

Covering the Low-Income, Uninsured in Oklahoma

Recommendations for a Medicaid Demonstration Proposal

Prepared for the Oklahoma Health Care Authority

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Introduction

In February 2013, the Oklahoma Health Care Authority (OHCA) contracted with Leavitt Partners to evaluate its current Medicaid program and to make recommendations on how to optimize access and quality of health care in the State. The outcomes produced from this work will support the OHCA's overall mission statement, which is to "purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care."¹

The contract includes two separate, but related, projects. The first project is an evaluation of the existing acute care component of SoonerCare, the State's Medicaid program. As part of this evaluation, Leavitt Partners addressed whether SoonerCare is operating efficiently and effectively, what value the program provides to the State, the strengths and weaknesses of the program, and the program's existing opportunities and threats.

For the second project, Leavitt Partners proposed a Medicaid demonstration proposal. This demonstration proposal provides the State with a creative approach for optimizing access and quality of health care in Oklahoma. It outlines recommendations for an "Oklahoma Plan," which will include state-based solutions to improve health outcomes, contain costs, and make efficient use of state resources in providing quality health care and reducing the number of uninsured families. The plan addresses and integrates all points of health care delivery in the State, including Medicaid, the public health system, and the commercial insurance system. It focuses on market-based solutions and population health management.

This report addresses the second component of the contract, providing recommendations for a Medicaid demonstration waiver proposal. It should be reviewed in tandem with the report evaluating the current SoonerCare acute care program,² as some of the areas identified for improvement influenced the proposals outlined in this paper.

Environmental Scan

Leavitt Partners used a two-fold approach in developing its recommendations. It first reviewed the State's current Medicaid program, gathering multiple perspectives of the program and its processes in order to gain an understanding of the social, political, and financial environment in which the program operates. As part of this review, Leavitt Partners performed an extensive environmental scan of SoonerCare by both reviewing publicly available documents and interviewing stakeholders to discuss the program and gain external perspectives on specific issues.

¹ "About Us," Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/about.aspx?id=32>.

² "Program Strengths and Areas for Continuing Improvement: An Evaluation of Oklahoma's SoonerCare Acute Care Program," Leavitt Partners (June 27, 2013).

During the interview process, Leavitt Partners met with the Chairs of five of SoonerCare's Advisory Committees (and forwarded requests for input from all advisory committee members), interviewed four OHCA Board members, and met with many others including:

- Executives of allied State Departments (Health, Human Services, Insurance, Mental Health and Substance Abuse Services)
- Tribal Leaders
- Hospital administrators and representatives from the Oklahoma Hospital Association
- Primary Care Association representatives
- Federally Qualified Health Center representatives
- Leadership of the George Kaiser Foundation
- Physician representatives
- The State Chamber of Commerce
- The Oklahoma City/County Health Department
- University representatives
- Commercial insurance executives
- Primary care providers
- Oklahoma State University School of Medicine Administrators
- SoonerCare and other program staff

The second part of Leavitt Partners' approach consisted of reviewing pertinent administrative data, including State Plans, waivers, cost data, legislation, and information gathered through requests made to OHCA and other agencies. In order to better understand and provide perspective on some of the findings from this review, Leavitt Partners gathered information from comparison states and conducted additional background research on specific issues and areas of interest.

Issue Brief

Leavitt Partners has maintained ongoing communications with OHCA and other State Department representation throughout the project. In May 2013, Leavitt Partners submitted a draft issue brief to OHCA outlining its recommended approach and presented its initial findings to the full OHCA Board on May 9, 2013. While some modifications were made to the approach to address specific issues brought up during the Board meeting and by OHCA, the core concepts of the proposal are largely the same as were outlined in the issue brief.

Oklahoma's Medicaid Program

Oklahoma's Medicaid program covers all federally mandated components as well as provides services to optional populations through targeted benefits. While the traditional mandated and optional populations covered in Oklahoma's base program are more limited in terms of income eligibility relative to other states, these programs are supplemented with additional programs implemented through State Plan Amendments and 1115 waivers.³

Program Funding

SoonerCare is the largest source of federal grants in Oklahoma, accounting for almost 40% of all federal funds coming into the State. The program's budget has steadily increased for at least the last seven years, reaching almost \$2.99 billion in FY2012. Almost 95% of SoonerCare expenditures go to medical payments, with the remaining 5% covering administrative costs. Expenditures equaled an average of \$4,350 per member in FY2012, up only 1% from the previous year. Although disabled members make up a small portion of enrollees, they account for over 47% of total medical expenditures.

Enrollment

Close to one million individuals were enrolled in the SoonerCare program during the 2012 federal fiscal year.⁴ This equates to about 25% of the State's total population. More than half of the enrollees are children and the program's monthly average enrollment is approximately 782,000 individuals.⁵ The January 2013 enrollment numbers for each SoonerCare program are listed in Figure 1. Total SFY2012 program expenditures were just under \$4.8 billion.

³ Information included in this section comes from documents OHCA provided to Leavitt Partners for its evaluation of the SoonerCare program as well as public information available from its website: <http://www.okhca.org/>.

⁴ "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

⁵ Ibid.

Figure 1

SoonerCare Enrollment Breakout, January 2013			
Category	Adult/Children	Number Enrolled	Percent of Total
Aged/Blind/Disabled	Children	19,577	2.5%
Aged/Blind/Disabled	Adults	132,548	17.0%
Children/Parents	Children	480,026	61.6%
Children/Parents	Adults	75,616	9.7%
Other	Children	54	0.01%
Other	Adults	21,161	2.7%
Oklahoma Cares		826	0.1%
SoonerPlan		49,313	6.3%
TEFRA		444	0.06%
TOTAL		779,565	
Insure Oklahoma			
Employees with ESI		16,705	55.0%
Individual Plan Members		13,791	45.0%
TOTAL INSURE OK		30,496	
TOTAL ENROLLMENT		810,061	

Source: "SoonerCare Fast Facts," OHCA (January 2013).

Current Eligibility Groups and Programs

While enrollment in SoonerCare is robust, its eligibility criteria are relatively modest compared to other states. The groups that generally qualify for SoonerCare services are listed in the following table.

Figure 2

SoonerCare Eligibility Groups, 2013	
Group	Income Limit
Adults with children under age 19	~30% FPL
Children under age 19	185% FPL*
Pregnant Women	185% FPL**
Individuals age 65 and older	~80% FPL
Individuals who are blind or disabled	~80% FPL
Women under age 65 in need of breast or cervical cancer treatment	185% FPL
Men and women age 19 and older with family planning needs	185% FPL

*Includes the Children’s Health Insurance Program.

** In 2009 Medicaid paid for approximately 64% of the State’s total births.

Source: “Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report,” OHCA (June 2012). Leavitt Partners interviews conducted with OHCA Administrators (March–June 2013).

In addition to the more traditional base programs, the State has added several optional groups based on the needs and priorities of the State. These optional groups include:

Oklahoma Cares (Breast and Cervical Cancer Treatment Program)

This program provides treatment for breast and cervical cancer and pre-cancerous conditions to eligible women. Oklahoma Cares is a partnership of the Oklahoma State Department of Health (OSDH), OHCA, the Cherokee Nation, the Kaw Nation of Oklahoma, and the Oklahoma Department of Human Services (OKDHS). Women with income up to 185% FPL are eligible for the program.

SoonerPlan

SoonerPlan is Oklahoma’s family planning program for women and men who are not enrolled in regular SoonerCare services and have income below 185% FPL. Services are limited to family planning services offered by contracted SoonerCare providers.

Insure Oklahoma

The Insure Oklahoma (IO) program is a premium assistance based program designed by the State to provide health care coverage for low-income working adults. It was authorized by the Oklahoma State Legislature in 2004. The statute specifically directs OHCA to apply for waivers needed to accomplish several goals of the State, including:⁶

- Increase access to health care for Oklahomans;
- Reform the Medicaid Program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing;
- Enable small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private, or state-sponsored health care coverage through a state premium assistance payment plan; and
- Develop flexible health care benefit packages based upon patient need and cost.

The statute also authorizes OHCA to “develop and implement a pilot premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or ‘buy-in’ to a state-sponsored benefit plan.”⁷ OHCA utilized this directive to create the IO program and enhance it over time.

The program now has a strong Oklahoma brand with wide acceptance and support throughout the community. The program is credited with providing coverage to thousands of individuals who would otherwise have remained uninsured and helping small businesses provide coverage that would have otherwise been cost prohibitive. IO’s success is attributed to several key factors, including its local design and its inclusion of premium sharing across enrollees, businesses, and government—resulting in an affordable option for all parties.

Covered populations include non-disabled working adults and their spouses, disabled working adults, employees of not-for-profit businesses with fewer than 500 employees, foster parents, and full-time college students. The program also offers coverage for dependent children of IO members. The qualifying income limit is 200% FPL.

The IO program consists of two separate premium assistance plans: the Employer-Sponsored Insurance premium assistance plan and Individual Plan premium assistance plan. Under the Employer-Sponsored Insurance (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.

Close to 17,000 individuals are currently enrolled in the ESI plan with almost 14,000 individuals enrolled in the IP plan. The program has an enrollment cap, which is determined by the State’s annual budget. The current enrollment cap is around 35,000.

⁶ Oklahoma Statute, 56-1010.1.D.1.

⁷ Oklahoma Statute, 56-1010.1.D.2.

CMS has indicated that it will not allow Oklahoma to extend Insure Oklahoma past 2013, unless the State is willing to make certain changes to comply with federal requirements, including benefit, cost-sharing, eligibility, and enrollment rules. For example, IO's current benefit package does not include Essential Health Benefits⁸ and its cost-sharing amounts would need to be adjusted to meet standards CMS set forth in its proposed rule.⁹ Eligibility for the program would need to be based on Modified Adjusted Gross Income (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.¹⁰

Benefits

As with most Medicaid programs, the scope of coverage within SoonerCare programs varies by type of enrollee and program. For example, the EPSDT benefit package¹¹ is richer for children than for adults, and some programs, like SoonerPlan, have very targeted benefits to reflect the intent of the program. However, the State's Medicaid benefit packages are generally broad, covering benefits that are comparable to or exceed what is typically covered in commercial plans. As with commercial plans, there are service limits. For example, inpatient hospital days are limited to 24 per year, home and office physician visits are limited to four per month, and pharmacy is limited to six prescriptions per month (two of which can be brand name drugs). There are also nominal copayments. A complete list of benefits and cost-sharing requirements can be found on OHCA's website.¹²

Aside from physician and in/outpatient hospital services, the services most utilized by SoonerCare members include non-emergency transportation, capitated services, prescription drugs, and dental services. Nursing facilities and behavioral health services have some of the highest program expenditures.

⁸ 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.

⁹ CMS, Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, Proposed Rule 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457 (January 22, 2013).

¹⁰ "Affordable Care Act: State Resources FAQ," CMS (April 25, 2013).

¹¹ The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT helps ensure that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. Available from "Early and Periodic Screening, Diagnostic, and Treatment," Medicaid.gov. Accessed June 17, 2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

¹² "What is Covered?" Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/individuals.aspx?id=95&parts=11601>.

SoonerCare Acute Care Delivery System

As a second part of this project, OHCA contracted with Leavitt Partners to evaluate the existing acute care component of its SoonerCare program.¹³ The SoonerCare acute care delivery system has undergone several transitions over the past two decades. Throughout this transition process the State has maintained a consistent focus on managed care approaches, although the way it administers managed care has evolved over time. Under the previous banner of “SoonerCare Plus,” the program administered risk-based contracts with commercial Medicaid managed care organizations (MCO). These contracts were terminated at the end of 2003 due to several issues and negative experiences the State experienced during SoonerCare Plus’ tenure. Some of these issues include:¹⁴

- Incorporating the aged, blind, and disabled (ABD) populations into the managed care contracts created unanticipated costs, resulting in health plan requests for increased rates.
- Some companies left the program, leaving an open question about the State’s ability to maintain a sufficient number of plans required under federal Medicaid regulations¹⁵ and to provide the plans with a strong position at the bargaining table.
- The plans continued to ask for higher rates during the 2002–2003 economic downturn, placing economic pressure on the State.
- In 2003, one plan turned down a 13.6% rate increase, holding out for an 18% increase.

During this same period, OHCA’s self-administered, partially capitated Primary Care Case Management (PCCM) SoonerCare Choice plan was performing well and producing results comparable to or better than the MCOs. A determination was also made that OHCA could operate the Choice program at about one quarter of the administrative cost of the Plus program. The Board voted to terminate the Plus program and by April 2004, all Plus enrollees were transitioned to SoonerCare Choice.

Today, Oklahoma offers a variety of programs in its acute care delivery system. Much of the program basics were put in place in 2004, but the program continues to evolve as OHCA sees opportunities for improvement. Today, the program has multiple components that address care access, care coordination, and provider incentives.

The follow section includes descriptions of some of Oklahoma’s acute care Medicaid programs. These programs provide different services to different populations in order to address the targeted population’s needs.

¹³ Additional detail on the SoonerCare program is provided in a companion report, “Program Strengths and Areas for Continuing Improvement: An Evaluation of Oklahoma’s SoonerCare Acute Care Program,” Leavitt Partners (June 27, 2013).

¹⁴ Leavitt Partners interviews conducted with SoonerCare stakeholders (March–June 2013); “SoonerCare 1115 Waiver Evaluation: Final Report,” Mathematica (January 2009).

¹⁵ Federal Medicaid regulation requires that enrollees have a choice of managed care plans, with the exception of enrollees in certain in rural areas.

SoonerCare Traditional

The traditional fee-for-service (FFS) SoonerCare program comprises a statewide network of providers that includes hospitals, family practice doctors, pharmacies, and durable medical equipment companies. SoonerCare FFS members may choose from any of the contracted providers for needed services.

Members enrolled in this program include:

- Residents of long-term care facilities
- Dually eligible SoonerCare/Medicare members
- Members with private health maintenance organization (HMO) coverage
- Members eligible for Home and Community-Based Services waivers
- Children in state or tribal custody

SoonerCare Choice

SoonerCare Choice is a PCCM program in which each member is assigned to a medical home. The medical home primary care provider (PCP) is responsible for coordinating each member's health care and services as well as providing 24-hour, 7-day telephone coverage. Unless exempt, all SoonerCare members are required to enroll in the PCCM program (enrollment is available on-line).

To qualify, an individual must:

- Qualify for SoonerCare
- Not qualify for Medicare
- Not reside in an institution such as a nursing facility or receive services through a Home and Community-Based Services waiver program
- Not be in state or tribal custody
- Not be enrolled in a HMO

SoonerCare Choice PCPs receive a monthly care coordination payment for each enrolled member. This payment is based on the services provided by the PCP. The PCP is responsible for providing, or otherwise assuring, the provision of primary care and case management services. The PCP is also responsible for making referrals for specialty care.

The SoonerCare Choice program uses three tiers of medical homes in its delivery system: 1) Entry Level Medical Home (Tier 1); 2) Advanced Medical Home (Tier 2); and 3) Optimal Medical Home (Tier 3). The PCP must meet certain requirements to qualify for payments in each tier. Payments are also determined according to patient characteristics as described in Figure 3.

Figure 3

SoonerCare Choice Care Coordination Payment Tiers, 2012			
Payments (PMPM)	Tier 1	Tier 2	Tier 3
Children	\$4.32	\$6.32	\$8.41
Children and Adults	\$3.66	\$5.46	\$7.26
Adults	\$2.93	\$4.50	\$5.99

Source: "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

Payments for Excellence

Providers may receive additional incentive payments through the State's Payments for Excellence program, which recognizes outstanding performance. Incentive payments may not exceed 5% of total FFS payments for authorized services provided during the established period. These payments are made to providers in Indian Health Service (IHS), Tribal, and Urban Indian clinics, as well as to providers in the Insure Oklahoma Network.

Health Management Program

The Health Management Program (HMP) provides additional services to SoonerCare Choice members who have chronic diseases. Individuals are identified through predictive modeling or other referral and enrollment sources and can enroll through an on-line application.

Services provided in the Health Management Program include:

- **Nurse Care Management:** Nurses provide members with education, support, care coordination, and self-management tools (either in person or by phone) that are aimed at improving members' health.
- **Behavioral Health Screening:** All HMP members are asked to complete a behavioral health screening to identify issues they need help managing.
- **Pharmacy Review:** To lessen the chance of medication errors, nurse care managers assist members create a list of their medications that will be reviewed by a contracted pharmacy specialist if problems are identified.
- **Community Resources:** The program helps members locate appropriate health and social service resources.
- **Primary Care Provider Involvement:** Nurse care managers send monthly updates to members' PCPs. These updates include self-management goals, member progress, and information on the health status of the member.

Health Access Networks (HANs)

HANs are non-profit, administrative entities that work with providers to coordinate and improve care for SoonerCare members. Networks receive a \$5 per member per month (PMPM) payment. HANs are not eligible for tiered PCP care coordination payments. To receive the payment, the HAN must:

- Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;
- Ensure patients have access to all levels of care within a community or across a broad spectrum of providers in a service region or the State;
- Submit a development plan to OHCA detailing how the network will reduce costs associated with the provision of health care services, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare members;
- Offer electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and
- Offer care management/coordination to persons with complex health care needs, including:
 - The co-management of individuals enrolled in the Health Management Program;
 - Individuals with frequent emergency department utilization;
 - Women diagnosed with breast or cervical cancer enrolled in the Oklahoma Care Program;
 - Pregnant women enrolled in the High Risk OB Program; and
 - Individuals enrolled in the Pharmacy Lock-In Program.¹⁶

Services for American Indians

Eligible SoonerCare members, with the exception of Insure Oklahoma members, may voluntarily enroll with an IHS, Tribal, or Urban Indian clinic for their PCP/care management services. Providers in these clinics receive the tiered PCP care coordination payment as well as an encounter payment rate that is 100% federally funded for certain outpatient services.

Per Member per Month (PMPM) Cost for Adult Populations

SoonerCare programs' per member costs have fluctuated over the past five years. The low-income adult populations per member cost increased relatively rapidly for a short period, but then declined, resulting in an average five year increase of 1.7%. A similar pattern occurred with the non-dually eligible disabled adults, although there was a slight decrease in costs between 2008 and 2012. While the cost of Insure Oklahoma Individual Plan adults increased at a much more rapid rate during this period, only the last few years should be considered given that the program was implemented in 2007 and underwent

¹⁶ The Pharmacy Lock-In Program is designed to assist health care providers monitor potential abuse or inappropriate utilization of controlled prescription medications by SoonerCare members. When warranted, a member may be "locked-in," and therefore required to fill all prescriptions at a single designated pharmacy in order to better manage his or her medication utilization. Available from "Pharmacy Lock-In Program," Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/providers.aspx?id=8738>.

several changes through 2010 (the increase in costs between 2010 and 2012 averaged about 7.5%). Figure 4 shows the annual PMPM cost for select groups of the adult population by year.

Figure 4

Annual PMPM Costs for Medicaid Enrolled Adults, SFY2008-2012			
State Fiscal Year	TANF-related Adults	IP Adults	Non-Dual Disabled Adults
SFY2008	\$293	\$221	\$1,549
SFY2009	\$323	\$304	\$1,594
SFY2010	\$328	\$347	\$1,615
SFY2011	\$308	\$343	\$1,562
SFY2012	\$298	\$373	\$1,506

Source: Special report generated by OHCA (2013).

