



Addressing the Uninsured In Kansas:
Alternative Models and
Policy Options

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Addressing the Low-Income Uninsured in Kansas:

Findings and Conclusions

The Kansas Hospital Association (KHA) contracted with Leavitt Partners to outline and analyze options for covering the State's low-income uninsured population. For this project Leavitt Partners completed:

1. A review of selected states' core policy elements in recently enacted state legislation, Medicaid 1115 Demonstration waivers, and related State Plan Amendments (SPAs), as well as additional options under consideration for extending coverage to low-income uninsured individuals.
2. An initial identification of the policy topics and options that warrant further consideration as potential "best fit" components of a "Kansas plan." To complete this portion of the project, Leavitt Partners reviewed relevant data and reports as well as conducted interviews with key health care stakeholders in the State.

Key Findings and Conclusions:

- **There is significant opposition to a traditional ACA Medicaid expansion. There is also openness to the idea of a Kansas designed plan to cover the low-income uninsured.**
- **Policy elements from several of the reviewed state models generated interest among stakeholders and warrant further exploration.**
- **The recent approval of state models such as Arkansas, Iowa, and Michigan signal the federal government's willingness to entertain and act favorably on plans that rely on state-designed, market-based solutions.**

As such, should Kansas decide to pursue a similar plan that includes federal participation, it would likely receive serious consideration from CMS.

Overall findings and conclusions:

1. There is a desire for additional information about the low-income uninsured population to frame and inform ongoing discussions, including:
 - a. Demographic, social, and economic characteristics of the uninsured population.
 - b. The types and sources of care currently provided to the low-income uninsured population and the associated direct and indirect costs to the public, private, and charitable sectors.
 - c. Estimates of the type, sources and costs of care that would be required if coverage is extended to this population.
2. While stakeholders expressed significant opposition to the ACA's traditional Medicaid expansion, there is a willingness to engage in conversations to identify the foundational approaches of a Kansas designed plan.
3. The policy elements from other state models that generated interest and warrant further exploration include:
 - a. A private market-based approach such as the Private Option model and other premium subsidy approaches.
 - b. Delivery and payment models that align with the KanCare managed care model and expect, incent, and reward care coordination and integration.
 - c. Principles and expectations related to personal responsibility and accountability, including effective cost sharing, healthy behavior inducing strategies, and workforce incentives or requirements.
 - d. Strategies that address the differing circumstances and needs of the various population segments that make up the low-income uninsured population and align eligibility and benefit packages accordingly.
 - e. Sustainable financing strategies based on the short- and long-term state fiscal environment and that produce a net positive contribution to the overall state budget and economy.

Addressing the Low-Income Uninsured in Kansas:

Alternative Models and Policy Options

The Kansas Hospital Association (KHA) recently commissioned a review of possible policy options for covering the low-income uninsured population. The follow table summarizes innovations and models being developed or considered in states with similar economic and political environments to Kansas. States are using various combinations of these policy options and, as such, they could be viable components of a future “Kansas Plan.”

Policy Option	Description
Private Option/ Premium Subsidy	Private Option programs use premium assistance to purchase qualified health plans (QHP) offered through the health insurance exchange for program participants. The model was designed by Arkansas and is now being implemented in Iowa and proposed in several other states. In the models approved to date, federally required Medicaid benefits not covered by participating QHPs must be “wrapped” and provided through traditional Medicaid. However, Iowa was successful in waiving non-emergency transportation for one year.
Care Coordination: Managed Care and Accountable Care Organizations	In terms of delivery systems, some states are using coordinated care models, such as managed care (MCO) or accountable care organizations (ACO), instead of, or in addition to exchange QHPs. In Michigan, for example, all program participants will be enrolled in a Medicaid Health Plan, one of the Medicaid MCOs with which the State currently contracts. In Iowa, however, individuals with income below 100% FPL will be enrolled in ACOs, which will be responsible for meeting a set of quality and cost outcomes for their assigned populations (participants above 100% FPL will be enrolled in a Private Option program).
Health Savings Accounts (HSA)	HSA-like models are being used to promote value-based decision making and personal health responsibility. Contributions to the account are made by the individual, the State, and, in some cases, other public/private entities, such as employers. Funds roll over from year to year, offsetting future contributions. Program participants are typically issued a “debit” card, which they use for cost-sharing. In Michigan, all cost sharing is billed to the Medicaid managed care organizations (MCO), who manage the “contribution accounts.”
Cost Sharing & Premiums	Some states have proposed to charge participants monthly premiums, either in addition to or in lieu of other cost sharing. For example, Iowa proposed a sliding scale contribution for all participants with income above 50% FPL. Ultimately, participants with income from 50-100% FPL will pay monthly premiums not to exceed \$5 per month and participants with income above 100% FPL will be charged monthly premiums not to exceed \$10 per month (both are subject to a total out-of-pocket max never to exceed 5% of annual income). Premium payment for participants with income from 50-100% FPL is not a condition of eligibility, but failure to pay premiums can be considered collectable debt.
Incentives for Healthy Behaviors	Many states are incorporating incentives for healthy behaviors into their plans. Several states plan to incentivize the use of health and wellness activities by waiving monthly premiums or reducing cost sharing. Indiana allows unspent funds in an individual’s HSA account to roll over if they have received all of their age and gender appropriate preventive services.
Work Component	Pennsylvania has proposed that working-age program participants working less than 20 hours per week must engage in a minimum level of work search activities to maintain eligibility. Qualified activities may include searching for jobs online, creating a resume, participating in job training or education classes, etc. Exemptions are provided for certain populations.

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Introduction

The Kansas Hospital Association (KHA) contracted with Leavitt Partners to provide a briefing paper outlining and analyzing possible options for covering the low-income uninsured population in Kansas. KHA seeks to further the conversation on this topic among policy makers and stakeholders in the State and this information will be used to support this endeavor.

As part of this project, Leavitt Partners was asked to complete:

- **A review and analysis of core policy elements in recently enacted state legislation, Medicaid 1115 Demonstration waivers, and related State Plan Amendments (SPA) for extending coverage to low-income individuals currently not eligible for Medicaid.** Leavitt Partners also reviewed alternative approaches and options for covering the low-income uninsured that are being considered in selected states.
- **An initial identification of the policy topics and options that warrant further exploration and consideration as potential “best fit” components of a “Kansas plan.”** This identification took into consideration relevant factors such as the state political and fiscal environment, the status of insurance coverage for Kansans, current medical assistance programs, and the health care provider system. To complete this portion of the project, Leavitt Partners reviewed relevant data and reports as well as conducted interviews with key health care stakeholders in the State, including legislators, executive branch officials, providers, business representatives, insurance market representatives, and researchers. Individuals interviewed were selected by KHA.

After completing the review of policy options from other states, stakeholder interviews, and the preliminary assessment of factors relevant to determining the “best fit” for Kansas, the following observations can be drawn:

- There is a desire to gain additional data, information, and analysis with respect to the low-income uninsured population to frame and inform ongoing discussions of the issue.
- While the option of providing coverage to the uninsured population, or segments of it, through the Affordable Care Act’s (ACA) traditional Medicaid expansion faces significant opposition, particularly from the Kansas Legislature, there is an openness and willingness to engage in continuing conversations to identify and assess policy options and approaches that could form the foundation of a Kansas designed plan.
- No singular model from the states reviewed could be directly transferred to the State and become a “Kansas Plan.” Policy elements from several of the state models generated interest among stakeholders and therefore warrant further exploration.
- The recent approval of state models such as Arkansas and Iowa, signal willingness on the part of the federal government to entertain and act favorably to plans that rely on state-designed, market-based solutions. As such, should Kansas decide to pursue a similar plan that includes federal participation, it would likely receive serious consideration from CMS.

Next steps and areas needing further exploration are identified at the end of this paper. Some of these areas may be addressed in a possible Phase II of this project, the goal of which would be to assist in developing a Kansas approach to covering the low-income uninsured. This approach would be unique to Kansas and developed in a way that meets both the objectives of the State and the needs of its residents.

Alternative Approaches to Covering the Low-Income Uninsured

The following section summarizes Leavitt Partners review and analysis of core policy elements in recently enacted state legislation, Medicaid 1115 Demonstration waivers and SPAs, and alternative policy approaches for covering low-income uninsured populations from selected states.

Leavitt Partners, working in consultation with KHA, developed a list of states to review based on the following criteria:

- States that have not chosen to pursue a traditional Medicaid expansion as outlined in the ACA;
- States that have obtained approval for innovative approaches to covering the low-income uninsured prior to the ACA;
- States that are pursuing market-based strategies to covering the uninsured; or
- States with similar political environments

This section is divided into three parts:

- States with 1115 Demonstration waivers or SPAs that have been approved by CMS¹
- States with 1115 Demonstration waivers or SPAs that are in development
- States with plans that are in the discussion stage

Knowing where these states are in the development and approval process may help shape what policy options Kansas chooses to consider in designing its own approach to covering the low-income uninsured.

¹ Includes approvals by CMS as of the publication date of this briefing paper.

Summary of Key Policy Options

POLICY OPTION/STRATEGY	1115 Demonstration waivers or SPAs that have been approved by CMS					In Development	Discussion Stage	
	Arkansas	Indiana	Iowa	Rhode Island	Michigan	Pennsylvania	Oklahoma	Utah
Private Option/Premium Subsidy	X		X			X	X	X
Health Savings Account Model	X	X			X			X
Cost Sharing – Premiums			X			X		
Cost Sharing – Service Copays (above federal levels)						X		
Incentives for Healthy Behaviors		X	X		X	X	X	
Medical Home/Care Coordination/ACOs	X		X				X	X
Work Component/Requirement				X		X		
Enrollment Limits					X			
Global Waiver/"Block Grant"				X				X
Payment Model Reforms	X						X	X

1115 Demonstration Waiver/State Plan Amendment (SPA) Approved by CMS

Arkansas: Private Option

Overview

On January 1, 2014, Arkansas implemented a market-driven approach to Medicaid expansion, known as the Private Option. The authority and structure for this approach lies in the Arkansas Health Care Independence Act, enacted by the Arkansas Legislature in 2013.

Delivery System

The Private Option uses premium assistance to purchase qualified health plans (QHPs) offered through the health insurance exchange for individuals “newly eligible” for Medicaid.² Each Private Option participant has the option to choose from silver-level commercial market plans offered on the Federally-Facilitated Marketplace (FFM) in their geographic regions.³

Populations Affected

Individuals newly eligible for Medicaid in Arkansas include childless adults and parents between the ages of 19 and 65 with income at or below 133% of the federal poverty level (FPL) who are not otherwise eligible for Medicaid.⁴ This includes childless adults with income 0–133% FPL and parents/caretakers with income 17–133% FPL. Arkansas estimated 225,000 individuals would be eligible for the Demonstration.

Method of Implementation

The approach was authorized under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Demonstration is statewide and is approved through December 31, 2016.

CMS Guidance: On March 29, 2013, the Department of Health and Human Services released FAQs indicating that states can pursue this type of expansion only if the proposal meets current premium assistance statutory requirements, such as cost-effectiveness, cost sharing, and benefit design. These requirements ensure that Medicaid enrollees “continue to be entitled to all cost-sharing protections.” As such, “states must have mechanisms in place to ‘wraparound’ commercial coverage to the extent that benefits are less and cost-sharing requirements are greater than those in Medicaid.”

Key Policy Highlights: Arkansas Private Option

- **Uses premium assistance to purchase commercial coverage through the exchange**
- **Affected populations include low-income childless adults and parents between the ages of 19–65 with income below 133% FPL**
- **Enrollees over 100% FPL are currently subject to cost sharing; the State is seeking approval to extend cost sharing to those between 50–100% FPL; all cost sharing meets federal limitations**
- **The State is also developing a pilot project to create a health savings account program to promote cost-effective health care use**
- **Participating providers are reimbursed at the rates negotiated with QHPs**

² State of Arkansas 1115 Waiver Application (August 2, 2013).

³ Silver level plans generally have an actuarial value of 70%.

⁴ Individuals determined to be medically frail or have exceptional medical needs are not eligible for the Private Option.

Proposals must also meet the parameters outlined by HHS, which include limiting enrollment in the exchange to healthy, less costly individuals—specifically “individuals whose benefits are closely aligned with the benefits available on the Marketplace” (i.e., individuals who are not medically frail).⁵ In addition, HHS notes that “a state may increase the opportunity for a successful demonstration by choosing to target within the new adult group, individuals with income between 100% and 133% FPL.⁶ Medicaid allows for additional cost-sharing flexibility for populations with incomes above 100% FPL; this population is more likely to be subject to churning and would be eligible for advance premium tax credits and Marketplace coverage if a state did not expand Medicaid to 133% FPL.”⁷

Benefits

Federally required Medicaid benefits not covered by participating Private Option QHPs will be “wrapped” and provided through the State’s fee-for-service (FFS) program.⁸ Out-of-network family planning services are also provided through the FFS program.

