

Protecting Medicaid's Role in Advancing a Healthy Kentucky

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By Mary Cobb

Kentucky Center for Economic Policy

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Protecting Medicaid's Role in Advancing a Healthy Kentucky

Kentucky is currently exploring options to modify its Medicaid expansion program through a waiver under Section 1115 of the Social Security Act. Proponents of this direction suggest it will improve sustainability and reduce costs by increasing enrollees' cost-sharing requirements. However, there are concerns a waiver could decrease health care access and health status for low-income Kentuckians, create administrative burdens on the state and potentially even cost more money overall.

This analysis was prepared to inform Kentucky's 1115 waiver process so potential negative impacts can be avoided. This paper brings together the latest available information about current Medicaid programming in the Commonwealth, provides an overview of Section 1115 waiver regulations and state examples, outlines waiver components rejected by the federal government in the past and presents recommendations for Kentucky's decision makers to consider during the waiver development process.

Kentucky's Current Medicaid Program

Medicaid and the Kentucky Children's Health Insurance Program (KCHIP) provide health insurance coverage for more than 1.4 million Kentuckians. This number is indicative of the high level of poverty in Kentucky. Just over 19 percent of Kentuckians live below the poverty line, compared to 15.5 percent nationwide; our poverty rate is the fifth highest in the U.S.¹

There are several routes to Medicaid coverage based on income, disability, age and other factors. Table 1 presents Kentucky's eligibility categories and enrollment. As the table shows, Medicaid expansion allows childless adults earning less than 138 percent of the federal poverty line (FPL) to access coverage, and nearly 450,000 Kentuckians are currently enrolled under the expansion. For 2016, 138 percent of FPL equates to just \$33,534 for a family of four.²

Table 1: Kentucky Medicaid Eligibility Categories and Enrollment

Enrollment Category	Eligibility/Purpose	Kentuckians Enrolled, September 2015
KCHIP and Traditional Income-Based Medicaid	KCHIP: children up to 218 percent FPL. Traditional: low-income parents and caretakers (up to 62 percent FPL), pregnant women and children. Uninsured breast and cervical cancer patients.	637,937
Medicaid Expansion	Adults up to 138 percent FPL.	449,628
Supplemental Security Income (SSI) Population	Individuals determined by the Social Security Administration to be eligible for SSI (low income w/ disability, blindness, aged 65+ or children).	116,844
Medicare Savings and Special Populations	Seniors with low incomes and limited assets who are ineligible for full Medicaid but who cannot afford the cost of Medicare premiums and co-pays.	84,210
Dual-Eligibles (Medicare and Medicaid)	Low-income Medicare enrollees. Medicaid covers services (such as nursing homes) that Medicare does not. Several categories with different eligibility and benefit levels. ³	72,935
Waiver - Populations Covered under KY's Medicaid Section 1915 waivers	Individuals with acquired brain injury, intellectual or developmental disability, mental retardation, or who, due to age, need long-term services and supports that can be provided in the home, adult day care, or community to prevent institutionalization.	24,087
Intermediate Care Facility, Nursing Home, and Hospice Populations	Low-income individuals requiring institutionalized care.	20,449
Foster, Former Foster, and Kinship Care Youth	Children in foster care or in the care of relatives, and former foster children who "aged out" of foster care (at ages 18-21) in any state. Eligible for Medicaid until age 26 regardless of income.	18,668
Total Enrollment		1,424,758

Source: Cabinet for Health and Family Services.

Kentucky's Medicaid participants include thousands of working families, veterans, pregnant women and people with disabilities, as well as hundreds of thousands of children and seniors. Medicaid enrollment is not permanent; many people qualify at some point, then move into job-based coverage or other private plans when circumstances change. The system has built-in checks for this; eligibility for traditional and expansion Medicaid is re-verified annually. Thousands of people "churn" in or out of Medicaid coverage each year.⁴

Current enrollees include the following:

- **Children:** 561,326 (39 percent) of enrollees are children.
- **Working adults:** The majority of Medicaid-eligible adults who gained coverage under the expansion in 2014 in Kentucky were low-wage workers. Among the estimated 73,800 Kentucky workers who gained Medicaid coverage in 2014, the most common industries were food service, construction, temp agencies and retail stores.⁵

- **Veterans:** An estimated 9,500 uninsured Kentucky veterans and 5,300 uninsured spouses of veterans became newly-eligible for Medicaid under the expansion.⁶
- **Pregnant women and infants:** 43.6 percent of all births in Kentucky were covered by Medicaid in 2010 (the most recent year for which data were published).⁷
- **Seniors:** 90,794 of current Kentucky Medicaid enrollees are ages 65 and older.
- **Disabled or requiring long-term care:** 161,380 Kentucky Medicaid enrollees are eligible through disability, blindness, long-term care needs or brain injury for which they require care either in a facility or at home.

Kentucky Medicaid Benefit Package

Mandatory Benefits

Federal regulations require several basic services to be Medicaid-covered in all states for standard Medicaid enrollees.⁸ The Centers for Medicare and Medicaid Services (CMS) lists these as:

- Inpatient and outpatient hospital services
- Physician, nurse midwife, certified pediatric and family nurse practitioner services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services for children under 21⁹
- Nursing facility services (skilled nursing, rehabilitation, and long-term care)
- Home health services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray
- Family planning
- Transportation to medical care (sometimes called non-emergency medical transportation, or NEMT)
- Tobacco cessation counseling for pregnant women

Optional Benefits

CMS also lists additional services states may cover under Medicaid programs. Kentucky Medicaid covers the optional benefits shown in Table 2, though service coverage is always limited to “medically necessary” cases (e.g. although dental care is listed as “covered” it does not include dentures, cosmetic dentistry, etc). The column on the right includes a count of states including the service in their Medicaid programs; counts sometimes surpass 50 because Washington DC, Puerto Rico, American Samoa, Guam, Northern Mariana Islands and the U.S. Virgin Islands are included. As noted, most of the optional services in Kentucky are also covered in at least 40 other states.