The PPACA’s Medicaid Expansion Provision

Newly Eligible Population

The most significant change to Medicaid made by the Patient Protection and Affordable Care Act (PPACA) is the eligibility expansion.¹⁷ This provision allows states to expand Medicaid eligibility to all adults, age 19–64, who are not otherwise eligible for Medicaid and with income below 138% of the Federal Poverty Level (FPL) (this is roughly equivalent to \$15,000 for an individual and \$30,000 for a family of four).¹⁸ Eligibility for these “newly eligible” individuals will be based on MAGI, which differs from the categorical eligibility determinations of the traditional Medicaid program.

¹⁷ Background information included in this section is drawn from a report Leavitt Partners developed for the Idaho Department of Health and Welfare titled “Idaho’s Newly Eligible Population: Demographic and Health Condition Information,” Leavitt Partners (September 18, 2012).

¹⁸ 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 PPACA, most income disregards will be replaced by a single 5% disregard, making the effective eligibility rate 138% FPL.

Enrollment Estimates

The Kaiser Commission on Medicaid and the Uninsured estimates that in 2011 roughly 253,300 uninsured individuals in Oklahoma had income below 138% FPL.¹⁹ Another study conducted by the Kaiser Commission estimates the total number of potentially new Medicaid enrollees in Oklahoma, including those who are currently eligible but not enrolled, would range between 357,000 and 470,400 by 2019.²⁰ This study uses two scenarios to develop its estimates: 1) a standard participation scenario and 2) an enhanced outreach scenario. The standard scenario assumes a 57% participation rate among the newly eligible and lower participation across other groups. The enhanced scenario assumes a 75% participation rate among the newly eligible. Under the standard participation scenario, Oklahoma state spending would increase by \$549 million between 2014 and 2019. Under the enhanced scenario, Oklahoma state spending would increase by \$789 million.

An Urban Institute Health Policy Center brief estimates that the total number of Oklahomans who would be eligible for Medicaid in 2014 is 303,000.²¹ The number of individuals who would be newly eligible for Medicaid is 225,000, while the number of individuals currently eligible, but not enrolled is 77,000. Of the 225,000 who are “newly eligible,” 172,000 have income less than 100% FPL.

Studies conducted for OHCA show that roughly 200,000 adult individuals would be eligible for Medicaid under an expansion (plus 17,000 currently eligible but not enrolled). By fully expanding, the State would receive \$3.5 billion in federal funds over a seven year period (roughly \$500 million per year). It is also estimated that the expansion could cost the State \$155 million over the same period and that the State would be paying close to \$56.5 million per year once the federal match rate was reduced to 90%.²² This cost would be indirectly offset by economic growth resulting from the expansion, which is estimated to be an increase of 16,000 jobs, \$495 million in new payroll taxes, and \$52 million in new state/personal tax revenues. Providers would also receive an estimated reduction of \$324 million in uncompensated care costs.²³

Leavitt Partners also estimated the number of individuals that would be eligible for Medicaid under its demonstration proposal. The estimates range from 187,035 to 274,994, depending on expected participation rates. More details on these numbers and the associated costs are provided in the Estimated Impact section.

Population Characteristics

The newly eligible group is not a homogenous population. Many individuals who could become newly eligible are relatively healthy and are employed or temporarily unemployed. Others are medically frail, having significant physical and behavioral health chronic conditions—often which are co-occurring and limit an individual’s ability to work. Others have fully disabling conditions, but are not currently receiving Medicaid coverage due to a waiting period or a lack of qualifying work history.

¹⁹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey. Available from Kaiser Family Foundation’s State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

²⁰ “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL,” Kaiser Commission on Medicaid and the Uninsured (May 2010).

²¹ “Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults would not Be Eligible for Medicaid?” The Urban Institute (July 5, 2012).

²² This assumes a 100% participation rate. “Oklahoman’s with Health Care: Expansion of Medicaid to Cover Adults,” OHCA (January 2013).

²³ Ibid.

Coverage Gap

Advanced Premium Tax Credits (APTC) will be provided to persons with income between 100% and 400% FPL. These credits will be available in all states, either through a state-based or federally-facilitated health insurance exchange. This creates a gap in coverage between those with income at 100% FPL who can access APTCs through an exchange and those who are eligible for Medicaid under a state's current eligibility limits. For example, in Oklahoma, adults with dependent children are eligible for Medicaid if they have income below about 30% FPL. By not expanding Medicaid, the State will have a population between 30% and 100% FPL that is not eligible for health care coverage assistance. Similar gaps will be created between other eligibility groups and the 100% threshold.

Studies have found that this coverage gap impacts employers as well. Employers in states that do not expand Medicaid will have an increased likelihood of receiving a shared responsibility penalty due to this coverage gap.²⁴ The PPACA mandates that employers with more than 50 full-time equivalent employees (working at least 30 hours) must offer minimal essential insurance coverage. If they do not offer coverage, or the coverage is found insufficient and the employee is eligible for an APTC, then the employer must pay a shared responsibility penalty of up to \$3,000 per employee that receives an APTC. In states that expand Medicaid, low-wage workers between 100% and 138% FPL will be eligible for Medicaid and employers will not be subject to the penalty. Jackson-Hewitt estimated the potential employer tax penalty in Oklahoma could range from \$35 million to \$52.6 million annually.²⁵

Funding

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.

The new federal match rates, however, only apply to the “newly eligible” or those who do not qualify for Medicaid under the traditional Medicaid categories. If a person applies for Medicaid after 2014, and is found to be eligible for the traditional programs, the state will only receive the regular match rate for that person (Oklahoma's FY2013 match rate was 64%, meaning the state is responsible for covering 36% of Medicaid costs).

Change in Eligibility Determinations

While the Supreme Court ruling allows states to opt out of the Medicaid expansion provision, other PPACA provisions may effectively expand Medicaid eligibility above current state levels, regardless of whether states choose to expand or not.²⁶ These changes are based on several factors, including: 1) the use of MAGI to determine income eligibility; 2) the elimination of asset tests; 3) changes in the definition

²⁴ “The Supreme Court's ACA Decision and Its Hidden Surprise for Employers: Without Medicaid Expansion, Employers Face Higher Tax Penalties under ACA,” Jackson Hewitt (March 13, 2012).

²⁵ While the actual liabilities that employers incur will depend on the “uptake,” or participation rates among eligible employees in new insurance exchanges, Jackson-Hewitt did not adjust its estimates for differing levels of participation. Ibid.

²⁶ The overall effect will vary by state. It should also be noted that CMS is developing methodologies for converting eligibility thresholds that attempt to prevent any significant increase in eligibility due to a change in income rules.

of a household; 4) changes in the application and redetermination process; and 5) coordination of eligibility determinations. More details on each of these factors are provided in Appendix 1.

Benefit Package Requirements

The PPACA requires states to provide most people who become newly eligible for Medicaid with “benchmark” benefits. The benchmark package must: 1) meet existing rules set forth in the Deficit Reduction Act of 2005; 2) be equal to one of the three available benchmark plans or be Secretary-approved coverage; 3) meet additional Medicaid requirements; and 4) provide all Essential Health Benefits. Summary information on the benchmark benefit package is provided below, while more detailed information is provided in Appendix 1.

Deficit Reduction Act of 2005

The Deficit Reduction Act (DRA) gave states the option to provide select Medicaid groups an alternative benefit package. Prior to the Act, states were required to offer all federally mandated services to all Medicaid enrollees (although states retained the discretion to offer optional benefits). All federally mandated traditional Medicaid benefits are listed in Figure 5. The PPACA added two new mandatory benefits (free-standing birth clinics and tobacco cessation services for pregnant woman) as well as new optional benefits to the Medicaid program (preventive services for adults, health home services for persons with chronic conditions, and the expansion of home and community-based services as an alternative to institutional care).

Figure 5

Federally Mandated Traditional Medicaid Benefits		
Inpatient hospital services	Federally qualified health center services	Nurse midwife services
Outpatient hospital services	Non-emergency transportation	Nurse practitioner services
Physician services	Home health services	Rural health clinic services
Early and Periodic Screening, Diagnostic, and Treatment services for individuals under 21	Laboratory and X-ray services	Tobacco cessation counseling and pharmacotherapy for pregnant women
Family planning services and supplies	Nursing facility services (for ages 21 and over)	Freestanding birth center services

Health Home Provision

The purpose of the health home provision was to provide states with “an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for state Medicaid programs.”²⁷ The option is available to individuals with co-occurring chronic conditions who select a designated health home provider.²⁸

States that implement a Health Home State Plan Amendment will receive a 90% federal match rate for all health home services for the first eight fiscal quarters the amendment is in effect. Eligible health home services include:²⁹

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

Alternative Benefit Package

The establishment of an alternative benefit package (i.e., benchmark or benchmark-equivalent coverage) through the DRA allows states to provide different benchmark benefit packages to different populations based on health status or geographic region. For example, states can offer a comprehensive benchmark plan to high-risk populations while offering a more limited benchmark plan to relatively healthy populations.³⁰

Available Benchmark Plans and Additional Medicaid Requirements: The Medicaid benchmark benefits must be equal to one of the three following benchmarks: 1) the standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP); 2) any state employee plan generally available in the state; or 3) the state HMO plan that has the largest commercial, non-Medicaid enrollment.³¹

²⁷ Letter to State Medicaid Directors Regarding Health Homes for Enrollees with Chronic Conditions, CMS (November 16, 2010).

²⁸ The chronic conditions described in section 1945(h)(2) of the Social Security Act include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a body mass index over 25). However, the Act also authorizes the Secretary to expand the list of chronic conditions. Additional chronic conditions, such as HIV/AIDS, will be considered. Ibid.

²⁹ Ibid.

³⁰ While benefit design cannot discriminate “on the basis of an individual's age, expected length of life, or on an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions” (PPACA 1302(b)(4)), benefit design non-discrimination policies do not prevent states from exercising Section 1937 targeting criteria.

³¹ Equal can also mean “equivalent in actuarial value.” States can reduce the actuarial value of coverage of some services in the benchmark plan by 25% of what is covered in the comparison plan.

States can select benefit packages that differ from these options, as long as it is approved by the HHS Secretary. HHS has indicated that a state’s traditional Medicaid benefit package will be a Secretary-approved option. The benchmark benefit options represent the minimum benefits to be provided to the newly eligible population and states can augment coverage with additional benefits. However, a base set of benefits must be provided (a complete list of required benefits is provided in Appendix 1).³²

Exempt Groups: Several Medicaid groups are excluded from being mandatorily enrolled in benchmark coverage. These groups include:³³

- Pregnant women
- Persons who are blind or disabled
- The dual eligible
- Terminally ill persons who are receiving hospice care
- Individuals that qualify for long-term/institutional care services based on medical condition
- Persons who are medically frail³⁴
- Children in foster groups or who are receiving adoption assistance
- Former foster care children
- Section 1931 parents
- Women who qualify for Medicaid due to breast or cervical cancer
- Individuals who qualify for medical assistance because of a TB-infection
- Individuals receiving only emergency services
- Medically needy

States can allow benchmark-exempt individuals to enroll in the benchmark benefit package, but their enrollment must be voluntary and the individual must retain the option to enroll in traditional standard benefits at any time.

The exemption rule implies that certain groups of individuals who would be considered “newly eligible” (because they don’t qualify for Medicaid under a state’s existing Medicaid eligibility rules) may not be eligible for mandatory enrollment in benchmark coverage. For example, if Oklahoma were to expand its Medicaid program under a traditional PPACA expansion, it would significantly expand eligibility for adults with dependent children and individuals who are blind and disabled. The State would also be adding a new eligibility group, childless adults (who do not otherwise qualify for Medicaid).

A portion of these groups may be exempt from mandatory enrollment due to being disabled or “medically frail” (i.e., have disabling mental disorders and/or physical/mental disabilities that significantly impair their ability to perform one or more activities of daily living). As such, this population would need to retain the option to enroll in Oklahoma’s standard Medicaid plan, even though they are considered newly eligible and the State would receive the increased federal match for them.

³² “Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline,” Congressional Research Service (August 19, 2010).

³³ 42 CFR 430–781.

³⁴ At a minimum, a state’s definition of “medically frail” and “special medical needs” must include children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly prevent them from performing one or more activities of daily living (42 CFR 440.315(f)). States have the flexibility to expand this definition.

Churn and Premium Assistance Programs: In addition to evaluating how to handle the population churn that may exist between traditional and alternative Medicaid benefit packages, states that choose to expand will also need to determine how to handle the churn that will occur between Medicaid and an exchange. Medicaid-eligible individuals with income near the upper end of the income threshold (138% FPL) are expected to frequently transition between being eligible for Medicaid and for APTCs offered through an exchange. A study published in Health Affairs estimated that within six months, 35% of all adults with income below 200% FPL will experience churn between Medicaid and an exchange, and within a year, 50% of adults will experience such churn.³⁵

One strategy states can use to help minimize the impact of this churn is the utilization of premium assistance programs. Premium assistance helps Medicaid-eligible individuals and families purchase qualified commercial insurance (either individual insurance or employer-based coverage). Under existing Medicaid rules, the purchase of premium assistance must be “cost-effective,” meaning “Medicaid’s premium payment to commercial plans plus the cost of additional services and cost-sharing assistance ... would be comparable to what it would otherwise pay for the same services.”³⁶ Premium assistance arrangements must also provide Medicaid-eligible enrollees with access to all Medicaid benefits and cost-sharing protections.

HHS has indicated that it will consider a limited number of premium assistance demonstrations for the purchase of qualified health insurance through an exchange’s individual market. It has stated that it will only consider proposals that:

- “Provide beneficiaries with a choice of at least two qualified health plans (QHPs);
- Make arrangements with the QHPs to provide any necessary wrap-around benefits and cost sharing along with appropriate data ...;
- Are limited to individuals ... in the new Medicaid adult group who must enroll in benchmark coverage and are not described in SSA 1937(a)(2)(B)(i.e., the medically frail)...; and
- End no later than December 31, 2016. Starting in 2017, State Innovation Waiver authority begins which could allow a range of state-designed initiatives.”³⁷

Cost Sharing: The cost-sharing amounts states can charge the Medicaid population depends on both the enrollees’ income and the service being provided.³⁸ For adults below 100% FPL, states cannot charge more than a nominal amount for most services and cannot charge a premium or copay for emergency or family planning services. Above 100% FPL, however, the amount of cost sharing allowed increases as the enrollee’s income increases.

Certain groups are exempt from any cost sharing, regardless of income (pregnant women, certain children, and individuals with special needs), and certain services are exempt from cost sharing as well (preventive care for children, emergency care, and family planning services).³⁹

³⁵ “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges,” Health Affairs, 30 No. 2 (2011).

³⁶ “Medicaid and the Affordable care Act: Premium Assistance,” CMS (March 2013).

³⁷ Ibid.

³⁸ “Medicaid: A Primer,” Congressional Research Service (July 15, 2010).

³⁹ Ibid.

CMS' proposed rule on Medicaid Premiums and Cost Sharing recommends increasing the maximum nominal cost-sharing amounts and providing new flexibility to impose higher cost sharing for non-preferred drugs and for non-emergency use of the emergency department. These changes are highlighted in Figure 6 and more details on the proposed rule are provided in Appendix 1.

Figure 6

Medicaid Premium and Cost-Sharing Limits for Adults				
	Current		Proposed Rule, 2013	
	≤100% FPL	101% – 150% FPL	≤100% FPL	101% – 150% FPL
Premiums	Not allowed	Not allowed	Not allowed	Not allowed
Cost Sharing (may include deductibles, copayments, or coinsurance)				
Most Services	Nominal	Up to 10% of the cost of the service or a nominal charge	\$4 for outpatient services Nominal for other services	Up to 10% of the cost of the service
Prescription Drugs: • Preferred • Non-preferred	Nominal Nominal	Nominal Nominal	\$4.00 \$8.00	\$4.00 \$8.00
Non-emergency use of emergency department	Nominal	Up to twice the nominal amount	\$8.00	\$8.00
Preventive Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Nominal	Up to 10% of the cost of the service or a nominal charge
Cap on total premiums, deductibles, and cost-sharing charges for all family members	5% of family income			
Service may be denied for non-payment of cost sharing	No	Yes	No	Yes

Note: Some groups are exempt from premium and cost-sharing limits described in this table. These groups include pregnant women (those above 150% FPL can be charged minimal premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. However, these groups can currently be charged cost sharing for non-emergency use of an emergency department and for non-preferred prescription drug use.

Source: Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser (August 2010). CMS, Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, Proposed Rule 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457 (January 22, 2013).

Other Medicaid Provisions

The Supreme Court's decision to make the Medicaid expansion optional does not affect other aspects of the law, meaning the provisions relating to the Medicaid Maintenance of Effort, Disproportionate Share Hospital (DSH) Program funding reductions, and primary care provider reimbursement increases are not affected.⁴⁰

In terms of DSH cuts, between 2014 and 2020, the HHS Secretary is required to make aggregate reductions to baseline Medicaid DSH allotments. The amount reduced each year varies from \$500 million in FY2014 to a high of \$5.6 billion in FY2019. Providers in states that decide not to expand Medicaid potentially face both the loss of DSH payments and the loss of payment for the expansion population. While the proposed rule CMS released in May 2013 indicates that the payment cuts made in 2014 and 2015 won't account for states' decisions to expand Medicaid, this decision may factor into the methodology post 2015.⁴¹ As such, providers in high DSH, non-expansion states could be hit twice as hard, particularly when the largest payment cuts go into effect. It is expected that hospitals will attempt to shift a portion of the increased uncompensated care costs onto payers, driving up premiums. Compared to other states, Oklahoma receives few DSH dollars (roughly \$10 DSH dollars per resident), so the impact of the cuts may not be as large as it would be in states like Louisiana and New Hampshire which receive upward of \$120 DSH dollars per resident.⁴²

State Medicaid Delivery System Reforms

As part of its environmental scan of the SoonerCare program, Leavitt Partners researched and gathered information from comparison states in order to evaluate concepts and possible approaches Oklahoma could use in its Medicaid system reform. This research showed that moving to Medicaid managed care models, particularly commercial managed care, has been the trend among states over the last several years. However, more recently states have begun to develop managed care models that differ from traditional commercial MCOs and PCCMs. In both FY2012 and FY2013, a number of states began implementing a range of initiatives to coordinate and integrate care. Many of these initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building accountability into the delivery of high-quality care.⁴³

Examples of such coordination strategies include health homes, patient-centered medical homes, and Accountable Care Organizations (ACOs)—as well as initiatives to coordinate physical and behavioral health, and long-term care and acute care services. Many of these initiatives are being used to improve

⁴⁰ Under the PPACA, HHS will reduce aggregate Medicaid DSH allotments between FY2014 and FY2020 to account for the decline in the number of uninsured. In 2013 and 2014, states must increase primary care provider rates so they are equal to Medicare rates.

⁴¹ CMS, Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, Proposed Rule 42 CFR Part 447 (May 15, 2013).

⁴² "Safety Net Hospitals won't be Docked in States that Don't Expand Medicaid," Stateline, The Pew Charitable Trusts (May 15, 2013).

⁴³ "Medicaid Today, Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2012," Kaiser Commission on Medicaid and the Uninsured (October 2012).

care for Medicaid populations with complex health needs as well as persons with mental health and substance abuse treatment needs.