Cost Sharing

The Arkansas model allows for “cost sharing for eligible individuals that is comparable to that for individuals in the same income range in the private insurance market and is structured to enhance eligible individuals’ investment in their health care purchasing decisions.”⁹ Cost sharing is also aligned to amounts that do not exceed Medicaid cost-sharing limitations, keeping it within the restrictions set by current federal rules. As such, Private Option participants are not required to pay premiums or deductibles, and participants with income above 100% FPL do not pay more than 5% of their family income in total cost sharing.¹⁰ Private Option participants with income below 100% FPL do not pay cost sharing in the Demonstration’s first year (see *Phase II* subsection below for proposed changes in 2015).

Consumer Engagement

The legislation authorizing the Private Option program instructed the Arkansas Department of Human Services to “explore design options that reform the Medicaid Program ... so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program [that utilizes] competitive and value-based purchasing to:

- Maximize the available service options;
- Promote accountability, personal responsibility, and transparency;
- Encourage and reward healthy outcomes and responsible choices; and
- Promote efficiencies that will deliver value to the taxpayers.”¹¹

⁵ Newly eligible individuals who are not described in SSA 1937(a)(2)(B)(e.g., the medically frail). Medicaid and the Affordable Care Act: Premium Assistance, CMS (March 2013).

⁶ In the current Medicaid program, a state determines the gross income and resources of the applicant, and then deducts certain items which may be disregarded (e.g., earned income, child care income, etc.). Under the ACA, most income disregards will be replaced by a single 5% disregard, making the effective eligibility rate 138% FPL.

⁷ Medicaid and the Affordable Care Act: Premium Assistance, CMS (March 2013).

⁸ Including non-emergency transportation and EPSDT.

⁹ The Health Care Independence Act of 2013, SB1020, Arkansas State Legislature (2013 Regular Session).

¹⁰ Arkansas pays the full cost of the QHP premiums and the monthly cost-sharing reduction payment amounts associated with the federal reduced cost sharing. State of Arkansas 1115 Waiver Application (August 2, 2013).

¹¹ The Health Care Independence Act of 2013, SB1020, Arkansas State Legislature (2013 Regular Session).

Phase II: Arkansas is currently in the process of developing waiver amendments that will allow it to expand the Private Option to additional populations and establish policies that promote more personal responsibility. First, the State is seeking to enroll traditional Medicaid populations in the Private Option, including parents with income below 17% FPL and CHIP-eligible children. Second, the State is seeking to implement cost sharing for participants with incomes from 50–100% FPL. This cost sharing is expected to be effective in years two and three of the Demonstration. Third, the State is developing a pilot project to create a health savings account program to promote cost-effective use of the health care system.¹² The State has not yet finalized these amendment requests.

Other Program Features

As indicated in the 1115 waiver application, all participating Private Option QHPs are required to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII), an “innovative, multi-payer initiative to improve quality and reduce costs statewide.”¹³ This initiative includes episode-based care delivery (including retrospective risk sharing), assigning participants a primary care provider, supporting patient-centered medical homes and health homes, and accessing clinical performance data for providers. The goal of the initiative is to shift Arkansas’ delivery system from one that rewards volume to one that rewards quality and affordability.

Costs/Economic Impact

In order to show that its proposal is cost effective, Arkansas assumed that it could keep Medicaid reimbursement rates low by moving the majority of the newly eligible population into commercial coverage. This would stymie demand for Medicaid providers and allow the State to avoid increasing rates in order to incentivize more providers to treat Medicaid patients.¹⁴ Costs would be further reduced by increased competition on the exchange, aggressive private-plan management, more conscientious consumer health care decision making, and selective population management (i.e., enrolling healthier, less costly Medicaid recipients in commercial plans).

Providers participating in the Private Option are reimbursed for care at the rates providers negotiate with QHPs. The State anticipates that provider payment rates in the Private Option will be equal to, if not greater, than provider payment rates offered under the Medicaid State Plan.¹⁵

Indiana: Healthy Indiana Plan

Overview

In 2008, Indiana implemented an expanded Medicaid program known as the Healthy Indiana Plan (HIP). The goals of the program include: 1) increasing the rate of insurance coverage in the low-income population; 2) reducing barriers and improving statewide access to health care services for this population; 3) promoting value-based decision making and personal health responsibility; 4) promoting primary care and disease prevention; 5) preventing chronic disease progression with secondary

¹² State of Arkansas 1115 Waiver Application (August 2, 2013).

¹³ Ibid.

¹⁴ Financial Impact of Arkansas’ Private Option Plan for Insurance Premium Assistance, Arkansas Insurance Department (2013).

¹⁵ State of Arkansas 1115 Waiver Application (August 2, 2013).

prevention; 6) providing appropriate and quality-based health care services; and 7) assuring state fiscal responsibility and efficient management of the program.¹⁶

Delivery System

HIP participants are currently enrolled in one of three health plans: Anthem or MDWise (both pre-paid, capitated plans), or the Enhanced Service Plan (ESP), which is designed for participants with significant medical needs.¹⁷ A questionnaire administered as part of the application process identifies high-need, high-risk participants who should enroll in the ESP.

Populations Affected

The HIP program covers two populations: custodial parents and childless adults with income below 200% FPL (who are not otherwise eligible for Medicaid, have been uninsured for six months, and do not have access to insurance through their employer). Effective January 1, 2014, the income limit is reduced to 100% FPL and those with income above 100% FPL will be transitioned to the exchange. Enrollment of childless adults is currently capped at 36,500. The original cap of 34,000 was reached in the first year. Enrollment is currently closed for childless adults, although it opens periodically to add members up to the cap.

Key Policy Highlights: Healthy Indiana Plan

- 1) Uses Medicaid managed care plans to deliver an alternative benefit package**
- 2) Affected populations include low-income, uninsured childless adults and parents with income below 100% FPL**
- 3) Coverage is subject to a \$1,100 deductible and benefits are capped at \$300,000 annually with a \$1 million lifetime cap**
- 4) Participants are provided with HSA-like “POWER” accounts to pay for deductibles and cost sharing; accounts are funded through a combination of participant and state contributions**
- 5) The State has proposed using this program as the basis for a Medicaid expansion**

Method of Implementation

The program was authorized under an 1115 waiver approved by CMS. The waiver was set to expire at the end of 2012; however, CMS extended the Demonstration and it now expires at the end of 2014.

Benefits

HIP participants have access to most services that are available in the State’s traditional Medicaid program. Services typically include: 1) mental health care services; 2) inpatient hospital services; 3) prescription drug coverage; 4) emergency room services; 5) physician office services; 6) diagnostic services; 7) outpatient services, including therapy services; 8) comprehensive disease management; 9) home health services, including case management; 10) urgent care center services; 11) preventive care services; 12) family planning services; 13) hospice services; and 14) substance abuse services. HIP does not cover dental, vision, chiropractic, or podiatry services (except for diabetics). It also does not cover hearing aids (except for 19–20 year olds), maternity services, and various other services.

¹⁶ Healthy Indiana Plan 1115 Waiver Extension Application, Indiana Family and Social Services Administration (April 12, 2013).

¹⁷ Healthy Indiana Plan Gets Mixed Reviews at Hearing, Associated Press (March 20, 2013).

Cost Sharing

Cost sharing in the HIP program is typically higher than in traditional Medicaid. HIP coverage is subject to a \$1,100 deductible and benefits are capped at \$300,000 annually with a \$1 million lifetime benefit cap. In an effort to promote preventive care, the State provides up to \$500 in preventive services each year. Any services used beyond the \$500, and services that are considered outside of preventive services, are subject to deductibles.

Consumer Engagement

Participants are provided with HSA-like accounts to pay for deductibles and cost sharing. These Personal Wellness Responsibility (POWER) accounts are funded through a combination of participant and state contributions. Participants' mandatory contribution amounts are scaled by household income and range from 0–5%, based on the participants' income. Unused POWER account funds roll over year to year (but only if a participant has received all of their age and gender appropriate preventive services).¹⁸ This provides incentives for members to obtain annual preventive care requirements first, which are provided at no charge to participants.

Because POWER accounts are capped at \$1,100, any funds that are rolled over effectively reduce the participants' account contribution amount in the following year. If a participant uses services in excess of the \$1,100, the State covers the excess costs. Research has found that this program incentivizes the use of preventive care, minimizing the use of unnecessary or more expensive treatments.¹⁹

Figure 1:

POWER Account Contributions by HIP Members	
Annual Household Income	Maximum Account Contribution
All participants at or below 100% FPL	No more than 2% of income
All participants 100% –125% FPL	No more than 3% of income
All participants 125% – 150% FPL	No more than 4% of income
HIP Caretakers 150% – 200% FPL	No more than 4.5% of income
HIP Adults 150% – 200% FPL	No more than 5% of income

SOURCE: External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2009, Burns & Associates, Inc. (November 30, 2010).

¹⁸ If preventive services are not completed, only the individual's pro-rated contribution to the account (not the State's portion) rolls over. Preventive services include yearly physicals, breast screenings (mammograms), cervical screenings (Pap test), colorectal screenings, certain immunizations, and smoking cessation services.

¹⁹ Experience under the Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured, Milliman (August 2009).

Other Program Features

The State recently proposed using this program as the basis for Medicaid expansion. In February 2013, Governor Pence sent Secretary Sebelius a letter indicating his desire to extend the program through 2016 and to use HIP as a vehicle for expansion.²⁰ As mentioned above, CMS extended the current program through 2014. Governor Pence has also indicated his desire to see the Medicaid program converted to a block grant.

Costs/Economic Impact

The health care costs for HIP participants have been higher than expected. In 2009, the costs of the HIP program exceeded the tax revenue collected that year (the state share of funding is provided through an increase in the state tobacco tax as well as funds diverted from the federal disproportionate share hospital program). Although the program's costs are high, steady enrollment and high retention rates indicate that many uninsured residents are willing to contribute to the cost of their health care. In the first two years of operation, only about 3% of HIP participants left the program because they failed to pay their monthly contributions.

Iowa: Iowa Wellness and Marketplace Choice Plans

Overview

In May 2013, Iowa Governor Branstad agreed to expand Medicaid through the State's "Iowa Health and Wellness Plan." The Plan consists of two waivers: the Iowa Wellness Plan and the Iowa Marketplace Choice Plan. The Plans were approved on December 10, 2013. On December 12, 2013, Governor Branstad indicated that his Administration had reached an agreement with CMS and would move forward with the Medicaid expansion plans.²¹

Delivery System

The plans use a two-fold approach to covering the State's uninsured population: 1) a coordinated care program (Wellness Plan); and 2) a premium assistance program (Marketplace Choice Plan).

The Wellness Plan includes care management activities conducted by Accountable Care Organizations (ACO). These organizations will be responsible for meeting a set of quality and cost outcomes for their assigned populations.²² ACOs will coordinate care through the use of medical homes, provide preventive services, and engage in member outreach activities. The program will be implemented under a shared savings model, meaning ACOs will be paid through a risk-adjusted global budget, and can receive a share of the savings that was achieved through greater care coordination if they are successful in meeting quality and cost measures.

Participants with income between 101% and 133% FPL will be eligible for the Marketplace Choice Plan and will select a qualified commercial health plan through the State's exchange. The Medicaid program

²⁰ Letter to Secretary Sebelius from Governor Pence regarding the State's application to extend the Healthy Indiana Plan, Office of the Governor, State of Indiana (February 13, 2013).

²¹ Gov. Branstad and Lt. Gov. Reynolds Reach Agreement with Federal Officials for Approval of Bi-Partisan Iowa Health and Wellness Plan, iowa.gov (December, 12, 2013). Available from <https://governor.iowa.gov/2013/12/gov-branstad-and-lt-gov-reynolds-reach-agreement-with-federal-officials-for-approval-of-bi-partisan-iowa-health-and-wellness-plan/>.

²² Iowa Health and Wellness Plan, Iowa Department of Human Services (June 2013).

will pay the participants' premiums and ensure that the health plan options provide the required benefits, provider network, and out-of-pocket costs.²³

Populations Affected

The Wellness and Marketplace Choice Plans cover newly eligible individuals, ages 19–64, with incomes under 133% FPL, who are not currently eligible for Medicaid. The Iowa Wellness Plan covers eligible individuals with income up to 100% FPL, who do not have access to cost-effective ESI, and medically frail individuals with income up to 133% FPL.²⁴ Around 100,000 individuals are expected to enroll in the Iowa Wellness Plan.

The Marketplace Choice Plan covers individuals with income between 101% and 133% FPL, who are more likely to transition to commercial coverage over time. Around 35,000 individuals are expected to enroll in the Marketplace Choice Plan.

