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WASHINGTON, DC

Department of Health Policy and Management

To: Medicaid HELP Amendment and
Medicaid WASP Amendment
Director's Office
Montana Department of Public Health and Human Services (DPHHS)
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By email to dphhscomments@mt.gov

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Date: August 17, 2021

Subject: Comments on Ending 12-month Continuous Eligibility under Montana's Medicaid HELP or WASP Amendments

We are responding to Montana's request for public comments on its draft Medicaid HELP and WASP amendments. We are public health researchers at George Washington University who have conducted substantial research about Medicaid continuous eligibility policies and hope we can contribute to your policy discussion. If you have any questions, please feel free to contact Leighton Ku at lku@gwu.edu or Erin Brantley at ebrantley@gwu.edu.

We urge DPHHS to withdraw the draft proposal to terminate 12-month continuous eligibility from the HELP and WASP demonstration projects. Terminating the policies would create unnecessary harm to the health insurance coverage and access for low-income Montanans who rely on Medicaid. As explained below, we conservatively estimate that ending 12-month continuous eligibility would reduce the enrollment periods of about 21,500 Medicaid enrollees, about 18,200 HELP enrollees and 3,400 WASP enrollees. A study estimated that the share of Montanans who are uninsured may have increased from 8.6% in 2019 to between 9.3% and 11.1% in 2020, due to the COVID pandemic.[1] This is a time to strengthen insurance coverage for Montanans, not weaken it.

A. Continuous Eligibility Stabilizes Coverage and Can Improve Health Access. Continuous eligibility policies are designed to improve stability and continuity of Medicaid coverage and to

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reduce "churning", making Medicaid coverage more like employer-sponsored health insurance or Medicare in which coverage is relatively stable across the year. An April 2021 federal review concluded that "Studies indicate that beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services."[2]

Continuous eligibility is a reliable strategy to reduce churning. Under 12-month continuous eligibility policy, beneficiaries have the option to remain on Medicaid coverage, for a year, rather than needing to meet certain criteria repeatedly. Continuous eligibility has long been permitted for children and pregnant women in Medicaid and is available for adults through a Section 1115 demonstration project waiver, as exercised by Montana.

We recently completed a study, forthcoming in the peer-reviewed journal Medical Care Research and Review, about the health effects of Medicaid 12-month continuous eligibility policies for children.[3] Continuous eligibility policies are associated with reduced levels of uninsurance, fewer insurance gaps and fewer administrative problems applying for coverage. More important, low-income beneficiaries living in states with continuous eligibility policies were more likely to be in good to excellent health than those in states without these policies. Moreover, children with more serious health care needs (e.g., asthma, etc.) were more likely to have received medical care, preventive health visits or specialist care in states with continuous eligibility. Adults generally have less stable coverage in Medicaid than children, so we would expect effects to be similar or somewhat stronger for adults than for children.

These findings are consistent with other research showing how churning and disruptions in Medicaid coverage can lead to health problems and how continuous Medicaid coverage can improve cancer care, immunizations, and use of prescription medications and other treatments for preventable problems like asthma or diabetes, as documented by researchers at Harvard,[4] the University of California[5], University of Minnesota[6] and Stanford.[7]

Continuity of eligibility helps low-income patients get better access to preventive and primary care services that can help prevent serious health problems that may ultimately require emergency medical care or hospitalizations. Our research has also found that as people have stabler enrollment in Medicaid, their monthly health care costs decline.[8]

For example, patients with diabetes may require regular medical care and prescription medications, such as insulin, to keep their blood sugar levels in the desired range and to prevent acute problems such as heart attacks, hypoglycemic or hyperglycemic comas, as well as longer term problems like eye disease or limb amputation. Even a short spell without medical care or access to medications can have grave consequences and lead to costly emergency or inpatient hospital care. For children, consistent access to medications for asthma can help avoid emergency department use due to acute asthma attacks. Those who are addicted to opioids can help control their addictions through regular care and use of medications like buprenorphine; even a brief loss of coverage can lead to renewed use of opioids and even

overdoses. The COVID-19 pandemic has increased stress, anxiety and depression for millions of Americans. Mental health services and use of medications can help reduce mental health problems but disruptions in coverage can harm mental health and even lead to suicidal thoughts or actions. These harmful consequences not only harm health, but they lead to unnecessary and costly medical care in the form of emergency room visits or hospitalizations for conditions that could be prevented with stable medical care.

B. Montana's Evaluation Found That 12-Month Continuous Eligibility Policy Was Beneficial. Montana sponsored an evaluation of its Sec. 1115 demonstration project, conducted by Social Scientific Systems and the Urban Institute.[9] The overall evaluation concluded that the HELP demonstration improved health insurance coverage and access to care, including preventive care use, and that satisfaction was high. The findings about 12-month continuous eligibility stated:

> 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."
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> 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."

Given this positive evaluation of 12-month continuous eligibility, what is the rationale for Montana discontinuing this policy?

