604-2410

Re: Section 1115 Demonstration Amendment and Extension Application

Dear Director Hogan:

The Montana Medical Association respectively submits these comments to the Department of Public Health and Human Services on the Montana's proposed Medicaid Section 1115 Demonstration to amend and extend the existing Montana Health Economic Livelihood Partnership (HELP) Demonstration Program. The MMA, as the largest statewide medical association, represents nearly 1,500 Montana physicians, medical residents and medical students and strongly supports the expanded Medicaid program.

On January 1, 2016, Montana expanded Medicaid coverage to newly eligible adults. The MMA voiced support of the HELP Demonstration Program and its policy objectives, including increasing the availability of quality health care to Montanans, encouraging Montanans to take greater responsibility for their personal health, and reducing the costs of uncompensated care and the resulting cost-shifting to patients with health insurance.

Significant progress has been made on the policy objectives. Medicaid expansion has afforded access to primary and preventative care, mental health and substance use treatment, cancer treatment and other essential health care services. Over 101,000 adults enrolled under the HELP Demonstration Program received preventative health care services, and 35,152 adults received outpatient mental health services and 3,484 adults received inpatient mental health services. As the MMA and the State deploy multiple strategies to end the opioid epidemic, Medicaid expansion enabled 3,610 adults to receive substance use outpatient services, and 2,337 adults to receive substance use residential services. With a current enrollment of about 92,500, the rate of uninsurance in Montana has declined to 8.6 percent and Montana hospitals reported a 49 percent decrease in uncompensated care.

The State's current Demonstration has shown success in these key areas. The MMA backs the continuation of the Demonstration to build upon this success, ensure for continuity of care, and to provide quality and affordable coverage. The MMA is also supportive of testing the new Medicaid expansion program features included in the application, resulting from the passage of the Medicaid Reform and Integrity Act (HB 658) by the Montana state legislature in 2019. We appreciate the Department's outline and explanation within the application of the new and amended features along with the additional details on how the current Demonstration can be maintained while testing new program features, like work/community engagement and cost-sharing requirements.

The MMA was engaged throughout the legislative session on the topic of Medicaid expansion and appreciates the efforts of the many interested parties and members of the state legislature who were able to find common ground on the new and amended features as it brings the certainty of permanent Medicaid expansion. While concerned that some aspects of the proposed

Demonstration could limit patients' access to care and bring additional administrative burden to physicians, our intent is to monitor those areas acknowledging that these features are being tested and could be modified.

The sustainability of the Demonstration is dependent on a number of factors, including the fortification of a strong, patient centered primary care delivery system. The MMA will continue to promote innovation, develop physician leaders, and encourage participation in delivery system transformation efforts undertaken by the Department. The Department has also invested in another factor, the establishment of a statewide health information exchange which promises to be a valuable tool in the coordination of care and a needed data source. The MMA will maintain its leadership role with the HIE recognizing the benefits of having immediate access to a patient's vital medical records extends beyond better patient care to transforming the delivery of care.

We look forward in optimism that CMS will approve the application after being thoughtful in its review and giving full consideration to the impact. The MMA stands ready to assist the Department where needed and as physicians continue to provide compassionate, quality care to Medicaid members. Should any questions arise regarding our comments, please contact me by telephone at [redacted].

Sincerely,

[redacted]

PO Box 1663, Helena, MT 59624 * www.bigsky55.org * info@bigsky55.org

August 23, 2019

To: Department of Health & Human Services
Waiver Program Officer, P.O. Box 202951, Helena, MT 59620-2951

From: Big Sky 55+, senior advocacy organization

Re: Waiver 1115 Comments from Big Sky 55+

Big Sky 55+ is an organization of Montanans 55 and older advocating for public policies that make a difference in our lives and the lives of future generations.

The core mission of Big Sky 55 + is to organize and mobilize Montana citizens 55 and older to have a strong and experienced voice that advocates for the legitimate interests of older Montanans without sacrificing the interests of younger Montanans and the natural environment that supports us all. Big Sky 55 + embraces and advocates for a vision in a new and better direction that works better for the majority of Montanans.

As an organization we strongly oppose the proposed work requirements and increased premiums in the Medicaid Section 1115 Waiver. We are pleased to offer these comments and hope you will consider them.

The proposed rule would essentially bring harm to many Montanans across our state and country and take away much needed care at a time when they most need it. We are concerned for our children, grandchildren and the people who care for us as we age.

Montana's most rural communities and tribal communities would be hit the hardest by these changes with a high percentage of aging Montanans. In Montana, Medicaid Expansion is critical to 25 counties and six American Indian reservation communities (Blackfeet Reservation, Crow Reservation, Fort Belknap Reservation, Fort Peck Reservation, Northern Cheyenne Reservation and Rocky Boy's Reservation).

Those who would be hurt by this rule change are extremely vulnerable, often living on incomes $12,140 per year or less. They include veterans, people struggling with mental illness or addiction, and adults living in rural areas without access to transportation. Taking health care away from these individuals will not help them find work, it will leave them unhealthy and further from economic stability. Given the detrimental impact work requirements will have on their young families and their communities, Big Sky 55+, remains in strong opposition to work requirements and increased premiums.

Big Sky 55+ finds any proposal to change Montana's current Medicaid expansion troubling. Many Montanans over the age of 55 use Montana's Medicaid expansion as their source of health care coverage and changes to the Montana Medicaid expansion program is bad policy for those younger than 55, affecting the caregivers who provide care in their homes and their families. Montana Medicaid Expansion currently works.

We hope the exemption process goes smoothly and that future proposals won't take health coverage away from people who do not meet strict work and reporting requirements. Creating more expensive bureaucracy and complicated paperwork is not what Montana seniors want for their children or grandchildren. This will result in greater administrative costs and a disruption of care at the provider level.

Work requirements in Arkansas and Kentucky are prime examples of the failings of these policies. In Arkansas over 18,000 people have lost health coverage by these strict reporting requirements according to the Kaiser Family Foundation. "Exemptions don't solve the problem. Most of those losing coverage in Arkansas are people who are already working or should be exempt but would lose coverage because of the increased red tape and paperwork."

Source: https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed. In Kentucky, the implementation of the work requirement program increased administrative costs by over 40%, a $35 million dollar administrative cost to taxpayers, According to Fitch.

The State says in the application that it expects disenrollment for nonpayment of premiums to continue at 2.9 %, yet page 65-66 of the interim federal evaluation reports that "half of the surveyed enrollees reported some degree of concern about their ability to make the monthly premiums."

Given that, doubling the premiums seems like a guarantee that more Montanans will be unable to afford their premium payments and lose coverage. We encourage the state to revise its projection of coverage losses for the increased premiums and update the waiver application accordingly.

We still think spending millions of Montana taxpayer dollars on oversight to collect, report and validate exemption status only to cancel coverage for thousands of Montanans is not sound policy and we caution against it here in Montana.

Sincerely,

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because they are not needed and will do way more harm than good. The poor are already struggling and do not need nearly impossible hoops to jump through, including unreasonable requirements for work. Increased premiums just take away even more from those that have very little to spend on survival. Medicaid has been working great with the expansion the way it is now, leave it alone to continue to help people and add jobs in our medical fields.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it puts an undue burden on individuals who are already in a stressful and sometimes dangerous situation. I work with individuals who are victims and survivors of domestic and sexual abuse. I can tell you from experience, adding the burden of work requirements will greatly increase the number of people facing homelessness, severe mental and physical medical conditions, and leave children vulnerable because of the lack of connection with the only parent they have to care for them. Please remove the work requirements for Medicaid.
[redacted]

I live on 748$ a month. If you raise my premiums and that will effectively cut me off from any available healthcare.
[redacted]

I am retired, and so on a fixed income. Thanks to Medicaid I was recently able to get some badly needed glasses. I now have a monthly premium, which I can afford, but if it increases it will be a hardship. Healthcare is an absolute necessity for people to live. Families need healthcare. Whether it's for their children, or the parents, who are working, or for those unable to work. Every developed country provides for free healthcare. Let's keep Montana on the side of what's a common sense plan to keep our people healthy. We already have work requirements, that make it hard on families, where people often work seasonal jobs, we don't need further barriers to healthcare. Increased premiums for low income families and individuals would also be barriers to healthcare. I urge you to forget this push for the barriers, and realize that expanded care is what the people need.
[redacted]

Work requirements and higher premiums will keep people living in poverty from being able to access healthcare. For people who cannot work due to disability or poor health, or people cannot find work or unemployed for large periods of time, work requirements will guarantee a greater decline in health and poverty. Higher premiums will likewise prevent Montanans from seeking health care when they need it. In order to lift people out of poverty, access to healthcare is imperative.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because of my background. I have supervised programs for seriously mentally ill people who could not work. If refused care due to this inability, our systems would be clogged with expensive care for people who have decompensated and require a higher level of care. I disagreed with any changes that reduce previous care.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it hurts families and individuals who are already struggling. Many Medicaid recipients are already working, if work is available in their community. Punishing families through harsh work requirements/time limits as well as higher premiums is NOT the Montana way.
[redacted]

We attended the Medicaid Expansion hearing on 3/16/2019. The stories people told were riveting. The work requirements could pose a hardship for MANY of the recipients! We support access to healthcare. Although we appreciate the bipartisan effort, we would prefer there be NO WORK REQUIREMENTS. Medicaid Expansion has been GREAT for Montana's economy & has helped to maintain the rural hospitals and to provide healthcare jobs state-wide! What we did before worked so well. We prefer our federal & state tax dollars go towards the previous Medicaid Expansion plan. Thank you, Humbly, [redacted]
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because most Medicaid recipients are working families who already work, or they're older adults living on fixed incomes who aren't able to afford the higher premiums. Not only does Medicaid help the recipients, but it's been proven that it reduces healthcare costs because more people will actually go to the doctor before they're condition worsens. It also helps rural communities keep their local clinics and hospitals open through Medicaid reimbursements.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because they are unfair to many people.

[redacted]

Work requirements add a burdensome cost for Medicaid Administration. Very few recipients are scamming. Though the Legislature works only 90 days every 2 years they receive Health Insurance. Perhaps they're the ones that need more skin in the game. We're trying to survive on low wages here in MT. While the millionaires from out of state inflate everything. Legislature needs to reverse the 2003 Martz Tax Cuts so the wealthy pay their fare share and MT recoups $$$$. Many Medicaid recipients are on disability and not allowed to work or are limited in the # of hours we can work. Many of us have out

of pocket medical expenses not covered by insurance. Thanks to all those who worked to get Medicaid Expanded for Montanans.
[redacted]

It is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program. These changes will increase healthcare barriers for low-income Montanans, kick working Montanans off their healthcare, and make it harder for people with chronic illnesses to visit their doctors.

[redacted]

1. Other states that implemented work requirements for Medicaid Expansion are suffering and people are losing benefits because they don't have timely access to a computer.
2. Many people who qualify for Medicaid are working. I am a full-time caregiver for a disabled child, but do work as a bus driver during the school year. Without expansion, I would not have insurance. I do not work enough hours through the school district to qualify for health insurance.
3. Increasing the co-pay could really hurt some families. We are already low-income and this would just be a bigger burden and something else would not be taken care of, like food.
4. Expansion needs to be made permanent and not be re-evaluated again in 2025. Medicaid Expansion has provided much needed healthcare for myself as well as many other people. Medicaid has help me to get a double mastectomy, partial knee replacement and tendon repair. Without these medically necessary surgeries, I would not have been able to continue to care for my child and work. My child would have ended up in a nursing facility, which costs much more than keeping her at home. Thank you for your time.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because people who make less than 138% fpl cannot afford to pay these premiums. $50 a month when you barely make $800 each month is a lot of money. This is not fair to people.
[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because Montanans are working already. My sister who works between 40-60 hours a week still has an income where she requires Medicaid. How can we ask her to work more? There should be no strings attached.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it not only raises premiums for low income Montana families, but also adds more red tape for Montanans to have to cut through by implementing confusing work requirements and diverting resources.

[redacted]

My name is [redacted] and I live in [redacted]. I am opposed to the changes in the Medicaid expansion waiver. Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program. These changes will increase healthcare barriers for low-income Montanans, kick working Montanans off their healthcare, and make it harder for people with chronic illnesses to visit their doctors. No Montanan should live at risk of becoming jobless and without healthcare. Thank you for your time.

[redacted]

I oppose the proposed changes because this would greatly affect my access to health care services because I am currently attending college but not up to the standards required in the proposed waiver. I would not have time for the work requirements to attend school while also trying to meet the requirements of my health care if this was to be passed.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the elderly people I know who utilize and need Medicaid coverage in Montana would not be able to meet these work and premium requirements. They are too old to be working and don't receive enough financial support to cover the higher premiums. I think this new amendment works against the geriatric population which is the most important population for health coverage.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because low income folks can't afford premium increases. The work requirement is ridiculous!!!... Create more benefit paying jobs that have health insurance as a benefit!!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it is bad for Montana families and the health of our state.

[redacted]

I oppose the new work requirements because they are unnecessary. Most Montana citizens covered under Medicaid Expansion already work or have legitimate reasons not to such as caregiving or being disabled. Higher premiums is a way of giving coverage then taking part of it back. Ridiculous.

[redacted]

I believe it is harmful to add burdensome work requirements and increased premiums to Montana’s Medicaid program. I have numerous relatives who are low income and live in rural areas where they can sometimes only get seasonal work. These changes will increase healthcare barriers for low-income Montanans, kick working Montanans off their healthcare, and make it harder for people with chronic illnesses to visit their doctors. No Montanan should live at risk of becoming jobless and without healthcare. This will be harmful to our state. Thank you for your time.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it’s bad for individuals.

[redacted]

My name is [redacted] and I live in [redacted]. I am opposed to the changes in the Medicaid expansion waiver. Specifically, I believe it is harmful to add burdensome work requirements and increased premiums to Montana’s Medicaid program. These changes will increase healthcare barriers for low-income Montanans, kick working Montanans off their healthcare, and make it harder for people with chronic illnesses to visit their doctors. No Montanan should live at risk of becoming jobless and without healthcare. Thank you for your time.

[redacted]

Increased premiums are bad and wrong for all Montanans.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are not necessary and are a bad idea. Most of the people who can work are doing so, and others have many and often complicated reasons that they are not able to. Adding a mandate for work requirements will be an expensive administrative burden that is simply not necessary. I am opposed to increasing premiums also - premium costs are already too high. Our lawmakers in Washington have fantastically cheap premiums with the federal health benefits program (I know, because I receive federal health benefits). We must not pass undue burden of higher costs on to those who are generally most in need. Thank you for the opportunity to comment.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and higher premiums are bad.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because I do not want to see extra burdens placed on people already in need. Healthcare does not need to be earned, but should be a right.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and increased premiums are bad for Montana!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because some of the most needful (the mentally ill, esp the homeless) will lose coverage. Many of them are able to function and some even work with ongoing healthcare but most are not able to work as much or consistently as is proposed. Many families can't afford increases especially families with children who have mental health issues.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because there is more to a person’s story than what is just on the surface.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver.

[redacted]

Medicaid helps disabled, working and non-employed Americans to make sure they have coverage for any incident that they can't prevent in the future. Taking medicaid away from low income individuals will cause absolute mistreatment for a human being needing medical help. Coverage for all Montanans is something I will stand by til I can no longer speak for my opinion!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because healthcare is a right, not something we have to prove our value through exploitative labor to earn! A state protects its people, not the other way around!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it implies people who need Medicaid assistance are lazy and stigmatizes the program.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because families living in [redacted] can't make enough to afford the premiums that we pay now and we all work as much as we can- what requirements are we going to have to meet that we don't already if we are not already working full-time. This is not New York City! Since the recent rise in population is raising our cost of living enough as it is. I oppose!!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because premiums are high enough for people working and supporting their families. Not everyone can work. The cost living in Montana is high and the wages are low.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because IT WOULD REQUIRE HIGHER PREMIUMS. THOSE, LIKE ME, ON A FIXED INCOME WOULD NOT BE ABLE TO MEET THE HIGHER RATE.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because I am currently working a serving position that pays me more than most first or second year teachers but I am still scraping by. I have so many loans and bills to pay and shopping for a health insurance has had to be put on the back burner because the lack of coverage and it’s something I can’t afford right now. All the other obligations I need to pay for have consequences if I don’t pay them. Medicaid or other health insurance companies are too expensive and though there lingers the consequence of debt if some health incident were to arise, I am forced to wait till I can actually afford which may take months and months. And if health insurance prices were to increase based off of my income, then I definitely would not be able to afford health insurance.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the cost of healthcare is prohibitive for many of us. We need help, not a handout. Just a fair shake. This shouldn’t be a rich or poor issue, but it is. If you aren’t well off, you can’t afford healthcare. A very sad and unacceptable situation for our country.

[redacted]

It is critical that receiving health insurance is accessible and affordable for everyone. Montanans shouldn't have to choose between paying for bills and getting needed health care. When my dad was diagnosed with stage IV intestinal cancer, our premiums were already high and reaching the deductible was a nightmare over his 8-month illness. It truly felt like my family had to choose between my dad's chemo and keeping our house. When it was clear that my dad would not make it, we breathed a sigh of relief at no longer needing to pay his medical bills. I am one of the lucky ones - I was able to work part time and care for my dad so my mom was still able to work full time while my dad was on disability. We would not have made it otherwise. When illness or disease touches a family, the last thing they should be worrying about is next month's payments. We need to put Montanans first.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because healthcare is a right and not a privilege that can be bought.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because healthcare is a human right! We need to provide access to it without burdensome requirements.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because they will harm those most venerable and helpless in our communities. We have enough to share if we are to teach our children the values Christian's hold. Love your neighbor as yourself. This legislation is not loving and will harm not hurt the women and children who we need to protect and support not exploit and blame for their being needy. We are bigger than this small distorted legislation and it needs to be canned!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it severely limits access to healthcare for people who have little to no other options.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because our legislature should not be in the business of making healthcare HARDER to access. Work requirements are not only immoral, they're also impractical and a waste of taxpayer money. Whatever small amount might be saved would be swallowed up by the administrative costs of implementing an oversight system. In most cases, Montana Medicaid recipients are ALREADY working, and the few who aren't often have child or elder care responsibilities, or face issues that make finding or maintaining employment difficult. Premium and other cost increases are based on the false notion that people seek out unneeded healthcare simply because it is affordable. That idea has been debunked over and over again. If we want to improve the health and lives of low-income Montanans, we should make healthcare more accessible, not less. Reject these proposed changes.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it makes it even harder for Montanans to access much-needed healthcare coverage. Work requirements have been used in other states, and those models have not been shown to be successful thus far...it is difficult for low-income folks (who often don't have internet) to even access information about the work requirements/sign-up, and the entire process (i.e. Arkansas) is clunky for those who are often already employed. This is just another set of busy-work/paperwork for poor folks trying to survive. In other state examples, you must prove "x" number of hours of work, which easily could compromise your healthcare access if you miss hours due to a sick kid/elderly parent or even your own healthcare issues. The system is so complex, that a person could be actually accessing healthcare for an acute or chronic condition, missing hours, and then losing their Medicaid coverage for said health condition.

Montana statistics on healthcare access and outcomes of certain conditions are dismal, and the overall health of the state would continue to be compromised with additional red tape of "proving" worthiness to access healthcare. Look at the data on other states that have adopted "work requirements" (even though the bulk of folks are already employed) and how much energy, money, and hassle is required not only for poor folks but states as well (the outcomes in Arkansas haven't been great). Consider the courts blocking work requirements & the cost to the states over that process as well, not to mention rising healthcare costs for an increasing number of uninsured due to clunky so-called work requirements. Even if the requirements are not exactly the same as states like AK, the courts will likely block this decision for placing similarly arbitrary rules on poor folks for simply trying to access affordable health coverage!

Folks who are uninsured have few options and often must resort to pricey & unnecessary ER care...which is very costly & straining for EMS and hospital staff. Chronic diseases go untreated and preventative cares are ignored, leading to further (and expensive) health conditions. I've seen it first-hand so many times after working in healthcare since 2004. And all because poor folks didn't complete their paperwork correctly to be worthy of healthcare access.

I'm very FOR Medicaid expansion and glad that it was passed due to those reasons...This increased access to healthcare for roughly 96,000 people in Montana with an increased # of folks working due to HELP-Link resulted in an overall cost-savings to the state based on an independent analysis (U of M, 2018).

Evidence from TANF has shown that work requirements will not move people out of poverty or eliminate their need for health insurance coverage (Pavetti, 2018). Voluntary employment programs can, however, increase employment without the negative consequences of ending health insurance coverage for those who cannot meet work requirements for whatever reason (Pavetti, 2018). There is a wealth of information & studies on this topic from other government programs as a model (not to follow often) such as TANF, as well as models of other states who have not had positive outcomes with work requirements for Medicaid such as Arkansas as mentioned. If you consider economics then, this proposal for work requirements does NOT make sense. The data already exists to tell us that work requirements do not work!

If you consider humanity, these work requirements will continue to oppress and block access to healthcare especially for poor folks, people of color, and the LGBTQ+ communities--all of who already face significant healthcare discrepancies.

As a healthcare provider and nursing clinical instructor in Montana, I strongly support Medicaid expansion. I strongly oppose any work requirements. Thank you.

References

Pavaetti, L. (2018). Work Requirements Don't Work. Retrieved from https://www.cbpp.org/blog/work-requirements-dont-work

University of Montana (2018). The Economic Impact of Medicaid Expansion in Montana. Retrieved from https://mthcf.org/resources/the-economic-impact-of-medicaid-expansion-in-montana/

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because there are many instances in which these changes could be harmful to people who are sincerely trying to do their best to improve their situation. This also includes trans people who sometimes have a hard time finding jobs due to discrimination. There are people who could literally die because of these changes.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because most people having to use Montana Medicaid use it because they have no other options for health care, due to illnesses and inability to find and maintain employment. Not because it is the easiest option, but because they need it. By making it more complicated and embarrassing to keep does not address the underlying need for health care. It is designed to be a band aid or short-term solution for some, and a definite need for some. By assigning mandatory work and then lessening premiums, those in power are trying to make people feel guilty about accessing help.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because access to health care is foundational to a just society. I fear the new work requirements and bureaucratic reporting will jeopardize access for Montanans.

[redacted]

As a parent of a son who qualifies for Medicaid, I see a big problem that probably has not been addressed. Is there a plan for transporting these very low-income people, many of whom who can't afford a car or public transportation, to their work requirement sites?

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because those who can work do and imposing specific work requirements hurt families who are already struggling and already working.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it stigmatizes folks who need Medicaid by implying that they are lazy.

[redacted]

I work at the local family planning and reproductive health clinic in Bozeman, and we see how important Medicaid is for our patients and the sustainability of our clinic. By making it harder to qualify, you are jeopardizing not only the health of the individual, but also their entire family (if they have one) and are undermining the important, empowering, dignifying aspects that access to healthcare has one a person and a community as a whole. If we lift up our most vulnerable and give them the keys to success... if we say we see you and you matter to us... if we say we trust you to work hard and do your best to make a better life for yourself and those you love... that is what empowering healthcare and state assistance looks like. A work requirement would undermine every benefit of Medicaid and it's core mission as a program. Please do not pass this Medicaid waiver with work requirements as they benefit no one (person or company) and do nothing to help our Montana communities stay healthy and thrive!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because I do not want higher premiums or a work requirements. Obviously, if someone is on Medicaid it is already apparent that that person cannot afford higher premiums and cannot work more than they already do.

[redacted]

I am one of many, may Montana citizens who are very worried that plans to tie work requirements for the state's Medicaid recipients to next year's Medicaid expansion are a bad deal.

These proposed changes include increased scrutiny for Medicaid eligibility, elimination of the program's current co-pays, and an 80 hour per month requirement for work or "community engagement" and increased premiums for people staying on Medicaid expansion longer than two years.

The new analysis released by DPHHS suggests that the number of people subject to the new requirements could be three times what was expected when lawmakers passed the Medicaid expansion law this spring.

I am very skeptical of the DPHHS theory that work and community engagement requirements will help people earn more money, improve their health and ultimately get them off Medicaid and onto private health coverage. The evidence for that theory is weak and these policies will likely take Medicaid coverage away from thousands of Montanans, including some who are working or should qualify for exemptions.

These changes will likely substantially increase premiums. Montana already charges premiums equal to 2 percent of income for many adults above 50 percent of the federal poverty level ($6,370 per year for a single person).

The changes would increase premiums for individuals who aren't eligible for exemptions from the work requirement and have been enrolled in the Medicaid expansion for more than two years, up to a maximum of 4 percent of income — the highest in the country for beneficiaries below the poverty line and nearly twice the share of income that near-poor adults pay for Affordable Care Act marketplace coverage. While only people above the poverty level will lose coverage if they don't pay their premiums, others can have their annual income tax assessed for the unpaid amount.

These changes will create red tape that will result in eligible people experiencing delayed coverage or not enrolling at all. The bill passed instructs state officials to create a process that would require expansion applicants to verify that they are state residents. Many people with low incomes have difficulty verifying residency, especially vulnerable groups including those who are homeless.

The legislation passed also stops individuals from getting Medicaid coverage temporarily while the state determines whether they satisfy all eligibility factors despite federal law requiring that some individuals gain access to Medicaid temporarily while they collect evidence that they meet certain eligibility factors, such as a newborn awaiting issuance of a birth certificate that proves his or her citizenship.

The legislation passed significantly improves on a previous proposal by providing broader exemptions from work requirements and making it less difficult for people who lose coverage to eventually regain it. But it will still cause many Montanans to lose coverage.

The state estimates that it can use administrative data matching to identify and exempt most people eligible for an exemption from the new work-related reporting requirement. Thousands of people will still be required, however, to report their working hours or eligibility for an exemption and will risk losing coverage if they don't meet the requirement or can't navigate the reporting requirement. In Arkansas, the first state with a Medicaid work requirement, almost 1 in 4 of those subject to the requirement have lost coverage despite the state's efforts to exempt administratively most of the people subject to it who could qualify for an exemption.

People with disabilities, caregivers, and American Indians are at particular risk because they will likely face special challenges complying with the new paperwork and reporting requirements. Perversely, some low-wage workers are also at risk, since they often have fluctuating work hours and spells between jobs that make it difficult or impossible to meet a work requirement.

The state estimates that about 4,000 people will lose coverage as a result of the bill's work requirement. That figure appears optimistic in several respects. It assumes that the state will always exempt as many people as possible using data matching, without requiring documentation from enrollees. It's also based on an estimate that roughly 88,000 people (out of about 96,000 expansion enrollees) either are meeting or will be exempt from the work requirement, and that half of the remaining 8,000 will fail to report their hours or eligibility. That's considerably different, however, from the actual experience in Arkansas, where the vast majority of those required to report did not do so, for various reasons.

Finally, Montana's estimate doesn't take into account additional coverage losses resulting from the increased premiums or the new eligibility verification requirements.

The bill passed includes a trigger intended to prevent even larger coverage losses, which will be pulled if more than 4,800 people lose coverage. Even then, however, it would halt coverage losses only if an audit finds that at least 10 percent of those losing coverage should have remained eligible. Such an audit would likely miss many wrongful terminations, since people who couldn't document their work hours or work-limiting disabilities in the first place generally wouldn't find it any easier to do so for an audit months later.

The new work requirement policy contrasts sharply with Montana's promising workforce promotion program, HELP-Link, which currently provides the state's Medicaid expansion beneficiaries with employment and training services. Since its start in 2016, some 25,000 expansion enrollees have enrolled in workforce training through Montana's Department of Labor and Industry, and 70 percent have found jobs within a year, according to the state. The legislation passed increases funding for HELP-Link, creating a new grant program for employers that hire or train Medicaid beneficiaries. Unfortunately, implementing the legislation's coverage restrictions will entail significant administrative costs and will consume resources the state could have used instead to further expand job training and workforce services.

For all of these reasons I am one of many, may Montana citizens who are very worried that plans to tie work requirements for the state's Medicaid recipients to next year's Medicaid expansion are a bad deal.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because Medicaid is already working - if anything make Medicaid better.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because all humans have the right to a thriving life!

[redacted]

Most people in expanded Medicaid work. They work more than the proposed requirements provide. However, many of the jobs people have provide uneven work hours. No matter what a person might want for work, the employer determines the number of hours a worker gets to work each month. Further, many people are lacking in the skills and focus to accurately and consistently report hours worked, appointments attended that satisfy proposed work requirements, etc.

I am a landlord with Section 8 housing tenants. By and large, they make the counseling, drug court appointments, and all the other meetings they are supposed to attend. But dealing with reporting and paperwork is very difficult for them. The anxiety related to financial matters is almost overwhelming. It is simply not worth the cost to require work when most people already are working and are trying hard to be responsible citizens. We need to support folks who need help--and we need them to have health care.

Premium increases make no sense when people are barely getting food on the table. We need people to have health coverage, so they don't use the emergency room as primary care. Premium increases present one more barrier to coverage.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it will restrict healthcare. Access to healthcare is a right for all Montanans.

[redacted]

I understand that searching for employment opportunities should be encouraged. However I think that it strips a person’s humanity to determine their worth and worthiness of health coverage on whether they are employed. There are myriad reasons why people cannot secure or even find work—many of these factors are beyond the individual control, including geographic and economic factors that are often overlooked.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because many who need the coverage are not able to work. Childcare is scarce and not affordable for many women who can work.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it's an ineffective use of public dollars to moderate the few people that are not working. The majority of people on Medicaid that are not working are doing so for a reason, illness, or are caring for others (i.e. their children) .This waiver would disproportionally hurt women that stay home with their children, often times because the cost of child care is greater than the wage they would make. If you want to change this than increase minimum wage to a living wage, instead of taking away health care and creating more bureaucracy and red tape for low income families that are living day to day.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because Montana needs reliable healthcare for all, not more red tape making it inaccessible.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because information available shows that most persons receiving Medicaid are employed with the exception of those who cannot be because of age or disability.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because many People with severe and persistent mental illness cannot work.

[redacted]

Health care should be available to all Montanans regardless of their work status. Adding this work requirement is a punishment on the poor, on people who already have life very hard. In ARKANSAS, the work requirement led to more uninsured and no increase in employment. Making access to healthcare more complicated, requiring more paperwork and more contact with the bureaucracy, will drive these people back into the uninsured population. Then local hospitals and other providers will be providing more uncompensated care. And it will cost taxpayers more. We should be striving for a healthy population for all of Montana, not trying to punish the poor. When will we ever learn? DO NOT IMPOSE WORK REQUIREMENTS ON MEDICAID PATIENTS. IT WILL ULTIMATELY COST MORE IN DOLLARS, IN HUMAN ANGUISH, AND IN MORE BUREAUCRACY.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because in this year 2019, it is time to fulfill the rights of every American to have access to health care. In this modern era, health care is a right not just a privilege. All our people need to have health care, regardless of ability to pay. Our nation will be stronger, our people will be stronger and happier. Happiness is not just a feel good idea but a necessity for a first world nation that we claim to be.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are bad policy disguised as flexibility. Higher premiums and work requirements are punitive and don't move low-income people out of poverty. Work requirements are impermissible under Medicaid law. They would actually increase the number of uninsured people and add an administrative burden to employees, which would in turn increase costs for the state and federal government.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it's unnecessary and cruel. Health care is a right, not a privilege.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because there’s a legitimate reason why people need assistance!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it unfairly burdens residents with limited resources.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because there are many Montanans who rely on this assistance; people who contribute to the community and add value to our lives. The elderly, the disabled, and special needs folks who cannot work would be unfairly impacted by proposed changes to Medicaid expansion. There are not enough charities or charitable people to pick up the slack. Montana is not a poor state: our ranking among states is respectable. There is no need to punish people for being poor or disabled.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because often persons who are struggling with recurring and/or extensive details caring for a child or disabled person cannot meet work requirements. There was a time in my life when I was caring for a child who was severely injured. I was her sole support since no one else would or could help. I tried to work but it was not possible. Adding work requirements would be the proverbial "straw that breaks the camel's back."

Similarly, for persons who are experiencing poverty increasing premiums adds stress to an already difficult situation. Perhaps the Republicans could find their souls by legislating requirements for corporations and wealthy persons to pay taxes.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because some folks can't work and do not have the medical records to help prove that, they are in waiting to see a doctor, or they do not have a car, or an advocate to help them. This is wrong to do for some folks. I have a friend who the doctor does not know what’s wrong with her, so they do nothing, she is unable to work and can barely walk. This is unfair. The only thing she has going for her is that she has friends who care, and we are trying to help. She gets food stamps nothing else.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and higher premiums are bad for Montana.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and higher premiums will erode the effectiveness of these programs in reaching those who need them.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are harmful to the most vulnerable members of our communities. Increased premiums are a bad deal for Montanans.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it will drastically reduce access to care for all Montanans.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because too many people are under employed or seasonal and need help to just get by.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it's a terrible idea. It will take more to administer and check, than to provide the services. Spend the money where it's needed helping people. A lot of the people who need medicaid often don't have the ability to complete all that paperwork and will lose the coverage they need to maintain health. Health care is a right not a privilege!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and higher premiums are systematic barriers to the people of Montana who need Medicaid the most! Many of these people have seasonal jobs, disabilities, and non-traditional work that take up their time while they are still contributing a lot to Montana's social and economic economy. Putting up barriers to Montana's Medicaid program simply means that many people will be kicked off of Medicaid due to complicated regulations, and not because they are not eligible for Medicaid.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it will pull a lot of people off Medicaid who cannot work and who need help with their medical bill. This expansion waiver is not going to help anyone really, just another ploy by the republicans to decrease the number of people on Medicaid.

[redacted]

I oppose the proposed changes to Medicaid expansion. Many of our most vulnerable populations will be unable to access the health care they need to be as healthy as possible. In the long run, maintaining health will cost less tax payer dollars than treatment of chronic disease.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because most people who require Medicaid are not able to work the hours required. Secondly, in [redacted] there's not enough work available.

[redacted]

Not only do I oppose making low-income people work for their medical insurance on an ethical basis, but I also don't think it is even feasible in rural areas of Montana. [redacted] does not have the job opportunities nor the volunteer placement sites available to place these individuals - especially in the winter when many people are laid off. Also, given that most of the county is very rural, and many people have neither reliable transportation nor money for gas, getting to job and volunteer sites is often impossible. Additionally, requiring participants to report income, hours worked, etc. on a regular basis creates a further hardship as many of our residents do not even have the means to communicate, forcing them to travel many miles to do so. Lastly, forcing to people to pay more for their medical treatments is counterproductive in the long run as people are forced to decide whether to use precious resources for living expenses or medical care, resulting in much sicker people seeking medical care (often in the ER) when they no longer can avoid it.

[redacted]

I am the [redacted] at the Montana Coalition Against Domestic & Sexual Violence (MCADSV). I submit this comment on behalf of MCADSV in opposition to changes in the Medicaid expansion waiver. Specifically, MCADSV argues that it is harmful to add burdensome work requirements and increased premiums to Montana's Medicaid program. These changes will increase healthcare barriers for low-income Montanans, kick working Montanans off their healthcare, and make it harder for people with chronic illnesses to visit their doctors.

MCADSV is a statewide organization committed to ending gender-based violence and oppression in Montana. Violence is widespread in the United States, and Montana is no exception. The physical violence that we are subjected to takes many shapes – for example: murder, rape, battering, sexual harassment, and pornography. We advocate for policy that supports and/or forwards them; and we work to increase public awareness on issues related to them. Many survivors of these forms of violence can experience physical injury, mental health consequences such as depression, anxiety, low self-esteem, and suicide attempts, and other health consequences such as gastrointestinal disorders, substance abuse, sexually transmitted diseases, and gynecological or pregnancy complications. These consequences can lead to hospitalization, disability, or death. The National Intimate Partner and Sexual Violence Survey (2010). Studies have shown the high economic cost of sexual violence and domestic violence in our country. It is not uncommon for survivors of a violent and damaging relationship to require time away from employment in order to heal. All survivors (and all Montanans) deserve the opportunity to seek healing after an assault.

Montana's Medicaid expansion allows for a limited exemption from the waiver for domestic violence survivors under certain circumstances. MCADSV would urge rejection of the waiver despite this language, as years of experience have shown us that survivors of sexual violence, stalking, dating

violence, and other non-intimate partner gender-based violence experience the harms described above and require time and support in their healing. Further, Montana is committed to the health and safety of all Montanans, regardless of their identification as survivors.

Recently, Arkansas became the first state in the nation to impose work requirements on Medicaid enrollees. While Arkansas's work requirements are not fully implemented (and the court has halted implementation), nearly 17,000 people lost their health insurance in 2018 for failing to meet the harsh work reporting requirements. Additionally, cases of people losing coverage even though they are meeting hourly requirements have surfaced. Many people who did not report and satisfy the requirement did not know about the new regulations or were unable to create accounts and navigate the online portal. We should not take healthcare away from people when they need it the most. No Montanan should live at risk of becoming jobless and without healthcare. Thank you for your time. Please feel free to call with additional questions.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and increased premiums will only hurt people who need this program. They are on Medicaid for a reason!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are illegal, and they don't raise people out of poverty. They do not help people who receive Montana Medicaid and actually hurt them.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the work requirements and the increased premiums are an unnecessary burden. Please remove the work requirements and the increased premiums. Thank you.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because demanding work requirements will only encourage a cycle of poverty and disparity in health care for citizens who may be facing major illnesses, family trauma, etc. Work requirements for sick people are counter-intuitive and would harm Montanans, the economy, and the welfare of families who need this coverage.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it hurts EVERYONE!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the work requirements are needlessly burdensome. It will be difficult for some people who truly need these to meet the requirements. Most of the people on Medicaid who can work, do.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because implementing work requirements and raising premiums is foolish, counter-productive and will result in fewer folks being covered, which will adversely impact us all as they won't get preventive medical attention in a timely fashion, waiting until they possibly end up in urgent care or the emergency room, needing more costly, possibly less effective attention. Frankly, this is a no-brainer. Retain the current Medicare expansion requirements and quit endeavoring to impose more ways to inflict more pain on more folks. We are better than that, I would hope.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are an unfair stipulation in return for health care, which is a human right.

[redacted]

My husband and I are on a fixed income and over 60. My husband is disabled, and I need to be around to care for him. Find a job? Pay a higher premium than we already are?? Quit moving the goal post.

[redacted]

We live on my fixed income. I am disabled and unable to work. I need my wife around to look after things; not be finding a job at her age and away from here all day. I oppose the changes to Montana's Medicaid expansion waiver.

[redacted]

I suffer from several chronic illnesses, but because I stayed home with my kids when they were small, and I had them in my early 20s, I have not built up enough work history to now qualify for disability. My illnesses keep me from working, and I have to rely on my spouse's income for our family of 4. People like me will be made MORE sick if we either have to work to maintain our health coverage, or if we do not

work, will become even more unhealthy by having the coverage terminated. Healthcare is a necessity, not something that should be tied to employment.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the work requirements and higher premiums are a bad deal for Montana. The people who will utilize this cannot work for various reasons. The others, already working, don't make enough from their two to four part time jobs to afford it. Helena Food Share served 2400+ families in May 2019. The people making the requirements MUST get in touch with the people they are going to be serving.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because adding work requirements to Medicaid expansion and increasing premiums will be harmful to many Montanans.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because the work requirements and premiums would create great hardship for the many already struggling.

[redacted]

The history of work requirements is clear. They add unnecessary costs, and they don’t work, ever, as advertised. Also, raising premiums is bad for Montana residents.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because a person needs to get well to work, not work to get well and premiums are already too high due to the changes made to the ACA since 2016 by the Trump administration and congress.

[redacted]

I work at a community health Center in [redacted]. Imposing work requirements will have a huge detrimental effect on our patients many of them that have significant mental health, addiction and physical problems. A lot of patients simply would be unable to keep jobs, no less be able to keep up on all the paperwork required. So many patients would be at risk of losing coverage and hence lifesaving medication to treat diabetes, blood pressure, cancer treatment, mental illness and more. Please don’t jeopardize healthcare for people who need it the most!

[redacted]

As a mental health provider, I see every day how financial instability intertwines with mental health concerns to make accessing care vital but also very challenging for Montanans who struggle with these concerns. It's important that as a state we help people get back on their feet. Please don't add any more barriers to care, the easier it is for people to get help, the easier time they have of getting back on their feet.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because it is not necessary; it is not a requirement for federal assistance in administering. This is a political 'compromise' to appease the attitudes of conservatives in regard to the 'stereotype' of people on assistance. The reality is that private enterprise and the medical industry has made affordable care out of reach for many. As it is, the care afforded with Medicaid is difficult to access. Try finding a dentist! The State website list of 'providers' isn't even accurate. Far from it! So, add another layer of bureaucracy, that will burden staff that are already struggling to keep up. Other programs administered by the same department, DHHS, have work requirements in place. This should suffice. The jump thru the hoops paperwork jungle is a mess as it is. Anytime I make a change to my reporting online, it is never processed! Fix the system before adding more to it please. The level of care and services provided with Medicaid are minimal; I need and utilize specialized chiropractic care, effective, crucial to my functioning, and a 1/3 of the price of a standard doctor's visit. Not covered! I need the care of a naturopathic physician, it has kept me functional and on the long road to healing for my myriad complex disorder. I prefer to find the 'root' and treat that, not take Rx drugs of which the system is designed for and to profit, of which the side-effects can be worse than the symptoms treating. Instead of focusing on what is best for the patient, this State would rather reinvent the wheel and instill more upon an already challenged citizen. Another 'stressor'. I urge opposition to the proposed changes in the expansion waiver in regard to adding work requirement. While I am grateful to have Medicaid, I think the State needs to extend the expansion, and can do so without adding premiums and more 'requirements' onto the criteria for eligibility. Thank you for your consideration in this regard.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because we need to have reasonable path for folks to receive health care and more importantly preventive care. And care that is a lowest cost. Let's support small businesses too. They have no real means to provide health care. There are a few who will take advantage but let's not punish the other 95 percent. Use common sense, be practical, not political .

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because healthcare would be unaffordable. People should not get sick so the already wealthy can have even more money!

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and increased premiums are bad for Montana!

[redacted]

Health Care is too important a factor in Montanans' lives NOT to support it as broadly as possible. Instituting work requirements and raising premiums can only impact the lives of our fellow Montanans negatively and make quality health care g after for them to acquire. If all Montanans are not healthy, our state suffers.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because everyone in the state of Montana should have access to the healthcare they need, not only to what they can afford. Protecting our fellow Montanans, no matter what their income, should be at the very top of our priorities list.

As someone who has still never fully recovered financially from cancer, even though I had insurance at the time, I know how financially debilitating doctor visits and treatment can be. We should be making it easier for Montanans to become healthy, productive members of society, not try to add more impediments to accessing the care they need.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are based on false, stigmatizing stereotypes and prevent people from living healthy, productive lives. Healthcare is a human right and should be guaranteed to all.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because in 2015, Medicaid expansion was passed without any conditions, and that is how it should be passed again!

[redacted]

Work requirements are an inherently classist and racist addendum because it assumes that everyone has equal access to jobs and that and equal amount of opportunities for jobs exist in Montana. Moreover, heath care is a right not a privilege, to suggest that we cannot provide health care to those that were given unlucky circumstances by virtue of their birth is preposterous and shameful.

On the note of higher premiums, this addendum unilaterally targets communities of color and those living under the poverty line and assumes that Montana provides an acceptable minimum wage for living which it does not.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because adding work requirements and increasing premiums will lead to more people who are unable to access affordable health care. Keep it simple and low cost. Please do not add work requirements (which will also increase costs to the state) and do not increase premiums.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements and higher premiums defeat the purpose of Medicaid. If people could find jobs that included benefits, they wouldn't be applying for Medicaid. Think about it.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements are more expensive to Montana because staff in the state are needed to supervise and record that participants are doing something that fills the requirement.

[redacted]

I have been in the position of needing public assistance such as Medicaid, after falling off a roof and breaking my back. While well meaning, work requirements are an impediment to healing from an illness or injury.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because this coverage is mostly covering the working poor. They can’t afford Insurance.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because people will lose services and suffer.

[redacted]

First, we need to provide reliable daycare for people if we're including a work requirement. Second, provide affordable mental health care to help those with anxiety or other mental illnesses get the help they need so they can work. Third, Raise the minimum wage so people can live on what they make. $8.50 an hour is not a livable wage anywhere in Montana.

[redacted]

I am a nurse. In Montana just getting to the Doctor can be a hardship for the number of miles you have to travel. High paying jobs and jobs with benefits are not obtainable for the majority of people living in this rural state. These requirements will take people just barely hanging on and take away access to Doctors for them and their children. This change is bad for Montana.

[redacted]

I oppose the proposed changes in Montana's Medicaid expansion waiver because work requirements can be a death sentence for some Montanans. For people experiencing homelessness, physical health issues, mental health care issues, and caregiving demands, among others, meeting a requirement for a specific number of work hours creates more hardship, not less, and it means many more people could face deteriorating health or death. It will also mean that people who cannot access health insurance will overburden emergency rooms and sliding scale clinics. This will cost taxpayers more than simply approving Medicaid Expansion without placing limits on it. As it is, signing up for Medicaid and going through the certification process every 6 months requires extraordinary stamina and massive amounts of paperwork. I know this because I'm on Medicaid. The existing requirements already serve as a deterrent and adding more requirements will only ensure that people who most need Medicaid will be the least likely to get it.

[redacted]

E. Federal Evaluation of HELP: Interim Evaluation Report, July 2019

Social & Scientific Systems
Improving Public Health Worldwide

Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report

July 22, 2019

PREPARED FOR:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services State Demonstrations Group Division of Demonstration Monitoring and Evaluation

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Chapter IV (Social & Scientific Systems)

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EXECUTIVE SUMMARY

In November 2015, Montana received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a Medicaid Section 1115 demonstration allowing the state's alternative Medicaid expansion under the Affordable Care Act (ACA). The demonstration is called the Montana Health and Economic Livelihood Partnership (HELP). Enrollment in HELP started January 1, 2016, and as of September 2018, more than 100,000 Montanans were enrolled.[1] In December 2017, CMS granted a demonstration amendment to HELP modifying two of its components to reduce demonstration costs and administrative burden.[2]

Similar to the ACA Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP encourages enrollees to be prudent health care purchasers and take responsibility for their health care through premiums, copayments, and strategies to promote healthy behaviors. HELP also includes provisions that allow Montana to disenroll some newly eligible individuals with incomes above 100 percent of the federal poverty level (FPL) who do not pay their premiums on a timely basis. To improve continuity of care and reduce the "churn" of individuals losing and then regaining insurance, Montana's demonstration provides 12-month continuous eligibility for all enrollees. Before the 2017 demonstration amendment, HELP included a public-private third-party administrator plan from which some enrollees received care and a premium credit that applied to some enrollees' cost-sharing obligations. These two components were removed from the demonstration in the 2017 waiver amendment.

What Did the Evaluation Examine?

In August 2015, CMS awarded a contract to Social & Scientific Systems, Inc. and their partner Urban Institute (henceforth known as the evaluation team) to conduct an evaluation of the HELP demonstration. The federal evaluation has three main goals:

- Understand and document the design, implementation, and ongoing operations of HELP;
- Document enrollee understanding of and experiences with HELP; and
- Estimate the overall effects of HELP on health insurance coverage, health care access and affordability, and health behaviors and health.

To fully assess the impact of the program and achieve the above goals, the evaluation team designed and implemented a comprehensive mixed-methods evaluation of HELP that is currently ongoing. The first phase of the evaluation included:

- A qualitative component with;
    - Site visits with information obtained from eight focus groups with HELP enrollees as part of the site visits—four in 2017 and four in 2018.

[1] "HELP Enrollment by Month," DPHHS Montana Medicaid Expansion Dashboard, October 4, 2018, retrieved from https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

[2] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare & Medicaid Services, December 20, 2017, retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

  - Semi-structured interviews in Billings, Browning, Bozeman, Butte, Havre, and Helena with HELP stakeholders, including state officials, health care providers and provider association representatives, consumer advocates, and other non-state observers of the demonstration.
  - Document review of published and gray literature, and program statistics.

- Mixed-mode surveys of 2,180 HELP enrollees and 2,187 HELP disenrollees conducted in late fall of 2017, that asked about HELP enrollees' and disenrollees' experiences with the program including knowledge of the program, cost as a barrier to access, affordability of the program, and satisfaction with the program.

- An impact analysis that relied on a quasi-experimental difference-in-differences evaluation design and data from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) that compares changes over time for adults in Montana to changes for similar adults in similar comparison states.

This report is part of the federal evaluation of Montana's 2016 Medicaid demonstration.[3] Results from follow-up surveys of HELP enrollees and disenrollees conducted in 2018, as well as additional impact analyses using administrative data from Montana will be presented in the forthcoming summative evaluation report.

Findings from the Evaluation

Findings from all three components of this HELP evaluation show that the program had significant and positive effects, although, as with any program, implementation and administration faced some challenges. Overall, there were substantial gains in health insurance coverage; beneficiaries for the most part expressed satisfaction with the program; and stakeholders believed it had positive economic impacts by decreasing hospital uncompensated care costs and stimulating economic growth in the state.

Allowing Montana to use a section 1115 demonstration resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage. As of September 2018, nearly 100,000 Montanans were enrolled in HELP. Moreover, based on results from the impact analysis, the expansion in health insurance coverage exceeded the gains that would have been expected if the state had expanded Medicaid without a demonstration or with a demonstration more similar to those of Michigan or New Hampshire. Apart from increases in health insurance coverage, the three components of the assessment of HELP provide results that may be informative to other states considering designing and implementing section 1115 Medicaid demonstrations.

From the key stakeholder interviews we found:

Strong stakeholder engagement and collaboration with the state expedites system change. While state officials and stakeholders acknowledged that it took time and compromise to pass the Medicaid expansion in Montana, once HELP legislation was enacted, the deep collaboration between the state

[3] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf.

and stakeholders in implementing HELP created a win-win situation for hospitals, the broader health care system, and the uninsured in Montana.

Changing patterns of health care use. While findings from stakeholder interviews and focus groups indicate continued gaps in enrollee understanding of HELP, there were evidence of changes in health care behaviors in response to program changes, as more enrollees were reported to be obtaining preventive care over time. These changes were noted by state officials and other interviewees, and also appeared to be supported by the early impact estimates.

Flexibility in program design is important. State officials and other interviewees highlighted the importance of periodically revisiting the HELP demonstration design based on actual program experience. Their findings that the 2 percent premium credit as well as copayments for non-emergent use of the emergency room were difficult to track and administer resulted in the elimination of both these program features.

Survey and focus group findings showed:

Satisfaction with the HELP program was high among current enrollees. A majority of enrollees reported being somewhat to very satisfied with individual features of HELP, such as monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of needed health care services. Among the disenrollee respondents, nearly 50 percent indicated that they would choose to re-enroll in HELP.

HELP enrollees' and disenrollees' had limited understanding of the individual features of HELP. Enrollees and disenrollees in focus groups in focus groups expressed confusion about some of the basic components of HELP such as what is coverage by the program as well as some of the more complex features of HELP such as premium credits. This was consistent with findings from the surveys of HELP enrollees and disenrollees.

Access to health care improved for many beneficiaries. Focus group and stakeholder interviews showed that access to needed healthcare services was viewed favorably by both beneficiaries and stakeholders. Survey results indicated that most beneficiaries reported receiving needed services and that cost was a barrier to receiving services for fewer than 20 percent of enrollees. With gains in health insurance coverage, beneficiaries perceived increases in access relative to their prior coverage status. However, even with HELP coverage, access barriers were more prevalent for dental and vision services than for other services, based on both focus group and survey results.

Findings from the impact analyses indicate:

Health insurance coverage increased in Montana. We find strong evidence that Montana's HELP demonstration expanded health insurance coverage for adults beyond what would have been expected if Montana had not expanded Medicaid, a view echoed by site visit interviewees. Health insurance coverage also increased in Montana relative to similar states that expanded Medicaid, without a demonstration or with a different demonstration.

Early evidence suggests that the use of preventive care increased in Montana relative to similar states, regardless of Medicaid expansion status. Given that the post-implementation period for this analysis only extends through 2017, it is still early to see changes in access and affordability measures under

Montana's 2016 demonstration. Even so, we do see some evidence of increases in the use of preventive care relative to similar states, with gains in routine check-ups and receipt of a flu vaccine in Montana for all adults and low-income adults, although only few of the estimates for low-income adults are statistically significant.

Policy Implications

Based on results from this evaluation, Montana's HELP program provided coverage and access to care for about 100,000 Montanans, and was viewed positively by the majority of stakeholders and beneficiaries we interviewed or surveyed. While the design of HELP was intended to encourage enrollees to take responsibility for their health care through premiums, copayments, and strategies to promote healthy behaviors, these features produced administrative complexity that sometimes confused beneficiaries, or were administratively difficult to implement (such as copayments for emergency room visits). In addition, programs are not implemented in a vacuum, and state infrastructure and budget affect both implementation and program administration. States contemplating implementing or revising their Medicaid programs may wish to learn from Montana's experiences with specific program features, such as use of a third-party administration (TPA), or with their experiences with beneficiary outreach and education, which appears to be necessary for many beneficiaries in order to use the program effectively.

I. Introduction

The Affordable Care Act (ACA) allows states to expand Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL). As of January 2019, 29 states had opted to implement the Medicaid expansion as set out in the ACA, while eight states had expanded coverage using alternate approaches through section 1115 demonstrations.[4] Though long a hallmark of Medicaid, section 1115 demonstrations have gained renewed prominence with the Trump Administration's interest in trying new ways to improve the Medicaid program.[5] Chief among the strategies that the Centers for Medicare & Medicaid Services (CMS) is interested in testing through section 1115 demonstrations are strengthening enrollee engagement in their health care, enhancing the alignment between Medicaid and private health insurance policies, and supporting initiatives that promote upward mobility, greater independence, and improved quality of life for Medicaid enrollees.[6]

Montana received approval to implement the ACA Medicaid expansion through a section 1115 demonstration in November 2015.[7] The State implemented the demonstration, called the Health and Economic Livelihood Partnership or HELP, on January 1, 2016.[8] In December 2017, CMS approved an amendment to Montana's section 1115 demonstration that is to continue through December 2020. As of September 2018, nearly 100,000 Montanans were enrolled in HELP.[9]

This report provides an overview of the HELP demonstration through 2018. It first outlines the design and scope of the federal evaluation of HELP, along with the scope of this Interim Evaluation Report and that of the Final Summative Evaluation Report for the federal evaluation. Subsequent sections describe the design of HELP and modifications made to the program over time, followed by results from focus groups, structured interviews, beneficiary surveys, and quantitative analyses of secondary datasets. Finally, this report presents an overall discussion and conclusions based on all of the evaluation components and thoughts on the HELP program moving forward.

[4] "State Health Facts: Status of State Action on the Medicaid Expansion," Kaiser Family Foundation, January, 2019, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[5] "Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program," U.S. Centers for Medicare & Medicaid Services, November 7, 2017, https://www.cms.gov/newsroom/press-releases/verma-outlines-vision-medicaid-announces-historic-steps-taken-improve-program.

[6] "About Section 1115 Demonstrations," Medicaid.gov, no date (accessed May 13, 2019), https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[7] The legislation that enacted the Medicaid expansion is to sunset on June 30, 2019 unless reauthorized by the Montana legislature.

[8] When Montana received approval for HELP, it also received a section 1915(b)(4) Fee-for-Service Selective Contracting Demonstration, which authorized a defined provider network and is associated with the HELP demonstration. The section 1915 demonstration is not covered under the federal evaluation of HELP.

[9] "HELP Enrollment by Month," Montana DPHHS Montana Medicaid Expansion Dashboard, October 4, 2018, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

Design of the Federal Evaluation

In 2015, Social & Scientific Systems, Inc. (SSS) and the Urban Institute (together referred to in this report as the evaluation team) were awarded a base year and three option year contract (September 2015 to September 2019) to conduct the federal evaluation of Indiana's section 1115 demonstration—Healthy Indiana Plan (HIP) 2.0. The evaluation of Montana's HELP demonstration was added to the contract in 2016. The federal evaluation of HELP has four principal objectives, namely:[10]

- Understand the design, implementation, and administrative costs of HELP;
- Document enrollee understanding of and experiences with HELP, including experiences with premiums, copayments, enrollment, and disenrollment;
- Estimate the impacts of Montana's Medicaid expansion, including the third-party administrator (TPA) plan, on health insurance coverage, access to and use of health care, quality of health care, health care affordability, and health behaviors; and
- Provide timely information on HELP that can inform CMS, Montana, and other states as they consider ways to improve the Medicaid program.

To achieve these objectives, the federal evaluation of HELP has three components that rely on qualitative and quantitate analyses:

- Qualitative analyses entailing document review and two rounds of site visits (September 2017 and September 2018), including conducting informational interviews with HELP stakeholders (including state officials, health care providers and provider association representatives, consumer advocates, and other non-state observers of the demonstration), and focus groups with HELP enrollees;
- HELP beneficiary surveys (2017 and 2018) and descriptive analyses based on Medicaid administrative data; and
- Impact analyses using both Medicaid administrative data (through 2018) and national survey data (through 2017).[11]

The goals of the qualitative analyses were to provide careful documentation of HELP implementation and operations, as well as successes and challenges Montana faced in managing the demonstration. The qualitative analyses were also to provide an in-depth assessment of consumer experiences with HELP through the enrollee focus groups and the beneficiary surveys. The qualitative analyses were designed to inform the evaluation's descriptive analyses and the impact analyses in two fundamental ways: 1) helping guide the focus of the descriptive and impact components and 2) providing invaluable context for interpreting results from those analyses. The goals of the impact analyses were to assess the extent

[10] "Evaluation Design Report for Montana HELP Federal Evaluation," Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2017), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf.

[11] Because the national survey data to be used for the impact analysis are released in the fall of the year after the survey is fielded (e.g., data for 2017 are released in fall 2018), the final year of survey data available to the HELP evaluation is 2017.

to which HELP led to changes in health insurance coverage, as well as changes in health care access and affordability, health care quality, health behaviors, and health status.

Scope of the Interim and Final Summative Evaluation Reports

The federal evaluation of HELP includes two major reports: an Interim Evaluation Report and a Final Summative Evaluation Report. The Interim Evaluation Report, which is presented in this document, covers findings from the 2017 and 2018 site visits, which includes information obtained from key informant interviews and enrollee focus groups; beneficiary surveys from 2017; and impact estimates using national survey data through 2017. The Final Summative Evaluation Report, which will be provided to CMS in late 2019, will update the Interim Evaluation Report to include the analyses of Medicaid administrative data through 2018 as well as the second wave of HELP beneficiary surveys from 2018. Importantly, while the 2018 site visit and beneficiary surveys conducted under the evaluation capture the changes Montana made to HELP in 2018 under the 2017 demonstration amendments, the impact analyses using national survey component is limited to 2011 to 2017.