States are developing these models in conjunction with the PPACA’s Medicaid expansion as well as part of their own state-based initiatives to improve the Medicaid program and reduce costs. The following section highlights models being developed and proposed by several states, including those promoting multi-payer systems, shared savings, increased use of quality measures, etc. Key highlights from each state are provided in Figure 7 while more detailed summaries are in Appendix 2.

Figure 7

State	Delivery System Reform Highlights
Accountable and Coordinated Care Models	
Alabama	<p>In 2013, Alabama passed legislation implementing “regional care organizations” (RCOs) to coordinate the care of Medicaid recipients within each region. RCOs will be will be risk-bearing entities responsible for managing and coordinating the full range of Medicaid benefits, including physical, behavioral, and pharmacy services.</p> <p>In its 1115 waiver concept paper, the State proposed CMS make additional funding available for items that would not otherwise be eligible for a federal match, including infrastructure investments, funding pools, and state health programs.</p>
North Carolina	<p>Due to rising costs and spending which consistently outstrips projected funding, North Carolina is currently in the process of revising its Medicaid program. The current program uses medical homes, managed under the Community Care of North Carolina program, to provide care to Medicaid enrollees. The “Partnership for a Healthy North Carolina” was announced by Governor McCrory on April 3, 2013 and includes coordinated care elements used in delivery system reforms implemented in Oregon and Alabama.</p> <p>As outlined in the press release announcing the Partnership, the State plans to implement Comprehensive Care Entities (CCEs) as a “single place” for recipients to receive coordinated care. CCEs will be responsible to conduct individualized comprehensive “functional needs assessments” and engage a “Comprehensive Care Network of providers” to deliver necessary care.</p>
Oregon	<p>In July 2012, Oregon received permission from CMS to manage its Medicaid program through a group of Coordinated Care Organizations (CCOs). A CCO is a local network of providers that provide physical health care, addiction and mental health care, and, in some cases, dental care. These partnerships are financially responsible for their patients and are risk-bearing entities. They must comply with 17 quality metrics and are able to receive a financial reward from a Quality Pool based on their performance.</p> <p>Each CCO is paid a lump sum to provide care to the Medicaid enrollees in its region. The providers that comprise each CCO operate under one budget that grows at a fixed rate for mental, physical, and dental care. The State is projecting a savings of \$3.1 billion over five years and close to \$11 billion over the next decade. Through an 1115 waiver, the State received a \$1.9 billion investment from CMS to support the coordinated care model.</p>

Accountable and Coordinated Care Models	
Utah	<p>In 2011, Utah’s Legislature passed a Medicaid Reform bill requiring the Department of Health to “develop a proposal to modify the Medicaid program in a way that maximizes the replacement of the FFS delivery model with one or more risk-based delivery models.” As such, the Department of Health proposed converting its current managed care contracts to an ACO model.</p> <p>The model is largely still in the implementation phase and the Department is currently seeking stakeholder input on how it will be developed over time. However, on January 1, 2013 over 170,000 Medicaid enrollees were moved to ACO contracts. The contracts are with four Medicaid MCOs that are paid on a risk-adjusted, PMPM amount. ACOs have the flexibility to distribute payments throughout their provider network and are to pay providers an amount equal to delivering necessary care for a specified period of time.</p>

State	Delivery System Reform Highlights
Alternative Expansions	
Arkansas	<p>Arkansas recently proposed a more market-driven approach to the Medicaid expansion, which will use the enhanced federal funds to purchase commercial insurance for the expansion population through the State’s health insurance exchange.</p> <p>On March 29, 2013, HHS 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. States must have mechanisms in place to provide “wrap-around” benefits and cost-sharing protections. More information on this model is provided in the Foundation for Recommended Approach section.</p>
Indiana	<p>In 2008, Indiana expanded its Medicaid program through the Healthy Indiana Plan (HIP) to two additional populations, custodial parents and childless adults with income below 200% FPL. HIP enrollees have access to most services that are available in the State’s traditional Medicaid program and are currently enrolled in one of two pre-paid, capitated plans or an Enhanced Service Plan (ESP), which is designed for enrollees with significant medical needs.</p> <p>HIP coverage is subject to a \$1,100 deductible and benefits are capped at \$300,000 annually with a \$1 million lifetime benefit cap. Enrollees are also provided with HSA accounts to pay for deductibles. These accounts are funded through a combination of enrollee, state, and federal contributions. The State has proposed using this program as the basis for a Medicaid expansion.</p>

Alternative Expansions	
Iowa	<p>The Iowa Health and Wellness Plan will cover individuals age 19–64 with incomes under 138% FPL using a two-fold approach; a coordinated care program and a premium assistance program. The coordinated care program will provide a benefit package equivalent to the State Employee Health Benefit Package. After the first year, monthly premiums are charged to adult enrollees with incomes greater than 50% FPL if certain preventative and wellness activities are not completed. The coordinated care program also includes care management activities conducted by ACOs, which operate under a shared savings model.</p> <p>Enrollees with income between 100% and 138% FPL will be eligible for the premium assistance program and will select a qualified commercial health plan through the State’s health insurance exchange. The Medicaid program will pay the enrollees’ premiums and ensure that the health plans provide the required benefits, provider network, and out-of-pocket costs.</p>
Wisconsin	<p>Wisconsin Governor Walker has rejected a traditional Medicaid expansion, but is proposing using the State’s current expansion program as an alternative to covering uninsured adults. Wisconsin’s BadgerCare Plus currently offers services to adults with income below 200% FPL.</p> <p>Governor Walker’s proposal includes reducing eligibility for BadgerCare Plus to 100% FPL for adults, while keeping the program unchanged for children, the disabled, and the elderly. Reducing program eligibility would allow the State to lift the enrollment cap—expanding coverage to those with income below 100% FPL. Those with income above 100% FPL would be removed from the program, but would be eligible to receive APTCs through the federally-facilitated exchange. A State Legislative Budget Committee also voted to provide hospitals with up to \$73.5 million over two years to offset an expected increase in uncompensated care costs.</p>

State	Delivery System Reform Highlights
Managed Care Models	
Arizona	<p>The Arizona Medicaid program operates on a managed care basis through an 1115 waiver. The State contracts with 19 different managed care entities, including a contract with the Department of Behavioral Health Services. Every Medicaid enrollee is required to receive services through an MCO, the exception being the American Indian population. This group has the option of receiving services from the State’s FFS program.</p> <p>Arizona’s approved 1115 waiver allows it to impose mandatory copayments for the childless adult expansion population (authority expires on December 31, 2013) as well as other copayments, such as \$3 fees for parents and childless adults who miss scheduled appointments (and live in certain counties).</p>

Managed Care Models	
Florida	<p>Florida recently received approval from CMS to establish a Statewide Managed Medical Assistance (MMA) Program. Since 2005, the State has been running its managed care program through an approved demonstration waiver in five pilot counties. The approved 1115 amendment waiver allows the State to implement Medicaid managed care statewide and require most Medicaid eligible individuals to enroll in a managed care plan.</p> <p>Florida’s MMA program includes four key components: 1) comprehensive Choice Counseling; 2) customized benefit packages with risk-adjusted premiums; 3) an Enhanced Benefits Account Program; and 4) a Low Income Funding Pool. The Enhanced Benefits Account Program provides incentives to enrollees for participating in wellness activities, such as health screenings, preventive care services, and disease or weight management programs. Enrollees may earn up to \$125 in credits per year and may use those credits to purchase approved health-related products and supplies at participating pharmacies.</p>
Louisiana	<p>In 2012, Louisiana implemented its new Medicaid Coordinated Care Network (CCN) program, known as Bayou Health. Bayou Health offers two types of health plans to enrollees: a prepaid plan and a shared savings plan. The two models have been implemented simultaneously, and enrollees may choose the type of model as well as the provider from which to receive services.</p> <p>The shared savings plan is an enhanced PCCM managed care model in which the plan receives a monthly fee to provide coordinated services and PCP care management. Prescription drugs and visits to specialists are available through Medicaid contracted providers. Plans are required to share a portion of the savings received with the participating providers.</p>
Texas	<p>On December 12, 2011, CMS approved the Texas Health and Human Services Commission’s (HHSC) 1115 waiver request. Under the waiver, Texas seeks to capture the savings generated from expanding Medicaid managed care statewide and reinvest those savings in health delivery system reform. The waiver will allow the State to replace current hospital funding mechanisms with a “funding pool” made up of federal funding and IGT transfers.</p> <p>Funding from this pool is used to support reform efforts channeled through Regional Healthcare Partnerships (RHP). RHPs are led by public hospitals and local governments who elect to use IGT transfers, coupled with federal funds, to finance reform efforts. In order to be eligible to receive the federal funds, each RHP must develop proposals for reform plans that address four categories: 1) Infrastructure Development; 2) Program Innovation and Redesign; 3) Quality Improvements; and 4) Population Focused Improvements.</p>

State	Delivery System Reform Highlights
Traditional Expansion	
Washington	<p>Washington is one of several states that will expand Medicaid under the comprehensive provisions outlined in the PPACA. In 2011, the state received approval to transform its state-funded general assistance programs to waiver coverage. The waiver provides the State with a bridge to national health care reform and, as such, changes eligibility for these programs to 138% FPL for all adult populations (jobless and working parents and other non-disabled adults).</p> <p>Washington also elected to establish a state-based exchange and is in the process of modifying existing Medicaid eligibility determination systems to coordinate with the exchange and meet new eligibility rules. The goal is to develop an interface between the exchange, Medicaid, and other programs, which will allow for seamless eligibility determinations across the State's multiple public assistance programs.</p>

Oklahoma's Political Landscape

Bills filed during Oklahoma's 2013 legislative session ranged from prohibiting enforcement of any PPACA provision in Oklahoma (i.e., HB1021 and SB203) to specifically creating a state-based exchange (HB1851), calling for implementation of the Medicaid expansion (SB777), and establishing a sliding scale based premium assistance program for the Medicaid expansion population (SB640). The bills that called for implementation of a state-based exchange and Medicaid expansion had no action since their introduction. HB1021 passed the House on March 13, 2013 with a vote of 72–20, but did not make it through the Senate. SB640 made an initial pass through the House and the Senate, but did not make it through the legislative process for final enrollment before the legislative session ended.

In the November 2010 General Election, Oklahoma voters enacted "...State Question 756, a constitutional amendment prohibiting the implementation of key components of PPACA."⁴⁴ This provision is cited as the foundation for state executive and legislative decisions and actions to forgo implementation of the health care reform law.

On November 19, 2012, Governor Mary Fallin issued a press release formally announcing that Oklahoma would not pursue either a Medicaid expansion or a state-based exchange under the PPACA.⁴⁵ "Such an expansion would be unaffordable, costing the State of Oklahoma up to \$475 million between now and 2020, with escalating annual expenses in subsequent years." Governor Fallin noted that expanding Medicaid would not only increase the State's reliance on unguaranteed federal money, but funding the State's portion of the expansion would require cuts to education, public safety, and existing health care programs.⁴⁶

However, Governor Fallin has also been consistent in calling for an alternative approach. Pursuit of an "Oklahoma Plan" was a key provision of her November 2012 announcement and was further explained in her 2013 State of the State Address.

"Health care funding should be tied to more flexible policies that significantly improve health outcomes while containing costs. Now, Oklahomans are compassionate people and we understand that there are individuals and families who need help. Moving forward, my administration will continue to develop an 'Oklahoma Plan' that focuses on improving the health of our citizens, lowering the frequency of preventable illnesses like diabetes and heart disease, and improving access to quality and affordable health care."⁴⁷

⁴⁴ "Oklahoma Will Not Pursue a State-Based Exchange or Medicaid Expansion," Office of Governor Mary Fallin, Press Release (November 19, 2012).

⁴⁵ Governor Fallin. Ibid.

⁴⁶ Gov. Fallin, "Governor Mary Fallin's 2013 State of the State Address," Office of Governor Mary Fallin, Press Release (February 4, 2013).

⁴⁷ Ibid.

Target Population: Low-Income, Uninsured Oklahomans

Target Population Characteristics

Since 2007, Oklahoma has ranked as one of the bottom five states in terms of overall health status—and the negative health factors that contribute to Oklahoma’s poor health are exacerbated in the low-income, uninsured population (the population that would be targeted in a demonstration waiver proposal). Understanding this population’s specific health characteristics and needs enables the development of effective approaches to covering the population that focus on improving the health of Oklahoma’s citizens, improving access to quality and affordable health care, and reducing levels of uncompensated care.

Figure 8

Oklahoma State Health Ranking by Health Indicator			
Health Indicator	National 2012 Rate	Oklahoma 2012 Rate	Oklahoma State Rank
Smoking	21.2%	26.1%	47
High Cholesterol	38.4%	41.8%	46
Fruits Consumed per Day	0.99	0.74	46
Physical Inactivity	26.2%	31.2%	45
Obesity	27.8%	31.1%	45
Diabetes	9.5%	11.1%	43
Immunizations ¹	90.3%	91.2%	20
Binge Drinking	18.3%	16.5%	12
Infectious Disease ²	12.4	7.1	11

¹ Average percentage of children ages 19 to 35 who have received specific vaccinations.

² Number of reported measles, pertussis, syphilis, and Hepatitis A cases per 100,000 population. Two-year average.

Source: National Association of Community Health Centers.

Several surveys and studies were used to analyze the characteristics of Oklahoma’s low-income, uninsured population. Some key points from Leavitt Partners’ analysis are provided below. More detailed information is provided in Appendix 3.

The prevalence of risk factors is higher among the low-income, uninsured population and this population is more likely to engage in risky behaviors. Uninsured individuals earning less than \$25,000 per year are much more likely to report poor health, smoke, and have diabetes, heart disease, and asthma—all risk factors for more serious chronic conditions. They also have higher rates of heavy drinking and obesity. Sedentary lifestyle and unhealthy eating have led to diabetes and cardiovascular disease rates that are 17% to 20% higher in Oklahoma than the national average.⁴⁸

Figure 9

Prevalence of Select Risk Factors Among Oklahoma Adults Age 18–64, 2010			
Select Risk Factor	Annual Wage < \$25,000	Annual Wage > \$50,000	Increased likeliness <\$25,000 has risk factor
Don't Have Health Coverage	46.7%	6.0%	7.8
Health is Fair or Poor ¹	37.3%	6.0%	6.2
Current Smoker	46.2%	14.0%	3.3
Diabetes	13.7%	5.5%	2.5
Heart Disease	4.7%	2.0%	2.3
Asthma	13.9%	7.4%	1.9
Obesity	40.7%	28.6%	1.4
Heavy Drinking ²	4.1%	3.5%	1.2
High Blood Pressure ³	32.4%	27.7%	1.2
High Cholesterol ⁴	38.3%	34.1%	1.1

¹ Self-reported health status.

² Heavy drinking is defined as men having 2+ drinks per day and women having 1+ drinks per day.

³ This measure is taken from 2009 data.

⁴ This measure is taken from 2009 data.

Source: Oklahoma's Behavioral Risk Factor Surveillance System Data, 2010.

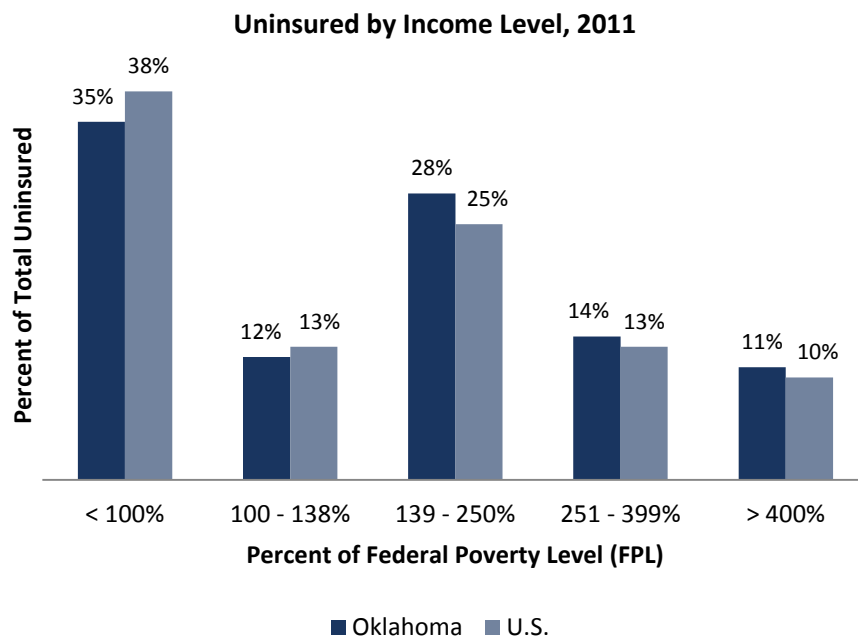
⁴⁸ "America's Health Rankings," United Health Foundation (2012).

While risk factors are higher among the target population, these factors seem to be more directly related to income than to insurance coverage status. This is the case at both state and national levels. Compared to all income levels, some risk factors for the low income in Oklahoma increase by as much as 20 percentage points.⁴⁹ This indicates that while increasing access to health care is important, encouraging positive healthy behaviors (both in terms of seeking appropriate treatment and making positive health choices) is critical to making lasting changes in the overall health of a community.

The population experiences an increasing rate of risk factors. Almost all risk factors for the low-income, uninsured population in Oklahoma have increased in prevalence since 2005.⁵⁰

Close to half of the uninsured have income below 138% FPL. In Oklahoma, 47% of the uninsured have income below 138% FPL, compared to 51% at national levels. Thirty-five percent have income below 100% FPL.⁵¹

Figure 10



Source: Kaiser State Health Facts. Based on the U.S. Census Bureau Current Population Survey, 2010-2011.

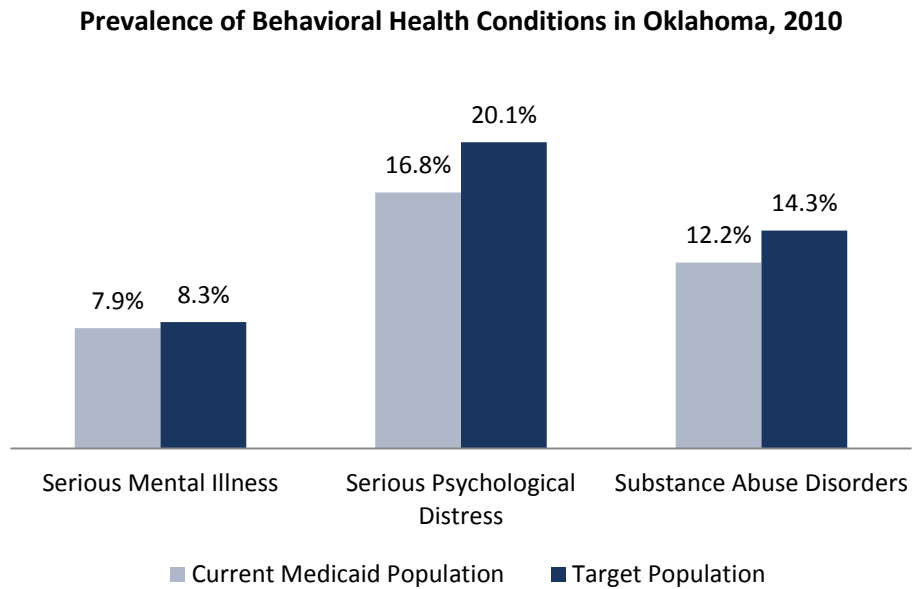
⁴⁹ Oklahoma’s Behavioral Risk Factor Surveillance System Data (2010).