Table 2: Optional Medicaid Services Covered in Kentucky

Service	Total # of States/ Territories Covering
Prescription drugs	56
Other diagnostic, screening, preventive, and rehabilitative services	48
Podiatry	48
Optometry/Vision services	56
Dental (limited for adults)	53
Prosthetic and orthotic devices	54
Chiropractor services (based on medical necessity)	27
Hospice	42
Case management	50
Services for Individuals Age 65+ in an Institution for Mental Disease	46
Services in an intermediate care facility for Individuals with Intellectual Disability	48
State Plan Home and Community Based Services - 1915 (i)	47
Inpatient psychiatric services for individuals under age 21	52

Source: Compiled from the Kaiser Medicaid Benefits Data Collection.

Services Not Covered

The box below is from the Kentucky Medicaid Member Handbook and lists services not covered by the state's Medicaid program.¹⁰ In general, all states must determine medical necessity for Medicaid coverage of services, but states define necessity differently. Some states do cover some of these services not covered in Kentucky, including glasses, dentures and hearing aids for adults; abortions (with state—not federal — funds); and sometimes even air conditioners in cases of medical conditions that are exacerbated by heat or dust.

Kentucky Medicaid only pays for services that are medically necessary. Below are some of the services that Kentucky Medicaid does not pay for. If you use services that Kentucky Medicaid does not pay for, you will have to pay for them yourself.

- Services from providers who are not Kentucky Medicaid providers
- Services that are not medically necessary
- Transportation to pick up prescriptions
- Massage and hypnosis
- Abortion (unless the mother's life is in danger, or in the case of incest or rape)
- In vitro fertilization
- Paternity testing
- Hysterectomy for sterilization purposes
- Hospital stays if you can be treated outside the hospital
- Cosmetic surgery
- Fertility drugs
- Braces for teeth, dentures, partials, and bridges for persons 21 or over
- Glasses and contact lenses for persons 21 and over
- Hearing aids for persons 21 and over
- Fans, air conditioning, humidifiers, air purifiers, computers, home repairs

Co-Payments in the Current Program

Federal rules allow states to require limited cost-sharing in Medicaid and CHIP programs through co-payments (co-pays), co-insurance, deductibles, premiums or enrollment fees, with pregnant women and children exempt from most cost-sharing.¹¹ Kentucky has opted to implement cost-sharing via co-pays, which vary by enrollee category, type of service and Managed Care Organization (MCO).¹² Co-pays range from \$0 to \$50, and cannot exceed 5 percent of total family income per quarter. Pregnant women, children, institutionalized individuals, hospice patients, emergency services, American Indians, family planning and preventive services are exempt from most co-pay requirements. In all cases, services are limited to those deemed medically necessary. A complete list of co-pay requirements, by service, as well as annual limits (e.g. adult dental services are covered, with a \$3 co-pay, but limited to one cleaning/x-ray per year) can be found in the Kentucky Medicaid Member Handbook.¹³

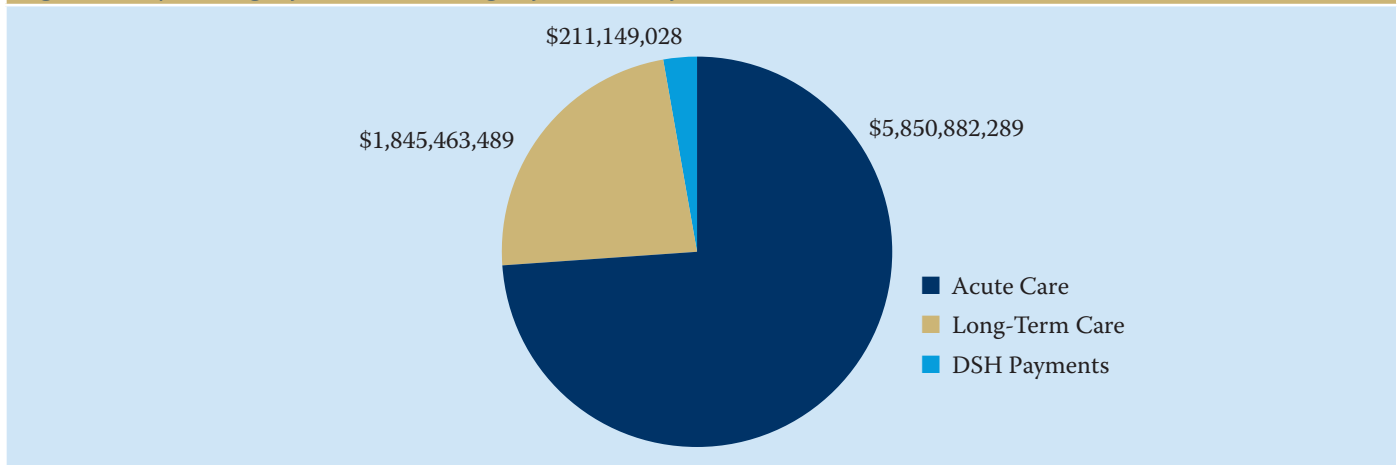
Although co-pays are officially part of Kentucky's Medicaid program, in practice they may not be collected in many cases. Providers (including pharmacists) reportedly often write off the co-pays, or MCOs may not enforce them, possibly either due to administrative complexity with collection, or as a way to compete for enrollees. For example, Humana — CareSource uses the tagline “Absolutely No Co-Pays” on its Medicaid website.

