Medicaid Waiver Stakeholder Convening

Stakeholder Input Report

May 2016

FOUNDATION FOR A HEALTHY KENTUCKY

Investing in communities. Informing Health Policy

Executive Summary

Kentucky has been operating an expanded Medicaid program since January 2014, as permitted under the Affordable Care Act (ACA). Nearly half a million Kentuckians have gained coverage through Medicaid expansion, making Kentucky the state with the greatest decrease in its uninsured rate. Most other states seeking and using 1115 waivers in the post-ACA era, have sought to expand eligibility for Medicaid. Because Kentucky has already achieved expanded coverage and the highest drop in uninsured in the nation, the 1115 waiver program could allow Kentucky to go beyond expanded coverage and to test new cost-effective approaches to providing accessible, quality health care for Kentucky's Medicaid beneficiaries.

The Foundation is committed to increasing access to care, decreasing health risks and disparities, and promoting health equity. We convened a meeting on May 12, 2016, to offer diverse stakeholders an opportunity to inform the 1115 waiver process. This diverse group of stakeholders heard two background presentations—one on Medicaid and the ACA, and the other on 1115 waivers implemented in other states since the ACA. The participants, organized by stakeholder group type, then held discussions to answer a set of open-ended questions.

Stakeholder Groups in Attendance:

1. **Physical and oral health providers**
2. **Behavioral health providers**
3. **Consumers and consumer advocates**
4. **Public health professionals**
5. **Health systems**
6. **Payer**
7. **Colleges/Universities**

Foundation staff performed qualitative analysis of the information submitted by participants in response to these questions, and were able to group responses into eight (8) themes.

Themes:

1. ***Cost-sharing and Penalties***
2. ***Incentives***
3. ***Benefits***
4. ***Reimbursement***
5. ***Systems Improvements***
6. ***Health Systems Transformation***
7. ***Current Medicaid Expansion***
8. ***Evaluation***

Additionally, two overarching themes were identified, which we have termed Integrated Care and Social Determinants of Health.

Cost-sharing and Penalties: Participants had diverse perspectives on this matter, ranging from opposing any cost-sharing in Medicaid to proposing specific premium and co-payment amounts. On the other hand, participants were unified in opposing penalties to enforce cost-sharing provisions.

2. **Incentives**: Participants were generally very supportive of implementing incentives for healthy behaviors such as smoking cessation and health risk assessments. Incentives might be reductions in the amount of cost-sharing or themselves supportive of healthy behavior (e.g. gym membership). Several indicated they wanted incentive practices to be evidence-based.

3. **Benefits**: Discussion of benefits ranged from participants advocating for retaining current Medicaid benefits to expanding existing benefits (i.e. expanded substance use treatment) to adding new benefits (i.e. housing, Uber as reimburseable transportation). There was limited interest in exploring tiered benefits, with the caveat that medically necessary services should be covered for all enrollees.

4. **Reimbursement**: Primary discussions in this category revolved around streamlining and accelerating the reimbursement process; increasing reimbursement rates to providers; and adding new categories of services and providers to be reimbursed (i.e. community health workers, telehealth, and home health).

5. **Systems Improvement**: Participants identified several areas that could be improved in the current Medicaid delivery and payment system. Suggestions for improvement included simplifying administrative processes for providers; expanding provider scope of practice of some health care providers; adding review panels; reducing the number of Medicaid Managed Care Organizations (MCOs) currently in the Medicaid system; creating a single formulary for all MCOs; and aligning all existing Medicaid waiver populations under the 1115 waiver program.

6. **Health Systems Transformation**: Conversations around 1115 waivers as opportunities to explore new ways of delivering and paying for care included enhancing price transparency, for example through the use of an All Payer All Claims Database; improving consumer health literacy; moving from volume-based to value-based and outcomes-based payment for care; and moving beyond coverage issues to addressing access and quality.

7. **Current Medicaid Expansion**: Many participants expressed opposition to changing the existing Medicaid expansion program.

8. **Evaluation**: Participants offered many ideas around the process and the metrics that should be employed for an 1115 waiver evaluation. Specifically, participants wanted the evaluation process to be inclusive of stakeholders and for findings to be shared publicly periodically.