We also note that a quantitative evaluation of New York's 12-month continuous eligibility policy for adults has been conducted by RAND researchers, although that report has not yet been cleared for public release. *Since New York's policy is similar to Montana's policy, DPHHS and CMS should review that evaluation before submitting or approving this amendment request.*

C. Ending Continuous Eligibility Increases Disparities. Medicaid serves low-income adults and children, so termination of continuous eligibility creates an inequitable harm on needy residents. Ending 12-month continuous coverage will lead to higher paperwork burdens to provide additional reporting and increase the risk that someone loses benefits because they were not able to file the right paperwork on time. If Montana does terminate 12-month continuous eligibility, the state should ensure that coverage is renewed no more frequently than once every 12 months, using automated processes to the extent possible, and give sufficient time for beneficiaries to respond when automated data checks indicate potential problems.[10]

Certain Montanans are likely to be more seriously affected by the end of continuous eligibility because they may encounter more difficulties keeping up with the additional paperwork burdens. For example,

- Many Montanans rely on seasonal work, including work in agriculture, construction, mining and forestry, food and hospitality and retail services, leading to more volatile incomes and risk of churning.
- Native Americans/American Indians often lack internet connections that can enable them to submit eligibility information and tend to live remotely, away from welfare offices they can visit for enrollment.
- Others living in rural and frontier areas will have similar difficulties with communications and logistics associated with more frequent eligibility checks.
- Those with mental health problems or substance use disorders could have more difficulties maneuvering the enrollment systems to retain their coverage.

D. The Budget Analysis is Flawed. The state waiver applications included estimates that ending continuous eligibility will lower coverage by about 2.6%, reducing HELP member months by 29,083, saving $22.2 million based on a per member per month (PMPM) cost of $763.77 and reducing WASP enrollment by 5,183 member months, saving $953,000 based on a total PMPM of $436.92. Curiously, the HELP application appears to include all federal and state costs which substantially overstates state savings while the WASP application cites state general fund savings, excluding federal savings.

We note that the 2.6% estimate is based on a study we did in 2013 about the cost of 12-month continuous eligibility for children, comparing states that adopted continuous coverage vs. states that did not.[11] It found that the 12-month continuous eligibility increased overall medical expenditures by 2.2%. Because adults have less stable coverage than children, in discussions with CMS, we estimated that continuous eligibility for adults could cost about 2.6%, which was included in the federal budget neutrality policy.

Some reasons why Montana's budget estimates are flawed:

1. Under the maintenance of effort requirement in the Families First Coronavirus Response Act, Montana cannot terminate Medicaid eligibility until the end of the Public Health Emergency, which is unlikely to expire until December 31, 2021, at the earliest (and

given the recent surge of COVID-19 infections due to the Delta variant, that date might be pushed back even later). After that date, states must gradually phase out the extensions of coverage as they redetermine eligibility. CMS has been advised that states will have difficulty processing redeterminations and renewals when that period ends and has authorized states to take up to 12-months to conduct those processes.[12] Thus, savings in State Fiscal Year (SFY) 2022 under the proposed amendments are likely to be small or nil.

2. Montana did not account for the increase in average monthly costs if continuous coverage ends.[1, 7] For example, we had estimated (using 2013 data) that 12-months of coverage could have an average monthly cost of $371 compared with $583 per month for six months of coverage, a 34% savings per month.
3. Montana has not accounted for the increased administrative costs that occur if 12-month continuous coverage is ended. This further reduces net savings.
4. Finally, we note that the 2.6% savings estimate understates the number of enrollees who would have their periods of enrollment shortened. Although this could result in an overall reduction of 2.6% of member months, it would affect more people because the typical beneficiaries will lose a fraction of their enrollment, not the whole years. If we conservatively estimate that the reduction of continuous eligibility means that each enrollee loses about two months of coverage, then the 2.6% cost savings means that the number of enrollees harmed would be about **six times larger**, or about **15.6% of enrollees would have enrollment shortened by about 2 months each**. This would equal about 18,188 HELP enrollees (115,588 HELP enrollees in 2020 * 0.156) and 3,362 WASP enrollees (21,552 WASP enrollees in 2020 * 0.156). **That is, terminating continuous eligibility could harm more than 21,500 Medicaid enrollees, based on recent caseloads.**

E. Montana Is Not Facing Serious Budget Pressures. It might make sense for Montana to pursue a small state savings if the state was facing serious budget pressures. But that just is not the case. A recent state budget analysis indicates that Montana expects to have a general fund surplus of more than $300 million in SFY 2022 and SFY 2023.[13] More important, Montana, like most states, will receive about $3 billion in additional federal funds under the American Rescue Plan Act.[14] The state has just received a major budget windfall and there is no compelling fiscal reason to cut coverage for low-income Montanans.

Rather than taking steps to reduce insurance coverage when health needs continue to be high due to the COVID-19 pandemic at a time that the state has ample budget resources, Montana should be strengthening health insurance coverage. If the state does not withdraw these amendments, CMS should not approve them.

Citations

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