Some enrollees (certain categories of KCHIP families and disabled working adults under a special Medicaid buy-in program) also pay premiums for their coverage. Dual-eligible and Medicare Savings enrollees do not have full health care costs covered by Medicaid, and may still be responsible for out-of-pocket expenses (there are several enrollment categories even within these populations, each with different eligibility and benefits).

Kentucky Medicaid Spending: Expenditure not Proportional to Enrollment

Figure 1 shows the distribution of Medicaid expenditures for fiscal year (FY) 2014 among the major spending categories. Acute care services represent 74 percent of the total, and long-term care services 23 percent of the total. The third category consists of Disproportionate Share Hospital (DSH) payments, made to hospitals that serve large numbers of low-income patients. Note the large share of spending devoted to long-term care, which relatively few enrollees need but which is expensive.¹⁴

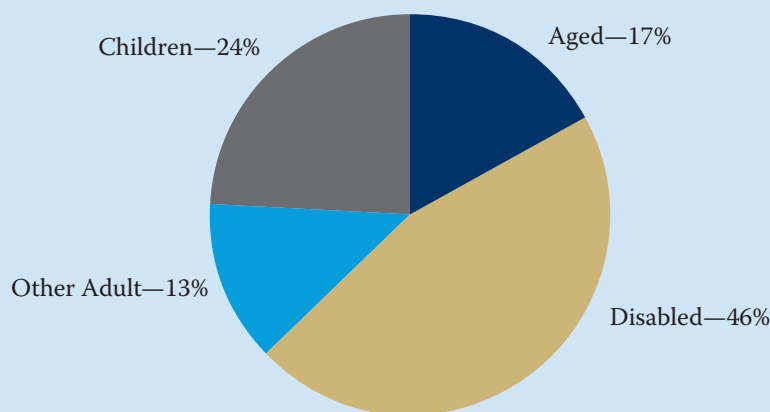
Figure 1: Spending by Service Category, Kentucky, FY 2014



Source: Kaiser Family Foundation State Health Facts.

For spending by enrollment group (aged, disabled, other adults and children), FY2011 data are the latest available in these categories. Figure 2 shows this distribution. Although the 2011 (pre-Affordable Care Act (ACA)) data represent a different Medicaid program than we have today, the distribution shows that a relatively small proportion of expenditure went to services for non-elderly, non-disabled adults in Kentucky (13 percent). And, early post-ACA data show spending on the Medicaid expansion group remains relatively small compared to overall Medicaid spending.

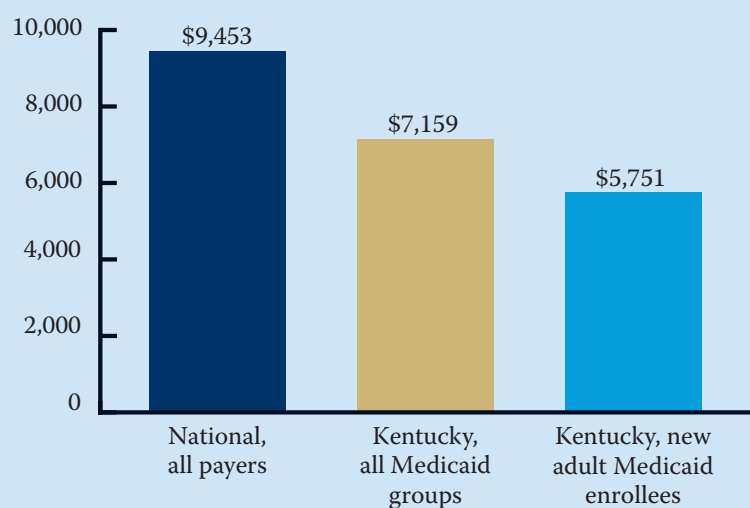
Figure 2: Spending by Enrollment Group, Kentucky, FY 2011



Source: Kaiser Family Foundation State Health Facts.

A January 2016 analysis of newly released 2014 CMS claims data found the new (expansion) adult group of enrollees accounted for 25 percent of total Medicaid spending in Kentucky (and 0 percent of state spending because the federal government is still paying 100 percent of costs). And, per-enrollee spending on the new adult group, at \$5,751, was lower than per-enrollee spending across Medicaid groups, which was \$7,159.¹⁵ As a comparison, the national per-person health expenditure was \$9,523 in 2014 (see Figure 3).¹⁶

Figure 3: Per-Person Health Expenditure, 2014



Sources: National Health Expenditure Accounts 2014 and Kaiser Analysis of 2014 CMS Claims Data for Medicaid Expansion States.

Comparing Kentucky's Program to Other States

Comparing Kentucky's Medicaid program to other states shows many similarities and a few key differences. On the whole, Kentucky has a benefit package that is very similar to most states, receives a larger federal match than most other states and has some differences in the distribution of spending, especially within the long-term care category.

- **Similar benefit packages:** Although Kentucky covers several services considered optional by federal rules, the optional services Kentucky has selected are offered by almost all other states (see Table 2), though many states offer benefits not covered in Kentucky.
- **Proportionally more federal funding:** Medicaid is a federal-state partnership, with the federal government funding a minimum of half of *traditional* Medicaid spending in each state and poorer states receiving an even larger federal match. The exact federal share in each state is called the Federal Medical Assistance Percentage (FMAP). Kentucky's FMAP for FY2017 is 70.46 percent; this means that every \$1 Kentucky spends on Medicaid brings in \$2.39 in federal funds. Kentucky has the sixth highest FMAP in the country.¹⁷ (For *expansion* Medicaid, the FMAP is 100 percent, gradually decreasing to 90 percent in 2020. At 100 percent, the state pays \$0 for Medicaid expansion enrollees.).¹⁸
- **Distribution of long-term care spending:** As Figure 1 showed, long-term care expenditures make up a substantial portion of overall Medicaid spending disproportionate to the number of enrollees covered. This is true in all states, but Kentucky spends a larger proportion of its long-term care expenditures on long-term care facilities than the national average (51.2 percent in KY vs. 41.3 percent nationwide), and therefore proportionally less than average on home/community-based health (37.8 percent vs. 45.9 percent).¹⁹ In 2014 there were 6,278 Kentuckians on waiting lists for Section 1915 waivers (which help people receive home or community-based long term care); most people on the waiting list were waiting for intellectual or developmental disability services.²⁰
- **Progressive policy for former foster children:** The ACA requires all states to offer Medicaid coverage to former foster children who were Medicaid-covered when they "aged out" of the foster care system within the state. But Kentucky is one of only 10 states that have extended this benefit to cover *all* former foster children regardless of which state they were fostered in.²¹