Method of Implementation

The Plans were authorized under 1115 waivers approved by CMS. The Demonstration is statewide and is approved through December 31, 2016.

Benefits

The Wellness Plan provides a comprehensive benefit package, which is indexed to the State Employee Health Benefit Package.²⁵

The benefit categories covered and cost-sharing requirements in the Marketplace Choice Plan are the same as those covered under the Wellness Plan. The State initially sought a waiver for wrapping benefits not offered by commercial plans on the exchange (such as nonemergency transportation and EPSDT services). It was argued that because participating Marketplace Choice Plans provide the Essential Health Benefits required by the federal government,²⁶ members were assured to receive comprehensive health care services.

However, CMS indicated in its Marketplace Choice Plan approval letter that Iowa will not be allowed to waive EPSDT. CMS did, however, allow Iowa to waive non-emergency transportation for one year for

Key Policy Highlights: Iowa Wellness and Marketplace Choice Plans

- 1) **Uses a combination of premium assistance (Marketplace Choice Plan) and ACOs (Wellness Plan) to provide coverage**
- 2) **The Wellness Plan covers primarily low-income adults with income below 100% FPL; Marketplace Choice covers adults with income between 101% and 133% FPL**
- 3) **Marketplace Choice participants will be charged monthly premiums not to exceed \$10 per month; Wellness Plan participants will pay monthly premiums not to exceed \$5 per month (both are subject to a total out-of-pocket max never to exceed 5%)**
- 4) **Participants who complete required health and wellness activities during year one will have their premiums waived in year two**
- 5) **Providers participating in the premium assistance program are reimbursed at the rates negotiated with QHPs**

²³ Ibid.

²⁴ American Indians and Alaska Natives and individuals who have access to ESI are also covered up to 133% FPL.

²⁵ Iowa Health and Wellness Plan, Iowa Department of Human Services (June 2013).

²⁶ Essential Health Benefits (EHB) are a baseline comprehensive package of items and services that all small group and individual health plans, offered both inside and outside the exchange, must provide starting in 2014.

both the Marketplace Choice and Wellness Plans. During this time CMS will consider the effect on access and reevaluate whether the benefit can be waived in subsequent years. Other Medicaid benefits not provided by exchange plans will be provided as wraparound services the participant can access through the use of a “Medicaid client identification number card” and will be billed on a FFS basis.

Cost Sharing

Iowa originally proposed that program participants would be charged \$10 copays for non-emergency use of the ER. In addition, after the first year of the program, monthly premiums would be charged to adults with incomes greater than 50% FPL if certain preventive services were not accessed or wellness activities were not completed.

In its approval letters, CMS stated that all cost-sharing obligations (other than premiums) would be consistent with State Plan requirements, indicating that the \$10 copay for non-emergency use of the ER was not approved. Instead, the State will charge \$8, which is the federally approved limit. Additionally, CMS did not approve premiums for individuals between 50% and 100% FPL at the levels Iowa was proposing in its waiver application. Instead CMS will allow the State to charge monthly premiums in the Wellness Plan that do not exceed \$5 per month starting in year two of the Demonstration. Premium payment is not a condition of eligibility (but can be considered collectible debt). Monthly premiums for participants in the Marketplace Choice Plan (who have incomes above 100% FPL) can also be imposed starting in year two of the Demonstration.²⁷ These premiums may not exceed \$10 per month and premium payment is a condition of eligibility. Both Plans’ premiums are to never exceed 5% of income.

Consumer Engagement

The Wellness and Marketplace Choice Plans will incentivize the use of health and wellness activities by waiving monthly premiums. Participants who complete all required healthy behavior activities during year one of the Demonstration will have their premiums waived in year two. If healthy behavior activities continue to be met each year, premiums will be waived in subsequent years. Healthy behaviors include completing a health risk assessment and annual wellness exam. The health risk assessment will be used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.²⁸

Other Program Features

As outlined in its waiver application, Iowa plans to use a three-pronged approach to identifying medically frail individuals, which includes both retrospective and prospective screening processes. First, Iowa will educate enrollment assisters and other providers about the definition of medically frail and how to identify qualifying individuals. Second, Iowa will utilize a self-attestation screening process. The screening process will ask participants questions regarding receipt of Social Security income and/or having a physical, mental, or emotional health condition limits daily activities. Third, Iowa will identify health conditions and diagnosis codes which qualify an individual for medically frail status and develop a process to screen and identify medically frail members currently enrolled with health plans, primary care providers, or ACOs.²⁹

²⁷ Letter to Iowa Medicaid Director regarding Iowa’s request for two three-year Medicaid Demonstrations, CMS (December 10, 2013).

²⁸ Centers for Medicare and Medicaid Services Special Terms and Conditions, Iowa Marketplace Choice Plan, CMS (2013).

²⁹ Iowa Marketplace Choice Plan 1115 Waiver Application, Iowa Department of Human Services (August 2013).

Costs/Economic Impact

Over the five-year Demonstration period (2014–2018), the Demonstration is expected to cost approximately \$5.6 billion in state and federal funds.³⁰ Providers participating in the Marketplace Choice Plan will be reimbursed for care at the rates providers negotiate with QHPs.³¹

Rhode Island: Global Waiver

Overview

In January 2009, CMS approved Rhode Island’s Global Consumer Choice Compact. The primary goal of this Demonstration is not to expand coverage or reduce the number of uninsured in the State, but rather to allow the State to operate its Medicaid program under global waiver caps. The caps combine federal and state Medicaid spending at roughly \$12 billion over the Demonstration’s timeframe (2009–2013).³² Under the agreement, the federal government continues to pay a fixed percentage of Rhode Island’s Medicaid costs up to the capped allotment. The global waiver also allows Rhode Island to claim federal matching funds for health care services that previously had been provided entirely with state dollars to individuals not eligible for Medicaid.³³

Delivery System

As the Demonstration does not create new coverage programs, the State’s existing delivery systems are used under the waiver. These include managed care for individuals receiving primary and acute care services, premium assistance for those who qualify for employer-sponsored insurance (ESI), pre-paid dental ambulatory health plans, and FFS for individuals who receive institutional and Home and Community-based long-term care services.³⁴

Key Policy Highlights: Rhode Island Global Waiver

- 1) **Allows the State to operate its Medicaid program under a global waiver (capped funds)**
- 2) **The State has expanded services to parents up to 175% FPL, uninsured adults with mental illness or substance abuse problems, and other low-income adults**
- 3) **As part of an addendum, the State has requested a “Healthy Works” program be included as an allowable Medicaid benefit; this program provides employment and prevocational services to certain adults**
- 4) **The capped funding approach has shown to produce savings, largely because the capped amount was set higher than estimated costs**
- 5) **As of January 2, 2014, Rhode Island had not yet received public approval for its waiver extension or addendum requests**

³⁰ Iowa Wellness Plan 1115 Waiver Application, Iowa Department of Human Services (August 2013).

³¹ Iowa Marketplace Choice Plan 1115 Waiver Application, Iowa Department of Human Services (August 2013).

³² Rhode Island’s Global Waiver Not a Model For How States Would Fare under a Medicaid Block Grant, Center on Budget and Policy Priorities (March 22, 2011).

³³ Ibid.

³⁴ Rhode Island Global Consumer Choice Compact Section 1115 Demonstration Fact Sheet (August 31, 2011).

Populations Affected

All State Medicaid participants are covered under the Demonstration. As mentioned above, the goal of the Demonstration is not to provide services to an expanded population, but to test a new method of funding Medicaid. However, through this and other waivers, the State has expanded services to some groups not traditionally eligible for Medicaid. These groups include parents and caretaker adults up to 175% FPL, uninsured adults with mental illness or substance abuse problems not currently eligible for Medicaid, and low-income adults eligible for the State's General Public Assistance Program (individuals ages 19–64, who are unable to work, but don't qualify for disability benefits).³⁵ It is important to note that Rhode Island did choose to expand Medicaid under the ACA, so many of these individuals will be covered under the State's Medicaid program starting in 2014.

Method of Implementation

The program was authorized under an 1115 waiver approved by CMS. The waiver merged a number of waivers the State had previously received from the federal government with new initiatives. The waiver also allowed Rhode Island's Medicaid program to operate under global waiver caps rather than receive the typical federal match payments. The global compact waiver expired December 31, 2013 and Rhode Island is in the process of applying for a waiver extension.

Benefits

The Global Consumer Choice Compact waiver does not directly affect Medicaid benefits. Most Medicaid participants receive State Plan benefits. Some Medicaid populations are eligible to receive expanded benefits, depending on their condition of eligibility and the program in which they are enrolled. The State currently offers a limited benefit package to low-income adults eligible for the State's General Public Assistance Program.

Cost Sharing

The Global Consumer Choice Compact waiver does not directly affect Medicaid cost sharing. As of 2011, participants with income above 133% FPL pay monthly premiums up to 5% of family income as well as copays on prescription drugs and non-emergency use of the emergency room (ER).³⁶ There is no cost sharing for participants with family income at or below 133% FPL.

Consumer Engagement

In August 2013, Rhode Island submitted an addendum to its waiver extension request. As part of this addendum, the State requested "Healthy Works" be included as an allowable Medicaid benefit. The Healthy Works Initiative consists of two separate programs. The first program will provide employment, prevocational, and habilitative services to adults up to age 64 who are eligible for Medicaid on the basis of a disability or who are diagnosed with a chronic illness or condition. The second program is a pilot limited to 200 people which focuses on young adults, ages 18–30, irrespective of health status. The pilot would include employment, prevocational, and habilitative services as well as a set of employment rewards that promote job placement, training, and retention.³⁷

³⁵ Ibid.

³⁶ Ibid.

³⁷ Rewards may take the form of bonuses for participants who stay on the job for a set period of time or cash rewards for employers who offer other core employment services/supports, jobs with higher wages, etc. Request to Extend the Rhode Island 1115 Research and Demonstration Waiver: Project No. 11-W-00242/1, Addendum to Rhode Island's March 12, 2013 Submission, Rhode Island (August 15, 2013).

Examples of services provided through the Healthy Works program include:

- Career planning and placement
- Customized employment services
- Prevocational supports (assisting participants acquire skills needed to succeed in the work place such as attendance, motor skills, interview skills, etc.)
- Transportation
- Health maintenance and social engagement

It is important to note that as of January 2, 2014, there is no public information on CMS' final action regarding Rhode Island's overall waiver extension request, including the addendum. Expectations are that CMS will provide a short-term extension to allow for further negotiations regarding the terms and conditions of a longer term extension.

Other Program Features

The State is seeking a number of additional benefits in its waiver extension request addendum. These include making telemedicine services available to the Medicaid-eligible population during the Demonstration extension period, providing peer supports and mentoring to Medicaid enrollees in community-based settings, offering in-home behavioral health programs to children in or at risk of entering State custody, and providing housing stabilization services.³⁸

Costs/Economic Impact

The global waiver cap was set at a level above the State's projected Medicaid costs for the five-year period. It was argued that a higher cap was needed because of the increased costs of an aging population, a weak economy, and the risk the State was assuming under the new financing system.³⁹

Evidence on the success of the capped funding approach is mixed. In general, the State has shown to produce savings, but this is largely because the capped amount was set higher than estimated costs. An independent report found that the State saved nearly \$23 million in the first three years.⁴⁰ However, other analyses have shown that even with these savings the State was not able to achieve some of the administrative flexibility it was seeking, largely due to the "historic structure and culture of CMS and unanticipated State restrictions."⁴¹ For example, the State was unable to increase premiums for families enrolled in managed care or make other eligibility changes due to the maintenance of effort requirements in the ACA and the American Recovery and Reinvestment Act of 2009 (ARRA). In a presentation to the Global Waiver Taskforce, it was implied that it may be just as effective to work through the existing regulatory flexibilities granted by CMS, rather than employing a global waiver.

³⁸ Ibid.

³⁹ Governor seeks waiver to cap Medicaid at \$12.4 billion, Providence Journal (July 30, 2008).

⁴⁰ An Independent Evaluation of Rhode Island's Global Waiver, The Lewin Group (December 6, 2011).

⁴¹ Rhode Island's 1115 Research and Demonstration Waiver: The Global Consumer Choice Compact, Presentation to Global Waiver Taskforce by Elena Nicoletta, RI Executive Office of Health and Human Services (October 22, 2012).

Michigan: Healthy Michigan Plan

Overview

On November 8, 2013, Michigan proposed its Healthy Michigan Plan, the purpose of which is to extend “affordable and accessible” quality health care to all Michigan citizens up to 133% FPL. The goals of the Plan are to reduce the number of uninsured in the State, reduce uncompensated care costs, incentivize healthy behaviors and improve health outcomes, and positively impact personal financial well-being.⁴²

Delivery System

Plan participants will be enrolled in a Medicaid Health Plan, one of the Medicaid managed care organizations with which the State currently contracts. Additionally, prepaid inpatient health plans will provide mental health services to Plan participants.