Two overarching themes were identified from participants' comments: **Integrated Care** and **Social Determinants of Health**. While neither of these themes was discussed or presented in the issue brief or opening presentations, they came up in discussion frequently. Integrated Care – specifically, integration of behavioral health with primary care services (and in some groups oral health was also included) -was mentioned by the Consumer/Advocate group, the Behavioral Health Provider group, and the Colleges/Universities group. Social Determinants of Health – environmental factors such as housing, access to social services, nutritious food- was mentioned by the Payer group, the Physical and Oral Health Provider group, the Consumer/Advocate group, and Behavioral Health Provider group. These topics were referred to by name and also described by participants without necessarily calling them "integrated care" or "social determinants of health." Suggestions under these two themes are captured above under the Health System Transformation, Systems Improvement, Benefits, and Reimbursement categories.

The ACA requires an opportunity for public comment and transparency of section 1115 demonstration projects. Among other things, states *must* hold at least two public hearings, which *must* be held at least 20 days prior to the state's submission to the Center for Medicare and Medicaid Services (CMS). Once a state submits an application to CMS and the application is found to be complete, CMS will post the state's application on Medicaid.gov and initiate a 30-day federal comment period. The Foundation encourages all stakeholders to actively participate in the pre-submission public comment period at the state level and the post-submission comment period at the federal level.

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Introduction

In January 2016, Governor Matt Bevin announced the Commonwealth of Kentucky's intent to pursue a Medicaid Waiver under the Centers for Medicare and Medicaid Services (CMS) waiver authority, Section 1115 of the Social Security Act. Section 1115 waivers allow states to test new approaches in Medicaid that differ from federal program rules.

Kentucky has been operating an expanded Medicaid program since January 2014, as permitted under the ACA. Nearly half a million Kentuckians have gained coverage through Medicaid expansion, making Kentucky the state with the greatest decrease in uninsured rate. While other states seeking 1115 waivers in the post-ACA era are seeking to expand eligibility for Medicaid and therefore decrease their uninsured rate, because Kentucky has already successfully expanded eligibility and coverage under Medicaid and decreased the uninsured rate, this 1115 waiver program could allow Kentucky to go beyond coverage and test new, cost-effective approaches to providing accessible, quality health care for Kentucky's Medicaid beneficiaries.

This report captures the comments submitted by the various stakeholders at an all-day convening at the Foundation for a Healthy Kentucky on May 12, 2016. This document presents the perspectives and views of the physical, behavioral and oral health providers; consumers and consumer advocates; public health professionals; academic researchers; health system representatives; and payers who attended this event. They are not necessarily the views of the Foundation.

Convening

The mission of the Foundation for a Healthy Kentucky is to address the unmet health care needs of Kentuckians. We are committed to playing a role in assuring that Kentucky's most vulnerable populations have access to needed, quality health care. Medicaid is an important public benefit that provides access to physical, behavioral and dental health services for low-income individuals in our state. Kentucky's Medicaid program has gone through many changes in the past few years: from the shift to Medicaid Managed Care in 2011 to Medicaid expansion as permitted under the ACA in 2014, the program has been transformed in an effort to better meet the needs of Kentuckians. The significant increase in Kentuckians covered by Medicaid means new policies will affect even more individuals. Thus, gathering perspectives and input from diverse stakeholders to inform the state in crafting policies to best serve Kentuckians is more important than ever.

Stakeholder Groups in Attendance:

1. **Physical and oral health providers**
2. **Behavioral health providers**
3. **Consumers and consumer advocates**
4. **Public health professionals**
5. **Health systems**
6. **Payer**
7. **Colleges/Universities**

The Foundation is committed to increasing access to care, to decreasing health risks and disparities, and to promoting health equity. As such, we hosted a meeting on May 12, 2016 to convene diverse stakeholders to inform the 1115 waiver process.

We are grateful for all those who spent many hours with us, learning about 1115 waivers and providing their insights, experiences, and expertise with us and each other. This report seeks to faithfully capture the input provided by all those in attendance.

Methodology

The Foundation for a Healthy Kentucky contracted with the State Health Access Data Assistance Center at the University of Minnesota (SHADAC) to develop an issue brief on components of 1115 waivers approved by CMS since the ACA, examples of states that have implemented such components, and relevant research on the application of those components. That issue brief (and accompanying slides with the same content) provided the framework for the convening. This report is intended to be read with the SHADAC issue brief as background.