Successes of Kentucky's Medicaid Expansion

Kentucky's substantial reduction in the uninsured rate under the ACA is well known among state and national stakeholders; the share of the population without insurance dropped from 20.4 percent in 2013 to 7.5 percent in 2015.²² The Medicaid and marketplace enrollment counts show these coverage gains were driven largely by the Medicaid expansion enrollment. Coverage alone is not the end goal, but it is the basis for better access to care, prevention of disease, cost-efficiency of long-term health spending and (over time) tremendous public health gains including reductions in preventable mortality.

The Center on Budget and Policy Priorities summarizes, "Numerous studies show that Medicaid has helped make millions of Americans healthier by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases. For example, expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1 percent reduction in childhood deaths. Also, expansions of Medicaid coverage for low-income pregnant women led to an 8.5 percent reduction in infant mortality and a 7.8 percent reduction in the incidence of low birth weight."²³

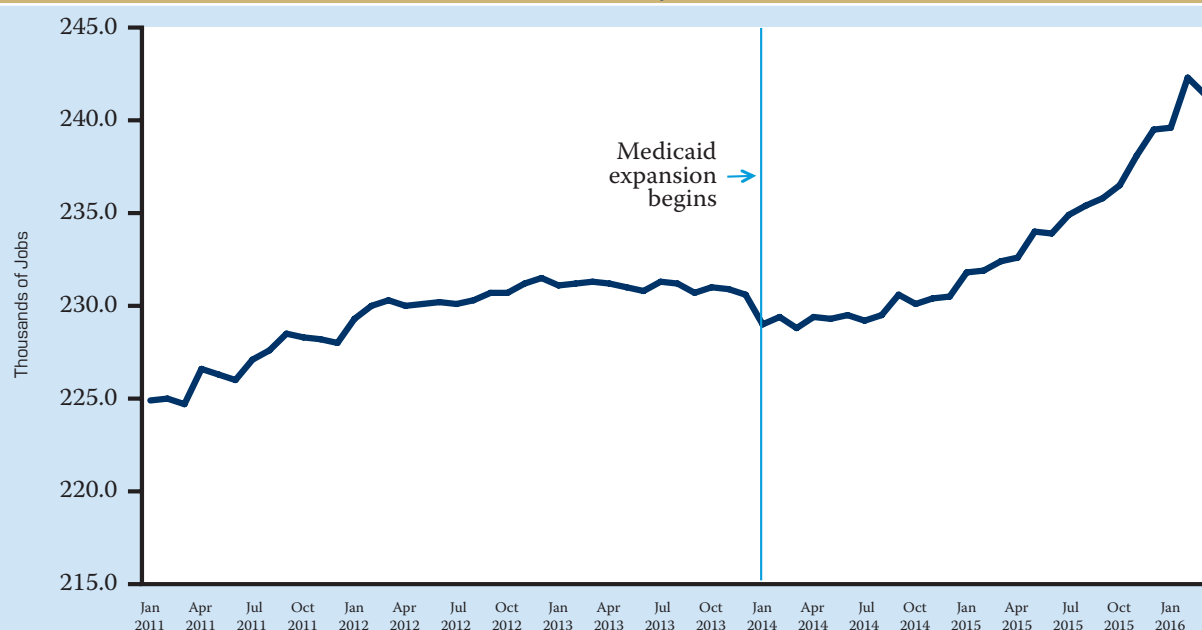
In Kentucky, increased coverage has so far led to better access to services, including the many preventive services on the essential list. State Medicaid data shows hundreds of thousands of people are using their new coverage for cost-effective preventive services. Comparing 2013 to 2014, the following services were funded by Medicaid:²⁴

- Cholesterol screening, 80,769 to 170,514 (up 111 percent)
- Preventive dental services, 73,739 to 159,508 (up 116 percent)
- Hemoglobin A1c tests (diabetes), 52,685 to 101,360 (up 92 percent)
- Cervical cancer screenings, 41,613 to 78,281 (up 88 percent)
- Breast cancer screenings, 24,386 to 51,292 (up 111 percent)
- Annual influenza vaccinations, 14,090 to 34,305 (up 143 percent)
- Colorectal cancer screenings, 17,164 to 35,633 (up 108 percent)
- Tobacco use counseling and interventions, 406 to 1,094 (up 169 percent)

Although each service does have a cost, the services being used by the expansion population are, for the most part, not the services that drive overall Medicaid spending. These enrollees are relatively cheap to cover and the coverage allows them to maintain health and continue working and caring for their families. And when a screening does indicate cancer or diabetes, it is still money well-spent. Left undiagnosed or untreated, these conditions worsen and become more complicated (and expensive) to treat later.