Populations Affected

The Plan will cover adults between the ages of 19 and 65 with income at or below 133% FPL, who are not otherwise eligible for Medicaid. It is estimated that approximately 300,000–500,000 individuals will meet these eligibility requirements.

Method of Implementation

Michigan is requesting the program be authorized under an 1115 waiver amendment. Approval of the amendment is still pending.

Benefits

Program participants will be provided with an Alternative Benefit Plan (ABP). This ABP will include the 10 Essential Health Benefits as well as additional benefits that align with the State’s base Medicaid benchmark plan. Services will equal services provided to traditional Medicaid enrollees in both scope and coverage. The ABP provides a few additional benefits that are not provided through the current State Plan, including habilitative services and preventive health care services.

Cost Sharing

Like Indiana, the Michigan Plan also establishes HSA-like Health Accounts to encourage participants “to become more active health care consumers, to save for future health care expenses, and become more aware of the cost of the services they receive.”⁴³ Enrollment in the Health Account is mandatory for all Healthy Michigan participants.

Key Policy Highlights: Healthy Michigan Plan

- 1) **Uses Medicaid managed care plans to deliver an alternative benefit package**
- 2) **The Plan covers adults age 19–65 with income below 133% FPL**
- 3) **Establishes HSA-like Health Accounts to encourage participants to become more active health care consumers**
- 4) **The account is funded through a combination of participant, state, employer, and private/public contributions**
- 5) **Individuals between 100–133% FPL are required to make an additional contribution limited to 2% of their income; reductions in cost-sharing are available if certain healthy behaviors are addressed**

⁴² Healthy Michigan Plan: A Waiver Amendment Request Submitted Under Authority of Section 1115 of the Social Security Act, State of Michigan (November 8, 2013).

⁴³ Ibid.

The MI Health Accounts are expected to be funded through a combination of participant, state, employer, and private/public contributions.⁴⁴ Once the participant is enrolled in a Medicaid Health Plan, all cost sharing becomes a function of the Medicaid Health Plan's collection of the participant's account contributions.⁴⁵ Meaning health care providers will not be responsible for collecting copays directly from the participant at the point of service and no distribution of funds from the MI Health Account will be made to the participant to meet cost-sharing obligations.⁴⁶ Instead, it is envisioned that the Medicaid Health Plans will be responsible for distributing and managing copayments and other cost sharing.^{47 48}

Payments made from the Health Account are expected to be sought from account funds using the following priority order: 1) state contributions; 2) contributions from any other non-state source; and 3) contributions made by the participant. Participant contributions will not be required during the first six months of enrollment. At the end of the six month period, an average monthly copay experience for the participant will be calculated. The participant is expected to remit this amount into the MI Health Account each month. The average copay amount will be re-calculated every six months to reflect the participant's current utilization of health care services. As part of this cost sharing, individuals between 100% and 133% FPL will be required to make an additional contribution to their MI Health Account limited to 2% of their income.⁴⁹

MI Health Account contributions will roll over and will be used to offset future contribution amounts. Participants who are no longer eligible for the program will receive the balance of their individual contributions in the form of a voucher to be used for the sole purpose of purchasing and paying for commercial insurance. As specified in CMS' terms and conditions, the State must develop and receive approval of a Contributions Accounts and Payments Infrastructure Protocol before implementing the MI Health Accounts.

Consumer Engagement

Credits to the MI Health Account or reductions to the cost sharing liability will be available for participants at 100–133% FPL, if certain healthy behaviors are addressed. The Michigan Department of Community Health will work with its stakeholders to identify uniform standards for the healthy behaviors. These uniform standards may include completing an annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and deficiencies in immunization status. As specified in CMS' terms and conditions, the State must

⁴⁴ The State will make contributions to the account: (a) in amounts varied based on the participant's existing contributions and circumstances, (b) in a manner that ensures participants are able to obtain necessary health care services, (c) to assure providers are paid for the covered health care services they provide, and (d) to ensure that cost transparency is maintained for the participant's benefit. Ibid.

⁴⁵ Michigan believes that by eliminating the copay requirement at point of service, participants will be assured of receiving needed health care services. Ibid.

⁴⁶ Healthy Michigan Plan: A Waiver Amendment Request Submitted Under Authority of Section 1115 of the Social Security Act, State of Michigan (November 8, 2013).

⁴⁷ Cost sharing includes both copays and, when applicable to the participant, contributions based on income to the MI Health Account. Ibid.

⁴⁸ Populations that are exempt from cost-sharing requirements per current federal law and regulations will be exempt from cost-sharing obligations in the program (e.g. Native Americans and pregnant women will not be required to pay copays or the contributions).

⁴⁹ The total amount of the participant's annual cost sharing will not exceed 5% of the participant's annual income.

develop and receive approval of a Healthy Behavior Incentives Program Operational Protocol before implementing the MI Health Accounts and providing incentives for healthy behaviors.

The State of Michigan plans to submit a second waiver for 2015 that would require Plan participants with income between 100% and 133% FPL to contribute up to 7% of their income to total cost sharing after 48 months. Alternatively, participants can choose to enroll in the health insurance exchange and receive an advanced premium tax credit (APTC), with no financial penalty to the State.⁵⁰

Other Program Features

Michigan is planning to significantly enhance substance use disorder services as part of the Demonstration. Services for substance use disorders will be provided in the same manner and in coordination with current mental health services and supports. Services will focus on prevention, wellness, and chronic disease management (including caretaker education and support services), health coaching, relapse prevention, and care coordination.

Costs/Economic Impact

A financial analysis of the Michigan Plan completed by the Michigan Senate Fiscal Agency shows that there would be significant savings to the State's General Fund in the first few years of the expansion (the State is expected to save \$206 million in 2014).⁵¹ However, it is estimated that over time, General Fund costs would exceed savings as the federal match rate for the expansion population drops from 100% in 2014 to 90% in 2020.⁵² As such, the Governor's 2014 proposed budget places \$103 million of those savings into a health savings fund to cover future Medicaid expansion costs.⁵³

This analysis does not take into account any economic impact the expansion may have on the State or additional savings that may result to non-General Fund accounts.

Waiver/SPA in Development

Pennsylvania: Healthy Pennsylvania

Overview

Governor Corbett released his Healthy Pennsylvania Plan in December 2013, which assists uninsured individuals purchase commercial health insurance. The plan also includes personal accountability provisions and proposes a job search component. The vision for the plan focuses on three priorities: improving access, ensuring quality, and providing affordability.⁵⁴

⁵⁰ HB4714, Michigan State Legislature (2013 Regular Session).

⁵¹ Facts about Medicaid Expansion: Improving Care, Saving Money. Michigan.gov. Available from http://www.michigan.gov/documents/reinvent/medicaid-factsheet-final-2_410672_7.pdf.

⁵² Fiscal Analysis of Governor Snyder's Medicaid Expansion Proposal, Senate Fiscal Agency (March 2013).

⁵³ Facts about Medicaid Expansion: Improving Care, Saving Money. Michigan.gov. Available from http://www.michigan.gov/documents/reinvent/medicaid-factsheet-final-2_410672_7.pdf.

⁵⁴ Healthy Pennsylvania: Reforming Medicaid, Pennsylvania Department of Public Welfare. Available from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_035843.pdf.

Delivery System

The Commonwealth proposes implementing a Private Coverage Option. This program will use premium assistance to purchase commercial plans for uninsured individuals offered in the FFM, the commercial market, or through ESI channels.

The Commonwealth is also planning to establish two new benefit packages for the traditional Medicaid population: the Low Risk Benefit Plan and the High Risk Benefit Plan. Both of these Plans will be offered by managed care plans through the State's current HealthChoices program. The HealthChoices program is a mandatory managed care program that provides both physical health services administered through managed care organizations, and behavioral health services administered through pre-paid inpatient health plans.

Individuals who are determined to be medically frail will be enrolled in the High Risk Benefit Plan. The medically frail include institutionalized individuals, Supplemental Security Income (SSI) recipients, and others with significant physical and behavioral health conditions.

The State is also proposing to streamline and simplify its existing Medicaid program by eliminating, or phasing out, some optional Medicaid programs where individuals would be either eligible for Medicaid under the base program or eligible for APTCs on the exchange.

Populations Affected

Individuals eligible for the Healthy Pennsylvania Private Coverage Option are uninsured individuals between the ages of 21 and 65. These newly eligible individuals consist of childless adults with income between 0% and 133% FPL, and adult parents/caretakers with incomes between 33% and 133% FPL.

Method of Implementation

Pennsylvania will be requesting program authorization under an 1115 Demonstration waiver. The waiver is still in the public comment period. The State is anticipating submitting the application to CMS in the first quarter of 2014.

Benefits

As mentioned above, Pennsylvania plans to simplify its existing 14 adult Medicaid benefit packages into two commercial-like alternative benefit packages: the Low Risk Benefit Plan and the High Risk Benefit Plan. Most adults, 21–64 years of age who qualify

Key Policy Highlights: Healthy Pennsylvania

- 1) Uses premium assistance to purchase commercial coverage through the exchange**
- 2) Covers low-income adults between the ages of 21 and 65 with income below 133% FPL**
- 3) Seeks to require individuals with income above 50% FPL to pay a monthly premium as a condition of eligibility (premiums are replacing all other copays except for non-emergent use of the ER)**
- 4) Premium payments can be reduced by participating in health and wellness appointments and actively engaging in work search and training programs**
- 5) Work search registration and activities are required as a condition or eligibility for unemployed, working-age Medicaid enrollees working less than 20 hours/week**

for Medicaid under current Medicaid eligibility levels, will be enrolled in the Low Risk Benefit Plan.⁵⁵ The Low Risk Benefit Plan contains both mandatory and optional services. Adults with more complex physical and behavioral health care needs will be enrolled in the High Risk Benefit Plan. This plan contains the same benefits, but includes higher limits on provider visits and admits.

Pennsylvania is seeking a waiver that would exempt the provision of wraparound benefits to newly eligible participants, including non-emergency transportation, family planning services (to the extent such services are not covered under the commercial plan), and Federally Qualified Health Center and Rural Health Center services (beyond what is provided by the commercial plans). It is assumed that all other benefits potentially subject to wraparound services are provided sufficiently through commercial plans due to the federal Essential Health Benefits requirement.

Cost Sharing

In terms of increasing access and encouraging personal accountability, the Commonwealth plans to eliminate copayments, with the exception of a \$10 dollar copay for inappropriate use of ER services.⁵⁶ In lieu of most other cost sharing, Pennsylvania is requesting that individuals with income above 50% FPL pay a monthly premium based on their income as a condition of eligibility. The monthly premiums will be structured in an upwards sliding scale of no more than \$25 for individuals or \$35 for households with more than one adult.⁵⁷

Consumer Engagement

Monthly premium payments can be reduced when individuals participate in health and wellness appointments and actively engage in work search and training programs. “Successful completion of healthy behavior activities can reduce the premium by 25% and working can reduce the premium by up to another 25% for a total reduction up to 50%.”⁵⁸

In terms of healthy behaviors, adults’ premiums will be reduced if they:

- Pay premiums on time (during most recent six months)
- Complete a Health Risk Assessment annually
- Complete a physical exam annually

In terms of work search, “adults who at the time of initial application or redetermination are working 30 or more hours per week will receive an initial 25% reduction in their monthly premium. Adults who are working less than 30 hours but at least 20 hours per week will have their premiums reduced by 15% after six months of eligibility.”⁵⁹

⁵⁵ Draft Healthy Pennsylvania 1115 Demonstration Application, Pennsylvania Department of Public Welfare (December 2013).

⁵⁶ Healthy Pennsylvania: Reforming Medicaid, Pennsylvania Department of Public Welfare. Available from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_035843.pdf.

⁵⁷ Certain individuals are exempt from paying the premium, including pregnant women, SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility, the dual eligible, and individuals who are institutionalized.

⁵⁸ Draft Healthy Pennsylvania 1115 Demonstration Application, Pennsylvania Department of Public Welfare (December 2013).

⁵⁹ Ibid.