⁵⁰ Ibid.

⁵¹ 138% represents the threshold for which enhanced federal Medicaid funds are available. 100% FPL represents the level for which APTCs are available. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey. Available from Kaiser Family Foundation’s State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

The need for behavioral health services is higher among the target population than the current Medicaid population. Oklahoma’s target population has a higher prevalence of serious mental illness, serious psychological distress, and substance use disorders than both the national low-income, uninsured population as well as Oklahoma’s current Medicaid population.

Figure 11



Source: Substance Abuse and Mental Health Services Administration, 2010.

The population consists of a range of individuals—from relatively healthy individuals to those with chronic, co-occurring conditions. The low-income, uninsured population is not a homogenous population and will require multiple approaches to address its varying needs. A possible solution to this problem is the implementation of health homes, which coordinate primary, acute, and specialty care with behavioral health and long-term care. Health homes can also promote coordination with community support services.

A more cost-effective approach is needed to provide care to this population. While some support services are currently available to this population, many of its health care treatments go unpaid, resulting in uncompensated care costs.⁵² These costs are ultimately paid by providers, the State, and the public. Developing avenues for the uninsured to access appropriate preventive and coordinated care could improve the efficiency and effectiveness in how care is provided, reducing costs over time.

⁵² The Oklahoma State Department of Health has contracted with Milliman to further study the issue and impacts of uncompensated care.

Methods for Addressing Target Population’s Needs

The target population’s characteristics highlight two important points:

1. While increasing access to health care is important, encouraging positive healthy behaviors is critical to making lasting changes in the overall health of a community.
2. The population’s prevalence of chronic, co-occurring conditions will require multiple approaches to address its varying needs—and a possible solution to this problem is the implementation of health homes.

To better understand these two points, Leavitt Partners conducted additional background information on the use of incentives in health care as well as the implementation of health homes. Summary information on these two topics is provided in the sections below. More detailed information on the use of incentives is provided in Appendix 4.

Use of Incentives in Health Care

Several state Medicaid programs have started exploring different approaches to incentivize positive health behaviors. To better understand these approaches and their effectiveness, Leavitt Partners performed a literature review to address the following questions:

1. What are the most effective approaches to motivate low-income adults to make positive changes in their behavior (for themselves and children)?
2. What are the most effective approaches to motivate low-income adults to change unhealthy behaviors and maintain positive healthy behaviors?
3. What are the most effective approaches to motivate Medicaid recipients to engage in positive healthy behaviors?

State and Federal leaders, charged with holding down costs without sacrificing access to or quality of medical services, agree that costs can be better contained if all people are practicing healthy life behaviors.⁵³ In an effort to encourage healthy behaviors, three states (Florida, Idaho, and West Virginia) developed incentive programs to encourage positive healthy behaviors in Medicaid populations.

Lessons learned from these attempts at incentivizing behaviors suggest:

- 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.);
- 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);

⁵³ Hale, J., Phillips C., & Jewell T., “Making the economic case for prevention – a view from Wales,” *BMC Public Health*, 12 No. 1 (2012). Schroeder, S. A. “We can do better – improving the health of the American people,” *New England Journal of Medicine*, 357 No. 12 (2007).

- 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).

More detailed information on the use of incentives in health care, as well as specific outcomes from Florida, Idaho, and West Virginia is provided in Appendix 4.

With any publicly funded program, there is an expectation that recipients be accountable for using services prudently and in a cost-effective manner. As such, OHCA should look to implement program components that provide individual and system accountability, reward positive behaviors, and mitigate potential negative externalities.⁵⁴ Based on the current research, some suggestions are outline below.

Use Care Coordination to Reduce Barriers to Achieving Individual Accountability: Given the needs and behaviors of Oklahoma’s target population, any incentive program the State develops to address individual accountability would need to be coupled with significant care coordination efforts. This would allow the care coordinators to address physical health, behavioral health, and community support needs, which would in turn allow individuals to more effectively engage in health improvement behaviors (smoking cessation, weight management, increased exercise, etc.). Such care coordination can be achieved through the use of medical homes or health homes.

OHCA can also leverage the State’s public and behavioral health infrastructure and coordinated care initiatives to connect improvements in individual behaviors to community-wide health outcomes. For example, the public health system can assist in the collection and interpretation of data necessary to identify and contact individuals who are in need of enhanced coordinated services. Public health also has expertise in developing population-based approaches for tobacco cessation and obesity reduction, both of which are areas of high need for target population. The behavioral health system can assist OHCA develop initiatives to address behavioral health needs that may encumber target enrollees’ accountability and adherence to treatment plans.

Use Appropriate Reductions in Cost-Sharing to Incentivize Positive Behaviors: Certain levels of cost sharing—or more importantly, appropriate reductions in cost-sharing requirements—can be used to help incentivize positive health behaviors and promote personal responsibility. This is particularly true if

⁵⁴ Potential barriers exist to imposing mainstream accountability requirements on the target population. For example, research demonstrates that cost sharing can cause lower-income populations and those with significant health care needs to forgo needed care, resulting in adverse health outcomes. The population’s income and support deficits can also make it difficult for them to adhere to treatment plans. “Premiums and Cost-Sharing in Medicaid: A Review of Research Findings,” Kaiser Commission on Medicaid and the Uninsured (February 2013).

the reduction is seen as real savings earned from engaging in healthy behaviors, such as seeking appropriate care from PCPs rather than an emergency department, using generic prescription drugs, or adherence to other state-defined criteria.

This type of approach could be used to reward discreet behaviors or be used more broadly to address lifestyle issues or care plan requirements. For example, one stakeholder Leavitt Partners interviewed suggested that OHCA incentivize the use of seeking appropriate follow-up care by waiving the associated copayment. More broadly, OHCA could incentivize adherence to chronic condition treatment plans by gradating, reducing, or eliminating the level of copayments for all services within the plan.

The benefit to this type of approach is that it rewards individuals who act accountable for their care and access the system appropriately. It is voluntary and, when combined with behavioral health supports and care coordination, can be implemented in ways that provide value to individuals who have more serious physical and behavioral health conditions (e.g., supports are provided to help individuals maintain adherence to a treatment plan, allowing them to achieve meaningful copayment reductions—further incentivizing positive behavior). If the individual ceases to adhere to the treatment plan, a higher copayment amount can be reinstated.

Health Homes

Health homes are envisioned as a way to coordinate care for Medicaid enrollees with chronic conditions through a “whole person” philosophy. They provide an opportunity for co-location of care coordinators with both physical and behavioral health specialists. In health homes, providers integrate and coordinate primary, acute, behavioral health, and long-term care—as well as promote greater coordination with other community services and supports.

The establishment of health homes and outcome-based incentives can help OHCA achieve higher levels of integrated physical and behavioral health care, which is critical for individuals with multiple, co-occurring chronic conditions. Recent research shows that for those with chronic conditions, health care costs are as much as 75% higher for individuals with mental illness and two to three times higher for individuals with co-occurring substance abuse disorders.⁵⁵ Providing enhanced care coordination to these individuals not only improves their health care quality and clinical outcomes, but it improves the patient care experience, promotes individual accountability, and reduces costs.

A policy brief published by the Integrated Care Resource Center outlines three core elements needed in any delivery system. These include:

- Alignment of financial incentives
- Multidisciplinary care teams accountable for care coordination
- Mechanisms for assessing and rewarding high-quality care⁵⁶

⁵⁵ “The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions,” Center for Health Care Strategies (October 2009). “Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations,” Center for Health Care Strategies (December 2010).

⁵⁶ “State Options for Integrating Physical and Behavioral Health Care,” Integrated Care Resource Center (October 2011).

These elements are critical to the successful implementation of a health home. The authors of this brief further describe additional mechanisms that can be applied in a health home model, including enhanced fees, developing community based teams, use of HIT, and providing incentives for integration.

Medicaid Demonstration Proposal

In order to provide cost-effective health care coverage for Oklahoma's low-income, uninsured population, Leavitt Partners recommends OHCA utilize a premium assistance approach based on the IO framework. The approach would 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 an advanced premium tax credit to assist in the purchase of commercial coverage through a health insurance exchange.

The State would provide premium assistance to eligible enrollees to purchase qualified health insurance through the federally-facilitated exchange or employer-sponsored insurance through the current IO ESI program. Eligible enrollees would include relatively healthy, low-cost, uninsured individuals with income up to 138% FPL. Wrap-around services would be provided to ensure that these enrollees receive required benefits and cost-sharing protections.

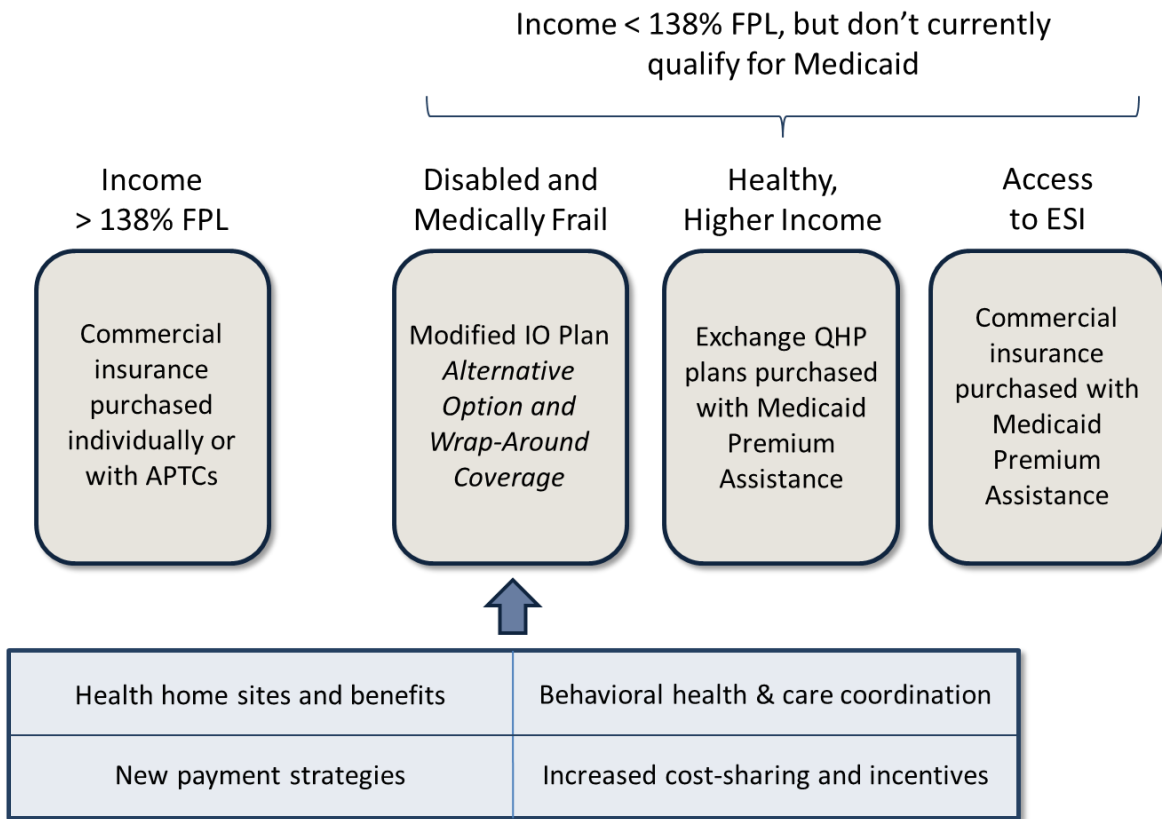
For uninsured individuals who don't qualify for Medicaid under the State's existing eligibility rules, but are disabled or considered medically frail, the State would use a modified version of the IO Individual Plan as the basis for benefit design and care delivery. This model will also serve as the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

Leavitt Partners recommends OHCA modify the current IO Individual Plan by:

- Incorporating a health home model and adding specific health home benefits;
- Using care coordination and behavioral health benefits to reduce barriers to achieving individual accountability;
- Imposing maximum allowable cost sharing, and utilizing appropriate reductions in cost-sharing requirements to incentivize positive health choices; and
- Implementing new payment strategies that incentivize providers to be efficient and to focus on improved patient and overall health outcomes.

Figure 12

Recommended Approach for Covering Low-Income, Uninsured Oklahoma Residents



To oversee the implementation of the approach, Leavitt Partners recommends OHCA create a Steering Committee made up of key executive, legislative, and community stakeholders. The Steering Committee should consider issues such as working toward multi-payer models for the program’s health home system, developing a strong evaluation component, and demonstrating cost-effectiveness.

The Steering Committee should also consider how best to leverage current OHCA initiatives as well as integrate public health initiatives into the approach. This will help ensure that the approach maintains a broader focus on health outcomes and improving the State’s overall health. Leavitt Partners also recommends that OHCA develop complementary proposals for the Indian Health System to preserve its unique program characteristics and maximize cost savings.

While the recommended approach is presented as an overall plan, each individual point can be considered separately and developed as its own proposal. Details on the development of this approach, as well as specific elements of the recommendation are provided below.

Key Principles

Leavitt Partners believes that OHCA has a unique opportunity to realign its Medicaid program to better address the needs of the State's low-income populations. This realignment is driven by four key principles:

- 1. Create a more uniform, equitable and stable definition of the Medicaid eligible population:** This can be accomplished by transitioning some existing SoonerCare members into commercial coverage by reducing current program income limits and eliminating optional programs for groups who will be eligible for similar coverage in the commercial market. This coverage will be made more affordable by premium tax credits offered through the federally-facilitated exchange. By leveling the income threshold for adult acute care coverage, the State will be better able to streamline Medicaid programs and processes and promote commercial market coverage.
- 2. Maximize the use of commercial plan enrollment:** This can be accomplished by using the Insure Oklahoma framework to provide care to low-income, uninsured populations.
- 3. Increase system and individual accountability for health outcomes:** By focusing on a higher degree of integration between SoonerCare and the public health and behavioral health delivery systems, there is an opportunity to adopt delivery system reforms that help move the State's Medicaid program toward a system of increased individual accountability and improved health outcomes.
- 4. Align program design with economic goals:** Basing reform on the three principles outlined above provides a natural opportunity to align delivery system reform with a more comprehensive approach to increasing the income and self-sufficiency of unemployed and under-employed Oklahomans. This in turn supports the ultimate goals of reducing the number of Oklahomans who qualify for Medicaid over time, lessening support on public assistance, and incentivizing businesses to provide employees with access to health insurance.

Based on these principles, Leavitt Partners proposes the following approach be used in an 1115 demonstration waiver.

Foundation for Recommended Approach

Leavitt Partners recommended approach is based on two foundational points: 1) changing current program eligibility; and 2) leveraging premium assistance to purchase commercial insurance.

Changing Current Program Eligibility

Starting in 2014, three federally mandated changes to both Medicaid and commercial insurance coverage create an opportunity for Oklahoma to streamline and simplify its existing Medicaid program.

First, new income and eligibility methodologies will impact the base Medicaid program covering low-income children, families, and pregnant women. These methodologies will apply one uniform standard to how income is counted and how eligibility is determined. This standard will be the same one used to determine whether individuals at a higher income level are eligible for an APTC through the federally-facilitated exchange.

Second, individuals who meet citizenship requirements and have incomes above 100% FPL will have access to commercial insurance products through the federally-facilitated exchange purchased with the assistance of APTCs.⁵⁷ Leavitt Partners recommends OHCA move currently eligible Medicaid enrollees with income above 138% FPL into the commercial insurance market, rather than using the 100% level, in order to streamline eligibility and enrollment processes.

Third, the Medicaid Maintenance of Effort (MOE) for adults expires with the implementation of exchanges in 2014—meaning states will again be able to change program eligibility within current federal regulation.⁵⁸

Due to these changes, Leavitt Partners recommends that Oklahoma eliminate optional Medicaid coverage where individuals would be:

1. Eligible for Medicaid under base Medicaid State Plan coverage; or
2. Eligible for commercial coverage covered through an APTC.

Figure 13 and 14 show SoonerCare's existing program eligibility and the suggested changes. As illustrated below, eliminating the State's optional Medicaid coverage would streamline and simplify current programs and eligibility processes, allowing OHCA to more easily move to the MAGI eligibility determination required in 2014. It is estimated that this change would transition roughly 26,000 current Medicaid enrollees to exchange coverage.⁵⁹

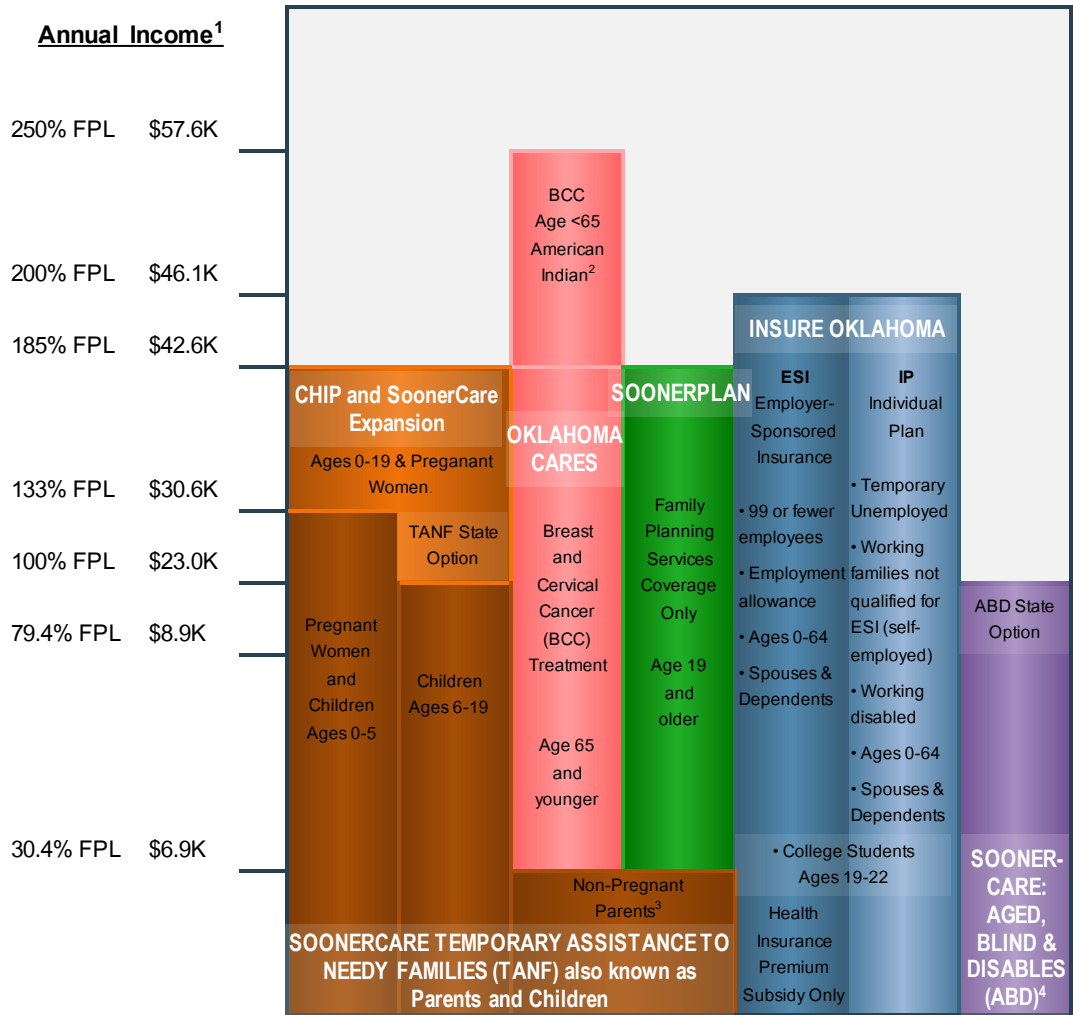
⁵⁷ In order for the State to access the 100% federal match rate, it must provide some sort of Medicaid coverage up to 138% FPL. CMS has indicated that it will not consider the enhanced match for a demonstration up to 100% FPL. Given the task was to provide a cost-effective proposal, Leavitt Partners believes that this can be best accomplished by keeping those below 138% FPL on Medicaid. There is also some concern about the ability of those between 100% and 138% FPL to afford premiums even with the APTC. An alternative recommendation can be developed using the 100% level if preferred.