The convening started with background information on Medicaid and the ACA provided by Emily Beauregard, Executive Director of Kentucky Voices for Health. Following the background presentation, the SHADAC 1115 waiver issue brief was presented by Foundation staff (Gabriela Alcalde, Vice President, Policy and Program). Following the presentations, stakeholders engaged in table discussions and reported out the key points of the conversation. The Foundation for a Healthy Kentucky developed six (6) questions to facilitate discussion among stakeholders:

Discussion Questions:

1) *What are the main issues concerning Kentucky's Medicaid program that you would like to see addressed by an 1115 waiver?*
2) *What components that we've discussed today about 1115 waivers (premium assistance, premiums/monthly contributions, benefits, penalties, healthy behavior incentives) would you like to see Kentucky adopt and why?*
3) *What are the components that we've discussed today about 1115 waivers that you would not want to see Kentucky adopt and why?*
4) *An 1115 waiver provides an opportunity to test new approaches to improve access to and delivery of care for beneficiaries. Is there anything that we haven't discussed today that you would like to see changed in Kentucky's Medicaid program?*
5) *Some states have implemented 1115 waivers for specific populations or applied components differently for different populations. Given the components that you would like to see Kentucky adopt, should they be applied to some populations and not others? Why?*
6) *1115 waivers require evaluation of the demonstration projects. What do you want to learn from Kentucky's evaluation efforts?*

Participants were asked to sit at tables by self-identified group (provider, consumer, payer, etc.). A webpage was created with the six questions so that each discussion table could submit their comments online. A total of 14 tables participated in the discussion, and all 14 tables made submissions on the webpage.

The submissions were printed out by question and identified only by table number and group type. No individual or organizational names were collected or used in the submissions. Two Foundation staff performed thematic analysis of the submission notes independently of each other. Gabriela Alcalde MPH, DrPH and Erica Bindner-Wooten, MPA, JD, independently coded the transcript of the submitted notes. We then met to discuss the emerging themes and through a consensus process developed a list of themes and examples or excerpts from the transcripts for each theme. This step allowed us to conduct two separate and independent coding of the text from the submissions.

Once we created a first round of descriptive themes, all entries under each theme were listed and organized by each of the six questions. Next, staff performed analysis of the themes across questions. We found significant overlap in the themes. Final analysis of the various themes yielded eight (8) general categories of entries, plus a summative category we referred to as Overarching Themes—themes that came up across most questions and from most participating groups, but which were not presented as components of 1115 waivers in the issue brief or initial presentations.

The information presented in this report is the result of a qualitative research method known as grounded theory. This method allows for a range of perspectives to be identified. Qualitative research design is well-suited to this report as it allows for the development of a nuanced and rich understanding of complex issues and perspectives. This type of analysis is exploratory and provides a guide for further investigation. This type of research, however, cannot provide insights into individual perspectives or views; does not provide quantitative information; and cannot be generalized to other groups of people. Further, because we collected information through open-ended questions and the groups of various stakeholders were not equal in size, we cannot make comparisons among groups or at a more granular level than the general themes presented in this report.

Findings from each of the eight themes are listed below. We also provide some direct quotes to exemplify the themes. The findings of this report can inform further exploration and gathering of stakeholder perspectives and inform the development of policies and programs.

Findings

Cost-sharing and Penalties

According to Healthcare.gov, cost-sharing is defined as "[T]he share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums." Penalties refer to the negative or punitive consequences for not paying cost-sharing as required. Both cost-sharing and penalties have been implemented in various forms in other states as part of their post-ACA Medicaid 1115 waivers.

Stakeholders identified the following as issues for consideration in developing an 1115 waiver proposal:

1. Sliding scale premiums
2. Discount for healthy behaviors (such as receiving preventive screenings)
3. Employer–sponsored insurance (ESI) premium assistance
4. Coverage assistance for workers above 138% of the Federal Poverty Level (FPL)

Themes:

1. ***Cost-sharing and Penalties***
2. ***Incentives***
3. ***Benefits***
4. ***Reimbursement***
5. ***Systems Improvements***
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Stakeholders expressed support for including the following:

1. Cost-sharing for non-medically necessary services
2. Low co-payments ($5 suggested)
3. Premium assistance for ESI
4. Charging co-payments for non-emergent Emergency Department (ED) use (although some supported only low co-pays and others opposed all ED use co-payments)

Stakeholders indicated the following should be *excluded* from an 1115 waiver in Kentucky:

1. Penalties as a way to enforce healthy-behavior incentives
2. Cost-sharing and penalties (consumers, who called these taxes, stated that they would lose their coverage if cost-sharing was applied)
3. Cost-sharing (public health professionals, who noted that Kentucky saw a drop in enrollment when it implemented cost-sharing for KCHIP in 2003)
4. Penalties for non-payment
5. Lock-out periods
6. Cost-sharing for medically necessary services; with providers deciding what is medically necessary rather than payers
7. Disenrollment for non-payment

8. Cost-sharing that must be collected by providers (providers and health systems, who indicated they have no way to obtain payments)
9. Employment requirements and work referrals