Work search registration and activities are required for most unemployed, working-age Medicaid enrollees working less than 20 hours per week as a condition of eligibility (with exceptions⁶⁰). One key element of this approach is Pennsylvania’s JobGatewaySM program. After registering with the program, participants have access to a number of features, including job opening announcements, a dashboard to track and manage job applications, and PA Career Coaches, “a career exploration tool with valuable employment data such as estimated earnings and local educational programs to help prepare for a specific occupation.”⁶¹ Healthy Pennsylvania participants must successfully complete 12 approved work search activities per month during their first six months to continue to be eligible for coverage.⁶²

Other Program Features

Enrollment in the Low Risk Benefit Plan, High Risk Benefit Plan, or Private Coverage Option is based on a health screening. The health screening will be completed as part of an online application process in the Commonwealth’s enrollment system. “The health screening tool will consist of a self-administered questionnaire that is completed by the individual, family member, or guardian. The questionnaire includes questions about an individual’s health care needs and conditions. The questions are specifically designed to identify an individual’s medical and behavioral health needs that align with the two Medicaid benefit plans—particularly any presence of complex medical conditions.”⁶³

Pennsylvania has also specified in its Demonstration waiver application that if federal funding drops below the levels set forth in the ACA, it will notify participants in the Private Coverage Option that the coverage will no longer be funded through the Commonwealth.⁶⁴

Costs/Economic Impact

Details on the Demonstration’s budget and cost neutrality have not yet been released. However, as part of the evaluation process, the State is hypothesizing that implementation of the program, particularly the Private Coverage Option, will maintain administrative costs and reduce both premium costs and average per-capita uncompensated care costs.

Providers will be reimbursed for care provided to Private Coverage Option participants at the rates providers negotiate with the respective commercial coverage plans.⁶⁵

⁶⁰ Exceptions include SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility, pregnant women, individuals 65 years of age and older, individuals under 21 years of age, individuals who are institutionalized, and individuals who are dually eligible for Medicare and Medicaid.

⁶¹ Healthy Pennsylvania: Reforming Medicaid, Pennsylvania Department of Public Welfare. Available from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_035843.pdf.

⁶² Draft Healthy Pennsylvania 1115 Demonstration Application, Pennsylvania Department of Public Welfare (December 2013).

⁶³ Ibid.

⁶⁴ Healthy Pennsylvania: Reforming Medicaid, Pennsylvania Department of Public Welfare. Available from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_035843.pdf.

⁶⁵ Draft Healthy Pennsylvania 1115 Demonstration Application, Pennsylvania Department of Public Welfare (December 2013).

Plans in Discussion Stage

Oklahoma: Insure Oklahoma Framework

Overview

In February 2013, the Oklahoma Health Care Authority (OHCA) contracted with Leavitt Partners to make recommendations on how to optimize access and quality of health care in the State, including providing recommendations for a Medicaid Demonstration waiver proposal.

Delivery System

In order to provide a different approach to health care coverage for Oklahoma's low-income, uninsured population, Leavitt Partners recommended that OHCA utilize a premium assistance approach based on the Insure Oklahoma (IO) framework. The IO program is a premium assistance based program designed by the State to provide health care coverage for low-income working adults. The qualifying income limit was 200% FPL, but effective January 1, 2014 it becomes 100% FPL. Those with income above 100% FPL will have access to health insurance through the exchange.

The IO program consists of two separate premium assistance plans: the ESI premium assistance plan and the Individual Plan premium assistance plan. Under the ESI plan, premium costs are shared by the State (60%), the employer (25%), and the employee (15%). ESI is available to employers with up to 99 employees. The Individual Plan (IP) allows people who can't access benefits through an employer (including those who are self-employed or may be temporarily unemployed) to buy health insurance directly through the State.⁶⁶

In addition to utilizing the IO framework, Leavitt Partners recommended the State streamline and simplify the State's existing Medicaid program by eliminating optional Medicaid coverage where individuals would be either eligible for Medicaid under the base program or eligible for APTCs.

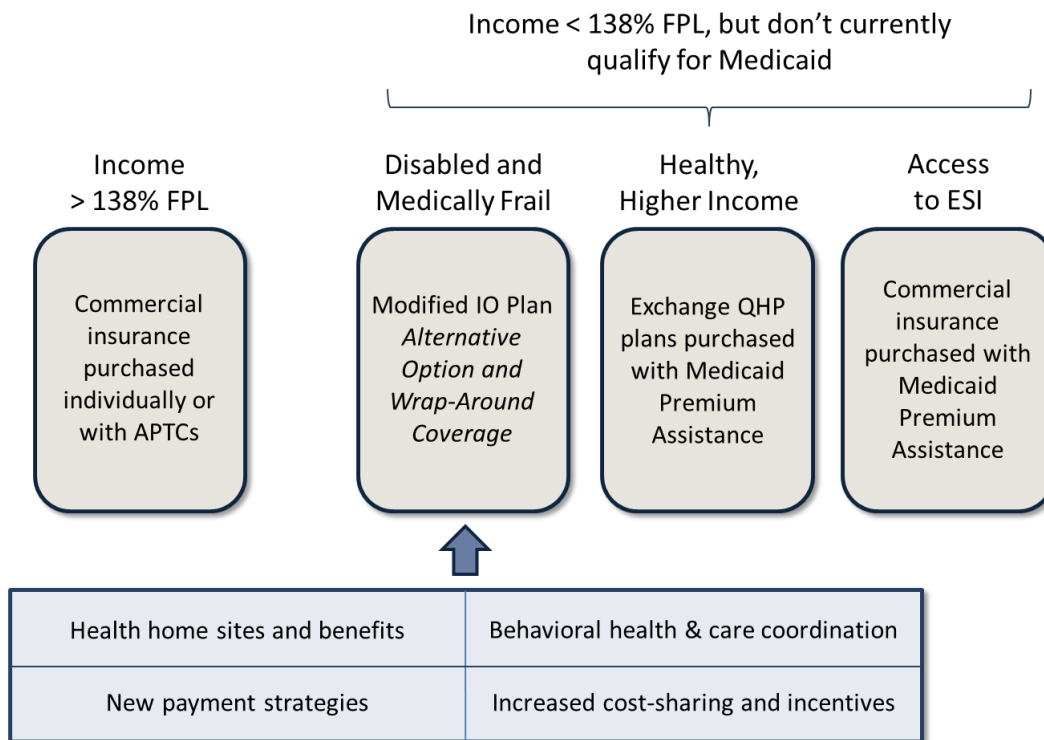
Key Policy Highlights: Insure Oklahoma Framework

- 1) **Uses premium assistance to purchase commercial coverage through the exchange as well as a modified version of an existing Medicaid alternative benefit plan**
- 2) **Would cover uninsured adults with income below 133% FPL**
- 3) **The modified benefit plan would include additional health home benefits**
- 4) **Maximum allowable cost sharing would be charged, but appropriate reductions to incentivize positive healthy behaviors and promote personal responsibility would also be utilized**
- 5) **This program is currently only in the discussion stage**

⁶⁶ CMS indicated that it will allow Oklahoma to extend its Insure Oklahoma past 2013 for one year. At that time the IO program will no longer have federal authority to continue unless the State is willing to make certain changes to comply with certain federal requirements, including benefit, cost sharing, eligibility, and enrollment rules. For example, IO's current benefit package does not include Essential Health Benefits and its cost-sharing amounts would need to be adjusted to meet standards CMS set forth in its proposed rule. Eligibility for the program would need to be based on MAGI. In addition, the U.S. Department of Health and Human Services (HHS) has stated it will no longer approve enrollment caps for the newly eligible or similar populations.

Through the recommended approach, the State would provide premium assistance to eligible participants to purchase either qualified health insurance through the FFM or ESI through the current IO ESI program.

Figure 2: Recommended Approach for Covering Low-Income, Uninsured Oklahoma Residents



Source: Covering the Low-Income, Uninsured in Oklahoma: Recommendations for a Medicaid Demonstration Proposal, Leavitt Partners (June 27, 2013).

For uninsured individuals who don't qualify for Medicaid under the State's existing eligibility rules, but are disabled or considered medically frail, the State would use a modified version of the IO Individual Plan as the basis for benefit design and care delivery. This model will also serve as the alternative option to the commercial buy-in choices as well as the wraparound coverage for the commercial products purchased through the exchange or group market.

Leavitt Partners also recommended that OHCA maintain SoonerCare Choice's current medical home program, but expand the program to include a few strategically placed health home sites. These sites will help address the needs of the target population's more vulnerable, high-risk individuals who account for a high percentage of program costs.⁶⁷ The health home sites would extend the coordination of primary, acute, and specialty care to include behavioral health and long-term care as well as promote greater coordination with other community support services.

⁶⁷ Medicaid, A Primer, Kaiser Commission on Medicaid and the Uninsured (March 2013). Medicaid's high cost enrollees: how much do they drive program spending? Kaiser Commission on Medicaid and the Uninsured (KCMU) (March 2006).

Populations Affected

Participants eligible for premium assistance would include relatively healthy, low-cost, uninsured adults with income up to 133% FPL. Other newly eligible individuals would be enrolled in the modified IO Individual Plan.

Method of Implementation

At this point, this program is only in the discussion phase; however, if implemented, the program would need to be authorized under an 1115 Demonstration waiver.

Benefits

Individuals in the premium assistance program would receive commercial benefits through their exchange or ESI plan. The State would provide wraparound Medicaid benefits on a FFS basis through the use of a secondary coverage card for the State's traditional Medicaid plan.⁶⁸

The modified IO Individual Plan would include the basic benefits required for Medicaid coverage and add additional health home benefits. Possible health home benefits could include those outlined in the ACA Section 2703, such as:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, which includes appropriate follow-up
- Individual and family support, which includes authorized representatives
- Referral to community and social support services
- The use of health information technology to link services

Cost Sharing

Leavitt Partners recommended the State impose maximum allowable cost sharing on the newly eligible population, but utilize appropriate reductions in the cost-sharing requirements to incentivize positive healthy behaviors and promote personal responsibility (e.g., using generic prescription drugs). Given the income range of the target population (0–133% FPL), a sliding schedule would likely be required when imposing cost sharing, with those at the lowest income levels being exempt.

Consumer Engagement

As mentioned above, Leavitt Partners recommended OHCA utilize appropriate reductions in the cost-sharing requirements to promote personal responsibility. While detail on specific approaches was not provided in the recommendation, research conducted for this project outlined the following “lessons learned” that could be utilized when developing an incentive program:

- It is difficult to engage participants in complex behaviors that are not clearly delineated (e.g., smoking cessation, weight management, increased exercise, etc.);
- It is easy to engage participants in simple behaviors involving office visits (e.g., vaccinations, screenings, wellness programs, etc.);

⁶⁸ Research indicates that the “several states that use this model, including Wisconsin and Iowa, have found that costs tend to be nominal, as most enrollees prefer to simply use their ‘mainstream’ employer benefits.” Challenges to Implementing Premium Assistance, Health Insurance for Children, The Future of Children, Princeton-Brookings, 13 No. 1 (Spring 2003).

- It is easy to engage parents in behaviors which provide benefit to their young children (however, these activities often involved office visits so there may be some confounding variables);
- If money is used as an incentive it needs to be immediately available to the participant to be of value;
- Informing potential participants of the availability of the incentive program is of utmost importance;
- Programs using the physician as a gatekeeper may have limited effectiveness as the physician may not be willing or able to adequately participate in this role;
- Enrollment in incentivized programs require action from the participant (as opposed to default assignment) in order to better educate and motivate the participant; and
- A voucher program will not be successful if other barriers exist that prevent the participant from using the voucher (e.g., a voucher provided for a gym membership cannot be used because of difficulties regarding childcare and transportation).

Other Program Features

As part of the new program, it was recommended that the State implement payment strategies that incentivize providers to be efficient and to focus on quality and positive patient outcomes. For example, using a community-of-practice shared savings model in the newly established health homes would both benefit providers as well as hold them accountable for care improvements by incentivizing them to meet specific performance and outcome metrics.

It was also suggested that the State work with the commercial plans that have the highest enrollment of subsidized coverage to implement multi-payer models for the program's health home and medical home systems. In multi-payer models, providers establish health home and medical home systems in which they are paid by both Medicaid and commercial payers to treat and provide services to all patients. Benefits of using such a model include, but are not limited to: 1) allowing providers to spread investment over more patients; 2) obtaining community alignment of performance measures and reporting structures; and 3) creating less administrative burden as providers use more standardized processes.

Costs/Economic Impact

In designing the Demonstration proposal, Leavitt Partners goal was to develop an approach that would improve the health of Oklahoma's citizens, improve access to quality and affordable health care, and provide a more cost-effective approach that reduces both direct and indirect costs to the State (including uncompensated care). While the proposal is expected to increase direct costs to the State over a 10-year period, the overall net effect is positive due to the enhanced federal funds, expected program savings, and increased tax revenue. Program savings include those realized by other state departments and programs, such as the Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma Department of Corrections, and the Oklahoma State Department of Health. These Departments will realize savings as they leverage enhanced federal funds for programs that were previously state-funded. State tax revenue also is expected to increase as federal funds are circulated and spent within the State's economy. When taking into account the Demonstration's direct, indirect, and induced economic effects,⁶⁹ including new job creation, the total economic benefit to the State is expected to range from \$13.6 to \$17.3 billion over a 10-year period.

