

Montana Highlights: A Model Providing Health Insurance for Direct Care Workers that is linked to Medicaid Reimbursement Rates

Program Summary:

Funds and initial terms established by Montana Legislature (2007 & 2008 study for 2009 start-up):

- Approved Health Care for Health Care Worker, Bill 2, for reimbursement rate increases for providers that deliver Medicaid personal assistance and private duty nursing services when they provide their direct care employees with health insurance coverage that meet defined criteria.
- Effective Jan 1, 2009, 2 years, \$5 million, funded in 6 month increments to Department of Human Services, Senior Long Term Care Division, Medicaid Community Services Bureau to fund and administer the program.
- Work group established in 2008 to set terms- criteria and insurance plan benchmarks (includes dental and prescription drug plan-see benchmarks, and negotiated options for supplementing high deductible plans. <http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/benchrmaks.pdf>)
- Maximum payment to provider for premium coverage is \$500/worker (increased from \$450, 2009 rate) with maximum worker premium of \$25/month.
- The state is not offering a health insurance plan, however the state established plan benchmarks and eligibility criteria for participating employers to select insurance plans and to set their eligibility policies for employee enrollment.

Eligibility criteria and terms, defined by DHS:

<http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

- Qualified agencies are those providing Medicaid personal assistance (PAS) services and/or Medicaid private duty nursing (PDN) services. An application and signed agreement of terms are required.
- The program is optional to these providers and there are no employee size restrictions, however funds are restricted to eligible workers – defined as providing services to Medicaid recipients for at least 50% of their work hours. The agency defines their own policy for the number of work hours required to participate in the benefit.
- Funding allocations are calculated based on a 6 month project budget (future plan to increase this to 1 year) and based on a \$500/month/employee premium maximum. “Additional funding may be available to providers who are unable to purchase a plan that includes dental and meets the Department’s benchmark standards within the \$500 limit”.
- Individual premium (worker cost) can not be greater than \$25.00/month
- Qualified workers- those providing services to Medicaid recipients for 50% or more of their work hours in a 30 day period, with 90 day grace period for workers.
- DHS/SLTC program staff work with providers through established application procedures, provide outreach and technical assistance, and monitor reporting requirements to verify compliance and appropriate use of funds.
- Participating providers must comply with application and reporting requirements.
- Fund recovery occurs if a provider is unable to provide health insurance coverage to the targeted number of eligible workers with a plan that meets the benchmark standards or an approved alternative plan.

Enhanced Reimbursement Payment Methodology:

- DHS/SLTC provides a monthly gross adjustment for participating providers (agencies) to be used only for health insurance coverage (this includes dental for 2010 enrollees- see benchmarks). These funds are paid in addition to the negotiated Medicaid rate that is established for each provider.
- The maximum adjustment amount the provider (agency) is eligible to receive is based on the portion of state Medicaid personal assistance (including agency-based, self-directed and HCBS) and private duty nursing service units they provide and the number of eligible workers the agency covers with health insurance. The amount is negotiated and finalized at the time of application. “The amount that the department determines payable to each provider will be final. No adjustments will be made in the payment amount to account for subsequent changes or adjustments in application and agreement to terms required”
- Records and Document: Reports are requested on a semi-annual basis and as necessary. These reports will include the insurance premium monthly payment and a list of eligible covered workers.
- Fund recovery can occur if a provider is unable to provide health insurance coverage to the targeted number of eligible workers with a plan that meets the Department’s benchmark standards or an approved alternative plan.

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Montana Update and Highlights:

At the close of the first year of operations, the program staff reported the following summary points:

- The program has been an overall success. Worker participation rates are less than initially expected but “new members are being added constantly”.
- Approximately 30 providers and 650 workers enrolled. (totals expected for 2010)
- Participating provider range in size from small to large and include some hospitals, are primarily providers serving people with physical disabilities and elders, and a few Development Disability service providers.
- Providers set their own policies for employee eligibility for minimum work hours. Most require 30 hours/week but some cover down to 20 hours/week. Staff stated that policies cover part time workers and have a mix of temporary and regular employees participating.
- To date only a few providers who requested applications have chosen not to participate due to challenges with insurance plans.
- Anecdotal feedback from providers claim improved worker retention, and more workers shifting from temporary to regular jobs.
- Employers continue to be supportive and engaged, and reported high levels of collaboration by insurance brokers and carrier flexibility that were noted as instrumental in working out questions and challenges in order to support the intent of the program to address concerns about direct care workers access to health insurance. No issues regarding state insurance codes, such as enrollment minimums or annual renewal dates were noted.
- Legal counsel was utilized to address ERISA questions and how to follow the eligibility targets of the program.
- A survey was conducted in 2008 and input from providers and workers was utilized to set rates, establish criteria and procedures. The \$25 individual premium rate was identified through the survey, which also indicated that premium rates over this amount would have a major impact on worker enrollment.
- Challenges noted:
 - A lot of education was necessary to inform workers and to get them to participate.
 - On-going education is needed.
 - Utilization rates of the Health Reimbursement Agreements, dental and prescription plans by workers is lower than expected.
 - Funding plan (6 month) enacted by the Legislature for the program is a concern. Full year would be better.
 - State budget problems are a rising concern. Funding is secure through 2010 and support is strong to continue the program. It may be necessary in the future to change the benchmarks to accept lower cost plans and the inclusion of dental will be re-evaluated.

Summarized by Elise Scala (Muskie School of Public Service) January 2010

Based on Montana website and interviews with Montana staff:

<http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

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