In terms of tailoring cost-sharing approaches to specific populations, stakeholders felt that:

1. Cost-sharing should be required only for working adults above 138% of the FPL
2. No cost-sharing for children
3. Exempt individuals with high-utilization rates and case management
4. Exempt persons with chronic illnesses or disabilities
5. Exempt persons with Serious Mental illness (SMI)
6. Participants stated that they would consider:
    a) Cost-sharing for tobacco users
    b) Monthly premiums, of $5 maximum
    c) Enrollment fees, of $10 per year

Excerpts

"We overwhelmingly agree that lock-outs should not be included. We are also against premiums and HSA contributions. Our shared experience has been that we've been prohibited from denying care if a patient refuses or is unable to pay: therefore the desired behavior isn't actually enforced." Physical and Oral Health Provider group

"If the administration chooses to explore lock-outs we recommend that lock-outs be immediately lifted (upon payment) and payment be retroactive to the date the consumer re-enrolls." Behavioral Health Provider group

"All services, including waiver services, should include a co-pay, increasing the perceived value of the service." Behavioral Health Provider group

"Premium contributions—the evidence speaks for itself, enrollment has been shown to decrease across the board in KCHIP here in 2003 as well as in the states that implemented it recently." Public Health group

"...[do not want] consumer penalties or reverse penalties, including disenrollment or lock-out penalties—they are costly, but do not facilitate positive results." Consumer/Advocate group

"We do not support punitive measures such as lock-out provisions, because we feel that they are short-term measures that are likely to lead to long-term harm for patients and the system." Colleges/Universities group

"[We do not want] premium and penalty fees as most of the population eligible [for Medicaid] would not have [the] ability to pay the fees and be penalized and then [would] lose their coverage and providers have no way to obtain payment." Health Systems group

"[We] would like to investigate having a sliding scale premium implemented with a discount for healthy behavior." Payer group

Incentives

According to SHADAC, healthy behavior incentives are intended to encourage individuals to take actions aimed at improving their health and potentially reducing longer-term health care costs. These incentives have been implemented in a majority of the post-ACA Medicaid 1115 waivers.

Stakeholders supported rewards in general, but opposed penalties, and suggested the following healthy behavior incentives be considered in an 1115 waiver:

1. Positive, evidence-based healthy behavior incentives (HBI)
2. Preventive screenings
3. Individual assessments upon enrollment
4. Case management based on individual assessment results

Of the components that were discussed in the issue brief and presentation, stakeholders supported including incentives for the following:

1. Tobacco cessation
2. Fitness center membership
3. Nutrition therapy
4. Healthy cooking classes
5. Wellness programs, such as Humana Vitality
6. Dental health incentives

7. Behavioral health incentives
8. Incentives for well-visits and women's health

Stakeholders also were interested in seeing the following:
1. Incentives to work and/or volunteer
2. Incentives for preventive screening by reduced cost-sharing
3. Annual health risk assessments, performed by Medicaid Managed Care Organizations (MCOs)

Excerpts

"We would like to see a focus on incentives instead of penalties." Payer group

"Implement healthy behavior incentives similar to those offered in private market such as allotment for fitness center memberships, incentives for nutrition therapy participation…." Public Health group

"We would like to see evidence-based positive incentives." Consumer/Advocate group

"Healthy behavior incentives as well, is a positive, and reduces cost to providers." Health System group

"[We would like to see] the use of behavioral health incentives." Behavioral Health Provider group

"Positive incentives to encourage healthy behavior." Physical and Oral Health Provider group

"We could support a menu of incentives, not punitive measures, for adopting and undertaking preventative services." Colleges/Universities group

Benefits

According to Healthcare.gov, benefits are "[T]he health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules." Some states have modified their benefits package through their 1115 waiver programs.

Stakeholders indicated that the following should be considered for the 1115 waiver:

1. Dental and vision care (with no cost-sharing)
2. Health literacy education
3. Transportation (including non-emergency transportation)

4. Housing support
5. Employment assistance
6. Care coordination and management for high-cost individuals
7. Care coordination for all enrollees
8. Social support services (housing, transportation and nutrition)
9. Services that address the social determinants of health
10. If tiered benefits are implemented, then all medical, dental and behavioral should be included for everyone at no cost, and non-medically necessary services (as determined by a health care provider) can be the second tier with some cost-sharing

Stakeholders expanded upon this list when asked for ideas not addressed in the issue brief and initial presentation:

