



Statement on the Kentucky HEALTH Medicaid 1115 Waiver Proposal

October 7, 2016

Background and Introduction

On June 22, 2016, Kentucky [Governor Matt Bevin announced](#) the release of [Kentucky HEALTH \(Helping to Engage and Achieve Long Term Health\)](#), a [Medicaid Section 1115 demonstration project](#) proposal. The state solicited feedback on the proposal and held three well-attended public hearings in Bowling Green, Frankfort, and Hazard, KY. After receiving public comments, Governor Bevin submitted a final version of [Kentucky HEALTH](#) to U.S. Department of Health and Human Services Secretary Sylvia Burwell on August 24, 2016.

Kentucky has experienced tremendous change over the past few years in an effort to transform its Medicaid program, including a shift to [Medicaid managed care](#) in 2011 and Medicaid expansion in 2014. Kentucky has made national headlines for enrolling Kentuckians in Medicaid and private insurance to achieve one of the highest drops in the uninsurance rate in the country. Recent [American Community Survey \(ACS\) data](#) shows Kentucky's rate dropped 8.3 percentage points between 2013 and 2015. Kentucky has one of the highest poverty rates in the nation ([about 1 in 5 Kentuckians live in poverty](#)), as well as some of the most [challenging health status](#) statistics in the U.S. Fifty-two percent of Kentucky Medicaid families have at least one [full-time worker in the home](#), and an additional 14 percent have part-time workers in the home. The Foundation has not been able to locate statistics on the percentage of those working independently or in the informal economy.

Since Kentucky expanded Medicaid, nearly half a million Kentuckians have gained coverage through Medicaid. We have seen an increase in [preventive care utilization](#) by Medicaid enrollees and a drop of 76.9 percent in [charity care](#) and care to the uninsured since Medicaid expansion was implemented. Despite such positive gains, concerns over the financial sustainability of Medicaid in Kentucky has led the current administration to consider alternatives for providing access to health care services to low-income Kentuckians. The [criteria](#) that CMS will apply in evaluating whether Medicaid program objectives are met by an 1115 waiver proposal are whether such a proposal:

1. Increases and strengthens overall coverage of low-income individuals in the state;
 2. Increases access to, stabilizes, and strengthens providers and provider networks available to serve Medicaid and low-income populations in the state;
 3. Improves health outcomes for Medicaid and other low-income populations in the state;
- or

4. Increases the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Public Input

While Section 1115 waivers have been in use long before the Affordable Care Act (ACA), the ACA requires “[opportunity for public comment and greater transparency of the section 1115 demonstration projects.](#)” The [Foundation for a Healthy Kentucky](#) agrees that public input is integral to designing a Medicaid program that is responsive to the needs of low-income Kentuckians. To that end, we held a stakeholder convening on May 12, 2016, to facilitate a discussion on [components of existing Medicaid 1115 waivers](#) and what participants would like to see implemented in Kentucky. A full report of the convening input can be found [on the Foundation’s website](#). Approximately 130 people attended the convening (including physical and behavioral health providers; consumers and consumer advocates; public health professionals; academic researchers; health system representatives; and payers) and provided their input and perspectives.

Some highlights of the input provided include:

1. Participants had diverse perspectives on **cost-sharing and penalties**, from opposing any cost-sharing in Medicaid to proposing specific premium and co-payment amounts. Participants were unified in opposing penalties to enforce cost-sharing provisions.
2. Participants were supportive of implementing **incentives for healthy behaviors** such as smoking cessation and health risk assessments.
3. Discussion of **benefits** ranged from retaining current Medicaid benefits to expanding existing benefits (i.e. expanded substance use treatment) to adding new benefits (i.e. support and assistance for housing, and Uber-like services as reimbursable transportation). Participants overall felt that medically necessary services should be covered for all enrollees.
4. Participants spoke of the need to streamline and accelerate the **reimbursement** process for providers; increase reimbursement rates to providers; and add new categories of services and providers to be reimbursed (i.e. community health workers, telehealth and home health).
5. Participants noted the need for **systems improvement** in the current Medicaid delivery and payment system, such as simplifying administrative processes for providers; expanding provider scope of practice; and increasing uniformity and consistency in processes among Medicaid Managed Care Organizations (MCOs).