⁶⁹ Direct effects occur when money is spent within the industry, such as the federal government paying for a hospital stay. An indirect effect occurs when the industry that is affected directly then interacts with another

Utah: Medicaid Expansion Block Grant Proposal

Overview

In determining whether to expand Medicaid, the State of Utah considered several options, including a Medicaid Expansion Block Grant-like waiver. The State has not yet made a final decision regarding if and when to expand, so the option is still in its basic proposal form (outlined below).⁷⁰ It is also important to note that this proposal was not one of the final three put forth for the Governor's consideration, and is therefore unlikely to be advanced by the State. The final three proposals include: 1) not expanding; 2) using premium support to purchase commercial insurance for individuals below 100% FPL (and allowing those above 100% FPL to purchase insurance on the exchange with the assistance of APTCs); and 3) using premium support to purchase private insurance for individuals below 133% FPL.⁷¹

Delivery System

Coverage for newly eligible individuals with income above 100% FPL would be provided through a premium assistance model. Newly eligible individuals with income below 100% FPL would receive services through the State's Medicaid ACOs (Utah's managed care program). The workgroup that developed this option believes that using this type of delivery system would highlight the strengths of both private health insurance and Utah's ACO system.⁷²

Populations Affected

The program would expand coverage to adults with income up to 133% FPL, who are not currently eligible for Medicaid.

Method of Implementation

Utah would seek an 1115 Demonstration waiver allowing it to access enhanced federal funds. The waiver would operate much like a block grant and federal funding would be based on per person estimates, calculated by eligibility groups.

Key Policy Highlights: Utah Medicaid Expansion Block Grant Proposal

- 1) **Allows the State to operate its Medicaid expansion program under a "block grant"**
- 2) **Uses a combination of premium assistance and ACOs to provide coverage**
- 3) **Low-income adults with income below 100% FPL would receive care through ACOs, individuals with income from 101–133% FPL would receive premium assistance**
- 4) **HSA's would be used to help individuals pay for premiums and other cost sharing**
- 5) **This program is currently in the discussion stage and has not been advanced to the Governor for consideration**

industry. For example, a hospital with an increase in patient volume will purchase more laundry services from a local laundry company. Induced effects estimate how the additional money spent on the industry will change individual behavior, such as a newly hired worker earning more at the hospital and then spending more money at local retail stores.

⁷⁰ Block Grant-Like Waiver: Expansion Medicaid Options, developed by Community Workgroups for Governor Herbert (2013).

⁷¹ Utah May Substitute Private Insurance for Medicaid Expansion, The Salt Lake Tribune (December 12, 2013).

⁷² The State's Medicaid Accountable Care Organizations are currently structured like commercial managed care. However, plans, providers, and stakeholders are working together to develop payment reform options, such as shared savings and quality-based payments, to be implemented in future years.

Calculating a capitated rate by eligibility group minimizes the risk the State could face if enrollment increased or there was a change in the distribution of enrollees over time. This model would not be a true block grant and therefore would not require Congressional action.

Cost Sharing/Consumer Engagement

HSAs would be used to help individuals pay for premiums and other cost sharing.

Other Program Features

Any Demonstration proposal the State develops would contain a “circuit breaker” that would end the Demonstration if the federal match changed or fell below the levels specified in the ACA.

Other expansion options the State has considered include: 1) using benchmark benefits to offer a more limited benefit package to the expansion population; and 2) expanding charity care. Potential problems identified with expanding charity care include:⁷³

- The number of paid staff and volunteers who work at charity clinics is limited
- Current clinics rely on foundations and individual donations (which can vary year to year)
- Many clinics do not cover tests, labs, or prescriptions
- Patients often prolong care before seeking treatment (which results in more costly and invasive procedures)

Costs/Economic Impact

Because the Demonstration would operate like a block grant, Utah would be at risk if costs exceeded funding estimates. However, if the waiver rates are lower than current Medicaid rates (or what Medicaid rates would have been without a waiver) then Utah will achieve budget savings.⁷⁴ These savings could be used to add individuals to the program or to provide services not currently covered by Medicaid (e.g., adult dental).

Policy Options likely to be a “Best Fit” for Kansas

In assessing the feasibility or “fit” of any of the policy options reviewed in the previous section, consideration must be given to relevant factors, including: the current political and fiscal landscape, the status of insurance coverage for Kansans (including a clear view of the uninsured population), the current Medicaid program and delivery system, and the health care provider system, among others. To help better understand these factors, Leavitt Partners completed interviews with key stakeholders in the State of Kansas. The stakeholders interviewed represent leaders from a spectrum of political, policy, and provider viewpoints as it relates to health care in Kansas.

The following subsections summarize the key themes that surfaced from these interviews within the context of the factors that should be considered in assessing the feasibility of alternative policy options for covering the uninsured.

⁷³ Is Charity Care an Alternative to Expanding Medicaid in Utah? KUER (September 15, 2013).

⁷⁴ Block Grant-Like Waiver: Expansion Medicaid Options, developed by Community Workgroups for Governor Herbert (2013).

Kansas Political Landscape

Republicans currently hold all statewide elected offices⁷⁵ and significant majorities in both the State House of Representatives⁷⁶ and the State Senate.⁷⁷ The majority held by Republicans in both the House and Senate was extended during the 2012 elections. Many of the stakeholders interviewed for this project pointed to political and ideological opposition to “Obamacare” as one contributing factor to this expansion. As a result, the expansion not only led to an increasing Republican majority, but a more conservative ideology across the Legislature as a whole. The general consensus of those interviewed is that Medicaid expansion will not be addressed by the Legislature in the near future and that any policy proposals that resemble “Obamacare” would be extremely difficult and likely impossible to garner the sufficient support needed to be enacted by the Legislature. The Legislature has been more open to market-based solutions to providing increased access to affordable insurance, such as creating “mandate-lite” insurance plans.

Governor Brownback began his first term as Kansas Governor in 2011 and will stand for re-election in 2014. While opposed to the ACA in general, Governor Brownback has not publicly declared his full opposition or support of Medicaid expansion. He has stated his concerns about the financial implications of expanding and skepticism that the enhanced federal funding will be provided into the future at the levels outlined in the ACA.⁷⁸ Media reports from as late as December 13, 2013, quote him as saying: “I’ve not declared a position on it because you’re seeing the federal government adjust monthly, Obamacare. They may adjust this one.”⁷⁹

Several individuals interviewed for this project highlighted the fact that Governor Brownback has not openly stated his opposition to Medicaid expansion, and thought that his leadership may be a possible avenue to pursue in furthering the discussions of available options. They felt it would be possible to put forth a potential “Kansas Plan” under his leadership. Some stated they felt this was the only viable option to developing a Kansas Plan for covering the uninsured, considering the level and breadth of opposition to the ACA in the Legislature.

Kansas State Revenue and Budget Environment

Kansas state revenue collections appear to be following trends reflected in most states—a slow, but steady increase in revenue as states recover from the 2008 recession, with a slight decline in estimated revenue growth in 2014. On November 6, 2013 consensus estimates of General Fund revenue for FY 2014 and FY 2015 were released by the Kansas Division of the Budget and the Kansas Legislative Research Department. The FY 2014 estimate was revised downward by \$29 million (0.5% from the prior

⁷⁵ Governor, Lt. Governor, Attorney General, Insurance Commissioner, Secretary of State, and State Treasurer.

⁷⁶ State House is comprised of 92 Republicans and 33 Democrats.

⁷⁷ State Senate is comprised of 32 Republicans and 8 Democrats.

⁷⁸ New federal match rates will provide 100% federal funding for the care of the newly eligible Medicaid population for three years (2014–2016). After 2016, the funding will gradually be reduced to 90% by 2020 and is expected to hold at 90% thereafter. States are responsible for covering the percent not paid by the federal government, as well as the associated administrative costs of providing coverage to the new population.

⁷⁹ Brownback Not Moving Toward Medicaid Expansion; Criticizes Health Exchanges, Lawrence Journal World (December 13, 2013). Available from http://www2.ljworld.com/news/2013/dec/13/brownback-not-moving-toward-medicaid-expansion-cri/?kansas_legislature.

estimate). Total anticipated revenue in FY 2014 reflects a 7.6% decrease from FY 2013 levels.⁸⁰ This percentage reduction is not unique to Kansas; 2013 saw state revenues “artificially boosted [by] personal income tax collections” due to capital gains tax decisions. Nationally, state revenue growth began to slow in the first quarter of SFY 2014.⁸¹ In its estimates released in August 2013, the National Conference of State Legislatures (NCSL) reported state overall anticipated revenue growth of just 1.3% in FY 2014;⁸² in its December 2013 report, the National Association of State Budget Officers (NASBO) reported lower estimates of 0.8% revenue growth in FY 2014.⁸³ However, 2013 was the first year since 2008 that most states saw their revenues match levels prior to the start of the recession. Overall, average state revenues from all 50 states grew 5.3% in 2013 and 41 states experienced year-over-year revenue growth.⁸⁴

Current consensus estimates for Kansas General Fund levels in FY 2015 show an increase of \$60.6 million over revised 2014 levels, or a 1% increase. Overall revenue receipts in FY 2015 are estimated to increase 1.8% over 2014 levels.⁸⁵

On November 12, 2013, the Kansas Legislative Research Department and Kansas Division of the Budget released updated FY 2015 consensus caseload estimates for human services programs, including KanCare.⁸⁶ Estimates for the FY 2015 KanCare budget total \$2.5 billion, \$986.3 million of which is state general funds. This represents an increase of \$63.2 million in state general funds over the FY 2014 level (\$140.3 million in total funds). “The increase is largely attributable to an anticipated increase in the caseload population growth.”⁸⁷

Stakeholder interviews conducted for this project reflect a wide range of views on the Medicaid program’s impact on the state budget. Some interviewees expressed that the Medicaid program constitutes too much of the state budget, while others felt it is in line with what other states spend. Interviewees also expressed concerns about the impact that the ACA and its provisions related to Medicaid will have on future state expenditures. Concern over the growing share of the state budget directed to Medicaid has been a concern of both executive and legislative leaders, and was a key reason cited for Kansas transitioning to a managed care delivery model in early 2013. Early indications

⁸⁰ State General Fund Revenue Estimate for FY 2014 and FY 2015, Kansas Division of the Budget, Kansas Legislative Research Department (Memorandum dated November 8, 2013). Available from http://www.budget.ks.gov/files/FY2015/CRE_Long_Memo-Nov2013.pdf.

⁸¹ Fourth quarter SFY 2013 revenue growth was 9% over the same time period in SFY 2012; First quarter SFY 2014 revenue growth was 6.1% over the same time period in SFY 2013.

⁸² State Budget & Tax Actions: Preliminary Report, National Conference of State Legislatures (August 2013). Available from <http://www.ncsl.org/issues-research/budget/state-budget-and-tax-actions-preliminary-report.aspx>.

⁸³ Fiscal Survey of State, National Association of State Budget Officers (Fall 2013). Available from <http://www.nasbo.org/publications-data/fiscal-survey-states/fiscal-survey-states-fall-2013>.

⁸⁴ State Budget & Tax Actions: Preliminary Report, National Conference of State Legislatures (August 2013). Available from <http://www.ncsl.org/issues-research/budget/state-budget-and-tax-actions-preliminary-report.aspx>.

⁸⁵ State General Fund Revenue Estimate for FY 2014 and FY 2015, Kansas Division of the Budget, Kansas Legislative Research Department (Memorandum dated November 8, 2013). Available from http://www.budget.ks.gov/files/FY2015/CRE_Long_Memo-Nov2013.pdf.

⁸⁶ Fall 2013 Human Services Consensus Caseload Estimates for FY 2014 and FY 2015, Kansas Division of the Budget, Kansas Legislative Research Department (Memorandum dated November 12, 2013). Available from <http://skyways.lib.ks.us/ksleg/KLRD/Publications/FY2014%262015FallHSCaseloadMemo.pdf>.

⁸⁷ Ibid.

are optimistic that this move has succeeded in lowering the annual growth rate in Medicaid expenditures. Caution was also expressed, however, that while this strategy may keep costs low for a few years, this lower trend is not sustainable without additional delivery system and payment model reforms.

Most interviewees noted the increase in Medicaid enrollment that will occur in 2014 regardless of whether the State chooses to expand Medicaid. This increase is generally referenced as the “woodwork effect.” They also acknowledged the additional state cost that will occur as a result of the increased enrollment, which will be at the regular state match rate of 43.5%. Several interviewees highlighted the inability to prioritize available state revenue on other critical state needs, most notably education, because of this added Medicaid cost.