Organization of the Interim Evaluation Report

Section II provides a brief overview of Montana's Medicaid program before HELP implementation and discusses key programmatic features of the demonstration. The qualitative assessment of HELP is provided in section III, followed by results from the HELP beneficiary surveys in section IV and the quantitative assessment of the impacts of HELP in section V. In section VI, we discuss lessons learned from HELP.

II. Montana's Medicaid Program and the Design of HELP

This section provides background on Montana's Medicaid program prior to the implementation of HELP and an overview of the design of the demonstration, including changes made to the demonstration as part of amendments made in 2017.

Montana's Medicaid Program Before HELP

Before HELP, Montana's Medicaid program covered traditional low-income populations generally comparable to the national average. In 2014, qualifying adults, including parents and other caretakers in families with dependent children, were covered up to 47 percent FPL, with pregnant women covered up to 157 percent FPL, and disabled adults up to 72 percent FPL.[12] Nondisabled childless adults were not eligible for Medicaid prior to HELP. Average monthly enrollment in Montana's Medicaid program was about 125,000, with children comprising more than 60 percent of enrollment in 2015, just before HELP was implemented.[13] Reflecting the broader Montana health care market, Medicaid services were (and continue to be) delivered and paid for primarily on a fee-for-service (FFS) basis, the one exception to this being Montana's Passport to Health, the state's primary care case management (PCCM) program, which provides a flat per member per month payment to providers for PCCM enrollees. Finally, though Montana's Medicaid eligibility standards were comparatively low before HELP, its Medicaid benefit packages for children and the aged/blind and disabled were relatively generous, covering several optional services, including dental, denture, and vision services.[14]

Between the 2013 and 2015 sessions, the state developed a compromise bill to put forward in the 2015 session that would expand Medicaid through a section 1115 demonstration. Interviewees said that other states' section 1115 demonstrations were reviewed, but HELP was "made in Montana and homegrown." Senate Bill 405 was passed in April 2015. Included in the underlying authorizing legislation was a "sunset" provision, which was originally slated to terminate on June 30, 2019 unless the legislation was reauthorized. Documents to establish the demonstration were submitted to CMS on September 15, 2015. After some revisions in the design negotiated between the state and CMS, Montana received approval to implement HELP on November 2, 2015.

HELP Design Features, 2016-2018

Like ACA Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP is designed to encourage enrollees to be prudent health care purchasers, taking responsibility for their health care through premiums, copayments, and provisions that allow Montana to disenroll some

[12] "The Montana Medicaid Program: Montana Department of Public Health and Human Services Report to the 2015 Legislature, State Fiscal Years 2013/2014", MT DPHHS, January 5, 2015, https://dphhs.mt.gov/Portals/85/Documents/2015MedicaidReport.pdf.

[13] "The Montana Medicaid Program: Montana Department of Public Health and Human Services Report to the 2017 Legislature, State Fiscal Years 2015/2016," MT DPHHS, (Helena: Montana Department of Public Health and Human Services, 2017).

[14] "Medicaid Benefits Data Collection," Kaiser Family Foundation, no date (accessed November 7, 2017), https://www.kff.org/data-collection/medicaid-benefits/.

demonstration enrollees who do not pay their premiums on time.[15] The demonstration also authorized 12-month continuous eligibility for expansion adults. In this section, the report describes key components of HELP when the demonstration was launched in 2016, as well as changes Montana made to the demonstration through the 2017 demonstration amendments, which were implemented January 1, 2018.

According to the CMS approved special terms and conditions (STCs) of Montana's 1115 demonstration, the HELP demonstration has two central objectives[16]:

- Encourage enrollees to be discerning health care responsibility, take personal responsibility for their health care decisions, and develop health-conscious behaviors through the use of premiums and copayments
- Promote continuity of coverage through 12-month continuous eligibility.

To help achieve these objectives, HELP included the following design features when it launched on January 1, 2016:

- Expanded Medicaid eligibility to adults with income up to 138 percent FPL who were not previously eligible for Medicaid in Montana;
- Required premiums equal to 2 percent of household income for HELP enrollees with incomes between 51 and 138 percent FPL who were not otherwise exempted from provisions of the demonstration;[17]
- Operated two health plans to deliver services to HELP enrollees. One was a public-private TPA plan that provided services to enrollees who were subject to premiums; the other, Montana's Medicaid state plan, delivered services to enrollees who were exempt from premiums;
- All HELP enrollees were subject to copayments that followed Montana's state plan, though the amount of some copayments varied by income;

[15] "Special Terms and Conditions: Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," Centers for Medicare and Medicaid Services, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[16] "Montana Health Economic Livelihood Partnership Plan (HELP) Program Section 1115 Research and Demonstration Waiver Application," Montana Department of Public Health and Human Services (DPHHS), September 15, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/HELP-program/mt-HELP-program-pending-app-09162015.pdf.

[17] In addition to exempting adults with incomes below 50 percent FPL from premiums, when HELP launched Montana also exempted individuals who were medically frail, individuals who the state had determined had exceptional health care needs, individuals who lived in a region where the TPA plan was not able to contract with sufficient providers, individuals who the state determined required continuity of coverage that was unavailable in the TPA plan or could not be effectively delivered through the TPA plan, and individuals otherwise exempted from premiums or copayments by federal Medicaid law (e.g., Native Americans). "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration", Centers for Medicare and Medicaid Services, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

- HELP enrollees subject to premiums received a credit toward copayments of up to 2 percent of income;
- Some nonexempt HELP enrollees could be disenrolled from HELP for failure to pay premiums; and
- All HELP enrollees had 12-month continuous eligibility in HELP.

Although not part of the HELP demonstration's STCs, Montana's demonstration also includes a voluntary workforce development program called HELP-Link.[18] Launched at the same time as HELP, HELP-Link aims to reduce reliance on Medicaid for health insurance and strengthen Montana's workforce.[19]

In September 2017, Montana formally submitted a request to CMS to amend the HELP demonstration. On December 20, 2017, CMS approved the amendments, which Montana implemented on January 1, 2018.[20] Under the amendment request, Montana asked to eliminate the public-private TPA plan and transition HELP enrollees who were previously served by the TPA plan to Montana's Medicaid state plan. Montana also asked to eliminate the premium credit that applied to some HELP enrollees' cost-sharing obligations. The amendments were designed to reduce demonstration costs and the administrative burden of the demonstration.

The following section describes specific program design features.

Covered Population and Exempt/Nonexempt Enrollees

Montana's demonstration covers adults ages 19-64 with income at or below 138 percent FPL, excluding adults who were eligible for Medicaid prior to the ACA's Medicaid expansion (e.g., in 2013, these included parents and other caretakers of dependent children with incomes up to 33 percent FPL and pregnant women up to 150 percent FPL).[21] As noted above, nondisabled childless adults were not eligible for Medicaid in Montana prior to HELP. HELP provides 12 months of continuous Medicaid eligibility to the HELP expansion population.

Within the HELP covered population, Montana identifies two key population subgroups: individuals who are exempt from paying premiums for HELP coverage and individuals who are not exempt from paying premiums for HELP coverage. In the initial design for HELP, exempt enrollees obtained their health care through Montana's traditional Medicaid program while nonexempt enrollees obtained care through the

[18] "Montana Health and Economic Livelihood Partnership (HELP) Act," Montana State Legislature, April 29, 2015, https://leg.mt.gov/bills/2015/sb0499/SB0405_x.pdf; "HELP-Link: The Montana HELP Plan Workforce Program," Montana Department of Labor and Industry, no date (accessed December 2017), https://montanaworks.gov/help-link.

[19] "HELP-Link Program Report," Montana Department of Labor and Industry, July 2018.

[20] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare and Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[21] "The Montana Medicaid Program: Montana Department of Public Health and Human Services Report to the 2015 Legislature, State Fiscal Years 2013/2014", MT DPHHS, January 5, 2015, https://dphhs.mt.gov/Portals/85/Documents/2015MedicaidReport.pdf.

public-private TPA plan. Under the state's 2017 demonstration amendments, the TPA was eliminated (discussed below).

In the initial design of HELP, exemptions from HELP premiums were based on both the characteristics of demonstration enrollees and on the health care that could be provided to enrollees under the TPA plan. Specifically, individuals were exempt from HELP premiums if they met any one of the following criteria:

- were medically frail;
- were determined by the state to have exceptional health care needs;
- lived in an area where the TPA was not able to contract with sufficient providers;
- the state determined that they require continuity of coverage that was not available or could not be effectively delivered through the TPA; or
- were otherwise exempted from premiums or copayments by federal Medicaid law (e.g., had income at or below 50 percent FPL or were American Indian/Alaska Native). [22]

With the elimination of the TPA plan under the 2017 demonstration amendments, the exemptions from premiums related to the TPA plan were also eliminated; other exemptions remained in effect.[23]

Delivery System

As noted above, when HELP launched, services were provided to demonstration enrollees through one of two delivery systems—the public-private partnership TPA plan or Montana's traditional Medicaid program plan (Table II.1). Both the TPA plan and the Montana state Medicaid plan reimbursed providers on a FFS basis. The TPA plan was responsible for, among other things, contracting with a network of providers, reimbursing providers, invoicing enrollees for premiums, and tracking premium payment levels to ensure that enrollees' out-of-pocket spending did not exceed the five-percent federal maximum consistent with federal requirements.

[22] "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration", Centers for Medicare and Medicaid Services, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[23] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare and Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

Table II.1: HELP delivery system and cost-sharing policies by HELP premium exemption status, 2016-2018

HELP Premium Exemption Status	Delivery System		Cost-Sharing				
	Plan Administrator		*Premiums 2016-2018*	*Copayments 2016-2018*	*Premium Credit*		*Cost-sharing Limit 2016-2018*
	2016-2017	2018			*2016-2017*	*2018*	
Exempt	Montana Medicaid	Montana Medicaid	None	Maximum allowed by federal law	Not applicable	Not applicable	Per quarter, up to 5% of household income
Nonexempt	TPA Plan	Montana Medicaid	Equal to 2% of household income	Maximum allowed by federal law	Per quarter, equal to 2% of household income	None	Per quarter, up to 5% of household income

Note: As of 2018, the following individuals are exempt from premiums under the HELP demonstration: individuals who are medically frail, individuals whom the state has determined have exceptional health care needs, individuals who live in an area where the state is unable to contract with sufficient providers, individuals whom the state determines require continuity of coverage that is not available, and individuals who are otherwise exempt from premiums or copayments by federal Medicaid law (e.g., American Indians/Alaska Natives and individuals with incomes at or below 50 percent FPL). Prior to the 2018 amendments to HELP, other populations were also exempt from the HELP demonstration, including individuals who lived in areas where the TPA was not able to contract with sufficient providers or individuals whom the state determined require continuity of coverage that was not available or could not be effectively delivered through the TPA. With the elimination of the TPA plan in 2018, these exemptions no longer applied. ("Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," CMS, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.)

Because of state budget concerns and the belief that eliminating the TPA plan would yield considerable savings in HELP administrative costs, Montana requested as part of its 2017 demonstration amendment submission that the TPA plan be eliminated and all TPA enrollees be transitioned to the Montana's Medicaid state plan. CMS approved the request, and on January 1, 2018 HELP enrollees whose services were delivered through the TPA plan transitioned to Montana's Medicaid state plan. In December 2017, just before the elimination of the TPA plan, about 21 percent of HELP enrollees (20,050 individuals) services were delivered through the TPA plan.[24]

Enrollee Cost-Sharing

All cost-sharing features of HELP have remained the same over the course of the demonstration except the premium credit, which was eliminated as part of Montana's 2017 demonstration amendment (Table II.2). We discuss the different component of HELP's cost-sharing provisions in this section.

Premiums. Exempt HELP enrollees are not subject to premiums whereas nonexempt enrollees are charged monthly premiums equal to 2 percent of individual income.

With the elimination of the TPA plan, the state became responsible for collecting enrollee premiums, a new administrative function for the state. To facilitate the transition, the state relied on its existing fiscal

[24] "HELP Program Demonstration: Section 1115 Waiver Annual Report Year 2," State of Montana, August 8, 2018.

division to collect HELP premiums, but established a new two-person call center. The new call center handles inquiries from HELP enrollees about premium collections, debt associated with past-due premiums, and other premium-related matters. Apart from these new programmatic tools, Montana relied on the existing infrastructure of its traditional Medicaid program to support onboarding TPA enrollees.

Premium credit. Until the 2017 demonstration amendments were implemented, the HELP demonstration included provisions that allowed for a premium credit. Under the credit, each calendar quarter nonexempt HELP enrollees received a credit equal to what they had paid in premiums. The credit could be applied toward any copayments they owed during that quarter. Thus, enrollees were *only* charged copayments if they exceed the dollar value of premiums they had paid in any given quarter. Every three months, enrollees' premium-copayment comparison was reset. The premium credit was established to help ease enrollees' financial burden of having to pay both a premium and copayments.

As of January 1, 2018, the premium credit was removed from the HELP demonstration. Unlike termination of the TPA plan, eliminating the premium credit was not done for budgetary reasons, but to eliminate the burden of administering the credit.

Copayments. Co-payments are not a feature of the demonstration but rather are authorized under Montana's state Medicaid plan. All HELP enrollees are subject to copayments set at the maximum level provided by federal Medicaid law.[25] The HELP demonstration eliminated copayments for preventive care, which was also seen as a way to promote personal responsibility—that is, encouraging HELP enrollees to be proactive in their health care and use primary care services.[26] As shown in Table II.2, with some exceptions, the level of copayment varies by income, consistent with federal law. For example, enrollees at or below 100 percent FPL are subject to a $4 copay for a doctor's visit and a $75 copayment for a hospital stay whereas for enrollees with income above 100 percent FPL, copayments are 10 percent of the reimbursement the state pays to the providers for the services rendered. As noted above, no copayments are charged for preventive services as broadly defined in the HELP demonstration. For prescription drugs, copayments are the same flat-fee regardless of income, though there is no copayment for generic drugs**.** With the exception of pharmacy services, copayments are not collected at the point of service to ensure individuals are not paying co-payments and premiums that are more than 5 percent of their aggregate household income or, if applicable, the premium credit is being applied. Providers can only bill HELP enrollees for copayments after the state adjudicates the claim and determines what copayment amount, if any, should be applied.

[25] "Overview of Medicaid Cost Sharing and Premium Requirements", Medicaid.gov, (PowerPoint presentation, November 25, 2014), https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf.

[26] Before the HELP demonstration, Montana charged Medicaid enrollees copayments for all services. As part of the demonstration, the state submitted a Preventive Services Protocol defining the procedure codes and services that would not be subject to copayments. "CMS Approved Amendment: HELP Program Demonstration, Attachment C, Appendix 1, "Centers for Medicare and Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

Copayments for non-emergent use of the emergency room are also the same regardless of income. As allowable under federal law and not a part of the HELP demonstration, Montana originally intended to charge demonstration enrollees an $8 copayment for non-emergent use of the emergency room. As stated in Montana's HELP Operational Protocol, all emergency department visits are "not subject to cost sharing unless the hospital provides a written attestation to the State that the provider meets the State's requirements for imposing co-payments for emergency department services."[27] Requirements include conducting an Emergency Medical Treatment and Labor Act–compliant screening that concludes the enrollee's condition is non-emergent, providing the enrollee with the name and location of an alternative services provider, and determining that the alternative provider can provide services at a lower cost-sharing amount. As described in further detail below, the state opted not to apply an $8 copayment for non-emergency use of the emergency room.

Table II.2: HELP copayment structure for selected services by enrollee income level, 2018

Service	Copayments for Enrollees with Incomes at or Below 100% FPL	Copayments for Enrollees with Incomes Above 100% FPL
Inpatient Hospital Stay	$75	10% of state provider reimbursement
Physician Office Visit (Primary or Specialty Care)	$4	10% of state provider reimbursement
Lab and Radiology	$4	10% of state provider reimbursement
Prescription Drugs		
Generic	$0	$0
Preferred Brand	$4	$4
Non-Emergent Emergency Room Use	$8	$8

Note: FPL = Federal poverty level. The following services are not subject to copayments under federal or state law: emergency services, preventive health care services, pregnancy-related services, family planning services, immunizations, generic drugs, and medically necessary health screenings.

Cost-sharing limit. Consistent with federal limits, for the entirety of the demonstration, HELP enrollees pay no more than 5 percent of their aggregate household income out-of-pocket (copayments and, if applicable, premiums) per calendar quarter.

Disenrollment and Debt Assessment for Nonexempt Enrollees

The HELP demonstration includes provisions for assessing debt on nonexempt enrollees and possible disenrollment for those who fail to make timely premium payments. These provisions were unchanged with the 2017 demonstration amendments. As reported in Table II.3, nonexempt enrollees with incomes at or below 100 percent FPL are not disenrolled from HELP for failure to pay premiums, but any unpaid

[27] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare and Medicaid Services, December 20, 2017.

premiums incurred by enrollees in this income group are considered a debt that the State of Montana may collect or assess.

Nonexempt enrollees with income above 100 percent FPL who fail to pay their premiums, after receiving a nonpayment notice and a 90-day grace period, can lose their HELP coverage. Individuals who are disenrolled may reenroll if they pay their past due premiums, or after the Montana Department of Revenue sends a debt notice (which can take no more than 90 days) informing them that a portion of their next state tax refund will be withheld to pay overdue HELP premiums.[28] Individuals seeking reenrollment within the same 12-month continuous eligibility period do not need to submit a new HELP application;[29] instead, HELP coverage can be reinstated online by paying their overdue premiums or after receiving a debt notice from the state indicating that the unpaid premium balance has been assessed.[30] Thus, HELP disenrollment provisions are a "soft" lockout akin to what many states use in their Children's Health Insurance Program (CHIP) but with debt assignment for unpaid premiums.

The state legislation that enacted HELP provided for several exemptions for disenrollment for failing to pay premiums by nonexempt enrollees with income above 100 percent FPL. Specifically, if a person meets any two of the following criteria they are not subject to disenrollment: they (1) have been discharged from the US military service within the previous 12 months; (2) are enrolled in college or a university in Montana; (3) are participating in a wellness program or enrolled in a state-approved healthy behavior plan (e.g., a diabetes prevention program; a tobacco cessation program); (4) are in a substance use treatment program; or (5) are seeing a primary care provider participating in a PCCM program such as a PCMH (patient-centered medical home).[31] However, these individuals are still subject to debt assessment.

[28] "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," State of Montana, approved November 2, 2015. See Attachment B—MT HELP Demonstration Operations Protocol.

[29] A new application is needed, however, if the enrollee reapplies outside the 12-month continuous eligibility period in which he or she was disenrolled.

[30] "Montana's Healthcare Plan: HELP Members," Montana DPHHS, no date (accessed November 8, 2017), http://dphhs.mt.gov/helpplan.

[31] S. 405, 64th Leg., Reg. Sess. (Mont. 2015).

Table II.3: HELP disenrollment and debt assessment policies by premium exemption status, 2016-2018

Premium Exemption Status	Subject to Disenrollment for Failure to Pay Premiums	Debt Assessment for Past-Due Premiums
Exempt	Not applicable	Not applicable
Nonexempt		
51-100% FPL	No	Yes
101-138% FPL	Yes, after 90-day grace period with some exceptions	Yes

Notes: FPL = Federal poverty level. Disenrollment for non-payment of premiums are not applied to nonexempt HELP enrollees who meet any two of the following requirements: enrollees who have been discharged from the US military service within the previous 12 months, are enrolled in a university in Montana, are participating in a wellness program or enrolled in a state-approved healthy behavior plan, are enrolled in a substance use treatment program, or are seeing a provider participating in a primary care case management program.

12-Month Continuous Eligibility

HELP provides for 12-month continuous eligibility for enrollees, which allow individuals to stay enrolled in the demonstration for a full year regardless of income changes. The purpose of providing 12-month continuous eligibility is to help increase overall coverage of newly eligible individuals.[32] It can also help stabilize insurance coverage by reducing the effects of insurance "churn" that can be caused by fluctuations in enrollee income.

[32] "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," State of Montana, approved November 2, 2015.

III. Qualitative Assessment of HELP

The goal of the qualitative component of the HELP evaluation is to understand and document the implementation and ongoing administration of HELP and evaluate enrollees' experience under Montana's Medicaid expansion. The qualitative assessment relies on document reviews and site visits to Montana in 2017 and 2018, which included key informant interviews and focus groups with HELP enrollees. We begin this chapter by describing the design for the qualitative component of the evaluation, its research questions, data, methods and limitations. We then present the qualitative results that, in this Interim Evaluation Report, provide findings from the 2017 and 2018 site visits, supplemented by context provided through the document review. Additional information on the 2017 site visit is provided in a separate report to CMS.[33] In this section, we discuss the development of HELP and how respondents viewed evolution of the demonstration over time. We then discuss respondents' views of implementation and ongoing operations of, and enrollee experiences with HELP for major components of the demonstration: outreach, enrollment and redetermination, enrollee education, cost-sharing and access to care. The chapter ends with a brief summary of the qualitative findings. Appendix A provides additional information on the methodology for the focus groups.

Research Questions

The qualitative assessment of HELP addresses three basic questions:

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

Data, Methods, and Limitations

Data

The primary data sources for the qualitative analysis was information obtained through document review and site visits to Montana during the weeks of September 11, 2017, and September 17 and September 24, 2018. During the site visits, Urban Institute researchers conducted semi-structured interviews in Billings, Browning, Bozeman, Butte, Havre, and Helena with HELP stakeholders, including state officials, health care providers and provider association representatives, consumer advocates, and other non-state observers of the demonstration.[34] Names of potential interviewees were obtained

[33] "Federal Evaluation of HELP: Montana Health and Economic Livelihood Partnership Plan- A Look at the Program a Year and a Half into Implementation," The Urban Institute and Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2018), https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/mt-help-focus-group-site-visit-rpt.pdf.

[34] Specifically, in 2017 Urban Institute researchers spoke with state officials (6), health care providers and provider association representatives (7), consumer advocates (3), and other non-state observers of the demonstration (2). Because of scheduling conflicts, we conducted 4 of the interviews by telephone before or after the 2017 site visit week. In 2018, we spoke with state officials (8), health care providers and provider association representatives (6), consumer advocate (2), and other non-state observers of the demonstration (2). Because of scheduling conflicts, we conducted 7 of the interviews by telephone before or after the site visit weeks in 2018.

through a variety of sources, including Montana state officials, state health care observers and experts, and our review of HELP documents and the grey literature. From this list of prospective interviewees, we selected interview respondents to provide us with a range of perspectives on HELP. Senior Urban Institute researchers conducted the stakeholder interviews with a second Urban Institute researcher taking verbatim notes. With the approval of interviewees, interviews were also audio recorded to provide back-up for the note taker. Recordings were destroyed after note taking was completed.

We also held a total of eight focus groups with HELP enrollees as part of the site visits--four in 2017 and four in 2018. In 2017, we conducted two focus groups in Helena, one with exempt HELP enrollees and one with nonexempt TPA plan enrollees. We also conducted two focus groups with a mixture of exempt and nonexempt TPA plan enrollees, one in Havre and one in Browning. Helena is the state capital and, with nearly 30,000 residents, is the sixth largest city in Montana. Havre and Browning are both small towns located in the northern center part of the state.

In 2018, we also conducted four focus groups in the eastern part of the state: two in Billings, one in Livingston, and one in Forsyth. Billings is the largest city in Montana with nearly 110,000 residents. Livingston and Forsyth are both rural towns, to the west and east of Billings. In a departure from the 2017 focus groups, in 2018 we purposefully recruited nearly twice as many nonexempt HELP enrollees as exempt enrollees to get perspectives from those affected by the elimination of the TPA plan and the premium credit under the 2017 demonstration amendments.

In both 2017 and 2018, researchers from the Urban Institute recruited HELP enrollees for the focus groups. Focus group participants had to meet several criteria as a prerequisite to participation. Specifically, they had to meet the following requirements:

- had been enrolled in HELP for at least four months;
- were between the ages of 18 and 64;
- spoke English as their primary language; and
- had a home address with a zip code located within one of the focus group areas.

More information on the selection of focus group participants is provided in Appendix A.

The focus groups were held in the facilities of local community organizations such as hospitals, health clinics and libraries. The focus group discussion was semi-structured and encompassed a core set of questions to be asked at each of the four groups. The topics addressed included: health insurance coverage history, HELP marketing and outreach, HELP eligibility determination, enrollment, and renewal, HELP cost-sharing and affordability, access to care and benefits under HELP, experience with HELP-Link, impacts of having health coverage on daily life, and suggestions for improving HELP. In 2018, we also covered the elimination of the TPA plan and the premium credit, and discussed the future of the HELP program given that the program was scheduled to sunset 9 months following our focus groups. Each focus group lasted approximately 90 minutes. The focus groups were audio recorded to provide back-up for the note taker. Recordings were destroyed after note taking was completed.

Finally, in addition to the site visit interviews and the focus groups, we relied on information gathered from various documents about HELP, including publicly available materials, program administrative data provided by state officials, and materials provided by CMS, state officials, and other stakeholder interviewees.

Methods

Notes from both the stakeholder interviews and focus groups were reviewed and confirmed using the audio-recordings. Interview notes and focus group notes were examined using two different methods. For the interview notes, the files containing the full set of interview notes were uploaded and coded with NVivo qualitative analysis software for thematic analysis using well-established techniques to facilitate reliability and validity.[35, 36] We used an iterative approach for data analysis that combined both inductive and deductive coding. We began by drafting a preliminary coding sheet to provide researchers with consistent guidelines on classifying notes into the major topics addressed in the interviews. Initially, the coding sheet contained high-level topic areas and major themes identified by the research team after the site visit. During the coding process, the coding sheet was updated as additional themes emerged. The notes were coded by three Urban Institute researchers who participated in the site visits interviews. The researchers carefully reviewed the notes from each interview and coded participant responses to the appropriate component following the coding sheet. Major themes and subthemes were identified through a process of cutting and sorting the coded notes to compare themes by different type of interviewed stakeholder, and for comparison between the interviewees and focus groups. Divergent opinions and common experiences were summarized. Lastly, supporting quotes were selected based on relevance or frequency of a common sentiment to a major theme.

Focus group notes however, did not use the coding sheet that was described above. Instead, the Urban Institute researchers who participated in the site visits and focus groups reviewed the full set of notes and categorized participant responses in accordance to the core set of topics contained in the moderator's guide. Similarly, to the treatment of interview notes, major themes, divergent opinions and supporting quotes were all summarized within each topic area for the focus group notes. Careful review of the HELP documents obtained to support the qualitative analysis provided context and understanding of the HELP program. This understanding informed the development of interview and focus group protocols, the initial drafting of the coding sheet used for qualitative analysis of interview and focus group notes, and interpretation of findings from the interviews and focus groups as themes emerged.

Limitations

The qualitative component of the evaluation is meant to tell the story of HELP from the perspective of a range of stakeholders involved, including state officials, health care providers and provider association representatives, and HELP enrollees. While this information provides important context for understanding and interpreting the impact findings of HELP presented in section V of this report, qualitative findings presented in this section are based on stakeholder assessments of HELP and should not be interpreted as providing estimates of the impacts of HELP. Data from stakeholder interviews and focus groups offer important perspectives but the information is self-reported and therefore limited by the memory and experience of the individuals we spoke to.

[35] Devers KJ. How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research. *Health Serv Res*. 1999;34(5 Pt 2):1153-1188.

[36] Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res*. 2007;42(4):1758-1772. doi:10.1111/j.1475-6773.2006.00684.x.

Finally, while interviewees are designated as representatives of their particular stakeholder type (for example, state officials can speak on behalf of state government, and provider association representatives can speak on behalf of providers), focus group participants are not meant to be representative of all HELP enrollees, but rather provide examples from a range of HELP enrollee perspectives. Further, the focus groups provide rich details on HELP enrollees' perceptions and experiences, but they do not provide full representation of enrollee feedback on the demonstration. This type of information is provided in section IV, which reports on the HELP Beneficiary Surveys.

Results

In this section we describe respondents' thoughts on the development of HELP. We first describe respondents' views of implementation, ongoing operations and enrollee experiences with HELP, including outreach, enrollment and coverage renewal, enrollee education, cost-sharing, disenrollment and assessed debt, and access to health care. We then present respondents' views how the demonstration changed and evolved between 2017 and 2018. We conclude with a discussion of stakeholder assessments of HELP. The discussion of the development of HELP is based on information reported by interviewees, including Montana officials, health care providers and provider association representatives, consumer advocates, and non-state observers, in our 2017 site visit. Focus group findings were not used in this discussion since HELP enrollees were likely unaware of how the demonstration was developed. Findings from 2017 and 2018 stakeholder interviews and the focus groups were used to inform the remainder of the analyses. When appropriate we add context based on published statistics and documents.

Development of HELP

In our 2017 site visit, interviewees, including state officials, health care providers, provider association representatives, consumer advocates, and non-state observers acknowledged that it took time and compromise to pass the Medicaid expansion in the Montana legislature. Certain program features in the HELP legislation were felt to be critical for passage, including requiring enrollees to "have some skin in the game" through premiums and copayments, having a public-private TPA plan administer program benefits, and implementing a workforce training program. In addition, stakeholders noted that it was important that the legislation provide sufficient flexibility to the state to conduct demonstration negotiations with CMS.

HELP legislation

It took time and considerable compromise among Montana stakeholders to reach consensus on taking up the ACA Medicaid expansion, according to interviewees, including state officials, health care providers, consumer advocates, and an outside observer. Interviewees readily acknowledged that the expansion "took some political maneuvering" and had to be analyzed not as a "pure policy problem but as a political problem" to pass in the Montana legislature. Stakeholders said the legislature worked to pass expansion in two consecutive sessions, 2013 and 2015.[37] Democratic Governor Steve Bullock was

[37] The Montana legislature meets for 90 days every other year.

described as advocating for a "pure" or "straight" Medicaid expansion during the 2013 legislative session, but the measure failed by one vote.

Essential program features required for legislation to pass

Interviewees across the board, including state officials, health care providers, provider association representatives, and consumer advocates, stated that covering low-income, uninsured Montanans was the main goal of HELP, but they also said several program features were critical to the legislation that ultimately was enacted. One was ensuring that HELP enrollees had "some skin in the game," which was accomplished by imposing financial and personal responsibility through copayments, premiums, and the risk of program disenrollment for failing to pay premiums.

During our 2017 site visit, a range of stakeholders, including state officials, health care providers, provider association representatives, a consumer advocate, and non-state observers, said having a TPA plan deliver health care services was critical to getting the HELP legislation enacted because it provided a public-private approach. As several interviewees, including state officials and consumer advocates explained, a TPA plan was something that "legislators and policymakers were comfortable with" because a comparable arrangement had long been used in Montana's CHIP program, which is generally well regarded in the state. In addition, including the TPA plan was a "quasi-private market" solution that was "politically palatable." One consumer advocate interviewee described the TPA plan as a "creative" compromise because it appealed to stakeholders who wanted to "contain the growth of government," as well as to those who wanted to keep HELP from becoming only a private-market endeavor. The TPA plan also provided the state with a large preexisting provider network, which health care providers and state officials said helped with the demonstration's rapid implementation.

Another feature many stakeholders, such as state officials, health care providers, and consumer advocates, said was critical to getting the HELP legislation enacted was the inclusion of HELP-Link. A voluntary workforce development program, HELP-Link was established with the passage of the HELP legislation to provide able-bodied HELP enrollees with job training and skills. A primary goal of HELP-Link is to raise HELP enrollees' income to reduce long-term dependence on Medicaid. Importantly, no Medicaid funds are used to fund HELP-Link; instead, it is financed solely with Montana state revenues.

Finally, a health care provider interviewee commented that it was a "really fine line" to craft legislation that would pass in Montana but "not be so far off the intent [of the ACA] that it would still be granted a waiver." Stakeholders also said that it was critical that the legislation "give the governor negotiating room [with CMS] on the waiver." For example, the HELP legislation called for all enrollees to pay premiums, but during demonstration negotiations CMS required Montana to eliminate premiums for those with incomes at or below 50 percent FPL and other groups, according to state officials. Also, during demonstration negotiations, CMS required Montana to add the premium credit to the demonstration.

Implementation, Ongoing operations, and Enrollee Experiences with HELP

In this section, we discuss implementation and ongoing operations of HELP and enrollee experience with the demonstration, examining six major program areas: outreach, enrollment and coverage renewal, enrollee education, cost-sharing, disenrollment and debt assessment, and access to health care. Both site visits revealed that HELP has enjoyed widespread support and appreciation since the demonstration

was first launched and which continued into 2018. This sentiment was expressed by all participants in the focus groups and across all stakeholders we spoke with. At the same time, some implementation glitches and targeted concerns about the ongoing operations of the demonstration were noted by both interviewees and focus group participants.

Outreach

When Montana launched HELP on January 1, 2016, a robust and coordinated outreach effort was mounted by the state, community organizations, and providers. A range of strategies were used to publicize HELP, including advertising campaigns and direct one-on-one outreach to prospective enrollees. By 2018, however, publicity campaigns for HELP by the state were reported to have stopped but interviewees and focus group participants said that outreach by enrollment assisters at federally-qualified health centers (FQHCs), financial counselors at hospitals, and state staff at local Offices of Public Assistance (OPAs) continued.

State and private organizations active in initial outreach for HELP

Early on in the demonstration, many private organizations and the state engaged in outreach to potential enrollees and providers about the availability of HELP coverage. For example, in 2017 several interviewees, including state officials and consumer advocates mentioned the TPA plan ran television, radio, and social media advertisements announcing the HELP program, and provider interviewees said hospitals, too, paid for ads. The Montana Primary Care Association (MPCA) was described by several interviewees, including health care providers and provider association representatives, consumer advocates, and an outside observer, as being a major player in publicizing HELP. MPCA created a website for consumers (www.coverMT.org); advertised on billboards, social media, and radio; and created and mailed brochures to providers to give to patients. Meanwhile, Montana Medicaid sent direct mailings and computer-dialed follow-up calls to individuals it had assessed likely to be eligible for Medicaid, based on income data from Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) programs. Montana Medicaid also sent letters to FQHCs that used national survey data to identify the number of potentially eligible individuals in their county. They also facilitated informational meetings with external stakeholders such as hospitals to educate them about the availability of HELP coverage.

How enrollees learn about HELP

When we asked HELP enrollees in our focus groups how they learned about HELP, in both 2017 and 2018 they most often reported hearing about the program when receiving assistance enrolling in other social services programs, like food stamps (SNAP), cash assistance (TANF), or publicly funded insurance for their child (through Medicaid/CHIP), often at their local OPA office. Several focus group participants also said providers or staff at health centers or hospitals referred them to HELP. Some also said they found out about HELP on their own, either on healthcare.gov or the state's Medicaid website. A minority heard about it from family and friends or outreach from the state or the local media.

Enrollment and Coverage Renewal

Most participants in our focus groups in both 2017 and 2018 said the HELP application process was easy to complete and most commonly enrolled in the program through one of the local state-operated OPAs,

a health care provider or online. Focus group participants found renewing coverage even easier, involving mailing back a form informing the state of any changes to an enrollee's income or other circumstances. However, we did hear more about enrollment problems in our 2018 focus groups among participants who had an issue or had a question about enrolling in, maintaining, or reactivating HELP coverage. Several focus group participants said they had to drive long distances to find an open OPA or had waited on hold for hours to speak with an OPA staff member (through the Montana Public Assistance Help Line).

Enrollment in HELP

Most focus group participants in both 2017 and 2018 reported they found the HELP application straightforward, as one participant put it, "I knew I was eligible right away, and then I got a card a few weeks later. It was the easiest thing I ever got from the government." Focus group participants reported using various methods to enroll in HELP coverage, including applying online through healthcare.gov or apply.mt.gov. As one participant shared, "2016 is when I signed up, through the government health care website, because they were making you pay if you don't have health care, so that was the main reason I signed up. So I put my income in there, and it said I was eligible [for HELP]."

Other focus group participants said they enrolled at a hospital or FQHC, often with assistance from staff. For example, one focus group enrollee said, "For me, I basically got signed up by one of the nurses when I had a heart attack. I was having a serious health problem and didn't have insurance at the time…They filled everything out while I was sitting there in the hospital." Another participant reported, "I went through [an enrollment assister at the health center] and I didn't have to turn anything in. She just did it all on the computer. [It took] 20 minutes."

Several focus group participants said they were asked if they wanted to apply for HELP during the application or renewal process for their participation in other government programs, such as food stamps or CHIP. For example, one focus group participant shared, "During a recertification for food stamps, they sent me a letter saying I could be eligible for the new expansion… They sent me a letter saying all I had to do was just put an 'x' in the box saying I wanted it, and I got it." Other participants reported OPA staff assisted them with enrollment, such as one participant who said, "[The office of public assistance] did all the work for me. They had all my information, so they transferred [all of it] to Medicaid. I had my answer in three to four days—it was very fast—and the rest is history."

HELP eligibility determination

A consistent problem reported in both 2017 and 2018 by focus group participants and health care providers was the length of time it took the state to make an eligibility determination for HELP and for enrollees to get their insurance identification card in the mail. In our 2018 focus group, participants said the time it took to get their HELP insurance identification card after submitting their application ranged from days to weeks, or sometimes even a month or two. Several focus group participants volunteered that their health care providers would look up whether they had HELP coverage online and treated them even if they did not yet have a card. While keeping within the federal required 45-day limit,[38] state officials acknowledged that processing Medicaid applications was taking longer than they preferred.

[38] 42 CFR §435.912

Though a hiring freeze had previously prevented the Montana Department of Public Health and Human Services (DPHHS) from replacing departed staff, one state official in our 2018 site visit told us they had recently received approval to hire more staff, which may speed up HELP application processing.[39]

State budget issues and enrollment

OPA staff help individuals enroll in social service programs, including Medicaid, and have played a significant role in enrolling people into HELP, according to several interviewees, including health care providers and consumer advocates. Because of budget matters and closure of some OPAs, fewer state staff were available in 2018 than in earlier years to help people encountering issues when enrolling in, trying to maintain, or reactivating HELP coverage. This was a major concern for focus group participants in 2018 but not in 2017. Some HELP enrollees in our 2018 focus groups, for example, commented that it has become more difficult to obtain assistance from OPAs due to the closures. Participants described scenarios that prompted them to call or try to meet with OPA staff about HELP coverage, some of which occurred after they were already enrolled in the HELP and needing help to find out how to pay their premiums, for example. Focus group participants reported that multi-hour hold times, sometimes up to four hours, can occur on the OPA-staffed helpline. For example, one focus group participant said, "When I first got on [HELP], it was easy to get a hold of a person [same] day, within 30 minutes. Then… they changed their phone system… It took me four hours of being on hold and no one talked to me, so I was like, 'I guess I lost that game.'" Another participant shared, "I called once and I waited for hours and hours, and I still didn't get anybody. I don't have that kind of time." A few focus group participants reported unreturned voicemails. For example, one participant said, "I hate calling the call center. It took them two weeks to get back to me… I called them every day."

Since only state staff can process Medicaid applications in Montana, closed OPAs meant some potential Medicaid enrollees, particularly in more rural areas of the state, no longer have access to local, in-person enrollment help. Despite these challenges, enrollment growth in HELP continued to be strong: between September 2017 and September 2018, HELP enrollment grew 15 percent, from 83,373 to 96,108 enrollees.[40] The state is aware of these issues, and one state official told us they were recently authorized to hire more OPA staff, which should increase HELP enrollees' access to staff assistance.

HELP renewal

In a typical month in 2017, about half of HELP enrollees up for redetermination renewed their coverage.[41,42] The vast majority of enrollees up for renewal did not renew on time because they either did not

[39] Notwithstanding the interview and focus group feedback that was provided, based on data compiled by the Centers for Medicare and Medicaid Services, for the time period of February to April 2018, Montana was processing 40 to 60 percent of its MAGI applications in under 7 days.

[40] "HELP Enrollment by Month," DPHHS Montana Medicaid Expansion Dashboard, October 4, 2018.

[41] "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Second Demonstration Year", data produced in Appendix B of the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

[42] Note that the State of Montana has made 2018 HELP program data available in its Annual Report for Demonstration Year 3. However, the state found issues with the computations of the monthly reporting measures, which were still in the process of being corrected at the time of writing this report (June 2019).

complete renewal paperwork in time to renew coverage, did not complete paperwork properly, did not provide required documentation or were lost to follow-up.[43]

Among HELP enrollees in both our 2017 and 2018 focus groups who had gone through at least one coverage renewal, most said the process was simple. (Because our focus groups were comprised of individuals currently enrolled in HELP, we do not know about the coverage renewal experiences of people no longer enrolled in the demonstration). Most reported receiving a letter containing their personal and income information that asked them to indicate if anything had changed and to mail back their response. For example, one participant reported, "They sent me a packet of paperwork to renew… They just wanted an update on if my information has changed, financial or otherwise, and I filled it out and sent it back to them." There were other focus group participants who reported not needing to do anything to renew their coverage, such as one participant who shared, "I just get letters saying that they renewed it… It is an automatic renewal."

Some participants said they needed to complete a telephone interview with OPA staff to finish the process. Though many said the interview was brief and easy, others said it was sometimes inconvenient and could take time to set up an appointment. For example, one focus group participant shared, "[The phone interview] is at their convenience is the only problem. So if you're working and they call back, you have to take the call. It took about 15 minutes. They have all of the information… they just want to know [if] anything has changed."

Enrollee Education

Since implementation of the demonstration, enrollees report having received limited education about how HELP coverage works. Many HELP enrollees in our focus groups in both 2017 and 2018 said that information they are provided with on how the program works was lacking. When asked how HELP could be improved, focus group participants most often mentioned that they wished they had been given more information about the program. External stakeholders, including health care providers and consumer advocates, also felt more enrollee education is needed. Though Montana officials in our 2017 site visit maintained that enrollee education was sufficient, by 2018 the state had started working on developing strategies to improve enrollee education.

<u>Education about HELP coverage</u>

With the termination of the TPA plan in 2018, education for all HELP enrollees consists of Montana Medicaid mailing enrollees an insurance identification card and a letter with a link to a website where a "member guide" containing plan benefits is posted.[44] In 2017, Montana officials felt that this was sufficient and did not view enrollee education as a problem. They also noted that they had not received

[43] "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Second Demonstration Year", data produced in Appendix B of the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018; "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Third Demonstration Year", data produced in Appendix B of the Annual Report for Demonstration Year 3, State of Montana, March 1, 2019. .

[44] The TPA plan, before it was eliminated, did more in the way of enrollee education. Among other things, the plan sent enrollees a welcome kit, which included a welcome letter, a participant guide, and instructions on accessing an online patient portal. In addition, because all TPA plan enrollees paid premiums, the plan sometimes included information about HELP with monthly premium invoices.

a lot of questions or comments from HELP enrollees. One state official reported that nitty-gritty details such as how copays are determined were "kept away from members" because it "isn't a member's job to know" such things.

Many external stakeholders in both 2017 and 2018, including health care providers and provider association representatives and consumer advocates felt that Montana Medicaid could do more to educate HELP enrollees, although some did not view this as a priority. One health care provider felt there was "a lot more that can and should be done to help with health insurance literacy," because many people gaining coverage through HELP have never had health insurance before and do not know what words like "copayments" mean. Another health care provider commented that HELP enrollees may not have access to a desktop computer and may only be able to access the internet from a smartphone, making it hard to read the "giant PDF" on HELP benefits available on DPHHS' website. At the same, another health care provider said, "Nobody really cares how their insurance works."

HELP enrollees in our focus groups said they *did* want more information about how their coverage works. Better information about what HELP does and does not cover and better customer service were the most common recommendations from participants. As one focus group participant said, "Tell us more about what's covered. Access to someone who can answer questions would be a good thing."

At the time of our 2018 site visit, Montana was working on strategies to improve enrollee education. As one state official acknowledged that "for a while, [enrollee] outreach was not [the state's contractor]'s priority," but the state has now directed its contractor to reallocate resources toward beneficiary education. This state official described several ways Montana is working to improve enrollee education, including:

- having its contractor call new enrollees at more convenient times (between the hours of 3 to 6 pm rather than midday) to tell them about their benefits and cost-sharing requirements and ask if they have any questions;
- having its contractor update a video on the DPHHS website describing enrollees' benefits to make it more engaging;
- revising language in enrollee notices the state mails so that they are easier to understand; and
- hiring a new employee to focus exclusively on Medicaid enrollee education.

Cost Sharing

HELP includes copayments for all enrollees and premiums for those with income above 50 percent FPL who are not exempt. Stakeholders universally viewed HELP premiums as affordable, and enrollees in focus groups agreed that premiums were affordable and fair. However, HELP administrative data indicate that many enrollees do not pay their pay premiums, suggesting that premiums may be challenging for some. Many 2017 interviewees, including state officials, health care providers, and provider association representatives, and focus group participants reported that, except for pharmacies, providers did not actively bill for copayments. In 2018 we heard a mixed story: Though most health care providers and provider association representatives again said that copayments were still not generally being collected in 2018, some focus group participants and other health care providers and provider association representatives reported otherwise.

Level of HELP premiums

State officials felt that HELP premiums were affordable. Given the strong enrollment in HELP, officials highlighted that premiums at 2 percent of income were less of a barrier than they had expected. As one state official put it, "We expected a lot more disincentive [to enroll in HELP] because of the premium." Focus group participants in both 2017 and 2018 similarly felt that their monthly premiums were fair and affordable. (Given focus groups and surveys consisted of HELP enrollees who at the time were enrolled in the program, we do not have the perspective of people who are eligible for HELP but decide not to enroll because of the cost of the premiums). Some focus group participants reported it was cheaper than what they had been paying for other coverage before, such as one who shared, "[The premium] is more than fair. I was paying $1,200 for COBRA!" Another focus group participant said, "Way before Obamacare, I used to pay $75 a week [for health insurance] … so I quit carrying it… because I couldn't afford it. I played insurance roulette for years… but I lucked out that the bullet never went off. I was young and really didn't care. Now I pay $24 a month." In addition, enrollees in the focus groups who were paying their premiums said they were happy to be contributing, as one participant put it, "I felt grateful because I feel like I should be paying something. They could charge me four times as much and it would still be half of what I was paying before. I would gladly pay more because I want to do my part."

At the same time, some enrollees in our focus groups reported difficulty making their monthly payments. For example, one 2018 focus group participant shared, "I thought a $20 premium was a little high when I was unemployed." Several focus group participants also reported falling behind on their premiums at times due to inconsistent or lost invoices, such as one enrollee who shared, "They didn't send me my invoice for three months, and then they sent it all at once and I paid it all. And my coverage kept going." Another focus group participant reported, "I didn't even know I had to pay; I thought it [HELP] was free. I didn't get any emails or anything… but according to them, I had fallen behind five months. I didn't lose my coverage… I paid, and I'm fine now."

Like these examples, nearly all focus group participants who reported being late in premium payments did not experience interruptions in coverage. This could be because disenrollment only applies to HELP enrollees with incomes above 100 percent of FPL (Table II.3). It could also be because HELP has several exemptions to disenrollment. Focus group participants appreciated the 90-day grace period to pay past due premiums before being disenrolled. As one 2017 focus group participant said, "The back of my card says you can be up to 90 days past due before they'll do anything; I used that to my advantage. There have been…. months when I couldn't pay [my premium], and I made up for it the following month. I appreciated that they didn't kick me off after just one month not paying."

Program administrative data suggest that paying monthly premiums is challenging for many HELP enrollees, particularly those with the lowest incomes. In December 2017, for example, HELP data show that among the 20,050 enrollees who owed premiums, roughly half (45.1. percent) paid them that month. For enrollees with income between 51 and 100 percent FPL 42.3 percent paid their premiums

for the month, whereas 49.1 percent of those with income above 100 percent FPL paid.[45,46] This share of enrollees paying their premiums in the month for different income levels was consistent throughout 2017.[47]

Administrative complexity of HELP copayments

As described in Section II, two copayment schedules are used in HELP: a flat copayment fee for those at or under 100 percent of FPL and a percentage of the state's reimbursement to the provider for those above 100 percent FPL (Table II.2). State officials said implementing the variable copayment has been challenging: "An operational nightmare…. [causing] more work and more difficulty," according to one state official. Since providers do not know enrollee income, the state must determine which copayment schedule should be applied to a claim. In addition, to comply with federal requirements and provide enrollee protection, the state tracks whether an enrollee has reached the quarterly 5 percent aggregate household cap in order to identify whether a copayment can be imposed. Because of these programmatic features, providers are not permitted to collect copayments at the point of service, which had been a long-standing part of Montana's traditional Medicaid program, but instead must send the enrollee a bill to collect any copayment. State officials (2017) and health care provider association representatives (2018) said pharmacists are the single exception because they typically have systems capable of billing in real time, and the same copayment level for prescription drugs applies to all enrollees regardless of income.

Provider billing for copayments from HELP enrollees

Provider association representatives and health care providers, including leaders of hospitals and FQHCs said they generally do not bill HELP enrollees for copayments, or only send bills if the amount owed is above some threshold. One health care provider in 2017 explained that they write off a bill if it is less than $4.99 in a 30-day billing cycle; if the amount owed exceeds that during the period, they will bill. A provider association representative said, "[HELP] copays are just a pain. They're just symbolic." Another health care provider said that HELP copayments are commonly referred to as "the faux pay." Accordingly, this same interviewee explained that HELP enrollees also qualify for the facility's financial assistance program, "so we don't even ask [HELP enrollees] by the very fact that they have a Medicaid card." It becomes part of our charity care and is written off, this interviewee explained. Some focus group participants were aware of write offs, such as one participant who reported, "My shot [copay] was $4. I said, 'Do I owe you guys anything?' and they said, 'No, we wrote it off.'"

Though most (estimated to be about 85 percent by one state official) Montana physicians are employed by hospitals, independent providers do not have a write-off option available to hospital physicians. For

[45] "HELP Program 1115 Waiver: Quarter 4 Measures December 2017 Data," data produced in the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

[46] Note that the State of Montana has made 2018 HELP program data available in its Annual Report for Demonstration Year 3. However, the state found issues with the computations of the monthly reporting measures, which were still in the process of being corrected at the time of writing this report (June 2019).

[47] "HELP Program Demonstration: Section 1115 Waiver Annual Report Year 2 (2017)," State of Montana, August 8, 2018.

independent physicians, not collecting copayments from HELP enrollees is "bad debt," as one provider association representative explained.

Montana officials were aware that providers are not generally billing enrollees for copayments and aware of the difficulty providers have with collecting them. As one state official said, copayments are "providers' biggest issue with [HELP]." At the same time, Montana officials said that collecting copayments is providers' responsibility and that eliminating copayments and having Medicaid pay the full amount to providers would be a "huge cost to the state," as one official put it.

While health care providers said they tend not to bill enrollees for copayments, several focus group participants in 2018 said they had been invoiced for these payments, a departure from what enrollees shared in our 2017 focus groups. In part the difference may be due to our purposefully overpopulating 2018 focus groups with higher-income HELP enrollees (who face the more substantial copayment schedule) to assess how enrollees were affected by the elimination of the TPA plan. It could be that copayments owed by this group were sufficiently high enough that providers billed them.

When copayments were required, most focus group participants said they were affordable, such as one participant who said, "I think they're fabulous. I went to the dentist and paid $4. I got medical tests at the doctor and it was $16. Our total copayment bill was $45, and they said pay however much you can or whenever you can. It was really flexible." Another participant shared, "I get copays… for my therapy. I go every week and it is $4. Compared to what I was paying, yes, [it's affordable]. I was paying $15-$20 every week." Only one focus group participant in 2018 reported copays created a barrier to receiving care, saying, "If I don't have [money for the copay], I don't go [to the doctor], which is why I am in pain right now. It's just not in the budget."

Emergency room copayments for nonemergent care

Though Montana originally intended to charge an $8 copayment for nonemergent emergency room use, it was not implemented. As one state official explained, "We did a cost-benefit analysis to see where we would financially land on how much it would take to administer [the copayment for nonemergent emergency room care] … compared to what it would recover, and how much [the] appeal process and burden on the hospital to be labeling and marking [patients]—and it did not pan out. We looked at this twice." State officials also noted that emergency room use has not materially changed over time under HELP. But, as one health care provider observed, without implementing the emergency room copayment a perverse incentive has been created: HELP enrollees who go to their primary care provider can be charged a copayment for that visit but if they instead go to the emergency room there is no copayment.

Disenrollment and Assessed Debt

Disenrollment of nonexempt enrollees from HELP for failing to pay premiums has been consistently low but program administrative data show that a sizable minority of HELP enrollees have accrued debt owed to the State of Montana because of past due premiums.

Disenrollment from HELP for failure to pay premiums

Disenrollment from HELP for not paying premiums was low in 2017. In December 2017, only 2.5 percent of premium paying enrollees with income above 100 percent of FPL, a group subject to disenrollment provisions for failing to pay premiums, were disenrolled for not paying their premiums.[48,49] At the same time, half (49.1 percent) of enrollees with income above 100 percent FPL paid their premiums in December 2017[50] The low disenrollment rate could be partly attributed to HELP's many disenrollment exemptions. Only one of our focus group participants in 2017 and two in 2018 had experienced disenrollment from HELP for not paying their premiums, including one who shared, "I had to start paying [premiums], and then I didn't pay, and I got behind. They gave me the boot I guess, but they took it out of my taxes.[51] But then I went recently, I think it was in January, and I reapplied and they just gave me Medicaid back."

Assessed debt for past due premiums

While disenrollment from coverage is low, a sizable share of HELP enrollees has accrued debt owed to the state because of past due premiums. As explained in Chapter II, any unpaid premiums incurred by nonexempt enrollees are considered a debt owed to the State of Montana. After a 90-day grace period, the Montana Department of Revenue sends a debt notice (which can take no more than 90 days) to enrollees who fail to make premium payments informing them that a portion of their next state tax refund will be withheld to pay their overdue HELP premiums.[52] December 2017 data show that more than a quarter (27.5percent) of HELP enrollees who owed premiums that month also had collectible debt owed to the State of Montana. Of those with collectible debt, 75.3 percent had income below 100 percent of FPL.[53,54]

[48] "HELP Program 1115 Waiver: Quarter 4 Measures December 2017 Data," data produced in the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

[49] "HELP Program 1115 Waiver: Quarter 3 Measures September: Note that the State of Montana has made 2018 Data,"HELP program data available in Annual Report for Demonstration Year 3, State of Montana, March 1. However, the state found issues with the computations of the monthly reporting measures, which were still in the process of being corrected at the time of writing this report (June 2019.).

[50] "HELP Program 1115 Waiver: Quarter 34 Measures September 2018December 2017 Data," data produced in the Annual Report for Demonstration Year 32, State of Montana, March 1, 2019August 8, 2018.

[51] This participant is likely referring to a provision under HELP that allows the State of Montana to deduct past due premiums from an individual's state tax refund.

[52] "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," State of Montana, approved November 2, 2015. See Attachment B—MT HELP Demonstration Operations Protocol.

[53] "HELP Program 1115 Waiver: Quarter 34 Measures September 2018December 2017 Data," data produced in the Annual Report for Demonstration Year 32, State of Montana, March 1, 2019.August 8, 2018.

[54] Note that the State of Montana has made 2018 HELP program data available in its Annual Report for Demonstration Year 3. However, the state found issues with the computations of the monthly reporting measures, which were still in the process of being corrected at the time of writing this report (June 2019).

Access to Care

Interviewees across the board, including state officials, health care providers, provider association representatives, and consumer advocates, and focus group participants said that HELP provides good access to health care services, despite the cutbacks in Medicaid dental and vision care services.

Access to core health care services

HELP enrollees in focus groups generally reported good access to services, perhaps because most providers in Montana accept Medicaid.[55] As one focus group participant shared, "My [access] has been really good. [HELP] has been accepted everywhere." Participants in our focus groups also told us they visit the doctor more often since enrolling in HELP, seeking care before health issues turn into medical emergencies. For example, one focus group participant said, "I go [to the doctor] twice a year now, but before I had insurance I would not go at all unless it was severe." Enrollees in our focus groups also said they obtain more preventive and dental services than before and were highly satisfied with their access to health care. As one participant reported, "You get the help you need. I hadn't had a teeth cleaning in 11 years until I got [this coverage]. That was really nice. It felt good to be able to do that." According to state data, as of December 2017, the most commonly used preventive services were dental care, followed by cholesterol screening and wellness exams.[56]

Interviewees, including state officials, health care providers, and provider association representatives agreed that a high share of HELP enrollees use preventive services. As further evidence that HELP provides enrollees good access to care, interviewees highlighted that emergency room use for nonemergent and general emergency room use has not increased with the implementation of HELP. Some interviewees, including provider association representatives and health care providers, however, did cite difficulties accessing primary care in rural communities and specialty services. Participants in our focus groups echoed this sentiment, such as one participant who shared, "Not everyone you need is in Livingston. If you have to see a specialist, you have to go to Billings, Bozeman, Helena." Provider association representatives reported these problems can be attributed to an inadequate supply of both primary and specialty care providers in the state, as opposed to being a HELP or Medicaid-specific issue.

2017 reductions in Medicaid benefits

As mentioned previously because of state budget issues, Montana implemented benefit reductions for the Medicaid program, including for HELP demonstration enrollees, in November 2017. Chief among the reductions were the elimination of some adult dental services (e.g., crowns, bridges, and dentures) and the shift from annual to biannual eye exams and glasses.[57] Focus group participants said they had been affected by recent reductions to Medicaid benefits. In particular, several expressed concern over the reduction in covered dental services and new limits to vision services. Several said they had already

[55] Kelly G. "Medicare and Medicaid Participation Rates for Doctors by State", *MD Magazine,* October 19, 2016, https://www.mdmag.com/physicians-money-digest/columns/the-doctor-report/10-2016/medicare-and-medicaid-participation-rates-for-doctors-by-state.

[56] "HELP Program Demonstration: Section 1115 Waiver Annual Report Year 2 (2017)," State of Montana, August 8, 2018.

[57] "Montana Healthcare Programs Member Notice", MT DPHHS, February 13, 2018, https://dphhs.mt.gov/Portals/85/hrd/documents/MemberNotice021318.pdf.

incurred large out-of-pocket costs, such as one participant who shared, "There were a lot of things that they took away. They took away a lot of dental stuff. I'm trying to pay for a root canal, and my poor dentist is getting $25 a month because we're going in the hole. I had to take money out of my retirement fund from when I was working just to pay the bills." Other enrollees in focus groups reported they had forgone needed care because of these benefit reductions. For example, one participant said, "With dental, some procedures weren't covered, so I just didn't get those procedures. I couldn't afford them, like root canals and crowns." Another focus group participant shared, "I can get my prescription at the eye checkup, but I can only get glasses every two years, but as a diabetic, my prescription changes every year."