Participants saw an 1115 waiver as an opportunity for Kentucky to explore new ways of delivering and paying for care and for moving beyond coverage issues to addressing access and quality to actually improve health outcomes. Many participants expressed opposition to making any changes to the existing Medicaid expansion program.

Promising Approaches

A number of [statements](#) and [blogs](#) have been written about Kentucky HEALTH, noting concern about many of its components. In August, the Foundation released a [statement](#) acknowledging some of the positive changes in the revised proposal; the waiver contains some promising components that stakeholders at the May 12 convening said they would like to see:

1. Substance use treatment expansion: Through a pilot project, as part of the 1115 waiver, Kentucky will increase access to mental health and substance use disorder treatment services. The project would allow adults to receive residential treatment in institutes for mental diseases (IMDs) for up to 30 days. Additionally, the proposal states that Kentucky will adopt [national best practices](#) in pilot communities and will require certain substance use providers to become accredited.
2. Medicaid managed care organization (MCO) reform: The proposal states that managed care contracts will be revised to control costs, improve patient experience, and accomplish population health goals. It also hints at a move from volume-based to value-based reimbursement. MCOs will be required to institute a quality-based bonus program for providers that will align with the health savings account given to some Medicaid enrollees. The changes are geared to align processes and requirements among MCOs, something that stakeholders at the May 12 convening strongly supported.
3. Healthy behavior incentives: Stakeholders attending the Foundation's May 12 convening strongly supported the use of healthy behavior incentives. While there is support for this strategy, it is important to note that research has found [mixed results](#) and Kentucky should be careful to implement only those programs that have been shown to benefit Medicaid enrollees' health. Kentucky should look to [other states](#) and existing research to design an effective healthy behavior incentive program to maximize the likelihood of improving health outcomes and decreasing health care costs.
4. Attempts to address social determinants of health: The connection between [health and education](#) has been well documented. The proposal raises concerns about educational attainment and, as a remedy, includes a benefit for GED certification. There is [some evidence](#) that GED certificates increases earnings for persons with low cognitive skills and adults who use their GEDs to obtain post-secondary education. Obtaining a GED also increases earnings and reduces [recidivism for former prisoners](#). Therefore, this appears to be a step in the right direction. However, given that GED recipients [earn less](#) than high school graduates, additional educational supports are recommended.

Areas of Concern

As a [mission](#)-driven organization that is data- and evidence-based in its work, the Foundation also finds areas of concern:

1. Loss of [dental](#) and [vision](#) benefits from the core Medicaid package: [Oral health](#) affects overall health and low-income Kentuckians [“are disproportionately affected by bad oral health.”](#) The Kentucky Center for Economic Policy believes removing dental care services from the core package could lead to higher health care costs due to increased emergency room (ER) use and preventable oral health problems going untreated.
2. No [retroactive eligibility](#): Removing retroactive eligibility will leave Medicaid-eligible individuals without coverage (especially those with chronic conditions) and providers who serve them won't be reimbursed.
3. Monthly premium payments at all income levels: In a recent [letter](#) denying Ohio's waiver request, CMS stated it had concerns that premiums regardless of income level undermine access to coverage and the affordability of care and do not support the objectives of the Medicaid program. There is evidence that premiums are a barrier to coverage and enrollment for low-income individuals. [A study found that enrollment dropped when premiums were instituted in the Kentucky Children's Health Insurance Program.](#) Further, [administrative costs](#) of collecting premiums are often higher than the revenue collected and, thus, the proposal may not be budget-neutral (a requirement of 1115 waivers).
4. Monetary penalties for nonpayment of premiums: For those making less than 100 percent of the FPL (\$11,770 or less for an individual), nonpayment of premiums results in copayments of \$3 to \$50. The waiver proposal states that MCOs will no longer be able to waive copayments and will be responsible for collecting copayments and premium payments. Additionally, not only does Kentucky have a high poverty rate, it also has one of the highest rates of families who are “unbanked,” with [estimates ranging between one-fourth and one-third of families](#). Stakeholders at the May 12 convening were opposed to penalties for failure to pay cost-sharing.
5. Lockout periods for nonpayment: For those making more than 100 percent of the FPL, and who are not otherwise exempt, nonpayment of premiums could result in a loss of coverage for up to six months. [A study found that when Oregon implemented lockouts for nonpayment, enrollment dropped.](#) More concerning, almost three-fourths of those who were [disenrolled](#) remained uninsured.