Medicaid expansion also has direct economic benefits for the Commonwealth. \$2.9 billion in federal funds were brought into Kentucky to fund this program as of mid-2015 — funds that go to Kentucky providers, hospitals and other health sector workers. Increased health insurance coverage has driven down uncompensated care in hospitals.²⁵ And, as a recent Kentucky Center for Economic Policy analysis of BLS data found, after modest growth in health care and social assistance jobs during the first year of Medicaid expansion, growth picked up at a rapid pace in 2015. The analysis found 4.6 percent job growth in the sector from 2014 to 2016, compared to 3.1 percent growth in other sectors (see graph below).²⁶ That growth results in income and sales tax revenue to the Commonwealth.

Health Care and Social Assistance Jobs in Kentucky



Source: KCEP analysis of Bureau of Labor Statistics data.

Clearly, Kentucky is getting benefits for the dollars it will spend on Medicaid expansion. In addition to those mentioned above, there is a direct budgetary benefit: a net savings of \$53.6 million in the 2-year state budget because the federal government now pays for things the state paid for in the past. The table below demonstrates these savings. Services such as behavioral health, some public health services, breast and cervical cancer screening, medical care for incarcerated individuals and several other budget line items will be reduced or removed from the state budget because they are now funded by federal dollars. This amounts to \$264.9 million in savings over two years. During the same two years, as Kentucky begins paying its first share of Medicaid expansion, the cost to the Commonwealth for that expense will be \$211.3 million.²⁷

Savings and Cost of Medicaid Expansion in the State Budget

	FY 17	FY 18	Total
Dept for Behavioral Health, Development & Intellectual Disabilities	-\$30.6	-\$31.2	
Dept for Public Health	-\$11.9	-\$12.2	
Dept of Corrections	-\$11.5	-\$11.7	
Quality Care Charity Trust Fund (QCCT)	-\$18.5	-\$18.9	
Dept for Community Based Services	-\$1.1	-\$1.1	
Subtotal	-\$73.6	-\$75.1	-\$148.7
Breast and Cervical Cancer Screening	-\$1.9	-\$2.0	
Spend Down Recipients	-\$37.2	-\$37.2	
Ky Transitional Assistance Program /TANF	-\$9.5	-\$9.2	
Nursing Facility-short term	-\$9.5	-\$9.7	
Subtotal	-\$58.1	-\$58.1	-\$116.2
Total	-\$131.7	-\$133.2	-\$264.9
State Cost for Medicaid Expansion	\$62.3	\$149.0	\$211.3
Net	-\$69.4	\$15.8	-\$53.6

Millions of dollars. Sources: Cabinet for Health and Family Services; OSBD, "General Fund 2016-2018 Budget Analysis."

In the long term, these health, economic and budgetary benefits will only grow as access to care preserves health and prevents more expensive complications later and as improved health leads to greater workforce participation.

1115 Waivers: Purpose, Current Programs, Impact

States have long used Section 1115 waivers to modify parts of their traditional Medicaid programs to extend benefits to special target groups, test new models of payment or service delivery or for other demonstration programs. Since 2013, several states have also used 1115 waivers to expand Medicaid as allowed by the ACA, but with state-specific variations approved by CMS for demonstration purposes. This section provides background on the legal authority and purpose for 1115 waivers as well as the current status of these waivers used for Medicaid expansion in other states.

Purpose and Legal Authority for 1115 Waivers

Section 1115 of the Social Security Act was enacted in 1962 and allows for waivers to state Medicaid programs for “experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.”²⁸ Such waivers must be approved by CMS; CMS says in deciding whether a waiver will promote the objectives of Medicaid and CHIP, it considers whether the proposed program will:

- increase and strengthen overall coverage of low-income individuals in the state;
- increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- improve health outcomes for Medicaid and other low-income populations in the state; or
- increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

While reducing costs may be part of a waiver’s goals, the waiver must still meet at least one of the main Medicaid objectives listed above. Cost savings alone is not sufficient criteria for meeting Medicaid objectives.

Because these are *demonstration* waivers, they are time-limited. Approvals are usually for a five-year period, but can be extended in three-year increments with CMS approval. Additional requirements include federal budget neutrality, a 30-day public comment period prior to submission to CMS and at least two public hearings on two dates in different locations at least 20 days before submission.

Many states, including Kentucky, have used 1115 waivers for various initiatives and demonstrations over the years. Arkansas was the first to design a state Medicaid expansion using an 1115 waiver after passage of the ACA, and currently, six states are implementing Medicaid expansion through 1115 waiver programs. Although federal and state evaluations are underway for these demonstrations, results are not yet available (more on this on p.14 below). Brief descriptions of each approved 1115 state expansion program are provided below, with a bit more detail on Indiana because it is often cited as a potential model for Kentucky and because it is a more complex design than most.

Approved, Active Expansion Waivers in Other States

Indiana: Two Tiers, HSAs, Lockouts²⁹

Indiana’s Medicaid expansion 1115 waiver, coupled with a Section 1915 waiver, took effect on Feb. 1, 2015 and expanded on the prior “Healthy Indiana Plan.” Indiana has set up a two-tiered benefit system: the lower tier (HIP Basic) provides a more basic benefit package, is only available to those at or below 100 percent FPL, and requires co-pays but no premiums; the higher tier (HIP Plus) adds more benefits (dental, vision), requires a monthly premium payment (limited to 2 percent of income) into a Health Savings Account (HSA), and is the only tier available to enrollees above 100 percent FPL (up to 138 percent).

Lower-income enrollees may choose HIP Plus by paying premiums. In addition to enrollee and state payments, Indiana’s HSAs can accept contributions from third parties (employers, donors, etc). HSA funds can be rolled over from year to year if the enrollee participates in wellness programs. Medicaid funds can also be used for premium assistance toward purchase of employer-sponsored insurance plans for the expansion population. Individuals below 5 percent FPL pay \$1 per month in

premiums. Indiana was also approved for a 2-year test charging co-payments of \$25 for non-emergency use of the emergency room (ER) on all visits after the first. The first ER visit requires an \$8 co-pay, the normal federally allowed maximum for this service. This test was approved under a 1915 waiver (not the 1115 waiver) and includes both tiers of enrollees, including medically frail individuals; a control group of 5,000 people will continue to be charged \$8 for each non-emergency ER visit rather than \$25.