⁵⁸ The MOE for children remains in place until 2019.

⁵⁹ This estimate is based primarily on SoonerCare programs monthly enrollment numbers.

Figure 13

SoonerCare's Current Program Eligibility Standards



¹ 2012 Federal Poverty Guidelines. U.S. Department of Health and Human Services. Based on a family of four.

² Oklahoma Cares qualifications are up to 250% FPL for American Indians only.

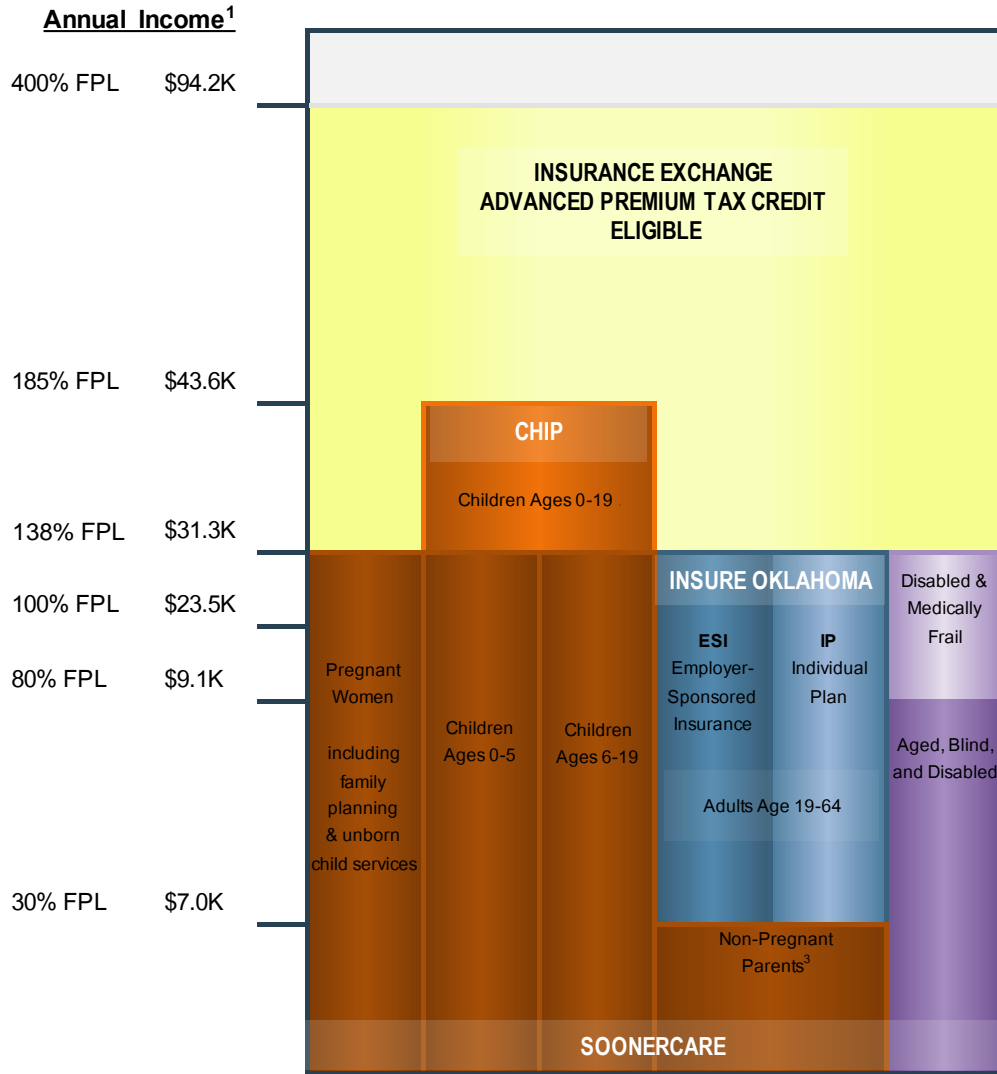
³ \$6,996 approximately 30% FPL, based on a single parent family of four. (29.6% family of 3 or 30.4% family of 4).

⁴ Federal Poverty Level for the ABD members is approximate and based on a single individual.

Source: OHCA's 2012 Annual Report.

Figure 14

Suggested Program Eligibility Standards under Recommended Approach



¹ 2013 Federal Poverty Guidelines. U.S. Department of Health and Human Services. Based on a family of four.

² Approximately 30% FPL, based on a single parent family of four.

³ Federal Poverty Level for the ABD members is approximate and based on a single individual.

Source: Leavitt Partners changes based on data from OHCA's 2012 Annual Report.

Eliminating the suggested optional Medicaid coverage also encourages individual accountability. If commercial insurance options are available and affordable, eligible individuals will obtain commercial coverage as opposed to using a safety net designed to cover the low-income, uninsured. Encouraging the use of the exchange will also support the individual commercial market, increase competition, and reduce potential for private market crowd-out.⁶⁰

Four of Oklahoma's Medicaid programs will be affected by this change: 1) pregnant women with income between 138% and 185% FPL;⁶¹ 2) the Breast and Cervical Cancer program; 3) the Family Planning program (SoonerPlan); and 4) Insure Oklahoma. As outlined above, affected individuals would either be enrolled in the new Medicaid option Leavitt Partners recommends or receive an APTC to purchase commercial coverage through the federally-facilitated exchange.

If Oklahoma chooses to adopt this recommendation, the State should conduct a vigorous public education and outreach campaign. This campaign would inform the public of the changes in program eligibility, help people understand that SoonerCare is no longer available to adults with incomes above 138% FPL, and detail options for obtaining commercial coverage.

Leavitt Partners also recommends that Oklahoma exempt the Indian Health Service, Tribal, and Urban Indian health systems from this change. This recommendation is based on a concern that commercial coverage may not be a viable option for portions of the American Indian population, which has traditionally relied on the Indian Health System. Additionally, since the federal Medicaid reimbursement to these facilities will continue to be 100%, there is no financial gain or loss to the State under this exemption.

Leveraging Premium Assistance

As Leavitt Partners advisors reviewed current programs within the SoonerCare portfolio, it became apparent that the State already had a potential framework for an alternative plan with its Insure Oklahoma (IO) program. As a premium assistance program designed by the State, IO has a strong Oklahoma brand with wide acceptance and support throughout the community. Its success in reducing the number of uninsured and extensive community support makes IO a natural means for extending access to health care in the State and a strong base for large-scale Medicaid reform. Further, by providing access to affordable mainstream, commercial-based coverage, the program emphasizes individual accountability and reduces long-term reliance on Medicaid.

New Premium Assistance Models

Arkansas recently proposed a more market-driven approach to the Medicaid expansion. The legislation, which was signed by Governor Beebe on April 23, 2013, instructs the Arkansas Department of Human Services to utilize a private insurance option to cover "low-risk" uninsured adults. In order to accomplish this task, the Department will provide premium assistance to eligible individuals to "enable their enrollment in a qualified health plan" through the State's exchange.⁶²

⁶⁰ Individuals dropping employer-sponsored insurance or other private coverage to move to Medicaid.

⁶¹ The federally mandated coverage level for pregnant women is currently 133% FPL (this will change to 138% with the 5% income disregard that will be implemented in January 2014).

⁶² A more detailed summary of the Arkansas proposal is provided in Appendix 2.

With the interest expressed by CMS in the Arkansas proposal, the use of the IO framework has become a viable alternative to providing coverage to low-income, uninsured Oklahomans. CMS has both published and internally discussed with states a number of requirements that this type of program may have to comply with under a waiver.^{63 64} These include:

1. Current cost-share requirements are not negotiable (however, CMS' proposed cost-sharing rule provides some limited cost-sharing flexibility in the traditional Medicaid program).
2. Wrap-around benefits will be required. The benefits required under Medicaid coverage, but not required under commercial coverage typically include:
 - Non-emergency transportation
 - Family planning
 - EPSDT for 19 and 20 year olds
 - Access to FQHCs and Regional Health Clinics (RHCs)
3. Disabled and medically frail populations may be voluntarily enrolled in a Medicaid alternative benefit plan.
4. An alternative option to the commercial buy-in choices must be provided, presumably designed more like a standard Medicaid plan.
5. Medicaid premium assistance may be limited to an exchange's individual market (i.e., enhanced federal funds cannot be used to provide premium assistance in an exchange's small group market).

Waiving Federal Requirements

Leavitt Partners believes that it is possible to design a workable approach within these constraints; however, OHCA is encouraged to negotiate with CMS for flexibility on some of the provisions. It is not likely that CMS will negotiate on the cost-sharing limitations given the recent proposed rule and minimum benefit package requirements. However, Leavitt Partners suggests that the State discuss the possibility of waiving the restriction that the Medicaid population cannot be charged a premium, especially for those with incomes above 100% FPL. It may also be worth seeking flexibility on the EPSDT provisions and the limitation of premium assistance to an exchange's individual market. More detail on each of these points is provided below.

Premiums: The restriction on charging Medicaid premiums does not currently apply to the IO population. Therefore, imposing a premium would be consistent with both current practice and future practice, given that Oklahoma will not be adopting a traditional Medicaid expansion. Additionally,

⁶³ "Medicaid and the Affordable Care Act: Premium Assistance," CMS (March 2013). Internal Revenue Service, Health Insurance Premium Tax Credit, Notice of Proposed Rulemaking § 1.36B-2(c), 76 F.R. 50940-50941 (August 17, 2011).

⁶⁴ In April 2013, CMS released additional guidance to states regarding 1115 demonstrations. The FAQs indicate that CMS will not approve enrollment caps or periods of ineligibility in section 1115 demonstrations. The FAQs also indicate that demonstrations that only focus on changes to the delivery of health care services, such as managed care, will not generally be eligible for the increased federal match. "Affordable Care Act: State Resources FAQ," CMS (April 25, 2013).

absent the waiver, individuals with incomes above 100% FPL will be paying premiums with assistance from a federally-funded APTC. Finally, collection of the premium would be beneficial in a cost neutrality calculation.

There is past precedent for CMS to waive the cost-sharing provisions for optional expanded populations, and while originally mandatory, the adult PPACA Medicaid expansion group is now optional. As outlined in the State Comparison section, CMS approved higher copayments for Arizona's expanded adult population. In its April 8, 2013 approval letter to Arizona, CMS acknowledges several key factors in its approval, one of which is that some cost sharing is "necessary in order to prevent the state from implementing other, more severe—and in our view, worse—alternatives, such as covering fewer people in this population by lowering the qualifying federal poverty level (FPL) percentage limit, reducing benefits for the currently covered population, or eliminating coverage of this expansion population entirely."

While Arizona's waiver expires on December 31, 2013, the same arguments could apply to the target population in Oklahoma—particularly since the expansion is optional. The major difference between the Arizona waiver and the PPACA expansion is the enhanced match rate, which does provide some justification for tighter policy controls by CMS. However, this precedence provides the State with some basis to discuss higher cost sharing with CMS.

EPSDT provision: The EPSDT requirement applies to 19 and 20 year olds. While states must provide this benefit as outlined in federal statute, there is precedent for having it waived.⁶⁵ A possible justification OHCA can use in its waiver request is that the individuals with the most severe conditions will already be eligible for a broader service package, as they will be considered disabled, medically frail, pregnant women, or part of other benchmark-benefit exempt groups. This primarily leaves relatively healthy, legal adults subject to the requirement. Given that the benefit package provided by commercial plans is a relatively robust, comprehensive package when combined with Medicaid wrap-around services, it seems unnecessary to include this benefit.

If CMS is unwilling to negotiate on the EPSDT issue, wrap-around coverage can be provided by issuing a medical card for enrollees to use when accessing EPSDT and other Medicaid services not included in the commercial plan. 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."⁶⁶ It is Leavitt Partners' recommendation that wrap-around services be provided through the alternative option. This plan will have a less expansive benefit package than the current State Plan and, under the recommended approach, include health home services.

Limiting premium assistance to an exchange's individual market: The State should also seek further clarification on the provision that the commercial buy-in plan may only be available through an exchange's individual market. Not only would this provision limit individuals' options, but it would negatively affect small businesses in Oklahoma that have found the current IO program to be an affordable way to offer coverage to their employees. Still, even if such a restriction exists, it is not fatal

⁶⁵ The state could also seek waivers for additional benefits, such as non-emergency transportation and dental benefits for 19 and 20 year olds.

⁶⁶ "Challenges to Implementing Premium Assistance, Health Insurance for Children," The Future of Children, Princeton-Brookings, 13 No. 1 (Spring 2003).

to the overall proposal. It would simply result in more individuals eventually enrolling in the individual market and the alternative option.

Recommended Approach

Using changes in program eligibility and leveraging premium assistance as the foundation for its approach, Leavitt Partners recommends the following plan be used by the State of Oklahoma in a new 1115 waiver proposal or in an amendment to the State's existing 1115 demonstration. While the ten recommendations outlined below are presented as part of an overall plan, each individual recommendation can be considered separately and developed as its own proposal.

- I. **Maintain the current ESI program.** OHCA should maintain its current ESI program, promote its success, and keep the program as true to its current form as federal approval eventually allows (e.g., allowing enhanced federal funds to be used to provide premium assistance in the group market). In order to move more individuals towards self-sufficiency and mainstream coverage, OHCA should encourage as many employed individuals who qualify for Medicaid assistance to use this program as is reasonable. Maintaining this program will help sustain the State's small group market, support small employers who want to provide a path to coverage, and help reduce private market crowd out. More detail can be provided once CMS releases further guidance on whether premium assistance can be provided through a small group exchange. If CMS does not provide flexibility on this point, Leavitt Partners recommends OHCA continue to operate its ESI program as currently structured.
- II. **Leverage premium assistance to enable the purchase of commercial insurance in the individual market.** Encouraging higher-income individuals to purchase commercial insurance through the federally-facilitated exchange aligns with the self-sufficiency goals of OHCA. Added benefits include increasing the number of lives and subsequent demand in the commercial individual insurance market, which could potentially reduce costs. Also, because the State will be providing this option to higher-income individuals in the target population, it places similarly situated individuals on a relatively level playing field, allowing for a more seamless transition from Medicaid to commercial coverage. Under this option the differences between Medicaid and commercial coverage would be relatively minor—the loss or gain of a few wrap-around services and a possible change in premiums—whereas moving between a standard Medicaid product and a commercial plan can be highly disruptive to an individual's access to care.
- III. **Modify the IO Individual Plan currently in place (the new Insure Oklahoma plan).**
 - Maintain this plan as currently designed (premium-based access to state-sponsored insurance) and present it as the alternative option to the commercial buy-in choices. The IO program has proven success and is strongly supported by the community, making it a natural point for system reform. As such, OHCA should continue its current marketing of the program, presenting it as a premium-based product with the cost determined by the value of services provided. This will help connect the alternative option to the commercial insurance environment as well as help individuals better understand its cost and value compared to commercial coverage, potentially reducing private market "crowd out."

- Use this alternative option as the wrap-around coverage for the commercial buy-in products and as the benefit package for eligible disabled and medically frail enrollees. If required, OHCA could provide a secondary coverage card for the SoonerCare Traditional plan that would allow the disabled and medically frail populations to access additional Medicaid benefits.
- Include a blended health home/medical home model. OHCA should 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 will extend the coordination of primary, acute, and specialty care to include behavioral health and long-term care. The health home model will also promote greater coordination with other community support services.

Due to its high rate of heart disease, stroke, chronic lower respiratory disease, lung cancer, and diabetes, Oklahoma has a higher mortality rate than the rest of the nation. The State’s population also has high rates of tobacco use and low engagement in physical activity. Due to these public health issues, the Oklahoma Legislature required the Oklahoma State Board of Health to prepare a health improvement plan for “the general improvement of the physical, social, and mental well-being of all people in Oklahoma through a high-functioning public health system.”⁶⁸ The plan envisions community-wide collaboration, working across multiple health care systems. Developing a health home model, which coordinates physical, public, and behavioral health care aligns tightly with the goals of this initiative.

It also aligns with the objective of integrating public health initiatives into the approach in order to maintain a broader focus on improving the State’s overall health (Point IV outlined below). Public health can serve as the entity that bridges the provision of social and community support services to individuals who are not directly included in the new Insure Oklahoma plan. This will help ensure that a comprehensive health and social service system is provided at the broader community level.

- Include the basic benefits required for Medicaid coverage and add additional health home benefits to the alternative option. Possible health home benefits could include those outlined in PPACA 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

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 (March 2006).

⁶⁸ “A Comprehensive Plan to Improve the Health of all Oklahomans, 2010-2014,” Oklahoma Health Improvement Plan (2008). Available from OK.gov. Accessed June 17, 2013. <http://www.ok.gov/health2/documents/OHIP-PLAN.pdf>.

- Individual and family support, which includes authorized representatives
- Referral to community and social support services
- The use of health information technology to link services

The State will want to ensure that the behavioral health and chronic care coverage benefits are adequate to address the needs of the target population.

- Use care coordination and behavioral health services to reduce barriers to achieving individual accountability. While the new Insure Oklahoma plan will provide health care access to many uninsured individuals, improvements in health won't be fully realized unless positive behavioral changes are made as well. Because the target population will have multiple physical and behavioral barriers to adhering to healthy lifestyles and wellness strategies, it will benefit from better coordinated care.

Working with public and behavioral health on reducing and mitigating the impacts of tobacco use, obesity, substance abuse issues, and other chronic conditions can align patient and health system objectives and accountability for the both target population and the broader state population. Leveraging the public health system's outreach efforts and ability to provide and coordinate care at a community level can also help reduce unnecessary utilization of high cost and uncompensated care.

- Impose maximum allowable cost sharing—and utilize appropriate reductions in the cost-sharing requirements to incentivize positive health behaviors and promote personal responsibility (e.g., using generic prescription drugs, seeking appropriate care, etc.). Given the income range of the target population (0%–138% FPL), a sliding schedule will be required, with those at the lowest income levels being exempt from cost sharing, at least initially.
- Implement new payment strategies that incentivize providers in conjunction with their patients 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 will both benefit providers as well as hold them accountable for care improvements by incentivizing them to meet specific performance and outcome improvement metrics.

Established metrics could reflect outcomes in a variety of ways. For example, reductions in inpatient and outpatient hospitalizations as a result of care coordination and other initiatives are already being measured by OHCA. Some additional measures might focus on survival rates for particular conditions; others might focus on public health measures like increasing the rate of prenatal care, reducing low birth weight babies, or achieving measurable reductions in tobacco use or weight loss. Other measures could focus on the State's goals related to improving employment and self-sufficiency.