6. Lockout periods for not enrolling on time: No other state has implemented lockouts for failure to enroll according to requirements. This increases the risk that low-income Kentuckians will be locked out of needed health care services.
7. Mandatory work and volunteer work requirements: The proposal requires nondisabled adults without dependent children or disabled adult dependents to engage in paid or unpaid work for 5 to 20 hours per week, starting on the fourth month of Medicaid enrollment. Not fulfilling that mandatory work requirement results in suspension of benefits. CMS has not approved mandatory work requirements in any other state proposal and has indicated that work requirements are not consistent with the purposes of Medicaid. The proposal refers to this component as community engagement and cites evidence that community engagement correlates with improved health and greater workforce participation. Research on mandatory work requirements has found that these programs do not significantly increase the likelihood of employment beyond program participation, do not decrease the likelihood of living in poverty (and in some cases may increase it), and that voluntary programs that provide skill and educational support are more beneficial for low-income participants than mandatory work programs. A recent study showed that mandatory work requirement could lead to loss of coverage for needy families and individuals. The value of skills training to increase work opportunities is reflected in a recent survey by Bridging the Talent Gap in Louisville (Kentucky), in which employers reported that only 44 percent of high school graduates in the labor pool have the math skills needed to do the jobs available.

The program cited in the proposal (Maine's SNAP program, which mandates work requirements), has seen a dramatic drop in enrollees in the SNAP program. While this drop is viewed by some as a success in savings for the SNAP program, a similar drop in the Medicaid program would leave many vulnerable Kentuckians uninsured, which is a detriment to enrollees, providers and the state as a whole. Medicaid recipients tend to be sicker and have lower incomes than those with private health insurance. Medicaid has been shown to improve access to and use of health care, improve self-reported health, and prevent catastrophic medical expenses—all of which are imperative to improving the health and economic well-being of Kentucky. Kentucky should closely review the evaluation data available to select an approach that will benefit low-income individuals and families and avoid harmful consequences. The state also will need to assess the cost and resources needed to create and sustain the necessary infrastructure to implement the proposed work requirement program, as well as the impact on individuals and families. Concern has also been expressed that the unpaid work requirement might supplant paid positions in small and rural communities with limited job opportunities.

8. Loss of non-emergency transportation (NEMT): CMS has stated that NEMT is “an important benefit for beneficiaries who need to get to and from medical services, but have no means of transportation.” Evaluation from Indiana and Iowa so far has been inconclusive on the effect of removing NEMT from Medicaid benefits. Kentucky should closely review Iowa’s and Indiana’s evaluations once completed to inform the availability of NEMT to Medicaid enrollees. Studies have found that Medicaid expansion increases access to care in rural communities, and that, specifically, NEMT is important to rural communities, especially when local rural hospitals close.
9. Emergency room penalties: Nonemergency use of the ER will carry a \$20 to \$75 fee. These fees are significantly higher than the \$8 maximum currently allowed under federal regulations, and higher than the fees implemented by Indiana through a 1916(f) waiver. Despite commonly held beliefs, studies have found that higher ER use by Medicaid enrollees is driven by “unmet health needs and lack of access to appropriate settings.” Kentucky should focus on ways to address the systemic access issues rather than create further barriers to care for low-income Kentuckians.
10. Deductibles: Research on high-deductible plans has shown that low-income individuals and families face financial barriers to accessing care when faced with a high deductible. High-deductible plans do lower health care spending, however, they do so in part by decreasing health care utilization, including use of necessary and preventive services. While Kentucky HEALTH would provide participants with the deductible amount, Kentucky should consider the impact of the increasing proportion of high-deductible plans, and of the added administrative burden, especially for low-income populations, given the unmet health care needs in Kentucky.
11. Rewards account: While the combination of high-deductible plans and health savings accounts have continued to attract interest, research so far shows that this combination is beneficial to higher-income and low medical need populations but could be harmful to lower-income and high medical need populations. Further, health savings accounts and high-deductible plans are limited in their ability to decrease system-wide costs, which is where Kentucky needs to focus.
12. Employer-supported insurance (ESI) and premium assistance: Research on ESI and premium assistance has found that administrative costs of running such a program can be high and not budget-neutral (a requirement of 1115 waivers). Kentucky will need to assess and take into account the administrative costs for providing necessary “wrap around” services not covered by ESI and of covering cost-sharing in ESI that goes beyond that approved for Medicaid. Further, we need to know what portion of the able-bodied Medicaid eligible population is already employed —full- or part-time —with employers

that offer health benefits. A recent [study](#) found that across private employers of all sizes in Kentucky, the percentage that offered health insurance dropped 6.6 percentage points from 2012 to 2015, from 54.4 percent to 47.8 percent. This reflects a long-term decline in employers offering health insurance.