12-Months Continuous Eligibility

State officials, health care providers and a health care provider association representative felt that offering 12-month continuous eligibility to HELP enrollees has been very helpful in providing stabilizing coverage and improving continuity of care, particularly for preventive care services. As one provider said, "I think that's [12-month continuous eligibility is] super super helpful…. because that in and out of coverage is really difficult to track from our perspective as to maybe I'm scheduled for surgery and maybe it's next month, and I lost my coverage but when I scheduled it I had coverage." Another provider noted the importance of continuous eligibility for seasonal workers, "Continuous eligibility is super important for folks who [are] low income, who are right on the [income eligibility] line. We see that all of the time. And it's just so challenging, especially in Montana where we have so much seasonal employment. We have so much [income] fluctuation."

Apart from providing better continuity of care and health care for enrollees, state officials said offering 12-month continuous eligibility seen as way to save on demonstration administrative spending: With 12-month eligibility, it takes fewer eligibility administrative staff to implement and maintain the eligibility function for HELP. As one official said, 12-month continuous eligibility has been "cost neutral if not beneficial…Very happy we did continuous eligibility. Frees them [state staff] to do one-time enrollment because you don't have people going on and off."

Stakeholder assessment of the effects of HELP

In our 2018 site visit, several interviewees, including state officials, health care providers, and provider associations representatives, noted that recently available data and reports suggest that HELP has achieved many goals stated in Montana's 2015 demonstration application, including increasing access to high-quality health care, encouraging Montanans to take greater responsibility for their health, reducing hospital uncompensated care costs, and boosting Montana's economy.

Enrollee access to health care and health

Many interviewees said the biggest achievement of HELP was providing coverage and access to health care to "100,000 lives in a state of a million people," as one state official put it. Enrollment was "way more than we anticipated," another state official highlighted. Correspondingly, several interviewees, including state officials, health care providers, provider association representatives, and a consumer advocate, noted the decline in Montana's uninsured rate, which dropped from 23.6 percent in 2013 to

16.5 percent in 2017 for nonelderly adults (18 to 64 years).[58] With the launch of HELP and associated expanded coverage, interviewees, such as state officials, health care providers and provider association representatives, also emphasized the number of enrollees using preventive services. In September 2018, the state reported that more than 85,000 demonstration enrollees had received preventive care since HELP began.[59] HELP was also credited with allowing the state to expand substance use disorder (SUD) services and helping rebuild the state's behavioral health care systems, which one interviewee said was "critically needed." As one state official explained, with HELP, many individuals now access SUD treatment services through Medicaid, which allows the state to use block grant funds for SUD prevention rather than SUD treatment.

Several participants in our focus groups reported that having HELP coverage and access to health care lead to improvements in their health which allowed them to be more productive, such as one focus group enrollee who said, "It has made me healthier and able to work." Another participant reported, "I've gotten more work done in the last four years than I have in all my life. Before I had this insurance, I had nothing, all my life basically. I couldn't afford to have it." Other enrollees in the focus groups shared that HELP has allowed them access to needed care that they previously could not afford, such as one focus group enrollee who said, "It has made a huge difference for us. We would not have been able to afford care… Without it, I might not be here. It has been lifesaving." Another participant shared, "I was letting my dental care spiral out of control because I couldn't afford it. [This care] got me back on track, health wise." Finally, several focus group participants shared that having HELP coverage "gives a sense of security and peace of mind," such as one participant who said, "It has changed my life. It makes me feel good that if I need to go see a doctor for something, I know I can instead of blowing it off."

Enrollee engagement in health care

Some state officials suggested that HELP has been successful in getting enrollees to take responsibility for their health care, highlighting the number of enrollees receiving preventive care, how much has been collected in premiums, and the demonstration's low disenrollment rate as indicators of engagement. However, several interviewees, including other state officials and a consumer advocate, felt it was too soon to make this assessment. As one state official observed, having the experience in HELP "will help [enrollees] when and if they go onto other insurance… but I think, right now, we are so early into [coverage]." In the first year of the demonstration, many enrollees "weren't ready to be engaged in their health care. They just needed their health care to be taken care of for the first time... but now as they have been able to stay on, they have really started taking a focus on their own and changing their life." Focus group participants said that with the coverage afforded by HELP they have been able to obtain health care services much more frequently than in the past. As one participant put it, "I go [to the doctor] twice a year now, but before I had insurance I would not go at all unless it was severe." Another

[58] "2011 to 2015 American Community Survey 5-Year Estimates for Montana", United States Census Bureau, no date (accessed June 3, 2019); "2013 to 2017 American Community Survey 5-Year Estimates for Montana", United States Census Bureau, no date (accessed June 3, 2019).

[59] "Montana Medicaid Expansion Dashboard," MT DPHHS, October 4, 2018, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

said, "I've probably been [to the doctor] 15 times in the past year. [During the previous year without insurance] I never went."

HELP and health care providers

Interviewees such as state officials, health care providers, provider association representatives, and a consumer advocate commented that HELP has benefited health care providers, particularly hospitals. One report states that, between 2015 and 2016, uncompensated care costs declined 44.9 percent, and declined further in 2017.[60] State officials, health care providers, a consumer advocate, and an outside observer also noted that funneling new resources to hospitals has especially helped stabilize some rural hospitals' finances and reduced their risk of closure. FQHCs have also benefited from HELP, according to health care providers. "Medicaid expansion has been a game changer [for us]," as reported by one FQHC executive.

HELP and state economic growth

State officials, a provider association representative, a consumer advocate and an outside observer mentioned recent studies that highlight how HELP has economically benefitted Montana.[61] Perhaps the report that has received the most attention used an economic forecasting model to predict the impact of Medicaid expansion on Montana's economy.[62] Based on that forecasting model, HELP is predicted to have brought at least $350 million in new spending to the state each year, which in 2018 is predicted to have generated $265 million in personal income and more than 5,000 new jobs.

Evolution of HELP Demonstration, 2017-2018

Elimination of TPA Plan

Effective January 1, 2018, Montana's state Medicaid plan became the only plan for HELP enrollees. When asked about the transition, enrollees in the focus groups reported that they did not experience any disruptions in coverage. Generally, focus group participants did not view elimination of the TPA as a big change, as one participant said, "I thought it was odd that there was a new card, but other than that, it didn't seem to be too different." Most recalled being notified of the changeover, but some enrollees said they were not made aware of the transition (see education section below.). In part, the lack of perceived change could reflect there was considerable overlap between the TPA plan and Medicaid's provider networks, which state officials said help to minimize disruption and to maintain enrollees' continuity of care. The state also reached out to the few providers in the TPA's provider network who

[60] "Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents," Manatt Health, June 2018.

[61] "2018 Report to the Governor and Legislative Finance Committee," HELP Act Oversight Committee, submitted August 2018; "Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents," Manatt Health, June 2018; and "The Economic Impact of Medicaid Expansion in Montana," The Bureau of Business and Economic Research, April 2018, https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

[62] The economic forecasting model used is the Regional Economic Models, Inc., which is contained in the *The Economic Impact of Medicaid Expansion in Montana* report produced by The Bureau of Business and Economic Research in April 2018.

were not in the state's Medicaid network to invite them to join Medicaid's network. If the state could not convince a provider to join the Medicaid network, it notified HELP enrollees served by this provider that the provider was no longer in network.

Transitioning TPA plan enrollees to Montana's Medicaid plan

Most interviewees, including state officials, health care providers, provider association representatives, a consumer advocate, and an outside observer, described the transition from the TPA plan to Montana Medicaid as a nonissue. State officials characterized the transition as a success, evidenced by various program measures, including seeing no real differences or gaps in HELP eligibility, continued premium payments, and limited program disenrollment. Non-state interviewees, including health care providers and one consumer advocate also recognized that the state handled the changeover well, particularly considering that the transition occurred while the DPHHS was dealing with staffing and resource cutbacks because of the state's budget crisis. At the same time, two interviewees (a health care provider association representative and a state official) said that early on in the transition there were a few issues concerning finalizing claims data and directing members' premium payments from the TPA plan to the state.

Montana state officials attributed the efficient transition to several factors, including having an existing Medicaid provider network that had extensive overlap with the TPA plan, which helped ensure enrollee continuity of care. Further, before the TPA plan was terminated the state already handled some aspects of claims processing for TPA enrollees, including prescription drugs and dental services. Thus, the state's Medicaid claims system already had some "contact" with the TPA plan enrollees which also was said to help smooth the transition.

Interviewees in our 2018 site visit, including state officials, health care providers, provider association representatives, and a consumer advocate, as well as HELP enrollees in focus groups reported no problems with the elimination of the TPA plan. Similarly, state officials said the elimination of the premium credit was without issue. Most focus group participants, however, were not aware that the premium credit had been removed in part because several did not understand what the credit was. As is discussed below, that may reflect a lack of copayments as most providers were said to not collect copayments from HELP enrollees.

Overwhelmingly, interviewees, including state officials, health care providers, provider association representatives, and non-state observers, said the budget reductions that began in July 2017 affected the HELP program and its enrollees more than the changes made through the 2017 demonstration amendment.

Bringing administration of HELP under a single entity

Most interviewees, including state officials, health care providers, and provider association representatives, stressed that removing the TPA plan and consolidating HELP into one entity simplified the administration of HELP. One state official claimed removing this "two-tiered system" in favor of a single program for service delivery made it "easier and clearer" for enrollees. Previously, as this state official explained, under the two-tiered system if an enrollee's income "go[es] up slightly you have a different customer service." Also, state officials remarked that with the elimination of the TPA plan the demonstration has become easier to manage because they now only administer one plan for all

Montana Medicaid enrollees, with HELP enrollees now in the traditional Medicaid plan, which the state has run for decades. Health care provider interviewees agreed that administration of the HELP has gotten easier from an eligibility and payment standpoint. Finally, eliminating the TPA has yielded substantial savings on program administrative costs, the reason Montana pursued the change, according to one state official. Specifically, according to this official, the state had been paying the TPA plan $25 per HELP member per month for administration, whereas the state's cost to administer its FFS plan is substantially cheaper, about $5.50 per member per month.

Enrollee education and outreach and elimination of the TPA plan

The state sponsored some special one-time enrollee mailings to educate HELP enrollees affected by the TPA plan elimination. The month before the handover, the state mailed out new insurance identification cards to HELP TPA enrollees who would continue to be eligible for coverage in 2018, along with a notice that their benefits would remain largely unchanged.[63] Montana also hosted conference calls for Medicaid enrollees to share their questions, which a state official said were well attended. In addition, the state offered in-person meetings for enrollees, but these were not well attended, according to state officials. The state also distributed a "frequently asked questions" document to staff in local OPAs. In addition, DPHHS' updated its website to reflect program changes. Meanwhile, the TPA plan included a notice with invoices mailed to HELP enrollees starting three months before the handover took place on January 1, 2018. TPA plan staff reported getting only a few calls from enrollees about these notices. Montana's FQHC association also educated enrollment assisters at health clinics about the forthcoming transition so they could talk with HELP enrollees about any changes to their coverage.

While Montana officials felt enrollee education about the elimination of the TPA was effective, enrollees in our focus groups did not understand why the change occurred. Several participants reported that they were sometimes unclear on changes being made to the program. Most participants who had been enrolled in the TPA plan said they remembered receiving a letter informing them of the change, but also said that the letter had no information about what the implications were for them. For example, one focus group participant said, "[They] didn't explain anything. They just said [the TPA] was ending the program and we are switching to someone else." Another participant shared, "I do remember something when it changed that freaked me out. They sent out a thing that said we were no longer covered, and then they sent another thing saying we were covered now by another thing. I don't remember exactly."

By 2018, the state was no longer actively purchasing advertising to promote the availability of HELP coverage though it continued to make Medicaid eligibility information available on its website. In response, Montana health care providers and provider association representatives said were they doing more outreach for HELP. This included training patient financial counselors to advise patients about websites with information on HELP (e.g., healthcare.gov or the Montana's Medicaid webpage), and directing patients to enrollment assisters at FQHCs. Local OPAs also have continued to perform some HELP outreach, according to interviewees and focus group participants.

[63] "Montana Medicaid Expansion Changes for Members," MT DPHHS, no date (accessed December 7, 2018), https://dphhs.mt.gov/Portals/85/hrd/documents/helpplan/MemberStufferAExistingMembers.pdf.

Termination of Premium Credit

The other major design change included in the 2017 demonstration amendments was removing the premium credit from the demonstration. Under the credit, TPA enrollees received a premium credit equal to the amount of premiums they paid during a calendar quarter that could apply toward any copayments incurred over the quarter. Interviewees, including state officials and an outside observer, said the premium credit was difficult to administer. For one, it required continuous tracking by the TPA of how much each enrollee had paid in premiums and copayments incurred as well as ensuring the 5 percent cost-sharing limit per enrollee was maintained. One interviewee noted that the TPA had the technology capabilities to support this level of tracking but not the state. With the elimination of the TPA and with all premium-paying HELP enrollees transitioned to Montana Medicaid plan, the state asked to eliminate the credit. As a Montana state official said in a 2017 interview, the credit was eliminated because it was "amazingly administratively inefficient for not a lot of gain—difficult for clients to understand and for us to administer."

State officials interviewed expected some complaints from enrollees about the elimination of the premium credit, because enrollees now go "right into the copay" without the protection of the credit, but that did not occur, according to officials. This could be partly explained by a lack of copayments, as most providers were said to not collect copayments from HELP enrollees (see below). Consistent with that, focus group participants who had been enrolled in the TPA plan expressed confusion over what the premium credit was, and many also said they had not noticed that it had been removed from the plan.

Montana's Budget Situation and HELP

State officials, health care providers, provider association representatives, a consumer advocate and an outside observer said general changes to Montana's Medicaid program and other state agencies had a more significant effect on HELP than terminating the TPA or eliminating the premium credit. In response to declining revenues, Montana reduced state government spending, including that for the DPHHS, beginning in July 2017.[64] Another wave of reductions occurred in November 2017.[65] As one state official interviewed in the 2018 site visit said, between 2017 and 2018, the "biggest impact [on the demonstration] has been our [general Medicaid] cuts to services," not eliminating the TPA or premium credit. Among the cuts made to Montana Medicaid, including HELP, was a 2.99 percent cut to provider reimbursements and reduced dental benefits. Though Medicaid, and, therefore, HELP, retained preventive dental services (e.g., cleanings, fillings, and x-rays), specialty dental services (e.g., dentures, crowns, and bridges) were eliminated. Of all the reductions and changes in the past 12 months, the dental cutbacks drew the most complaints from Medicaid and HELP enrollees, according to state officials.

Enrollees in the 2018 focus groups echoed this with many saying they had been affected by the recent cuts to Medicaid. In particular, many expressed concern over the reduction in covered dental services and new limits to vision services. Several said they had already incurred large out-of-pocket costs, such as one participant who shared, "There were a lot of things that they took away. They took away a lot of

[64] S. 261, 65th Leg., Reg. Sess. (Mont. 2017).

[65] "2017 November Special Session Fiscal Report," Legislative Fiscal Division, December 11, 2017, https://leg.mt.gov/content/Publications/fiscal/interim/Dec-2017/LFC-Special-Session-Fiscal-Report.pdf.

dental stuff. I'm trying to pay for a root canal, and my poor dentist is getting $25 a month because we're going in the hole. I had to take money out of my retirement fund from when I was working just to pay the bills." Other focus groups participants reported they had forgone needed care because of these cuts. For example, one participant said, "With dental, some procedures weren't covered, so I just didn't get those procedures. I couldn't afford them, like root canals and crowns."

With improving revenue projections as of the time of our 2018 site visit, Montana has begun backfilling some of the recent cutbacks, including reinstating provider rates and restoring specialty dental benefits effective October 1, 2018.[66]

Summary of Implementation Findings

Findings from the qualitative component of the evaluation indicate that Montana was successful in implementing the core components of HELP in a timely and effective way. Interviewees comprising state officials, health care providers, provider associations, consumer advocates and non-state observers universally viewed HELP as a major Medicaid expansion with just a few glitches. Enrollees in our focus groups agreed. Interviewees stressed the importance of compromise among health care stakeholders to reach a consensus on the design of HELP, one that could pass muster in the Montana legislature.

Initial outreach for HELP was viewed as a success in large measure because of the collaboration relationship established between the state and Montana health care stakeholders. Reflecting this, enrollment in the demonstration ramped up quickly and reached more than 70,000 within the first year—a number the state had originally projected would take four years to achieve. As of September 2018, nearly 100,000 Montanans were enrolled in HELP. Interviewees representing all stakeholder categories and focus group enrollees described access to care provided under HELP as being good, which could partly reflect that Montana Medicaid is a fairly generous payer, ranking second among states for physician payment across all services in 2016.[67] . Several focus group participants commented how HELP has improved their health and wellbeing. In addition, stakeholders universally viewed HELP premiums as affordable, and enrollees in focus groups agreed that premiums were affordable and fair. However, HELP administrative data indicate that many enrollees do not pay their pay premiums, suggesting that premiums may be challenging for some.

At the same time, interviewees and HELP enrollees in focus groups identified some issues with the demonstration. A consistent problem reported in both 2017 and 2018 by focus group participants and health care providers was the length of time it took the state to make an eligibility determination for HELP and for enrollees to get their insurance identification card in the mail. These issues could reflect the fallout from the state hiring freeze and the closure of several OPAs due to Montana's budget problems. Focus group participants and external stakeholders in both 2017 and 2018 also said that the state provides only limited education about how HELP works, with focus group participants often mentioning that they wished they had more information on the program. Though Montana officials in

[66] "Senate Bill 9 Base Budget Appropriations 2018 Biennium," Governor's Office of Budget and Program Planning, August 30, 2018, http://budget.mt.gov/Portals/29/docs/SB%209%20Appropriation%20Restoration.pdf.

[67] "Medicaid-to-Medicare Fee Index," Kaiser Family Foundation, no date (accessed December 7, 2018), https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-feeindex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

our 2017 site visit maintained that enrollee education was sufficient, by 2018 the state had started working on developing strategies to improve enrollee education.

Importantly, the work presented here is descriptive and thus does not provide definitive evidence on the impacts of the demonstration, but the qualitative findings suggest that Montana has made headway on some major goals set out for HELP. Most prominently, interviewees across the board report that HELP extended Medicaid coverage and provided good access to care to nearly 100,000 additional individuals, which is about 10 percent of the Montana's total population.

IV. Beneficiary Surveys

The purpose of the HELP beneficiary surveys is to enable the evaluation team to answer the following fundamental research questions:

- What are beneficiaries' experiences under HELP, including premiums and copays, and health care access and affordability?
- To what extent do beneficiaries understand how the HELP plan works, including premiums and copays, premium credits, and nonpayment premium consequences?
- How do experiences vary for HELP enrollees and disenrollees, and for key population subgroups (e.g., based on age, income, health status)?

To fully assess the impact of the program, SSS designed and implemented a comprehensive mixed-methods evaluation of HELP that included surveys of HELP beneficiaries who were nonexempt from the demonstration. A follow-up survey covering the period December 2017-October 2018 has been fielded, the findings from which will be presented in a follow-up report. This chapter presents findings from surveys of HELP current and former enrollees and their knowledge and experiences with the plan for the period January 2016 – November 2017.

Overview of the Survey Approach

We conducted a mixed-mode (mail and web) survey of individuals who were enrolled in the Montana HELP program as of May 2017, and another mixed-mode (mail and web) survey of individuals who had been previously enrolled but had disenrolled from that program as of May 2017. Survey questions covered five major topic areas, also called domains. Substantive domains reflecting priority policy areas include: *beneficiary understanding*, *beneficiary experience*, *affordability*, *access to care, and satisfaction with HELP*. These topics for evaluation were identified to help assess beneficiary understanding and experience in HELP across both the enrollee and disenrollee versions of the survey.

We randomly sampled 2,180 enrollees and 2,187 disenrollees from the sample frame. These sample sizes aimed to yield 700 completed enrollee and 700 completed disenrollee surveys. We targeted 700 completed enrollee and disenrollee surveys as the number of completes we would need to detect differences between sub-groups within each respondent group, although we anticipated that disenrollees would be difficult to reach and/or be less likely to respond, and that this targeted response rate would be challenging to achieve. A total of 655 individuals (30.0%) of the enrollee cohort submitted an enrollee survey form. This response rate is comparable to that seen in other surveys of Medicaid enrollees.[68] For the disenrollee survey, only 178 individuals (8.1%) in the sample returned a disenrollee survey. This low response rate may be attributable to a combination of factors including disenrollees being difficult to locate; and disenrolled respondents' status changing back to being enrolled during survey field period, thereby excluding them from answering the disenrollee survey.

Weighting of the enrollee and disenrollee survey data produced estimates representative of their respective sampling frames. In particular, we compared respondents and non-respondents on available demographic factors of sex, race, age group, urban/rural residence, and Federal Poverty Level (FPL)

[68] Barnett & Sommers, 2017; Carlson, DeVoe, & Wright, 2006.

category. For each survey, sample weights were developed to account for the probabilities of selection and to adjust for known ineligibility and nonresponse to reduce potential bias. All reported results are from analysis of weighted surveys. More information on survey methodology and design may be found in Appendix B.

Survey Administration

We conducted a mixed-mode (mail and web) survey of individuals who were enrolled in the Montana HELP program as of May 2017, and another mixed-mode (mail and web) survey of individuals who had been previously enrolled but had disenrolled from that program as of May 2017.[69]

The survey field period began in late July 2017 with an initial survey packet mailed to enrollees and disenrollees, and continued for fourteen weeks. The survey packet included a cover letter notifying them of survey selection and explaining the purpose of the survey. Also included in the survey packet were an invitation with a URL to the web version of the survey, a printed survey questionnaire, and a stamped pre-addressed return envelope. The survey fieldwork continued with additional mailings and telephone follow-up by trained interviewers through late fall 2017. We concluded the field period in mid-November 2017 and accepted web and paper survey submissions through December 2017.

Survey Sample and Response Rates

The sample frames (i.e., the lists of individuals meeting the inclusion criteria, and thus eligible to be sampled) for the enrollee and the disenrollee survey were derived from the State of Montana HELP administrative database. At the time of sample frame creation, this database contained HELP program participation records for each month during January 2016 – May 2017. Any individual who participated in the HELP program at any time during that period was included in the database.

We randomly sampled 2,180 enrollees and 2,187 disenrollees from the sample frame. These sample sizes aimed to yield 700 completed enrollee and 700 completed disenrollee surveys. We targeted 700 completed enrollee and disenrollee surveys as the number of completes we would need to detect differences between sub-groups within each respondent group, although we anticipated that disenrollees would be difficult to reach and/or be less likely to respond, and that this targeted response rate would be challenging to achieve.

A total of 655 individuals (30.0%) of the enrollee cohort submitted an enrollee survey form. This response rate is comparable to that seen in other surveys of Medicaid enrollees.[70] For the disenrollee survey, only 178 individuals (8.1%) in the sample returned a disenrollee survey. This low response rate may be attributable to a combination of factors including disenrollees being difficult to locate; and disenrolled respondents' status changing back to being enrolled during survey field period, thereby excluding them from answering the disenrollee survey.

We calculated response rates based on complete survey submissions received through November 19, 2017, where as long as the respondents answered at least one question in addition to the screening

[69] Further details about the survey methodology may be found in Appendix B.

[70] Barnett & Sommers, 2017; Carlson, DeVoe, & Wright, 2006.

questions, we considered it a response, and included all answered questions in the analysis. Particularly in light of the low response rate, we saw no reason to discard any information that was provided. Response rates for the primary questions (those not subject to being skipped based on other answers) were generally 90%-95%.

Table IV.1A-H below presents the survey data elements that are specific to the enrollee and disenrollee surveys, as well as those that overlap across both surveys. Areas of overlap included the eligibility screening questions for the survey that asked about current enrollment in the program, demographic questions, and the domains on access to care, affordability of HELP, and satisfaction with HELP.

Table IV.1: Survey domains and questions by respondent group

A. About Your HELP Enrollment

	Enrollee Survey	Disenrollee Survey
Are you currently enrolled in the "Montana Health and Economic Livelihood Partnership Plan" (also called "HELP")?	✓	✓
How long have you been enrolled in HELP?	✓	
Since you enrolled in HELP, was there ever a time you lost your coverage or were disenrolled from HELP?	✓	
About how long were you disenrolled from HELP?	✓	
Have you ever been enrolled in HELP?		✓
Were you enrolled in HELP within the last 12 months?		✓
How long ago did your HELP enrollment end?		✓
Why did your HELP enrollment end? *(I got an increase in my income and was no longer eligible for HELP; I had other health insurance available to me; I could not afford my monthly HELP premiums; I no longer wanted HELP coverage; I did not pay my premium within 90 days)*		✓
Would you try to re-enroll in HELP if you could?		✓

B. Before you enrolled in HELP

	Enrollee Survey	Disenrollee Survey
In the 12 months before you enrolled in HELP, did you have any health insurance?	✓	
How long did you have that health insurance?	✓	
What type of health insurance did you have**?**	✓	
In the 12 months before you enrolled in HELP, did you get any preventive care (such as a routine checkup, blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screening)?	✓	

C. About your HELP Plan

	Enrollee Survey	Disenrollee Survey
How well do you think you understand how your HELP plan works?	✓	
When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?	✓	
How helpful was the information about the HELP plan?	✓	
When you enrolled in HELP, did you get information or help from a customer service representative?	✓	
How helpful was the information you got?	✓	
From the time you submitted your application until your HELP coverage started, how much time did it take?	✓	

D. Experiences after Leaving HELP

	Enrollee Survey	Disenrollee Survey
After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?		✓
After you were no longer enrolled in HELP, what types of health care were you unable to get because of cost?		✓
After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?		✓
After you were no longer enrolled in HELP, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.		✓
Do you have any health insurance coverage right now?		✓
What type of health insurance do you have?		✓
How long have you had your current health insurance?		✓
After you were no longer enrolled in HELP, how long did it take you to get your current health insurance?		✓

E. Premiums and Copayments

	Enrollees	Disenrollees
How much is/was your monthly HELP premium?	✓	✓
How is/was that monthly premium paid, if at all?	✓	✓
Which of the following groups help/helped pay for monthly premium?	✓	✓
Would you say the amount of your monthly premium is/was: *(more than I can afford, an amount that I can afford, less than I can afford, not sure/don't know)*	✓	✓
In the last 6 months/while you were in help, how worried were you about not having enough money to pay your monthly premium?	✓	✓
What do you think will happen/would happen, if anything, if your monthly premium is not paid within 90 days?	✓	✓
Please tell us whether each of the following are/were a part of your HELP Plan: *(payment of any unpaid premiums within 90 days will allow me to keep my HELP coverage; payment of any unpaid premiums after 90 days will allow me to re-enroll in HELP within 12 months of my HELP plan start date; any unpaid premium balance may be collected from my future state income tax refunds)*	✓	✓
In the last 6 months/while you were in HELP, have you paid any copays?	✓	✓
In the last 6 months/while you were in HELP, would you say the amount you were required to pay for copays was: *(more than I can afford, an amount that I can afford, less than I can afford, not sure/don't know)*	✓	✓
The last time you received a bill for a copay, how was that copay paid, if at all?	✓	
How easy or hard was it to understand how HELP copays work?	✓	✓
For each of the following statements about HELP premiums, premium credits, and copays, please tell us whether each of the following are/were a part of your HELP Plan: *(monthly premiums depend on my income; copays depend on which health care service(s) I use; premium credits go toward copays owed; copays must be paid out of my own pocket once my premium credit is used up; copays will not be collected at the time of my health care service(s); unpaid premiums may be collected against my future state income tax refunds)*	✓	✓

F. Access to Care

	Enrollees	Disenrollees
In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?	✓	
In the last 6 months, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.	✓	
In the last 6 months, was there any time you needed health care but did not get it because of cost?	✓	
In the last 6 months, what types of health care were you unable to get because of cost? *(a visit to the doctor when I was sick; preventive care; a follow up visit to get tests or care recommended by my doctor; dental care; vision (eye) care; prescription drugs; emergency room care)*	✓	
As part of your HELP plan, is/was there an $8 copay for going to the emergency room for a non-emergency condition?	✓	✓
In the last 6 months/while you were in HELP, was there a time you thought about going to the emergency room when you needed care?	✓	✓
In the last 6 months/while you were in HELP, when you needed care did you go to the emergency room?	✓	✓
What was the main reason you did not go to the emergency room for care?	✓	✓

G. Satisfaction with HELP

	Enrollees	Disenrollees
Thinking about your overall experience with HELP, would you say you are: *(very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, very dissatisfied, not sure/don't know)*	✓	✓
Please tell us how satisfied or dissatisfied are you with each HELP item below: *(enrollment process; length of time for coverage to begin; ability to see my doctor; choice of doctors; coverage of health care services that I need; how copays work; cost of premiums; paying the same amount each month for premiums)*	✓	✓
For each of the following items, how does your current HELP plan compare to your previous health insurance plan? *(ability to afford my plan; coverage of health care services that I need; ability to see my doctor; ability to get health care services that I need)*	✓	

H. About You

	Enrollees	Disenrollees
Would you say that in general your health is: *(excellent, very good, good, fair, poor)*	✓	✓
What is the highest grade or level of school that you have completed?	✓	✓
What best describes your employment status?	✓	✓
What is your age?	✓	✓
Are you male or female?	✓	✓
Are you of Hispanic, Latino/a, or Spanish origin?	✓	✓
What is your race?	✓	✓
Please circle the number of people in your family (including yourself) that live in your household. Mark only one answer that best describes your family's total income over the last year before taxes and other deductions. Your best estimate is fine.	✓	✓
Did someone help you complete this survey?	✓	✓
How did that person help you?	✓	✓

Sample Characteristics

Table IV.2 shows self-reported demographic features of the 655 enrollee and 178 disenrollee survey respondents. Of the HELP enrollees, about 57 percent were female. The enrollee respondents were roughly evenly spread among age groups. Over one-third of enrollees were employed full-time, and close to 40 percent had at least some high school or had graduated from high school. The vast majority of enrollee respondents were white. With respect to self-reported health status, just over half of enrollee respondents reported being in excellent or very good health.

In the case of the HELP disenrollees, 62 percent were female. Over 40 percent of the disenrollees were between 25 and 34 years of age and approximately the same proportion were employed full-time, while one-third only had a high school education (or less). Ninety-three percent of disenrollees were white. A little over one-half of disenrollees reported being in excellent or very good health.

Table IV.2: Self-reported characteristics of enrollees and disenrollees

	Enrollees (N=655)		Disenrollees (N=178)	
	N	***Wgtd. Percent†***	***N***	***Wgtd. Percent†***
Sex				
Female	387	57% (2.17)	108	62% (3.71)
Age				
18-24	56	13% (1.78)	33	19% (3.06)
25-34	185	35% (2.10)	73	42% (3.82)
35-44	131	19% (1.59)	27	19% (3.25)
45-54	105	13% (1.23)	15	8% (2.13)
55 and older	172	20% (1.50)	27	10% (1.86)
Employment Status				
Employed, full-time	238	38% (2.12)	73	43% (3.84)
Employed, part-time	176	27% (1.87)	24	13% (2.60)
Self-employed	121	17% (1.53)	23	12% (2.45)
Student or Homemaker*	38	6% (1.07)	18	11% (2.52)
Unable to work for health reasons	28	4% (0.76)	20	10% (2.34)
Unemployed	45	7% (1.08)	17	9% (2.10)
Highest Level of Education Completed				
8th grade or less	12	2% (0.47)	-	-
Some high school/high school graduate or GED	259	39% (2.11)	61	33% (3.60)
Some college or 2 year degree	242	36% (2.03)	62	36% (3.73)
4 year college graduate	86	14% (1.56)	34	19% (3.06)
More than 4 year college degree	47	8% (1.15)	19	11% (2.42)
Self-Reported Health Status				
Excellent	87	14% (1.47)	32	18% (2.89)
Very Good	247	39% (2.09)	60	34% (3.64)
Good	225	33% (2.06)	55	31% (3.59)
Fair	71	10% (1.24)	23	13% (2.61)
Poor	17	3% (0.66)	6	4% (1.57)
Race				
White	631	96% (1.00)	164	93% (1.95)
Other	10	2% (0.74)	10	5% (1.71)

***Note**: Employment status categories "Student" and "Homemaker" have been combined into one category.
Standard error in parentheses.

Survey Data Analysis

Based on the enrollee and disenrollee data files, the evaluation team developed tabular analyses to assess overall awareness and understanding of the HELP program among enrollees and disenrollees. We also present their responses to questions about their experiences accessing health care while in HELP and after leaving HELP. Weighting of the enrollee and disenrollee survey data produced estimates representative of their respective sampling frames. Analyses consisted of univariate and bivariate statistics on key evaluation questions, complemented by statistical tests where comparison of subgroups were relevant and appropriate.

As sample sizes permitted, we conducted analyses by key demographic features. In addition to sex, subgroups consisted of age, employment status, educational background, urban/rural residence and federal poverty level (FPL). Given the small number of respondents, particularly among disenrollees, we had to consolidate some of these demographic categories to allow subgroup sample sizes large enough to run statistical significance tests. Accordingly, these demographic variables were consolidated to two levels each:

1) Sex (Male; or Female)
2) Age Group (19-44 years; or 45+ years)
3) Educational Attainment (Some high school/high school diploma; or some college/college graduate)
4) Employment status (Any employment; or No employment)
5) Residence (Rural; or Urban)
6) Federal poverty level (>50-100%; or >100-133%)

Z scores and other tests of significance, as appropriate, were used to determine whether enrollee and disenrollee subgroups differed statistically with respect to the key variables that measure understanding, access, affordability, and satisfaction with the HELP program. Statistical significance was defined as any comparison with $p<0.05$.

In addition, we also looked at key measures within the previously-outlined domains for different subgroups including by age, sex, educational attainment, FPL, and employment status. Because of the small sample size associated with the disenrollee sample, particularly when stratified by demographic subgroups, estimates may appear to be different but are not statistically significantly different due to large standard errors.

Survey Findings

We present key survey findings below for respondent characteristics and for each of the following survey domains; understanding/awareness of the HELP program; access to care while in HELP and after leaving HELP; affordability of HELP; and satisfaction with the HELP program. We report key findings separately by enrollees and disenrollees. Because of the differences between enrollees and disenrollees, the study is not designed for cross-comparisons between the two groups. However, the analysis looks at similar issues for the two groups including each group's knowledge of and satisfaction with the program, as well as how it affected their access to health care.

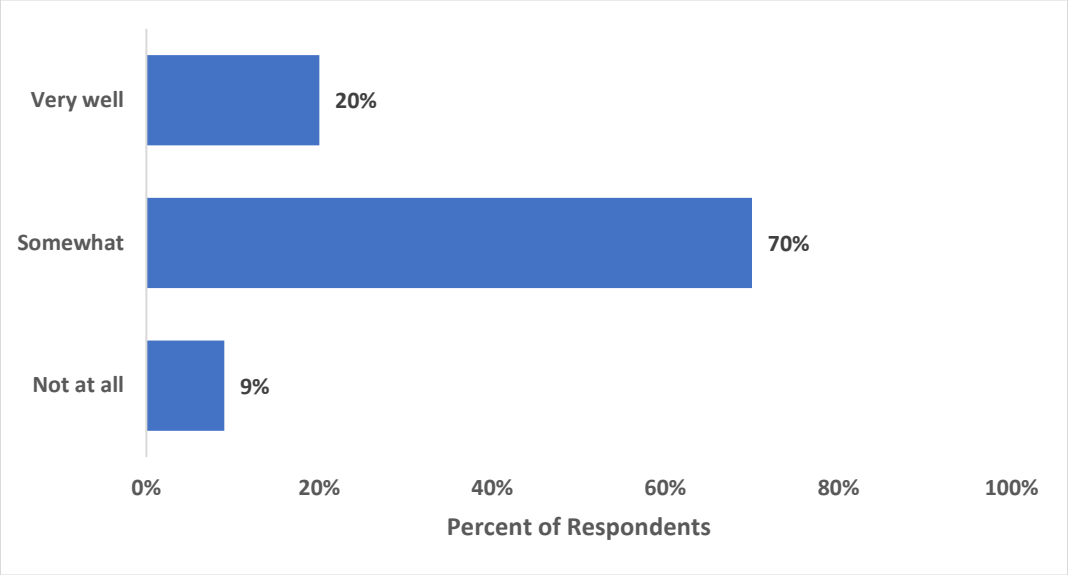
Enrollee Experiences with and Perception of HELP

Survey questions in this domain examine how well beneficiaries understand their premiums and copays, premium credits, and the consequences of premium non-payment.

Understanding of the HELP Program

When asked about their overall understanding of the HELP program, the majority of enrollee respondents said they only understood the program 'somewhat well' (Figure IV.1). This is consistent with enrollee responses to questions about their understanding of the specific features of the HELP program.

Figure IV.1: Overall understanding of HELP

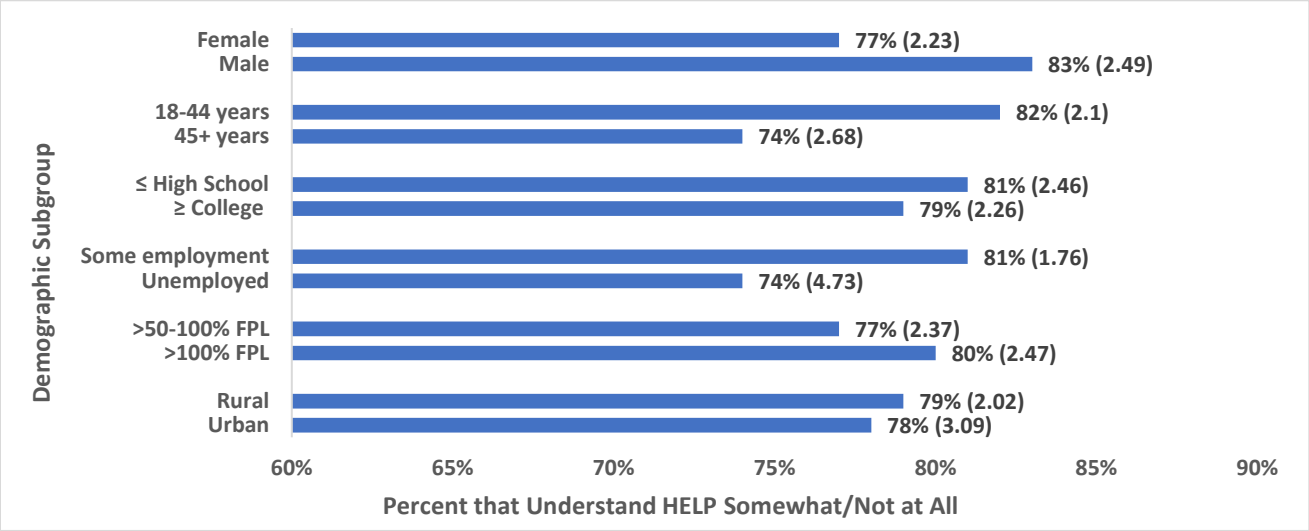


Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Weighted averages presented in chart.

A smaller proportion of females reported they only understood HELP somewhat or not at all relative to males (Figure IV.2). Members of the 18-44 age group were significantly more likely to report that they only understood HELP somewhat or not at all, compared to older individuals. Respondents did not differ significantly on other demographic characteristics when reporting that they understood the HELP

program somewhat/not at all well. Given the minimal variation we note for questions about enrollee "understanding of HELP" when stratifying by subgroups, for the rest of the questions we will present them for enrollees overall, and not by demographic subgroups.

Figure IV.2: Understanding of HELP by demographic subgroup

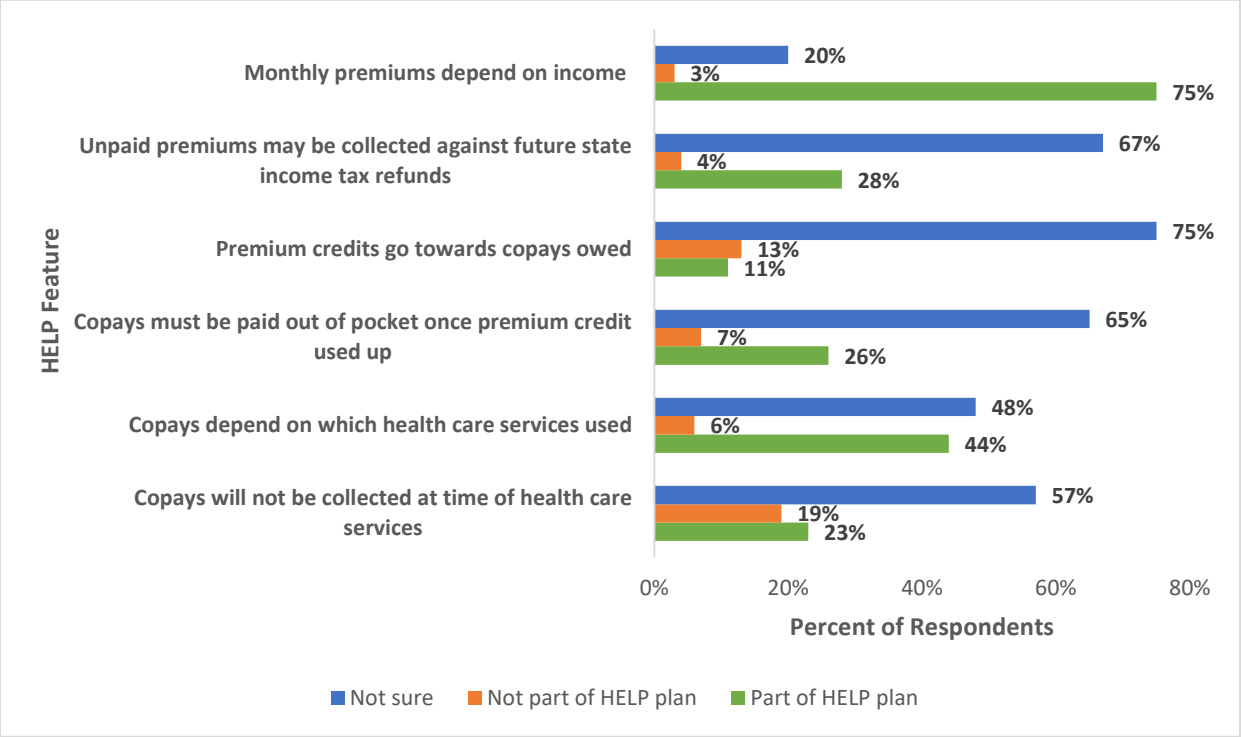


Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Standard errors in parentheses; * indicates statistically significant differences at the p <0.05 level.

Figure IV.3 displays respondents' understanding of HELP premium and copay policies. The HELP plan features that enrollees were most familiar with included monthly premiums being a function of income, and copays depending on the particular health care services that are used.

However, far fewer respondents demonstrated awareness of the other features of HELP such as being able to use premium credits towards copays owed, or that copays must be paid out of pocket once premium credits are used up or that copays would not be collected at the time of health care services.

Figure IV.3: Understanding of HELP premiums and copay features

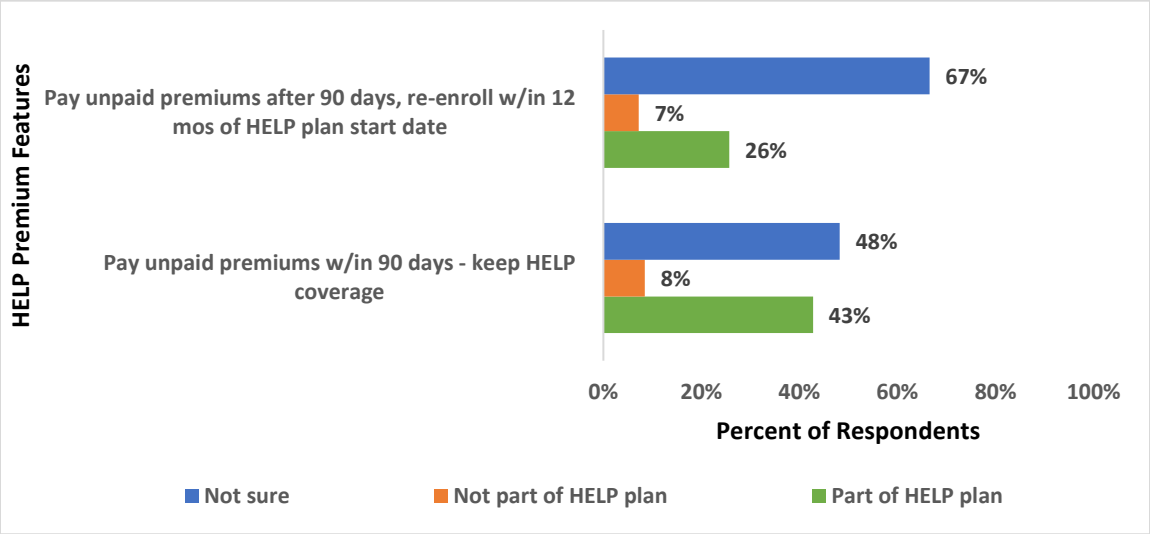


Source: Survey of HELP enrollees covered between January 2016 – May 2017 **N**=655
Note: Standard errors in parentheses; * indicates statistically significant differences at the p <0.05 level.

Figure IV.4 examines whether enrollees understood the specificities about the monthly premium payment features of the HELP plan. This question was asked only of enrollees who indicated that they knew their HELP coverage would end as a result of non-payment of premium within 90 days.

Of those who indicated that they knew their coverage would end as a result of non-payment of premium within 90 days, less than half the respondents were aware that paying unpaid premiums within 90 days would enable them to retain HELP coverage, while only about one quarter of enrollees were aware that paying unpaid premiums after 90 days would allow them to re-enroll within 12 months of their HELP plan start date.

Figure IV.4: Understanding of the unpaid premium payment policies and their linkage to HELP coverage



Source: Survey of HELP enrollees covered between January 2016 – May 2017**: N**=471
Note: Weighted averages presented in chart.

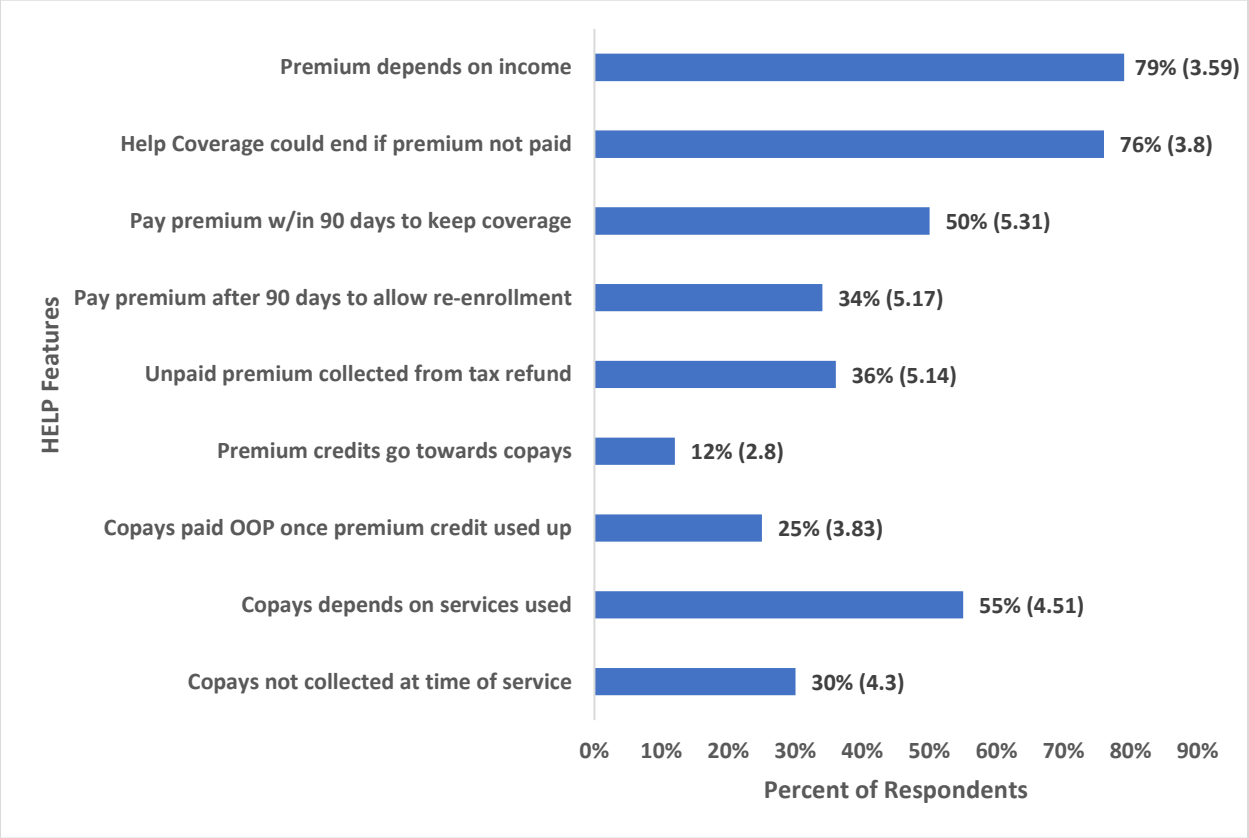
In total, responses to questions about the details of the program indicate that enrollees are either unaware of or do not fully understand the nuances of the program.

Understanding of HELP Premiums and Copays by Self-Reported Overall Understanding of HELP

As noted previously, about 90 percent of enrollees claimed to understand HELP "Very well" or "Somewhat", with the great majority claiming the latter category. We were interested in examining whether this self-assessment represents true understanding, or perhaps, instead, some level of false confidence. Several survey questions asked the enrollees about some of the important details of the HELP program.

Enrollees' functional understanding of premium payment policies relative to self-reported understanding of HELP is displayed in Figure IV.5. In general, self-reported understanding of HELP was positively correlated with functional understanding, although the level of demonstrated understanding differed considerably across topic areas. For example, 76 percent of those who reported understanding "Very well" knew that non-payment of HELP premiums could lead to disenrollment from HELP. Conversely, only 12 percent of those who reported understanding "Very well" knew that their premium credits go towards copays.

Figure IV.5: Functional Understanding of Premium Payment Policies Relative to Self-Reported Understanding of HELP



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Standard errors in parentheses; * indicates statistically significant differences at the p <0.05 level.

Information-Seeking about HELP

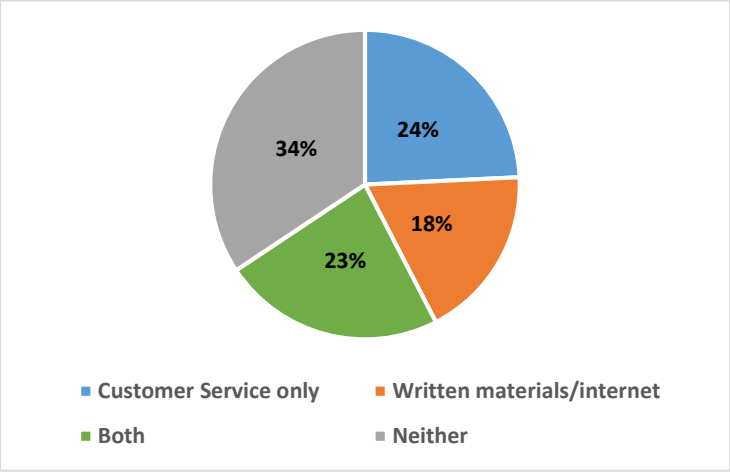
As part of the implementation of HELP, the state of Montana was required to perform an outreach and education campaign to provide information about the program to newly eligible beneficiaries. As mentioned in section I – a variety of strategies were used by the state, as well as community organizations and providers to publicize HELP. These included advertising campaigns, as well welcome packets and brochures provided by the TPA to new enrollees. In this section, we explore whether respondents sought to avail themselves of the informational materials and services.

Respondents were asked about their information-seeking behavior and whether or not they searched for information in written materials or on the internet about the HELP plan, or if they tried to get information or help from a customer service representative. As the information presented above in Figures IV.4 and IV.5 show, it appears that functional understanding of HELP was incomplete, at best, among enrollees. This section examines whether enrollees sought assistance in understanding HELP through either internet searches or telephone customer support.

Overall, most enrollees sought some information about the HELP program. About 34 percent of individuals sought no information about HELP, while about one quarter sought information from both

customer service as well as written materials/internet (Figure IV.6). The design of the survey did not include specific questions about the content of the information requests.

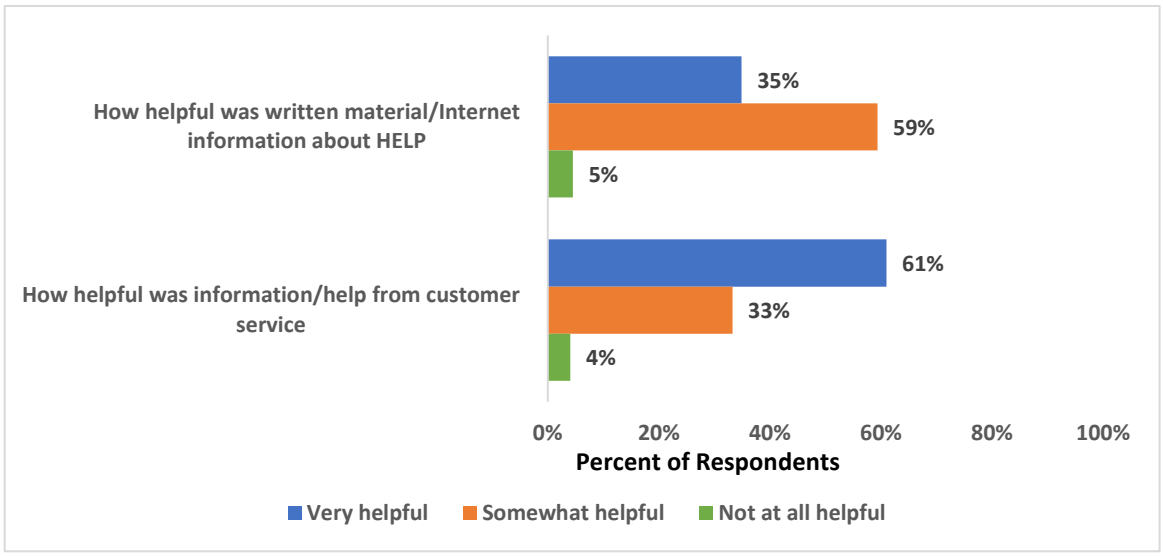
Figure IV.6: Information-seeking about HELP



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655.
Note: Weighted averages presented in chart

A larger proportion of respondents answered reported information/help received from a customer service representative was very helpful (61 percent) compared to 35 percent who said they found the written materials/internet information about HELP to be very helpful (Figure IV.7). We also analyzed information-seeking behavior by demographic subgroups and found no significant differences.

Figure IV.7: Helpfulness of information regarding HELP among those who sought information/assistance



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=318;
Note: Weighted averages presented in chart.

Key Takeaways

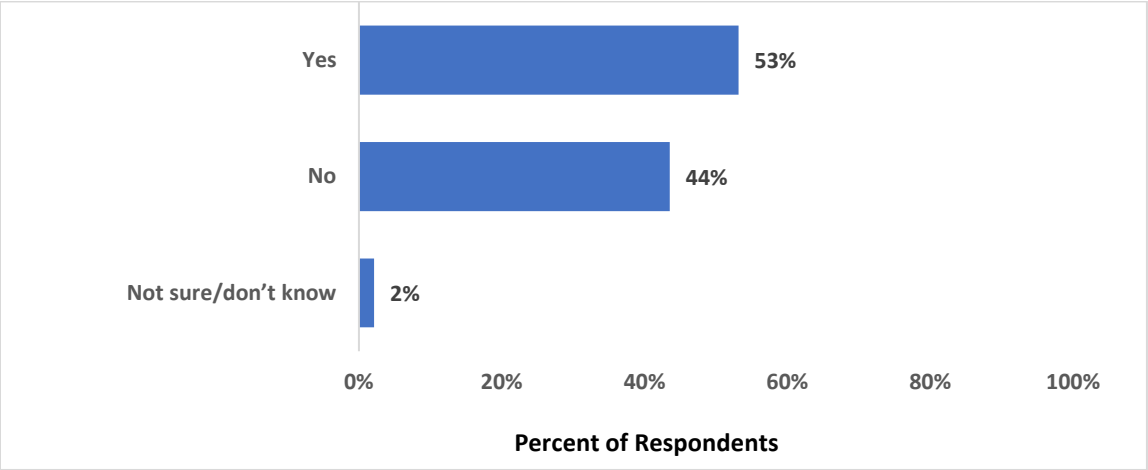
In general, while a large proportion (70 percent) of enrollee respondents reported that they understood "somewhat well" how HELP works overall, their responses to questions on individual program features including premium credits being used towards copays, demonstrated an incomplete understanding of program specifics. In addition, a greater proportion of respondents (43 percent) reported being aware of features such as paying unpaid premiums within 90 days would help them retain HELP coverage, while only 5 percent were aware of the $8 copay for visiting the emergency room for a non-emergent condition. However, we noted that while two-thirds of enrollees had sought information, either via the internet or telephone customer support, about HELP, it appears that enrollees' understanding of the program's nuances was not necessarily improved despite having accessed additional information.

Cost as a Barrier to Accessing Care

In this section, we examined whether the premium and copayments features of HELP posed a barrier to access to care for enrollees. We also examined whether respondents understood that non-emergent use of the ER would lead to a copayment.

Eighty-five percent of enrollees said they did not face any cost barriers to accessing care. Only 14 percent mentioned not being able to get health care due to cost considerations in the past 6 months. Of those reporting any barriers to access due to cost, 59 percent reported problems accessing dental care and 45 percent reported problems accessing vision care. As shown in Figure IV.8 below, about half of enrollees reported having had health insurance prior to enrolling in HELP.

Figure IV.8: Had any health insurance in 12 months prior to enrolling in HELP



Source: Survey of HELP enrollees covered between January 2016 – May 2017. **N**=655.
Weighted averages shown in chart.