Though CMS does not often waive wrap-around benefits, it allowed Indiana to waive non-emergency medical transportation (NEMT) during the first year of the waiver (later extended until January 2016); in April 2016, the Office of Management and Budget approved an emergency CMS request to rapidly fund a patient survey on the impact of the NEMT waiver, to inform whether the provision will be renewed.³⁰ There are also three kinds of time limits on coverage: 1) a 60-day waiting period for coverage for people not making initial premium payments; 2) a waiver of the requirement (codified in federal statutes) to provide 3-month retroactive coverage to new enrollees who have received medical services that would have been covered had they been enrolled; and 3) authority to disenroll individuals above 100 percent FPL who fail to pay premiums, followed by a 6-month lockout period. Indiana first initiated lockout periods in 2007 under a previous waiver; no other current 1115 Medicaid expansion program has one. Federal regulations bar disenrollment of individuals below 100 percent FPL for non-payment of premiums, but individuals below 100 percent FPL in HIP Plus who fail to pay premiums are moved into HIP Basic.

Arkansas: Private Option with HSAs³¹

Arkansas was the first state to expand Medicaid using an 1115 waiver, securing CMS approval in September 2013. The Arkansas approach is to use Medicaid funds as premium assistance to purchase silver-level Qualified Health Plans (QHPs) on the ACA marketplace (Arkansas uses the federal exchange, healthcare.gov, for this). Enrollees must have a choice of at least two plans in the marketplace. Arkansas covers adults up to 138 percent FPL under this program. The expansion population must enroll in QHPs in order to receive Medicaid services, but the state still provides Medicaid-required services (called

1115 Waivers: Frequently Used Terms

100 percent FPL: The poverty line. People at or below the poverty line are exempt from many cost-sharing or disenrollment provisions in Medicaid. For 2016, 100 percent FPL is \$11,880 for one person and varies by family size; it is \$24,300 for a family of four.

EPSDT: Early periodic screening, diagnosis and testing, a mandated service for children under 21 enrolled in Medicaid.

HSA: Health Savings Account. An account, usually set up by the state, to hold state, enrollee and sometimes third party cost-sharing contributions, to be used for health care expenses.

Lockout: A period of time during which a disenrolled individual (for failure to pay premiums) is barred from re-enrolling in Medicaid coverage.

Medically frail: People who have intensive medical needs. Each state has its own definition, but must include disabling mental disorders, serious and complex medical conditions, etc. CMS requires that the medically frail be exempt from waiver conditions limiting full access to benefits.

NEMT: Non-emergency medical transportation, a Medicaid-mandated benefit.

Premium assistance: The use of Medicaid funds to purchase private plans (including ACA marketplace QHPs) for enrollees. Also called the “private option.” Potentially could reduce churn in and out of Medicaid, but may be more expensive than regular expansion.

Wrap-around services: States must provide the full list of mandatory Medicaid benefits (see page 3). When states enroll Medicaid beneficiaries into private insurance plans that do not include some of the mandatory benefits, the states must offer the additional services as a “wrap-around” to accompany the private/QHP coverage.

“wrap-around services”) that are not included in QHP plans — such as NEMT and EPSDT (see box on page 11 for definitions). Arkansas also set up HSAs to which enrollees pay monthly contributions (ranging from \$5-\$25) to be used toward out-of-pocket health costs. HSA participation is not mandatory, but people who do not participate and are above 100 percent FPL still have co-pay requirements. There are special exceptions to the standard program for medically frail individuals.

Montana: Third-Party Administrator, Premiums and a Wellness Program³²

Montana’s Medicaid expansion for adults up to 138 percent FPL took effect Jan. 1, 2016 under an 1115 waiver coupled with a 1915(b) waiver. For service delivery, collection of premiums and co-pays, and administrative functions, Montana has contracted with a Third-Party Administrator (TPA) to provide all services within its network, waiving the usual Medicaid requirement for freedom of choice of providers. Services are provided on a fee-for-service basis. Certain vulnerable groups are exempt from using the TPA services. Premiums are charged for enrollees at 51 percent FPL and above, and cannot exceed 2 percent of monthly income. Enrollees above 100 percent FPL can be disenrolled for failure to pay premiums, though participation in wellness programs can sometimes exempt people from disenrollment. Total out-of-pocket expenses for premiums and co-pays cannot exceed five percent of income. Montana also includes 12-month continuous eligibility for enrollees, so income fluctuations within the year do not affect enrollment.

New Hampshire: From Expansion to 1115 Waiver, Private Option³³

Like Kentucky, New Hampshire initially expanded Medicaid by enrolling adults up to 138 percent FPL into the state’s Medicaid managed care plans. But, with a CMS-approved 1115 waiver, New Hampshire transitioned to a premium assistance program starting in January 2016. This program (similar to Arkansas model) provides funds to eligible families to purchase silver-level QHP coverage through the ACA health insurance marketplace. Medically frail individuals are exempt and will remain in Medicaid managed care. Enrollees must have a choice of at least two QHPs. New Hampshire will provide wrap-around benefits through its regular Medicaid program and will maintain cost-sharing consistent with the pre-existing state plan, with out-of-pocket expenses capped at five percent of income.