13. **Evaluation:** The proposal presents some initial ideas for an evaluation plan. It will be important to look at the impact of the new initiatives on those who remain on Medicaid, as well as those who transition onto ESI and those who lose coverage due to new Medicaid cost-sharing, enrollment or work-requirement elements. We will want to know how the changes affect ER use, preventive care, hospitalizations and re-admissions, as well as access to care. Further, given that research has found that [Medicaid improves behavioral health](#) and protects low-income individuals and families from [medical catastrophes](#), it will be important to look at the impact on access to, and unmet needs for, mental health and substance use and the economic impact of Medicaid changes in terms of medical debt and self-reported ability to meet basic needs.

Overall, the Kentucky HEALTH proposal leaves many questions unanswered. Kentucky needs a strong, sustainable and fact-based proposal that addresses the needs, challenges and opportunities of Kentuckians to improve the health and economic wellbeing of the state.

Opportunities

Kentucky approaches the 1115 waiver process from a very advantageous position. The Commonwealth has been one of the most successful states in terms of enrollment and coverage, attributable primarily to the Medicaid expansion. Data indicates that this increase in coverage is translating to early increases in access to care. However, it takes years to fully realize the potential gains from increased insurance coverage and access to care. Because of Kentucky's current position, an 1115 waiver provides an opportunity to pursue demonstrations to improve access, quality, and equity in health and health care—often referred to as Health Systems Transformation. The Centers for Disease Control and Prevention explains Health System Transformation this way: “The U.S. health system—consisting of public health, health care, insurance, and other sectors—is undergoing a critical transformation in both financing and service delivery. These changes include improving the efficiency and effectiveness of health organizations and services, as well as increasing connections and collaborations among public health, health care, and other sectors.” The 1115 waiver process provides states with an opportunity to explore ways to do care differently through various health system

transformation approaches, assuring sustainability by reducing care delivery costs while improving outcomes. Here are some examples that could be included in a waiver proposal:

1. Integrated care (primary, behavioral, and oral health). The Foundation for a Healthy Kentucky has been [committed to and supported](#) efforts for care integration in Kentucky for many years. [Research](#) supports integration of physical, behavioral and oral health to improve access to care, reduce stigma, and improve patient adherence to appropriate care. Through the 1115 waiver and MCO reform, Kentucky can take steps to truly integrate delivery and payment of physical, behavioral and oral health to improve care, health and cost-efficiency.
2. Patient- and community-centered care. While there is still much to be learned from patient-centered approaches, they offer a [promising approach](#) to using primary care in achieving better outcomes, better quality, and lower costs for health care. Further, the Prevention Institute has developed a [Community-Centered Health Home](#) model that incorporates community prevention efforts and resources to address the social context that affects health behaviors and outcomes. Kentucky should look to this model to improve health in a way that incorporates community reality and proven prevention approaches.
3. Population health approaches, including prevention efforts, regulatory action, changes to create healthier environments, and taxation of unhealthy products. A strong example of this is the implementation of smoke-free policies. [Smoke-free policies reduce smoking and prevent some from initiating](#) tobacco use; decreases in [smoking rates translate into improved population health and reduced health care costs](#).
4. Price transparency, including the adoption of an all payers claims database (APCD) to provide information on prices of medical services and devices as well as quality and outcomes reports. The Foundation for a Healthy Kentucky has supported the development and implementation of an APCD that incorporates best practices for price transparency tools for consumers, providers, policy makers, and researchers. Kentucky already has made tremendous progress in establishing the [Kentucky Health Data Trust](#) and should pursue this option to its fullest potential. For more details about APCD and price transparency, see the Foundation's [issue brief](#).
5. Payment reform, including exploration of bundled payments, capitation, paying for outcomes and other approaches being explored and evaluated. The health care system in the United States has been moving away from fee-for-service payment to alternative approaches that are more patient-centered, efficient, and reward quality and positive

health outcomes. Kentucky can apply [lessons learned](#) so far to support positive health care system changes through payment reform.