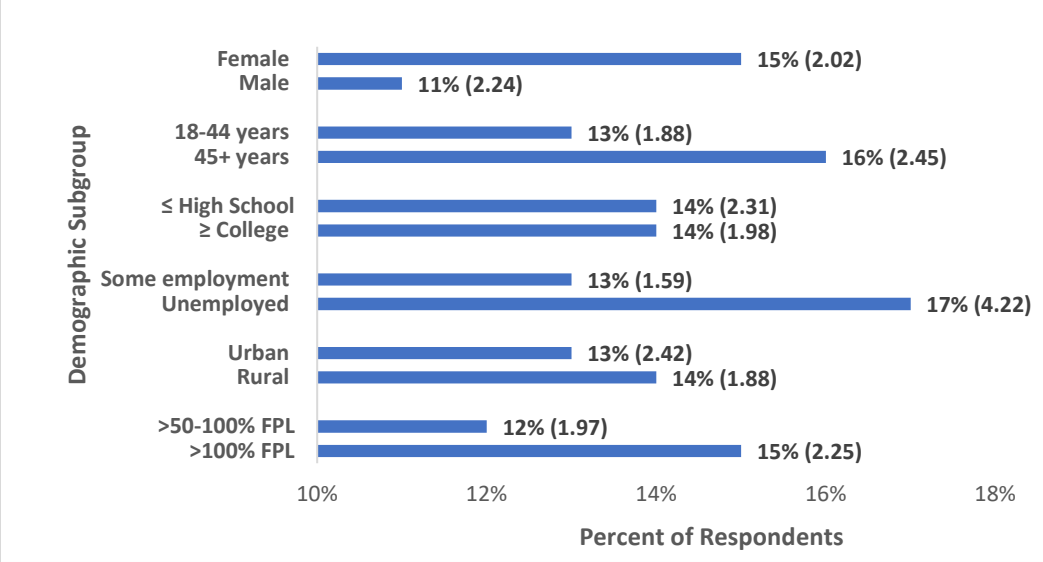
Of enrollees who had health insurance prior to HELP, 77 percent of the respondents had health insurance for all 12 months prior to enrollment in HELP, and 61 percent had received some preventive care prior to enrolling in HELP. In addition, we examined whether cost considerations had acted as a barrier to accessing specific types of care after enrollment in HELP, including visits to health professionals, getting a prescription, and preventive care to name a few. We found that seventy one

percent of enrollees reported having gone to a health professional or getting a prescription in past six months. Only 14 percent reported not being able to get health care due to cost considerations in the past six months. These respondents went on to answer the questions about which types of care they were unable to access, and reported that the greatest challenges were accessing dental (59 percent) and/or vision care (45%) detailed findings are presented in the tables in Appendix D.

Cost as a Barrier to Access by Demographic Subgroups

Among those who responded that they could not access needed health care in the last six months due to cost considerations, none of the differences between demographic groups approached statistical significance. Figure IV.9 shows the percentages of enrollees, by demographic groups, who reported that they did not get some needed care due to concerns over cost. Since there is little variation across subgroups, the remainder of the findings will only be reported for enrollees overall and not by subgroup.

Figure IV.9: Cost as a barrier to accessing needed care by demographic subgroups



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655.
Note: Standard errors in parentheses; No statistically significant differences found between demographic subgroups; Weighted averages shown in chart.

Key Takeaways

Among HELP enrollees, cost does not appear to be a barrier to accessing care, as only 14 percent of enrollee respondents mentioned not being able to get health care due to cost considerations in the past 6 months. This is consistent with other nationwide studies that show that Medicaid enrollees in general report low rates of being unable to access medical, specialty, dental/vision care, or prescription drugs due to cost, particularly compared to uninsured adults.[71] Dental and vision care were more problematic,

[71] Medicaid Access in Brief: Adults' Experiences in Obtaining Medical Care

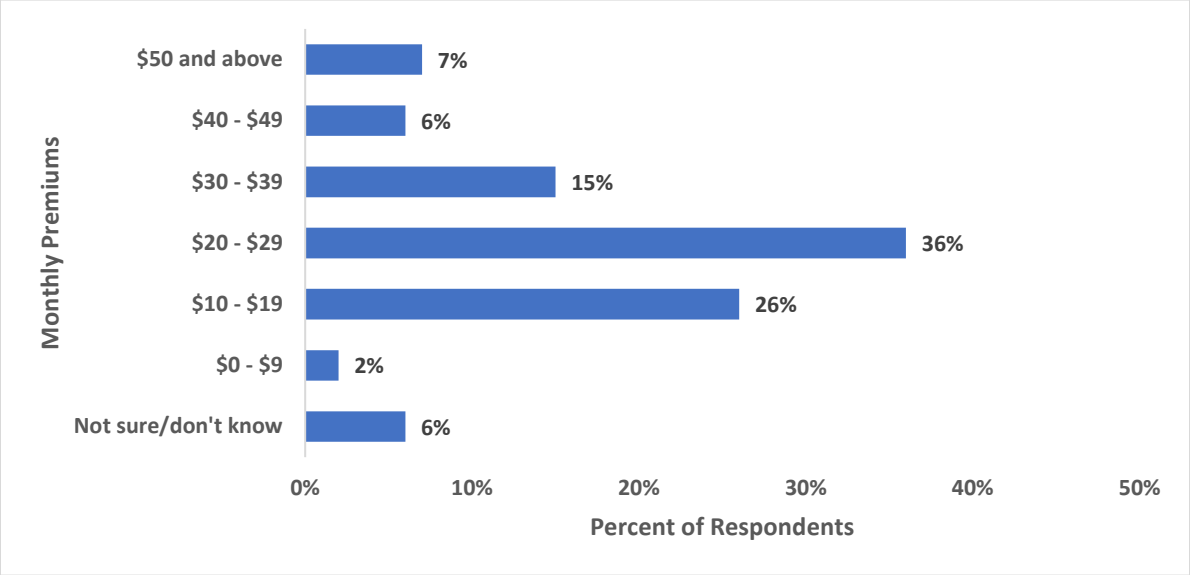
with a large proportion of the enrollee respondents reporting being unable to access dental care (59 percent) and/or vision care (45 percent).

Affordability of the HELP Program

This domain examines whether respondents found their monthly premiums and any copayments for services to be affordable, and whether they had concerns about not being able to make their premium payments. Respondents were queried on their monthly premium payment amounts, how affordable they found their premium, how worried they were about making their premium payments, and if they self-paid their premiums or if someone other than the respondent paid their premium for them.

Most enrollee respondents had a monthly premium payment between $10 and $39. Only six percent reported having monthly premiums between $40 and $49, while about seven percent reported monthly premium amounts in excess of $50 (Figure IV.10). About 15 percent thought the premiums were more than they could afford. Fifty percent reported that they were "not at all" worried about being able to make their monthly premium payments.

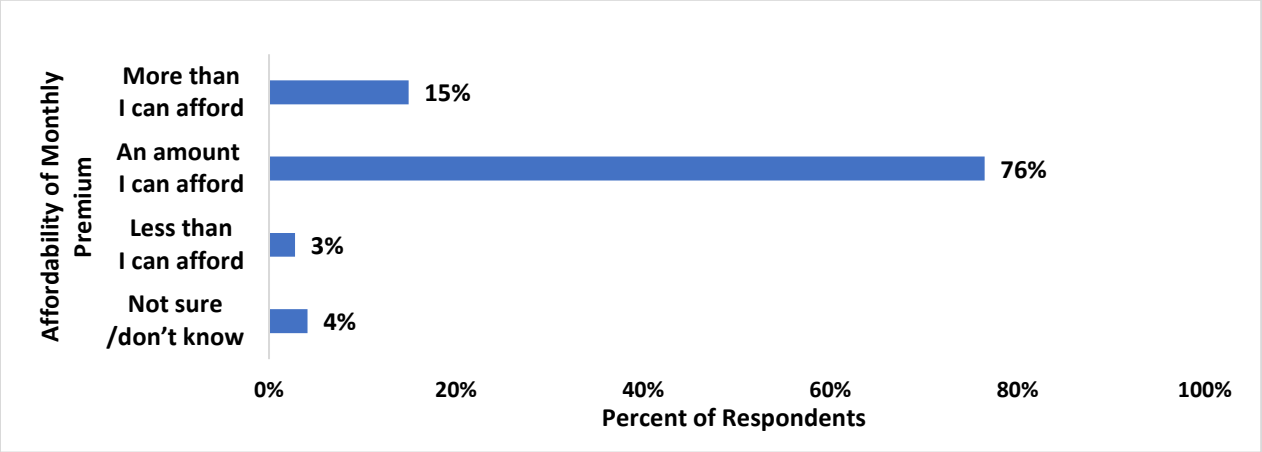
Figure IV.10: Monthly premium amounts



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655.
Note: Weighted averages shown in chart

Furthermore, as Figure IV.11 depicts, a majority of 76 percent felt that the premiums were an amount of they could afford. About 15 percent of enrollees thought the premiums were more than they could afford, while three percent of enrollees considered their premiums to be less than they could otherwise afford.

Figure IV.11: Affordability of monthly premium

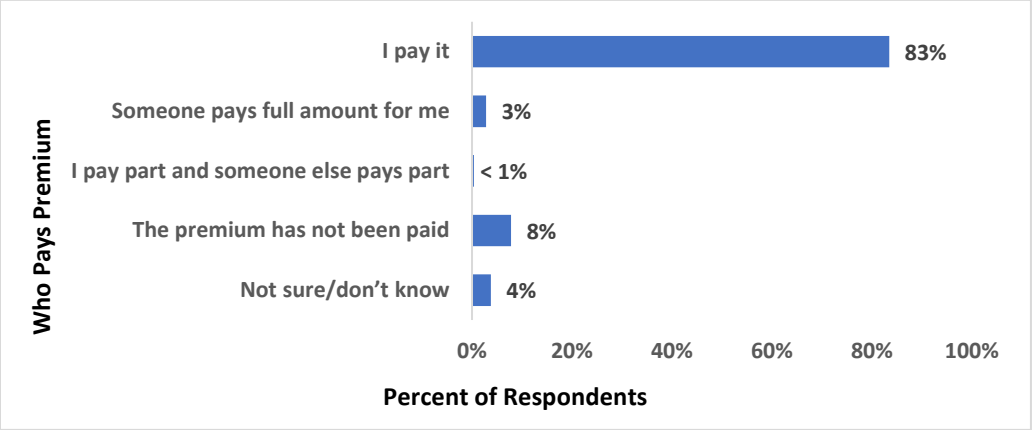


Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655.
Note: Weighted averages shown in chart

In order to understand how premium affordability may vary by demographic subgroups, we also looked into the proportion of enrollee respondents who had concerns about HELP premiums being more than they could afford, by demographic subgroup. Differences in responses by demographic subgroups were not statistically significant.

In an attempt to understand to what extent beneficiaries could afford the premiums on their own or required help paying them, a follow-up question asked enrollees who paid their premiums for them – whether they were self-paid or paid by someone else. While, 83 percent of enrollees reported paying for their premiums themselves, three percent reported that someone else paid the full amount of their premium, and eight percent said their premium had not been paid (Figure IV.12).

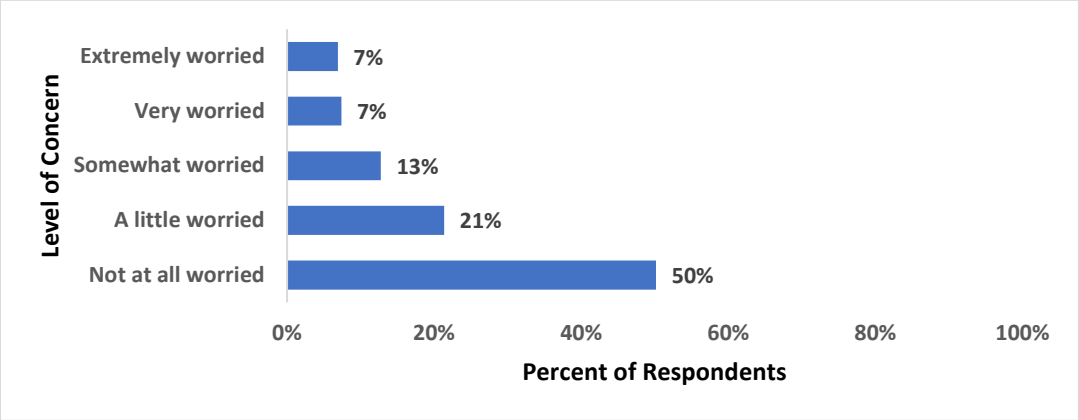
Figure IV.12: Who pays premium?



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Weighted averages shown in chart

We also examined whether or not respondents were worried about paying their monthly premiums. Half of the surveyed enrollees reported some degree of concern about their ability to make the monthly premiums (Figure IV.13).

Figure IV.13: Concerns about affordability of premium



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Weighted averages shown in chart

Only about 24 percent of enrollees reported paying copays in the last six months, and of those who did pay the copay, 69 percent said it was an amount they could afford. About 25 percent said it was more than they could afford (see Appendix D tables). As was noted in the context of the affordability of premiums, there does not appear to be any demographic variation in the level of anxiety/concern/worry in making the monthly premium payments.

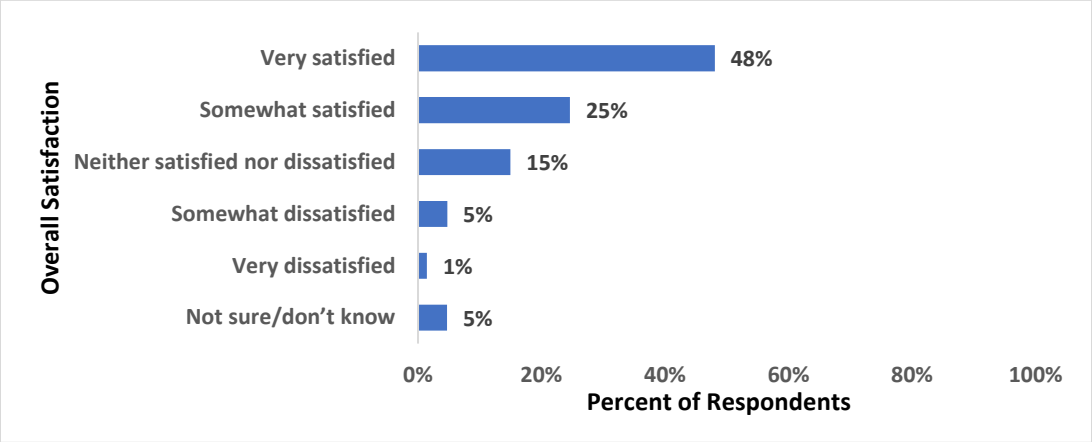
Key Takeaways

The majority (79 percent) of enrollee respondents considered their monthly premiums to be affordable, and half of the enrollee respondents reported that they were not at all worried about being able to make their monthly premiums. When asked to compare HELP to their prior health insurance (for those with prior coverage), 63 percent of enrollee respondents found it the same or better than their previous coverage with respect to their ability to afford their plan.

Satisfaction with HELP

Finally, to assess overall enrollee perception about HELP, beneficiaries were asked how satisfied they were with the HELP program overall. Respondents were asked to rate both their overall satisfaction with the HELP program, as well as their satisfaction with key features of the program. Close to half the enrollee respondents reported being very satisfied with the program, while about one-quarter were somewhat satisfied (Figure IV.14). A large proportion (77 percent) of enrollees also felt that the affordability of HELP was as good as, or better than, whatever insurance they previously held.

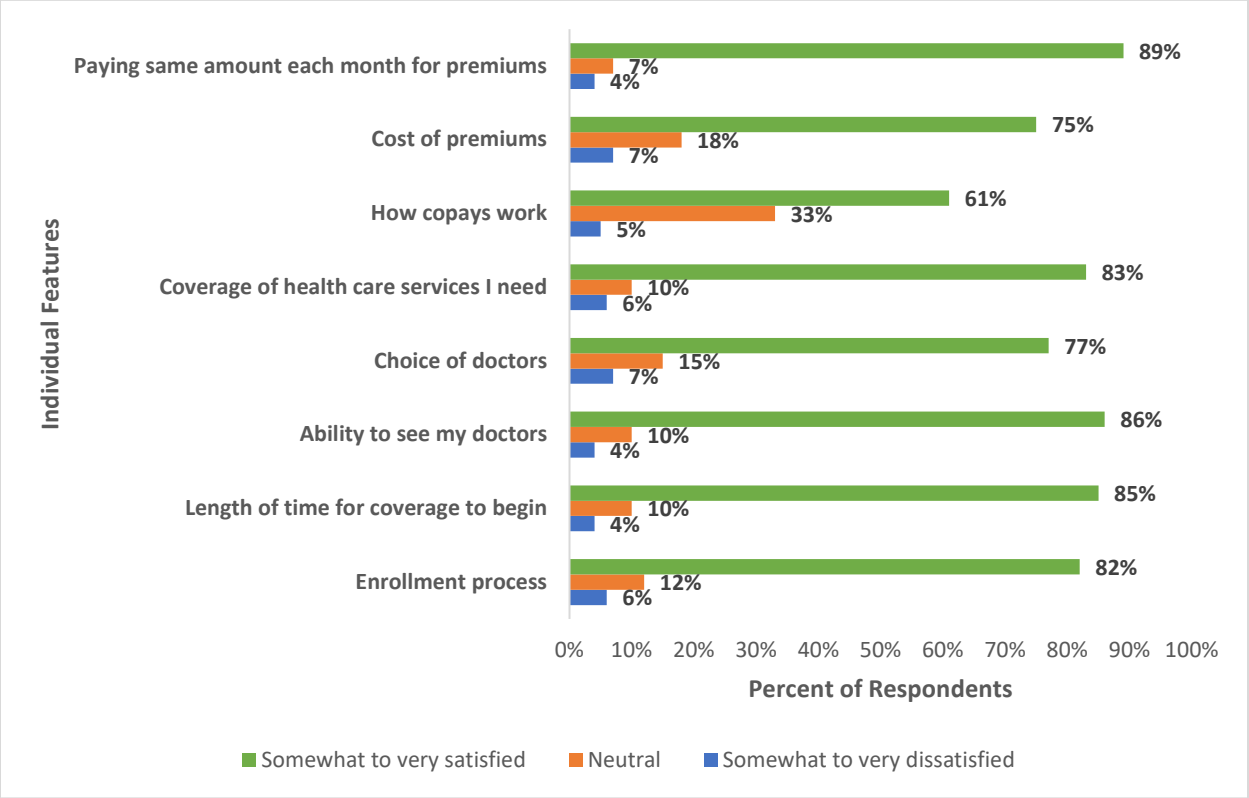
Figure IV.14: Overall satisfaction with HELP



Source*:* Survey of HELP enrollees covered between January 2016 – May 2017; **N**=655
Note: Weighted averages shown in chart

When respondents were asked about their satisfaction with particular features of the HELP program, more than half reported being somewhat to very satisfied with these various plan elements (Figure IV.15). More than 80 percent of respondents were somewhat to very satisfied with paying the same amount each month for premiums, the length of time it took for their coverage to begin, the ability to see their doctors, the enrollment process and coverage of health care services they needed. Around three quarters of enrollee respondents were somewhat to very satisfied with their choice of doctors as well as the cost of their premiums, while over 60 percent were satisfied with how copays work.

Figure IV.15: Satisfaction with individual features of HELP



Source: Survey of HELP enrollees covered between January 2016 – May 2017; **N**=529;
Note: Weighted averages shown in chart

In total, enrollee respondents felt that HELP was as good as, or better than, whatever insurance they previously held (Table IV.3). In particular, most enrollee respondents appeared to feel that HELP coverage was the same or better than their coverage under their prior insurance, particularly when it came to their ability to afford the HELP plan coverage.

Table IV.3: Comparison of HELP to Prior Health Insurance

Health Insurance Features	Better	Same	Worse	Not sure
Ability to afford plan (N=345)	63%	14%	13%	5%
Coverage of needed health care services (N=345)	35%	38%	10%	12%
Ability to see my doctor (N=322)	25%	54%	7%	9%
Ability to get needed health care services (N=323)	31%	46%	10%	8%

Source: Survey of HELP enrollees covered between January 2016 – May 2017;
Note: Weighted averages shown in table

Key Takeaways

A majority of enrollees were somewhat to very satisfied with individual features of HELP including a consistent monthly premium payment amount and the ability to see their doctors as well as choice of doctors, and coverage of healthcare services needed. About 60 percent of enrollees were somewhat to very satisfied with how copays work in HELP. In general, although there were several features of HELP that many enrollees did not fully understand, they expressed satisfaction with the program and believe it improved their access to care, and ability to see their doctors as well as giving them their choice of doctors.

Disenrollees Experiences with and Perception of HELP

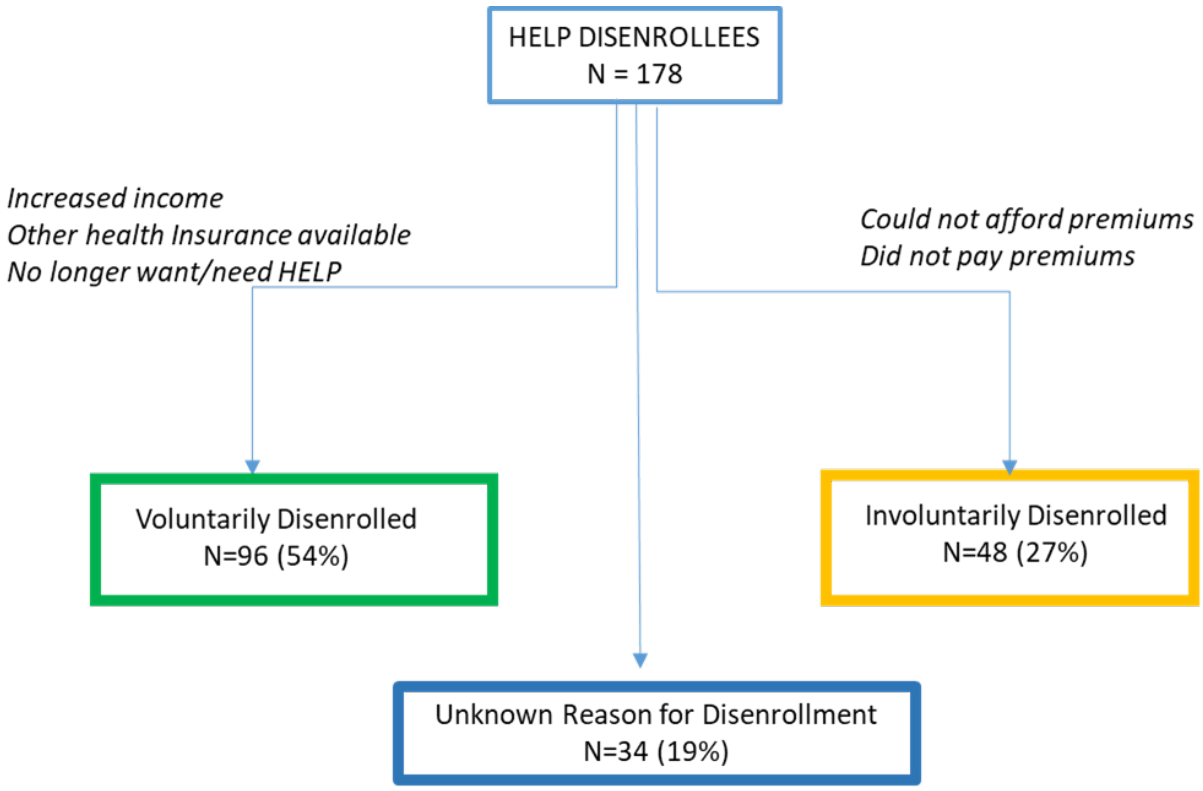
Among the 178 disenrollees responding, we looked to see if there were any patterns in their disenrollment and their perceptions of the HELP program and experiences after leaving HELP. A majority of disenrollees became disenrolled through improvement in their circumstances, hereby referred to in this report as "voluntary disenrollees." A smaller but still sizeable proportion indicated that they were disenrolled due to being unable to afford the premium or because they did not pay the premium. The third category of disenrollees includes individuals who did not select any of the offered reasons for their loss of coverage. Since the response offerings for this group may not have included their specific reason for disenrollment, we assumed their loss of coverage was not related to increased income or availability of other health insurance.

We found it important to examine three groups among disenrollees according to the general reason individuals disenrolled. We expected that responses to many of the questions on the disenrollee survey would differ according to these two sets of circumstances (voluntary vs. involuntary disenrollment). For example, we might expect the first subgroup to have obtained other insurance coverage and therefore to have an easier time getting care after disenrollment than those in the involuntarily enrolled subgroup. As shown in Figure IV.16 below, the three groups of disenrollees were:

1) There were 96 (54 percent) disenrollee respondents who reported no longer needing or qualifying for subsidized health coverage either due to increased income or coverage availability from other sources; we refer to these individuals as "voluntary disenrollees";
2) There were 48 (27 percent) disenrollee respondents who cited inability or failure to pay premiums as a reason for disenrollment; we refer to these individuals as "involuntary disenrollees"; and finally,
3) There were 34 (19 percent) disenrollee respondents who did not provide a reason for disenrollment in their response to the survey; we refer to these individuals as "unspecified disenrollees".

Among respondents who said they did not need/want HELP coverage anymore, 91 percent had some form of other insurance coverage. Among those who said they were disenrolled for non-payment, 76 percent indicated they had some other form of coverage. Of this 76 percent, over four-fifths said they now were covered by standard Medicaid. In contrast, those who said they did not need/want HELP coverage but currently have other insurance coverage, only one quarter were enrolled in standard Medicaid after disenrollment from HELP.

Figure IV.16: Disenrollee Groups by Disenrollment Reasons

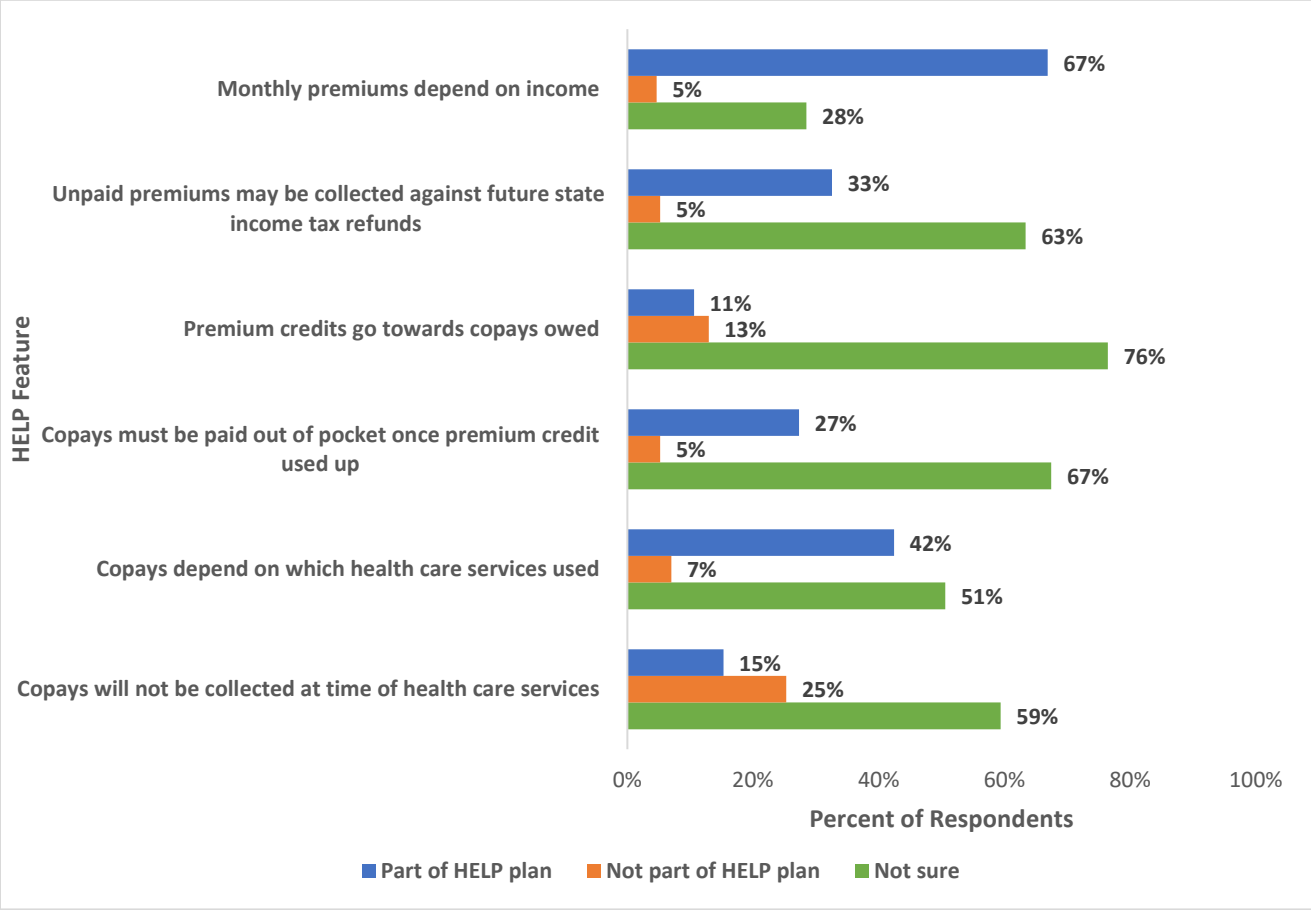


Because of the small size of the response for disenrollees, we conducted regression analyses using SAS® Proc Surveyreg to test for differences between voluntary and involuntary disenrollees, and voluntary and *unspecified* disenrollees, on select variables of interest across the four key survey domains. Results are presented in Tables IV.4-IV.7 placed under each key survey domain below.

Understanding/Awareness of the HELP Program

As with enrollees, we were interested in examining how well disenrollees had understood the specific features of the HELP program during the time that they were enrolled. Responses were solicited across three dimensions – whether the feature was *part of the HELP Plan*, *not part of the HELP plan*, and *not sure*. Overall, as depicted in Figure IV.17, while 67 percent of disenrollees knew that monthly premiums depend on income, the proportions of disenrollees who knew that the other features were also part of the HELP plan were much smaller, ranging from 15 percent who knew that copays will not be collected at the time of health care services, to 42 percent who knew that copays depend on which health care services used.

Figure IV.17: Understanding of HELP premium and copayment features



Source: Survey of HELP disenrollees who were disenrolled between January 2016-May 2017**; N**=118
Note: Weighted averages shown in chart

The pattern for the disenrollees held even when disaggregated by type of disenrollment (Table IV.4). All three types of disenrollees were more likely to indicate that they thought monthly premiums depended on income, and copays depended on health care services used. However, fewer proportions of all three disenrollee types exhibited understanding of the other features specific to HELP. No significant differences were seen across these types of disenrollees in their understanding of the program features.

Table IV.4: Differences between disenrollee groups in understanding of HELP

Understanding of HELP	**Voluntary**	**Involuntary**	**Unspecified**
Pay unpaid premiums w/in 90 days – keep HELP coverage	31% (6.08)	34% (8.14)	29% (9.38)
Pay unpaid premiums after 90 days, re-enroll w/in 12 mos. of HELP plan start date	16% (4.76)	19% (6.37)	23% (9.03)
Unpaid premium balance may be collected from future state income tax refunds	39% (6.46)	40% (8.57)	26% (9.20)
Monthly premiums depend on income	69% (4.82)	66% (7.07)	62% (8.61)
Copays depend on health care services used	43% (5.19)	40% (7.32)	50% (8.90)
Premium credits go towards copays owed	11% (3.17)	13% (5.18)	5% (3.71)
Copays paid OOP once premium credits used up	29% (4.74)	27% (6.73)	30% (8.22)
Copays not collected at time of health care service	21% (4.30)	9% (4.45)	16% (6.52)

Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=178

Key Takeaways

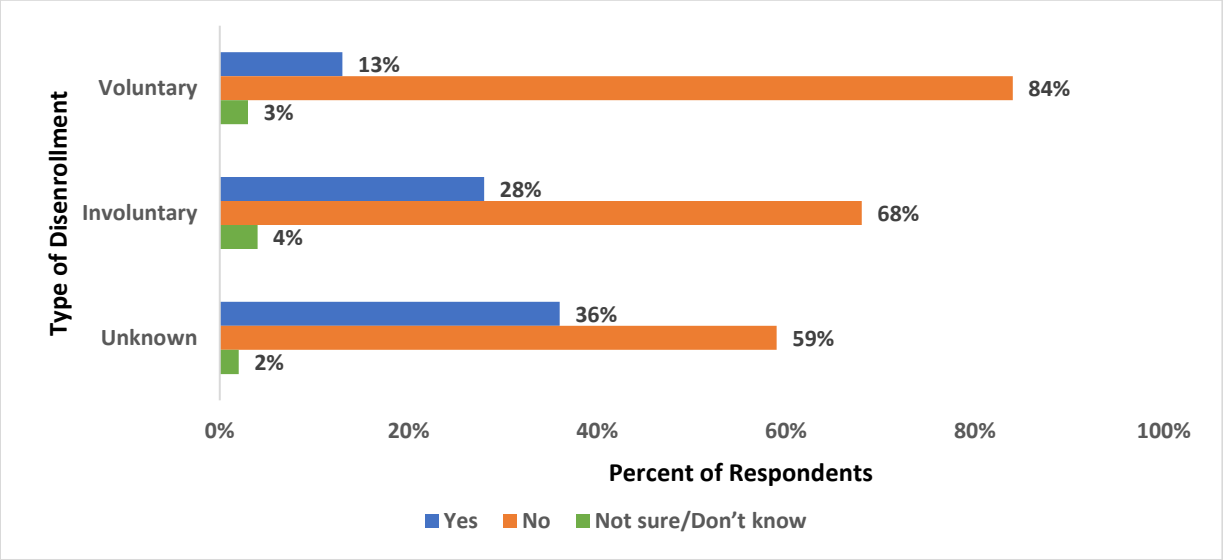
Similar to enrollee respondents, disenrollee respondents also demonstrated an incomplete understanding of individual program features. However, the understanding of individual program features did not appear to differ significantly by type of disenrollment. The features understood by a large proportion of disenrollees both overall and by type of disenrollment appear to be monthly premiums being a function of income, and copays depending on health care services used.

Cost as a Barrier to Accessing Care

In contrast to the enrollee analysis, for disenrollees we examined whether they reported any barriers to accessing health care due to cost concerns after being disenrolled from HELP. We examine this for disenrollees stratified by type of disenrollment.

Seventy five percent of disenrollees reported no barriers to accessing care due to cost concerns after their disenrollment from HELP. As seen in Figure IV.18, by disenrollee group, voluntary disenrollees reported fewer barriers to accessing care due to cost concerns after being disenrolled from HELP than involuntary and unknown reason disenrollees.

Figure IV.18: Unable to get health care due to cost, by type of disenrollment



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=178
Note: Weighted averages shown in chart.

In addition to looking at the inability to access care due to cost considerations for disenrollees overall, we also stratified disenrollees by disenrollment type and examined specific elements of access to care that they faced challenges with due to cost considerations (Table IV.5). Involuntary and unspecified disenrollees were significantly more likely to be unable to get a visit to the doctor, or access prescription drugs, and ER care. Unspecified disenrollees were more likely to also be unable to access ER care compared to voluntary disenrollees.

Table IV.5: Differences between disenrollee groups in access to care

Access to care	**Voluntary**	**Involuntary**	**Unspecified**
Unable to get health care due to cost	13% (3.50)	28% (6.78)*	36% (8.83)*
Unable to get visit to doctor	21% (13.05)	74% (11.81)*	78% (13.81)*
Unable to get preventive care	38% (14.88)	40% (14.23)	72% (14.26)
Unable to get follow up visit/tests	42% (14.83)	62% (13.40)	79% (13.65)*
Unable to get dental care	60% (14.72)	76% (12.69)	61% (15.75)
Unable to get vision care	40% (15.09)	40% (13.85)	61% (15.75)
Unable to get Rx	17% (9.95)	70% (13.05)*	68% (15.48)*
Unable to get ER care	0%	50% (14.42)*	48% (16.20)*

Note: *Indicates differences that were significant from voluntary disenrolled at p<0.05 level. Standard error in parentheses.

Key Takeaways

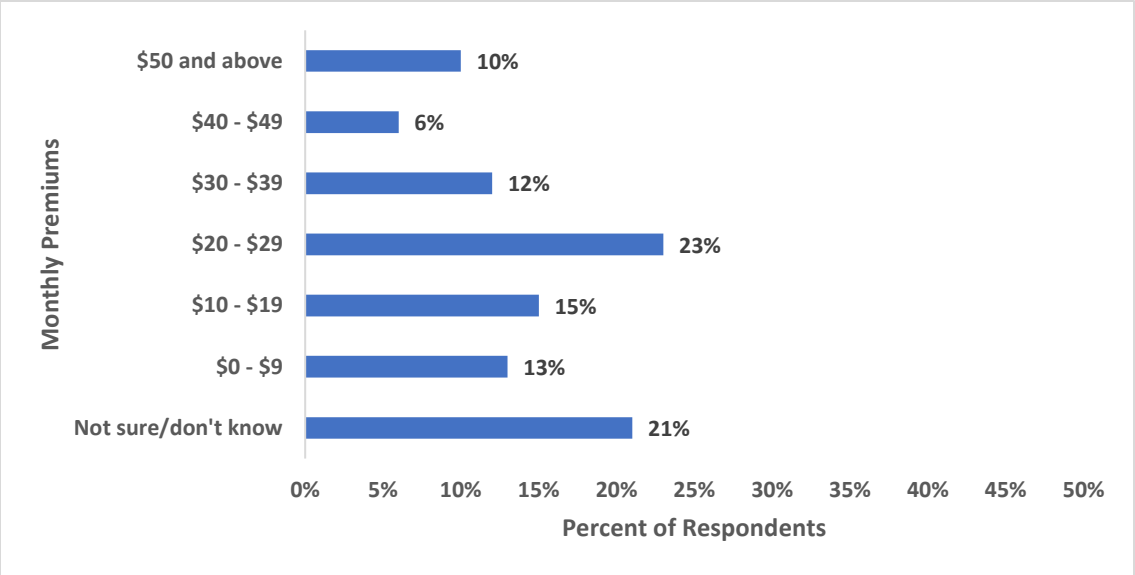
In general cost did not appear to be a barrier to accessing care for disenrollees after leaving HELP. By type of disenrollment, involuntary and unspecified disenrollees were more likely to report that they faced barriers to accessing care due to cost. When there were cost barriers, this pattern held, with involuntary and unspecified disenrollees being more likely to report barriers to accessing specific types of care compared to voluntary disenrollees.

Affordability of the HELP Program

Because affordability or premiums and copayments or the lack thereof might be a factor in respondents no longer being enrolled in HELP, we examined the affordability of HELP overall as well as stratified by type of disenrollment.

We note that only about 10 percent of disenrollee respondents indicated that they paid a premium of over $50 monthly. A little less than one quarter of respondents said their monthly premium was between $20-$29, and a little over one-fifth of the respondents were unsure about or did not know their premium payment amount (Figure IV.19).

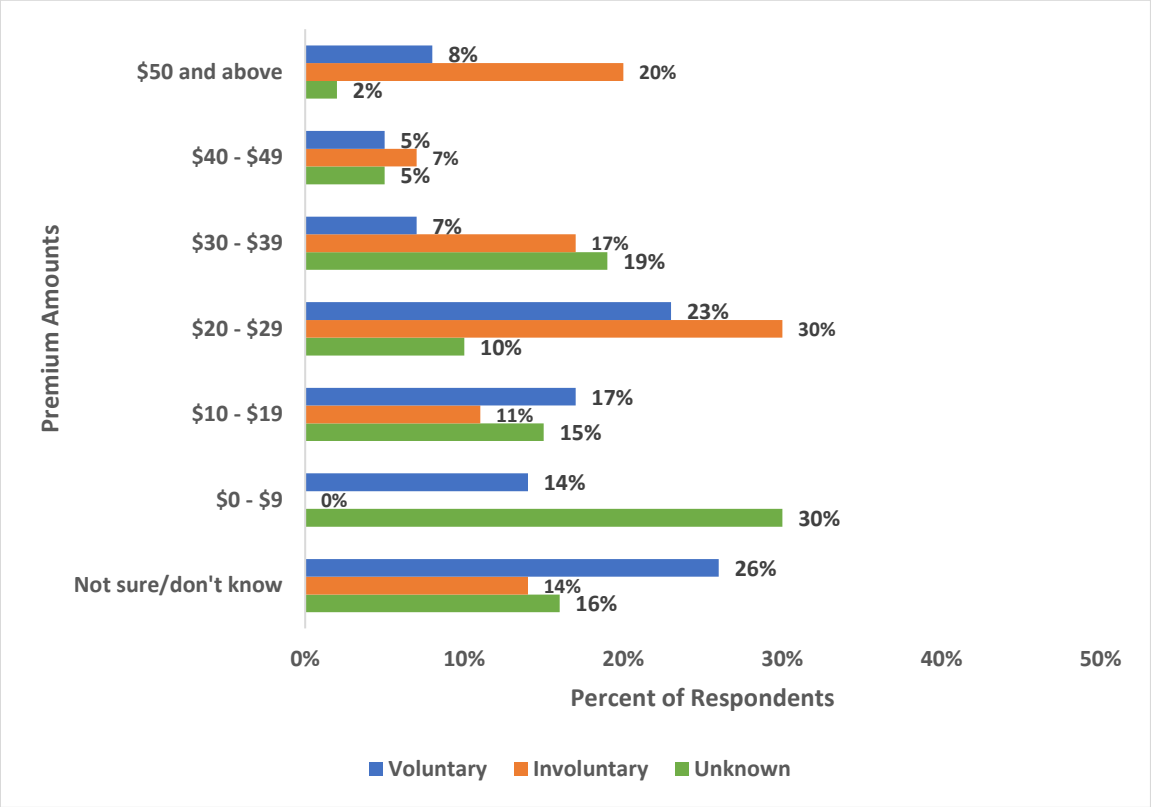
Figure IV.19: Premium amounts for disenrollees as a whole



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=178
Note: Weighted averages shown in chart.

Figure IV.20 shows the distribution of premium amounts by type of disenrollment. Involuntary disenrollees were more likely to have premiums between $20 and $29 or greater than $50 compared to other disenrollees.

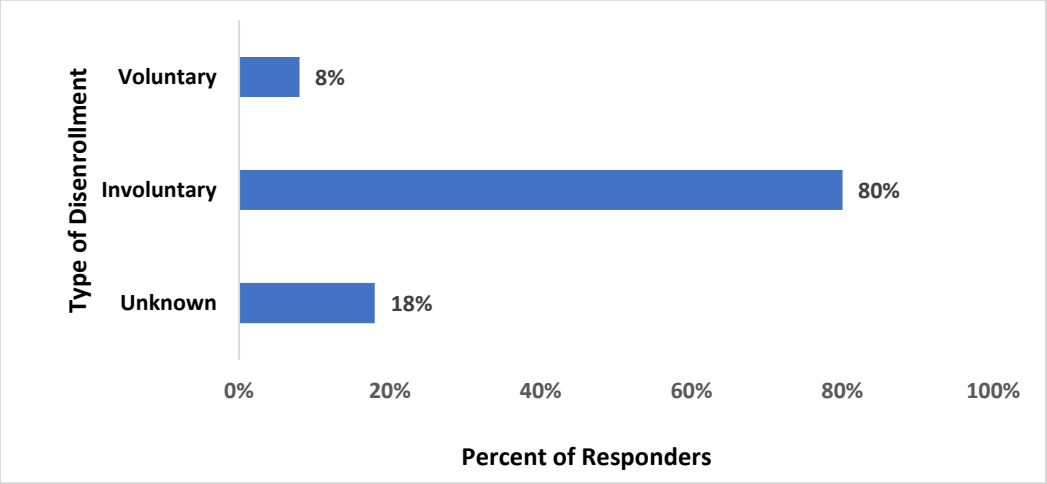
Figure IV.20: Premium amounts, by type of disenrollment



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=178
Note: Weighted averages shown in chart.

We then examined what disenrollees perceived about premiums being more than they could afford, broken out by type of disenrollment, because we were interested in seeing whether the type of disenrollment was related to perceptions of affordability. A larger proportion of involuntary disenrollees reported finding their premiums to be more than they could afford, when compared to voluntary or unknown disenrollees (Figure IV.21).

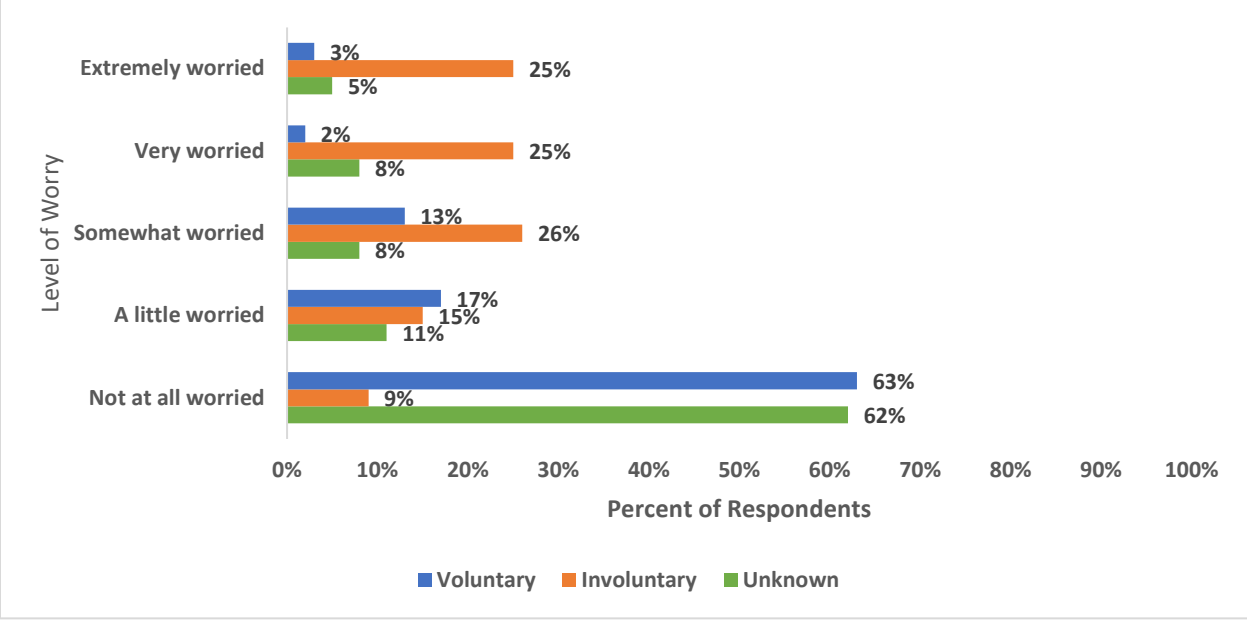
Figure IV.21: Premium affordability, by type of disenrollment



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=52
Note: Weighted averages shown in chart.

We also looked into disenrollees' concerns about their premium payments by type of disenrollment, to see if there was a larger proportion of involuntary disenrollees who reported being worried about making their payments (Figure IV.22). Involuntary disenrollees were also more likely to report being somewhat, very or extremely worried about their premiums compared to voluntary or unknown disenrollees.

Figure IV.22: Worries about making premiums, by type of disenrollment



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017; **N**=178;
Weighted averages shown in chart.

Furthermore, as Figure IV.22 depicts, voluntary disenrollees and those disenrolled for unknown reasons were more likely to respond that they were not at all worried about their premiums, compared to involuntary disenrollees. Conversely involuntary disenrollees were more likely than voluntary or unspecified reason disenrollees to respond that they were extremely worried about their premiums.

In addition, we examined differences between disenrollee groups in their perceptions of the affordability of HELP premiums and copays (Table IV.6).

Table IV.6: Differences between disenrollee groups in affordability of HELP

Affordability of HELP	**Voluntary**	**Involuntary**	**Unspecified**
Paid any copays	24% (4.47)	33% (7.03)	48% (8.91)*
Affordability of copays (Copays more than I can afford)	21% (8.65)	47% (13.03)	12% (8.61)
Affordability of monthly premium (Premiums more than I can afford)	8% (2.86)	80% (5.82)*	18% (6.93)
Very/Extremely worried about monthly premium	5% (2.33)	50% (7.45)*	12% (5.93)

Source: Survey of HELP disenrollees disenrolled between January 2016-May 2017**; N**=178;
Note: *Indicates differences that were significant from voluntary disenrolled at p<0.05 level. Standard error in parentheses.

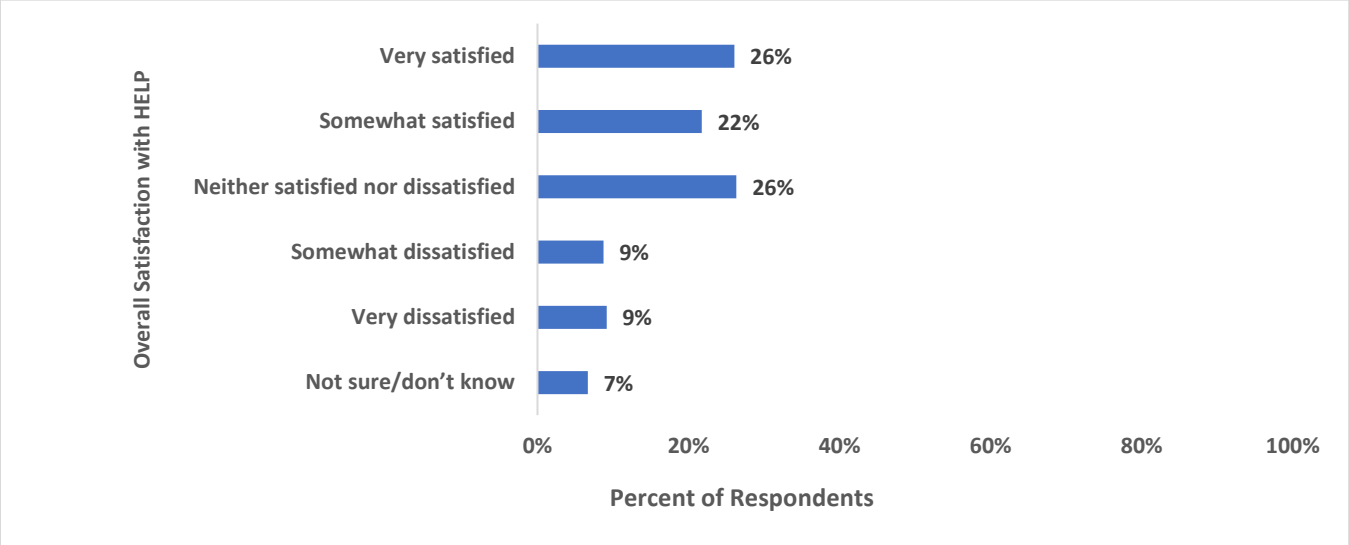
Key Takeaways

About half of disenrollee respondents considered premium payments to be affordable. Involuntary disenrollees were more likely than voluntary or unknown reason disenrollees to respond that they were extremely worried about their premiums, while those disenrolled for unspecified reasons were more likely than voluntary disenrollees to have paid any copayments.

Satisfaction with the HELP Program

We examined disenrollees satisfaction with the HELP program overall, as well as with specific program features, for all disenrollees as well as stratified by disenrollee groups based on type of disenrollment. For disenrollee respondents as a whole, we found that a little over a quarter reported being very satisfied with the program, and about the same proportion reported being neither satisfied nor dissatisfied, while 22 percent reported being somewhat satisfied (Figure IV.23).

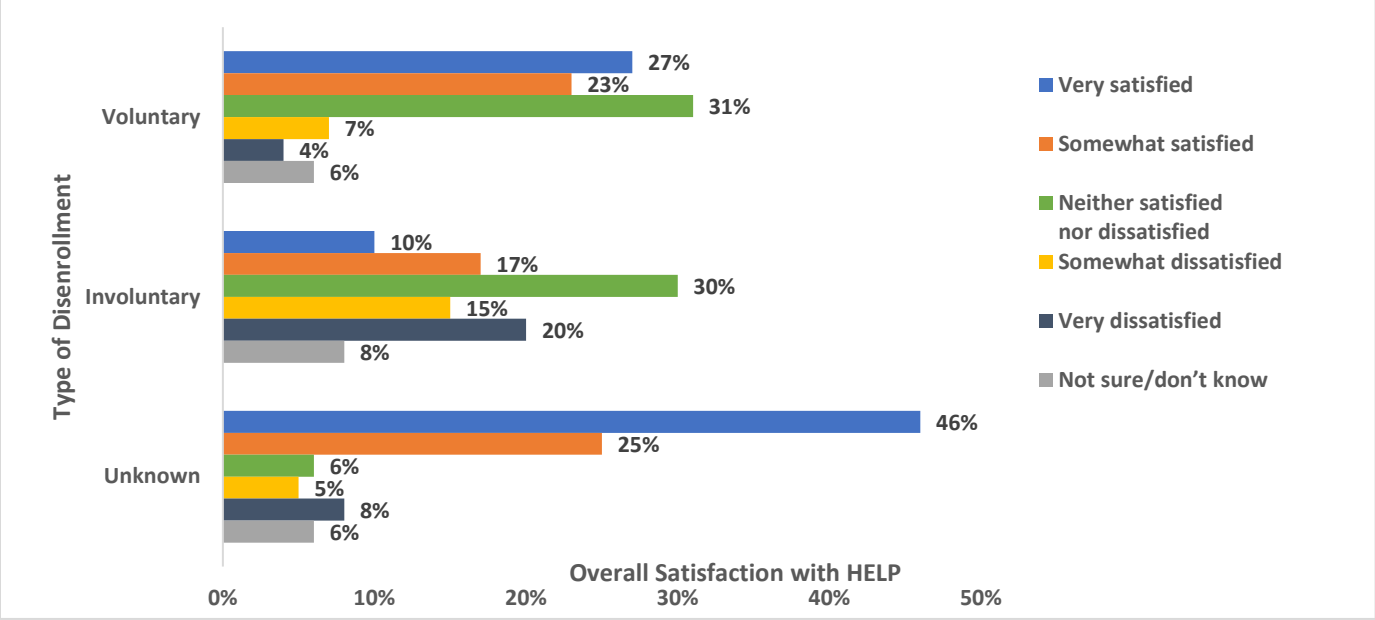
Figure IV.23: Overall satisfaction with HELP



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017**; N**=178
Note: Weighted averages shown in chart.

When asked about their overall level of satisfaction with the HELP program, those disenrolled for unspecified reasons reported the most satisfaction, while involuntary disenrollees appeared to be the least satisfied (Figure IV.24).

Figure IV.24: Overall satisfaction with HELP by type of disenrollment



Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017**; N**=178
Note: Weighted averages shown in chart.

After examining overall satisfaction for disenrollees as a whole and by disenrollment type, we also stratified disenrollees by type of disenrollment and examined their satisfaction with specific elements of HELP. Consistent with how the different disenrollee types responded to questions about their overall satisfaction with the different elements of HELP – in general those disenrolled for unknown reasons were the most satisfied with specific HELP features, followed by voluntary disenrollees, while the involuntary disenrollees reported the least satisfaction (Table IV.7). The proportion of respondents disenrolled for unspecified reasons who reported being somewhat to very satisfied overall with HELP was significantly higher than voluntary disenrollees, and similarly the proportion of involuntary disenrollees who reported being somewhat to very satisfied was significantly lower than voluntary disenrollees. The proportion of involuntary disenrollees who reported being somewhat to very satisfied with paying the same amount every month for premiums as well as the cost of premiums was significantly lower than voluntary disenrollees.

Table IV.7: Differences between disenrollee groups in satisfaction with HELP

Overall Satisfaction with HELP	**Voluntary**	**Involuntary**	**Unspecified**
Somewhat to very satisfied	50% (5.24)	27% (6.51)*	72% (7.98)*
Satisfaction with specific HELP features (Somewhat to very satisfied)			
How copays work	48% (6.67)	31% (8.56)	70% (8.82)
Paying same amount each month for premiums	77% (5.67)	29% (8.60)*	71% (9.28)
Length of time for coverage to begin	68% (6.25)	47% (9.41)	72% (9.10)
Cost of premiums	67% (6.35)	26% (8.53)*	71% (9.28)
Enrollment process	64% (6.51)	41% (9.31)	65% (9.53)
Ability to see my doctor	68% (6.33)	62% (9.17)	76% (8.55)
Choice of docs	60% (6.61)	52% (9.44)	67% (9.29)
Coverage of health care services respondent needed	63% (6.52)	54% (9.44)	69% (9.28)

Source: Survey of HELP disenrollees who were disenrolled between January 2016 – May 2017**; N**=178
Note: Weighted averages shown in chart.

Key Takeaways

Based on their recall of the HELP program, close to 50 percent of disenrolled respondents reported being somewhat to very satisfied with the program when enrolled in it. Respondents who were disenrolled because they had obtained other insurance coverage (i.e. voluntarily disenrolled) reported higher satisfaction levels with HELP compared to those who were disenrolled for non-payment of premiums.

Discussion

As part of the federal evaluation of HELP, the evaluation team conducted the first wave of surveys with enrolled and disenrolled HELP beneficiaries in the late summer/ fall of 2017. Respondents were surveyed about their understanding of and experiences with HELP, as well as on other domains including affordability of HELP, and for those disenrolled from the program, experiences after leaving HELP.

Although most HELP enrollees and disenrollees claim to understand the overall HELP program well or somewhat well, HELP enrollees' and disenrollees' understanding of the individual features of HELP appears to be incomplete. Two-thirds of enrollee respondents appear to have sought assistance with understanding HELP either via the internet or through contacting customer support. This was particularly true for some of the more complex features such as premium credits going towards copays owed, and that copays must be paid out of pocket once premium credits are used up, as well as the feature that unpaid premiums are collected against future state income tax refunds. This is consistent with findings from focus groups with HELP enrollees as well as interviews with HELP stakeholders. Stakeholders expressed concern that the concept of a premium credit is complex, and that the feature has been difficult for state officials to explain and for enrollees to understand.

A large majority of enrollee respondents found their monthly premiums to be affordable. In contrast, only a slight majority (55 percent) of disenrollees said that the amount of their monthly premium was affordable or less than they could afford. About twice the proportion of disenrollees thought their premium amounts were more than they could afford compared to enrollees. Few enrollee respondents had been subject to copays in the six months prior to answering the survey, but of those that reported paying copays, close to three-quarters indicated that the copays were affordable

In general, HELP enrollees and disenrollees did not appear to have experienced barriers to accessing care, particularly with respect to cost. Over two-thirds of enrollees reported visiting a health professional in the last six months or getting prescription drugs. Only 13 percent of enrollee respondents mentioned not being able to get health care due to cost considerations in the past six months, and for 45-59 percent of these individuals, it was dental and/or vision care that proved challenging to obtain. The majority of disenrollees reported that they did not have trouble accessing care after being disenrolled from HELP -- potentially because many of them were voluntarily disenrolled and obtained other insurance coverage post-disenrollment from HELP.

Satisfaction with the HELP program was high among current enrollees, but somewhat less so among those disenrolled from the program. A majority of enrollees were somewhat to very satisfied with individual features of HELP including monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of health care services needed by these enrollee respondents. A smaller proportion expressed satisfaction with how copays work, which could be attributable to their lack of understanding about copays in HELP. Among the disenrollee respondents, as is to be expected, those who voluntarily disenrolled from the program appeared to be more satisfied than those who were disenrolled from the program for non-payment of premiums. However, nearly 50 percent of disenrollee respondents did indicate that they would choose to re-enroll in HELP.

Limitations

As noted previously, response rates on the surveys were low. In addition, respondents who switched statuses between the time that the sample was drawn, and their receipt of the survey had to be analyzed separately. Our sample non-response analysis found disproportionate response rates by age group among enrollees, and by age and urban/rural residence among disenrollees. However, differences in responses between the differing demographic groups were quite modest, thus minimizing concern about a demographic bias in survey results.