1. Improve adult dental services and coverage
2. Preventive services for all enrollees
3. Group therapy
4. Home health
5. Expanded treatment for opioid addiction
6. Vision and hearing coverage, including adaptive technologies
7. Reimbursement for "Uber"
8. Community-based services
9. Housing assistance
10. Wrap-around services
11. Mobile services/mobile clinics
12. Expanded substance use services and coverage

Participants said that special consideration should be given to continuity of care for re-entry populations (those who have been involved in the criminal justice system) and to persons with a substance use diagnosis. Additionally, participants said that the following tailored benefits should be considered:

1. Housing for Seriously Mentally Ill (SMI) and those with an addiction diagnosis at risk of homelessness
2. Presumptive eligibility for pregnant women
3. Case management for high utilizers
4. Special and additional benefits for substance use treatment
5. Services for autism
6. Use of behavioral health incentives for mental health diagnosis

7. More services for those under 100% of the FPL
8. Free care policy for school-based health services

Stakeholders opposed:

1. Excluded benefits
2. A tiered benefits system was opposed by some
3. Transportation exclusions, as transportation is critical to access in rural areas

Excerpts

"We believe any waiver should include a focus on the opioid epidemic facing our state. Waivers should include expansion of treatment options, support for providers in appropriate treatment of pain, educational resources for providers and family support." Behavioral Health Provider group

"We would not like to see any reduction in benefits until new or innovative benefits are established." Payer group

"We do not want tiered benefits (especially for adult dental) because a tier benefit system cannot be better than what we currently have." Consumer/Advocate group

"Should be the same, because everyone deserves the same care." Physical and Oral Health Provider group

"Providing a Home Health component to all that would be eligible for the 1115 waiver is strongly recommended." Physical and Oral Health Provider group

"We discussed more aggressive interpretation and incorporation of telehealth/virtual care within the care coordination paradigm." Colleges/Universities group

Reimbursement

According to Medicaid.gov, "States can establish their own Medicaid provider payment rates within federal requirements. States generally pay for services through fee-for-service or managed care arrangements." Kentucky implemented Medicaid managed care at the end of 2011. Except for current waiver populations, Medicaid is delivered through a managed care system. "Under managed care arrangements, states contract with organizations to deliver care through networks and pay providers."

Below is a list of the numerous reimbursement issues that stakeholders said should be considered, regardless of whether they had been addressed by other states.

1. Increased reimbursement for behavioral day services
2. Fixed same-day billing of same provider agency (including FQHCs)
3. Fixed same-day billing of same code, different provider (including FQHCs)
4. Outcomes-based reimbursement
5. Incident billing, to enable reimbursement of cost for unlicensed personnel
6. Home health care
7. Telehealth (to incentivize more providers to use telehealth)
8. Behavioral "drop-in" centers
9. Peer-to-peer models
10. Bundled payments
11. Reimbursement for community health workers (CHWs)
12. Increased reimbursement rates for all providers
13. Presumptive eligibility for home health
14. Incentives for Patient-centered Medical Homes (PCMHs) through reimbursement
15. Reimbursement for registered behavior technicians (RBTs)
16. Elimination of Institutes of Mental Diseases (IMD) exclusion
17. Reimbursement for Uber
18. Mobile clinics
19. Reimbursement for wrap-around, social support services
20. Free care policy for school-based health services

Excerpts

"Expand compensation for telehealth services to address rural disparity in available providers for primary and acute care services and decrease emergency room use in these populations." Public Health group

"Smaller agencies should be reimbursed for providing community-based services, community health workers, and home–based care services." Consumer/Advocate group

"We support the adoption of free care policy and reimbursement for schools billing Medicaid." Behavioral Health Provider group

"[To] incentivize providers to participate in Medicaid—improved reimbursement, reduced paperwork." Physical and Oral Health Provider group

"May introduce bundled payments by services including health homes for targeted complex conditions, initially." Payer group

"The expansion coverage currently adopted in Kentucky seems to be a good idea, however, in reality it is still not effective in getting providers paid in a timely fashion." Health Systems group

"Incentivize primary care providers and health homes to extend primary care to public school clinics." Colleges/Universities group

System Improvement

Various topics concerning systems improvement came up in all but the evaluation question discussions. System improvements refer to ways to make the current Medicaid delivery and financing system more effective, efficient and responsive to enrollees and providers.