The use of shared savings can also help drive the formation of the coordinated care models needed for the state health improvement plan collaborative model to be developed by the Oklahoma State Board of Health (as directed by the Oklahoma Legislature). Public health can assist in this formation by using its expertise to develop

incentives and performance metrics that focus on community level changes, rather than just improved clinical outcomes for the target population.

If OHCA decides to move in the direction of linking payment strategies to public health improvement initiatives, it may consider applying for a Health Care Innovation Award as part of a collaborative with other agencies or commercial market entities. CMS released a Funding Opportunity Announcement (FOA) for a second round of Health Care Innovation Awards in May 2013.⁶⁹ These awards are available to both public and private organizations to test new payment and service delivery models.

One proposal category, which may be of most interest to OHCA, centers on models that improve the health of populations either at a community, socioeconomic, or disease-specific level (e.g., improving the health of those with diabetes). CMS' priority areas include models that lead to better prevention and control of specific diseases, promote behaviors to reduce risk for chronic disease, promote medication adherence and self-management skills, and link clinical care with community-based interventions.⁷⁰

Models should focus on enrollee engagement, prevention, wellness, and comprehensive care that extend beyond the clinical setting to leverage community health improvement efforts.⁷¹ As part of the proposal, applicants must submit a payment model design that will be used to support the initiative. Examples of payment models include multi-payer models, shared savings, tiered value-based payment schedules, etc.⁷² Establishing collaboratives with other agencies or commercial market entities will allow the State to more cost-effectively address the target population's needs as well as advance health care delivery innovation and reform.

- IV. Integrate public health initiatives to maintain a broader focus on health outcomes and improving the State's overall health.** By focusing on a higher degree of integration between SoonerCare and the public health and behavioral health delivery systems, there is an opportunity to adopt reforms that help move the State's Medicaid program toward a system of increased individual accountability and improved health outcomes. As such, OHCA should leverage the State's public health infrastructure and current initiatives to connect individual behaviors and health needs to community-wide health outcomes.

For example, working with public and behavioral health on reducing and mitigating the impacts of tobacco use, obesity, substance abuse, and other chronic conditions can align patient and health system objectives and accountability, not only for target population, but for the broader state population as well. This will in turn reduce both Medicaid and other state health care costs by preventing the onset of disease and chronic conditions. Leveraging the public health system's outreach efforts and ability to provide and coordinate care at a community level can also help

⁶⁹ "Health Care Innovation Awards Round Two," CMS.gov. Accessed June 17, 2013.

<http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html>.

⁷⁰ "Health Care Innovation Awards Round Two, Cooperative Agreement," U.S. Department of Health and Human Services (May 15, 2013).

⁷¹ Ibid.

⁷² Ibid.

reduce the utilization of higher cost care (such as the utilization of emergency department and inpatient hospital visits) for those who have already developed chronic conditions.

Public health could also serve a role in providing care coordination at a community level, particularly in rural areas, as well as in connecting both the target population and other the non-Medicaid populations to social and community services. While it is recommended that OHCA develop health homes to coordinate and provide these services to the target population, public health can serve as the entity that bridges the provision of these services to individuals in the community who are not included in the new Insure Oklahoma plan. This will ensure that a comprehensive system is provided at the broader community level.

Additionally, public health can be used to identify community-level needs and track changes over time. Public health can assist OHCA develop evidenced-based interventions, performance metrics, and evaluations that focus on community-level changes, rather than just improved clinical outcomes for the target population. Public health's experience in evaluating and tracking data can be used to assist OHCA determine the effectiveness of its program and make appropriate changes.

OHCA should work closely with public health when developing care coordination plans, payment incentives, performance metrics, and evaluation strategies for the new Insure Oklahoma plan. Public health's ability to identify population health needs, provide community supports, coordinate care, build coalitions, and track data will help ensure that the new plan incentivizes meaningful behavior changes that positively impact the broader community.

V. **Work toward multi-payer models.** 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. Reasons for doing so include:

- Allowing providers to spread investment over more patients;
- Obtaining community alignment of performance measures and reporting structures;
- Creating less administrative burden as providers use more standardized processes;
- Reducing the problem of payer investment with the benefits accruing to other payers downstream; and
- Aligning the new system with the State's overarching interest in population-based approaches that include commercial as well as Medicaid involvement.

Several states have already moved in this direction, including Pennsylvania and Massachusetts. Shared savings models are also more often utilized in these states.⁷³

⁷³ "About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations," *Health Affairs*, 31 No. 11 (November 2012).

VI. Create a steering committee to implement the proposal, which could include the:

- The Governor
- President Pro Tempore of the Senate
- Speaker of the House of Representatives
- Oklahoma Secretary of Health and Human Services
- CEO of Oklahoma Health Care Authority
- Commissioner of the State Health Department
- Commissioner of the Department of Mental Health and Substance Abuse Services
- Director of the Department of Human Services
- Insurance Commissioner
- Representative from the Oklahoma Hospital Association (OHA)
- Physician representative from the Oklahoma State Medical Association (OSMA)
- Physician representative from the Oklahoma Osteopathic Association (OOA)
- Representative from the private health insurance industry

It is expected that this Committee will need to address and coordinate on many issues as elements of the approach are implemented in the State, including issues related to behavioral health, public health, and commercial insurers.

For example, care coordination under a health home model will require close work with mental health professionals. Ideally, there will be co-location of mental health professionals with physical health providers, as well as community support services. If co-location is not possible, then a close connection with easy referral processes and follow-up will need to exist. While the mental health professionals in these settings can be connected to the ODMHSAS or be private providers, the administrators at ODMHSAS will be the most knowledgeable about available behavioral health resources and best practices—and therefore in the best position to provide guidance on how best to establish these connections. They will also be able to identify the opportunities and barriers to establishing the coordination required for a new delivery system. Additionally, there are issues related to enrollee accountability that are directly related to behavioral health issues. Implementing successful initiatives to address these issues will take close coordination with ODMHSAS at both the state and local levels.

The Steering Committee will also provide an avenue for OHCA to work closely with public health in implementing the proposals, particularly in developing care coordination plans, payment incentives, performance metrics, and evaluation strategies. Public health's ability to identify population health needs, provide community level supports, coordinate care, build coalitions, and track data will help ensure that the new plan targets and incentivizes meaningful behavior changes that impact the broader community.

In terms of issues with commercial insurers, there is an interest in developing system approaches to public health initiatives that include commercial carriers. The Steering Committee should consider creating a process that would allow it to regularly consult IO commercial plan administrators (specifically those that are part of the new buy-in program). This will provide an opportunity to create and implement common initiatives and multi-payer models that benefit both SoonerCare and commercial plan enrollees.

OHCA and other stakeholders can use this committee to ensure that they are in alignment with the overall policy direction of the State as well as to ensure state-wide buy-in with any major initiatives that emerge from the discussions. The cross-cutting workings of this committee will help expedite the many policy and process decisions that will have to be made in relation to delivery system reform.

VII. Develop a strong evaluation component, which should include:

- Provider and recipient satisfaction surveys and other instruments;
- Health outcomes at individual and population health levels;
- A comparison group to compare to those enrolled in commercial buy-in plans;
- Outcome measurements from providers, communities, and OHCA (e.g., HEDIS, CAHPS, HEDIS-like measures, and other measures participants agree to track for incentive considerations); and
- Comparisons of the cost of health incentive programs to the value of the outcomes to determine that the investments made are justified by the returns seen in health outcomes and savings.

As mentioned above, public health can be used to identify community-level needs and track changes over time. Public health's experience in evaluating and tracking data can be used to assist OHCA determine the effectiveness of its program and make appropriate changes.

VIII. Demonstrate cost effectiveness. Both federal and state governments want to ensure that demonstration waiver proposals are a cost-effective approach to providing care. There is some concern that an insurance buy-in model may be more expensive than providing coverage through a traditional Medicaid expansion, especially if Medicaid cost-sharing requirements must be maintained.⁷⁴

However, based on some of the preliminary arguments made by Arkansas in its proposal,⁷⁵ as well as some of Oklahoma's unique Medicaid program factors, OHCA should be able to address the cost effectiveness issue.

⁷⁴ There are several explanations for this cost differential, but the main factors seem to be the differences in provider reimbursement rates and administrative costs. A 2012 CBO report estimated the cost per person for providing exchange tax credits was \$9,000, while to cost for providing Medicaid \$6,000 per person. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," CBO (July 2012).

⁷⁵ In order to show that its proposal to use enhanced federal funds to provide premium assistance to the expansion population is cost effective, Arkansas assumed that it could keep Medicaid reimbursement rates low by moving the majority of the newly eligible individuals into the private sector. This would allow the State to avoid having to increase rates in order to incentivize more providers to treat Medicaid patients. Costs would be further reduced by increased competition on the exchange, aggressive private-plan management, increased cost sharing, more conscientious consumer health care decision making, and selective population management (i.e., only enrolling, healthier, less costly Medicaid recipients in private plans). "Financial Impact of Arkansas' Private Option Plan for Insurance Premium Assistance," Arkansas Insurance Department (2013).

Possible points to consider include:

- Medicaid provider rates are already comparable to Medicare rates;
- Savings generated by utilizing a medical home/health home model (e.g., reduced in-patient and out-patient care, etc.);
- The possibility of using the health home enhanced match rate in calculating the costs of the demonstration waiver (for first 24 months);
- The argument that increased competition from enrolling more individuals in an exchange will reduce overall costs;⁷⁶ and
- The hypothetical idea that the State could legally expand with a full, more costly Medicaid benefit package.

IX. **Leverage current program initiatives.** OHCA is currently developing program initiatives that could strengthen this proposal, including:

- The College of Pharmacy at the University of Oklahoma already provides a resource to review the medication regimes of high risk recipients. This resource would add value to a health home model where medication management can lead to the efficient and high-quality use of prescription drugs.

Extension of this program should be explored to examine the feasibility of utilizing this resource to:

- Review and coordinate pharmacy with health home providers
- Tie local pharmacies into the health home network

Leavitt Partners received comments from one community contact that physicians might face some liability issues if they relied on advice from a consulting pharmacist that led to a bad treatment outcome. If this concern is a barrier to utilizing the School as described above, there is still the possibility of leveraging back-end analysis where the College would provide information and analytic work on how drugs are prescribed across the program, the need for medication management, etc.

- OHCA and the surrounding health community have developed relationships with the University of Oklahoma's medical school specialty providers. In the implementation of new payment models there may be an opportunity to expand these relationships to benefit both the program's recipients and the schools.⁷⁷

⁷⁶ A similar argument was made in Arkansas (see above). Ibid.

⁷⁷ OHCA should seek to expand these relationships in a way that would not to infringe on the opportunities of community providers.

- X. **Develop complementary proposals for the Indian Health System to preserve unique program characteristics and maximize savings.** These proposals will allow the State to mitigate costs associated with uncompensated care, provide continuous coverage, and reduce state costs (more information on these proposals is provided in the Indian Health System section below).

Timing

It is not likely that this plan in its entirety could be implemented by January 1, 2014. Given the need to obtain State leadership approval, create a more detailed design, negotiate with CMS, and actually implement the plan, a 2015 start-up date is more realistic. This extended timeline will also provide a buffer from some of the inevitable start-up challenges associated with the new exchange environment. However, it will create a potential problem with the sun-setting of the current IO waivers. If Oklahoma wants to pursue a premium buy-in approach like the one outlined in this brief, Leavitt Partners suggests OHCA continue to aggressively negotiate for a one-year extension to the existing waiver with the agreement that Oklahoma will amend or replace it based on the plan it outlines in its waiver proposal.

Additional Benefits

- By modifying the IO Individual Plan, the State is able to build on its success and provide a premium-based product that encourages self-sufficiency while simultaneously making modifications that will better meet the needs of the target population. It can also leverage savings in the base program to expand and strengthen the behavioral health aspect of the program. This will allow the State to experiment at a low cost with which models work best and, if appropriate, apply them to the current program.
- By implementing new payment strategies with a focus on provider incentives, the State can evaluate and begin to build the capacity to transition to new care delivery models like ACOs (given these models prove to be successful in improving quality and reducing cost).
- Utilizing new payment models, such as shared savings, also provides an opportunity to evolve to a community-based delivery system, better integrating OHCA with public and mental health communities and creating a greater focus on population health outcomes.
- Use of the health home model and current program medical home model will provide the State with information as to what works best in the Oklahoma environment. This information can be useful in the development and evolution of the State's dual eligible project.
- If establishing health home sites proves to be more successful than the current medical home model (SoonerCare Choice), then it can potentially be used in the base Medicaid program with less risk and potential disruption than establishing a new model with no previous evaluation.

Leavitt Partners believes that using an approach that relies heavily on providing commercial insurance for the low-income, uninsured, population combined with an alternative option that includes a health home and new payment strategies, meets the State's objectives on multiple levels.

Not only does it move more people into mainstream coverage and align with the State's self-sufficiency goals, but it will:

- Maximize service options
- Promote accountability and personal responsibility
- Encourage and incentivize healthy outcomes and responsible choices
- Promote efficiency in the delivery of health care services

Leavitt Partners believes that the recommended approach is also beneficial in that it provides potential recipients with system choices, while moving the program further away from a FFS payment system. It also provides a health home option that promotes more integration between medical care, behavioral health, and public health.

State Funded Approach

Any of the approaches outlined above could be implemented using only state dollars— and without federal participation, there would be more flexibility in the program's design. For example, the State would be able to implement more aggressive cost sharing approaches and narrow the benefits provided to the target population. The State would also not have to provide an alternative approach to the premium assistance program. However, it is likely that enrollment in the state-funded program would be limited, and over time the State's capacity to cover the same number of individuals would erode unless appropriations for the plan increased.

Another state-funded approach is to run the premium assistance program with state dollars and use the funding opportunities made available through Section 2703 of the PPACA to develop health home services for enrollees with chronic conditions. A 90% enhanced federal match rate is available for these health home services, but the enhanced funding is time limited and will return to the regular match rate after two years. CMS has also authorized states to spend up to \$500,000 of Medicaid funding (provided at the state's regular match rate) for planning related to the design and development of Health Home State Plan Amendment initiative.

Finally, the State could implement a state-funded approach, while simultaneously implementing the proposals for IHS and other Tribal health facilities outlined below, which utilizes current, on-going 100% federal match dollars for the tribal component. This would provide additional coverage to the American Indian and Alaska Native populations with no additional financial exposure to the State.

Indian Health System Proposals

It is estimated that there are 41,000 uninsured American Indians and Alaska Natives (AI/ANs) in Oklahoma.⁷⁸ Nearly half of these individuals are unemployed, many lack health insurance, and almost 70% have a high school education or less (decreasing the possibility of obtaining employer-sponsored insurance). They are notably younger than current adult Medicaid enrollees in Oklahoma and, as a low-income population, have significant health needs—making this group an important component of the low-income, uninsured population that would be targeted in a demonstration waiver proposal.

While it is expected that the federal government will reimburse between \$154 and \$172 million in uncompensated care provided by IHS, Tribal, and Urban Indian clinics (I/T/U) in 2014, it is important to note that current federal funding provided to these facilities is not sufficient to cover total costs. As such, providers, the State, and the public assume the uncompensated costs of providing care to this population. According to information provided by the Choctaw Nation of Oklahoma, there are 63 contracted facilities across the State of Oklahoma that partner with the State to provide care to nearly 124,000 American Indians.

Developing complementary demonstration proposals for the Indian Health System will allow the State to mitigate costs associated with uncompensated care, provide continuous coverage, and reduce state costs. It will also allow the State to preserve unique program characteristics related to how Medicaid interacts with the I/T/U system in order to maximize savings.

Federal Medicaid Requirements for the American Indian Population

For decades, Federal law, statutes, and treaties have outlined specific health services and benefits to be provided to the AI/AN population. For example, the Indian Health Care Improvement Act (IHCA) identifies specific health care obligations of the federal government, and in recent amendments to the IHCA, Congress declared a National Indian Health Policy. Section Two of the IHCA states:

“A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.”

The National Indian Health Policy further states that “it is the policy of this Nation ... to ensure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy...”

As a result of the legal status of the I/T/U system, as well as the federal government-to-tribal government relationship, a unique arrangement has been established in how Medicaid interacts with I/T/U facilities. As part of this arrangement, Medicaid services provided through these facilities receive a 100% federal fund match rate.⁷⁹

⁷⁸ “Analysis of a Medicaid Waiver to Reduce Tribal Uncompensated Care in Oklahoma,” Health Policy Center at the Urban Institute (March 6, 2013).

⁷⁹ Social Security Act 1905(b).

To reflect these issues, as well as address I/T/U facility needs, Leavitt Partners offers three 1115 waiver options, the latter two of which were presented to Leavitt Partners at the Tribal meeting in Oklahoma City on March 6, 2013. These proposals are meant to complement the approach developed for the SoonerCare program. As mentioned above, they can be developed as part of the recommended approach, implemented in conjunction with a state-funded approach, or developed as a separate proposal.

Proposed 1115 Waivers

The first waiver proposal would continue to allow full federal reimbursement to I/T/U clinics through Medicaid for: 1) pregnant women with income up to 185% FPL; 2) family planning services up to 185% FPL; and 3) breast and cervical cancer up to 250% FPL. This reimbursement would occur even though Oklahoma is eliminating or reducing these income levels in the base SoonerCare program. Continuing the full federal reimbursement would reduce the potential for an increase in uncompensated care that would likely result if similar eligibility reductions were applied to the I/T/Us.⁸⁰

There is precedent for this type of approach in Arizona, where the I/T/Us were exempt from program cuts required for the base Medicaid program. The facilities were able to continue to receive 100% federal funding through the Medicaid program, helping to maintain their financial viability. This is parallel to how hospitals are provided DSH and other funding to address the costs of providing uncompensated care.

The second waiver proposal would allow full federal reimbursement through Medicaid for uncompensated care provided by I/T/Us to individuals with incomes up to 138% FPL. The PPACA increases federal reimbursement to 100% for the Medicaid expansion population. Since the I/T/Us currently receive 100% federal reimbursement for services provided to AI/ANs, this population is clearly not included in the Medicaid expansion costs. This proposal would allow Oklahoma to opt out of the Medicaid expansion provision, but ensures that I/T/Us will receive 100% federal reimbursement for AI/ANs up to 138% FPL.

Six tribes in Oklahoma currently provide services to non-AI/AN clients. Under the waiver, costs of providing uncompensated care for non-AI/AN clients below 138% FPL would be partially reimbursed by the federal government at the current FMAP rate.

As described above, this proposal is not without precedent. CMS recently approved a waiver in Arizona that allows the State to reimburse the Indian Health facilities for benefits that were eliminated for other Medicaid enrollees. As such, the Indian Health facilities continue to be reimbursed at 100% of the cost of providing services no longer covered by the State Plan. California has developed a similar waiver that is currently being reviewed by tribal consultation.

Should Oklahoma adopt a commercial insurance buy-in proposal, it should consult with Tribal leaders on the best ways to address obtaining 100% federal reimbursement for those AI/ANs who choose to enroll in commercial plans, but also continue to utilize the I/T/Us.

⁸⁰ While it is not clear how an increase in uncompensated care would ultimately impact these facilities, the State should determine the potential impacts of the eligibility changes on the I/T/U system before payments for the current population is reduced.