Given the low overall response rate, it is reasonable to wonder if the decision to respond or not respond to the survey is more directly related to a respondent's experience, understanding and usage. For example, it is conceivable that participants who have had negative experiences with the program would be more likely to respond in order to air any grievances, thus distorting estimates of program usage and satisfaction. Conversely, it is also conceivable that individuals who do not understand or make use of the HELP program may be reluctant to respond, thus distorting estimates of program understanding and usage.

It is important to interpret results as representing respondents' *perceptions* of the program. In some cases, this may not give an accurate reflection of the program itself. For example, respondents self-evaluated on how well they believed they understood the HELP program, but these self-evaluations had little connection to actual understanding demonstrated on questions about specific features of HELP. In fact, some important facets of the program were almost completely unfamiliar – even to respondents who claimed a very strong understanding of HELP. In such a case, a high self-evaluation of understanding might be better interpreted as a level of misunderstanding rather than of understanding.

V. Impact Analysis Through 2017

The qualitative analysis of Chapter III and the survey results from Chapter IV established that Montana was successful at implementing the core components of HELP, including launching a major Medicaid coverage expansion to most adults up to 138 percent of FPL. The goal of the impact analysis is to assess the extent to which HELP has caused the changes in enrollee outcomes that were intended under the demonstration. Specifically, the impact analysis assesses whether HELP led to gains in health insurance coverage, health care access and affordability, and health behaviors and health status relative to what would have been expected under the other policy choices available to Montana--not expanding Medicaid, expanding Medicaid without a demonstration, and expanding Medicaid with a different demonstration. In making that assessment, the impact analysis relied on a quasi-experimental difference-in-differences evaluation design and data over time from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) that compares changes over time for adults in Montana to changes for similar adults in similar comparison states. In this Interim Evaluation Report, we report on impact estimates for changes from the baseline period (2011-13) through 2017, which is the first full year of operation for HELP.

To preview our findings through 2017, HELP led to a significant increase in health insurance coverage in Montana. Between 2011-13 and 2016-17, health insurance coverage for adults increased significantly more in Montana than what would have been expected if Montana had not expanded Medicaid. Further, under HELP Montana achieved larger gains in coverage than would have been expected if Montana had expanded Medicaid without a demonstration or with a different demonstration such as the demonstrations in Michigan and New Hampshire. There is also some early evidence of gains in health care access and affordability, as well as health status under HELP relative to both states that did and did not expand Medicaid.

While these findings point to early successes under HELP, the impact analysis has several limitations. Most importantly, we rely on quasi-experimental methods, which compare changes over time between Montana and similar states that provide the counterfactual for what would have happened in Montana in the absence of HELP. Because it is not possible to identify states that match Montana across all dimensions (e.g., demographic, social, economic, health, and political context), any differences identified in the comparisons between Montana and the comparison states will reflect those factors as well as differences in Medicaid expansion strategies. In addition, this Interim Evaluation Report is limited to national survey data from the ACS and BRFSS, which means the impact analysis focuses on the overall impacts of HELP for the outcomes available in those surveys. We do not have the data needed to disentangle the impacts of different components of HELP nor do we have the data to look at outcomes beyond those available in the ACS and BRFSS. However, the Final Summative Evaluation Report will include an analysis based on Medicaid administrative data through 2018. Finally, the impact estimates reported here are based on data through 2017, which is early in the post-implementation period for Montana, which implemented HELP in 2016.

In the remainder of this chapter, we present the research questions that motivate the impact analysis, followed by a discussion of our data and methods, and the limitations of our data and methods. We then present the results from the assessment of the impacts of HELP. There are three appendices to this chapter: Appendices E and F provide more detailed information on two data preparation tasks and the

development of the comparison groups for Montana, respectively. Appendix G provides supplemental tables to support the impact estimates.

Research Questions

The impact analysis is organized around three research questions:

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

We hypothesize that Montana's alternative Medicaid expansion demonstration will lead to gains in health insurance coverage and other outcomes relative to not expanding Medicaid. In particular, given Montana's focus on encouraging preventive care, we would expect the state to see gains in preventive care use over time relative to non-expansion states. We have no *a priori* expectations regarding the impacts of Montana's expansion demonstration relative to other strategies for expanding Medicaid, including expanding without a demonstration and expanding with a different type of demonstration than MT HELP.

We expect the changes introduced under the HELP demonstration to first affect the overall health insurance coverage and the mix of public and private health insurance coverage in the state, with any gains in coverage translating into improvements in health care access and affordability over time, followed later still by improvements in health behaviors and health status as access improves. We would also expect the impacts on the latter outcomes to be smaller than any impacts on health insurance coverage as uninsured individuals generally have access to some health care, including, in some cases, low-cost health care.

Data, Methods, and Limitations

Data

We used data from the ACS and BRFSS from 2011 to 2017. The ACS is a nationally representative survey of the US population conducted by the Census Bureau that collects information on Americans' demographic, housing, and socioeconomic characteristics, including their health insurance coverage at the time of the survey. The ACS is conducted by internet and mail, with telephone and in-person follow-up. The BRFSS is a nationally representative survey conducted by state health departments in conjunction with the Centers for Disease Control and Prevention that collects information on health insurance coverage at the time of the survey, health care access and affordability over the past 12 months, and health behaviors and health status.[72] Because the BRFSS is fielded continuously over the year, the 12-month look-back period for some measures will include months from the prior calendar

[72] "About BRFSS," Centers for Disease Control and Prevention, last reviewed and updated May 16, 2014, https://www.cdc.gov/brfss/about/index.htm.

year. The BRFSS is conducted by telephone based on random-digit-dial telephone samples of landline telephone and cell phone numbers.

Compared with the BRFSS, the ACS has the advantage of a larger sample size (5,493 versus 3,648 adults for Montana in 2017),[73] a higher response rate (93.7[74] versus 54.2[75] in 2017), and greater consistency in survey fielding and data processing across states and over time. To increase the consistency of the BRFSS data across states and over time, we reweighted the state BRFSS samples using a consistent set of variables based on the ACS. We also imputed for item nonresponse for key variables in the BRFSS; the Census Bureau imputes for item nonresponse in the public use files for the ACS. The imputation and reweighting processes for the BRFSS are described in Appendix E.

Study time period. We define the pre-HELP period as 2011 to 2013.[76] This provides a three-year baseline period before implementation of the ACA's Medicaid expansion and the start of the Marketplace provisions.[77] We exclude 2014 from the study period as a transition year associated with the Marketplace rollout and Medicaid expansions in many states. We treat 2016-17 as the post-HELP period, but also report estimates for 2017 alone since 2016, the first year of the HELP demonstration, was a transition year in Montana. Since we are limited to a single year after full implementation of the demonstration, the estimates reported here should be considered early estimates of the impacts of Montana's Medicaid expansion demonstration, particularly for measures of health care access and affordability and measures of health behaviors and health.

Study population. The ACA's Medicaid expansion targets adults with family income at or below 138 percent of the federal poverty level (FPL). As described in Chapter II, under Montana's alternative Medicaid expansion demonstration there are different provisions applied to different income groups under HELP. Unfortunately, the ACS and BRFSS do not provide the information needed to identify those groups. Therefore, we focus on the impacts for all adults and the low-income adult population targeted by the Medicaid expansion: adults with family income at or below 138 percent of FPL. We also examine the impacts for subsets of adults within the low-income group, including those with family income at or

[73] While the ACS has the advantage of a larger Montana sample size in the 2016-17 period, the Montana BRFSS had a larger sample size in the 2011-13 period.

[74] "American Community Survey Response Rates," US Census Bureau, no date (accessed July 26, 2018), https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/.

[75] Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System: 2016 Summary Data Quality Report* (Atlanta: Centers for Disease Control and Prevention, 2017); https://www.cdc.gov/brfss/annual_data/2016/pdf/2016-sdqr.pdf.

[76] We explored two alternate pre-HELP periods. First, given the potential for spillover effects on Medicaid enrollment from the first Marketplace open enrollment period in 2013, we also considered a pre-HELP period of 2011-12. Second, because 2011 was the first year of a major redesign of the BRFSS, a key data source for the evaluation, we considered a pre-HELP period of 2012-13. The choice of pre-period had little effect on the findings. Thus, we focus on the results using the 2011-13 pre-period in the report and provide estimates for key outcomes using the 2011-12 and 2012-13 pre-periods in Appendix G (Table G.3). The 2011-13 pre-period provides the larger sample size for the pre-period, which is important for analyses that rely on subsets of the overall sample.

[77] Some states implemented the ACA's Medicaid expansion before 2014. As discussed in Appendix F, those states are excluded from this analysis.

below 50 percent of FPL and at or below 100 percent of FPL.[78] However, identifying those income groups in the BRFSS involves some degree of measurement error (see below), and sample sizes are often small (rendering the impact estimates less precise). We focus on adults ages 19 to 64.

Identifying low-income adults. The income eligibility standards for adults ages 19 to 64 under the ACA's Medicaid expansion is based on the income of the adult and his or her family. While the majority of adults 19 to 64 are in single-family households, 41.9 percent were part of multiple family households in 2011-13.[79] Since the ACS collects detailed information on household composition and income for all members of the household, it is possible to identify members of the same family within the household and to construct measures of family income relative to FPL that align with Medicaid income-eligibility categories. By contrast, the BRFSS has little information on household composition and provides a single measure of household income based on broad categories.[80] Consequently, we cannot approximate Medicaid income-eligibility categories using the income measure in the BRFSS.

We attempt to address this limitation of the BRFSS by using the information from the ACS on the relationship between household income and family income relative to FPL to impute family income relative to FPL in the BRFSS. As outlined in Appendix E, we impute measures of family income at or below 50 percent of FPL, at or below 100 percent of FPL, at or below 138 percent of FPL, and above 500 percent of FPL for adults ages 19 to 64 in the BRFSS based on data from the ACS. While we are not able to assess the imputation accuracy of family income in the BRFSS directly, we can apply the same imputation process to the ACS and compare reported family income relative to FPL and imputed family income relative to FPL in the ACS as one check on the BRFSS imputation process. That comparison indicates a fair amount of error in the imputation process. As shown in Table V.1, 19.1 percent of the adults in Montana imputed to have family income at or below 138 percent of FPL in the ACS reported family income above that level in 2011-13. Further, 8.7 percent of the adults imputed to have family income above 138 percent of FPL reported income below that level in 2011-13. The patterns of measurement error were similar in 2016.

[78] Impact estimates for lower income adults for key outcomes are provided in Appendix G (Table G.4).

[79] Authors' tabulation of the 2011-13 ACS.

[80] The household income categories available in the BRFSS are: less than $10,000, $10,000-$14,999, $15,000-$19,999, $20,000-$24,999, $25,000-$34,999, $35,000-$49,999, $50,000-$74,999, and $75,000 or more.

Table V.1: Crosswalk of Reported and Imputed Family Income Relative to FPL for Adults Ages 19 to 64 in Montana based on American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Imputed Family Income Relative to FPL				
	At or below 50%	**At or below 100%**	**At or below 138%**	**Above 138%**	**Above 500%**
Years 2011-13					
Reported family income relative to FPL (%)					
At or below 50%	63.2	49.7	39.1	2.6	0.3
At or below 100%	80.9	75.1	61.9	4.6	0.5
At or below 138%	87.6	86.4	80.9	8.7	1.0
Above 138%	12.4	13.6	19.1	91.3	99.0
Above 500%	0.7	1.0	0.9	27.2	75.3
Sample size	425	678	922	2,451	732
Years 2016-17					
Reported family income relative to FPL (%)					
At or below 50%	58.4	47.3	37.6	1.9	0.4
At or below 100%	78.5	74.3	61.8	4.4	0.9
At or below 138%	82.6	83.2	75.4	8.1	1.2
Above 138%	17.4	16.8	24.6	91.9	98.8
Above 500%	1.3	0.8	1.3	32.4	74.4
Sample size	250	410	550	1,650	549

Source: 2011-13 and 2016-17 American Community Survey (ACS);
Notes: FPL = Federal poverty level. Cells show column percentages. Since the rows are not mutually exclusive the columns will sum to more than 100%. The imputation of family income relative to FPL is described in Appendix E. The imputation process was based on a random sample of 80% of the ACS sample. These estimates are based on the 20% of the ACS sample reserved for testing the imputation process.

In presenting impact estimates for low-income adults in the body of the report, we focus on adults with family income at or below 138 percent of FPL. However, we provide estimates for a range of lower income groups based on both household income and family income relative to FPL as a sensitivity analysis in Appendix G (Table G.4). Because of the limitations of the imputed family income measures in the BRFSS, we also provide estimates for adults with low educational attainment as another proxy for low income. However, low educational attainment is only a rough proxy for low income. Among US adults ages 19 to 64 with a high school education or less, 38.9 percent reported family income at or below 138 percent of FPL over the 2011-13 period based on the ACS. The comparable figure for Montana was much lower, at 37.0 percent (data not shown). Given the measurement error in the income measures in the BRFSS, we have more confidence in estimates for the full sample than those for subgroups of the sample based on income.

Outcome measures. We focused on the following measures of health insurance coverage, health care access and affordability, and health behaviors and health status:

- Health insurance coverage at the time of the survey, including type of health insurance coverage (Medicaid or other public coverage, employer-sponsored insurance, or direct purchase or other coverage);
- Health care access and affordability:
    - Had a personal doctor at the time of the survey;
    - Had a routine check-up in the past 12 months;
    - Had a flu vaccine in the past 12 months; and
    - Had no unmet need for doctor care due to costs in the past 12 months.[81]
- Health behaviors and health status:
    - Smoker at the time of the survey;
    - Smoker who did not try to quit in the past 12 months;
    - Health status was fair or poor at the time of the survey;
    - Physical health was not good in the past 30 days (defined as not good for at least one day);
    - Mental health was not good in the past 30 days (defined as not good for at least one day); and
    - Had an activity limitation due to health issues at the time of the survey.

Health insurance coverage at the time of the survey is available in the ACS and BRFSS. We focus on the health insurance measures from the ACS because the ACS provides a larger sample size for Montana than does the BRFSS and because the ACS provides information on a respondent's type of health insurance coverage. Although we report on the type of health insurance coverage, evidence suggests

[81] We frame this as a "positive" outcome so that higher values indicated better access and affordability across all the measures examined.

that respondents misreport their coverage type in surveys, particularly between Medicaid or other public coverage and direct purchase.[82, 83, 84]

Measures of health care access and affordability, health behaviors, and health status are from the BRFSS.[85] Given the larger sample sizes in the ACS, the estimates of the impacts on health insurance coverage from the ACS are more precise than the impact estimates for the remaining measures based on the BRFSS.

Because the ACS and BRFSS are both fielded continuously over the year (with one-twelfth of the sample interviewed in each month), the estimates for outcomes measured at the time of the survey (e.g., a respondent's health insurance coverage, whether he or she has a personal doctor, and his or her health status) are averages for the calendar year. By contrast, the estimates for outcomes that have a 12-month look-back period (e.g., whether the respondent had a routine check-up in the past 12 months and whether the respondent tried to quit smoking in the past 12 months) will include periods from the previous calendar year. For adults interviewed in July 2016, for example, the past 12 months would include August through December 2015 and January through July 2016. Consequently, the look-back period in the BRFSS for those measures exacerbates the lag between the likely impacts of Montana's demonstration on health care access and affordability and health outcomes (which are expected to be on a slower path than any impacts on health insurance coverage) and the ability to detect those impacts with the available data, which are limited to 2017 in this report.

Methods

The impacts of Montana's Medicaid expansion demonstration are estimated using a quasi-experimental difference-in-differences (DD) framework, meaning changes over time in Montana are compared with changes over time in comparison groups. The comparison groups provide an estimate of the counterfactual for what would have happened in Montana absent HELP. The empirical model for the DD analysis can be written as

$$Y_{ist} = \beta_1 \text{MONTANA}_t + \beta_2 \text{POST}_t + \beta_3 (\text{MONTANA} * \text{POST}_t) + \boldsymbol{X}_i \beta_4 + \varepsilon$$

Where Y is the outcome of interest for individual *i* in state *s* and time *t*; MONTANA takes the value one for individuals from Montana and zero for individuals in the comparison group; POST is a dummy for the post-HELP period relative to the pre-HELP period; and $\boldsymbol{X}$ is a vector of individual and family characteristics. β_3, the coefficient on the interaction term between MONTANA and POST, provides the

[82] Call, Kathleen T., Michael E. Davern, Jacob A. Klerman, and Victoria Lynch. "Comparing Errors in Medicaid Reporting across Surveys: Evidence to Date." *Health Services Research* 48, no. 2pt1 (2013): 652-664.

[83] Boudreaux, Michel H., Kathleen Thiede Call, Joanna Turner, Brett Fried, and Brett O'Hara. "Measurement error in public health insurance reporting in the American Community Survey: evidence from record linkage." *Health services research* 50, no. 6 (2015): 1973-1995.

[84] Noon, James M., Leticia E. Fernandez, and Sonya R. Porter. "Response error and the Medicaid undercount in the current population survey." *Health services research* 54, no. 1 (2016): 34-43.

[85] Although not a formal part of the federal evaluation, we also examined changes in employment over time as a supplement to understanding any changes in employer-sponsored insurance (ESI) coverage over time. Those estimates are provided in Appendix G (Table G.14). There were no significant differences in changes in employment for adults in Montana and similar adults in the comparison states between 2011-13 and 2016.

DD estimates of the impact of Montana's Medicaid expansion on the outcome in the post-HELP period relative to the comparison group.

Defining the comparison groups. As noted, we consider three counterfactuals for Montana's Medicaid expansion demonstration: (1) not expanding Medicaid, (2) expanding Medicaid without a demonstration, and (3) expanding Medicaid with a different demonstration. We describe in detail the process to select the states to be included in each comparison group in Appendix F. We provide an overview of the process here. We began by sorting states by their Medicaid expansion status (i.e., did not expand Medicaid under the ACA, expanded Medicaid without a demonstration, and expanded Medicaid with a demonstration) and by their similarity to Montana over the baseline period (2011-13) in terms of Medicaid and section 1115 income-eligibility standards.

We selected comparison states that were similar to Montana in terms of Medicaid and section 1115 income-eligibility standards, the uninsurance rate, and measures of health care access and health status for adults over the baseline period. As described in Appendix F and shown in Table V.2, we identified the group of best comparison states and the single-best comparison state from among that group. We focus on impact estimates using the group of best comparison states, but also report on impact estimates based on the single-best comparison state, as well as each of the comparison states within the group of best comparison states, since there is not a definitive approach for identifying an appropriate counterfactual to estimate the impacts of HELP. Given our inability to control for all the potential differences between Montana and the comparison states that could confound the impact estimates, we have more confidence in estimates that are consistent across multiple comparison groups.

Table V.2: Comparison States for Adults Ages 19 to 64 in Montana

	Group of Best Comparison States	Single-best Comparison State
Similar states that did not expand Medicaid	GA, NC, WY	WY
Similar states that expanded Medicaid without a demonstration	KY, ND	ND
Similar states that expanded Medicaid with a different demonstration	MI, NH	MI

Notes: See Appendix F for a description of the process for defining the group of best comparison states and the single-best comparison state.

As shown in Table V.2, the group of best comparison states includes three states that did not expand Medicaid, two states that expanded Medicaid without a demonstration, and two states that expanded Medicaid with a different demonstration. The two states in that last group are New Hampshire, which focused on expanding private coverage through the Marketplace using premium assistance under its demonstration, and Michigan, which requires premium-like contributions through a version of a health savings account under its demonstration.

Reweighting the comparison groups. After selecting the states to be included in each of the comparison groups, we adjusted the weights of each group of best comparison states to account for differences in

the states' populations[86] and implemented propensity score reweighting[87] for the groups of best comparison states, the single-best comparison state, and each of the remaining states in the group of best comparison states to increase the comparability of the adults between the comparison states and Montana. We describe the reweighting of the comparison groups in detail in Appendix F.

Propensity score models identify the adults in each comparison group who are most similar to the adults in Montana. By using the propensity scores to create inverse probability weights, adults in the comparison states who were more similar to adults in Montana received larger weights while those who were less similar to Montana adults received lower weights. This reweighting pulled the distribution of characteristics of comparison group members closer to the characteristics of adults in Montana. After the propensity score reweighting, the demographic and socioeconomic characteristics of the Montana sample and the comparison group samples were quite similar, as shown in Tables F.16-F.18 using the ACS. The companion tables using the BRFSS are provided in Tables F.19-F.21.

Estimation approach. All the outcomes examined here are binary outcomes—which means their value can be either one or zero. For simplicity in comparing across the outcomes, we estimated the DD models using linear probability models,[88] controlling for the individual and family characteristics from the propensity score models as an additional adjustment for differences between adults in Montana and the comparison states. For the BRFSS, where we have additional data on elements of survey design, we also controlled for survey month and whether the respondent was a member of the cell phone sample in the BRFSS.[89] The analyses using the ACS and BRFSS were conducted using Stata version 15.1.[90] All estimates using the BRFSS and ACS were weighted and used Stata's "svy" command to control for the complex designs of the surveys.[91] An example of the DD estimation results for health insurance coverage for adults using the ACS and BRFSS is provided in Table G.1.

Sensitivity analyses and falsification tests. We assessed the robustness of our findings to an alternate approach to propensity score reweighting (entropy balancing; described in Appendix E) and alternate estimation strategies for the DD models (using logit and probit regression rather than linear probability models) for a subset of key outcomes. We report on those sensitivity analyses for selected outcomes in

[86] Balancing for state population ensures that a very large state does not overwhelm the contributions of smaller states in the group of comparison states.

[87] As a sensitivity test, we also reweighted using entropy balancing. The choice of reweighting approach had little impact on the findings, as shown for key outcomes in Appendix G (Table G.2).

[88] Linear probability models generally provide reliable estimates over average effects. See Joshua D. Angrist and Jorn-Steffen Pischke, *Mostly Harmless Econometrics: An Empiricist's Companion* (Princeton, NJ: Princeton University Press, 2008).

[89] As noted above, the BRFSS conducts interviews with individuals drawn from landline and cell phone samples. Because there are differences across the two samples in how the respondent is selected (the landline sample selects a random adult from among all adults in the household while the cell phone sample respondent is the individual who answers the cell phone) and in some of the questions asked of the respondents, we controlled for the survey sample in the analysis.

[90] StataCorp, *Stata Statistical Software: Release 15* (College Station, TX: StataCorp LLC, 2017).

[91] We also ran models that incorporated clustering by state rather than the design variables specific to the surveys, given the state focus of the analyses. Because those models yielded very small differences in standard errors (i.e., changes in the second or third decimal place), however, we do not report the results from those models here.

Table G.2. We find that the alternate approach to propensity score reweighting and the alternate estimation methods had little effect on the DD estimates. Therefore, we focus in the report on the results based on the linear probability models using propensity score reweighting.

We also conducted falsification tests for higher-income adults who should not be affected by Montana's Medicaid expansion demonstration. We use high family income (above 500 percent of FPL), high household income (at or above $75,000), and, as a proxy for higher income, high levels of education (four-year college graduate or more). Among US adults ages 19 to 64 with a college degree or more, 48.4 percent reported family income above 500 percent of FPL over the 2011-13 period based on the ACS. The comparable figure for Montana was 35.1 percent (data not shown). Thus, higher education attainment is only a rough proxy for higher income.

The falsification tests based on family income at or above 500 percent of FPL in the ACS are strongest because the sample reflects a high-income population relative to Medicaid eligibility standards. The falsification tests based on household income for the ACS and BRFSS and on imputed family income for the BRFSS are weaker because those "high-income" populations include some low- and moderate-income adults who could be affected by the demonstration or other coverage provisions of the ACA, including the introduction of the Marketplace (see Appendix E). For example, based on Table E.4, we expected about 24.7 percent of those imputed to have family income above 500 percent of FPL in the BRFSS over the 2011-13 period to be below that level, and based on Table E.2, we expected more than 47.2 percent of those reporting household income at or above $75,000 in 2011-13 to have family income below 500 percent of FPL in both the ACS and BRFSS. Thus, for instances where we estimate an effect of HELP based on measures of household income, we would expect to estimate smaller effects under the falsification tests rather than no effects.

The estimates from the DD models are based on two-tailed hypothesis tests in which we reject the null hypothesis of no difference between Montana and the comparison groups if the likelihood of the observed data under the null hypotheses is low. We report on statistical significance at the 10, 5 and 1 percent levels. When multiple hypotheses are tested (as is the case here), the likelihood of incorrectly rejecting a null hypothesis of no difference between Montana and the comparison group (i.e., making a Type I error) increases. To address this issue, we are cautious about interpreting isolated findings of significance (e.g., a single significant estimate on access to care among multiple access outcomes) as evidence of an impact, particularly when the statistical significance level is relatively low. We have more confidence when our findings are consistent (e.g., all positive or all negative and statistically significant across several related measures and/or comparison groups).

Limitations

The impact analysis has several limitations. These include an inability to disentangle the impacts of different components of HELP. In addition, because we rely on quasi-experimental methods, our impact estimates likely incorporate some omitted variable bias because, absent random assignment, the potential for unmeasured differences between Montana and the comparison groups persist. To reduce the potential for omitted variable bias, we include a rich array of measures in both the propensity score reweighting and in the DD models. We also test the sensitivity of our estimates of HELP impacts using multiple comparison groups.

Further, the national surveys, like all surveys, are subject to measurement error, including reporting error by respondents. This is particularly true for the household income measure in the BRFSS relative to the income measures in the ACS. Thus, we have more confidence in the measures of family income relative to FPL in the ACS than in the BRFSS. We also have more confidence in the estimates from the ACS because it provides much larger sample sizes than the BRFSS. Because of the ACS's larger samples, we are better able to detect small changes in Montana relative to the comparison groups for measures of health insurance coverage than for the remaining outcomes examined.

Finally, as noted, these estimates are from early in the Montana demonstration (2017) and thus may not capture the eventual effects of HELP. This is particularly true for effects on health care access and affordability, health behaviors, and health status, which will likely take longer to be influenced by HELP than changes in health insurance coverage. The delay in impacts on those outcomes is further complicated because many of them rely on variables with a 12-month look-back period in the BRFSS so that the data for 2017 includes some months in 2016 for nearly all sample members, where 2016 was a transition year for Montana.

Results

Simple Differences over Time

Table V.3 provides simple differences in the study outcomes for adults ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period). As shown, we see significant gains in health insurance coverage for Montana adults in 2016-17 relative to the pre-period, as well as significant gains in health care access and affordability. There was also a significant reduction in the share of Montana adults who were smoking at the time of the survey and in having days in which their physical health was not good in the past 30 days, although there were no significant changes in the remaining measures of health behaviors or health status.

Table V.4 provides simple differences in study outcomes for adults ages 19 to 64 in Montana between 2011-13 (pre-period) and a post-period limited to 2017. The patterns of change here are similar to those observed for 2016-17, although with smaller sample sizes. We report on 2016-17 in the remainder of the chapter to take advantage of the larger sample sizes. Appendix Tables G.9 and G.10 provide DD estimates based on the 2017 post-period. In the remainder of this section, we present DD models to assess the changes over time for adults under Montana's HELP *relative* to states that did not expand Medicaid, expanded Medicaid without a demonstration, and expanded Medicaid with a different demonstration, respectively. Unlike the simple differences in study outcomes over time, the DD models provide estimates of changes in the study outcomes that were likely caused by the HELP demonstration.

Table V.3: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period)

	2011-13	2016-17	Difference	
Health insurance coverage (%)				
Had health insurance coverage at the time of the survey	75.6	87.9	12.3	***
Type of coverage				
Medicaid or other public coverage	9.2	16.5	7.3	***
Employer-sponsored insurance	56.8	59.0	2.2	**
Direct purchase or other coverage	9.6	12.4	2.8	***
Health care access and affordability (%)				
Had a personal doctor at the time of the survey	68.2	68.6	0.4	
Had a routine checkup in past 12 months	56.2	62.1	6.0	***
Received flu vaccine in past 12 months	31.4	34.8	3.5	***
No unmet need for doctor care due to costs in past 12 months	85.9	88.6	2.7	***
Health behaviors and health status (%)				
Smoker at the time of the survey	21.3	18.2	-3.1	***
Smoker who did not try to quit in past 12 months	9.9	9.0	-1.0	
Health status was fair or poor at the time of the survey	13.6	13.3	-0.4	
Physical health was not good in past 30 days	35.0	30.8	-4.1	***
Mental health was not good in past 30 days	34.7	33.8	-0.9	
Had an activity limitation due to health at the time of the survey	21.6	20.7	-0.9	
Sample size for ACS	16,604	10,903		
Sample size for BRFSS	18,997	7,271		

Source: Health insurance coverage: 2011-13 and 2016-17 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). Notes: ***/**/***** Significantly different from value for 2011-13 at the .10/.05/.01 levels, using a two-tailed test.

Table V.4: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 (post-period)

	2011-13	2017	Difference	
Health insurance coverage (%)				
Had health insurance coverage at the time of the survey	75.6	87.6	12.1	***
Type of coverage				
Medicaid or other public coverage	9.2	16.3	7.2	***
Employer-sponsored insurance	56.8	59.4	2.7	**
Direct purchase or other coverage	9.6	11.9	2.3	***
Health care access and affordability (%)				
Had a personal doctor at the time of the survey	68.5	67.1	-1.4	
Had a routine checkup in past 12 months	56.9	63.6	6.8	***
Received flu vaccine in past 12 months	31.9	34.9	3.1	**
No unmet need for doctor care due to costs in past 12 months	86.5	87.6	1.1	
Health behaviors and health status (%)				
Smoker at the time of the survey	21.0	17.3	-3.7	***
Smoker who did not try to quit in past 12 months	9.8	8.9	-0.8	
Health status was fair or poor at the time of the survey	13.5	13.9	0.4	
Physical health was not good in past 30 days	34.2	31.5	-2.7	*
Mental health was not good in past 30 days	34.3	34.9	0.6	
Had an activity limitation due to health at the time of the survey	21.1	22.4	1.3	
Sample size for ACS	16,604	5,493		
Sample size for BRFSS	18,997	3,648		

Source: Health insurance coverage: 2011-13 and 2017 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
/**/** Significantly different from value for 2011-13 at the .10/.05/.01 levels, using a two-tailed test.

Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults

Adults in Montana experienced significant gains in health insurance coverage between 2011-13 and 2016-17 relative to the changes for adults in similar states that did not expand Medicaid (Table V.5). Under HELP, health insurance coverage for all adults increased 6.1 percentage points ($p<.01$) relative to similar adults in the group of best comparison states that did not expand Medicaid. As would be expected given HELP's focus on low-income adults, the relative gains in coverage under HELP were larger for low-income adults (defined as adults with family income at or below 138 percent of FPL), at 10.9 percentage points ($p<.01$).

When compared with similar states that expanded Medicaid (whether without a demonstration or with a different demonstration), there were also significant gains in health insurance coverage in Montana between 2011-13 and 2016-17. Health insurance coverage increased by about 3.0 percentage points ($p<.01$) for all adults in Montana relative to both states that expanded Medicaid without a demonstration and those that expanded with a different demonstration, while the gain in coverage for low-income adults was only statistically significant relative to states that expanded with a different demonstration (4.1 percentage points, $p<.05$). Relative to states that expanded with a different demonstration, Montana saw statistically significant gains in Medicaid coverage for all adults (1.4 percentage points, $p<.05$) and for low-income adults (3.3 percentage points, $p<.10$). Thus, the gains in health insurance coverage under HELP relative to the gains that would have been expected had Montana pursued other Medicaid expansion strategies tended to be larger.

Table V.5: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		*95% confidence Interval*	*Estimate*		*95% confidence Interval*
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	6.1	***	4.5, 7.7	10.9	***	7.5, 14.2
Type of coverage						
Medicaid or other public coverage	6.1	***	4.8, 7.4	14.3	***	10.9, 17.7
Employer-sponsored insurance	0.2		-1.7, 2.2	-0.2		-3.8, 3.3
Direct purchase or other coverage	-0.2		-1.6, 1.1	-3.2	**	-5.7, -0.8
Compared to Expanding Medicaid without a Demonstration						
Had health insurance coverage at the time of the survey	3.0	***	1.4, 4.6	2.1		-1.4, 5.6
Type of coverage						
Medicaid or other public coverage	0.3		-1.1, 1.7	-0.2		-3.8, 3.4
Employer-sponsored insurance	0.3		-1.7, 2.4	1.4		-2.3, 5.2
Direct purchase or other coverage	2.4	***	0.9, 3.8	0.9		-1.8, 3.6
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	3.3	***	1.7, 4.8	4.1	**	0.9, 7.4
Type of coverage						
Medicaid or other public coverage	1.4	**	0.1, 2.7	3.3	*	-0.0, 6.7
Employer-sponsored insurance	1.4		-0.5, 3.3	2.0		-1.4, 5.4
Direct purchase or other coverage	0.4		-0.9, 1.7	-1.2		-3.6, 1.2

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

The estimates of the impacts of HELP on health insurance coverage relative to the different comparison groups are consistent across population subgroups for adults, with significant gains for men and women and older and younger adults (Table V.6) and for parents (Table V.7). For childless adults, the findings are more mixed, with significant gains in Montana relative to states that did not expand Medicaid and those that expanded Medicaid without a demonstration, but similar relative changes for states that expanded Medicaid with a different demonstration.

State-specific impact estimates. As a check on the impact estimates based on the group of best comparison states, we also estimated the impacts of Montana's demonstration relative to the single-best comparison state and to each of the remaining states in the group of best comparison states. As shown in Table V.8, we find significantly larger coverage gains in Montana relative to the single-best comparison state (Wyoming) and each of the two remaining comparison states that did not expand Medicaid (Georgia and North Carolina). In each of the three states, the findings can be attributed to the significantly larger relative gains in Medicaid coverage in Montana of roughly 6 percentage points ($p<.01$).

In contrast, the results were mixed when we compared Montana with the states in the group of best comparison states that expanded Medicaid without a demonstration. Montana had a significantly larger gain in health insurance coverage relative to the single-best comparison state (North Dakota), but the same relative gain as the other comparison state (Kentucky). Those differences were driven by a significantly larger gain in Medicaid coverage in Montana relative to North Dakota and a significantly smaller gain in Medicaid coverage in Montana relative to Kentucky.

Finally, compared to each of the states that expanded Medicaid with a different demonstration (Michigan and New Hampshire), Montana had a significantly larger gain in health insurance coverage, reflecting, in part, a significantly larger gain in Medicaid coverage. Thus, the relative impact of Montana's section 1115 demonstration on health insurance coverage tended to be larger than the impacts of similar states that expanded Medicaid with a different demonstration and within the range of impacts observed for similar states that expanded Medicaid without a demonstration.

Table V.6: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Gender and Age

	By Gender				By Age			
	Men		Women		Younger than age 45		Age 45 or older	
Compared to Not Expanding Medicaid								
Had health insurance coverage at the time of the survey	6.6	***	5.7	***	7.7	***	4.3	***
Type of coverage								
Medicaid or other public coverage	5.0	***	7.2	***	6.5	***	5.5	***
Employer-sponsored insurance	1.5		-0.8		0.3		0.4	
Direct purchase or other coverage	0.1		-0.6		0.9		-1.6	*
Compared to Expanding Medicaid without a Demonstration								
Had health insurance coverage at the time of the survey	3.6	***	2.5	**	4.1	***	1.6	*
Type of coverage								
Medicaid or other public coverage	-0.3		0.9		1.2		-0.8	
Employer-sponsored insurance	1.5		-0.7		0.3		0.4	
Direct purchase or other coverage	2.4	**	2.3	**	2.7	***	2.1	**
Compared to Expanding Medicaid with a Different Demonstration								
Had health insurance coverage at the time of the survey	3.1	***	3.6	***	4.6	***	1.8	*
Type of coverage								
Medicaid or other public coverage	0.3		2.6	***	1.8	*	0.8	
Employer-sponsored insurance	2.3	*	0.6		1.6		1.4	
Direct purchase or other coverage	0.4		0.4		1.2		-0.4	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.7: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Parent Status

	By Parent Status			
	Parent		Childless Adult	
Compared to Not Expanding Medicaid				
Had health insurance coverage at the time of the survey	7.7	***	5.4	***
Type of coverage				
Medicaid or other public coverage	7.2	***	5.6	***
Employer-sponsored insurance	0.4		0.2	
Direct purchase or other coverage	0.1		-0.4	
Compared to Expanding Medicaid without a Demonstration				
Had health insurance coverage at the time of the survey	5.6	***	1.7	*
Type of coverage				
Medicaid or other public coverage	3.3	**	-1.0	
Employer-sponsored insurance	-0.2		0.5	
Direct purchase or other coverage	2.5	**	2.3	**
Compared to Expanding Medicaid with a Different Demonstration				
Had health insurance coverage at the time of the survey	7.1	***	1.4	
Type of coverage				
Medicaid or other public coverage	4.3	***	0.2	
Employer-sponsored insurance	1.6		1.2	
Direct purchase or other coverage	1.2		0.0	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.8 Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) for the Single-best Comparison State and Each Remaining Best Comparison State

	Single-best Comparison State		Remaining Best Comparison States			
Compared to Not Expanding Medicaid	**WY**		**GA**		**NC**	
Had health insurance coverage at the time of the survey	6.3	***	6.1	***	6.0	***
Type of coverage						
Medicaid or other public coverage	6.2	***	6.2	***	6.0	***
Employer-sponsored insurance	-0.4		0.1		0.3	
Direct purchase or other coverage	0.5		-0.2		-0.3	
Compared to Expanding Medicaid without a Demonstration	**ND**		**KY**			
Had health insurance coverage at the time of the survey	5.9	***	0.9			
Type of coverage						
Medicaid or other public coverage	4.8	***	-3.0	***		
Employer-sponsored insurance	-1.0		2.0	**		
Direct purchase or other coverage	2.2	**	1.9	***		
Compared to Expanding Medicaid with a Different Demonstration	**MI**		**NH**			
Had health insurance coverage at the time of the survey	3.1	***	3.5	***		
Type of coverage						
Medicaid or other public coverage	1.3	**	1.9	**		
Employer-sponsored insurance	1.0		1.8			
Direct purchase or other coverage	0.8		-0.2			

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: For sample sizes, see Table G.6 (Montana) and G.7 (each of Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Differences in impact estimates by income. The estimates of the relative impacts of HELP on changes in health insurance coverage relative to not expanding Medicaid tend to be larger for lower-income adults, as would be expected given the focus of HELP policies on low-income adults (Table V.9). For example, the estimated effect of HELP on changes in health insurance coverage relative to not expanding Medicaid is 6.1 percentage points (p<.01) for all adults, 10.9 percentage points (p<.01) for adults with family income at or below 138 percent FPL, and 12.3 percentage points (p<.01) for adults with family income at or below 50 percent of FPL (p<.01). Although smaller in magnitude, there were also significant differences for lower-income adults under HELP relative to expanding Medicaid with a different demonstration. By contrast, there were no significant differences in the impacts of HELP for lower-income adults relative to similar adults in states that expanded Medicaid without a demonstration, which is consistent with the findings in Table V.5.

Table V.9: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Lower-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, Based on Alternate Measures of Lower Income

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Had health insurance coverage at the time of the survey						
Core model	6.1	***	3.0	***	3.3	***
With family income at or below 50% FPL	12.3	***	-0.8		4.9	**
With family income at or below 100% FPL	12.4	***	1.9		5.3	***
With family income at or below 138% FPL	10.9	***	2.1		4.1	**
With household income below $25,000	10.1	***	1.9		4.0	*
With household income below $50,000	10.0	***	3.3	**	3.9	***
High school graduate/GED or less	11.4	***	3.5	**	6.1	***

Source: 2011-13 and 2016-17 American Community Survey (ACS);
Notes: FPL = Federal poverty level. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Consistent with the focus of the policy changes on lower-income adults under HELP, we find little change in health insurance coverage in Montana for higher-income adults with income above 500 percent FPL relative to the comparison groups regardless of the Medicaid expansion status of the comparison group (Tables G.5).

Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults

As discussed, we would expect a lag between any changes in health insurance coverage under HELP and any subsequent effects on health care access and affordability. This lag is further compounded because of the 12-month look-back period for many of the health care access and affordability measures in the BRFSS. Given those data limitations, we would not necessarily expect to see robust changes in health care access and affordability in Montana between 2011-13 and 2016-17 relative to the comparison states. Nonetheless, we do see significant increases in Montana in the shares of adults with a routine checkup and a flu vaccine in the past 12 months relative to not expanding Medicaid, to expanding Medicaid without a demonstration, and to expanding Medicaid with a different demonstration (Table V.10).

The gains in health care access in Montana relative to the comparison states are generally consistent across population subgroups, with significant gains for men and women and older and younger adults (Table V.11) and for parents and childless adults (Table V.12). Consistent with the findings reported in Table V.10, the effects are strongest for the comparison to states that did not expand Medicaid and to states that expanded Medicaid without a demonstration. There are weaker findings for the comparison to states that expanded Medicaid with a different demonstration, which likely reflects the mixed findings for the two states in that comparison group—there are no significant differences relative to the single-best comparison state (Michigan), while there were significant differences relative to the other comparison state (New Hampshire) (Table V. 13). For the comparison to states that did not expand Medicaid and states that expanded Medicaid without a demonstration, there were significant gains in Montana relative to each of the comparison states for at least one outcome, as well as a few cases where the gains in Montana were significantly less than the comparison state (e.g., less likely to have a personal doctor relative to North Carolina and more likely to have affordability issues relative to Kentucky.

Table V.10: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		*95% confidence Interval*	*Estimate*		*95% confidence Interval*
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	0.8		-1.3, 2.9	0.6		-3.9, 5.2
Had a routine checkup in past 12 months	4.7	***	2.5, 6.9	4.7	**	0.1, 9.3
Received flu vaccine in past 12 months	2.9	***	0.8, 5.1	2.4		-2.1, 7.0
No unmet need for doctor care due to costs in past 12 months	1.3	*	-0.2, 2.8	4.5	*	-0.1, 9.0
Compared to Expanding Medicaid without a Demonstration						
Had a personal doctor at the time of the survey	1.9	*	-0.1, 3.9	0.1		-4.4, 4.5
Had a routine checkup in past 12 months	4.6	***	2.4, 6.8	-0.4		-5.7, 4.8
Received flu vaccine in past 12 months	3.6	***	1.5, 5.8	-0.2		-4.5, 4.1
No unmet need for doctor care due to costs in past 12 months	-0.5		-1.9, 1.0	-1.7		-5.6, 2.2
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	0.2		-1.8, 2.2	-1.1		-5.9, 3.7
Had a routine checkup in past 12 months	2.6	**	0.4, 4.8	-0.3		-5.7, 5.0
Received flu vaccine in past 12 months	1.8	*	-0.3, 4.0	0.5		-3.7, 4.7
No unmet need for doctor care due to costs in past 12 months	-1.0		-2.5, 0.5	-1.5		-5.4, 2.4

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.11: Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Gender and Age

	By Gender				By Age			
	Men		*Women*		*Younger than age 45*		*Age 45 or older*	
Compared to Not Expanding Medicaid								
Had a personal doctor at the time of the survey	1.1		0.5		2.2		-0.8	
Had a routine checkup in past 12 months	3.4	**	6.0	***	5.9	***	3.5	**
Received flu vaccine in past 12 months	2.5		3.4	**	1.5		4.5	***
No unmet need for doctor care due to costs in past 12 months	1.0		1.6		2.3	*	0.1	
Compared to Expanding Medicaid without a Demonstration								
Had a personal doctor at the time of the survey	3.5	**	0.3		3.4	**	0.0	
Had a routine checkup in past 12 months	4.4	***	4.8	***	4.1	**	5.0	***
Received flu vaccine in past 12 months	3.6	**	3.8	**	1.7		5.8	***
No unmet need for doctor care due to costs in past 12 months	-0.9		0.0		-1.5		0.6	
Compared to Expanding Medicaid with a Different Demonstration								
Had a personal doctor at the time of the survey	0.7		-0.4		1.6		-1.4	
Had a routine checkup in past 12 months	2.0		3.0	**	3.0	*	2.1	
Received flu vaccine in past 12 months	1.3		2.2		1.6		2.2	
No unmet need for doctor care due to costs in past 12 months	-2.2	**	0.2		-1.0		-1.1	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.12: Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Parent Status

	By Parent Status			
	Parent		*Childless Adult*	
Compared to Not Expanding Medicaid				
Had a personal doctor at the time of the survey	0.7		0.9	
Had a routine checkup in past 12 months	6.2	***	3.8	***
Received flu vaccine in past 12 months	2.6		3.2	**
No unmet need for doctor care due to costs in past 12 months	1.8		1.0	
Compared to Expanding Medicaid without a Demonstration				
Had a personal doctor at the time of the survey	1.7		1.9	
Had a routine checkup in past 12 months	4.8	***	4.3	***
Received flu vaccine in past 12 months	3.1	*	3.9	***
No unmet need for doctor care due to costs in past 12 months	-1.0		-0.2	
Compared to Expanding Medicaid with a Different Demonstration				
Had a personal doctor at the time of the survey	0.5		0.0	
Had a routine checkup in past 12 months	5.3	***	0.9	
Received flu vaccine in past 12 months	1.6		2.1	
No unmet need for doctor care due to costs in past 12 months	-0.1		-1.6	*

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.13: Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) for the Single-best Comparison State and Each Remaining Best Comparison State

	Single-best Comparison State		Remaining Best Comparison States			
Compared to Not Expanding Medicaid	**WY**		**GA**		**NC**	
Had a personal doctor at the time of the survey	1.1		3.4	***	-2.0	*
Had a routine checkup in past 12 months	1.6		7.3	***	6.6	***
Received flu vaccine in past 12 months	2.3	*	2.9	**	3.0	**
No unmet need for doctor care due to costs in past 12 months	2.3	**	1.0		0.2	
Compared to Expanding Medicaid without a Demonstration	**ND**		**KY**			
Had a personal doctor at the time of the survey	2.6	**	1.4			
Had a routine checkup in past 12 months	7.9	***	1.1			
Received flu vaccine in past 12 months	3.3	***	4.3	***		
No unmet need for doctor care due to costs in past 12 months	3.0	***	-2.3	***		
Compared to Expanding Medicaid with a Different Demonstration	**MI**		**NH**			
Had a personal doctor at the time of the survey	-0.1		0.9			
Had a routine checkup in past 12 months	1.8		3.8	***		
Received flu vaccine in past 12 months	1.5		2.5	*		
No unmet need for doctor care due to costs in past 12 months	-0.6		-1.1			

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: For sample sizes, see Table G.6 (Montana) and G.7 (each of Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status for Adults

As with the expected lag in any impacts of Montana's Medicaid expansion demonstration on health care access and affordability, we would not necessarily expect to see robust changes in health behaviors and health status in Montana relative to the comparison states between 2011-13 and 2016-17. Consistent with that expectation, we find few significant differences in changes in health behaviors or health status in Montana relative to the comparison states, regardless of Medicaid expansion status (Table V.14). However, Montana residents were significantly less likely to report that their physical health was not good in the past 30 days relative to each group of comparison states. Further, there was evidence of gains in health status in Montana relative to states that expanded Medicaid with a different demonstration across several other measures, including smokers who had not tried to quit and activity limitations due to health.

Gains in health behaviors and health status in Montana relative to the comparison states are also observed across population subgroups, although the particular gains vary for men and women and older and younger adults (Table V.15) and for parents and childless adults (Table V.16). For example, women and older adults, but not men and younger adults, in Montana were less likely to report that their mental health was not good in the past 30 days relative to each group of comparison states.

State-specific impact estimates. As a check on the impact estimates based on the group of best comparison states, we also estimated the impacts of Montana's demonstration relative to the single-best comparison state and to each of the remaining states in the group of best comparison states. As shown in Table V.17, adults in Montana reported improvements in health behaviors relative to two of the seven comparison states and improvements in health status relative to five of the seven comparisons states. The only states where there were no significant differences in relative changes in health behaviors or health status were Wyoming and Kentucky.

Table V.14: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		*95% confidence Interval*	*Estimate*		*95% confidence Interval*
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	0.1		-1.6, 1.9	0.6		-3.8, 4.9
Smoker who did not try to quit in past 12 months	-0.3		-1.6, 1.1	0.3		-3.5, 4.0
Health status was fair or poor at the time of the survey	-0.2		-1.6, 1.1	-0.5		-4.3, 3.3
Physical health was not good in past 30 days	-2.6	**	-4.7, -0.6	-3.3		-7.9, 1.4
Mental health was not good in past 30 days	-1.6		-3.8, 0.6	-2.5		-7.3, 2.3
Had an activity limitation due to health at the time of the survey	-0.8		-2.6, 0.9	-1.6		-6.0, 2.9
Compared to Expanding Medicaid without a Demonstration						
Smoker at the time of the survey	0.4		-1.4, 2.1	0.7		-3.6, 4.9
Smoker who did not try to quit in past 12 months	0.5		-0.8, 1.8	1.4		-2.7, 5.5
Health status was fair or poor at the time of the survey	-0.9		-2.2, 0.5	-1.4		-5.4, 2.5
Physical health was not good in past 30 days	-2.0	*	-4.1, 0.1	-2.5		-6.8, 1.9
Mental health was not good in past 30 days	-1.7		-3.9, 0.5	-3.0		-7.4, 1.5
Had an activity limitation due to health at the time of the survey	-1.0		-2.8, 0.8	-1.3		-5.2, 2.7
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-1.2		-3.0, 0.5	-0.9		-5.0, 3.2
Smoker who did not try to quit in past 12 months	-1.2	*	-2.5, 0.1	-0.5		-3.6, 2.6
Health status was fair or poor at the time of the survey	-0.8		-2.2, 0.5	-1.9		-5.4, 1.5
Physical health was not good in past 30 days	-4.1	***	-6.2, -2.0	-4.4	*	-9.2, 0.3
Mental health was not good in past 30 days	-1.5		-3.6, 0.7	-1.0		-5.9, 3.9
Had an activity limitation due to health at the time of the survey	-3.2	***	-5.0, -1.4	-3.1		-7.1, 0.9

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). **Notes:**
Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.15: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Gender and Age

	By Gender				By Age			
	Men		*Women*		*Younger than age 45*		*Age 45 or older*	
Compared to Not Expanding Medicaid								
Smoker at the time of the survey	0.9		-0.5		1.1		-0.8	
Smoker who did not try to quit in past 12 months	-0.5		0.1		0.5		-1.0	
Health status was fair or poor at the time of the survey	-1.5		1.1		-1.0		1.0	
Physical health was not good in past 30 days	-3.1	**	-2.1		-3.9	**	-1.1	
Mental health was not good in past 30 days	-0.4		-2.7	*	-0.8		-2.4	*
Had an activity limitation due to health at the time of the survey	-0.9		-0.7		-1.3		-0.2	
Compared to Expanding Medicaid without a Demonstration								
Smoker at the time of the survey	-0.1		0.8		2.3	*	-1.4	
Smoker who did not try to quit in past 12 months	0.2		0.9		2.4	**	-1.5	*
Health status was fair or poor at the time of the survey	-1.6	*	-0.2		-1.7	*	0.3	
Physical health was not good in past 30 days	-2.2		-1.8		-2.2		-1.7	
Mental health was not good in past 30 days	-0.2		-3.3	**	-0.8		-2.7	*
Had an activity limitation due to health at the time of the survey	-0.5		-1.4		-0.6		-1.3	
Compared to Expanding Medicaid with a Different Demonstration								
Smoker at the time of the survey	-1.3		-1.0		-0.7		-1.6	
Smoker who did not try to quit in past 12 months	-2.0	**	-0.3		-0.6		-1.7	**
Health status was fair or poor at the time of the survey	-1.6	*	0.0		-1.3		0.1	
Physical health was not good in past 30 days	-4.1	** *	-4.1	***	-4.7	** *	-3.0	**
Mental health was not good in past 30 days	0.8		-3.8	**	-0.6		-2.3	*
Had an activity limitation due to health at the time of the survey	-2.4	*	-4.0	***	-3.1	**	-3.0	**

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.16: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, by Parent Status

	By Parent Status			
	Parent		*Childless Adult*	
Compared to Not Expanding Medicaid				
Smoker at the time of the survey	-1.6		1.3	
Smoker who did not try to quit in past 12 months	-1.4		0.5	
Health status was fair or poor at the time of the survey	-1.5		0.7	
Physical health was not good in past 30 days	-2.4		-2.7	**
Mental health was not good in past 30 days	-1.6		-1.6	
Had an activity limitation due to health at the time of the survey	-1.9		-0.1	
Compared to Expanding Medicaid without a Demonstration				
Smoker at the time of the survey	0.2		0.6	
Smoker who did not try to quit in past 12 months	-0.4		1.0	
Health status was fair or poor at the time of the survey	-2.1	**	-0.1	
Physical health was not good in past 30 days	-1.0		-2.7	**
Mental health was not good in past 30 days	-2.9		-1.0	
Had an activity limitation due to health at the time of the survey	-1.0		-1.0	
Compared to Expanding Medicaid with a Different Demonstration				
Smoker at the time of the survey	-1.8		-0.8	
Smoker who did not try to quit in past 12 months	-2.6	***	-0.3	
Health status was fair or poor at the time of the survey	-2.3	**	0.1	
Physical health was not good in past 30 days	-1.7		-5.6	***
Mental health was not good in past 30 days	-1.9		-1.4	
Had an activity limitation due to health at the time of the survey	-2.4	*	-3.7	***

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Table V.17: Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) for Single-best Comparison State and Each Remaining Best Comparison State

	Single-best Comparison State		Remaining Best Comparison States			
Compared to Not Expanding Medicaid	***WY***		***GA***		***NC***	
Smoker at the time of the survey	0.4		-0.9		0.9	
Smoker who did not try to quit in past 12 months	0.1		-0.5		-0.2	
Health status was fair or poor at the time of the survey	0.2		-0.6		-0.5	
Physical health was not good in past 30 days	-1.8		-3.5	**	-2.8	**
Mental health was not good in past 30 days	0.0		-1.4		-2.4	*
Had an activity limitation due to health at the time of the survey	0.8		-1.8		-1.0	
Compared to Expanding Medicaid without a Demonstration	***ND***		***KY***			
Smoker at the time of the survey	0.5		0.3			
Smoker who did not try to quit in past 12 months	0.2		0.7			
Health status was fair or poor at the time of the survey	-1.0		-0.7			
Physical health was not good in past 30 days	-2.3	*	-1.6			
Mental health was not good in past 30 days	-2.7	**	-0.7			
Had an activity limitation due to health at the time of the survey	-1.5		-0.7			
Compared to Expanding Medicaid with a Different Demonstration	***MI***		***NH***			
Smoker at the time of the survey	-0.6		-2.4	**		
Smoker who did not try to quit in past 12 months	-1.5	**	-1.2			
Health status was fair or poor at the time of the survey	-0.7		-1.3			
Physical health was not good in past 30 days	-4.7	***	-3.4	**		
Mental health was not good in past 30 days	-2.6	**	0.1			
Had an activity limitation due to health at the time of the survey	-3.5	***	-2.9	**		

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: For sample sizes, see Table G.6 (Montana) and G.7 (each of Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Summary of Impact Analysis

Between 2011-13 (the period just before the ACA's Medicaid expansion and the launch of the Marketplace) and 2016-17 (the first two years after the implementation of Montana's section 1115 HELP demonstration), health insurance coverage in Montana was significantly higher than what would have been expected if Montana had not expanded Medicaid. Specifically, the change in health insurance coverage in Montana was 6.1 percentage points ($p<.01$) higher for all adults and 10.9 percentage points ($p<.01$) higher for low-income adults relative to the group of best comparison states (Georgia, North Carolina, and Wisconsin) that did not expand Medicaid.

Beyond simply examining the impact of HELP relative to no Medicaid expansion, an equally important question is how the impact of HELP on health insurance coverage compared to the impacts of alternate strategies for Medicaid expansions, such as, expanding without a section 1115 demonstration or expanding with a different demonstration. We find that the gains in health insurance coverage for adults under HELP were significantly larger than those achieved by either the group of best comparison states (Kentucky and North Dakota) that expanded Medicaid without a demonstration or the group of best comparison states (Michigan and New Hampshire) that expanded Medicaid with a different demonstration.

VI. Lessons Learned from HELP

This evaluation explored stakeholder as well as beneficiary views on the Montana HELP demonstration and assessed the impact of the demonstration on health insurance coverage and access to care. Findings from all three components of this HELP evaluation show that the program had significant and positive effects. However, as with any program, implementation and administration were not seamless. Overall, health insurance coverage increased substantially; beneficiaries were largely satisfied with the program; and stakeholders believed it had positive economic impacts by increasing hospital payments and reducing uninsurance rates.

One of the principal lessons from Montana's section 1115 demonstration is that allowing Montana to use a section 1115 demonstration resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage. As of September 2018, nearly 100,000 Montanans were enrolled in HELP. Moreover, the expansion in health insurance coverage exceeded the gains that would have been expected if the state had expanded Medicaid without a demonstration or with a demonstration more similar to those of Michigan or New Hampshire.

Apart from increases in health insurance coverage, the three components of the assessment of HELP provides a number of additional insights, which lessons other states considering designing and implementing section 1115 Medicaid demonstrations may find beneficial to take into account:

- **Satisfaction with the HELP program was high among current enrollees, but somewhat less so among those disenrolled from the program.** A majority of enrollees were somewhat to very satisfied with individual features of HELP including monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of health care services needed by these enrollee respondents. Among the disenrollee respondents, as is to be expected, those who voluntarily disenrolled from the program appeared to be more satisfied than those who were disenrolled from the program for non-payment of premiums. However, nearly 50 percent of disenrollee respondents did indicate that they would choose to re-enroll in HELP.

- **HELP enrollees' and disenrollees' understanding of the individual features of HELP appears to be incomplete.** This finding consistency came across from focus groups with HELP enrollees, interviews with HELP stakeholders, as well as from the survey results. This was particularly true for some of the more complex features such as premium credits going towards copays owed, and that copays must be paid out of pocket once premium credits are used up, as well as the feature that unpaid premiums are collected against future state income tax refunds. Focus groups and survey results also show issues with beneficiary outreach and assistance, which could reduce beneficiary, and in some cases provider, confusion about who is eligible, what is covered and what copayments are required.

- **Access to health care improved for many beneficiaries.** Focus group and stakeholder interviews showed that access was viewed favorably by both beneficiaries and stakeholders. With gains in health insurance coverage, enrollees in focus groups said their access to care had improved relative to their access before being covered under HELP. Access barriers were more prevalent for dental and vision services than for other services, even with HELP coverage. There is also some early evidence of gains in health care access and affordability, as well as gains in health behaviors and health status in Montana relative to states that did not expand Medicaid and

those that expanded Medicaid with or without a demonstration. However, given that the results are based on the first two years under HELP, a longer follow-up period is needed to more fully assess the impacts of HELP on health care access and affordability, health behaviors, and health status.