6. [Care delivery reform](#), including exploring the expansion of provider scope of practice, better use of health information technology—especially telehealth which holds tremendous promise for rural communities, as well as medical homes, accountable care organizations, care coordination and management strategies. Community [health workers](#), an approach used in Kentucky and around the world, have shown [success and significant promise](#). Kentucky should continue its exploration of [payment and delivery reform](#) while applying [lessons learned](#) thus far.
7. [Health equity](#) as the overriding framework for any payment and delivery reform proposal. The Foundation for a Healthy Kentucky believes that health equity is necessary to achieve the best possible health outcomes in Kentucky. The [ACA provides tools for addressing health disparities](#) and moving toward a health equity approach, where all communities and groups of people have access to conditions, resources, and opportunities necessary for a safe and healthy life. Extensive research proves that health is a result of [multiple factors](#), most outside of the health care system. By [addressing and incorporating the social and economic circumstances in which people live into policy and program development](#), we can best serve the needs and realize the potential of our state. [Policies and programs can be designed to address health equity](#) and the 1115 waiver provides an opportunity to put this into action. Further, there are [economic](#) as well as [health](#) arguments in favor of using a [health equity approach](#).

What We Don't Know

In tailoring a Medicaid waiver program to the challenges and strengths of Kentucky, it is important to start with a clear and shared awareness of who the Kentuckians are that we seek to serve more efficiently and effectively through the waiver. The Foundation has not been able to answer these questions sufficiently as of this writing, but believe that some answers can be obtained from data already available to the Kentucky Cabinets for Health and Family Services and the for Education and Workforce Development. The MCOs may also have insights on these issues. Working together, cost-effective answers can be crafted that are tailored to their needs and circumstances:

- How many of the current Medicaid recipients would be considered able-bodied adults who are not responsible for the care of dependent children or caregivers for adult family members with disabilities?

- How many of these able-bodied adults are presently employed full time? Of these, how many work for employers who offer health insurance to employees and employees' family members?
- How many are working in one or more part-time jobs, or as independent contractors?
- How many of Kentucky's lowest-income residents have a permanent place of residence — as reflected by ownership or lease of an apartment, house or trailer?
- How many have access to computers? Cell phones?

Conclusion

Like so many others, we come to this work with a deep and abiding respect for the worth and dignity of the lives of all Kentuckians. We know that it costs Kentucky less in the long-run (in both human and economic terms) for all Kentuckians to be healthy and to have timely access to needed preventive and therapeutic care than to delay or forego care. Kentucky should carefully consider before implementing elements with [evidence](#) that is mixed or shows potential harm to low-income individuals, or components that have only been deemed effective with high-income and low medical need populations.

Kentucky's Medicaid-eligible population is low-income and faces numerous health and socioeconomic challenges. Our state's commitment to all persons living in Kentucky should be to first "do no harm" and to treat all Kentuckians with respect, dignity and compassion. Medicaid 1115 waivers provide a unique opportunity for innovation and experimentation. Given our success in enrollment and coverage, Kentucky can take this chance to adopt new ways of providing care that limit the risk of vulnerable populations losing coverage or foregoing needed health care, and improve health care's quality, value, and positive impact on population health. Health systems transformation strategies listed above offer opportunities for taking Kentucky's Medicaid program to a next level of best practices.

It will be important to listen to the extensive input provided during the public comment period and to look to lessons learned in other states and from past health services research literature. The [Department of Health and Human Services](#) has given us some indication of how it will review Kentucky's proposal by reiterating that "[\[w\]e are hopeful that Kentucky will ultimately choose to build on its historic improvements in health coverage and health care, rather than go backwards.](#)" Evaluation will be key in understanding how the waiver affects current and former enrollees and providers, and findings should be shared publicly to assure that evaluation informs appropriate course-corrections.

We believe that the opportunity costs for low-income Kentuckians to obtain health coverage and participate in their own health care, and that of their children, are far greater than those of Kentuckians who have higher incomes and benefits; that is low-income Kentuckians' skin in the

game. The Foundation for a Healthy Kentucky is committed to addressing the unmet health care needs of Kentuckians by increasing access to care, reducing health risks and disparities, and promoting health equity.