Stakeholders said it is important to assess how the system works and provided some ideas for system review:

1. Create independent review panels
2. Establish (independent) quality assessment and assurance mechanisms
3. Specific regulatory and administrative changes that were cited:
    a. Expand scope of practice for various health care providers
    b. Provider licensing processes

Participants said the current system is highly complex and suggested the following as ways to simplify:

1. Eliminate MCOs
2. Reduce the number of MCOs
3. Use a non-profit third party to manage care

Various groups brought up the lack of sufficient providers accepting Medicaid and new Medicaid patients. They made the following suggestions for addressing this problem:

1. Establish consistency in administrative requirements across all MCOs
2. Prior authorization is currently a barrier to treatment and needs to be addressed
3. Length of stay is currently too short for behavioral health and substance use
4. Several issues pertaining to provider credentialing were raised:
    a. Need to streamline process
    b. Should not take longer than 2 weeks
    c. Process should be consistent across MCOs
    d. Medicaid and MCO processes should be combined to reduce burden on providers
5. Address same-day billing issues
6. Increase reimbursement rates
7. Provide positive incentives for provider participation in Medicaid
8. Increase the number of providers accepting Medicaid and accepting new Medicaid patients
9. Integrate physical and behavioral health at the MCO level
10. Implement "hotspot" tracking to improve care delivery
11. Develop mechanism to alert providers when enrollees lose coverage

Further, stakeholders identified several ways to create systems improvements:

1. Improve communications to enrollees
2. "Overhaul DCBS"
3. Establish independent review boards (technical assistance, audits and reviews should not be conducted by the same people)
4. Simplify regulations and administrative processes for providers
5. Create a single formulary for all MCOs
6. Increase the Medical Loss Ratio (MLR)
7. Monitor and enforce MCO contracts
8. Eliminate wait time on calls for providers
9. Keep retroactive payments/reimbursement for providers
10. Ensure due process for enrollees who lose coverage
11. Align all waivers and waiver populations

Excerpts

"We would like to see easy access to coverage for enrollees and timely payment to providers for services rendered." Health System group

"We believe the number of MCOs should be reduced to two and that the MLR [Medical Loss Ratio] requirement for these organizations should increase to 92%, as in Virginia." Physical and Oral Health provider group

"Streamline the prior authorization process across all managed care organizations to provide for consistency in patient access to needed services." Public Health group

"Make sure that Kentucky's new 1115 waiver that replaces current Medicaid expansion acts as an umbrella for all current Kentucky waivers and is inclusive of all Medicaid services." Behavioral Health Provider group

"Ensure transparency of Medicaid Managed Care Organization performance and outcomes." Consumer/Advocate group

"Would like to see streamlining administrative burden for all parties including the Medicaid recipients." Payer group

"Not doing things that will reduce access or disincentivize providers from participating in the program [Medicaid]." Colleges/Universities group

Health System Transformation

The Centers for Disease Control and Prevention explains Health System Transformation this way: "The US 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.

The theme of health systems transformation came up frequently in three of the questions. Below are the issues that were discussed by various groups:

1. All interventions should be evidence-based
2. Kentucky is ready to move beyond coverage issues
3. Kynectors should assist with education, enrollment, and accessing services
4. Care coordination should be provided for high need individuals (for example, incarcerated populations, refugees)
5. Use of community health workers (CHW)
6. Implementation of medical-legal partnerships
7. Health literacy and promotion efforts
8. Interdisciplinary teams, including pharmacists
9. Co-location of urgent care centers with Emergency Departments
10. Use and reimbursement of Recovery Oriented Systems of Care

Issues that were not addressed in the issue brief or presentation that came up in the discussion:

1. Price transparency (APCD, Kentucky Health Data Trust)
2. MCO performance reviews
3. "Systematic facilitators to reduce ED use"
4. A "fair and just" system
5. Value-based and outcomes-based reimbursement and education for providers
6. Support for rural hospitals to transition
7. Medicaid coverage for housing (and other social support services)
8. Free care policy for school-based health

Excerpts

"Support Kentucky Health Data Trust and move towards an All Payers Claim Database (APCD)." Consumer/Advocate group

"Increase health insurance literacy and increase consumer skills in navigating the systems." Consumer/Advocate group

"Solutions should be standardized across providers and payers." Payer group

"Invest in educating providers on how to manage care. Consider demonstration projects on upside risk to help providers learn about what will be necessary in the transformation to outcomes-based reimbursement." Physical and Oral Health Provider group

"There was also interest among our group in examining a PCMH (patient-centered medical home) or health homes model to promote care coordination, and we feel strongly that pharmacists are essential part of the team and should be used in novel and more expansive ways." Colleges/Universities group

"Simplified Medicaid—as close to single payer / provider as possible." Behavioral Health Provider group