- **Strong stakeholder engagement and collaboration with the state expedites system change.** While state officials and stakeholders acknowledged that it took time and compromise to pass the Medicaid expansion in Montana, once HELP legislation was enacted, the deep collaboration between the state and stakeholders in implementing HELP created a win-win situation for hospitals, the broader health care system, and the uninsured in Montana.

- **Changing patterns of health care use is hard and requires a long-term commitment.** One of HELP's goals is to promote personal health responsibility. State officials and other interviewees noted that changing health care behaviors takes time as enrollees, especially enrollees who may never have had health insurance, learn how health insurance works and gain experience with the health care system. While state officials, other interviewees, and focus group participants reported continued gaps in enrollee understanding of HELP, they also noted evidence of changes in health care behaviors in response to the program as more enrollees were reported to be obtaining preventive care over time, a finding that our early impact estimates appear to support.

- **Flexibility in program design is important.** State officials and other interviewees highlighted the importance of periodically revisiting the HELP demonstration design based on actual program experience. For example, the administrative complexity of the original design of the 2 percent premium credit was difficult for the TPA plan to track and was a source of confusion for enrollees. As a result, Montana eliminated the premium credit as part of its 2017 demonstration amendments. Similarly, owing to administrative concerns and after conducting several cost-benefit analyses, the state decided not to implement copayments for non-emergent use of the emergency room.

- **Broader state contextual issues have important implications.** Montana experienced a significant budget crisis in 2017. In a cost saving measure, Montana as part of its 2017 demonstration amendments eliminated the TPA plan and brought all HELP enrollees into the state's traditional Medicaid plan, thereby removing the public-private partnership feature of HELP. Montana's budget crisis also affected the state hiring which caused Medicaid eligibility and enrollment problems, both for the general Medicaid program and for the HELP demonstration enrollees

While this federal evaluation will not continue to track HELP as it moves forward, there is more that can be learned from Montana's section 1115 demonstration beyond the first two years of implementation. This is especially true for HELP given that on May 8, 2019, the Montana legislature reauthorized HELP as part of the Medicaid Reform and Integrity Act, which calls for several program changes including introducing community engagement requirements for some HELP enrollees and eliminating copayments. It will be important to continue to track the implementation and management of the demonstration, as well as to examine the impacts of the demonstration in 2018 and beyond.

Appendices

Appendix A: Methodological Approach for Focus Groups

As part of our qualitative data collection under the Montana Medicaid expansion evaluation, we conducted focus groups with current beneficiaries enrolled in coverage through HELP. These focus groups captured HELP enrollees' reflections on their experiences in the program and obtained their perspectives and opinions on the program's strengths and weaknesses. Focus groups provide valuable and nuanced insights into individuals' experiences with a product, process, or program, but by their nature, they obtain information from relatively few people and thus cannot be presumed to represent the entire population of interest. Over three consecutive days in September 2018, Urban Institute researchers conducted four focus groups in Billings, Livingston, and Forsyth, Montana. All four focus groups included both exempt and premium-paying enrollees.

To help recruit HELP enrollees for focus groups, the Montana Medicaid agency gave evaluators recruitment lists containing names, contact information, and demographic information (e.g., income, ethnicity, Native American status) of both exempt and premium-paying HELP enrollees living in Billings, Livingston, and Forsyth. In each locality, we drew proportional subsamples from the larger full samples to approximately represent the distributions of enrollees by income (less than 51 percent, 51 to 100 percent, and more than 100 percent of FPL), eligibility status (exempt or paying premiums), and self-reported Native American status. A focus group ideally has between 8 and 10 people; to allow for attrition, we recruited 16 people for each group. Thus, for each of the four focus groups, recruitment efforts proceeded until recruiters secured commitments from 16 participants.

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

As detailed in **Appendix Table A1**, 33 HELP enrollees participated in the four focus groups (though 16 recruits had repeatedly confirmed their intent to attend each focus group). Researchers purposefully recruited about twice as many premium-paying enrollees as exempt enrollees to get perspectives from those affected by the elimination of the TPA and the premium credit. Nineteen of the 33 participants were female, and all participants were white. Though researchers attempted to recruit participants of other races, as well as of Native American status, all declined to participate.

Appendix Table A1. Focus Group Composition and Participation

	Premium-Paying Participants	Exempt Participants	Total
Focus Group 1	7	3	10
Focus Group 2	5	2	7
Focus Group 3	7	2	9
Focus Group 4	4	3	7
Total	23	10	33

Each focus group lasted between 90 and 120 minutes, and each participant received a $60 gift card in appreciation of their participation. We also provided a light meal to participants. During the focus group design phase, the evaluation team developed a moderator's guide with a core set of questions exploring enrollees' experiences with HELP across the following dimensions:

- marketing and outreach
- enrollment process
- first impressions of the program
- renewal process
- cost sharing and affordability
- access to care, benefits, and health care use
- satisfaction with care quality
- impacts of having health coverage on daily life
- suggestions for improving the program
- HELP-Link program
- future issues, including the I-185 ballot initiative

We explored all dimensions, except the HELP-Link program and future issues, in the first wave of focus groups conducted in 2017.

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

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

Appendix B: Methodological Approach for the HELP Beneficiary Surveys

Survey Sample and Response Rates

The sample frames (i.e., the lists of individuals meeting the inclusion criteria, and thus eligible to be sampled) for the enrollee and the disenrollee survey were derived from the State of Montana HELP administrative database. At the time of sample frame creation, this database contained HELP program participation records for each month during January 2016 – May 2017. Any individual who participated in the HELP program at any time during that period was included in the database.

Once included in the database, HELP enrollees had at least one record for each calendar month indicating current status (enrolled/disenrolled), reason for enrollment/disenrollment, income category relative to the federal poverty level, and demographic/residential information including zip codes which were then used to classify individuals as living in urban/rural areas[1]. In the event of a change in any component of an individual's status or demographics in a given month, the individual would have an additional record.

We devised processing rules for the administrative data to best approximate our inclusion/exclusion criteria for the sample frame for the survey using the information available. The enrollee survey sample frame consisted of all individuals aged 19-64 who resided in Montana and were enrolled in the HELP program in May 2017 and had indication of enrollment in each of the prior five months. "Unequivocal enrollment" was defined as having a record for May 2017 in which the "Eligibility_Indicator" field had an entry of "1" with no indication of failure to pay premium, and no separate record for that month indicating ineligibility. This definition was intended to capture individuals who were currently enrolled, and had been enrolled for sufficient time (at least 6 months) to have experience with the aspects of the program examined in this survey.

The disenrollee sample frame consisted of all individuals aged 19-64 who had been enrolled in Montana HELP at some point during the previous 6 months, but were unequivocally listed as disenrolled from the HELP program as of May 2017. "Unequivocal disenrollment" was defined as having a record for May, 2017 in which the "Eligibility_Indicator" field had an entry of "0", and no separate record for that month indicating eligibility. We excluded anyone whose first enrollment in the program occurred more than 12 months prior to the time of sample frame determination (May, 2017).

We randomly sampled 2,180 enrollees and 2,187 disenrollees from the sample frames of 19,994 records and 2,378 records, respectively. These sample sizes aimed to yield 700 completed enrollee and 700 completed disenrollee surveys. We calculated response rates based on complete survey submissions received through December 22, 2017, where as long as the respondents answered at least one question in addition to the screening questions, we considered it a response, and included all answered questions in the analysis. Particularly in light of the low response rate, we saw no reason to discard any information that was provided. Response rates for the primary questions (those not subject to being skipped based on other answers) was generally 90%-95%. A total of 655 individuals (31.1%) of the enrollee cohort submitted an enrollee survey form. This response rate is comparable to that seen in

[1] Urban/rural was defined by mapping respondent zip codes to their corresponding county FIPS, and then using the county FIPs codes to classify them into core-based statistical areas (CBSAs). If a county fell in a CBSA it was considered urban. Counties that did not meet the definition of a CBSA were assigned as rural.

other surveys of Medicaid enrollees (Barnett & Sommers, 2017). For the disenrollee survey, only 178 individuals (9.3%) in the sample returned a disenrollee survey. This low response rate is comparable to that seen in other surveys targeting subjects with low socioeconomic status.

We anticipated that between the date of survey subject selection and the date of subject response, some individuals in the samples would change status from enrollee to disenrollee, or vice versa. For those selected for the disenrollee survey, 197 (9.0%) of the disenrollee sample reported that they were currently enrolled or unsure if currently enrolled in HELP, 74 (3.4%) had never been enrolled or were unsure if ever enrolled in HELP, and 5 (0.2%) said they had not been enrolled in the last 12 months. Seventy-four (3.4%) of the enrollee sample reported that they were not currently enrolled or unsure if they were currently enrolled in HELP.

Sample Non-Response Analysis

We conducted a non-response analysis to examine whether survey respondents and non-respondents differed on demographic factors by which program experiences or opinions might conceivably differ. In particular, we compared respondents and non-respondents on available demographic factors of sex, race, age group, urban/rural residence, and FPL category. Table B1 below shows percentage distributions of sex, race, urban/rural, FPL, and age group for the two sample populations, separately for those who responded and those who did not. Note that the information source for this table is the Montana administrative file, so that non-respondent information can be included and fairly compared to respondent information. For all other tables with demographic variables, the information comes from survey responses. Hence, the demographics in Table B1 may vary slightly from what is shown in other tables.

Among disenrollees there were no significant differences between the respondents and non-respondents on the demographic factors examined. For the enrollee population, the only statistically significant difference we found on the five observable characteristics between respondents and non-respondents was for age group, with only 49% of respondents being in the 19-39 age group, compared to 68% among non-respondents. The sample survey data are weighted in order to compensate for bias introduced by these differences between the respondents and non-respondents.

Sample Weights

For each survey, sample weights were developed in three steps to account for the probabilities of selection and to adjust for known ineligibility and nonresponse to reduce potential bias. The initial weight for each person in the sampling frame was calculated as the reciprocal of a given record's probability of selection from the sampling frame. To create the base weight, the initial weight was further adjusted by multiplying it by the number of records each person had in the sampling frame to compensate for unequal probabilities of selection.

The adjustment for ineligibility and nonresponse involved the creation of strata defined by demographic characteristics related to response. For the enrollees, the variables used for the adjustment strata were age (19-29 years, 30-39 years, 40-59 years, and 60+ years), race (nonwhite and white), gender, and residential location (urban and rural). Age (19-34 years, 35-49 years, and 50+ years) and residential

location (urban and rural) were used for the adjustment strata for the disenrollees. Within these strata, adjustment factors for ineligibility and nonresponse were computed and applied to the base weights of the samples.

The eligibility weight is calculated using the ratio of the sum of the weights for the survey respondents, nonrespondents and known ineligible participants to the sum of the weights for the respondents and nonrespondents. The base weight is multiplied by the ineligibility adjusted ratio for respondents and nonrespondents to yield the eligibility weight.

The final weight accounts for differential non-response by demographic groups. The nonresponse adjustment factor is calculated as the ratio of the sum of eligible respondents plus eligible nonrespondents over eligible respondents. The nonresponse adjusted weight is calculated as the product of the eligibility weight and the nonresponse adjustment factor for survey respondents to derive the final sampling weight.

Appendix Table B1: Demographic Features of Respondents, Non-respondents and Sample Pools

Enrollee Sample

	Respondents (N=655)	Non-Respondents (N=1,449)
Sex		
Female	59%	55%
Male	41%	45%
Race		
White	85%	81%
Other/Unspecified	15%	19%
Age Group*		
19-39	49%	68%
40-59	37%	26%
60+	14%	6%
FPL		
0 - <= 50%	1%	1%
>50% - <=100%	51%	56%
>100% - 133%	48%	44%
Residence		
Urban	35%	38%
Rural	65%	62%

*** P<0.05 for comparison of Respondents to Non-Respondents by Pearson chi-square test.**

Appendix Table B2: Demographic Features of Respondents, Non-respondents and Sample Pools

Disenrollee Sample

	Respondents (N=178)	Non-Respondents (N=1,728)
Sex		
Female	61%	57%
Male	39%	43%
Race		
White	86%	80%
Other/Unspecified	14%	20%
Age Group*		
19-34	61%	59%
35-49	19%	27%
50+	20%	14%
FPL		
0 - <= 50%	88%	85%
>50% - <=100%	4%	7%
>100% - 133%	8%	8%
Residence*		
Urban	31%	39%
Rural	69%	61%

***** P<0.05 for comparison of Respondents to Non-Respondents by Pearson chi-square test**.**

Appendix C: HELP Beneficiary Survey Questionnaires

Appendix C1: HELP Beneficiary Survey: Enrollee Survey

Montana Health and Economic Livelihood Partnership Plan Beneficiary Survey: Enrollees

Introduction and Directions for Completing the Survey

The Centers for Medicare & Medicaid Services is conducting this survey to ask about your recent experiences receiving health care and should take about **15 minutes** to complete.

Your participation is voluntary, and there is no loss of benefits or penalty of any kind for deciding not to participate. You may skip any questions that you do not feel comfortable answering. Your participation in this research is private, and we will not share your name or any other identifying information with any outside organization. You may notice a number on the cover of the survey. This number is ONLY used to let us know if you returned the survey. Please contact the survey help desk toll-free at 1-855-443-2692 with questions about this research.

- Use pen with blue or black ink.
- Mark all your answers with an 'X'.
- If you make an error, cross it out with a single line and mark the correct answer.
- If you are told to skip a question, follow the arrow for instructions about what question to answer next.

Study ID

About Your HELP Enrollment

The State of Montana currently runs an insurance program called the Montana Health and Economic Livelihood Partnership (HELP) Plan for adults ages 19 to 64.

1. Are you currently enrolled in the "Montana Health and Economic Livelihood Partnership Plan" (also called "HELP")?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO END

2. How long have you been enrolled in HELP?

- ☐ 1 to 3 months
- ☐ 4 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

3. Since you enrolled in HELP, was there ever a time you lost your coverage or were disenrolled from HELP?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 5

4. About how long were you disenrolled from HELP?

- ☐ Less than 1 month
- ☐ 1 to 3 months
- ☐ More than 3 months
- ☐ Not sure/Don't know

Before You Enrolled in Your HELP Plan

For the next few questions, please think back to the 12 months **before you enrolled** in HELP.

5. In the 12 months before you enrolled in HELP, did you have any health insurance?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 9

6. How long did you have that health insurance?

- ☐ All 12 months
- ☐ 6 to 11 months
- ☐ Less than 6 months

7. What type of health insurance did you have? *Mark one or more.*

- ☐ Medicaid
- ☐ Private (insurance from an employer or union or purchased directly from insurance company)
- ☐ TRICARE or other military health care, including Veterans Health (VA enrollment)
- ☐ Indian Health Service
- ☐ Other
- ☐ Not sure/Don't know

8. In the 12 months before you enrolled in HELP, did you get any preventive care (such as a routine checkup, blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screening)?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

About Your HELP Plan

For the following questions please think about your **current** experience in your HELP plan.

9. How well do you think you understand how your HELP plan works?

- ☐ Very well
- ☐ Somewhat
- ☐ Not at all

10. When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?

- ☐ Yes
- ☐ No → **GO TO QUESTION 12**

11. How helpful was the information about the HELP plan?

- ☐ Very helpful
- ☐ Somewhat helpful
- ☐ Not at all helpful

12. When you enrolled in HELP, did you get information or help from a customer service representative?

- ☐ Yes
- ☐ No → **GO TO QUESTION 14**

13. How helpful was the information you got?

- ☐ Very helpful
- ☐ Somewhat helpful
- ☐ Not at all helpful

14. From the time you submitted your application until your HELP coverage started, how much time did it take?

- ☐ Less than a month
- ☐ 1 to 3 months
- ☐ More than 3 months
- ☐ Not sure/Don't know

Premiums and Copays

The following questions are about your understanding and experience with HELP premiums and copays.

15. How much is your <u>monthly</u> HELP premium?

- ☐ $0 to $9
- ☐ $10 to $19
- ☐ $20 to $29
- ☐ $30 to $39
- ☐ $40 to $49
- ☐ $50 and above
- ☐ Not sure/Don't know

16. How is that monthly premium paid, if at all?

- ☐ I pay it → **GO TO QUESTION 18**
- ☐ Someone pays the full amount for me
- ☐ I pay part and someone else pays part
- ☐ The premium has not been paid
- ☐ Not sure/Don't know

} **GO TO QUESTION 18**

17. Which of the following groups help pay for your monthly premium? *Mark one or more.*

- ☐ Family or friends
- ☐ Community or non-profit organization (such as church, multi-cultural organization)
- ☐ Health services organizations
- ☐ Health care provider
- ☐ Employer
- ☐ Other

18. Would you say the amount of your monthly premium is:

- ☐ More than I can afford
- ☐ An amount that I can afford
- ☐ Less than I can afford
- ☐ Not sure/Don't know

19. In the last 6 months, how worried were you about not having enough money to pay your monthly premium?

- ☐ Not at all worried
- ☐ A little worried
- ☐ Somewhat worried
- ☐ Very worried
- ☐ Extremely worried

20. What do you think will happen, if anything, if your monthly premium is <u>not paid</u> within 90 days?

- ☐ Nothing will happen → **GO TO QUESTION 22**
- ☐ My HELP coverage could end
- ☐ Not sure/Don't know → **GO TO QUESTION 22**

21. For each of the following statements, please tell us whether you think it is part of your HELP plan.
Please mark one answer in each row.

	Part of your HELP plan	Not part of your HELP plan	Not sure
a. Payment of any unpaid premiums **<u>within 90 days</u>** will allow me to keep my HELP coverage	☐	☐	☐
b. Payment of any unpaid premiums **<u>after 90 days</u>** will allow me to re-enroll in HELP within 12 months of my HELP plan start date	☐	☐	☐
c. Any unpaid premium balance may be collected from my future state income tax refunds	☐	☐	☐

22. In the last 6 months, have you paid any copays? Copays are payments owed by you to your health care provider for health care services that you receive. You are responsible for paying the provider after the claim has been processed.

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 26

23. In the last 6 months, would you say the amount you were required to pay for copays was:

- ☐ More than I could afford
- ☐ An amount that I could afford
- ☐ Less than I could afford
- ☐ Not sure/Don't know

24. The last time you received a bill for a copay, how was that copay paid, if at all?

- ☐ I paid it
- ☐ Someone paid it for me
- ☐ The copay has not been paid
- ☐ Not sure/Don't know

25. How easy or hard was it to understand how HELP copays work?

- ☐ Very easy
- ☐ Somewhat easy
- ☐ Neither easy nor hard
- ☐ Somewhat hard
- ☐ Very hard

26. For each of the following statements about <u>HELP premiums, premium credits, and copays</u>, please tell us whether you think it is part of your HELP plan. *Please mark one answer in each row.*

	Part of your HELP plan	Not part of your HELP plan	Not sure
a. Monthly premiums depend on my income	☐	☐	☐
b. Copays depend on which health care service(s) I use	☐	☐	☐
c. Premium credits go toward copays owed	☐	☐	☐
d. Copays must be paid out of my own pocket once my premium credit is used up	☐	☐	☐
e. Copays will not be collected at the time of my health care service(s)	☐	☐	☐
f. Unpaid premiums may be collected against my future state income tax refunds	☐	☐	☐

Access to Care

For the following questions please think about your health care experiences in the **last 6 months**.

27. In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

} **GO TO QUESTION 29**

28. In the last 6 months, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

29. In the last 6 months, was there any time you needed health care but did not get it because of cost?

- ☐ Yes
- ☐ No → **GO TO QUESTION 31**

30. In the last 6 months, what types of health care were you unable to get because of cost? *Please mark one answer in each row.*

	Yes	No	N/A
a. A visit to the doctor when I was sick	☐	☐	☐
b. Preventive care (such as blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screenings)	☐	☐	☐
c. A follow up visit to get tests or care recommended by my doctor	☐	☐	☐
d. Dental care	☐	☐	☐
e. Vision (eye) care	☐	☐	☐
f. Prescription drugs	☐	☐	☐
g. Emergency room care	☐	☐	☐

The next set of questions is about emergency room (ER) care and treatment.

Some people use emergency rooms for both **emergency** and **non-emergency care**. An emergency is defined as any condition that could endanger your life or cause permanent disability if not treated immediately.

31. As part of your HELP plan, is there an $8 copay for going to the emergency room for a non-emergency condition?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

32. In the last 6 months, was there a time you thought about going to the emergency room when you needed care?

- ☐ Yes
- ☐ No → **GO TO QUESTION 35**

33. In the last 6 months, when you needed care did you go to the emergency room?

- ☐ Yes → **GO TO QUESTION 35**
- ☐ No

34. What was the main reason you did not go to the emergency room for care?

- ☐ Did not have a way to get there or could not afford to get there
- ☐ Went to my doctor's office or clinic instead
- ☐ Did not want to pay a copay
- ☐ Waited to see if I would get better on my own
- ☐ Some other reason

Satisfaction with HELP

35. Thinking about your overall experience with HELP, would you say you are:

- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Neither Satisfied nor Dissatisfied→ **GO TO QUESTION 37**
- ☐ Somewhat Dissatisfied
- ☐ Very Dissatisfied
- ☐ Not sure/Don't know → **GO TO QUESTION 37**

36. Please tell us how satisfied or dissatisfied you are with each <u>HELP</u> item below.
Please mark one answer in each row.

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
a. Enrollment process	☐	☐	☐	☐	☐
b. Length of time for coverage to begin	☐	☐	☐	☐	☐
c. Ability to see my doctor	☐	☐	☐	☐	☐
d. Choice of doctors	☐	☐	☐	☐	☐
e. Coverage of health care services that I need	☐	☐	☐	☐	☐
f. How copays work	☐	☐	☐	☐	☐
g. Cost of premiums	☐	☐	☐	☐	☐
h. Paying the same amount each month for premiums	☐	☐	☐	☐	☐

Now think about your current HELP plan compared to the health insurance plan you had in the 12 months before you enrolled in HELP.

If you <u>did not</u> have a health insurance plan <u>in the 12 months before you enrolled in HELP</u> → **GO TO QUESTION 38**

37. For each of the following items, how does your <u>current HELP plan</u> compare to your <u>previous health insurance plan</u>? *Please mark one answer in each row.*

	Better	The same	Worse	Not sure
a. Ability to afford my plan	☐	☐	☐	☐
b. Coverage of health care services that I need	☐	☐	☐	☐
c. Ability to see my doctor	☐	☐	☐	☐
d. Ability to get health care services that I need	☐	☐	☐	☐

About You

38. Would you say that in general your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

39. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

40. What best describes your employment status?

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Self-employed
- ☐ A homemaker
- ☐ A full-time student
- ☐ Unable to work for health reasons
- ☐ Unemployed

41. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

42. Are you male or female?

- ☐ Male
- ☐ Female

43. Are you of Hispanic, Latino/a, or Spanish origin? *Mark one or more.*

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

44. What is your race? *Mark one or more.*

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

45. Please circle the number of people in your family (including yourself) that live in your household. Mark only one answer that best describes your family's total income over the last year before taxes and other deductions. Your best estimate is fine.

Family size (including yourself)	Family Income Per Year			
One person	☐ At or below $6,000	☐ Above $6,000 and up to $12,000	☐ Above $12,000 and less than $17,000	☐ At or above $17,000
Two people	☐ At or below $8,000	☐ Above $8,000 and up to $16,000	☐ Above $16,000 and less than $22,000	☐ At or above $22,000
Three people	☐ At or below $10,000	☐ Above $10,000 and up to $20,000	☐ Above $20,000 and less than $28,000	☐ At or above $28,000
Four people	☐ At or below $12,000	☐ Above $12,000 and up to $25,000	☐ Above $25,000 and less than $34,000	☐ At or above $34,000
Five people	☐ At or below $14,000	☐ Above $14,000 and up to $29,000	☐ Above $29,000 and less than $40,000	☐ At or above $40,000
Six people	☐ At or below $16,000	☐ Above $16,000 and up to $33,000	☐ Above $33,000 and less than $45,000	☐ At or above $45,000
Seven people	☐ At or below $19,000	☐ Above $19,000 and up to $37,000	☐ Above $37,000 and less than $51,000	☐ At or above $51,000
Eight people	☐ At or below $21,000	☐ Above $21,000 and up to $41,000	☐ Above $41,000 and less than $57,000	☐ At or above $57,000
Nine people	☐ At or below $23,000	☐ Above $23,000 and up to $45,500	☐ Above $45,500 and less than $63,000	☐ At or above $63,000
Ten or more people	☐ At or below $25,000	☐ Above $25,000 and up to $50,000	☐ Above $50,000 and less than $69,000	☐ At or above $69,000

46. Did someone help you complete this survey?

☐ Yes

☐ No → **THANK YOU.** ***Please return the completed survey in the postage-paid envelope.***

47. How did that person help you? *Mark one or more.*

☐ Read the questions to me

☐ Wrote down the answers I gave

☐ Answered the questions for me

☐ Translated the questions into my language

THANK YOU

Please return the completed survey in the postage-paid envelope.

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Appendix C2: HELP Beneficiary Survey: Disenrollee Survey

Montana Health and Economic Livelihood Partnership Plan Beneficiary Survey: Disenrollees

Introduction and Directions for Completing the Survey

The Centers for Medicare & Medicaid Services is conducting this survey to ask about your recent experiences receiving health care and should take about **15 minutes** to complete.

Your participation is voluntary, and there is no loss of benefits or penalty of any kind for deciding not to participate. You may skip any questions that you do not feel comfortable answering. Your participation in this research is private, and we will not share your name or any other identifying information with any outside organization. You may notice a number on the cover of the survey. This number is ONLY used to let us know if you returned the survey. Please contact the survey help desk toll-free at 1-855-443-2692 with questions about this research.

- Use pen with blue or black ink.
- Mark all your answers with an 'X'.
- If you make an error, cross it out with a single line and mark the correct answer.
- If you are told to skip a question, follow the arrow for instructions about what question to answer next.

About Your HELP Enrollment

The State of Montana currently runs an insurance program called the Montana Health and Economic Livelihood Partnership (HELP) Plan for adults ages 19 to 64.

1. Are you currently enrolled in the "Montana Health and Economic Livelihood Partnership Plan" (also called "HELP")?

- ☐ Yes → **GO TO END**
- ☐ No
- ☐ Not sure/Don't know → **GO TO END**

2. Have you ever been enrolled in HELP?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO END

Study ID

3. Were you enrolled in HELP within the last 12 months?

- ☐ Yes
- ☐ No → **GO TO END**

4. How long ago did your HELP enrollment end?

- ☐ Less than 3 months
- ☐ 3 to 6 months
- ☐ More than 6 months
- ☐ Not sure/Don't know

5. Why did your HELP enrollment end? *Please mark one answer in each row.*

My HELP enrollment ended because…	Yes	No	Not Sure
a. I got an increase in my income and was no longer eligible for HELP	☐	☐	☐
b. I had other health insurance available to me	☐	☐	☐
c. I could not afford my monthly HELP premiums	☐	☐	☐
d. I no longer wanted HELP coverage	☐	☐	☐
e. I did not pay my premium within 90 days	☐	☐	☐

6. Would you try to re-enroll in HELP if you could?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

Experiences After Leaving HELP

The following questions are about your understanding and experiences **since you left HELP.**

7. After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 9

8. After you were no longer enrolled in HELP, what types of health care were you unable to get because of cost?
Please mark one answer in each row.

	Yes	No	N/A
a. A visit to the doctor when I was sick	☐	☐	☐
b. Preventive care (such as blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screenings)	☐	☐	☐
c. A follow up visit to get tests or care recommended by my doctor	☐	☐	☐
d. Dental care	☐	☐	☐
e. Vision (eye) care	☐	☐	☐
f. Prescription drugs	☐	☐	☐
g. Emergency room care	☐	☐	☐

9. After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 11

10. After you were no longer enrolled in HELP, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

11. Do you have <u>any</u> health insurance coverage right now?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 15

12. What type of health insurance do you have? *Mark one or more.*

- ☐ Private (insurance from an employer or union or purchased directly from insurance company)
- ☐ TRICARE or other military health care, including Veterans Health (VA enrollment)
- ☐ Medicaid
- ☐ Medicare
- ☐ Indian Health Service
- ☐ Other
- ☐ Not sure/Don't know

13. How long have you had your current health insurance?

- ☐ Less than one month
- ☐ Between 1 and 6 months
- ☐ More than 6 months

14. After you were no longer enrolled in HELP, how long did it take you to get your current health insurance?

- ☐ Less than one month
- ☐ Between 1 and 6 months
- ☐ More than 6 months

Premiums and Copays

The following questions are about your understanding and experiences with HELP monthly premiums and copays **while you were in HELP.**

15. While you were in HELP, how much was your monthly HELP premium?

- ☐ $0 to $9
- ☐ $10 to $19
- ☐ $20 to $29
- ☐ $30 to $39
- ☐ $40 to $49
- ☐ $50 and above
- ☐ Not sure/Don't know

16. How was that monthly premium paid, if at all?

- ☐ I paid it → **GO TO QUESTION 18**
- ☐ Someone paid the full amount for me
- ☐ I paid part and someone else paid part
- ☐ The premium has not been paid
- ☐ Not sure/Don't know

} **GO TO QUESTION 18**

17. Which of the following groups helped pay for your monthly premium? *Mark one or more.*

- ☐ Family or friends
- ☐ Community or non-profit organization (such as church, multi-cultural organization)
- ☐ Health services organizations
- ☐ Health care provider
- ☐ Employer
- ☐ Other

18. While you were in HELP, would you say the amount of your monthly premium was:

- ☐ More than I could afford
- ☐ An amount that I could afford
- ☐ Less than I could afford
- ☐ Not sure/Don't know

19. While you were in HELP, how worried were you about not having enough money to pay your monthly premium?

- ☐ Not at all worried
- ☐ A little worried
- ☐ Somewhat worried
- ☐ Very worried
- ☐ Extremely worried

20. While you were in HELP, what did you think would happen, if anything, if your monthly premium was <u>not paid</u> within 90 days?

- ☐ Nothing would change → **GO TO QUESTION 22**
- ☐ My HELP coverage would end
- ☐ Not sure/Don't know → **GO TO QUESTION 22**

21. For each of the following statements, please tell us whether you thought it was part of your HELP plan.
Please mark one answer in each row.

	Part of your HELP plan	Not part of your HELP plan	Not sure
a. Payment of any unpaid premiums **<u>within 90 days</u>** would have allowed me to keep my HELP coverage	☐	☐	☐
b. Payment of any unpaid premiums **<u>after 90 days</u>** would have allowed me to re-enroll in HELP within 12 months of my HELP plan start date	☐	☐	☐
c. Any unpaid premium balance may be collected from my future state income tax refunds	☐	☐	☐

22. While you were in HELP, did you pay any copays? Copays are payments owed by you to your health care provider for health care services that you receive. You are responsible for paying the provider after the claim has been processed.

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

GO TO QUESTION 25

23. While you were in HELP, would you say the amount you were required to pay for copays was:

- ☐ More than I could afford
- ☐ An amount that I could afford
- ☐ Less than I could afford
- ☐ Not sure/Don't know

24. How easy or hard was it to understand how HELP copays work?

- ☐ Very easy
- ☐ Somewhat easy
- ☐ Neither easy nor hard
- ☐ Somewhat hard
- ☐ Very hard

25. For each of the following statements about <u>HELP premiums, premium credits, and copays</u>, please tell us whether you thought they were part of your HELP plan. *Please mark one answer in each row.*

	Part of your HELP plan	Not part of your HELP plan	Not sure
a. Monthly premiums depend on my income	☐	☐	☐
b. Copays depend on which health care service(s) I use	☐	☐	☐
c. Premium credits go toward copays owed	☐	☐	☐
d. Copays must be paid out of my own pocket once my premium credit is used up	☐	☐	☐
e. Copays will not be collected at the time of my health care service(s)	☐	☐	☐
f. Unpaid premiums may be collected against my future state income tax refunds	☐	☐	☐

Access to Care

Some people use emergency rooms for both **emergency** and **non-emergency care**. An emergency is defined as any condition that could endanger your life or cause permanent disability if not treated immediately.

For the following questions, please think about your experience **while you were in HELP**.

26. As part of your HELP plan, was there an $8 copay for going to the emergency room for a non-emergency condition?

- ☐ Yes
- ☐ No
- ☐ Not sure/Don't know

27. While you were in HELP, was there a time you thought about going to the emergency room when you needed care?

- ☐ Yes
- ☐ No → **GO TO QUESTION 30**

28. While you were in HELP, when you needed care, did you go to the emergency room?

- ☐ Yes → **GO TO QUESTION 30**
- ☐ No

29. What was the main reason you did not go to the emergency room for care?

- ☐ Did not have a way to get there or could not afford to get there
- ☐ Went to my doctor's office or clinic instead
- ☐ Did not want to pay a copay
- ☐ Waited to see if I would get better on my own
- ☐ Some other reason

Satisfaction with HELP

30. Thinking about your overall experience with HELP, would you say you are:

- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Neither Satisfied nor Dissatisfied→ **GO TO QUESTION 32**
- ☐ Somewhat Dissatisfied
- ☐ Very Dissatisfied
- ☐ Not sure/Don't know → **GO TO QUESTION 32**

31. Please tell us how satisfied or dissatisfied you are with each <u>HELP</u> item below.
Please mark one answer in each row.

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
a. Enrollment process	☐	☐	☐	☐	☐
b. Length of time for coverage to begin	☐	☐	☐	☐	☐
c. Ability to see my doctor	☐	☐	☐	☐	☐
d. Choice of doctors	☐	☐	☐	☐	☐
e. Coverage of health care services that I need	☐	☐	☐	☐	☐
f. How copays work	☐	☐	☐	☐	☐
g. Cost of premiums	☐	☐	☐	☐	☐
h. Paying the same amount each month for premiums	☐	☐	☐	☐	☐

About You

32. Would you say that in general your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

33. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

34. What best describes your employment status?

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Self-employed
- ☐ A homemaker
- ☐ A full-time student
- ☐ Unable to work for health reasons
- ☐ Unemployed

35. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

36. Are you male or female?

- ☐ Male
- ☐ Female

37. Are you of Hispanic, Latino/a, or Spanish origin? *Mark one or more.*

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

38. What is your race? *Mark one or more.*

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

39. Please circle the number of people in your family (including yourself) that live in your household. Mark only one answer that best describes your family's total income over the last year before taxes and other deductions. Your best estimate is fine.

Family size (including yourself)	Family Income Per Year			
One person	☐ At or below $6,000	☐ Above $6,000 and up to $12,000	☐ Above $12,000 and less than $17,000	☐ At or above $17,000
Two people	☐ At or below $8,000	☐ Above $8,000 and up to $16,000	☐ Above $16,000 and less than $22,000	☐ At or above $22,000
Three people	☐ At or below $10,000	☐ Above $10,000 and up to $20,000	☐ Above $20,000 and less than $28,000	☐ At or above $28,000
Four people	☐ At or below $12,000	☐ Above $12,000 and up to $25,000	☐ Above $25,000 and less than $34,000	☐ At or above $34,000
Five people	☐ At or below $14,000	☐ Above $14,000 and up to $29,000	☐ Above $29,000 and less than $40,000	☐ At or above $40,000
Six people	☐ At or below $16,000	☐ Above $16,000 and up to $33,000	☐ Above $33,000 and less than $45,000	☐ At or above $45,000
Seven people	☐ At or below $19,000	☐ Above $19,000 and up to $37,000	☐ Above $37,000 and less than $51,000	☐ At or above $51,000
Eight people	☐ At or below $21,000	☐ Above $21,000 and up to $41,000	☐ Above $41,000 and less than $57,000	☐ At or above $57,000
Nine people	☐ At or below $23,000	☐ Above $23,000 and up to $45,500	☐ Above $45,500 and less than $63,000	☐ At or above $63,000
Ten or more people	☐ At or below $25,000	☐ Above $25,000 and up to $50,000	☐ Above $50,000 and less than $69,000	☐ At or above $69,000

40. Did someone help you complete this survey?

☐ Yes

☐ No → **THANK YOU.** ***Please return the completed survey in the postage-paid envelope.***

41. How did that person help you? *Mark one or more.*

☐ Read the questions to me

☐ Wrote down the answers I gave

☐ Answered the questions for me

☐ Translated the questions into my language

THANK YOU

Please return the completed survey in the postage-paid envelope.

Social & Scientific Systems, Inc.
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Appendix D: Results from the HELP Beneficiary Surveys

RESULTS FROM THE ENROLLEE SURVEYS

Understanding of and Information-Seeking About HELP

How well do you think you understand how your HELP plan works?	Weighted Percent	Standard Error of Weighted Percent
Very well	20%	1.62
Somewhat	70%	1.96
Not at all	9%	1.28

When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?	Weighted Percent	Standard Error of Weighted Percent
Yes	41%	2.10
No	57%	2.13
{If Yes} How helpful was the information about the HELP plan?		
Very helpful	35%	3.13
Somewhat helpful	59%	3.23
Not at all helpful	5%	1.26

When you enrolled in HELP, did you get information or help from a customer service representative?	Weighted Percent	Standard Error of Weighted Percent
Yes	47%	2.14
No	51%	2.15
{If Yes} How helpful was the information you got?		
Very helpful	61%	3.10
Somewhat helpful	33%	2.90
Not at all helpful	4%	1.94

What do you think will happen, if anything, if your monthly premium is not paid within 90 days?	Weighted Percent	Standard Error of Weighted Percent
Nothing will happen	2%	0.61
My HELP coverage could end	71%	1.93
Not sure/Don't know	25%	1.83
{If response=My HELP coverage could end} Please tell us whether each of the following are a part of your HELP Plan		
Payment of any unpaid premiums within 90 days will allow me to keep my HELP coverage		
Part of your HELP plan	43%	2.52
Not part of your HELP plan	8%	1.30
Not sure	48%	2.56
Payment of any unpaid premiums after 90 days will allow me to re-enroll in HELP within 12 months of my HELP plan start date		
Part of your HELP plan	26%	2.23
Not part of your HELP plan	7%	1.25
Not sure	67%	2.40
Any unpaid premium balance may be collected from my future state income tax refunds		
Part of your HELP plan	30%	2.28
Not part of your HELP plan	5%	0.94
Not sure	65%	2.38

How easy or hard was it to understand how HELP copays work?*	Weighted Percent	Standard Error of Weighted Percent
Very easy	24%	3.58
Somewhat easy	36%	4.00
Neither easy nor hard	21%	3.64
Somewhat hard	9%	2.22
Very hard	7%	2.39

*Only answered by respondents who said they had paid copays in the last 6 months

Please tell us whether each of the following are a part of your HELP Plan	Weighted Percent	Standard Error of Weighted Percent
Monthly premiums depend on my income		
Part of your HELP plan	75%	1.90
Not part of your HELP plan	3%	0.72
Not sure	20%	1.76
Copays depend on which health care services(s) I use		
Part of your HELP plan	44%	2.15
Not part of your HELP plan	6%	1.00
Not sure	48%	2.15
Premium credits go toward copays owed		
Part of your HELP plan	11%	1.28
Not part of your HELP plan	13%	1.34
Not sure	75%	1.81
Copays must be paid out of my own pocket once my premium credit is used up		
Part of your HELP plan	26%	1.84
Not part of your HELP plan	7%	1.16
Not sure	65%	2.04
Copays will not be collected at the time of my health care service(s)		
Part of your HELP plan	23%	1.79
Not part of your HELP plan	19%	1.74
Not sure	57%	2.14
Unpaid premiums may be collected against my future state income tax refunds		
Part of your HELP plan	28%	1.91
Not part of your HELP plan	4%	0.71
Not sure	67%	2.01

As part of your HELP plan, is there an $8 copay for going to the emergency room for a non-emergency condition?	Weighted Percent	Standard Error of Weighted Percent
Yes	5%	0.98
No	10%	1.49
Not sure/Don't know	82%	1.78

Cost as a Barrier to Access to Care

In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?	Weighted Percent	Standard Error of Weighted Percent
Yes	71%	2.01
No	26%	1.94
Not sure/Don't know	1%	0.54
{If Yes} In the last 6 months, were any of your health care visits for a routine checkup?		
Yes	47%	2.50
No	50%	2.51
Not sure/Don't know	2%	0.57
In the last 6 months, was there any time you needed health care but did not get it because of cost?		
Yes	14%	1.49
No	85%	1.58
{If Yes} What types of health care were you unable to get because of cost?		
A visit to the doctor when I was sick		
Yes	25%	5.22
No	55%	5.95
N/A	17%	4.79
Preventive care		
Yes	33%	5.79
No	51%	5.96
N/A	13%	4.41

	Weighted Percent	Standard Error of Weighted Percent
A follow up visit to get tests or care recommended by my doctor		
Yes	34%	5.61
No	49%	5.96
N/A	14%	3.61
Dental care		
Yes	59%	5.93
No	30%	5.43
N/A	8%	4.04
Vision (eye) care		
Yes	45%	5.85
No	42%	5.90
N/A	10%	4.20
Prescription drugs		
Yes	31%	5.55
No	56%	5.86
N/A	10%	3.05
Emergency room care		
Yes	14%	3.84
No	66%	5.36
N/A	17%	4.04

In the last 6 months, was there a time you thought about going to the emergency room when you needed care?	Weighted Percent	Standard Error of Weighted Percent
Yes	23%	1.85
No	75%	1.90
{If Yes} In the last 6 months, when you needed care did you go to the emergency room?		
Yes	62%	4.64
No	38%	4.64
{If No} What was the main reason you did not go to the emergency room for care?		
Did not have a way to get there or could not afford to get there	13%	9.06
Went to my doctor's office or clinic instead	29%	6.93
Did not want to pay a copay	3%	2.30
Waited to see if I would get better on my own	42%	7.84
Some other reason	11%	4.24

Affordability of HELP

How much is your monthly HELP premium?	Weighted Percent	Standard Error of Weighted Percent
$0 to $9	2%	0.96
$10 to $19	26%	1.87
$20 to $29	36%	2.01
$30 to $39	15%	1.48
$40 to $49	6%	0.94
$50 and above	7%	1.29
Not sure/Don't know	6%	1.11
How is that monthly premium paid, if at all?		
I pay it	83%	1.83
Someone pays the full amount for me	3%	0.80
I pay part and someone else pays part	0%	0.23

	Weighted Percent	Standard Error of Weighted Percent
The premium has not been paid	8%	1.38
Not sure/Don't know	4%	0.93
{If response= "Someone pays the full amount for me" or "I pay part and someone else pays part"}		
Which of the following groups help pay for monthly premium?*		
Family or friends	78%	10.08
Other (includes community or non-profit organization, health services organizations, health care provider, employer, and other)	22%	10.08

***respondents could pick more than one category of the above

Would you say the amount of your monthly premium is:	Weighted Percent	Standard Error of Weighted Percent
More than I can afford	15%	1.65
An amount that I can afford	76%	1.91
Less than I can afford	3%	0.64
Not sure/Don't know	4%	0.89
In the last 6 months, how worried were you about not having enough money to pay your monthly premium?		
Not at all worried	50%	2.15
A little worried	21%	1.66
Somewhat worried	13%	1.39
Very worried	7%	1.12
Extremely worried	7%	1.36

In the last 6 months, have you paid any copays?	Weighted Percent	Standard Error of Weighted Percent
Yes	24%	1.79
No	65%	2.04
Not sure/Don't know	9%	1.25
{If Yes}		
In the last 6 months, would you say the amount you were required to pay for copays was:		
More than I could afford	25%	3.70
An amount that I could afford	69%	4.07
Less than I could afford	3%	2.21
Not sure/Don't know	1%	1.03
The last time you received a bill for a copay, how was that copay paid, if at all?		
I paid it	77%	3.79
Someone paid it for me	5%	2.44
The copay has not been paid	10%	2.71
Not sure/Don't know	5%	1.71

Satisfaction with HELP

Thinking about your overall experience with HELP, would you say you are:	Weighted Percent	Standard Error of Weighted Percent
Very Satisfied	48%	2.14
Somewhat Satisfied	25%	1.83
Neither Satisfied nor Dissatisfied	15%	1.72
Somewhat Dissatisfied	5%	1.03
Very Dissatisfied	1%	0.45
Not sure/Don't know	5%	0.94

{If response= "Very/Somewhat Satisfied" or "Very/Somewhat Dissatisfied}	Weighted Percent	Standard Error of Weighted Percent
How satisfied or dissatisfied are you with:		
Enrollment Process		
Very Satisfied	57%	2.33
Somewhat Satisfied	25%	2.07
Neutral	12%	1.58
Somewhat Dissatisfied	4%	0.84
Very Dissatisfied	2%	0.61
Length of time for coverage to begin		
Very Satisfied	63%	2.26
Somewhat Satisfied	23%	1.97
Neutral	10%	1.42
Somewhat Dissatisfied	3%	0.80
Very Dissatisfied	1%	0.38
Ability to see my doctor		
Very Satisfied	69%	2.17
Somewhat Satisfied	16%	1.74
Neutral	10%	1.41
Somewhat Dissatisfied	2%	0.77
Very Dissatisfied	2%	0.58
Choice of doctors		
Very Satisfied	60%	2.27
Somewhat Satisfied	17%	1.69
Neutral	15%	1.63
Somewhat Dissatisfied	5%	1.10
Very Dissatisfied	2%	0.59
Coverage of health care services that I need		
Very Satisfied	58%	2.32
Somewhat Satisfied	26%	2.06

	Weighted Percent	Standard Error of Weighted Percent
Neutral	10%	1.42
Somewhat Dissatisfied	4%	0.92
Very Dissatisfied	2%	0.61
How copays work		
Very Satisfied	41%	2.29
Somewhat Satisfied	19%	1.89
Neutral	33%	2.20
Somewhat Dissatisfied	3%	0.78
Very Dissatisfied	2%	0.69
Cost of premiums		
Very Satisfied	61%	2.29
Somewhat Satisfied	14%	1.56
Neutral	18%	1.86
Somewhat Dissatisfied	4%	0.91
Very Dissatisfied	3%	0.79
Paying the same amount each month for premiums		
Very Satisfied	75%	2.06
Somewhat Satisfied	14%	1.65
Neutral	7%	1.24
Somewhat Dissatisfied	2%	0.78
Very Dissatisfied	1%	0.45

In the 12 months before you enrolled in HELP, did you have any health insurance?	Weighted Percent	Standard Error of Weighted Percent
Yes	53%	2.15
No	44%	2.14
Not sure/Don't know	2%	0.68
{If Yes}		
How long did you have that health insurance?		
All 12 months	77%	2.50
6 to 11 months	14%	2.00
Less than 6 months	7%	1.70
What type of health insurance did you have?*		
Medicaid	20%	2.32
Private	54%	2.87
Other (including TRICARE, Indian Health Service, and other)	22%	2.40
Not Sure/Don't Know	3%	0.93
For each of the following items, how does your current HELP plan compare to your previous health insurance plan?		
Ability to afford my plan		
Better	63%	2.81
The same	14%	2.05
Worse	13%	1.96
Not sure	5%	1.31
Coverage of health care services that I need		
Better	35%	2.75
The same	38%	2.82
Worse	10%	1.66
Not sure	12%	1.86
Ability to see my doctor		
Better	25%	2.52
The same	54%	2.88
Worse	7%	1.48

	Weighted Percent	Standard Error of Weighted Percent
Not sure	9%	1.64
Ability to get health care services that I need		
Better	31%	2.71
The same	46%	2.87
Worse	10%	1.74
Not sure	8%	1.50

*****respondents could pick more than one category of the above

Before Enrolled in HELP and HELP Coverage

In the 12 months before you enrolled in HELP, did you get any preventive care (such as a routine checkup, blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screening)?	**Weighted Percent**	**Standard Error of Weighted Percent**
Yes	61%	2.84
No	30%	2.65
Not sure/Don't know	8%	1.62

*Only answered by respondents who said they had health insurance before they enrolled in HELP

From the time you submitted your application until your HELP coverage started, how much time did it take?	**Weighted Percent**	**Standard Error of Weighted Percent**
Less than a month	40%	2.08
1 to 3 months	33%	2.04
More than 3 months	4%	0.79
Not sure/Don't know	21%	1.81

How long have you been enrolled in HELP?	Weighted Percent	Standard Error of Weighted Percent
1 to 3 months	3%	0.78
4 to 6 months	16%	1.75
7 to 12 months	31%	1.94
More than 12 months	49%	2.15
Since you enrolled in HELP, was there ever a time you lost your coverage or were disenrolled from HELP?		
Yes	10%	1.50
No	83%	1.84
Not sure/Don't know	7%	1.16
{If Yes} About how long were you disenrolled from HELP?		
Less than 1 month	30%	8.49
1 to 3 months	44%	7.97
More than 3 months	12%	5.30
Not sure/Don't know	14%	5.70

RESULTS FROM THE DISENROLLEE SURVEYS

Understanding of HELP

While you were in HELP, what did you think would happen, if anything, if your monthly premium was not paid within 90 days?	Weighted Percent	Standard Error of Weighted Percent
Nothing would change	6%	1.87
My HELP coverage would end	66%	3.66
Not sure/Don't know	26%	3.37
{If response=My HELP coverage would end} **Please indicate whether you thought the following features were part of your HELP Plan**		
Payment of any unpaid premiums within 90 days would have allowed me to keep my HELP coverage		
Part of your HELP plan	31%	4.34
Not part of your HELP plan	13%	3.17
Not sure	54%	4.71
Payment of any unpaid premiums after 90 days would have allowed me to re-enroll in HELP within 12 months of my HELP plan start date		
Part of your HELP plan	18%	3.54
Not part of your HELP plan	11%	2.98
Not sure	69%	4.33
Any unpaid premium balance may be collected from my future state income tax refunds		
Part of your HELP plan	37%	4.56
Not part of your HELP plan	4%	1.89
Not sure	57%	4.69

Please indicate whether you thought the following features were part of your HELP Plan	Weighted Percent	Standard Error of Weighted Percent
Monthly premiums depend on my income		
Part of your HELP plan	67%	3.62
Not part of your HELP plan	4%	1.42
Not sure	28%	3.47
Copays depend on which health care service(s) I use		
Part of your HELP plan	43%	3.83
Not part of your HELP plan	7%	2.14
Not sure	48%	3.86
Premium credits go toward copays owed		
Part of your HELP plan	11%	2.35
Not part of your HELP plan	12%	2.52
Not sure	76%	3.27
Copays must be paid out of my own pocket once my premium credit is used up		
Part of your HELP plan	29%	3.51
Not part of your HELP plan	5%	1.71
Not sure	65%	3.69
Copays will not be collected at the time of my health care service(s)		
Part of your HELP plan	17%	2.93
Not part of your HELP plan	25%	3.37
Not sure	57%	3.84
Unpaid premiums may be collected against my future state income tax refunds		
Part of your HELP plan	33%	3.64
Not part of your HELP plan	5%	1.69
Not sure	61%	3.77

As part of your HELP plan, was there an $8 copay for going to the emergency room for a non-emergency condition?	Weighted Percent	Standard Error of Weighted Percent
Yes	4%	1.48
No	18%	2.98
Not sure/Don't know	76%	3.29

How easy or hard was it to understand how HELP copays work?	Weighted Percent	Standard Error of Weighted Percent
Very easy	33%	6.73
Somewhat easy	21%	5.77
Neither easy nor hard	27%	6.06
Somewhat hard	15%	5.15
Very hard	3%	2.41

Access to Care

After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?	Weighted Percent	Standard Error of Weighted Percent
Yes	21%	3.19
No	75%	3.37
Not sure/Don't know	3%	1.30
{If Yes} What types of health care were you unable to get because of cost?		
A visit to the doctor when I was sick		
Yes	57%	8.59
No	37%	8.33
N/A	6%	4.07
Preventive Care		
Yes	49%	8.77
No	45%	8.68
N/A	6%	4.07
A follow up visit to get tests or care recommended by my doctor		
Yes	60%	8.48
No	34%	8.08
N/A	6%	4.44
Dental care		
Yes	66%	8.32
No	25%	7.57
N/A	9%	5.14
Vision (eye) care		
Yes	46%	8.75
No	47%	8.74
N/A	6%	4.44
Prescription drugs		
Yes	52%	8.77
No	41%	8.65
N/A	7%	4.85

	Weighted Percent	Standard Error of Weighted Percent
Emergency room care		
Yes	33%	8.25
No	56%	8.71
N/A	11%	5.62
While you were in HELP, was there a time you thought about going to the emergency room when you needed care?		
Yes	23%	3.32
No	75%	3.36
{If Yes} While you were in HELP, when you needed care, did you go to the emergency room?		
Yes	63%	8.06
No	34%	7.99
{If No} What was the main reason you did not go to the emergency room for care?		
Did not have a way to get there or could not afford to get there	16%	10.97
Went to my doctor's office or clinic instead	15%	10.64
Did not want to pay a copay	16%	10.97
Waited to see if I would get better on my own	23%	12.35
Some other reason	20%	13.01

After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?	**Weighted Percent**	**Standard Error of Weighted Percent**
Yes	64%	3.70
No	35%	3.67
Not sure/Don't know	1%	0.53
{If Yes} After you were no longer enrolled in HELP, were any of your health care visits for a routine checkup?		
Yes	45%	4.86
No	46%	4.86
Not sure/Don't know	7%	2.31

Affordability of HELP

How much was your monthly HELP premium?	Weighted Percent	Standard Error of Weighted Percent
$0 to $9	13%	2.62
$10 to $19	15%	2.71
$20 to $29	23%	3.29
$30 to $39	12%	2.51
$40 to $49	6%	1.77
$50 and above	10%	2.34
Not sure/Don't know	21%	3.11
How was that monthly premium paid, if at all?		
I paid it	44%	3.83
Someone paid the full amount for me	4%	1.65
I paid part and someone else paid part	1%	0.53
The premium has not been paid	26%	3.41
Not sure/Don't know	24%	3.30
{If response= "Someone paid the full amount for me" or "I paid part and someone else paid part"}		
Which of the following groups helped pay for monthly premium?*		
Family or friends	50%	19.11
Other (includes community or non-profit organization, health services organizations, health care provider, employer, and other)	39%	18.75

*respondents could pick more than one category of the above

While you were in HELP, would you say the amount of your monthly premium was:	Weighted Percent	Standard Error of Weighted Percent
More than I could afford	29%	3.53
An amount that I could afford	51%	3.86
Less than I could afford	4%	1.43
Not sure/Don't know	14%	2.64

While you were in HELP, how worried were you about not having enough money to pay your monthly premium?	Weighted Percent	Standard Error of Weighted Percent
Not at all worried	48%	3.86
A little worried	15%	2.79
Somewhat worried	16%	2.82
Very worried	9%	2.20
Extremely worried	9%	2.26

While you were in HELP, did you pay any copays? Copays are payments owed by you to your health care provider for health care services that you receive. You are responsible for paying the provider after the claim has been processed.	Weighted Percent	Standard Error of Weighted Percent
Yes	31%	3.57
No	57%	3.82
Not sure/Don't know	12%	2.37

While you were in HELP, would you say the amount you were required to pay for copays was:	Weighted Percent	Standard Error of Weighted Percent
More than I could afford	26%	6.22
An amount that I could afford	71%	6.45
Less than I could afford	2%	2.21
Not sure/Don't Know	1%	1.28

Satisfaction with HELP

Thinking about your overall experience with HELP, would you say you are:	Weighted Percent	Standard Error of Weighted Percent
Very Satisfied	26%	3.38
Somewhat Satisfied	22%	3.14
Neither Satisfied nor Dissatisfied	26%	3.46
Somewhat Dissatisfied	9%	2.28
Very Dissatisfied	9%	2.22
Not sure/Don't know	7%	1.81

Please tell us how satisfied or dissatisfied you are with each HELP item below.	Weighted Percent	Standard Error of Weighted Percent
Enrollment process		
Very Satisfied	37%	4.58
Somewhat Satisfied	21%	3.87
Neutral	25%	4.18
Somewhat Dissatisfied	8%	2.72
Very Dissatisfied	8%	2.64
Length of time for coverage to begin		
Very Satisfied	43%	4.71
Somewhat Satisfied	21%	3.85
Neutral	28%	4.28
Somewhat Dissatisfied	3%	1.67
Very Dissatisfied	5%	2.09
Ability to see my doctor		
Very Satisfied	48%	4.77
Somewhat Satisfied	20%	3.71
Neutral	21%	3.92
Somewhat Dissatisfied	5%	2.15

	Weighted Percent	Standard Error of Weighted Percent
Very Dissatisfied	5%	2.25
Choice of doctors		
Very Satisfied	41%	4.68
Somewhat Satisfied	19%	3.60
Neutral	30%	4.47
Somewhat Dissatisfied	7%	2.44
Very Dissatisfied	2%	1.13
Coverage of health care services that I need		
Very Satisfied	41%	4.66
Somewhat Satisfied	21%	3.83
Neutral	19%	3.81
Somewhat Dissatisfied	10%	2.89
Very Dissatisfied	8%	2.66
How copays work		
Very Satisfied	30%	4.35
Somewhat Satisfied	18%	3.61
Neutral	39%	4.67
Somewhat Dissatisfied	7%	2.48
Very Dissatisfied	6%	2.24
Cost of premiums		
Very Satisfied	45%	4.73
Somewhat Satisfied	12%	3.19
Neutral	21%	3.93
Somewhat Dissatisfied	9%	2.83
Very Dissatisfied	10%	2.84
Paying the same amount each month for premiums		
Very Satisfied	51%	4.77
Somewhat Satisfied	13%	3.21

	Weighted Percent	Standard Error of Weighted Percent
Neutral	24%	4.09
Somewhat Dissatisfied	4%	1.99
Very Dissatisfied	7%	2.44

End of HELP Enrollment

How long ago did your HELP enrollment end?	Weighted Percent	Standard Error of Weighted Percent
Less than 3 months	16%	2.83
3 to 6 months	27%	3.35
More than 6 months	50%	3.86
Not sure/Don't know	8%	2.05

Why did your HELP enrollment end?	Weighted Percent	Standard Error of Weighted Percent
I got an increase in my income and was no longer eligible for HELP		
Yes	22%	3.23
No	55%	3.84
Not Sure	19%	3.03
I had other health insurance available to me		
Yes	53%	3.85
No	30%	3.56
Not Sure	14%	2.63
I could not afford my monthly HELP premiums		
Yes	25%	3.34
No	52%	3.86
Not Sure	21%	3.08

	Weighted Percent	Standard Error of Weighted Percent
I no longer wanted HELP coverage		
Yes	17%	2.85
No	57%	3.81
Not Sure	23%	3.25
I did not pay my premium within 90 days		
Yes	16%	2.85
No	57%	3.82
Not Sure	24%	3.30

Would you try to re-enroll in HELP if you could?	Weighted Percent	Standard Error of Weighted Percent
Yes	50%	3.86
No	30%	3.53
Not sure/Don't know	20%	3.03

Health Insurance Coverage after HELP

Do you have any health insurance coverage right now?	Weighted Percent	Standard Error of Weighted Percent
Yes	83%	2.88
No	15%	2.78
Not sure/Don't know	1%	0.65
{If Yes} What type of health insurance do you have?*		
Private	41%	4.18
Medicaid	47%	4.23
Other (includes TRICARE or other military health care, Medicare, Indian Health Service, and other)	18%	3.10
Not Sure/Don't Know	100%	0.00
How long have you had your current health insurance?		
Less than one month	4%	1.67
Between 1 and 6 months	40%	4.14

	Weighted Percent	Standard Error of Weighted Percent
More than 6 months	56%	4.20
How long did it take you to get your current health insurance?		
Less than one month	75%	3.66
Between 1 and 6 months	18%	3.29
More than 6 months	6%	1.97

*respondents could pick more than one category of the above

Appendix E: Data Preparation for the Impact Analysis

This appendix addresses our data preparation work for impact analyses using the American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS). All tables for Appendix E are included at the end of the appendix.