The third waiver proposal identifies specific issues significantly impacting health care in Oklahoma, defines quality measures and metrics, and implements new payment strategies that focus on provider incentives and shares savings between the I/T/Us and the federal government (since the State doesn't provide any funding for these services it is not included in the shared savings). The tribes have an extensive database tracking health issues and outcomes and have developed proven best practices for smoking cessation, substance abuse, and mental health issues. Leavitt Partners suggests that once the health issues are identified, and the measures and metrics have demonstrated success in providing improved care at a lower cost, OHCA consider adopting these measures as best practices for all Oklahoma providers.

While Leavitt Partners is recommending that the I/T/Us be provided federal support to address uncompensated care and on-going Indian Health structure needs, it also recommends that the State work with Tribal leaders to obtain health improvement plans that outline how the new revenue will be used to help improve I/T/U systems and ultimately the health of those accessing their services.

Estimated Impacts

New Enrollees and Total Cost

The purpose of this section is to estimate the total number of people that will enroll in Insure Oklahoma under Leavitt Partners' recommended approach, the proposal's total cost and cost to the State, and the economic impact.

Model

The following estimates were calculated using a microsimulation model. A microsimulation takes known information about individuals to estimate how certain changes may affect the population as a whole. In this case, it is estimated whether individuals will be eligible for the proposed program, whether they are likely to join, and, if so, how much they will cost. Total cost represents the sum of each individual's costs.

With any program change there is a significant degree of uncertainty as to how people will respond. In recognition of this uncertainty, Leavitt Partners performed a "Monte Carlo analysis" where, based on set assumptions about the population, it is estimated whether each individual person will join the program in a given year. For example, one estimate is that 57% of uninsured, eligible adults will enroll in the new Insure Oklahoma plan. For each eligible individual, a randomly generated number is used to estimate whether that specific person would join if they had a 57% chance of joining. This process is then repeated for all eligible individuals in the sample, which generates an estimated total number of people who will join the program. Of the total eligible population, it is possible that more or less than 57% of the people joined could be estimated, based on random chance. This process is repeated for 10,000 cycles, each time estimating the percent that join. By repeating this process multiple times, an average of the number of new enrollees, as well as a range of potential enrollees is generated. A similar process is repeated which estimates the cost for the population over the next ten years.

Data

The underlying data for this evaluation come from the 2011 American Community Survey (ACS) and data provided by OHCA. The ACS is a yearly survey that samples approximately 2.5% of all American housing units and asks a detailed set of questions, similar to the long-form census that was administered in the past.⁸¹ The survey collects demographic information including data on age, income, employment, family size, etc. In 2011, 57,766 Oklahoma housing units were sampled and final interviews were obtained from 38,820 housing units.⁸² Cost and utilization data for the Oklahoma Medicaid and Insure Oklahoma programs were provided by the Oklahoma Health Care Authority.

Assumptions

The model's estimates are heavily dependent upon underlying assumptions relating to eligibility, take-up, crowd-out, costs, and cost savings. For some of these variables, a sensitivity analysis was performed, which allows for low, medium, and high estimates.

Eligibility

Eligibility for the new Insure Oklahoma plan is based on age and household income. Those eligible for the program are in the age range of 19–64 and have a household income below 138% FPL. In the past, Oklahoma has disregarded a set amount of income when determining eligibility for public programs (\$240 per month per worker); under the standardized approach mandated by the PPACA, 5% of income is disregarded, effectively bringing the eligibility to 138% FPL. The calculation of income is also standardized to equal the MAGI eligibility determination criteria, which is the adjusted gross income on federal tax returns with some specific modifications such as excluding VA benefits, workmen's compensation, some child support, etc. Based on these assumptions, it is estimated that approximately 628,000 adults will be eligible for the New Insure Oklahoma plan based on household income (including those that are currently insured and uninsured).

Take-Up and Crowd-Out

Starting with this estimate of the total number of individuals eligible for the program, some assumptions were made about how many adults will actually enroll in the new program. The adults the new Insure Oklahoma plan intends to target are those that are uninsured; when individuals enroll, they "take-up" the program. Multiple studies have been conducted which estimate Medicaid take-up rates for the uninsured.⁸³ For this analysis a low, medium, and high estimate for take-up was selected in order to provide a sensitivity analysis. The values modeled, from low to high, include the Congressional Budget Office's (CBO) national estimate of Medicaid take-up (57%),⁸⁴ the Urban Institute's estimate of a

⁸¹ "American Community Survey," American Community Survey Office. Accessed June 5, 2013. <http://www.census.gov/acs/www/>.

⁸² "American Community Survey Sample Size Data," American Community Survey Office. Accessed June 5, 2013. http://www.census.gov/acs/www/methodology/sample_size_data/.

⁸³ For an overview of estimated take-up rates, see "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," ASPE Issue Brief, U.S. Department of Health and Human Services (March 2012).

⁸⁴ "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," CBO (March 2013).

traditional Medicaid expansion (68.2%),⁸⁵ and the U.S. Department of Health and Human Services TRIM3 Microsimulation Model (81.3%).⁸⁶ For each of these estimates individual variability was added equal to a standard deviation of 50% of the estimated take-up rate.

The second issue with eligibility is “crowd-out.” This relates to individuals who would have private insurance if not for the existence of the public insurance option. Of particular interest are those that are currently privately insured and will disenroll from their private plans to enroll in the public option. Past work, based on survey data, has estimated the percent of those who substitute private for public insurance to range from 3% to 14%.⁸⁷ For this analysis an estimate of 10% is used and a similar individual variability is applied to this estimate as was applied to the estimated take-up rate.

It is also important to note that the total number of individuals that will enroll in the plan will not necessarily enroll in the first year. Using the CBO’s estimates of adults moving to Medicaid as a proxy, it is expected that 55% of total enrollees will join in 2014, 73% by 2015, 94% by 2016 and then gradually increasing to 100% by 2022. Total estimates of the newly enrolled lives are presented in figures 15–17.

⁸⁵ Unpublished data mentioned in "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," ASPE Issue Brief, U.S. Department of Health and Human Services (March 2012). For an explanation of the model, see "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act," *Inquiry*, 49 No. 3 (November 2012). "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," Urban Institute (August 2011).

⁸⁶ Results available in "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," ASPE Issue Brief, U.S. Department of Health and Human Services (March 2012). Methodology explained in "TRIM3 Simulations of Full-Year Uninsured Children and Their Eligibility for Medicaid and SCHIP," U.S. Department of Health and Human Services (June 14, 2007).

⁸⁷ Based on experiences from other states, Leavitt Partners does not believe many people will drop their employer-sponsored insurance to move to Medicaid. While some employers may drop coverage to allow employees to take advantage of premium tax credits available through the exchange, evidence from Massachusetts and other states found very few employers “dumped” employees. Therefore it is assumed that the effect of employers dropping coverage is captured in take-up and crowd-out estimates. “Public-Private Substitution Among Medicaid Adults: Evidence from Ohio,” *Medicare & Medicaid Research Review*, 1 No. 1 (March 29, 2010). “Substitution Of SCHIP For Private Coverage: Results From A 2002 Evaluation In Ten States,” *Health Affairs*, 26 No. 2 (March 1, 2007).

Estimates of Newly Enrolled Lives

Low Estimate of Newly Enrolled Lives

Figure 15

Low Estimate of Newly Enrolled Lives, 2023 (57% of Uninsured Enroll)				
Estimate: 204,911		Breakdown		
		Insured Status	Total Population	Number to Enroll
Minimum	187,035	Uninsured	308,304	172,826
Maximum	222,386	Insured	319,743	32,085

Source: Leavitt Partners analysis.

Medium Estimate of Newly Enrolled Lives

Figure 16

Medium Estimate of Newly Enrolled Lives, 2023 (68% of Uninsured Enroll)				
Estimate: 233,334		Breakdown		
		Insured Status	Total Population	Number to Enroll
Minimum	216,939	Uninsured	308,304	201,223
Maximum	249,188	Insured	319,743	32,111

Source: Leavitt Partners analysis.

High Estimate of Newly Enrolled Lives

Figure 17

High Estimate of Newly Enrolled Lives, 2023 (81% of Uninsured Enroll)				
Estimate: 257,493		Breakdown		
		Insured Status	Total Population	Number to Enroll
Minimum	241,522	Uninsured	308,304	225,398
Maximum	274,994	Insured	319,743	32,096

Source: Leavitt Partners analysis.

Cost Estimates

Individual cost estimates are based on two factors: 1) the average cost of care for enrollees; and 2) historical growth in costs. The average cost of care was based on the average monthly cost of care provided by the State in FY2013 (beginning in July 2012, with data through February 2013). Specifically, cost estimates are based on the State's portion of costs associated with individuals currently enrolled in the Insure Oklahoma Individual Plan (\$340.85 per month) and Employer-Sponsored Plan (\$312.94 per month).

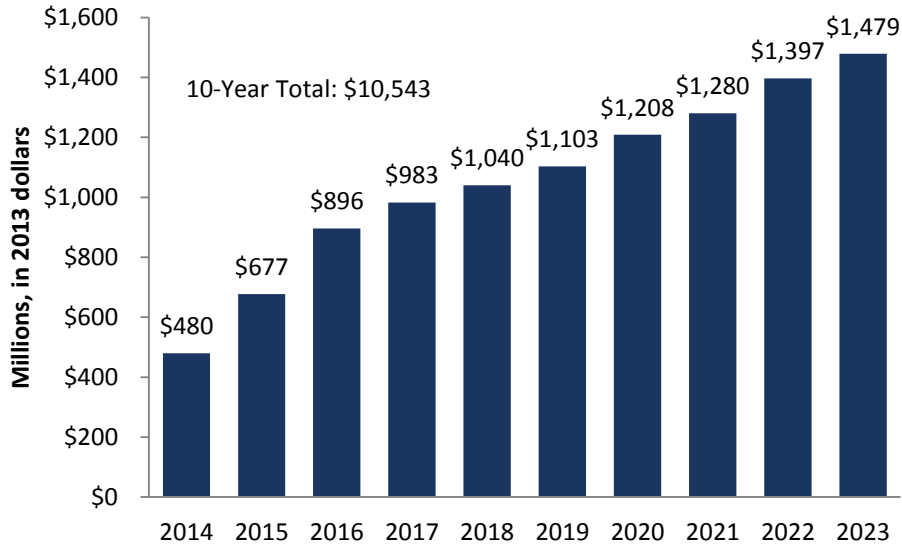
Cost growth estimates were obtained by averaging the cost growth in the Insure Oklahoma plan since 2008. Individual years experienced a PMPM cost growth rate ranging from a low of 0.6% to a high of 11.4%. The average, which was used for the estimated year-over-year increase in costs, was 5.9%.

10-Year Estimate of Demonstration's Total Cost (Federal and State)

Total Cost for Low Take-Up Rate: \$10.5 billion

Figure 18

**Estimated Total Cost (Federal and State) for Newly Enrolled Lives, 2014-2023
Low Take-Up Rate: 57% of Uninsured Enroll**

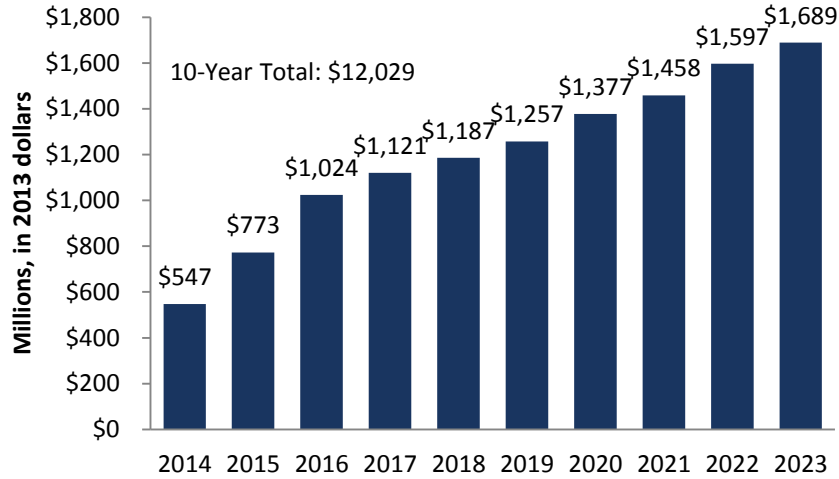


Source: Leavitt Partners analysis.

Total Cost for Medium Take-Up Rate: \$12.0 billion

Figure 19

**Estimated Total Cost (Federal and State) for Newly Enrolled Lives, 2014-2023
Medium Take-Up Rate: 68% of Uninsured Enroll**

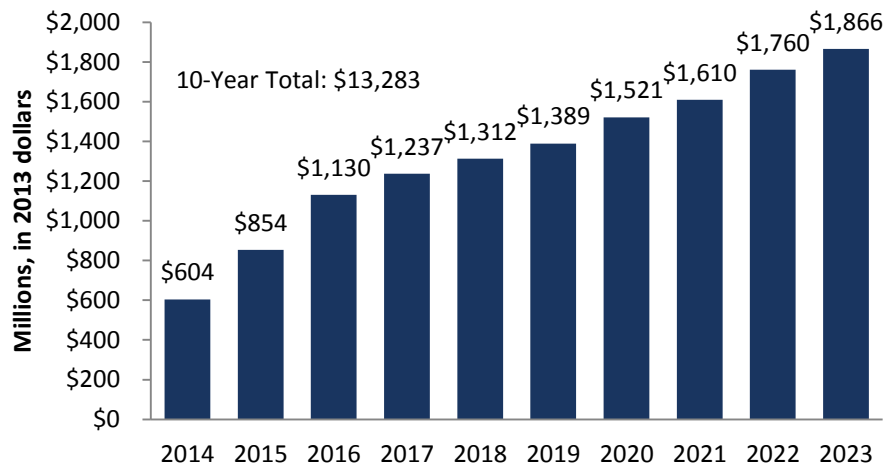


Source: Leavitt Partners analysis.

Total Cost for High Take-Up Rate: \$13.3 billion

Figure 20

**Estimated Total Cost (Federal and State) for Newly Enrolled Lives, 2014-2023
High Take-Up Rate: 81% of Uninsured Enroll**



Source: Leavitt Partners analysis.

10-Year Estimate of Demonstration's Cost to the State

Oklahoma's share of total costs will not be constant during the 10-year period. Initially, the federal government is expected to pay 100% of the demonstration for the first three years (2014-2017) and then the match rate will gradually reduce to 90%.⁸⁸ The exception to this is individuals who receive the majority of their care through I/T/Us; these individuals would not have a decreasing federal match as services would continue to be provided at a 100% match. It is estimated that these individuals will represent roughly 12% of the target population.⁸⁹

Administrative costs, of which Oklahoma would be responsible for during each year of the program, were estimated to represent 2.31% of the total cost. This estimate is based on the current percentage of OHCA's administrative budget and the assumption that the majority of the increase would fall within OHCA's direct administrative costs, rather than other contracting departments. A 56% federal match is also used, based on a blended rate of enhanced match for claims processing and medical professionals with the regular match rate of 50% for administrative components within OHCA.

Figure 21

Oklahoma's Share of the Demonstration's Cost (in millions), 2014-2023											
Take-up	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total Cost
Low	\$ 4.87	\$ 6.88	\$ 9.11	\$ 53.2	\$ 65.5	\$ 79.1	\$ 118.6	\$ 125.6	\$ 137.0	\$ 145.1	\$745.3
Med	\$ 5.55	\$ 7.85	\$ 10.40	\$ 60.6	\$ 74.7	\$ 90.2	\$ 135.2	\$ 143.1	\$ 156.7	\$ 165.7	\$850.3
High	\$ 6.13	\$ 8.67	\$ 11.48	\$ 66.9	\$ 82.6	\$ 99.6	\$ 149.3	\$ 157.9	\$ 172.8	\$ 183.1	\$938.8

Source: Leavitt Partners analysis.

⁸⁸ CMS, Medicaid Program; Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010, Final Rule with Request for Comment 42 CFR Part 433 (April 2, 2013).

⁸⁹ Due to different data sources this estimate may differ from the numbers presented in "Analysis of a Medicaid Waiver to Reduce Tribal Uncompensated Care in Oklahoma," Health Policy Center at the Urban Institute (March 6, 2013). Given that the estimate used in this analysis is smaller than the one in the Urban Institute report, any differential would likely result in more savings to the State.

Economic Impact

A second analysis shows the estimated economic impact of Oklahoma adopting this proposed demonstration. IMPLAN version 3.1⁹⁰ was used to estimate the 10-year economic impact using the most recent state-level multipliers (2011 IMPLAN State Totals for Oklahoma⁹¹). Estimates are based on government spending within the State and the specific Industries affected were determined based on past health care utilization patterns of Insure Oklahoma enrollees.

This analysis estimated the 10-year impact on the Oklahoma economy as well as the number of new jobs to be created. This impact comes from direct, indirect, and induced effects. Direct effects occur when money is spent within the industry, such as the federal government paying for a hospital stay in Oklahoma. An indirect effect occurs when the industry that is affected directly then interacts with another 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. The total effect is the sum of the individual effects.

In addition, IMPLAN estimates the number of jobs that will be created from the proposal. Leavitt Partners generated two estimates based on: 1) the cost of the program; and 2) the cost of the program minus any savings generated by implementing the program. These estimates are displayed in Figure 22, the total 10-year economic impact, and Figure 23, the net 10-year economic impact (total spending less savings). Potential program savings are explained in the Cost Comparisons section.

Figure 22

Demonstration's 10-Year Economic Impact, 2023						
Take-up	Total Cost Estimate	Average Jobs Created	Direct Impact	Indirect Impact	Induced Impact	Total Impact
Low	\$10.5 billion	12,062	\$8.3 billion	\$2.2 billion	\$3.7 billion	\$14.2 billion
Medium	\$12.5 billion	13,762	\$9.5 billion	\$2.5 billion	\$4.3 billion	\$16.2 billion
High	\$13.3 billion	15,196	\$10.4 billion	\$2.7 billion	\$4.7 billion	\$17.9 billion

Source: Leavitt Partners analysis.

⁹⁰ "Economic Impact Analysis | IMPLAN," IMPLAN Group, LLC. Accessed June 6, 2013. <http://implan.com/V4/Index.php>.

⁹¹ "IMPLAN Databases," IMPLAN Group, LLC. Accessed June 6, 2013. http://implan.com/V4/index.php?option=com_content&view=article&id=630%3A630&catid=185%3Adata-information&Itemid=118.

Figure 23

Demonstration's Net 10-Year Economic Impact (Total Spending Less Savings), 2023						
Take-Up	Cost Estimate	Average Jobs Created	Direct Impact	Indirect Impact	Induced Impact	Total Impact
Low	\$10.5 billion	11,501	\$7.9 billion	\$2.1 billion	\$3.6 billion	\$13.6 billion
Medium	\$12.5 billion	13,211	\$9.1 billion	\$2.4 billion	\$4.1 billion	\$15.6 billion
High	\$13.3 billion	14,644	\$10.1 billion	\$2.6 billion	\$4.6 billion	\$17.3 billion

Source: Leavitt Partners analysis.

Cost Comparisons

A third analysis compares the cost of the proposed program to a baseline of having no demonstration. To estimate the cumulative effect, it is first necessary to estimate the expected costs that Oklahoma would incur if the State proceeds with their existing programs—costs that would be avoided by implementing the demonstration. These include expected cost reductions in existing programs and possible savings in other areas of state spending.