Current Medicaid Expansion

Kentucky expanded Medicaid in January 2014 to cover adults with incomes up to 138% of the Federal Poverty Level. Throughout the discussion, many participants expressed opposition to changing the current Medicaid expansion. Below are some of the ways in which this sentiment was expressed:

1. No changes
2. No services should be cut from Medicaid
3. No adoption of components presented in the 1115 waiver issue brief
4. Everyone deserves the same benefits
5. Concern regarding how changes will affect low-income people

Excerpts

"Recipients are not the problem; the system is the problem." Consumer/ Advocate group

"No existing services or accessibility cut." Behavioral Health Provider group

"Group does not want to exchange expansion for 1115 with reduced coverage or access." Consumer/Advocate group

"No premiums, co-pays, health savings accounts, modified cost-sharing, excluded benefits, disenrollment for nonpayment, or lock-out periods." Physical and Oral Health Provider group

Evaluation

One of the key changes to 1115 waivers in the post-ACA era is the requirement that states perform an evaluation and make that evaluation public. Participants discussed and proposed ways in which the evaluation should be conducted and metrics that the evaluation should measure.

1. Evaluation metrics:

a. Health outcomes
b. Access to care/services
c. Costs:
    i. Administrative versus direct services
    ii. Long-term versus short-term costs and savings
    iii. Public costs saved by providing adequate health services (for example, food stamps, housing, etc.)
d. Healthy behaviors incentives: compare costs versus savings
e. Healthy behavior incentives: did behavior change?
f. Job expansion
g. Poverty reduction
h. Preventive services utilization (trends)
i. Satisfaction of providers and enrollees
j. Health literacy and education: did it lead to behavior change?
k. Barriers to care: pre and post-waiver
l. Emergency department (ED) utilization
m. Health equity metrics
n. Case load trends (enrollment and time on Medicaid)
o. Tracking of enrollees with chronic conditions
p. Tracking of enrollees who identify as persons of color: comparisons of experiences, outcomes, time on Medicaid with persons who identify as white

2. Evaluation process:
    a. Quantitative and qualitative
    b. External evaluator
    c. Involve stakeholders in design
    d. Share results publicly and periodically
    e. Assess enrollee needs before implementing an 1115 waiver
    f. Create a dashboard to display evaluation metrics publicly

Excerpts

"We would like to see stakeholder participation in the evaluation team and data made publicly available through a dashboard." Consumer/Advocate group

"We want the evaluation to address the impact of the waiver on: Enrollment; Access, with a particular focus on use of preventative services, management of chronic conditions, and reduction in unnecessary ER use; and long-term cost trajectory." Colleges/Universities group

"Evaluation should include a comprehensive study that considers the savings to the state on housing, food stamps, and other costs associated with inadequate health care." Consumer/Advocate group

"How health incentives can impact the health statistics of Kentucky and which incentives are effective at driving healthier lifestyles overall." Public Health group

"We would like to see stakeholders involved throughout the process. These discussions should be continued as the waivers are being developed." Behavioral Health Provider group

"What works and what doesn't? Is it cost-effective? Does it improve health outcomes? Where should we invest our dollars for the future to get the best return on investment?" Payer group

"Have we maintained coverage levels? Have we improved access to care?" Physical and Oral Health Provider group

"[Medicaid] needs to evaluate and understand the needs of beneficiaries prior to enacting specific requirements that are not realistic for payment." Health System group

Overarching Themes

These two themes were not discussed or presented in the issue brief or presentation but came up in discussion frequently. Integrated Care came up with the Consumer/Advocate group, the Behavioral Health Provider group, and the Colleges/Universities group. Social Determinants of Health came up with the Payer group, the Physical and Oral Health Provider group, the Consumer/Advocate group, and the Behavioral Health Provider group. These topics were referred to by name and also described by participants without necessarily calling them "integrated care" or "social determinants of health," Suggestions under these two themes are captured above under the Health System Transformation, Systems Improvement, Benefits, and Reimbursement categories.

1. Integrated care: According to SAMHSA (the federal Substance Abuse and Mental Health Services Administration), this includes integrating mental health, substance abuse, and primary care services to produce the best outcomes and most effective approach to caring for people with multiple health care needs. Additionally, new models of integrated care include the provision and payment of physical, behavioral and oral health in a coordinated manner. There are various levels of integration from coordination to co-location to fully integrated seamless systems, but all acknowledge and address the interconnectedness of physical, behavioral and oral health issues.