1. American Community Survey (ACS)

The ACS is used to analyze the impacts of HELP on having health insurance coverage at the time of the survey and on type of health insurance coverage. The ACS required minimal data preparation work. We downloaded the 2011-2017 raw ACS data files from the Integrated Public Use Microdata Series (IPUMS) USA website (https://usa.ipums.org/usa/), which provides Census data with harmonized variables over time and enhanced documentation. We identified our analytic sample as all civilian, noninstitutionalized adults 19 to 64 who were living in Montana or one of Montana's comparison states. We constructed the analytic variables needed for the analysis. Those variables included outcome measures and control variables used in the regression analyses. The outcome variables in the ACS were health insurance coverage at the time of the survey and type of health insurance coverage: (1) Medicaid or other public coverage, (2) employer-sponsored insurance, or (3) direct purchase or other coverage. The control variables for the ACS analyses included gender, age, race/ethnicity, educational attainment, marital status, employment status, family size, family income, whether the family has investment income, multiple family household status, household size, household income, homeownership and state of residence. For the family measures, we defined the family based on the "health insurance unit" (HIU) typically used for insurance coverage, comprising the adult, his or her spouse (if present in the household), and any related children under age 19 present in the household. For the family income measure, we calculated family income relative to the federal poverty level (FPL) based on the modified adjusted gross income (MAGI) definition that is used to determine Medicaid eligibility under the Affordable Care Act (ACA). [1, 2]

2. Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is used to analyze the impacts of HELP on health care access and affordability, health behaviors, and health status. The data preparation work for the BRFSS was more involved than that required for the ACS. We downloaded the 2011-17 raw BRFSS Data files from the Centers for Disease Control and Prevention (CDC) website (https://www.cdc.gov/brfss/annual_data/annual_data.htm). We identified our analytic sample as all civilian, noninstitutionalized adults 19 to 64 who were living in Montana or one of Montana's comparison states. However, before we could construct the analytic variables for the analysis, we needed to impute values for missing data in the BRFSS.[3] Once we had addressed missing data, we constructed the analytic variables needed for the analysis. Those variables

[1] A person's MAGI income is the sum of their wage, business, investment, retirement, and Social Security incomes. The family's MAGI income is the sum of individual MAGI incomes for all filers in the family, including all individuals age 18 and older and individuals below age 18 with wage, business, investment, and retirement income above the dependent filing threshold.

[2] In constructing family income relative to FPL, we use the guidelines outlined in State Health Access Data Assistance Center, "Defining 'Family' for Studies of Health Insurance Coverage," issue brief 27 (Minneapolis: University of Minnesota, 2012); http://shadac.org/sites/default/files/publications/SHADAC_Brief27.pdf.

[3] Unlike BRFSS public use files, the ACS public use files include imputations for item nonresponse.

included outcome measures and control variables used in the regression analyses. The outcome variables in the BRFSS included:

- Health care access and affordability
    - Had a personal doctor at the time of the survey
    - Had a routine check-up in the past 12 months
    - Had a flu vaccine in the past 12 months
    - Had no unmet need for doctor care due to costs in the past 12 months[4]
- Health behaviors and health status
    - Smoker at the time of the survey
    - Smoker who did not try to quit in the past 12 months
    - Health status was fair or poor at the time of the survey
    - Physical health was not good in the past 30 days (defined as not good for at least one day)
    - Mental health was not good in the past 30 days (defined as not good for at least one day)
    - Had an activity limitation due to health issues at the time of the survey

Larger values for the health care access and affordability measures indicate better access and affordability, while larger values for the health behaviors and health status indicate poorer health behaviors and health status.
The control variables for the BRFSS analyses included gender, age, race/ethnicity, educational attainment, marital status, employment status, multiple family household status, household size, household income, homeownership and state of residence.

Another data preparation task for the BRFSS was the need to construct consistent weights for the BRFSS samples to support comparisons across states (e.g., between Montana and its comparison states) and over time (e.g., between 2011-13 and 2016-17). Unlike the ACS, which provides a weight that is constructed consistently across all the states and over time, each state in the BRFSS constructs its own weight in each year of the survey. We discuss our approach to imputing for missing data and developing consistent weights for the BRFSS across states and over time below.

a) Imputing for Missing Data.

Because the BRFSS does not provide imputed values for item nonresponse in the public use files, we imputed values for item nonresponse for key demographic and socioeconomic variables in the BRFSS. We also assign values for missing data for one important variable that the BRFSS does not ask about at all, but which is needed for the analysis: family income relative to FPL. Similarly, we assign values for missing data for one variable that the BRFSS asks about in the landline samples but did not ask about in the cell-phone samples in 2011-13: the number of adults in the household. That is, we address a problem with missing data that arises because of missing questions in the survey. This type of imputation, which relies on an external data source to predict values for a missing variable, is most

[4] We frame this as a "positive" outcome so that higher values indicated better access and affordability across all the measures examined.

common in microsimulation models, which often need to supplement existing data sources with additional measures to support policy analyses.[5] For example, the Congressional Budget Office uses a similar regression-based imputation strategy that relies on the Survey of Income and Program Participation, the Health and Retirement Study, and the Current Population Survey to impute missing variables in the primary database used in its microsimulation model.[6] Because these two variables, which are predicted with error, are critical to identifying adults who are predicted to be low-income families in the BRFSS, we have more confidence in the estimates based on the overall population in the BRFSS than those based on the predicted income groups.

Imputing for item nonresponse and missing data on number of adults. The variables we imputed values for included gender, age categories, race/ethnicity, educational attainment, marital status, number of adults in the household, number of children in the household, employment status, household income categories, and household home ownership. All of the variables to be imputed were either binary variables or categorical variables. Item nonresponse was low for most variables (1.5 percent or less) but was more of an issue for household income (between 10.1 and 15.7 percent). Missing data for the number of adults in the household was less than 0.1 percent for the landline sample and at 3.5 percent for the cell-phone sample in 2016 but was missing for every cell phone survey for 2011-13 because those respondents were not asked about the other adults in their household in those years.

The categories used in imputing values for the variables were as follows:

- age: 19-20, 21-25, 26-44, 45-64, and 65 and older;
- race/ethnicity: non-Hispanic white and another race/ethnicity;
- educational attainment: less than high school graduate, high school degree, some college, and four-year college degree or more;
- marital status: married, widowed/separated/divorced, and never married;
- number of adults in the household: 1, 2, and 3 or more;
- number of children in the household: 0, 1, 2, and 3 or more;
- employed: employed and not employed;
- household income: less than $10,000, $10,000-$14,999, $15,000-$19,999, $20,000-$24,999, $25,000-$34,999, $35,000-$49,999, $50,000-$74,999, and $75000 or more; and
- homeownership: someone in household owns or is buying the residence and no one in household owns or is buying the residence.

We imputed for missing values in the BRFSS in three stages using Stata's "mi chained" command, which executes multiple imputation using a sequential process in which missing data for multiple variables are imputed in a specified order (from variables with lower levels of missing to variables with higher levels of missing within the chain of variables), with imputed values included in each successive stage of the

[5] For simplicity, we refer to all of our efforts to address missing data as imputation, although the assignment of family income in the BRFSS based on the data in the ACS can also be considered an out-of-sample prediction model.

[6] AJ Schwabish and JH Topoleski, "Modeling Individual Earnings in CBO's Long-Term Microsimulation Model," Working paper 2013-04 (Washington, DC: Congressional Budget Office, 2013).

imputation process as the imputation moves through the chain of variables. We first imputed for demographic characteristics across the full sample for each individual year (Stage 1), followed by imputation for the number of adults in the household for the cell-phone samples in the combined years of 2011-13 (Stage 2), and then imputation for employment, homeownership, and household income categories for the full sample for each individual year (Stage 3).

- **Stage 1.** The first stage of the imputation process imputed for missing values for the following chain: gender, age, marital status, educational attainment, race/ethnicity, and number of children in the household. The model was estimated separately for each year and included indicators for state of residence and being in the cellphone sample of the survey.[7] Age, educational attainment, and number of children in the household were imputed using ordered logit regressions given that they are ordered categorical variables. Marital status, which is an unordered categorical variable, was imputed using multinomial logit regression. Gender and race/ethnicity, which are binary variables, were imputed using logit regression.

- **Stage 2.** The second stage of the imputation process imputed for missing values for the number of adults in the household that arises because the question was not asked of the cellphone sample in 2011-13.[8] Since the question was asked in other years of the BRFSS, we used data from the cell phone sample for those years to impute for the missing data in 2011-13. [9] For this imputation, we appended BRFSS data from the years 2011 through 2016 into a single file and imputed the number of adults in the household, an ordered categorical variable, using ordered logit regression.[10] The model included gender, age, race/ethnicity, educational attainment, marital status, number of children in the household, and state of residence.

- **Stage 3.** The third stage of the imputation process imputed for missing values for employment status, homeownership and household income. For this imputation, we created separate files for each year and imputed employment status and homeownership, which are both binary variables, using logit regression and household income, which is an ordered categorical variable, using ordered logit regression.[11] The model included gender, age, race/ethnicity, educational attainment, marital status, number of children in the household, number of adults in the

[7] As noted above, the BRFSS conducts interviews with individuals drawn from landline and cell phone samples. Because there are differences across the two samples in how the respondent is selected (the landline sample selects a random adult from among all adults in the household while the cell phone sample respondent is the individual who answers the cell phone) and in some of the questions asked of the respondents, we controlled for the survey sample in the analysis.

[8] The landline sample also has a few observations where the number of adults in the household is missing. Given how few observations are missing, we dropped these observations rather than impute for them.

[9] We rely on later years of the BRFSS rather than the ACS for imputing number of adults in the household in order to impute within a cellphone sample that is similar to cellphone sample of the 2011-13 BRFSS. We cannot identify a similar sample in the ACS.

[10] Estimating the model using multinomial logit regression instead of ordered logit regression for these variables yielded comparable findings.

[11] Estimating the model using multinomial logit regression instead of ordered logit regression yielded comparable findings.

household, multiple family household status,[12] state of residence, and being in the cell phone sample for the survey.

Table E.1 provides a summary of demographic and socioeconomic characteristics of adults in Montana during the 2011-13 baseline period before and after imputation for item nonresponse and for missing data on number of adults in the household for cell phone respondents in 2011-13.

Imputing for missing family income. Because the population targeted by the Medicaid expansion under the HELP demonstration is defined based on family income relative to FPL, we needed to be able to identify that population in the BRFSS. Unfortunately, the BRFSS only provides broad categories of household income and has no information on family size or family income. To address this gap, we imputed family income relative to FPL in the BRFSS using the relationship between family income and household income in the ACS. Specifically, we estimated a regression model for family income as a function of the BRFSS household income categories and other variables and used the coefficient estimates from that model to predict family income in the BRFSS. The remainder of this section discusses that process.

We constructed four measures of family income relative to FPL in the ACS: at or below 50 percent of FPL, at or below 100 percent of FPL, at or below 138 percent of FPL, and at or above 500 percent of FPL. Table E.2 shows the crosswalk between the BRFSS "household income" measures and the "family income relative to FPL" measures that we calculated in the ACS. As shown, the BRFSS household income measure does not provide a strong approximation of family income relative to FPL, highlighting the need to impute for family income relative to FPL to better approximate the target population for Montana's Medicaid expansion.

The imputation model for family income relative to FPL relied on demographic and socioeconomic variables that were defined consistently in the BRFSS and ACS, including gender, age, race/ethnicity, educational attainment, marital status, number of adults in the household, number of children in the household, employment status, household income categories,[13] and state of residence. Because BRFSS collects little information on other household members, we were not able to control for other variables that are likely to be strong predictors of family income relative to FPL (e.g., a spouse's age, education, work status, and family size).

To allow for differences in the relationship between family income and household income for different types of households, we conducted the imputation separately for adults in three different living situations: living alone, living in single-family households, and living in multiple family households. Adults living alone were adults living in a household with one adult and no children. Adults living in

[12] A multiple family household is defined in the BRFSS as a household with more than two adults or a household with two adults in which the individual surveyed is not married. Because the ACS collects information on every individual in a household rather than the single household member surveyed in the BRFSS, multiple family households in the ACS are defined as households with more than two adults or households with two adults in which at least one member of the household is not married.

[13] Although many of the variables are based on very similar questions in the two surveys, that is not true for the household income measure. The ACS household income measure is constructed by aggregating across reported income from several income sources for each member of the household; the BRFSS measure is based on the respondent's reported total household income.

single-family households were adults living in a household with either two married adults (with or without children) or one adult with one or more children. Adults living in multiple family households were adults in households with more than two adults or with two adults, at least one of whom was not married. If one adult was married and the other was not, both adults were considered to be in a multiple family household.

The first step in the imputation process was based on the assignment of family income relative to FPL for adults in BRFSS household income categories that mapped strongly to one "family income relative to FPL" cell. A "strong" map is defined as one for which 95 percent of the adults in the household income category were in the same "family income relative to FPL" category in each year of the base period (2011-13); hereafter, we refer to this as the 95 percent rule. For example, at least 95 percent of adults living alone with household income less than $10,000 had family income at or below 100 percent of FPL for each year in the base period. Thus, all adults living alone with income less than $10,000 in the BRFSS are assigned as having family income at or below 100 percent of FPL.[14] Table E.3 summarizes the circumstances where family income relative to FPL was assigned based on the 95 percent rule for household income. Family income based on the 95 percent rule was used to assign family income relative to FPL to about 60 percent of the Montana adults ages 19 to 64 in the 2011-13 BRFSS sample and 52 percent in the 2016 sample. The comparable figures were about 60 percent for the 2011-13 BRFSS sample and 56 percent for the 2016 sample for Montana's comparison states. The selection of comparison states is discussed in Appendix F, with the list of comparison states provided in Table F.1 (column 5).

For the remaining adults who could not be assigned a "family income relative to FPL" category using the 95 percent rule, we used Stata's multiple imputation command "mi" to impute income based on regression models. We estimated logit regression models for each of the income categories (i.e., family income at or below 50, 100, and 138 percent of FPL and family income above 500 percent of FPL, respectively). Separate models were run for each "family income relative to FPL" category and for each household type. Table E.4 provides a crosswalk of predicted and reported family income relative to FPL for adults ages 19 to 64 in Montana based on the ACS.[15] As shown, roughly 80 percent of the adults who were predicted to have family income at or below 138 percent of FPL reported their income in that category. However, that of course means that roughly 20 percent of the adults who were predicted to have family income at or below 138 percent of FPL reported income above that level. There is also error in the prediction of income above 138 percent of FPL, with almost 10 percent of the adults predicted to have income above that level reporting income at or below 138 percent of FPL. The patterns of prediction error in the imputation process were similar in Montana's comparison states, as shown in Table E.5. Thus, the impact estimates for low-income adults should be viewed as rough approximations of the actual impacts of HELP.

[14] In a few instances in the ACS data for AK and HI, everyone or nearly everyone in the sample of adults living alone was in the same "family income relative to FPL" cell. For similar respondents in AK and HI in the BRFSS, we assigned that same family income relative to FPL from the ACS data.

[15] The imputation process was based on 80 percent of the ACS sample. These estimates are based on the 20 percent of the ACS sample reserved for testing the imputation process.

The parameter estimates from the regression models using the ACS were used to predict family income relative to FPL for the adults in the BRFSS in each year of the pre-period (2011-13) and for the post-period. Table E.6 summarizes the predicted family income for adults ages 19 to 64 in Montana in the BRFSS sample in 2011-13 and 2016 by reported household income. Table E.7 provides comparable information for adults 19 to 64 in Montana's comparison states.

b) Revising the BRFSS Weights.

Because the BRFSS is conducted by each state, the survey fielding, data preparation, and sample weighting vary across states and over time. To address these differences, we reweighted each year of the BRFSS to a common set of population characteristics across states and over time based on the ACS. Those variables include: gender, age, race/ethnicity, educational attainment, marital status, number of children in the household, number of adults in the household, employment status, and household income. We limited the BRFSS sample for reweighting to adults ages 19 to 64, the age group targeted by the HELP demonstration, and reweighted to ACS population characteristics for adults ages 19 to 64.

For the reweighting, we used the user-written "ipfweight" command in Stata[16] to implement a raking process to adjust the existing BRFSS weights. Raking is an iterative adjustment of survey sampling weights to make the composition of the sample match the known composition of the population for a predetermined set of characteristics. It differs from poststratification in that weights are adjusted to make the sample total for a given characteristic (e.g., marital status) equal to the population total. The adjustment proceeds one characteristic at a time, iterating until the sample composition matches that of the population for the whole set of characteristics.

Given the challenge of obtaining convergence across multiple measures in the raking process, the targets for the population characteristics were constrained to just two or three categories within each variable. They were also constrained so that the categories can be consistently defined between the ACS and BRFSS. The final categories used for each of the variables included in the reweighting process were as follow:

- gender: male and female;
- age: 21-25, 26-44, and 45-64;
- race/ethnicity: non-Hispanic white and another race/ethnicity;
- educational attainment: four-year college degree or more and less than four-year college degree;
- marital status: married, widowed/separated/divorced, and never married;
- number of adults in the household: 1, 2, and 3 or more;
- number of children in the household: 0, 1, and 2 or more;
- employed: employed and not employed;

[16] M Bergmann, "IPFWEIGHT: Stata Module to Create Adjustment Weights for Surveys," statistical software components S457353 (Boston: Boston College Department of Economics, 2011).

- household income: less than $35,000, $35000-$74,999, and $75,000 or more; and
- homeownership: someone in household owns or is buying the residence and no one in household owns or is buying the residence.

Tables E.8 and E.9 show the distribution of the samples for Montana and Montana's comparison states, respectively, for the original BRFSS weights and for the revised BRFSS weights for selected measures.[17]

[17] The reweighting program converged relatively quickly for all states except Wisconsin, where the reweighting program failed to converge for some years because there was not a set of weights that satisfied all the reweighting targets. We determined that this was caused by a highly irregular distribution of the number of adults in a household in the BRFSS relative to the ACS for Wisconsin. A conversation with the BRFSS coordinator for Wisconsin confirmed that there was a mistake in the coding of the number of adults for some years. Because Wisconsin is not included as a comparison state for Montana (described later in this section), this data problem does not affect the analyses for Montana.

Appendix Table E.1: Selected Characteristics of Adults Ages 19 and Older in Montana Before and After Imputation for Item Nonresponse in the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	2011-13		2016-17	
	Before Imputation	After Imputation	Before Imputation	After Imputation
Gender (%)				
Female	49.7	49.7	49.9	49.9
Male	50.3	50.3	50.1	50.1
Missing	0.0		0.1	
Age (%)				
19-25	11.8	11.8	11.9	11.9
26-44	29.6	29.7	30.1	30.1
45-64	37.3	37.5	34.4	34.4
65+	20.9	21.0	23.7	23.7
Missing	0.4		0.0	
Race/ethnicity (%)				
Non-Hispanic white	10.5	10.5	11.2	11.4
Other race/ethnicity	88.7	89.5	87.5	88.6
Missing	0.8		1.4	
Educational attainment (%)				
Less than high school graduate/GED	8.9	8.9	7.9	7.9
High school graduate/GED	30.7	30.8	29.8	30.0
Some college	34.1	34.2	35.0	35.2
College graduate or more	26.1	26.1	26.9	27.0
Missing	0.2		0.4	
Marital status (%)				
Married	57.6	57.8	54.8	55.0
Widowed/separated/divorced	20.4	20.5	21.9	22.0
Never married	21.6	21.7	22.9	23.0
Missing	0.4		0.5	

	2011-13		2016-17	
	Before Imputation	After Imputation	Before Imputation	After Imputation
Number of adults in household (%)				
1	13.3	23.3	25.7	26.0
2	39.5	57.7	55.3	55.6
3 or more	11.0	19.0	18.3	18.4
Missing	36.2		0.7	
Number of children in household (%)				
No children	66.7	66.8	67.9	68.3
1	12.5	12.5	12.2	12.3
2	12.4	12.5	10.9	11.1
3 or more	8.2	8.3	8.2	8.3
Missing	0.2		0.7	
Employment status (%)				
Not employed	41.8	41.9	40.6	40.8
Employed	57.9	58.1	58.8	59.2
Missing	0.3		0.6	
Household Income (%)				
Less than $25,000	30.0	34.5	23.6	29.5
$25,000-$49,999	27.2	30.0	23.6	28.3
$50,000-$74,999	14.1	15.5	15.3	17.4
$75,000 or more	18.6	20.0	21.8	24.7
Missing	10.1		15.7	
Household owns home (%)				
Does not own home	28.4	28.5	29.0	29.2
Owns home	71.1	71.5	70.4	70.8
Missing	0.6		0.6	
Sample size	28,301	28,301	11,772	11,772

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). Note: Estimates are weighted by the original BRFSS weights.

Appendix Table E.2: Crosswalk of Household Income Categories from Behavioral Risk Factor Surveillance System and Reported Family Income Relative to FPL for Adults Ages 19 to 64 in the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Behavioral Risk Factor Surveillance System Household Income Categories							
	Less than $10,000	**$10,000 to 14,999**	**$15,000 to $19,999**	**$20,000 to $24,999**	**$25,000 to $34,999**	**$35,000 to $49,999**	**$50,000 to $74,999**	**At or above $75,000**
Years 2011-13								
Reported family income (%)								
At or below 50% FPL	84.5	37.1	26.1	20.7	15.5	11.7	7.9	6.0
At or below 100% FPL	99.9	78.7	55.5	40.9	26.4	17.8	11.7	9.0
At or below 138% FPL	99.9	99.9	79.9	62.9	42.7	25.0	15.1	11.2
Above 138% FPL	0.1	0.1	20.1	37.1	57.3	75.0	84.9	88.8
Above 500% FPL	0.0	0.0	0.0	0.0	0.0	0.0	6.0	52.8
Sample size	311,582	179,852	189,197	214,372	439,991	666,225	1,014,778	2,267,039
Year 2016-17								
Reported family income (%)								
At or below 50% FPL	87.7	40.8	28.8	20.7	15.9	11.6	8.0	5.9
At or below 100% FPL	100.0	82.7	59.7	45.0	28.9	18.3	12.1	8.9
At or below 138% FPL	100.0	100.0	83.3	64.5	47.9	27.2	16.2	11.2
Above 138% FPL	0.0	0.0	16.7	35.5	52.1	72.8	83.8	88.8
Above 500% FPL	0.0	0.0	0.0	0.0	0.0	0.0	4.6	48.8
Sample size	158,329	90,792	96,050	114,504	242,438	385,836	632,492	1,815,413

Source: 2011-13 and 2016-17 American Community Survey (ACS);
Notes: FPL = Federal poverty level. Cells show column percentages. Since the rows are not mutually exclusive the columns will sum to more than 100%.

Appendix Table E.3: Strategy for Assigning Family Income Relative to FPL Based on the 95-Percent Rule for Adults in the Behavioral Risk Factor Surveillance System

	Behavioral Risk Factor Surveillance System Household Income Categories							
	Less than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$24,999	$25,000-$34,999	$35,000-$49,999	$50,000-$74,999	$75,000 or more
Adults who live alone								
At or below 50% FPL			B	B	B	B	B	B
At or below 100% FPL	A			B	B	B	B	B
At or below 138% FPL	A	A		B	B	B	B	B
Above 138% FPL	B	B		A	A	A	A	A
Above 500% FPL	B	B	B	B	B	B		
Adults who live in a single-family household								
At or below 50% FPL				B	B	B	B	B
At or below 100% FPL	A	A				B	B	B
At or below 138% FPL	A	A	A				B	B
Above 138% FPL	B	B	B				A	A
Above 500% FPL	B	B	B	B	B	B	B	
Adults who live in a multiple-family household								
At or below 50% FPL								
At or below 100% FPL	A							
At or below 138% FPL	A	A						
Above 138% FPL	B	B						
Above 500% FPL	B	B	B	B	B	B	B	

Notes: FPL = Federal poverty level. The 95-percent rule is explained in the text. A = assigned to have family income in category; B = assigned to not have family income in category; Blank = not affected by 95-percent rule.

Appendix Table E.4: Crosswalk of Reported and Imputed Family Income Relative to FPL for Adults Ages 19 to 64 in Montana in the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Imputed Family Income Relative to FPL				
	At or below 50%	**At or below 100%**	**At or below 138%**	**Above 138%**	**Above 500%**
Years 2011-13					
Reported family income (%)					
At or below 50% FPL	63.2	49.7	39.1	2.6	0.3
At or below 100% FPL	80.9	75.1	61.9	4.6	0.5
At or below 138% FPL	87.6	86.4	80.9	8.7	1.0
Above 138% FPL	12.4	13.6	19.1	91.3	99.0
Above 500% FPL	0.7	1.0	0.9	27.2	75.3
Sample size	425	678	922	2,451	732
Year 2016-17					
Reported family income (%)					
At or below 50% FPL	58.4	47.3	37.6	1.9	0.4
At or below 100% FPL	78.5	74.3	61.8	4.4	0.9
At or below 138% FPL	82.6	83.2	75.4	8.1	1.2
Above 138% FPL	17.4	16.8	24.6	91.9	98.8
Above 500% FPL	1.3	0.8	1.3	32.4	74.4
Sample size	250	410	550	1,650	549

Source: 2011-13 and 2016-17 American Community Survey (ACS);
Notes: FPL = Federal poverty level. Cells show column percentages. Since the rows are not mutually exclusive the columns will sum to more than 100%. The imputation of family income relative to FPL is described in Appendix E. The imputation process was based on a random sample of 80% of the ACS sample. The estimates reported here are based on the 20% of the ACS sample reserved for testing the imputation process.

Appendix Table E.5: Crosswalk of Reported and Imputed Family Income Relative to FPL for Adults Ages 19 to 64 in Montana's Comparison States in the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Imputed Family Income Relative to FPL				
	At or below 50%	**At or below 100%**	**At or below 138%**	**Above 138%**	**Above 500%**
Years 2011-13					
Reported family income (%)					
At or below 50% FPL	67.5	54.4	45.9	3.1	0.8
At or below 100% FPL	82.3	75.7	66.6	5.9	1.3
At or below 138% FPL	87.7	84.4	80.0	9.6	1.8
Above 138% FPL	12.3	15.6	20.0	90.4	98.2
Above 500% FPL	1.4	1.6	1.7	35.1	76.1
Sample size	158,866	242,388	309,420	744,695	278,339
Year 2016-17					
Reported family income (%)					
At or below 50% FPL	66.2	52.4	44.0	3.2	0.8
At or below 100% FPL	80.4	73.0	64.2	6.1	1.4
At or below 138% FPL	85.9	81.8	76.9	9.7	2.0
Above 138% FPL	14.1	18.2	23.1	90.3	98.0
Above 500% FPL	1.6	1.9	2.1	36.3	71.8
Sample size	92,687	143,702	184,393	521,078	206,418

Source: 2011-13 and 2016-17 American Community Survey (ACS);
Notes: FPL = Federal poverty level. Cells show column percentages. Since the rows are not mutually exclusive the columns will sum to more than 100%. The selection of comparison states is described in Appendix F. These tabulations include all comparison states in Table F.1, column 5. The imputation of family income relative to FPL is described in Appendix E. The imputation process was based on a random sample of 80% of the ACS sample. The estimates reported here are based on the 20% of the ACS sample reserved for testing the imputation process.

Appendix Table E.6: Crosswalk of Reported Household Income and Imputed Family Income Relative to FPL for Adults Ages 19 to 64 in Montana in the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Imputed Family Income Relative to FPL				
	At or below 50%	**At or below 100%**	**At or below 138%**	**Above 138%**	**Above 500%**
Years 2011-13					
Reported household income (%)					
Less than $15,000	47.5	40.2	32.9	0.0	0.0
$15,000-$19,999	14.1	17.8	18.0	1.5	0.0
$20,000-$24,999	11.0	14.0	16.0	3.6	0.0
$25,000-$34,999	7.0	8.1	10.6	6.7	0.0
$35,000-$49,999	8.0	8.6	11.3	21.4	0.0
$50,000-$74,999	5.2	5.0	5.4	21.9	4.4
$75,000 or more	7.2	6.2	5.7	44.9	95.6
Sample size	2,226	4,017	5,872	13,342	3,497
Year 2016-17					
Reported household income (%)					
Less than $15,000	34.5	30.0	24.0	0.0	0.0
$15,000-$19,999	15.5	18.4	18.2	0.9	0.0
$20,000-$24,999	10.1	13.0	14.0	2.4	0.0
$25,000-$34,999	9.9	10.1	12.9	4.8	0.0
$35,000-$49,999	10.9	11.5	14.1	16.0	0.0
$50,000-$74,999	9.1	7.9	8.0	20.8	2.3
$75,000 or more	10.1	9.2	8.8	55.2	97.7
Sample size	966	1,691	2,336	4,996	1,405

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). Notes: FPL = Federal poverty level. Cells show column percentages. Estimates are weighted by the revised BRFSS weights (see Table E.8).

Appendix Table E.7: Crosswalk of Reported Household Income and Imputed Family Income Relative to FPL for Adults Ages 19 to 64 in Montana's Comparison States in the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Imputed Family Income Relative to FPL				
	At or below 50%	**At or below 100%**	**At or below 138%**	**Above 138%**	**Above 500%**
Years 2011-13					
Reported household income (%)					
Less than $15,000	39.9	33.7	28.4	0.0	0.0
$15,000-$19,999	12.8	15.5	15.4	0.9	0.0
$20,000-$24,999	10.0	12.7	13.9	2.4	0.0
$25,000-$34,999	7.3	8.7	10.8	4.6	0.0
$35,000-$49,999	10.8	11.6	13.7	16.8	0.0
$50,000-$74,999	7.1	7.1	7.4	20.3	4.1
$75,000 or more	12.0	10.8	10.4	55.0	95.9
Sample size	124,745	209,399	280,802	667,612	237,331
Years 2016-17					
Reported household income (%)					
Less than $15,000	31.7	26.3	21.9	0.0	0.0
$15,000-$19,999	12.4	14.6	14.4	0.6	0.0
$20,000-$24,999	9.8	12.8	13.6	1.7	0.0
$25,000-$34,999	7.5	8.8	10.7	3.3	0.0
$35,000-$49,999	12.8	13.5	15.8	13.7	0.0
$50,000-$74,999	8.5	8.6	8.9	17.9	2.7
$75,000 or more	17.2	15.4	14.7	62.7	97.3
Sample size	79,666	134,663	177,563	403,385	150,661

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). **Notes**: FPL = Federal poverty level. Cells show column percentages. Estimates are weighted by the revised BRFSS weights (see Table E.9). The selection of comparison states is described in Appendix F. These tabulations include all comparison states Table F.1, column 5.

Appendix Table E.8: Selected Characteristics of Adults Ages 19 to 64 in Montana Before and After Reweighting to Create More Consistent Weights Across States and Over Time in the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Original BRFSS Weights	Revised BRFSS Weights
Female (%)	49.8	50.0
Age (%)		
21-25	11.6	15.1
26-44	29.3	37.6
45-64	35.6	47.3
Race/ethnicity (%)		
Non-Hispanic white	88.9	88.0
Other race/ethnicity	11.1	12.0
Educational attainment (%)		
High school graduate/GED or less	30.9	28.9
Some college	34.2	36.7
College graduate or more	26.0	28.3
Marital status (%)		
Married	55.7	55.2
Widowed/separated/divorced	20.7	17.3
Never married	23.6	27.6
Household size (%)		
1	19.5	12.3
2	38.6	38.3
3 or more	41.9	49.3
Multiple family household (%)	66.2	57.4
Employed (%)	41.7	25.9
Household Income (%)		
Less than $25,000	32.5	21.9
$25,000-$49,999	29.3	25.2
$50,000-$74,999	16.3	17.1
$75,000 or more	22.0	35.8
Household owns home (%)	29.3	30.2
Sample size	40,346	40,346

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).

Appendix Table E.9: Selected Characteristics of Adults Ages 19 to 64 in Montana's Comparison States Before and After Reweighting to Create More Consistent Weights Across States and Over Time in the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Original BRFSS Weights	Revised BRFSS Weights
Female (%)	48.7	49.2
Age (%)		
21-25	12.1	15.1
26-44	32.5	40.9
45-64	34.1	44.1
Race/ethnicity (%)		
Non-Hispanic white	64.9	69.5
Other race/ethnicity	35.1	26.4
Educational attainment (%)		
High school graduate/GED or less	28.5	26.4
Some college	30.6	35.2
College graduate or more	26.4	29.9
Marital status (%)		
Married	50.9	52.6
Widowed/separated/divorced	20.2	16.0
Never married	29.0	31.5
Household size (%)		
1	16.4	10.6
2	32.9	31.8
3 or more	50.8	57.6
Multiple family household (%)	55.0	49.4
Employed (%)	43.5	26.3
Household Income (%)		
Less than $25,000	31.1	17.8
$25,000-$49,999	25.1	21.3
$50,000-$74,999	14.8	16.1
$75,000 or more	29.1	44.8
Household owns home (%)	32.6	30.8
Sample size	2,326,051	2,326,051

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: The selection of comparison states is described in Appendix F. These tabulations include all comparison states in Table F.1, column 5.

Appendix F: Constructing the Comparison Groups for the Impact Analysis

The impact analysis estimates the effects of Montana's HELP demonstration using difference-in-differences (DD) methods based on data for 2011-2017 from two national surveys: the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS). DD models compare changes over time in a treatment group (in this case, Montana) to changes over time in a comparison group that provides the counterfactual for what would have happened in the treatment group in the absence of the intervention (in this case, the HELP demonstration). This technical appendix describes the process for selecting the comparison groups to be used in the DD models to estimate the effects of the HELP demonstration. All tables for Appendix F are provided at the end of the appendix.

Constructing the comparison groups for Montana's demonstration involved two steps: (1) identifying the groups of states that would serve as the counterfactuals for Montana's demonstration, and (2) identifying the people in those groups of comparisons states who were most similar to people in Montana on a range of individual and family characteristics using propensity scores. By using propensity scores to reweight the residents of the comparison states, we obtained a comparison group that more closely matches the characteristics of the Montana sample, reducing the potential for omitted variable bias in the impact estimates caused by unmeasured differences between residents of Montana and the comparison states.

1. Identifying the Potential Comparison States.

To identify the comparison states for each counterfactual for each research question, we began by sorting all states by their expansion status—that is, by whether they had not expanded Medicaid, expanded Medicaid without a demonstration, expanded Medicaid with a demonstration, as summarized in Table F.1 (column 3). We then excluded states that had made changes in Medicaid eligibility over the baseline period (2011-13) or were not good matches for other reasons (outlined later in this section). This created the set of potential comparison states for Montana (column 4).

From the potential comparison states, we then sought to identify the subset of states that provided the best comparison based on similar Medicaid and section 1115 demonstration eligibility standards in 2011 (within 10 percentage points for all categories) and relative stability in eligibility standards over the baseline period of 2011 to 2013 (changes of less than 10 percentage points for all categories). To determine income eligibility for Medicaid and section 1115 demonstration coverage expansions, we relied heavily upon annual reports from the Kaiser Family Foundation that detail income eligibility standards for Medicaid and section 1115 demonstration coverage by state for January of a given year.[1, 2, 3, 4] When section 1115 demonstration coverage provided coverage equivalent to Medicaid, we listed whichever income standard was higher as the threshold for full Medicaid benefits. When reports are unclear about the extent of the section 1115 demonstration coverage, we attempted to verify the extent of coverage using additional tables by the Kaiser Family Foundation that list the income eligibility limits for coverage providing full Medicaid benefits.[5,6] When still in doubt about the scope of benefits,

[1] M Heberlein, T Brooks, J Alker, S Artiga, and J Stephens, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013" (Menlo Park, CA: Kaiser Family Foundation, 2013); https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf .

[2] M Heberlein, T Brooks, J Guyer, S Artiga, and J Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and Chip, 2010-2011" (Menlo Park, CA: Kaiser Family Foundation, 2011); https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8130.pdf .

[3] M Heberlein, T Brooks, J Guyer, S Artiga, and J Stephens, "Performing under Pressure: Annual Findings of A 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and Chip, 2011-2012" (Menlo Park, CA: Kaiser Family Foundation, 2012). https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8272.pdf .

[4] Programs that were closed were given an eligibility standard of zero because they were not accepting new enrollees. Oklahoma's section 1115 demonstration coverage was limited to a subset of adults who had incomes below the eligibility threshold and worked for a small employer, were self-employed, were unemployed and seeking work, were working while disabled, were a full-time college student, or were the spouse of a qualified worker. Although those requirements were consistent across the period examined, in 2011 and 2012 the Kaiser Family Foundation considered this coverage as available to both working and nonworking adults, though in 2013 the organization interpreted this coverage as only available to working adults. Although the emphasis is on work, coverage is not strictly limited to working adults, so we consider this coverage as available to both working and nonworking adults for all years. As noted in the Kaiser Family Foundation reports, Louisiana and Missouri had section 1115 demonstration coverage for the greater New Orleans and greater Saint Louis areas, respectively. Because these areas constituted a significant share of the overall state population in their respective states, we included the income eligibility for these programs as the section 1115 demonstration coverage threshold for the state.

[5] "Medicaid Income Eligibility Limits for Other Non-Disabled Adults, 2011-2016," Kaiser Family Foundation, no date (accessed October 19, 2016), http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-other-non-disabled-adults/ .

[6] "Medicaid Income Eligibility Limits for Parents, 2002-2016," Kaiser Family Foundation, no date (accessed October 19, 2016), http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents / .

we turned to outside sources for Delaware,[7] Louisiana,[8] Missouri,[9] and Vermont.[10, 11] Information on the states included in the group of potential comparison states (Table F.1, column 4) is discussed below. Information on the states that were excluded from the group of potential comparison states is provided in Table F.2.

In addition to selecting comparison states based on Medicaid and section 1115 demonstration eligibility standards, we also selected states that were similar to Montana based on measures of uninsurance, health status, and health care outcomes over the baseline period. These measures, which were based on the BRFSS, included the share of nonelderly adults who reported affirmatively to the following: being uninsured, being of fair or poor health, having ever been diagnosed with a chronic condition, having a health limitation, having a personal doctor or health care provider, and having had a routine check-up in the past year.[12]

The subset of states that provided the best comparison for adults based on similar Medicaid and section 1115 demonstration eligibility standards in 2011 (within 10 percentage points of Montana for all categories), relative stability in eligibility standards over the baseline period of 2011-13 (changes of less than 10 percentage points for all categories), and similar baseline health and health outcomes (within 10 percentage points of Montana across almost all measures) are listed in Table F.1 (column 5). To select the single-best comparison states for adults in Montana, we identified the state most similar to Montana across both the Medicaid and section 1115 demonstration eligibility standards, uninsurance rate, and health and health outcomes. We relied on two sets of comparison states for the DD analyses:

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[7] "Delaware Diamond State Health Plan Special Terms and Conditions," Centers for Medicare and Medicaid Services, amended as of April 1, 2012, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/Diamond-State-Health-Plan/de-dshp-stc-01312011-12312013-amended-042012.pdf.

[8] Centers for Medicare & Medicaid Services, "National Summary of State Medicaid Managed Care Programs as of July 1, 2011" (Baltimore, MD: Centers for Medicare & Medicaid Services, 2011). https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-national-summary-mc-report.pdf.

[9] Missouri Department of Social Services, *Gateway to Better Health Demonstration Amendment Request* (Jefferson City, MO: Missouri Department of Social Services, 2015). https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mo/Gateway-to-Better-Health/mo-gateway-to-better-health-amend-cvrg-brand-drug-02192015.pdf.

[10] Pacific Health Policy Group on behalf of the State of Vermont Agency of Human Services, *Global Commitment to Health 2013 Interim Program Evaluation* (Highland Park, IL: Pacific Health Policy Group, 2013). https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-interim-program-eval-042013.pdf.

[11] State of Vermont Agency of Human Services, "Global Commitment to Health Extension Request" (Montpelier, VT: State of Vermont Agency of Human Services, 2015. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-pa.pdf .

[12] The measures of the uninsurance rate and health and health care outcomes for the states' populations were regression-adjusted for differences in the age and sex distribution across the states. We did this by regressing each outcome measure on indicators for age, sex, and state and deriving the mean of the predicted value of the outcome measure for each state using the national sample, assuming the entire sample lives within that state. This allowed us to separate state-specific effects from the effects of differences in age and sex distribution of the state population.

the group of best comparison states (column 5) and the single-best comparison state from among the group of best comparison states (column 6).

States differ in many ways beyond the Medicaid expansion strategies being examined here, including the demographic, social, economic, health and political context, and it is not possible to identify states that match Montana across all those dimensions. Thus, any differences identified in the comparisons between Montana and the various comparison groups will reflect those factors, as well as differences in Medicaid expansion strategies. The group of best comparison states and the single-best comparison state that did not expand Medicaid, expanded Medicaid without a demonstration, and expanded Medicaid with a different demonstration are described below. Given that we are not able to control for all of the potential differences between Montana and the comparison states, we have more confidence in findings that are robust across the different comparison states in the group of best comparison states.

2. The Comparison States that did not Expand Medicaid.

The states that had not expanded Medicaid as of January 1, 2018, are listed in row 1 of Table F.1 (column 3). In selecting the set of potential comparison states (column 4), we excluded Missouri, Maine, Utah, and Wisconsin. Although Missouri has not implemented the Medicaid expansion, the Gateway to Better Health section 1115 demonstration was implemented in St. Louis, which represents a substantial share of the state's population, making Missouri an inappropriate nonexpansion comparison state. Utah also had not expanded Medicaid eligibility, but in 2012 the state increased eligibility for their employer-sponsored insurance (ESI) premium assistance program. Maine and Wisconsin are excluded because both states were already covering parents under their Medicaid programs in 2011 at roughly the level the ACA expanded coverage to.

From the set of potential comparison states, we sought to identify the subset of states that provided the best comparisons to Montana based on similar Medicaid and section 1115 eligibility standards in 2011 (within 10 percentage points of Montana for all categories) and relative stability in eligibility standards over the baseline period of 2011 to 2013 (changes of less than 10 percentage points for all categories) as summarized in Table F.3. Based on those comparisons, we find that Georgia, North Carolina, and Wyoming are similar to Montana on baseline Medicaid and section 1115 eligibility standards. The three states were generally similar to Montana on baseline health and health outcomes (Table F.4), although nonelderly adults in Georgia and North Carolina were more likely to have a routine check-up in the past year in 2011 (about 18 percentage points higher than the level for Montana). Wyoming provides the single best comparison state because it is most similar to Montana across the baseline Medicaid and section 1115 eligibility criteria, uninsurance, and the health and health outcomes.[13]

3. The Comparison States that Expanded Medicaid without a Demonstration.

The states that expanded Medicaid without a demonstration are shown in the second row of Table F.1 (column 3). In selecting the potential set of comparison states for Montana (column 4), we exclude states that expanded Medicaid before 2014 (California, Connecticut, District of Columbia, Minnesota, New Jersey and Washington), states with eligibility levels that met ACA standards before 2011

[13] We define "most similar" as having the smallest total differences from Montana for the baseline Medicaid and section 1115 eligibility standards and the health and health outcomes.

(Massachusetts, New York, Rhode Island and Vermont), states that made other changes to Medicaid eligibility during the baseline period (Arizona, Hawaii, Illinois, Nevada, Oregon) and states that expanded Medicaid after the date of Montana's expansion (Louisiana). From the final set of comparison states, we sought to identify the subset of states that provided the best comparison to Montana based on similar Medicaid and section 1115 eligibility standards in 2011 (within 10 percentage points of Montana for all categories) and relative stability in eligibility standards over the baseline period of 2011 to 2013 (changes of less than 10 percentage points for all categories) as summarized in Table F.5. We find that Kentucky and North Dakota are similar to Montana on baseline Medicaid and section 1115 eligibility standards. Both states were generally similar to Montana on baseline health and health outcomes (Table F.6), although nonelderly adults in Kentucky were somewhat more likely than those in Montana in the baseline period to have a personal doctor and a routine check-up in the past year (both about 10 percentage points higher than in Montana). North Dakota provides the single best comparison state because it is most similar to Montana across the baseline Medicaid and section 1115 eligibility criteria, uninsurance, and the baseline health and health outcomes.

4. The Comparison States that Expanded Medicaid with a Different Demonstration.

The states that expanded Medicaid with a different demonstration are listed in the third row in Table F.1 (column 3). In selecting the set of potential comparison states for Montana (column 4) no states were excluded since the states that expanded Medicaid with a different demonstration had implemented their demonstration before the date of Montana's expansion. We sought to identify the subset of states that provided the best comparison based on similar Medicaid and section 1115 eligibility standards in 2011 (within 10 percentage points of Montana for all categories) and relative stability in eligibility standards over the baseline period of 2011 to 2013 (changes of less than 10 percentage points for all categories) as summarized in Table F.7. We find that Michigan and New Hampshire are similar to Montana on baseline Medicaid and section 1115 eligibility standards. Both states were roughly similar to Montana on baseline health and health outcomes (Table F.8), although nonelderly adults in both states were more likely than those in Montana to have a personal doctor and a routine checkup in the past year (between about 11 and 17 percentage points higher than in Montana). Michigan provides the single best comparison state for childless adults because it is most similar to Montana across the baseline Medicaid and section 1115 eligibility criteria, uninsurance, and the baseline health and health outcomes.

5. Identifying Residents in the Comparison States who are Similar to Montana Residents.

The next step was to estimate propensity score models to identify the residents of each group of best comparison states and the residents of each individual comparison state who were similar to residents of Montana on a range of individual and family characteristics.[14] The list of the explanatory variables included in the propensity score models for the ACS and BRFSS are summarized in Table F.9. The models varied for the ACS and BRFSS because the two surveys include different variables. Before estimating the

[14] We had proposed including county characteristics in the analyses based on the ACS; however, the relatively small number of counties in Montana and some of the comparison states made matching on county characteristics problematic.

models for the groups of best comparison states, we first adjusted the ACS and revised BRFSS weights to balance for state population differences. These state population-balanced-weights (PBW) ensure equal contribution from each state within the group of best comparison states. This limits the introduction of any biases caused by unobserved idiosyncrasies from any individual state within the group of best comparison states. In this process, the weights for the Montana sample were left unchanged.

Given the binary nature of the outcome (a person either lives in Montana or another state), we estimated logit regression models to derive propensity scores for each of the groups of best comparison states and the single-best comparison states. The estimation results for the group of best comparison states based on the ACS are reported in Tables F.10-F.12 for states that did not expand Medicaid, states that expanded Medicaid without a demonstration, and states that expanded Medicaid with a different demonstration, respectively. The comparable estimation results based on the BRFSS are reported in Tables F.13-F.15. Similar models were estimated to support estimates for the comparisons to the single-best comparison states and each of the remaining states in the group of best comparison states and for each of the income and education groups used in the sensitivity analyses and falsification tests.

The parameter estimates from the regression models were used to estimate the propensity score (PS) for everyone in each group of best comparison states and each individual comparison state, providing the predicted probability that the individual is from Montana. We then used these propensity scores to create inverse probability weights. For the individual comparison states, the inverse probability weights are defined as PS/(1-PS) times the weight from the ACS (for the ACS sample) or the revised weight from the BRFSS (for the BRFSS sample). For the group of best comparison states, the inverse probability weights are defined as PS/(1-PS) times the state population-balanced weight constructed for the ACS (for the ACS sample) or BRFSS (for the BRFSS sample). By doing this, residents of the group of best comparison states and individual comparison states who were more similar to Montana residents received larger weights; those who were less similar to Montana residents received lower weights. This reweighting pulled the distribution of the characteristics of the weighted comparison groups closer to that of Montana residents, increasing the comparability between Montana and its comparison groups.

We assessed the resulting comparison groups by comparing the distribution of the propensity scores and of the covariates between Montana and the comparison groups to ensure that the resulting distributions are similar (i.e., “balanced”). Observations from the group of best comparison states that had propensity scores that are smaller than the smallest propensity score in the Montana sample were excluded from the analysis.

As a check on the weights generated using propensity scores, we conducted similar analyses using entropy balancing, a reweighting method that aligns the characteristics of the residents of comparison groups to the characteristics of Montana residents. We used Stata’s “ebalance” command to implement entropy balancing. We used the same variables as in the propensity score models for the application of entropy balancing.

Tables F.16-18 report on the characteristics of adults in Montana and the group of best comparison states based on the different reweighting strategies for the ACS for states that did not expand Medicaid, states that expanded Medicaid without a demonstration, and states that expanded Medicaid with a different demonstration, respectively. The comparable tables for the comparison of the characteristics

of adults in Montana and the group of best comparison states based on the BRFSS are reported in Tables F.19-F.21. As shown, both propensity score reweighting and entropy balancing aligned the characteristics of the adults in the group of best comparison states with the characteristics of adults in Montana.

Appendix Table F.1: Selecting the Comparison States for Estimating the Impacts of Montana's Section 1115 Demonstration Based on Difference-in-Differences Models

Research Question (1)	Comparison Group (2)	States Sorted Based on Medicaid Expansion Status (3)	Potential Comparison States (4)	Group of Best Comparison States (5)	Single-best Comparison State (6)
What are the impacts of Montana's Medicaid demonstration as compared to not expanding Medicaid?	Similar persons in comparison states that have not expanded Medicaid	AL, FL, GA, ID, KS, MS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WY	AL, FL, GA, ID, KS, MS, NE, NC, OK, SC, SD, TN, TX, VA, WY	GA, NC, WY	WY
What are the impacts of Montana's Medicaid demonstration as compared expanding Medicaid without a demonstration?	Similar persons in comparison states that expanded Medicaid without a demonstration	AZ, AK, CA, CO, CT, DE, DC, HI, IL, KY, LA, ME, MD, MA, MN, MO, NV, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, WV, WI	AK, CO, DE, KY, MD, NM, ND, OH, PA, WV	KY, ND	ND
What are the impacts of Montana's Medicaid demonstration as compared to expanding Medicaid with a different demonstration?	Similar persons in comparison states that expanded Medicaid with a different demonstration	AR, IN, IA, MI, NH	AR, IN, IA, MI, NH	MI, NH	MI

Notes: See text for explanation of different comparison group categories.

Appendix Table F.2: Comparison of Medicaid and Section 1115 Eligibility Standards for Adults Ages 19 to 64 for Montana and States that Did Not Meet Criteria for Inclusion in Potential Comparison States, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana									
		AZ	CA	CT	DC	HI	IL	LA	ME	MA	MN
Level in 2011											
Income eligibility for full benefits											
Nonworking parents	32%	68	68	153	168	68	153	-21	168	101	183
Working parents	56%	50	50	135	151	44	135	-31	144	77	159
Nonworking adults	0%	100	0	56	200	0	0	0	0	0	0
Working adults	0%	110	0	73	211	0	0	0	0	0	0
Income eligibility for limited benefits											
Nonworking parents	0%	0	200	0	0	200	0	200	0	300	275
Working parents	0%	0	200	0	0	200	0	200	0	300	275
Nonworking adults	0%	0	200	0	0	200	0	200	0	300	0
Working adults	0%	0	200	0	0	200	0	200	0	300	0
Change between 2011 and 2013											
Income eligibility for full benefits											
Nonworking parents	-1	1	-1	1	-1	34	-86	86	-86	86	-86
Working parents	-2	2	-2	2	-3	36	-88	87	-87	87	-87
Nonworking adults	0	-100	100	-101	101	32	-32	32	-32	32	43
Working adults	0	-110	110	-113	113	20	-20	20	-20	20	55
Income eligibility for limited benefits											
Nonworking parents	0	0	0	0	0	-200	200	-200	200	-200	200
Working parents	0	0	6	-6	6	-206	206	-206	206	-206	206
Nonworking adults	0	0	0	0	0	-200	200	-200	200	-200	400
Working adults	0	0	10	-10	10	-210	210	-210	210	-210	410

Appendix Table F.2: (continued)

	Montana	Difference from Value for Montana									
		MO	NV	NJ	NY	OR	RI	UT	VT	WA	WI
Level in 2011											
Income eligibility for full benefits											
Nonworking parents	32%	-13	15	-3	118	0	143	6	153	5	168
Working parents	56%	-19	2	77	94	-16	125	-12	135	18	144
Nonworking adults	0%	0	0	0	100	0	0	0	150	0	0
Working adults	0%	0	0	0	100	0	0	0	160	0	0
Income eligibility for limited benefits											
Nonworking parents	0%	0	0	0	0	201	0	0	300	0	0
Working parents	0%	0	0	0	0	201	0	150	300	0	0
Nonworking adults	0%	0	0	0	0	201	0	0	300	0	0
Working adults	0%	0	0	0	0	201	0	150	300	0	0
Change between 2011 and 2013											
Income eligibility for full benefits											
Nonworking parents	-1	85	-108	212	-212	210	-210	0	210	-212	212
Working parents	-2	85	-59	59	-59	58	-58	0	58	-61	61
Nonworking adults	0	-43	43	-43	43	-43	43	0	-43	43	-43
Working adults	0	-55	55	-55	55	-55	55	0	-55	55	-55
Income eligibility for limited benefits											
Nonworking parents	0	0	0	0	0	-201	201	0	-201	201	-201
Working parents	0	-6	6	-6	6	-207	207	50	-207	207	-207
Nonworking adults	0	-200	200	-177	177	-378	378	0	-378	378	-378
Working adults	0	-210	210	-187	187	-388	388	50	-388	388	-388

Source: Kaiser Family Foundation

Appendix Table F.3: Comparison of Medicaid and Section 1115 Eligibility Standards and Uninsurance Rate for Adults Ages 19 to 64 for Montana and Comparison States that Did Not Expand Medicaid, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana							
		AL	FL	GA	ID	KS	MS	NE	NC
Level in 2011									
Income eligibility for full benefits									
Nonworking parents	32%	-21	-12	-4	-11	-6	-8	15	4
Working parents	56%	-32	3	-6	-17	-24	-12	2	-7
Nonworking adults	0%	0	0	0	0	0	0	0	0
Working adults	0%	0	0	0	0	0	0	0	0
Income eligibility for limited benefits									
Nonworking parents	0%	0	0	0	0	0	0	0	0
Working parents	0%	0	0	0	185	0	0	0	0
Nonworking adults	0%	0	0	0	0	0	0	0	0
Working adults	0%	0	0	0	185	0	0	0	0
Uninsurance rate for nonelderly adults	20.4%	-1.5	5.0	2.9	1.8	-4.1	5.0	-4.6	0.7
Change between 2011 and 2013									
Income eligibility for full benefits									
Nonworking parents	-1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	-1.0
Working parents	-2.0	1.0	-1.0	0.0	0.0	1.0	-13.0	2.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Income eligibility for limited benefits									
Nonworking parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsurance rate for nonelderly adults	-1.1	-0.6	-0.4	-0.2	-2.5	1.2	-0.4	-1.0	0.0

Appendix Table F3: (continued)

	Montana	Difference from Value for Montana						
		OK	SC	SD	TN	TX	VA	WY
Level in 2011								
Income eligibility for full benefits								
Nonworking parents	32%	5	18	20	38	-20	-7	7
Working parents	56%	-3	37	-4	71	-30	-25	-4
Nonworking adults	0%	0	0	0	0	0	0	0
Working adults	0%	0	0	0	0	0	0	0
Income eligibility for limited benefits								
Nonworking parents	0%	200	0	0	0	0	0	0
Working parents	0%	200	0	0	0	0	0	0
Nonworking adults	0%	200	0	0	0	0	0	0
Working adults	0%	200	0	0	0	0	0	0
Uninsurance rate for nonelderly adults	20.4%	2.0	1.1	-7.4	-1.8	7.1	-6.7	0.1
Change between 2011 and 2013								
Income eligibility for full benefits								
Nonworking parents	-1.0	0.0	1.0	-1.0	-2.0	1.0	1.0	-1.0
Working parents	-2.0	0.0	-2.0	0.0	-3.0	1.0	1.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Income eligibility for limited benefits								
Nonworking parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsurance rate for nonelderly adults	-1.1	-2.9	-0.9	0.6	-0.5	-0.4	0.9	-0.2

Sources: Medicaid/Section 1115 eligibility: Kaiser Family Foundation; uninsurance rate: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Shading indicates states included in the group of best comparison states.

APPENDIX TABLE F4: Comparison of Health and Health Care Outcomes for Adults Ages 19 to 64 for Montana and Comparison States that Did Not Expand Medicaid, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana							
		AL	FL	GA	ID	KS	MS	NE	NC
Level in 2011									
Share reporting fair/poor health	12.2%	5.2	3.5	1.6	0.4	-1.4	6.4	-1.6	2.4
Share ever diagnosed with a chronic condition	53.5%	5.7	-1.9	-2.1	-2.2	-2.1	3.6	-2.9	-0.6
Share with a health limitation	22.6%	3.4	0.2	-3.1	-0.9	-3.6	1.4	-4.6	-2.3
Share with a personal doctor	69.3%	9.5	2.2	4.1	1.9	10.0	3.0	10.6	5.1
Share with a routine checkup in the past 12 months	52.0%	17.2	12.2	18.5	1.3	13.3	12.0	2.5	18.9
Change between 2011 and 2013									
Share reporting fair/poor health	0.2	-0.5	-1.3	0.3	-2.2	0.4	0.4	-1.3	-0.7
Share ever diagnosed with a chronic condition	0.7	-0.4	0.2	2.9	0.3	0.3	-0.8	-0.5	-0.1
Share with a health limitation	-3.2	1.2	-1.9	0.3	-0.4	0.0	0.9	-0.3	1.1
Share with a personal doctor	-3.5	-0.3	2.0	1.5	2.1	2.1	6.5	1.6	0.3
Share with a routine checkup in the past 12 months	5.2	-5.0	-3.9	-5.8	-2.2	-3.4	-1.2	-1.0	-5.2

APPENDIX TABLE F4. (continued)

	Montana	Difference from Value for Montana						
		OK	SC	SD	TN	TX	VA	WY
Level in 2011								
Share reporting fair/poor health	12.2%	3.9	2.7	-1.5	2.7	2.7	0.2	-1.8
Share ever diagnosed with a chronic condition	53.5%	3.2	2.1	-2.9	0.0	-2.5	-1.4	-0.4
Share with a health limitation	22.6%	1.5	0.0	-2.1	-0.8	-4.2	-3.2	-2.8
Share with a personal doctor	69.3%	5.5	7.3	3.9	9.2	-0.5	7.5	-2.4
Share with a routine checkup in the past 12 months	52.0%	2.8	10.5	10.1	22.7	7.4	19.8	0.1
Change between 2011 and 2013								
Share reporting fair/poor health	0.2	-1.0	-0.8	-1.7	1.9	-0.6	-1.5	-0.1
Share ever diagnosed with a chronic condition	0.7	0.5	0.8	-0.2	-1.8	-1.6	-0.9	-1.4
Share with a health limitation	-3.2	-0.7	0.4	-1.2	1.9	-2.1	-1.5	-0.6
Share with a personal doctor	-3.5	1.1	0.5	2.9	0.2	1.7	2.0	3.0
Share with a routine checkup in the past 12 months	5.2	-1.5	-5.0	-5.1	-6.8	2.2	-7.0	-1.1

Sources: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Shading indicates states included in the group of best comparison states.