Michigan: Managed Care, HSAs, Wellness Incentives³⁴

Michigan’s initial 1115 expansion waiver was approved in December 2013 and has since been modified. The current program covers adults up to 138 percent FPL and uses managed care plans for service delivery. Cost-sharing is included, with premiums charged at two percent of income (for those above the poverty line) and co-pays for services, with total out-of-pocket spending capped at five percent of income. Failure to pay premiums does not result in disenrollment. Michigan sets up HSA accounts to hold state and enrollee contributions; the account balance can be rolled into a voucher for purchase of a private insurance plan if the individual becomes ineligible for Medicaid at any point. Michigan also uses a wellness program as an incentive; practicing certain positive health behaviors results in lower cost-sharing requirements. Starting in 2018, individuals who do not participate in wellness programs will be shifted out of managed care plans and given premium assistance to purchase QHPs. In March 2016, CMS approved an amendment to Michigan’s 1115 waiver to expand coverage and waive cost-sharing requirements to residents of Flint affected by the water contamination emergency.

Iowa: Premiums, Wellness Incentives, Waives Non-Emergency Medical Transportation³⁵

CMS approved Iowa's 1115 Medicaid expansion plan in December 2013, though the original program has been amended. Iowa initially required expansion enrollees with incomes from 101 percent to 138 percent FPL to enroll in QHPs, then (due to a lack of QHP competition) shifted to voluntary QHP or managed care enrollment, and finally (when the state's only QHP would no longer accept new Medicaid enrollees) Iowa began routing all new enrollees into managed care plans as of January 2016. Iowa charges premiums of \$5 to \$10 per month starting in the second year of enrollment, with exemptions for the medically frail, and potential to waive premiums for individuals participating in wellness activities. Individuals who fail to pay premiums can be terminated from coverage if they are above 100 percent FPL, but can re-enroll any time without a lockout period. Iowa's program also waives NEMT as a Medicaid benefit for a one-year trial period.

Components Rejected by CMS in 1115 Waiver Applications

Many requests have been made to CMS to waive standard benefits or go beyond federal cost-sharing caps, and these are not often approved.³⁶ To date, CMS has denied:

Premium and cost-sharing requests:

- Michigan's request to extend the maximum out-of-pocket cap from five percent to seven percent of income.
- Multiple states' requests to charge premiums exceeding two percent of income.
- Two states' requests to charge higher than federally-allowed (i.e. \$8) cost-sharing for non-emergency use of the ER.
- Requests to impose premiums for people below the poverty line, if payment is a condition for eligibility.

Disenrollment, lock-out and waive retroactive requests:

- Pennsylvania's request to impose lockout periods for non-payment of premiums.³⁷
- Pennsylvania and Iowa's requests to waive three-month retroactive coverage.
- Iowa's request to disenroll individuals below 100 percent FPL for non-payment of premiums.

Benefit-reduction requests:

- Pennsylvania's request to waive all wrap-around benefits (i.e. Medicaid-mandated services not included in QHPs under a private option program.)
- Iowa's request to waive wrap-around benefits for enrollees above 100 percent FPL in QHPs through the private option.
- Iowa and Pennsylvania's requests to waive free choice of family planning providers.
- Iowa's request to waive EPSDT services for newly eligible 19-20 year olds.
- Indiana's request to waive EPSDT for children 19-20 years old who did not make the required HSA contributions.
- Arkansas' request to limit NEMT to eight trip legs annually.

Work requirements:

Indiana and Pennsylvania's requests to impose work-related requirements for Medicaid eligibility (CMS has not approved employment-related requirements in any 1115 proposal).

Partial expansions:

In guidance released in December 2012, CMS said it would not approve partial expansions (to less than 138 percent FPL) at the enhanced (100 percent federal) FMAP rate. States may request partial expansions (for example, for adults only up to 115 percent FPL) but these would only be eligible for the state's regular FMAP matching rate rather than the enhanced federal match.³⁸

Enrollment caps:

CMS has said enrollment caps “do not further the objectives of the Medicaid program, which is the statutory requirement for allowing section 1115 demonstrations. As such, we do not anticipate that we would authorize enrollment caps or similar policies through section 1115 demonstrations for the new adult group or similar populations.”³⁹

Evaluating Common 1115 Provisions

Pending Studies

Evaluation data for the current state expansion programs using 1115 waivers is, for the most part, not yet available. Several state and federal evaluations are pending or underway, including a CMS-initiated “cross-state” evaluation that will have final results publicly available in 2019 but with interim results available along the way.⁴⁰ Indiana's program has at least three evaluations pending (a state-contracted evaluation, a federally-contracted evaluation and the rapid evaluation of the NEMT waiver).

A recent policy brief from the Center on Budget and Policy Priorities points out several issues that suggest Indiana's implementation varies from the state's approved plan and emphasizes the need for robust evaluation before states like Kentucky, Ohio and Arizona consider duplicating aspects of Indiana's plan. For example, Indiana is likely vastly overestimating the number of enrollees with very low incomes, therefore actually charging lower premiums than should be the case under the program (the minimum premium of \$1 per month rather than a higher amount based on percent of income). This likely makes premiums much easier to collect and administer, but as the brief points out, participation and compliance rates will not be indicative of the impact of the program as designed. Similarly, third party payments into Indiana HSAs are largely informal and not being reported to CMS, which means “the demonstration is not a true test of the impact of premiums on enrollment and utilization of services.”⁴¹

Across states, some 1115 waiver components may or may not affect access or cost, but are not proven to be better than standard Medicaid programming. Premium assistance (the private option) has not yet been thoroughly tested, so the costs and effectiveness compared to regular Medicaid are inconclusive. Wellness incentives have not been shown to be effective, nor have they been shown to be harmful, though Families USA recommends that wellness programs should be formulated as incentives (gift cards, gym memberships) rather than as penalties tied to eligibility in order to avoid disruptions in coverage and access.⁴²

Meanwhile, as we await further evaluation of some waivers and components, many common program components used in states' waivers (premiums, HSAs, disenrollment and lock-outs) *have* been evaluated under traditional Medicaid and CHIP programs for many years. From this research, two main concerns emerge regarding common waiver components: administrative inefficiency, and disrupted access to care (often resulting in poor health outcomes and increased costs in the long term).