With respect to the cost of a potential Medicaid expansion, the views expressed by stakeholders were varied. Some general themes on one side of the issue included:

- An inability to “count on” enhanced federal funding at the levels promised by the ACA
- The negative impact of spending federal funds, as it contributes to the overall federal debt and deficit
- Unsustainability of expansion from a state expenditure viewpoint

General themes from the other side of the issue included:

- The State will still be responsible for covering the cost of providing care to the uninsured expansion population if the State does not expand
- By not expanding and receiving the enhanced federal funds, Kansas tax dollars will go to support other states’ expansion efforts
- The additional revenue coming into the State would outweigh additional costs and generate economic activity resulting in increased state revenue

It is clear that any discussion regarding expanding health care coverage or benefits to currently insured or uninsured populations will need to consider both the short- and long-term state economic and revenue landscape—particularly as it relates to estimated federal revenue receipts and the state share of total costs. Several studies containing estimates of these economic dynamics related to the ACA’s Medicaid provisions have been conducted at both a national and state level with varied results. In February 2013, three separate analyses were publicly released for the State of Kansas, with each reporting different estimates and conclusions. A brief summary of these reports is provided below.

The **Kansas Department of Health and Environment (KDHE)** contracted with Aon Hewitt to analyze the impact of the ACA on the Medicaid and CHIP programs in Kansas. This analysis looked at estimated enrollments and expenditures under both an expansion and non-expansion scenario. Without expansion, Medicaid enrollment is expected to grow as ACA outreach efforts capture those currently eligible, but not enrolled. Aon Hewitt estimated non-expansion enrollment growth to be 20,563 in 2014 and 41,538 by 2016; the cumulative state budget impact over the CY 2014–2023 period was estimated to be \$513.5 million due to the

“woodwork” effect.⁸⁸ Estimated enrollment growth in Medicaid and CHIP under an expansion scenario would reach 111,880 in CY 2014 and 226,003 in CY 2016, and the corresponding 10 year state budget impact estimate for both the “woodwork” and expansion populations is \$1.1 billion.⁸⁹

The **Kansas Policy Institute** (KPI) estimated increased state general fund spending that would be required over a 10-year period (2014–2023) under what they term the ACA “mandate effect” (non-expansion scenario) and an “expansion effect.” Under the mandate effect, KPI estimates enrollment increases of 102,000 into Medicaid/CHIP. Under an “expansion effect,” it estimates an additional 130,000 enrollments.⁹⁰ Ten-year cumulative additional state general fund spending is estimated reach \$4.1 billion under the mandate effect alone and \$4.72 billion with the combined impact of the expansion effect.⁹¹ As noted and explained in the report, while the estimates of additional enrollment used by KPI are not significantly different from those used by other studies, “the KPI study’s total annual dollar cost projections from the two effects of ACA are larger than those of other studies.”⁹² The key reason for this difference is the methodology used to calculate per enrollee costs. “The KPI study does not ‘flat-line’ the cost per person to be used to calculate future expenditure increments... Rather, historical trends in Medicaid costs per person are (a) differentiated by demographic/age/income group and (b) future years’ costs are based on extrapolating the historical trend for each separate category of enrollees.”⁹³

A report prepared for the **Kansas Hospital Association** (KHA) by George Washington University (GW) and Regional Economic Models, Inc. (REMI) used similar ACA enrollment impact estimates in developing their estimates of increased state Medicaid costs from 2014 to 2020.⁹⁴ In addition to estimating increased state costs associated with Medicaid expansion, this study also estimated new state revenues and offsetting state health savings resulting from the Medicaid expansion. This allowed them to develop net state cost estimates. “The estimates suggest that the combination of new state revenues and offsetting savings could actually lead to substantial state savings from 2014 to 2016 and would be essentially almost budget neutral from 2017 to 2020, saving about \$89 million from 2014 to 2020.”⁹⁵

Both the KPI and KHA reports addressed the overall expected impact of Medicaid expansion on the Kansas state economy—each with a different conclusion. Among the KHA report findings were a job creation estimate of 3,500–4,000 jobs and increases in Gross State Product (GSP) averaging “\$319

⁸⁸ Analysis of Affordable Care Act Impact to Kansas Medicaid/CHIP Program, prepared for Kansas Department of Health and Environment (KDHE), Aon Hewitt Health and Benefits (February 13, 2013). Available from http://www.kdheks.gov/hcf/kancare/download/KS_Medicaid_Expansion_Analysis_Report.pdf.

⁸⁹ Ibid.

⁹⁰ Should Kansas Expand Medicaid under the Affordable Care Act: A Perspective on Weighting the Costs and Benefits, Kansas Policy Institute (February 2013). Available from

<http://www.kansaspolicy.org/ResearchCenters/HealthCare/StudiesAnalysis/102862.aspx>.

⁹¹ Ibid.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ C. Brown, R. Motamedi, C. Stottlemeyer, B. Bruen and L. Ku, Economic and Employment Effects of Expanding KanCare in Kansas, prepared for the Kansas Hospital Association (February 2013). Available from

<http://www.kha-net.org/Communications/MediaReleases/102615.aspx>.

⁹⁵ Ibid.

million per year for a cumulative increase of \$2.24 billion from 2014 through 2020.”⁹⁶ The KPI report concludes that “the additional federal dollars from the generous matching rate promised for Medicaid expansion is unlikely to result in any significant expansion of economic activity in the State. Those dollars would only add demand pressure to a sector where supply responses are highly inelastic in the short and medium terms.”⁹⁷

More recently, **The Commonwealth Fund** explored the relative relationship between expected federal revenue if a state expanded Medicaid to expected federal revenue from two other major federal sources of state revenue—federal highway transportation funding and federal defense procurement contracts, both in the year 2022.^{98 99} Among the conclusions reached in this report is “the value of new federal funds flowing annually to states that choose to participate in the Medicaid expansion in 2022, will be, on average, about 2.35 times as great as expected federal highway funds going to state governments in that year and over one-quarter as large as expected defense procurement contracts to states.”¹⁰⁰ Applying these estimates to Kansas’ economy in 2022, additional federal revenue from Medicaid expansion would be 1.6 times as great as expected federal highway transportation funds and 31% as large as expected federal defense procurement contract revenue.¹⁰¹ This study also provided a comparison between the state share of Medicaid expansion costs in 2022¹⁰² to the level of state spending for incentive payments used to attract private business. For all states, the state share for Medicaid expansion averages less than one-sixth of incentive payments; for Kansas, the estimated state share for Medicaid expansion of \$108 million is 8.6% of the estimated \$1.25 billion in incentive payments.¹⁰³

These reports, as well as numerous others that have been published nationally in the past three years, highlight the divergence of Medicaid expansion costs estimates and the level of economic affect, if any, that will result from expanding Medicaid. This raises question as to whether agreement or consensus could ever be found.

Stakeholders interviewed for this project expressed a shared desire to explore both these cost and economic impact questions further. The goal of such exploration would be to provide policy makers

⁹⁶ Ibid.

⁹⁷ Should Kansas Expand Medicaid under the Affordable Care Act: A Perspective on Weighting the Costs and Benefits, Kansas Policy Institute (February 2013). Available from <http://www.kansaspolicy.org/ResearchCenters/HealthCare/StudiesAnalysis/102862.aspx>.

⁹⁸ S. Glied and S. Ma, How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion, The Commonwealth Fund (December 2013). Available from <http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Dec/Federal-Funds-Medicaid-Expansion.aspx>.

⁹⁹ The Commonwealth Fund reports that this is based on the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM) projections of Medicaid enrollment and expenditures under an expansion scenario.

¹⁰⁰ Ibid.

¹⁰¹ Based on expected federal Medicaid revenue of \$767 million, federal highway transportation funds of \$486 million and federal defense procurement contracts of \$2.483 billion.

¹⁰² Kansas share of expansion costs is estimated to be 10%.

¹⁰³ Glied and S. Ma, How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion, The Commonwealth Fund (December 2013). Available from <http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Dec/Federal-Funds-Medicaid-Expansion.aspx>.

and stakeholders with additional data and information to expand common understanding of various viewpoints and to assist in assessing possible policy options.

Insurance Coverage Status of Kansans

Frequent themes that arose during the stakeholder interviews include: 1) there is a prevalence of misperceptions regarding the circumstance and motivations of uninsured individuals in Kansas; and 2) there a desire to have a better understanding of the uninsured population and the various subgroups that it comprises. While all those interviewed had at least a general knowledge of the State's uninsured population, some had questions such as:

- What income levels do the uninsured fall into?
- What percent are employed?
- What is the demographic makeup of the population, including what percent are children and what is the citizenship status of this population?
- What proportion has access to health coverage, but makes a conscious decision to remain uninsured?
- If the uninsured do have access to health coverage, what is the cost of this coverage and how affordable is it based on their income level and competing needs for other basic necessities such as food and housing?
- What level of pent-up need for care exists among the uninsured population and how will that affect costs of providing coverage or care in the short and long term?
- What are the costs borne by the public, charitable, and private sectors for the care that is currently provided to the uninsured?

While a detailed analysis of the uninsured population is not a part of this project, some baseline information can be drawn from recent national estimates and reports.

The U.S. Census Bureau's 2012 American Community Survey (ACS) estimate of the number of uninsured in Kansas is 356,000 or 12.6% of the population (this estimate reflects no change from 2011 levels). Census Bureau estimates based on the Current Population Survey (CPS) are slightly higher at 369,000 or 13.1% of the State's population. Both estimates are below the national uninsured rate of 14.8%. The uninsured population is predominantly comprised of adults, age 18–64, (86%) and children (13.5%) with less than 1% of the population consisting of seniors age 65 and over. Using the ACS estimate, Kansas's uninsured population includes 6.6% of all children in the State (47,858), 17.7% of all adults age 18–64 (305,904), and 0.5% of all adults age 65 and over (1,802). Within the adult 19–25 age group, the uninsured rate declined from 26.8% in 2009 to 22.9% in 2012; a new insurance provision which took effect in 2010 allowing adults up to age 26 to remain on their parent's insurance plans is credited with contributing to this decline.

For the insured group, 51.9% of insured Kansans received coverage through an employer-sponsored plan, 2.1% through TRICARE or other military associated plan, and 27% through publicly financed coverage. Approximately half of those enrolled in public coverage are in Medicaid and CHIP (13.1%) with the other half (13.9%) are in Medicare, Veteran's Administration, and other public health care programs.

Medicaid Assistance Eligibility in Kansas

Kansas provides medical coverage to low-income individuals through three primary programs:¹⁰⁴

- KanCare (Medicaid) covering certain groups of individuals with limited income
- KanCare (CHIP) covering children up to age 19 who do not qualify for Medicaid
- MediKan covering individuals who are in the process of applying for Social Security disability benefits

In order to be eligible for KanCare, individuals must first fall into one the following groups:

- Children up to age 19
- Pregnant women
- Persons who are blind or disabled as defined by Social Security
- Persons age 65 and older
- Persons receiving inpatient treatment for tuberculosis
- Low-income families with children
- Persons screened and diagnosed with breast or cervical cancer through the Early Detection Works program

Individuals in these groups must also fall within defined income standards, which vary by coverage group and program.

One of the provisions of the ACA that applies to all state Medicaid programs effective January 1, 2014 is using a new methodology to calculate income for purposes of eligibility determination (for groups such as children, pregnant women, and adults). The Modified Adjusted Gross Income, or MAGI methodology is consistent with what is used by the Internal Revenue Service. The ACA also establishes a standard income disregard level of 5%.

To comply with this provision, states must convert their existing income eligibility standards for certain groups to the MAGI methodology. For Kansas, CMS reports the new eligibility standards for each impacted group as (effective January 2014):¹⁰⁵

- KanCare Medicaid for children ages 0–1: 166% FPL
- KanCare Medicaid for children ages 1–5: 149% FPL
- KanCare Medicaid for children ages 6–18: 133% FPL
- KanCare CHIP for children ages 0–18, not otherwise eligible for Medicaid: 245% FPL
- KanCare Medicaid for pregnant women: 166% FPL
- KanCare Medicaid for adults with children: 33% FPL

¹⁰⁴ Kansas Medical Assistance, Basic Eligibility Requirements, KDHE. Available from http://www.kancare.ks.gov/download/factsheets/Fact_Sheet_Medical_Coverage_Basic_Eligibility_Requirements.pdf.

¹⁰⁵ State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014, CMS. Available from <http://www.medicare.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>.