Appendix Table F.5: Comparison of Medicaid and Section 1115 Eligibility Standards and Uninsurance Rate for Adults Ages 19 to 64 for Montana and Comparison States that Expanded Medicaid without a Demonstration, Level in 2011 and Change Between 2011 and 2013

Variable	Montana	Difference from Value for Montana									
		AK	CO	DE	KY	MD	NM	ND	OH	PA	WV
Level in 2011											
Income eligibility for full benefits											
Nonworking parents	32%	45	68	68	4	84	-3	2	58	-6	-15
Working parents	56%	25	50	64	6	60	11	3	34	-10	-23
Nonworking adults	0%	0	0	100	0	0	0	0	0	0	0
Working adults	0%	0	0	110	0	0	0	0	0	0	0
Income eligibility for limited benefits											
Nonworking parents	0%	0	0	0	0	0	0	0	0	0	0
Working parents	0%	0	0	0	0	0	0	0	0	0	0
Nonworking adults	0%	0	0	0	0	116	0	0	0	0	0
Working adults	0%	0	0	0	0	128	0	0	0	0	0
Uninsurance rate for nonelderly adults	20.4%	-2.4	-3.6	-9.9	-1.0	-8.1	1.0	-7.0	-5.8	-7.2	0.6
Change between 2011 and 2013											
Income eligibility for full benefits											
Nonworking parents	-1.0	-2.0	1.0	1.0	-2.0	1.0	0.0	0.0	1.0	0.0	0.0
Working parents	-2.0	-1.0	2.0	2.0	-3.0	8.0	20.0	0.0	8.0	14.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Income eligibility for limited benefits											
Nonworking parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working parents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsurance rate for nonelderly adults	-1.1	-1.0	0.3	2.6	0.7	-0.1	1.1	-1.7	0.5	0.6	0.1

Sources: Medicaid/Section 1115 eligibility: Kaiser Family Foundation; uninsurance rate: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).

[a] While adults were eligible for coverage, there was a cap on enrollment.

Appendix Table F.6: Comparison of Health and Health Care Outcomes for Adults Ages 19 to 64 for Montana and Comparison States that Expanded Medicaid without a Demonstration, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana									
		AK	CO	DE	KY	MD	NM	ND	OH	PA	WV
Level in 2011											
Share reporting fair/poor health	12.2%	-0.9	-1.5	-1.5	5.5	-2.1	3.2	-2.0	1.2	-0.3	8.3
Share ever diagnosed with a chronic condition	53.5%	-1.3	-2.9	3.3	4.7	-2.4	-0.3	-2.0	0.7	0.5	5.3
Share with a health limitation	22.6%	0.0	-1.1	-3.1	4.5	-3.4	-0.2	-4.6	-1.6	-1.1	5.4
Variable	69.3%	-3.3	6.6	18.3	9.2	13.4	-0.5	3.2	10.8	16.3	4.6
Share with a routine checkup in the past 12 months	52.0%	6.0	4.6	24.6	10.6	21.5	3.0	5.7	14.2	12.7	20.7
Change between 2011 and 2013											
Share reporting fair/poor health	0.2	-0.8	-0.7	2.7	0.2	-0.1	0.1	-0.3	-0.5	-0.3	-0.5
Share ever diagnosed with a chronic condition	0.7	1.4	-0.3	0.1	0.0	0.6	-1.0	-0.5	0.5	0.2	2.0
Share with a health limitation	-3.2	-2.8	-1.7	0.8	-0.4	-2.6	0.3	-1.8	-0.6	-1.9	0.6
Share with a personal doctor	-3.5	2.8	2.8	0.9	1.0	-0.2	0.8	1.1	2.1	2.1	2.5
Share with a routine checkup in the past 12 months	5.2	-6.6	-3.0	-9.0	-2.6	-6.2	-1.8	-2.9	-4.9	-2.8	-7.8

Sources: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Shading indicates states included in the group of best comparison states.

Appendix Table F.7: Comparison of Medicaid and Section 1115 Eligibility Standards and Uninsurance Rate for Adults 19 to 64 for Montana and Comparison States that Expanded Medicaid with a Different Demonstration, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana				
		AR	IN	IA	MI	NH
Level in 2011						
Income eligibility for full benefits						
Nonworking parents	32%	-19	-13	-4	5	7
Working parents	56%	-39	-20	27	8	-7
Nonworking adults	0%	0	0	0	0	0
Working adults	0%	0	0	0	0	0
Income eligibility for limited benefits						
Nonworking parents	0%	0	200	200	0	0
Working parents	0%	200	200	250	0	0
Nonworking adults	0%	0	0	200	0	0
Working adults	0%	200	0	250	0	0
Uninsurance rate for nonelderly adults	20.4%	1.9	-0.7	-8.1	-4.3	-7.8
Change between 2011 and 2013						
Income eligibility for full benefits						
Nonworking parents	-1.0	1.0	0.0	0.0	1.0	0.0
Working parents	-2.0	1.0	-10.0	-1.0	2.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0
Income eligibility for limited benefits						
Nonworking parents	0.0	0.0	0.0	0.0	0.0	0.0
Working parents	0.0	0.0	6.0	0.0	0.0	0.0
Nonworking adults	0.0	0.0	0.0	0.0	0.0	0.0
Working adults	0.0	0.0	0.0	0.0	0.0	0.0
Uninsurance rate for nonelderly adults	-1.1	1.3	-1.2	-0.9	-0.1	1.4

Sources: Medicaid/Section 1115 eligibility: Kaiser Family Foundation; uninsurance rate: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).

Appendix Table F.8: Comparison of Health and Health Care Outcomes for Adults Ages 19 to 64 for Montana and Comparison States that Expanded Medicaid with a Different Demonstration, Level in 2011 and Change Between 2011 and 2013

	Montana	Difference from Value for Montana				
		AR	IN	IA	MI	NH
Level in 2011						
Share reporting fair/poor health	12.2%	6.3	2.1	-2.8	1.6	-2.6
Share ever diagnosed with a chronic condition	53.5%	3.8	1.8	-5.1	5.7	1.4
Share with a health limitation	22.6%	2.4	-1.7	-6.6	1.6	-1.7
Share with a personal doctor	69.3%	7.6	10.5	9.8	13.7	17.0
Share with a routine checkup in the past 12 months	52.0%	6.3	7.4	13.5	10.6	16.1
Change between 2011 and 2013						
Share reporting fair/poor health	0.2	-0.6	-0.7	0.1	0.0	-0.9
Share ever diagnosed with a chronic condition	0.7	1.9	-1.1	1.5	-1.6	-1.0
Share with a health limitation	-3.2	1.3	0.0	2.5	-1.2	-1.6
Share with a personal doctor	-3.5	2.8	2.9	2.4	1.1	2.5
Share with a routine checkup in the past 12 months	5.2	-0.9	-2.9	-4.3	-2.1	-6.2

Sources: 2011-13 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Shading indicates states included in the group of best comparison states.

Appendix Table F.9: Explanatory Variables Included in the Propensity Score Models based on the American Community Survey and Behavioral Risk Factor Surveillance System

	American Community Survey	Behavioral Risk Factor Surveillance System
Gender	X	X
Age	X	X
Gender*Age interactions	X	X
Race/ethnicity	X	X
Educational attainment	X	X
Marital status	X	X
Household size		X
Family size	X	
Multiple family household	X	X
Employment status	X	X
Household income		X
Family income relative to federal poverty level	X	
Family has investment income	X	
Household owns home	X	X

Appendix Table F.10: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Did Not Expand Medicaid, Based on the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.893		1.046		0.938	
Age 26-44	0.872		1.061		1.048	
Age 45-64	1.089		1.365	***	1.258	*
Female*Age interactions						
Female*Age 26-44	1.038		0.866		0.987	
Female*Age 45-64	1.089		0.930		1.026	
Non-Hispanic white	3.353	***	3.553	***	3.652	***
Educational attainment						
Some college	1.127	*	1.001		1.177	***
College graduate or more	1.315	***	1.053		1.072	
Marital status						
Widowed/separated/divorced	1.148		1.105		1.010	
Never married	1.205	**	1.357	***	1.085	
Multiple family household	0.870	*	0.812	***	0.928	
Employment status						
Adult is employed	1.146	**	1.192	***	1.153	**
Other family member is employed	1.212	***	1.402	***	1.163	**
Family income relative to FPL						
50% FPL or less	1.000		1.000		1.000	
Above 50 to 138% FPL	1.280	**	0.962		0.889	
Above 138 to 200% FPL	1.316	**	1.033		0.755	**
Above 200 to 300% FPL	1.024		0.803	**	0.715	***
Above 300 to 400% FPL	0.961		0.742	***	0.676	***
Above 400 to 500% FPL	0.848		0.691	***	0.614	***
Above 500% FPL	0.599	***	0.451	***	0.418	***
Family has investment income	1.246	***	1.280	***	1.491	***
Household owns home	0.915		0.916		0.897	
Constant	0.016	***	0.016	***	0.019	***
Sample Size	116,580		118,445		118,500	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are GA, NC, and WY.
/**/** Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.10: (continued)

	2016		2017	
Female	1.021		0.910	
Age 26-44	0.985		0.921	
Age 45-64	1.086		0.955	
Female*Age interactions				
Female*Age 26-44	0.915		1.089	
Female*Age 45-64	1.009		1.119	
Non-Hispanic white	3.495	***	3.467	***
Educational attainment				
Some college	0.958		1.031	
College graduate or more	1.014		0.990	
Marital status				
Widowed/separated/divorced	1.112		1.049	
Never married	1.231	**	1.206	**
Multiple family household	0.876	*	0.897	
Employment status				
Adult is employed	1.204	***	1.263	***
Other family member is employed	1.178	**	1.173	**
Family income relative to FPL				
50% FPL or less	1.000		1.000	
Above 50 to 138% FPL	1.151		0.976	
Above 138 to 200% FPL	1.191		0.929	
Above 200 to 300% FPL	0.943		0.864	
Above 300 to 400% FPL	0.862		0.714	***
Above 400 to 500% FPL	0.839		0.734	**
Above 500% FPL	0.634	***	0.593	***
Family has investment income	1.513	***	1.617	***
Household owns home	0.997		1.006	
Constant	0.015	***	0.018	***
Sample Size	118,325		120,419	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are GA, NC, and WY.
/**/** Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.11: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Expanded Medicaid without a Demonstration, Based on the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.925		1.088		0.947	
Age 26-44	1.053		1.277	*	1.239	
Age 45-64	1.331	**	1.591	***	1.516	***
Female*Age interactions						
Female*Age 26-44	1.048		0.826		1.047	
Female*Age 45-64	1.052		0.910		1.017	
Non-Hispanic white	0.947		1.078		1.134	
Educational attainment						
Some college	1.138	**	1.083		1.244	***
College graduate or more	1.572	***	1.345	***	1.319	***
Marital status						
Widowed/separated/divorced	1.029		1.037		0.986	
Never married	1.002		1.061		1.012	
Multiple family household	1.056		1.006		1.095	
Employment status						
Adult is employed	1.008		1.091		0.962	
Other family member is employed	0.997		1.299	***	1.054	
Family income relative to FPL						
50% FPL or less	1.000		1.000		1.000	
Above 50 to 138% FPL	1.247	**	1.050		0.927	
Above 138 to 200% FPL	1.349	**	0.985		0.811	*
Above 200 to 300% FPL	1.041		0.772	**	0.756	**
Above 300 to 400% FPL	0.965		0.683	***	0.814	*
Above 400 to 500% FPL	0.973		0.536	***	0.624	***
Above 500% FPL	0.746	**	0.451	***	0.546	***
Family has investment income	1.155	*	1.250	***	1.470	***
Household owns home	0.910		0.962		0.932	
Constant	0.154	***	0.136	***	0.144	***
Sample Size	34,226		34,724		34,920	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are KY and ND.
/**/** Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.11: (continued)

	2016		2017	
Female	0.982		0.900	
Age 26-44	1.124		0.992	
Age 45-64	1.330	**	1.095	
Female*Age interactions				
Female*Age 26-44	0.992		1.146	
Female*Age 45-64	1.037		1.140	
Non-Hispanic white	1.226	**	1.184	*
Educational attainment				
Some college	1.053		1.105	*
College graduate or more	1.284	***	1.205	***
Marital status				
Widowed/separated/divorced	0.959		1.032	
Never married	1.020		1.053	
Multiple family household	1.111		1.025	
Employment status				
Adult is employed	1.125	*	1.218	***
Other family member is employed	1.040		1.005	
Family income relative to FPL				
50% FPL or less	1.000		1.000	
Above 50 to 138% FPL	1.202	*	0.986	
Above 138 to 200% FPL	1.252	*	0.964	
Above 200 to 300% FPL	0.910		0.852	
Above 300 to 400% FPL	0.780	**	0.660	***
Above 400 to 500% FPL	0.763	**	0.694	***
Above 500% FPL	0.595	***	0.600	***
Family has investment income	1.638	***	1.746	***
Household owns home	1.078		1.151	*
Constant	0.112	***	0.135	***
Sample Size	34,371		34,524	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are KY and ND.
/**/** Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.12: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Expanded Medicaid with a Different Demonstration, Based on the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.902		0.982		0.919	
Age 26-44	0.847		0.910		0.910	
Age 45-64	0.909		0.945		0.874	
Female*Age interactions						
Female*Age 26-44	0.987		0.871		0.971	
Female*Age 45-64	1.047		0.970		1.049	
Non-Hispanic white	1.346	***	1.423	***	1.500	***
Educational attainment						
Some college	1.145	**	1.061		1.207	***
College graduate or more	1.205	***	1.012		0.990	
Marital status						
Widowed/separated/divorced	1.168	*	1.061		0.991	
Never married	0.940		0.874		0.796	***
Multiple family household	0.758	***	0.689	***	0.791	***
Employment status						
Adult is employed	1.189	***	1.168	***	1.114	**
Other family member is employed	1.173	**	1.290	***	1.111	*
Family income relative to FPL						
50% FPL or less	1.000		1.000		1.000	
Above 50 to 138% FPL	1.412	***	1.060		0.957	
Above 138 to 200% FPL	1.356	***	1.107		0.754	***
Above 200 to 300% FPL	1.050		0.876		0.735	***
Above 300 to 400% FPL	0.968		0.734	***	0.750	***
Above 400 to 500% FPL	0.818		0.655	***	0.618	***
Above 500% FPL	0.582	***	0.413	***	0.442	***
Family has investment income	1.267	***	1.382	***	1.529	***
Household owns home	0.773	***	0.764	***	0.755	***
Constant	0.082	***	0.105	***	0.112	***
Sample Size	69,790		69,112		69,683	

Appendix Table F.12: (continued)

	2016		2017	
Female	0.907		0.830	
Age 26-44	0.844		0.808	*
Age 45-64	0.750	**	0.686	***
Female*Age interactions				
Female*Age 26-44	1.013		1.152	
Female*Age 45-64	1.105		1.194	
Non-Hispanic white	1.492	***	1.445	***
Educational attainment				
Some college	0.974		1.047	
College graduate or more	0.952		0.935	
Marital status				
Widowed/separated/divorced	1.009		1.013	
Never married	0.775	***	0.800	***
Multiple family household	0.682	***	0.723	***
Employment status				
Adult is employed	1.128	**	1.272	***
Other family member is employed	1.028		1.114	*
Family income relative to FPL				
50% FPL or less	1.000		1.000	
Above 50 to 138% FPL	1.154		0.899	
Above 138 to 200% FPL	1.088		0.851	
Above 200 to 300% FPL	0.839	*	0.718	***
Above 300 to 400% FPL	0.719	***	0.602	***
Above 400 to 500% FPL	0.667	***	0.576	***
Above 500% FPL	0.478	***	0.433	***
Family has investment income	1.699	***	1.731	***
Household owns home	0.860	**	0.886	*
Constant	0.125	***	0.132	***
Sample Size	68,128		68,372	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are MI and NH.
/**/** Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.13: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Did Not Expand Medicaid, Based on the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.825		1.059		0.976	
Age 26-44	0.818	*	1.062		0.990	
Age 45-64	0.963		1.295	**	1.236	
Female*Age interactions						*
Female*Age 26-44	1.121		0.896		1.040	
Female*Age 45-64	1.159		0.914		0.919	
Non-Hispanic white	3.499	***	3.746	***	3.921	
Educational attainment						***
Some college	1.087		1.056		1.003	
College graduate or more	1.381	***	1.175	***	1.080	
Marital status						
Widowed/separated/divorced	0.960		0.845	***	0.877	
Never married	1.017		0.969		0.911	**
Multiple family household	0.740	***	0.831	***	0.959	
Employed	1.186	***	1.178	***	1.063	
Household income						
$15,000-$19,999	0.930		1.039		1.014	
$20,000-$24,999	0.842	*	1.016		0.931	
$25,000-$34,999	0.857		0.916		0.920	
$35,000-$49,999	0.720	***	0.740	***	0.730	
$50,000-$74,999	0.573	***	0.620	***	0.641	***
$75,000 or more	0.452	***	0.484	***	0.483	***
Household owns home	0.914		0.869	**	0.906	***
Constant	0.227	***	0.171	***	0.211	*
Sample Size	25,885		21,717		21,929	

Appendix Table F.13: (continued)

	2016		2017	
Female	0.860		0.922	
Age 26-44	0.831		0.831	
Age 45-64	0.948		0.869	
Female*Age interactions				
Female*Age 26-44	1.166		1.079	
Female*Age 45-64	1.192		1.102	
Non-Hispanic white	3.709	***	3.616	***
Educational attainment				
Some college	0.996		0.999	
College graduate or more	1.130		1.068	
Marital status				
Widowed/separated/divorced	0.994		0.994	
Never married	1.073		1.184	**
Multiple family household	0.829	***	0.673	***
Employed	1.187	**	1.245	***
Household income				
$15,000-$19,999	0.999		1.034	
$20,000-$24,999	0.828		0.759	**
$25,000-$34,999	0.934		0.924	
$35,000-$49,999	0.774	*	0.675	***
$50,000-$74,999	0.710	***	0.607	***
$75,000 or more	0.554	***	0.575	***
Household owns home	0.925		0.923	
Constant	0.187	***	0.229	***
Sample Size	14,121		13,765	

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are GA, NC, and WY.
/**/ Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.14: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Expanded Medicaid without a Demonstration, Based on the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.761	*	0.922		0.888	
Age 26-44	0.708	***	0.857		0.812	*
Age 45-64	0.694	***	0.851		0.816	*
Female*Age interactions						
Female*Age 26-44	1.168		0.959		1.120	
Female*Age 45-64	1.306	*	1.013		1.047	
Non-Hispanic white	1.461	***	1.516	***	1.554	***
Educational attainment						
Some college	1.135	**	1.106	*	1.028	
College graduate or more	1.283	***	1.127	**	1.007	
Marital status						
Widowed/separated/divorced	0.940		0.750	***	0.814	***
Never married	0.791	***	0.624	***	0.658	***
Multiple family household	0.650	***	0.733	***	0.835	***
Employed	1.336	***	1.217	***	1.116	**
Household income						
$15,000-$19,999	1.055		0.927		1.031	
$20,000-$24,999	0.810	**	0.941		0.899	
$25,000-$34,999	0.724	***	0.772	**	0.787	**
$35,000-$49,999	0.675	***	0.676	***	0.713	***
$50,000-$74,999	0.514	***	0.578	***	0.578	***
$75,000 or more	0.354	***	0.348	***	0.428	***
Household owns home	0.863	**	0.755	***	0.768	***
Constant	1.137		1.032		0.996	
Sample Size	18,533		17,344		19,075	

Appendix Table F.14: (continued)

	2016		2017	
Female	0.782		0.856	
Age 26-44	0.744	**	0.763	*
Age 45-64	0.718	**	0.671	***
Female*Age interactions				
Female*Age 26-44	1.203		1.128	
Female*Age 45-64	1.231		1.174	
Non-Hispanic white	1.445	***	1.527	***
Educational attainment				
Some college	1.068		1.097	
College graduate or more	1.093		1.036	
Marital status				
Widowed/separated/divorced	0.885		0.895	
Never married	0.710	***	0.739	***
Multiple family household	0.629	***	0.629	***
Employed	1.133	*	1.215	***
Household income				
$15,000-$19,999	1.472	***	1.195	
$20,000-$24,999	0.970		0.926	
$25,000-$34,999	1.020		1.012	
$35,000-$49,999	0.878		0.779	**
$50,000-$74,999	0.895		0.662	***
$75,000 or more	0.507	***	0.504	***
Household owns home	0.749	***	0.775	***
Constant	0.636	**	0.704	*
Sample Size	15,442		13,985	

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are KY and ND.
/**/ Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.15: Odds Ratios from Propensity Score Models for Adults Ages 19 to 64 for Montana and Group of Best Comparison States that Expanded Medicaid with a Different Demonstration, Based on the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	2011		2012		2013	
Female	0.795		0.836		0.981	
Age 26-44	0.905		0.993		1.214	*
Age 45-64	1.016		1.229	*	1.468	***
Female*Age interactions						
Female*Age 26-44	1.206		1.252		1.055	
Female*Age 45-64	1.311	*	1.192		0.964	
Non-Hispanic white	0.945		1.083		1.164	**
Educational attainment						
Some college	1.095		1.071		1.079	
College graduate or more	1.550	***	1.294	***	1.240	***
Marital status						
Widowed/separated/divorced	1.073		0.856	**	0.937	
Never married	1.092		0.860	**	0.974	
Multiple family household	0.804	***	0.994		1.110	**
Employed	1.036		1.017		0.900	*
Household income						
$15,000-$19,999	1.305	**	1.094		1.356	***
$20,000-$24,999	1.096		1.313	**	1.249	**
$25,000-$34,999	0.898		0.968		0.953	
$35,000-$49,999	0.992		0.888		1.143	
$50,000-$74,999	0.832	*	0.809	**	0.891	
$75,000 or more	0.679	***	0.625	***	0.780	**
Household owns home	1.075		0.898	*	0.986	
Constant	0.679	**	0.577	***	0.359	***
Sample Size	17,720		16,646		19,171	

Appendix Table F.15: (continued)

	2016		2017	
Female	0.904		0.950	
Age 26-44	1.044		0.997	
Age 45-64	1.257		1.125	
Female*Age interactions				
Female*Age 26-44	1.104		1.072	
Female*Age 45-64	1.121		1.048	
Non-Hispanic white	1.240	**	1.265	***
Educational attainment				
Some college	1.050		1.034	
College graduate or more	1.280	***	1.212	**
Marital status				
Widowed/separated/divorced	0.914		0.982	
Never married	0.985		1.020	
Multiple family household	1.064		1.032	
Employed	1.026		1.111	
Household income				
$15,000-$19,999	1.330	**	1.411	**
$20,000-$24,999	1.055		1.142	
$25,000-$34,999	1.017		1.112	
$35,000-$49,999	1.076		1.041	
$50,000-$74,999	1.095		0.897	
$75,000 or more	0.867		0.850	
Household owns home	0.881	*	0.968	
Constant	0.253	***	0.258	***
Sample Size	14,106		13,744	

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are MI and NH.
/**/ Significantly different from one at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table F.16: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Did Not Expand Medicaid, After Reweighting Using the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using ACS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	51.8	50.0	50.0
Age (%)				
21-25	15.1	15.0	15.1	15.1
26-44	37.8	41.9	37.8	37.8
45-64	47.1	43.2	47.1	47.1
Non-Hispanic white (%)	87.9	60.5	87.9	87.9
Educational attainment (%)				
High school graduate/GED or less	34.8	38.6	34.8	34.8
Some college	36.6	33.0	36.6	36.6
College graduate or more	28.6	28.4	28.5	28.6
Marital status (%)				
Married	55.1	51.8	55.1	55.1
Widowed/separated/divorced	17.0	17.1	17.1	17.0
Never married	27.8	31.1	27.8	27.8
Multiple family household (%)	38.8	45.7	38.8	38.8
Employment status (%)				
Adult is employed	74.5	70.8	74.5	74.5
Other family member is employed	40.8	36.6	40.8	40.8
Family income relative to FPL				
At or below 138%	29.5	33.4	29.6	29.5
Above 138% to less than 200%	11.3	10.3	11.2	11.3
200% to less than 500%	38.4	34.5	38.3	38.4
500% or more	20.8	21.9	20.8	20.8
Family has investment income (%)	17.9	11.1	17.9	17.9
Household owns home (%)	67.5	64.0	67.6	67.5
Sample size	27,507	564,762	564,581	564,762

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are GA, NC, and WY.

Appendix Table F.17: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Expanded Medicaid without a Demonstration, After Reweighting Using the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using ACS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	50.5	50.0	50.0
Age (%)				
21-25	15.1	15.2	15.1	15.1
26-44	37.8	40.0	37.8	37.8
45-64	47.1	44.8	47.1	47.1
Non-Hispanic white (%)	87.9	86.5	87.9	87.9
Educational attainment (%)				
High school graduate/GED or less	34.8	42.6	34.9	34.8
Some college	36.6	33.9	36.6	36.6
College graduate or more	28.6	23.5	28.5	28.6
Marital status (%)				
Married	55.1	54.3	55.1	55.1
Widowed/separated/divorced	17.0	18.5	17.1	17.0
Never married	27.8	27.2	27.8	27.8
Multiple family household (%)	38.8	41.6	38.8	38.8
Employment status (%)				
Adult is employed	74.5	70.0	74.5	74.5
Other family member is employed	40.8	38.7	40.8	40.8
Family income relative to FPL				
At or below 138%	29.5	32.6	29.3	29.3
Above 138% to less than 200%	11.3	10.0	11.5	11.5
200% to less than 500%	38.4	36.8	38.3	38.4
500% or more	20.8	20.5	20.9	20.8
Family has investment income (%)	17.9	11.2	17.9	17.9
Household owns home (%)	67.5	67.6	67.6	67.5
Sample size	27,507	145,258	145,219	145,258

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are KY and ND.

Appendix Table F.18: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Expanded Medicaid with a Different Demonstration, After Reweighting Using the American Community Survey, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using ACS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	50.9	50.0	50.0
Age (%)				
21-25	15.1	15.2	15.1	15.1
26-44	37.8	37.9	37.8	37.8
45-64	47.1	46.9	47.1	47.1
Non-Hispanic white (%)	87.9	78.6	87.9	87.9
Educational attainment (%)				
High school graduate/GED or less	34.8	36.0	34.9	34.8
Some college	36.6	36.3	36.6	36.6
College graduate or more	28.6	27.8	28.5	28.6
Marital status (%)				
Married	55.1	51.9	55.0	55.1
Widowed/separated/divorced	17.0	15.8	17.1	17.0
Never married	27.8	32.3	27.8	27.8
Multiple family household (%)	38.8	46.1	38.8	38.8
Employment status (%)				
Adult is employed	74.5	70.7	74.5	74.5
Other family member is employed	40.8	37.4	40.8	40.8
Family income relative to FPL				
At or below 138%	29.5	31.2	29.3	29.3
Above 138% to less than 200%	11.3	9.3	11.5	11.5
200% to less than 500%	38.4	35.3	38.3	38.4
500% or more	20.8	24.1	20.9	20.8
Family has investment income (%)	17.9	13.2	17.9	17.9
Household owns home (%)	67.5	72.0	67.6	67.5
Sample size	27,507	317,578	317,430	317,578

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Best comparison states are MI and NH.

Appendix Table F.19: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Did Not Expand Medicaid, After Reweighting Using the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using Revised BRFSS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	51.1	49.8	50.0
Age (%)				
21-25	15.1	15.0	15.2	15.1
26-44	37.6	41.6	37.6	37.6
45-64	47.3	43.4	47.2	47.3
Non-Hispanic white (%)	88.0	67.0	88.0	88.0
Educational attainment (%)				
High school graduate/GED or less	35.0	36.5	35.2	35.0
Some college	36.7	36.3	36.7	36.7
College graduate or more	28.3	27.2	28.1	28.3
Marital status (%)				
Married	55.2	53.2	55.3	55.2
Widowed/separated/divorced	17.3	17.2	17.3	17.3
Never married	27.6	29.6	27.5	27.6
Multiple family household (%)	42.6	48.9	42.8	42.6
Employed (%)	74.1	71.9	73.8	74.1
Household income (%)				
Less than $25,000	21.9	21.0	21.9	21.9
$25,000-$49,999	25.2	23.0	25.0	25.2
$50,000-$74,999	17.1	16.8	17.1	17.1
$75,000 or more	35.8	39.2	36.0	35.8
Household owns home (%)	69.8	69.4	69.8	69.8
Sample size	26,268	71,149	71,106	71,149

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are GA, NC, and WY.

Appendix Table F.20: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Expanded Medicaid without a Demonstration, After Reweighting Using the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using Revised BRFSS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	49.9	49.9	50.0
Age (%)				
21-25	15.1	16.1	15.1	15.1
26-44	37.6	40.0	37.6	37.6
45-64	47.3	44.0	47.3	47.3
Non-Hispanic white (%)	88.0	86.7	88.0	88.0
Educational attainment (%)				
High school graduate/GED or less	35.0	38.4	35.3	35.0
Some college	36.7	36.8	36.5	36.7
College graduate or more	28.3	24.8	28.3	28.3
Marital status (%)				
Married	55.2	55.1	55.2	55.2
Widowed/separated/divorced	17.3	17.0	17.3	17.3
Never married	27.6	27.9	27.6	27.6
Multiple family household (%)	42.6	44.5	42.7	42.6
Employed (%)	74.1	73.2	74.0	74.1
Household income (%)				
Less than $25,000	21.9	20.1	21.9	21.8
$25,000-$49,999	25.2	23.1	25.1	25.2
$50,000-$74,999	17.1	17.1	17.1	17.1
$75,000 or more	35.8	39.7	35.8	35.8
Household owns home (%)	69.8	70.5	69.7	69.8
Sample size	26,268	55,119	55,091	55,119

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are KY and ND.

Appendix Table F.21: Selected Characteristics of Adults Ages 19 to 64 in Montana and Group of Best Comparison States that Expanded Medicaid with a Different Demonstration, After Reweighting Using the Behavioral Risk Factor Surveillance System, 2011-13 (pre-period) and 2016-17 (post-period)

	Montana	Group of Best Comparison States		
		Using Revised BRFSS Weight	Using Propensity Score Weight	Using ebalance Weight
Female (%)	50.0	50.8	49.9	50.0
Age (%)				
21-25	15.1	14.6	14.9	15.1
26-44	37.6	37.5	37.9	37.6
45-64	47.3	47.9	47.2	47.3
Non-Hispanic white (%)	88.0	82.2	87.9	88.0
Educational attainment (%)				
High school graduate/GED or less	35.0	33.7	35.5	35.0
Some college	36.7	36.6	36.4	36.7
College graduate or more	28.3	29.7	28.1	28.3
Marital status (%)				
Married	55.2	53.1	55.2	55.2
Widowed/separated/divorced	17.3	15.9	17.3	17.3
Never married	27.6	31.1	27.5	27.6
Multiple family household (%)	42.6	51.1	42.6	42.6
Employed (%)	74.1	72.9	73.8	74.1
Household income (%)				
Less than $25,000	21.9	16.8	21.9	21.8
$25,000-$49,999	25.2	21.0	25.0	25.2
$50,000-$74,999	17.1	16.3	17.1	17.1
$75,000 or more	35.8	45.8	36.0	35.8
Household owns home (%)	69.8	74.8	69.8	69.8
Sample size	26,268	58,111	58,099	58,111

Source: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Best comparison states are MI and NH.

Appendix G: Supplemental Tables for the Impact Analysis

Appendix Table G.1: Difference-in-Differences Coefficient Estimates for Models of Change in Health Insurance Coverage for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Compared to Not Expanding Medicaid Using Group of Best Comparison States, Based on American Community Survey and Behavioral Risk Factor Surveillance System

Explanatory Variable	ACS			BRFSS		
	Coefficient estimate		Standard error	Coefficient estimate		Standard error
Montana	-0.032	***	0.006	0.006		0.005
Year is 2016	0.058	***	0.004	0.049	***	0.005
Montana*Year is 2016	0.061	***	0.008	0.029	***	0.008
Female	0.028	***	0.003	0.021	***	0.004
Age 26-44	-0.119	***	0.008	-0.088	***	0.009
Age 45-64	-0.088	***	0.008	-0.050	***	0.009
Non-Hispanic white	0.094	***	0.007	-0.001		0.006
Educational attainment						
Some college	0.083	***	0.005	0.083	***	0.005
College graduate or more	0.128	***	0.005	0.127	***	0.005
Marital status						
Widowed/separated/divorced	-0.034	***	0.007	-0.035	***	0.006
Never married	-0.026	***	0.008	-0.043	***	0.007
Multiple family household	-0.060	***	0.006	-0.030	***	0.004
Employment status						
Adult is employed	0.005		0.005	-0.020	***	0.005
Other family member is employed	0.002		0.005			
Family income relative to FPL						
Above 138% to less than 200%	0.031	***	0.009			
200% to less than 500%	0.152	***	0.007			
500% or more	0.192	***	0.008			
Household income						
$25,000-$49,999				0.148	***	0.007
$50,000-$74,999				0.223	***	0.008
$75,000 or more				0.245	***	0.008
Family has investment income	0.001		0.005			
Household owns home	0.060	***	0.005	0.051	***	0.006
Cell-phone sample				-0.013	***	0.004

(continued)

Explanatory Variable	ACS			BRFSS		
	Coefficient estimate		Standard error	Coefficient estimate		Standard error
Month of survey						
February				0.018	*	0.010
March				0.029	***	0.009
April				0.022	**	0.009
May				0.022	**	0.010
June				0.016	*	0.010
July				0.003		0.010
August				0.020	**	0.010
September				0.008		0.010
October				0.020	**	0.009
November				0.004		0.010
December				0.015		0.010
Constant	0.601	***	0.012	0.617	***	0.013
Sample size	592,088			97,023		
R^2	0.143			0.146		

Source: 2011-13 and 2016-17 American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level.
/**/ Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests

Appendix Table G.2: Difference-in-Differences Estimates of Changes in Selected Outcome Measures for Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, Based on Alternate Estimation Methods and Weights

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Had health insurance coverage at the time of the survey						
Core model	6.1	***	3.0	***	3.3	***
Switch to logit estimation	6.2	***	2.9	***	3.2	***
Switch to probit estimation	5.9	***	2.9	***	3.1	***
Switch to ebalance weights	6.1	***	3.0	***	3.2	***
Had a routine checkup in the past 12 months						
Core model	4.7	***	4.6	***	2.6	**
Switch to logit estimation	4.7	***	4.6	***	2.6	**
Switch to probit estimation	4.7	***	4.6	***	2.6	**
Switch to ebalance weights	4.7	***	4.6	***	2.6	**
Received flu vaccine in past 12 months						
Core model	2.9	***	3.6	***	1.8	*
Switch to logit estimation	2.9	***	3.6	***	1.8	
Switch to probit estimation	2.9	***	3.6	***	1.8	
Switch to ebalance weights	2.9	***	3.6	***	1.8	*
No unmet need for doctor care due to costs in the past 12 months						
Core model	1.3	*	-0.5		-1.0	
Switch to logit estimation	1.6	**	-0.6		-1.0	
Switch to probit estimation	1.3	*	-0.5		-1.1	
Switch to ebalance weights	1.3	*	-0.5		-1.0	

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Smoker at the time of the survey						
Core model	0.1		0.4		-1.2	
Switch to logit estimation	0.1		0.3		-1.2	
Switch to probit estimation	0.2		0.4		-1.2	
Switch to ebalance weights	0.1		0.4		-1.2	
Health status was fair or poor at the time of the survey						
Core model	-0.2		-0.9		-0.8	
Switch to logit estimation	-0.2		-1.1		-0.8	
Switch to probit estimation	-0.3		-1.2	*	-0.8	
Switch to ebalance weights	-0.2		-0.9		-0.9	

Source: Health insurance: 2011-13 and 2016-17 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level. Family income relative to FPL is imputed in the BRFSS (See Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).

/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests**.**

Appendix Table G.3: Difference-in-Differences Estimates of Changes in Selected Outcome Measures for Adults Ages 19 to 64 in Montana between Alternate Pre-periods and 2016-17 (post-period) Using Group of Best Comparison States

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Had health insurance coverage at the time of the survey						
Core model	6.1	***	3.0	***	3.3	***
Compared to 2011-12	6.4	***	3.7	***	3.8	***
Compared to 2012-13	5.9	***	2.4	***	2.7	***
Had a routine checkup in the past 12 months						
Core model	4.7	***	4.6	***	2.6	**
Compared to 2011-12	6.1	***	5.7	***	3.8	***
Compared to 2012-13	3.9	***	3.9	***	1.2	
Received flu vaccine in past 12 months						
Core model	2.9	***	3.6	***	1.8	*
Compared to 2011-12	3.9	***	4.6	***	3.0	***
Compared to 2012-13	1.7		2.6	**	0.9	
No unmet need for doctor care due to costs in the past 12 months						
Core model	1.3	*	-0.5		-1.0	
Compared to 2011-12	1.6	*	0.1		-0.8	
Compared to 2012-13	1.3		-0.7		-1.0	
Smoker at the time of the survey						
Core model	0.1		0.4		-1.2	
Compared to 2011-12	-0.3		-0.3		-1.6	*
Compared to 2012-13	0.7		1.1		-0.5	
Health status was fair or poor at the time of the survey						
Core model	-0.2		-0.9		-0.8	
Compared to 2011-12	-0.2		-1.0		-0.8	
Compared to 2012-13	-0.1		-0.5		-0.6	

Source: Health insurance: 2011-13 and 2016-17 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS). Family income relative to FPL is imputed in the BRFSS (See Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.4: Difference-in-Differences Estimates of Changes in Selected Outcome Measures for Lower-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, Based on Alternate Measures of Lower Income

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Had health insurance coverage at the time of the survey						
Core model	6.1	***	3.0	***	3.3	***
With family income at or below 50% FPL	12.3	***	-0.8		4.9	**
With family income at or below 100% FPL	12.4	***	1.9		5.3	***
With family income at or below 138% FPL	10.9	***	2.1		4.1	**
With household income below $25K	10.1	***	1.9		4.0	*
With household income below $50K	9.9	***	3.3	**	3.9	***
High school graduate/GED or less	11.4	***	3.5	**	6.1	***
Had a routine checkup in the past 12 months						
Core model	4.7	***	4.6	***	2.6	**
With family income at or below 50% FPL	4.7		-0.9		-2.1	
With family income at or below 100% FPL	6.2	**	0.3		-0.3	
With family income at or below 138% FPL	4.7	**	-0.4		-0.3	
With household income below $25K	4.3	*	0.0		-0.8	
With household income below $50K	4.1	**	1.9		0.9	
High school graduate/GED or less	4.6	**	0.8		1.2	
Received flu vaccine in past 12 months						
Core model	2.9	***	3.6	***	1.8	*
With family income at or below 50% FPL	1.4		0.3		0.4	
With family income at or below 100% FPL	1.7		0.2		0.0	
With family income at or below 138% FPL	2.4		-0.2		0.5	
With household income below $25K	3.4		1.6		2.4	
With household income below $50K	2.7	*	0.9		0.6	
High school graduate/GED or less	2.8		3.1	*	1.6	

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
No unmet need for doctor care due to costs in the past 12 months						
Core model	1.3	*	-0.5		-1.0	
With family income at or below 50% FPL	3.2		-3.1		-2.4	
With family income at or below 100% FPL	5.0	**	-2.2		-0.7	
With family income at or below 138% FPL	4.5	*	-1.7		-1.5	
With household income below $25K	5.6	***	-2.4		-1.6	
With household income below $50K	3.3	**	-1.3		-1.6	
High school graduate/GED or less	2.1		-2.0		-0.5	
Smoker at the time of the survey						
Core model	0.1		0.4		-1.2	
With family income at or below 50% FPL	-1.3		1.0		-2.0	
With family income at or below 100% FPL	0.7		0.5		-0.9	
With family income at or below 138% FPL	0.6		0.7		-0.9	
With household income below $25K	1.2		0.1		1.1	
With household income below $50K	1.0		2.0		-0.5	
High school graduate/GED or less	0.1		1.1		-1.2	
Health status was fair or poor at the time of the survey						
Core model	-0.2		-0.9		-0.8	
With family income at or below 50% FPL	1.7		0.5		-0.2	
With family income at or below 100% FPL	0.0		-1.3		-2.1	
With family income at or below 138% FPL	-0.5		-1.4		-1.9	
With household income below $25K	-0.8		-0.9		-2.3	
With household income below $50K	-0.9		-2.1	*	-2.2	*
High school graduate/GED or less	-0.3		-0.3		-0.6	

Source: Health insurance: 2011-13 and 2016-17 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level. Family income relative to FPL is imputed in the BRFSS (See Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.5: Difference-in-Differences Estimates of Changes in Selected Outcome Measures for Higher-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using Group of Best Comparison States, Based on Alternate Measures of Higher Income

	Compared to Not Expanding Medicaid		Compared to Expanding Medicaid without a Demonstration		Compared to Expanding Medicaid with a Different Demonstration	
Had health insurance coverage at the time of the survey						
Core model	6.1	***	3.0	***	3.3	***
With family income above 500% FPL	1.5		1.4		1.1	
With household income at or above $75K	2.4	**	2.5	**	2.0	**
College graduate or more	2.3	**	2.5	**	1.5	
Had a routine checkup in the past 12 months						
Core model	4.7	***	4.6	***	2.6	**
With family income above 500% FPL	6.0	**	6.4	***	4.4	*
With household income at or above $75K	5.9	***	6.1	***	3.9	**
College graduate or more	5.9	***	7.2	***	2.8	
Received flu vaccine in past 12 months						
Core model	2.9	***	3.6	***	1.8	*
With family income above 500% FPL	1.4		5.1	*	1.4	
With household income at or above $75K	2.7		4.6	**	2.5	
College graduate or more	2.8		4.3	**	1.4	
No unmet need for doctor care due to costs in the past 12 months						
Core model	1.3	*	-0.5		-1.0	
With family income above 500% FPL	-0.4		-0.6		-1.3	
With household income at or above $75K	0.3		0.1		-0.7	
College graduate or more	-0.5		-0.8		-2.0	**
Smoker at the time of the survey						
Core model	0.1		0.4		-1.2	
With family income above 500% FPL	0.7		0.1		-1.2	
With household income at or above $75K	-1.1		-1.3		-2.1	
College graduate or more	2.4	**	1.7		0.4	
Health status was fair or poor at the time of the survey						
Core model	-0.2		-0.9		-0.8	
With family income above 500% FPL	1.0		0.3		1.2	
With household income at or above $75K	0.2		-0.4		0.3	
College graduate or more	1.1		0.8		1.3	

Source: Health insurance: 2011-13 and 2016 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2016-17 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level. Family income relative to FPL is imputed in the BRFSS (See Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.6: Sample Sizes for Montana Adults Ages 19 to 64

	American Community Survey	Behavioral Risk Factor Surveillance System
All adults	27,507	26,268
Lower income adults		
With family income at or below 50% FPL	3,251	3,192
With family income at or below 100% FPL	5,380	5,703
With family income at or below 138% FPL	7,226	8,165
With household income below $25K	4,797	7,768
With household income below $50K	11,246	15,134
High school graduate/GED or less	9,601	9,177
Higher income adults		
With family income above 500% FPL	6,292	4,889
With household income at or above $75K	10,445	6,540
College graduate or more	7,886	8,939
Adults by demographic groups		
Men	13,517	12,072
Women	13,990	14,196
Adults younger than age 45	12,611	10,393
Adults age 45 and older	14,896	15,875
Parents	9,113	9,635
Childless adults	18,394	16,633
Alternate post-period		
2017	5,493	3,648
Alternate pre-period		
2011-12	11,017	12,587
2012-13	11,105	12,162

Source: 2011-13 and 2016-17 American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level.

Table G.7: Sample Sizes for Montana's Comparison Group Adults Ages 19 to 64 Based on Group of Best Comparison States

	ACS	BRFSS
Compared to Not Expanding Medicaid		
All adults	564,762	71,149
Lower income adults		
With family income at or below 50% FPL	86,877	3,192
With family income at or below 100% FPL	133,186	5,703
With family income at or below 138% FPL	170,327	8,165
With household income below $25K	105,193	20,790
With household income below $50K	230,767	38,146
High school graduate/GED or less	208,356	25,175
Higher income adults		
With family income above 500% FPL	139,515	4,889
With household income at or above $75K	224,701	21,560
College graduate or more	172,889	25,558
Adults by demographic groups		
Men	266,826	29,856
Women	297,936	41,293
Adults younger than age 45	288,361	28,950
Adults age 45 and older	276,401	42,199
Parents	195,061	26,229
Childless adults	369,701	44,920
Alternate post-period 2017	114,926	10,117
Alternate pre-period		
2011-12	224,008	35,015
2012-13	225,840	31,484
Each comparison state		
GA	274,411	23,788
NC	273,726	29,457
WY	16,444	17,861

	Group of Best Comparison States	
	ACS	**BRFSS**
Compared to Expanding Medicaid without a Demonstration		
All adults	145,258	55,119
Lower income adults		
With family income at or below 50% FPL	21,367	3,192
With family income at or below 100% FPL	33,601	5,703
With family income at or below 138% FPL	42,604	8,165
With household income below $25K	28,062	14,301
With household income below $50K	59,969	28,014
High school graduate/GED or less	60,726	20,370
Higher income adults		
With family income above 500% FPL	33,709	4,889
With household income at or above $75K	56,759	17,240
College graduate or more	36,788	17,743
Adults by demographic groups		
Men	70,685	23,578
Women	74,573	31,541
Adults younger than age 45	71,671	21,326
Adults age 45 and older	73,587	33,793
Parents	50,127	19,558
Childless adults	95,131	35,561
Alternate post-period 2017	29,031	10,096
Alternate pre-period		
2011-12	57,933	21,779
2012-13	58,539	23,655
Each comparison state		
KY	124,831	35,025
ND	20,388	20,066

	ACS	BRFSS
Compared to Expanding Medicaid with a Different Demonstration		
All adults	317,578	58,111
Lower income adults		
With family income at or below 50% FPL	45,027	3,192
With family income at or below 100% FPL	69,361	5,703
With family income at or below 138% FPL	88,256	8,165
With household income below $25K	50,984	14,230
With household income below $50K	117,535	27,933
High school graduate/GED or less	115,165	17,896
Higher income adults		
With family income above 500% FPL	81,177	4,889
With household income at or above $75K	136,565	20,297
College graduate or more	88,911	23,151
Adults by demographic groups		
Men	155,076	25,290
Women	162,502	32,821
Adults younger than age 45	150,141	21,933
Adults age 45 and older	167,437	36,178
Parents	103,003	20,920
Childless Adults	214,575	37,191
Alternate post-period 2017	62,879	10,337
Alternate pre-period		
2011-12	127,885	23,290
2012-13	127,690	24,257
Each comparison state		
MI	278,623	37,371
NH	38,807	20,728

Source: 2011-13 and 2016-17 American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS).
Notes: FPL = Federal poverty level. Best comparison states for expanding Medicaid without a demonstration are GA, NC, and WY; single-best comparison state is WY. Best comparison states for expanding without a demonstration are KY and ND; single-best comparison state is ND. Best comparison states for expanding with a different demonstration are MI and NH; single-best comparison state is MI. Sample size for individual regressions may vary due to item nonresponse for outcome measures.

Appendix Table G.8: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	6.1	***	4.2, 8.1	13.1	***	9.1,17.1
Type of coverage						
Medicaid or other public coverage	6.2	***	4.6, 7.9	13.9	***	9.5,18.3
Employer-sponsored insurance	-0.2		-2.7, 2.3	1.0		-3.4, 5.5
Direct purchase or other coverage	0.1		-1.6, 1.8	-1.8		-4.9, 1.2
Compared to Expanding Medicaid without a Demonstration						
Had health insurance coverage at the time of the survey	2.8	***	0.8, 4.8	4.1	**	0.0, 8.1
Type of coverage						
Medicaid or other public coverage	0.8		-1.0, 2.6	0.7		-3.8, 5.3
Employer-sponsored insurance	-0.2		-2.8, 2.4	2.0		-2.7, 6.7
Direct purchase or other coverage	2.2	**	0.4, 4.0	1.3		-2.0, 4.6
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	2.5	***	0.7, 4.3	3.9	**	0.2, 7.7
Type of coverage						
Medicaid or other public coverage	1.6	*	-0.0, 3.3	2.6		-1.7, 7.0
Employer-sponsored insurance	0.6		-1.7, 3.0	2.0		-2.3, 6.4
Direct purchase or other coverage	0.2		-1.4, 1.8	-0.7		-3.6, 2.2

Source: 2011-13 and 2017 American Community Survey (ACS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.9: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	0.6		-2.1, 3.2	-0.2		-5.7, 5.4
Had a routine checkup in past 12 months	6.4	***	3.5, 9.3	6.1	**	0.3,11.9
Received flu vaccine in past 12 months	2.5	*	-0.4, 5.3	3.2		-2.9, 9.3
No unmet need for doctor care due to costs in past 12 months	1.2		-0.8, 3.2	4.0		-2.4,10.3
Compared to Expanding Medicaid without a Demonstration						
Had a personal doctor at the time of the survey	1.1		-1.5, 3.8	-1.7		-7.3, 3.8
Had a routine checkup in past 12 months	6.2	***	3.3, 9.1	0.8		-5.6, 7.2
Received flu vaccine in past 12 months	2.2		-0.6, 5.0	-0.8		-6.5, 4.9
No unmet need for doctor care due to costs in past 12 months	-0.7		-2.7, 1.2	-1.9		-6.9, 3.1
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	-0.2		-2.8, 2.4	-2.0		-7.9, 4.0
Had a routine checkup in past 12 months	3.2	**	0.3, 6.1	-0.2		-6.4, 6.0
Received flu vaccine in past 12 months	0.6		-2.2, 3.5	0.6		-5.2, 6.4
No unmet need for doctor care due to costs in past 12 months	-1.7	*	-3.6, 0.3	-2.9		-8.0, 2.2

Source: 2011-13 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/ Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.10: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	-0.6		-2.8, 1.6	0.9		-4.4, 6.2
Smoker who did not try to quit in past 12 months	-0.4		-2.0, 1.3	0.6		-3.7, 4.9
Health status was fair or poor at the time of the survey	0.1		-1.7, 1.9	0.7		-4.1, 5.5
Physical health was not good in past 30 days	-2.6	*	-5.3, 0.2	-2.1		-7.7, 3.6
Mental health was not good in past 30 days	-1.1		-3.9, 1.7	-1.8		-7.7, 4.0
Had an activity limitation due to health at the time of the survey	-0.4		-2.8, 1.9	-1.3		-6.9, 4.2
Compared to Expanding Medicaid without a Demonstration						
Smoker at the time of the survey	-0.1		-2.3, 2.1	2.3		-2.7, 7.2
Smoker who did not try to quit in past 12 months	0.8		-0.8, 2.5	3.5		-0.8, 7.7
Health status was fair or poor at the time of the survey	-1.3		-3.1, 0.6	-1.7		-6.5, 3.2
Physical health was not good in past 30 days	-3.0	**	-5.8,-0.3	-3.6		-9.2, 2.0
Mental health was not good in past 30 days	-2.0		-4.8, 0.8	-3.3		-9.4, 2.9
Had an activity limitation due to health at the time of the survey	-0.7		-3.1, 1.6	-0.5		-5.9, 4.8
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-1.2		-3.4, 1.1	0.7		-4.5, 5.8
Smoker who did not try to quit in past 12 months	-0.9		-2.5, 0.8	0.4		-3.5, 4.3
Health status was fair or poor at the time of the survey	-0.4		-2.2, 1.4	-1.3		-6.2, 3.5
Physical health was not good in past 30 days	-4.6	***	-7.4,-1.9	-6.0	*	-12.1, 0.0
Mental health was not good in past 30 days	-2.3		-5.2, 0.5	-2.9		-9.4, 3.7
Had an activity limitation due to health at the time of the survey	-2.2	*	-4.6, 0.2	-2.3		-7.7, 3.2

Source: 2011-13 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.11: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 for Montana/2015 for Comparison States (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	5.4	***	3.5, 7.3	13.5	***	9.6,17.4
Type of coverage						
Medicaid or other public coverage	7.1	***	5.5, 8.8	15.5	***	11.2,19.9
Employer-sponsored insurance	-0.5		-3.0, 1.9	1.1		-3.4, 5.6
Direct purchase or other coverage	-1.2		-2.9, 0.5	-3.1	**	-6.1,-0.0
Compared to Expanding Medicaid without a Demonstration						
Had health insurance coverage at the time of the survey	3.3	***	1.4, 5.3	5.5	***	1.4, 9.6
Type of coverage						
Medicaid or other public coverage	1.9	**	0.2, 3.7	2.0		-2.7, 6.7
Employer-sponsored insurance	0.2		-2.4, 2.7	3.3		-1.4, 8.0
Direct purchase or other coverage	1.3		-0.5, 3.0	0.2		-3.2, 3.5
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	4.0	***	2.2, 5.9	7.5	***	3.7,11.3
Type of coverage						
Medicaid or other public coverage	3.7	***	2.1, 5.4	7.1	***	2.8,11.4
Employer-sponsored insurance	0.4		-2.0, 2.7	1.5		-2.9, 5.9
Direct purchase or other coverage	-0.1		-1.6, 1.6	-1.1		-4.0, 1.8

Source: 2011-13, 2015 and 2017 American Community Survey (ACS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.12: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 for Montana/2015 for Comparison States (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	0.2		-2.5, 2.9	-1.3		-7.1, 4.5
Had a routine checkup in past 12 months	7.9	***	5.0,10.8	8.3	***	2.6,14.0
Received flu vaccine in past 12 months	1.5		-1.3, 4.3	0.0		-5.7, 5.7
No unmet need for doctor care due to costs in past 12 months	-1.6		-3.5, 0.3	1.3		-3.3, 5.9
Compared to Expanding Medicaid without a Demonstration						
Had a personal doctor at the time of the survey	0.4		-2.4, 3.0	-2.3		-8.8, 4.2
Had a routine checkup in past 12 months	4.9	***	2.0, 7.9	1.6		-4.8, 8.0
Received flu vaccine in past 12 months	-0.3		-3.3, 2.6	-1.6		-7.8, 4.5
No unmet need for doctor care due to costs in past 12 months	-0.8		-2.8, 1.1	-1.3		-6.3, 3.7
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	-1.2		-3.7, 1.4	-3.2		-9.2, 2.9
Had a routine checkup in past 12 months	4.4	***	1.5, 7.2	0.0		-6.2, 6.3
Received flu vaccine in past 12 months	0.8		-2.0, 3.6	3.5		-2.5, 9.4
No unmet need for doctor care due to costs in past 12 months	-1.5		-3.4, 0.5	-0.7		-5.8, 4.3

Source: 2011-13, 2015 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.13: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2017 for Montana/2015 for Comparison States (post-period) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	-1.0		-3.3, 1.2	1.4		-4.3, 7.2
Smoker who did not try to quit in past 12 months	0.0		-1.7, 1.6	2.6		-1.8, 7.0
Health status was fair or poor at the time of the survey	1.1		-0.7, 2.8	0.7		-4.2, 5.6
Physical health was not good in past 30 days	-2.4	*	-5.2, 0.3	-3.0		-8.8, 2.9
Mental health was not good in past 30 days	1.2		-1.6, 4.0	0.6		-5.2, 6.3
Had an activity limitation due to health at the time of the survey	0.8		-1.6, 3.1	1.8		-3.9, 7.5
Compared to Expanding Medicaid without a Demonstration						
Smoker at the time of the survey	-1.5		-3.8, 0.8	0.2		-5.3, 5.7
Smoker who did not try to quit in past 12 months	0.0		-1.8, 1.7	1.9		-2.5, 6.4
Health status was fair or poor at the time of the survey	1.1		-0.7, 3.0	2.2		-2.6, 7.0
Physical health was not good in past 30 days	-2.1		-4.9, 0.7	-1.8		-7.5, 3.9
Mental health was not good in past 30 days	0.0		-2.8, 2.9	0.9		-5.0, 6.8
Had an activity limitation due to health at the time of the survey	0.9		-1.5, 3.3	2.6		-2.8, 8.1
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-1.8		-4.0, 0.4	-0.2		-5.5, 5.1
Smoker who did not try to quit in past 12 months	-0.8		-2.4, 0.8	1.1		-2.8, 5.0
Health status was fair or poor at the time of the survey	1.1		-0.7, 2.8	1.9		-2.3, 6.0
Physical health was not good in past 30 days	0.2		-2.5, 2.9	0.4		-5.2, 5.9
Mental health was not good in past 30 days	1.4		-1.4, 4.2	2.1		-4.7, 9.0
Had an activity limitation due to health at the time of the survey	1.9	*	-0.3, 4.2	3.3		-1.9, 8.5

Source: 2011-13, 2015 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the federal poverty level (FPL). Family income relative to FPL is imputed in the BRFSS (see Appendix E). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Significantly different from zero at the .10/.05/.01 levels, using two-tailed tests.

Appendix Table G.14: Difference-in-Differences Estimates of Changes in Employment for All Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (pre-period) and 2016-17 (post-period) Using the Group of Best Comparison States

	All Adults		Low-income Adults	
Compared to Not Expanding Medicaid				
Employed at the time of the survey	0.0		0.6	
Compared to Expanding Medicaid without a Demonstration				
Employed at the time of the survey	0.1		2.1	
Compared to Expanding Medicaid with a Different Demonstration				
Employed at the time of the survey	0.0		0.2	

Source: 2011-13 and 2016-17 American Community Survey (ACS).
Notes: FPL = Federal poverty level. Low-income is defined as family income at or below 138% FPL. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. For sample sizes, see Tables G.6 (Montana) and G.7 (Montana's comparison states).
/**/** Estimate differs significantly from zero at the .10/.05/.01 levels, using two-tailed tests.