"Integrated health care. One-stop shops that provide transportation. Multiple appointments in one day if necessary." Consumer/Advocate group

"Encourage interdisciplinary team options." Behavioral Health Provider group

"In Federally Qualified Health Centers, we must allow multiple appointments with different providers in the same day…as long as the providers are providing different services even if

they are using the same CPT code." Behavioral Health Provider group

"Coordination of care needs dramatic improvements. Medical, behavioral, and oral." Colleges/Universities group

2. Addressing the social determinants of health: According to the World Health Organization, the social determinants of health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. A robust and growing body of research supports improving health and health equity through addressing the SDOH.

"We would like to see alternative and innovative components added to the current program to include capacity to address factors in communities that would impact health (i.e. transportation, supported housing, supportive employment) with benefits to demonstrate whether the investment would help address and offset rising costs." Payer group

"Use of Medicaid to pay for housing, particularly for super-utilizers, dual diagnosis (can have guidelines around who is eligible)." Consumer/Advocate group

"Waivers should include methods to address social determinants of health as these areas are proving most effective in improving outcomes and reducing cost. We encourage inclusion of community health workers, peer support, medical respite care and other innovations to support social needs of patients." Physical and Oral Health Provider group

"We would like to address poverty as a way of health prevention." Consumer/Advocate group

Next Steps

The ACA requires an opportunity for public comment and transparency in the section 1115 demonstration projects. In 2012, CMS issued a final regulation which lays out the process for ensuring public comment. A summary of those requirements can be found below.

The public will have a minimum of 30 days to provide comments before the state submits its application to CMS. The rule directs states to use the following methods to reach out to stakeholders:

- electronic mailing lists
- public notices
- state website postings *and*
- public hearings

States *must* hold at least two public hearings, which *must* be held at least 20 days prior to the state's submission to CMS. The state will compile a report of the issues raised through the public comment period and describe how the state considered those comments when developing its application for submission to CMS.

Once a state submits an application to CMS and the application is found to be complete, CMS will post the state's application on Medicaid.gov and initiate a 30-day federal comment period.

The Foundation encourages all stakeholders to actively participate in the pre-submission public comment period at the state level and the post-submission comment period at the federal level.

Resources List

Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers
Jesse Cross-Call and Judith Solomon, Center on Budget and Policy Priorities

The ACA and Medicaid Expansion Waivers
Robin Rudowitz and MaryBeth Musumeci, The Henry J. Kaiser Family Foundation

The ACA and Medicaid Expansion Waivers
Robin Rudowitz, Samantha Artiga and MaryBeth Musumeci The Henry J. Kaiser Family Foundation

Evaluation Needed Before Allowing Replication of Indiana's Medicaid Waiver
Judith Solomon and Jesse Cross-Call, Center on Budget and Policy Priorities

Expansion Waivers, Drug Pricing Among Top Medicaid Concerns
Nathaniel Weixel, Bloomberg

Five Key Questions And Answers About Section 1115 Medicaid Waivers
The Henry J. Kaiser Family Foundation

Healthy Behavior Incentives: Opportunities for Medicaid

How Common Medicaid Waiver Provisions Impact People and State Budgets
Community Catalyst

How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?
Sara Rosenbaum, Sara Schmucker, Sara Rothenberg, Rachel Gunsalus, The Commonwealth Fund

Medicaid Expansion in Indiana
The Henry J. Kaiser Family Foundation

Medicaid Expansion Waivers: What Will We Learn?
Robin Rudowitz, MaryBeth Musumeci and Alexandra Gates, The Henry J. Kaiser Family Foundation

Medicaid Incentive Programs To Encourage Healthy Behavior Show Mixed Results To Date And Should Be Studied And Improved, Health Affairs

Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers
Robin Rudowitz and MaryBeth Musumeci, The Henry J. Kaiser Family Foundation

Section 1115 Demonstrations, Center for Medicare and Medicaid Services (CMS)

Social Determinants of Health, World Health Organization

A State Policy Framework for Integrating Health and Social Services
Tricia McGinnis, Maia Crawford, and Stephen A. Somers, PhD, Center for Health Care Strategies, Inc.

Study of the Impact of the ACA Implementation in Kentucky: Special Issue Brief
University of Minnesota State Health Access Data Assistance Center

Too Soon to Replicate Indiana's Medicaid Waiver
Jesse Cross-Call, Center on Budget and Policy Priorities

Using Medicaid Resources to Pay for Health Related Supportive Services: Early Lessons
Anna Spencer, James Lloyd, and Tricia McGinnis, Center for Health Care Strategies, Inc.

Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09
Elizabeth Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Siagle, Chima Ndumele, Lauren Taylor and Leslie Curry, Health Affairs

With Federal Policy Change, More Money for School-Based Health Services, Pew Charitable Trust