The Uninsured Population and Access to Coverage through the Health Insurance Marketplace

Beginning in January 2014, uninsured Kansans with incomes between 100%¹⁰⁶ and 400% FPL,¹⁰⁷ who are not otherwise eligible for coverage under KanCare Medicaid or CHIP, will have access to health insurance coverage through the FFM and will be eligible for APTCs to assist them in purchase of coverage.¹⁰⁸

Uninsured adults with income less than 100% FPL, who are not otherwise eligible for Medicaid or CHIP, are not eligible for APTCs and therefore fall into what has become known as the “coverage gap”. Estimates from the Kaiser Commission on Medicaid and the Uninsured (KCMU) show that the coverage gap population nationwide nears five million and represents about 27% of all uninsured nonelderly adults; for Kansas the estimate is 77,290 or 29% of the total uninsured nonelderly adult population.¹⁰⁹

Nationally, the coverage gap adult population exhibits the following characteristics:¹¹⁰

- Over one-third (37%) are age 35–54 and 15% are age 55–64
- Nearly half (47%) are White non-Hispanics, 21% Hispanic, and 27% Black; overall 53% are people of color
- 76% are adults with no dependent children
- 60% are in a family with at least one worker
- 54% are employed; 29% are employed full time and 25% are employed part-time; half (51%) work for small companies with less than 50 employees

The adult coverage gap population in Kansas mirrors national population characteristics in some respects and deviates in others:¹¹¹

- 30% are people of color (which is lower than the national estimate)
- 68% are adults without dependent children (which is lower than the national estimate)
- 76% reside in a family with at least one worker (which is higher than the national estimate)

The “coverage gap” population has limited options for affordable coverage and further analysis of the makeup of this group will be necessary to facilitate discussions and design policy options to provide effective and efficient health care coverage to this group.

In addition, while it is too early to assess what proportion of the uninsured in Kansas with income above the poverty level will access coverage through the FFM, this is an area also that warrants further analysis—particularly as more complete take up rate data become available. This will help determine

¹⁰⁶ For an individual, 100% FPL equates to an annual income of \$11,490; for a family of four it equates to \$23,550.

¹⁰⁷ For an individual, 400% FPL equates to an annual income of \$45,960; for a family of four it equates to \$94,200.

¹⁰⁸ The uninsured population with incomes between 100% and 133% FPL are not subject to the individual mandate tax penalty for failing to obtain coverage; this population also overlaps with the a portion of the Medicaid expansion population.

¹⁰⁹ The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, KCMU (October 2013). Available from <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

¹¹⁰ Characteristics of Poor Uninsured Adults who Fall into the Coverage Gap, KCMU (December 2013). Available from <http://kff.org/health-reform/issue-brief/characteristics-of-poor-uninsured-adults-who-fall-into-the-coverage-gap/>.

¹¹¹ Ibid.

whether policy options that include use of the FFM are a viable option to increasing the insured rate of low-income individuals in Kansas.

KanCare Program and Delivery System

As discussed earlier in the *Kansas State Revenue and Budget Environment* subsection, there is a shared concern amongst policy makers in Kansas with respect to the future stability and sustainability of financing the Medicaid program. This concern was one of the driving forces behind Governor Brownback’s decision to transition to a private-sector managed care delivery system. The first phase of managed care enrollment began in January 2013 with the second phase originally scheduled to begin in January 2014.¹¹² While evaluating the KanCare model was not included in the scope of this project, interviewees were asked to provide their general perceptions of the system—particularly around the willingness and capacity of providers in the current system to serve the low-income population.

All interviewees noted that it is still too early to know whether KanCare’s stated goals of reducing long-term costs by improving health outcomes will be achieved. However, there was broad-based support for the overall approach of KanCare as a “state-based, private-market solution.” Additional supportive themes from the interviews included:

- The managed care model provides increased flexibility in terms of negotiating provider reimbursement rates, which should support provider recruitment and retention.
- Greater flexibility also means patients have been able to receive needed wrap services (identified by care coordinators) that weren’t available in the prior Medicaid model.

Interviewees also expressed some cautionary comments about the program, including that changes in patient care and access are not yet visible and that many patients are still seeking care through emergency rooms. Additionally, there is no evidence yet which supports a measurable increase in patients’ attachment to primary care providers. While recognizing that the use of managed care in the State is still in the early stages, several interviewees indicated that no perceived pressure has been placed on providers to modify their current practices. Other interviewees noted that the level of attention directed to remedying “provider administrative hassles” during the transition to KanCare has detracted from the State’s ability to achieve desired clinical practice changes.

Additionally, providers throughout the system have had to invest their own time and resources in navigating transitional activities such as provider enrollment and credentialing, adjusting billing procedures, and adapting to the prior authorization procedures of KanCare’s Medicaid managed care plans. As with any major system transformation effort, issues and problems have arisen between providers and the managed care plans. Interviewees credited the Department of Health and Environment with recognizing and taking action to address these implementation problems. However, issues related to claims processing and prior authorization were cited as continuing frustrations. While these problems were not viewed as insurmountable, several interviewees noted a concern that continuation of these issues could erode providers’ willingness to serve Medicaid patients in the program.

¹¹² On December 27, 2013, CMS delayed implementation of the second phase of KanCare enrollment.

Optimism, however, remains strong among most interviewees that the design of KanCare as a more patient centric delivery system, utilizing integrated care and care coordination, will produce both improved patient care and outcomes as well as reduce long-term care costs.

Exploration of policy options to extend coverage to low-income uninsured populations in Kansas, whether through KanCare or other approaches, should include consideration of how those efforts would align with a managed care delivery system model. For example, the alternative approaches being proposed by both Michigan and Pennsylvania are based, in part, on their existing managed care systems.

Personal Responsibility and Accountability

A common element of health reform efforts being pursued by public and commercial payers as well as provider initiatives at the local, state, and national levels is heightened expectations for increased personal accountability. One of the most common phrases used in this regard is that consumers should have “more skin in the game” when it comes to health care. This sentiment is particularly strong when it comes to the Medicaid program. One of the key concerns expressed by stakeholders opposed to expanding Medicaid is that it further expands reliance on government entitlements and runs counter to efforts to encourage and support self-reliance.

During the course of conducting interviews for this project, Leavitt Partners explored stakeholder views on increasing the personal accountability of KanCare enrollees. When asked, interviewees identified this as an area of concern and one that warrants further attention. Some stakeholders noted that improving individual accountability is one of the goals of the KanCare managed care model. However, it is too early to tell whether the model will be effective at achieving this or not.

Among the priority areas identified for further attention is the need to address overuse and improper use of the emergency room. The perception is that for generations, individuals have gone to the ER for care and that many view it as their primary care provider. Stakeholders expressed a lack of confidence in the effectiveness of the traditional approach of imposing copays to limit emergency room use, as the allowable copay amount is not sufficient to actually change behavior and, as such, the effort required to collect and enforce the copayment is not worth pursuing. Rather than implementing copays, interviewees recommended that efforts focus on developing incentives that target specific behaviors and that are proven to be effective. For example, one stakeholder mentioned that “to be effective one can’t think about how people ‘should’ behave, but rather think about what can be done to change behavior.”

Additional guidance provided by the interviewees included the need to couple efforts to change consumer behavior with monetary incentives for providers. It was suggested that this will induce providers to better support and reinforce behavior change. Hospitals were cited as key to diverting individuals from emergency rooms and connecting them with a primary care provider or other provider, such as an urgent care center. To achieve and sustain this type of broad system and individual behavior change, it was suggested that providers, especially hospitals, need to assume increased risk by increasing their participation in risk-based payment arrangements such as shared savings models.

Some interviewees suggested that addressing issues of personal accountability will be a critical and necessary component in any state-based solution or effort to cover the uninsured population.

Additional guidance included the need to recognize that changing consumer behavior may incur short-term costs in order to achieve the longer term goal of cost savings. Even with that recognition, interviewees acknowledged that finding ways to “sell” and fund the short-term costs may prove to be difficult.

A second area of personal responsibility that was explored during the interviews relates to employment, specifically how the provision of health care coverage should encourage, rather than discourage entry into the labor market. As reflected in the first part of this report, this is a relatively new policy option that is being integrated in coverage proposals from Rhode Island and Pennsylvania. Stakeholders expressed a high level of interest in further exploring this policy option as well as monitoring current and future proposals from other states.

Kansas Health Care Provider System

A common theme expressed by the spectrum of individuals interviewed for this project was strong support and respect for the health care provider system in Kansas—as well as respect for the large number of providers across multiple facilities, practice areas, and health care professions who accept and serve Medicaid patients. Also highlighted during multiple interviews was the willingness of health care facilities, practices, and professionals to extend their services to the uninsured population through their own practices as well as community and charitable venues.

While providing this level of service to the uninsured is something stakeholders expressed pride in, it was also cited as a reason why the general public as a whole, and policy makers in specific, are not as aware of the unmet needs of the uninsured population or the true public and private costs of providing them care. The perception that the uninsured can and do get the health care that they need through charity care—and a lack of clarity regarding the costs of that care—reduces the sense of urgency for developing coverage options for this population. Several interviewees mentioned a desire to have more information about the private and public costs of providing charity care to the uninsured to assist in forming public health care policy.

During the interviews, one possible avenue that surfaced for expanding access to care to the uninsured, while simultaneously supporting safety net providers who deliver the care, was expansion of state support through avenues such as the current Kansas Community Based Primary Care Clinic Program. However, other stakeholders expressed skepticism that sufficient state revenue would be available to pursue this strategy, particularly at the levels needed to cover the range of providers and settings that would be required beyond community clinics to meet the demand of the uninsured population.

Impact of Funding Reductions on Providers

One specific area of inquiry pursued in this project was perceptions and concerns related to the reductions in federal disproportionate share hospital (DSH) funding associated with care for the uninsured. These funding reductions have already begun to occur and are scheduled to increase in coming years. A range of views were expressed by interviewees on this topic, depending on their role. One view expressed by several interviewees in policy making roles is that these reductions are “self-inflicted damage” resulting from the decision of the American Hospital Association to accept these reductions in exchange for the ACA’s individual mandate and Medicaid expansion. As such, it should not be the responsibility of Kansas to address this issue at the state level. There is also a perception

that this is not an immediate problem and that it will get resolved at the federal level prior to its having a full and damaging impact on hospitals.

The other view expressed by those more directly involved or aligned with providers, is that these reductions will significantly and negatively impact hospital finances. The reductions will have a particularly strong impact on rural hospitals, jeopardizing their continuing viability. Contrary to the view outlined above, providers maintained that the negative impacts of DSH reductions, along with other reductions in federal funding, are already being realized. It was also noted that while DSH primarily affects hospitals, the impact of reductions are likely to indirectly extend to other provider groups as well.

The varying and, at times, contradictory perceptions of DSH reductions highlights a more general need for understanding the various ways in which federal DSH funds flow to a hospital, including the interplay between Medicare and Medicaid DSH funds. There is also a need to understand how these funds have contributed to the ability of hospitals to serve the uninsured population in the past and how the loss of these funds will impact their ability to serve the uninsured in the future in the absence of federal Medicaid expansion dollars.

Conclusion

After completing the review of policy options from other states, stakeholder interviews, and the preliminary assessment of factors relevant to determining the “best fit” of those options in Kansas, the following observations can be drawn:

1. There is a desire to gain additional data, information, and analysis with respect to the low-income uninsured population to frame and inform ongoing discussions of the issue. Specific areas where additional information is needed include:
 - a. Further delineation of the demographic, social, and economic characteristics of the uninsured population, both as a whole and as segmented groups.
 - b. Information regarding the types and sources of care currently provided to the low-income uninsured population and the associated direct and indirect costs to the public, private, and charitable sectors.
 - c. Future estimates of the type and sources of care that would be required if coverage is extended to this population, or segments of it, and the associated direct and indirect costs of this care.
 - d. The extent to which the currently uninsured population with incomes between 100% and 133% FPL access coverage through FFM.
2. While the option of providing coverage to the uninsured population, or segments of it, through the ACA’s traditional Medicaid expansion faces significant opposition, particularly from the Kansas Legislature, there is an openness and willingness to engage in continuing conversations to identify and assess policy options and approaches that could form the foundation of a Kansas designed plan.

3. No singular model from the states reviewed in this report could be directly transferred to the State and become a “Kansas Plan.” Policy elements from several of the state models generated interest among stakeholders and therefore warrant further exploration. These include:
 - a. Pursuing coverage through a private market-based approach such as the Private Option model and other premium subsidy approaches.
 - b. Aligning with the KanCare managed care model and relying on delivery and payment models that expect, incent, and reward care coordination and integration.
 - c. Embedding principles and expectations related to personal responsibility and accountability, including effective cost sharing, strategies that have proven effective in modifying healthy behaviors, and incentives or requirements to enter and stay in the workforce (for those who are able).
 - d. Recognizing the differing circumstances and needs of the various population segments that make up the low-income uninsured population and aligning eligibility and benefit packages accordingly.
 - e. Requiring financing levels and strategies that are sustainable based on the short- and long-term state fiscal environment and produce a net positive contribution to the overall state budget and economy.

The recent approval of state models such as Arkansas and Iowa signal willingness on the part of the federal government to entertain and act favorably to plans that rely on state-designed, market-based solutions. As such, should Kansas decide to pursue a similar plan that includes federal participation, it would likely receive serious consideration from CMS.

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