Administrative Inefficiency: Cost of Collection May Exceed Revenue Collected

Creating new requirements for premiums or HSA payments also means creating state administrative structures to bill, collect, track, answer customer questions and otherwise administer the program, including tracking expenditures against each enrollee's income to ensure that premiums collected remain under federal caps. This tracking would require either expanded state government structures, or having the state contract (and oversee) the service to a third party.

Studies from other states have examined the costs of collecting premiums in Medicaid programs and found that the costs of collection would exceed revenue collected. For example, several years ago Virginia introduced \$15 monthly premiums to some families, but cancelled the program when the data showed the state was spending \$1.39 to collect each \$1 in premiums.⁴³ Arizona concluded that even if it charged the maximum allowed premiums, it would cost four times more to collect them than the value of the collected funds.⁴⁴

Regarding HSAs, the Urban Institute examined the evidence and concluded, "HSAs for the poor are highly likely to be administratively inefficient. The amounts collected from individuals would be small relative to health care costs. Because there are large numbers of individuals in these programs, there would be a relatively large number of small monthly transactions. Similarly, the money that flows out of these accounts, also small amounts each time a service is used, would have to be managed.... Although these payments may lead to lower enrollment rates and more disenrollment, it is unlikely they will lead to more appropriate use of care by enrollees."⁴⁵

Decreased Access to Services, Impact on Health and Increased Costs

Many components in active 1115 waivers raise concerns about creating access barriers for Medicaid enrollees who need health care services. The negative effects of cost-sharing requirements on access to care and health status have long been studied by health services researchers and health economists.

Premiums in particular have been shown to create a barrier for health coverage for many low-income individuals - especially those below the poverty line. For instance, Oregon received approval in 2003 to increase the premiums it charged participants in its Medicaid waiver program and also impose a six-month lock-out period for non-payment of premiums. A study found that following these changes, enrollment in the program dropped by almost half. Similar effects occurred with programs in Utah, Washington and Wisconsin.⁴⁶

There is also evidence that disruptions in access (from premiums, cost-sharing, disenrollment and lock-out periods) ultimately lead to *higher* health care spending on the individuals who have experienced the access disruptions. The studies are numerous; three are briefly summarized here as illustrative examples.

In a study published in the *Journal of the American Medical Association*, adding co-payments for prescription drugs for low-income individuals resulted in fewer prescriptions being filled, a 78 percent increase in poor health outcomes (including hospitalization and death), and an 88 percent increase in ER visits.⁴⁷ In a study published in the journal *Health Affairs*, Medicaid enrollees in Oregon who left the program due to increases in cost-sharing used less primary care and more ER visits after disenrollment than their counterparts who left the program for reasons unrelated to cost-sharing.⁴⁸ And, a study published in the journal *Medical Care* showed that diabetic patients who experienced Medicaid coverage lapses of a month or more had higher spending after a lapse compared to before a lapse, with an average increase of \$239 per member per month for three months; this was due to increased inpatient and ER episodes after a coverage lapse.⁴⁹ Overall, creating coverage and access barriers may temporarily save some funds, but often results in more spending (on expensive ER care and poor health outcomes) later.

Considerations for a Kentucky Waiver Process

Given the complexity of Kentucky's Medicaid program and its success to date, along with the available evidence on waiver options for modifying the expansion program, Kentucky's health policy leaders should consider the following principles in any waiver design.

- **Improved, not Decreased, Access to Coverage and Care.** Any change made to the program must be to improve the program in terms of the goals of broader coverage, strengthening provider networks, improved health outcomes and/or transformation of service delivery networks. Consider which criteria are being “claimed” on the CMS list (p.8) of how waivers can meet Medicaid program objectives. Cost savings alone is insufficient.
- **Public Participation.** True public participation should be sought and respected throughout the process. This should include public discussion, comment and debate beyond the minimum federal requirements. Consultations should be accessible to a wide audience including Medicaid enrollees, providers, consumers, advocates and others. Kentucky has a well-informed, active group of stakeholders and citizens whose input should be heard.
- **Evidence-Based Decision Making.** Research and evidence should guide decisions about the program design. Other states and programs have valuable experiences (successful and unsuccessful) to learn from. We should look not only at other states' designs, but at actual experiences and results, rigorous evaluations and related studies from the health services research literature. We should not move forward on strategies that are being tested in other states, such as Indiana's aggressive waiver, but not yet evaluated.
- **Improved, not Decreased, Efficiency.** Changes should not introduce onerous administrative costs or inefficiencies. For example, certain cost-sharing ideas including premiums and HSA payments can introduce significant new administrative burdens to the Medicaid system.
- **Long-Term Impact.** Ideas should be examined in light of their long-term impact on the well-being of Kentuckians. We should beware of temporary savings that lead to long-term higher costs such as lower coverage and access that will result in higher spending in the future because of untreated health problems.
- **Robust, Independent Evaluation.** Any waiver design for Kentucky must include a plan for independent, third-party evaluation of the program and the state should commit to public transparency about costs and other data associated with the waiver.

Medicaid is of enormous importance to Kentucky's health, and the state's Medicaid expansion has brought tremendous benefits to the Commonwealth. While improvements can surely always be made, we must take care not to undermine our successes or impair our fellow Kentuckians' access to essential health care services. We can make decisions that are good for the budget, good for the workforce, good for health care providers and good for our families, friends and neighbors.

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