Four current programs are expected to be reduced in scope or eliminated under the proposal. Value estimates of these programs come from the OHCA annual report⁹² and from data provided directly by OHCA. All savings represent 10-year cost savings to the State of Oklahoma. These programs include reductions in eligibility to individuals earning less than 138% FPL for Insure Oklahoma (\$188 million), Oklahoma Cares (\$5.2 million), and the Sooner Plan (\$13 million), as well as only providing pregnancy related coverage to pregnant woman with incomes over 138% FPL (\$3.9 million, assuming that these women will access commercial insurance through the federally-facilitated exchange for their total delivery costs). These 10-year savings are estimated at \$210.5 million. Depending on the year, the net effect on the State may be savings (a negative net cost) or a cost (a positive net cost).⁹³

⁹² "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

⁹³ Due to the limitations of the ACS source data, Leavitt Partners was unable to estimate the proportion of enrollees that would qualify as being disabled or "medically frail" and their accompanying higher health care costs. If a high percentage of the target population qualifies as disabled or medically frail individuals, then the estimates will be low. However, if those that are disabled or medically frail already have insurance through existing programs, then the estimates will be high. A subjective estimate of the medically frail based on the Robert Wood Johnson Foundation's estimates of chronic disease prevalence would result in an increase in the 10-year cost estimate of 5-14%.

Figure 24

Demonstration's Net Cost to Oklahoma by Year (in millions) Factoring in Potential Program Savings from Removed Programs, 2014-2023											
Take-Up	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total Cost
Low	(\$ 9.9)	(\$ 8.7)	(\$ 7.4)	\$ 35.6	\$ 46.8	\$ 59.4	\$ 97.7	\$ 103.5	\$ 113.6	\$ 104.0	\$ 534.7
Medium	(\$ 9.2)	(\$ 7.8)	(\$ 6.1)	\$ 43.1	\$ 56.0	\$ 70.5	\$ 114.3	\$ 121.0	\$ 133.3	\$ 124.6	\$ 639.7
High	(\$ 8.6)	(\$ 6.9)	(\$ 5.1)	\$ 49.4	\$ 64.0	\$ 79.9	\$ 128.4	\$ 135.8	\$ 149.4	\$ 141.9	\$ 728.3

Source: Leavitt Partners analysis.

Additionally, the State may realize savings in other areas. OHCA, based on a study by the Pacific Group on Health, estimates that expanding Medicaid to 138% FPL may result in additional cost savings to the Oklahoma Department of Mental Health and Substance Abuse Services (\$340 million), the Oklahoma Department of Corrections (\$118 million), and the Oklahoma State Department of Health (\$24 million). Figure 25 shows the estimates taking into account these additional savings.⁹⁴

Figure 25

Demonstration's Net Cost to Oklahoma by Year Factoring in Removed Programs and Other Savings (in millions), 2014-2023											
Take-Up	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total Cost
Low	(\$ 46.6)	(\$ 47.6)	(\$ 48.6)	(\$ 7.9)	\$ 0.6	\$ 10.5	\$ 45.9	\$ 48.6	\$ 55.5	\$ 42.4	\$ 52.7
Med	(\$ 45.9)	(\$ 46.7)	(\$ 47.3)	(\$ 0.5)	\$ 9.8	\$ 21.5	\$ 62.5	\$ 66.1	\$ 75.2	\$ 63.0	\$ 157.7
High	(\$ 45.3)	(\$ 45.9)	(\$ 46.3)	\$ 5.7	\$ 17.8	\$ 31.0	\$ 76.6	\$ 81.0	\$ 91.2	\$ 80.4	\$ 246.3

Source: Leavitt Partners analysis.

⁹⁴ Data provided by the Pacific Group on Health were the best available estimates of additional program saving resulting from an expansion-like program; however, they should be reviewed with caution. The study performed by the Pacific Group on Health was a high level review of cost savings and did not include considerations that would need to be accounted for in a more detailed cost study. Examples of additional considerations include continued service provision for those who remain uninsured, service provision differentials between private and public providers, service demand levels and capacity of the public agency, the impact on public health protection, and projected revenue reductions for these services.

As part of the economic impact of the additional spending on health care, Oklahoma will also earn taxable income from the direct, indirect, and induced spending. Leavitt Partners estimated the taxable income of the additional spending (total cost of the program factoring in removed programs and other savings, data which is presented in Figure 25). This in turn provided an estimate of the cumulative effect on the state budget for ten years. The negative value of the net effect for each of the scenarios implies a net cost savings for the State over ten years.

Figure 26

Tax Revenue from Increased Spending and Overall Effect on Oklahoma’s Budget (in millions), 2023						
Take-Up	Tax on Employee Compensation	Tax on Production and Imports	Tax on Households	Tax on Corporations	Total Tax Revenue	Overall Net Effect (Surplus)
Low	\$10.8	\$405.2	\$112.4	\$9.5	\$538.0	(\$485.2)
Medium	\$12.5	\$468.5	\$129.9	\$11.0	\$622.0	(\$464.2)
High	\$13.9	\$521.8	\$144.7	\$12.3	\$692.8	(\$446.4)

Source: Leavitt Partners analysis.

Total Costs and Economic Impact

Finally, cumulative estimates are presented in Figure 27. Each of the three take-up levels includes a 10-year estimate of the number of enrolled lives, the total cost of the proposed program, the net cost to the State (taking into account new tax revenue), and the estimated economic impact of the program. The negative net cost to the State suggests a 10-year surplus. It is important to note that these numbers do not represent a range of potential impacts, but are estimates of three potential impact scenarios.

While the proposed demonstration is expected to increase direct costs to the State over a 10-year period, the overall net effect is positive due to program savings and increased tax revenue. Total economic impact is expected to range from \$13.6 to \$17.3 billion.

Figure 27

Estimates of 10-Year Financial Cost and Economic Impact of the Proposed Demonstration Program, 2023				
Take-Up	New Enrollees	Total Cost (Federal and State)	Net Cost to State (Surplus)	Total Economic Impact
Low	204,911	\$10.5 billion	(\$486 million)	\$13.6 billion
Medium	233,334	\$12.0 billion	(\$465 million)	\$15.6 billion
High	257,493	\$13.3 billion	(\$447 million)	\$17.3 billion

Source: Leavitt Partners analysis.

Conclusion and Next Steps

In order to provide cost-effective health care coverage for Oklahoma’s low-income, uninsured population, Leavitt Partners recommends OHCA utilize a premium assistance approach based on the IO framework. The approach would 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 an advanced premium tax credit to assist in the purchase of commercial coverage through a health insurance exchange.

The State would provide premium assistance to eligible enrollees to purchase qualified health insurance through the federally-facilitated exchange or employer-sponsored insurance through the current IO ESI program. Eligible enrollees would include relatively healthy, low-cost uninsured individuals with income up to 138% FPL. Wrap-around services would be provided to ensure that these enrollees receive required benefits and cost-sharing protections.

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 wrap-around coverage for the commercial products purchased through the exchange or group market.

Leavitt Partners recommends OHCA modify the current IO Individual Plan by:

- Incorporating a health home model and adding specific health home benefits;
- Using care coordination and behavioral health benefits to reduce barriers to achieving individual accountability;
- Imposing maximum allowable cost sharing, and utilizing appropriate reductions in cost-sharing requirements to incentivize positive health choices; and
- Implementing new payment strategies that incentivize providers to be efficient and to focus on improved patient and overall health outcomes.

To oversee the implementation of the approach, Leavitt Partners recommends OHCA create a Steering Committee made up of key executive, legislative, and community stakeholders. The Steering Committee should consider issues such as working toward multi-payer models for the program's health home system, developing a strong evaluation component, and demonstrating cost-effectiveness.

The Steering Committee should also consider how best to leverage current OHCA initiatives as well as integrate public health initiatives into the approach. This will help ensure that the approach maintains a broader focus on health outcomes and improving the State's overall health. Leavitt Partners also recommends that OHCA develop complementary proposals for the Indian Health System to preserve its unique program characteristics and maximize cost savings.

The recommended approach is presented as an overall plan, but each individual point in the recommendation can be considered separately and developed as its own proposal.

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 program savings and increased tax revenue. Total economic impact is expected to range from \$13.6 to \$17.3 billion.

Sunsetting of Insure Oklahoma

Since the IO framework serves as the basis for Leavitt Partners' recommendation, it is important to note that CMS has indicated that it will not allow Oklahoma to extend Insure Oklahoma past 2013, unless the State is willing to make certain changes such as complying with federal requirements, including benefit, cost-sharing, eligibility, and enrollment rules. HHS has also suggested that the State use the program as a vehicle for Medicaid expansion. Also, during its 2013 legislative session, the Oklahoma State Legislature did not to approve a proposal to maintain Insure Oklahoma as a state-funded program.

Despite these challenges, Leavitt Partners suggests that the State continue to seek an extension of the existing IO program for one year as necessary changes and modification are made. If Oklahoma is successful in this effort, it will be able to maintain IO's existing administrative framework and connections to the commercial insurance market, allowing for an easier transition to future health care system reform.

While discontinuing the current IO program will result in a coverage gap between the time when the program terminates and when the State can implement a new program, a reintroduction of a premium support program in the future can still be accomplished. Other recommendations put forth in this paper can also be put into effect should the State decide to adopt all or elements of the approach (either through state-based options or under new 1115 authority).

The disadvantage to discontinuing the program, however, is that it would significantly disrupt the program's administration (assuming current IO staff would be reassigned and/or reduced). Staff, program partners, and enrollees would need time to understand and implement new policies. Discontinuing the program would also result in approximately 9,000 current enrollees losing health care coverage (disrupting their current treatment plans), as their incomes would be too high to qualify for Medicaid and too low to receive an advanced premium tax credit through the federally-facilitated exchange. Consequently, these individuals would have to pay for continuing treatment plans themselves, discontinue treatment, or continue plans without paying for the treatments, increasing total uncompensated care costs to providers, the State, and the public.

Next Steps

Insure Oklahoma has a strong Oklahoma brand with wide acceptance and support throughout the community. The stakeholders Leavitt Partners interviewed as part of this project all viewed it as a positive addition to the SoonerCare program. IO is credited with providing coverage to thousands of individuals who would otherwise have remained uninsured and helping small businesses provide coverage that would have otherwise been cost prohibitive. If an agreement cannot be reached with CMS to extend the existing program, the State should move forward with creating the suggested Steering Committee and examining ways to use elements of the IO program in delivery system reform.

As part of this process, OHCA should also conduct a Tribal consultation to address and refine its approach to Tribal health and the uninsured. Several suggestions around eligibility and using Medicaid to support the I/T/U system surfaced during Leavitt Partners' discussions with the Tribes. This consultation should be initiated early in the process in order to identify any policy and procedural issues the Tribes may have with the proposal before necessary rules or statutory changes are made.

Whether the IO program continues or not, OHCA should continue to work with CMS to better understand what constraints will be imposed on a future 1115 demonstration waiver, particularly around premiums and cost sharing, the need for wrap-around services, cost neutrality formulas, the use of premium assistance in a small group exchange, and the design of an alternative plan for persons with disabilities and the medically frail. When the parameters of a demonstration are more fully understood, more concrete policy and budget analyses can be initiated.

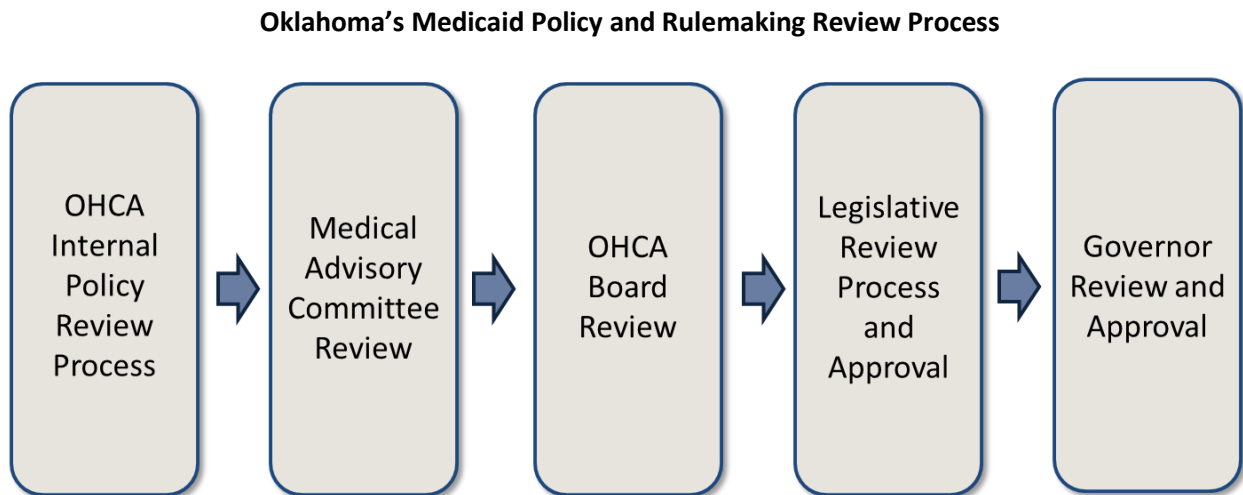
Should OHCA decide to move forward with one or more of the proposed recommendations, it will need to work with CMS on developing any necessary waivers. It will also need to determine what actions

should be taken with regard to the State’s established policy and rulemaking processes, including consulting with its legal counsel to determine the need for any legislation.

It is likely that many of the recommended approaches will require state statute or rule changes. This is one of the reasons why Leavitt Partners suggests 2015 is a more realistic target date for implementation. If the State decides to pursue recommendations which require an 1115 waiver, it will need to account for the time that it takes to write a waiver application and receive approval from CMS. Once general agreement is reached with CMS, the State will have to develop waiver details, including establishing a budget neutrality formula. CMS will then have 90 days or more to make a decision on the waiver.

If the recommendation requires rules changes, then additional time will be needed. The State’s rulemaking process is likely to take at least six months (factoring in time for OHCA’s internal policy review process, the required review by the Medical Advisory Committee which meets bi-monthly, a review by the OHCA Board, and final reviews by the Oklahoma Legislature and the Governor). If any of the recommendations require legislation, then the issue likely won’t even be considered until the next legislative session begins in January 2014.

Figure 28



In Figure 29, Leavitt Partners has outlined which recommendations it believes may require a statutory or rule change. However, these are preliminary categorizations and OHCA should work closely with its legal counsel to verify the information given the complexity of state code and the level of expertise needed to fully understand state code requirements.

Figure 29

Initiative	Require legislation?	Require Rulemaking?	Budget Issue?*
Establish a Steering Committee	No	No	No
Continue IO (no changes)	No	No	No
Implement IO as recommended with new populations and benefits (1115 waiver)	Yes	Yes	Yes
Eliminate programs or reduce income limits	Yes	Yes	Yes
Adopt health home models	No	Yes	Yes
Integrate public health initiatives	No	Yes	Yes
Implement cost-sharing changes	No	Yes	Yes
Develop incentive programs	No	Yes	Yes
Exempt Tribal systems from eligibility changes	Yes	Yes	No
Implement I/T/U uncompensated care program	Yes	Yes	Yes
Develop an I/T/U quality initiative	No	Yes	No
Develop an evaluation component	No	No	Yes (admin)

* Budget impacts assume that the initiative is developed in isolation of other recommended approaches (i.e., that enhanced federal dollars are not accessed through program rebalance). The exception being the IO changes associated with new populations and benefits.

Appendix 1: The PPACA's Medicaid Expansion Provision

Change in Eligibility Determinations

While the Supreme Court ruling allows states to opt out of the Medicaid expansion provision, other PPACA provisions may effectively expand Medicaid eligibility above current state levels, regardless of whether states choose to expand or not.^{95 96} These changes are based on several factors, including: 1) the use of Modified Adjusted Gross Income to determine eligibility; 2) the elimination of asset tests; 3) changes in the definition of a household; 4) changes in the application and redetermination process; and 5) coordination of eligibility determinations.

Modified Adjusted Gross Income

Starting in 2014, eligibility for the expansion population and other Medicaid groups will no longer be based on various categorical income determinations, but will be based on a standard income definition—the Modified Adjusted Gross Income (MAGI). MAGI will be used to determine Medicaid and CHIP eligibility, premiums, and cost sharing. Under the MAGI methodology, asset tests and most income disregards will no longer be used in determining an individual's eligibility. A single income disregard of 5% FPL will be applied instead. Examples of excluded income disregards include VA benefits, workmen's compensation and some pretax contributions like retirement savings and the employee portion of flexible spending accounts.⁹⁷ Additionally, self-employment income deductions are treated differently.⁹⁸

Starting in 2014, the expansion population's eligibility will be determined using MAGI methodologies, as will the eligibility of children, pregnant women, and TANF parents.⁹⁹ Groups that are exempt from the mandatory use of MAGI include: 1) groups for whom the Medicaid Agency is not required to make an income determination (e.g., the SSI population, foster care children, etc.); 2) the aged, blind, or disabled; 3) the elderly and individuals with long-term care needs; 4) the medically needy; and 5) some dually eligible (i.e., enrollees in a Medicare Savings Program).^{100 101 102}

⁹⁵ The overall effect will vary by state. It should also be noted that CMS is developing methodologies for converting eligibility thresholds that attempt to prevent any significant increase in eligibility due to a change in income rules.

⁹⁶ Background information included in this section is drawn from a report Leavitt Partners developed for the Idaho Department of Health and Welfare titled "Idaho's Newly Eligible Population: Demographic and Health Condition Information," Leavitt Partners (September 18, 2012).

⁹⁷ The Repeal and Job Creation Act (Pub. L. 112-56, enacted November 21, 2011), changed the MAGI definition of income to include all Social Security benefits. "Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA," Congressional Research Service (February 5, 2013).

⁹⁸ "Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014," Kaiser Commission on Medicaid and the Uninsured (June 2011).

⁹⁹ Temporary Assistance for Needy Families or adults covered under Section 1931.

¹⁰⁰ "Medicaid and CHIP in 2014: A Seamless Path to Affordable Coverage, Seniors and Individuals with Disabilities in the New World of MAGI," CMS (April 26, 2012).

¹⁰¹ "How States Can Implement the Standardized Modified Adjusted Gross Income (MAGI) Conversion Methodology from State Medicaid and CHIP Data," ASPE Issue Brief, U.S. Department of Health and Human Services (January 2013, Updated April 2013).

¹⁰² CMS issued a letter outlining the ways states could simplify enrollment in Medicaid to handle the increased number of enrollees in 2014. Methods include: 1) early adoption of MAGI-based rules; 2) extending the Medicaid renewal period; 3) using SNAP eligibility; 4) using children's income eligibility; and 5) adopting 12-month continuous eligibility. "Letter to State Medicaid Directors Re: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," CMS (May 17, 2013).

Elimination of Asset Tests

If an individual qualifies for Medicaid based on the MAGI determination, they must be enrolled in the Medicaid program.¹⁰³ States are prohibited from applying asset or resource tests on populations whose eligibility is based on MAGI.¹⁰⁴ This could potentially increase the number of persons who are eligible for Medicaid under current income thresholds, even though the thresholds have not changed.

Changes in the Definition of a Household

By transitioning to the MAGI determination, family size becomes based on the number of personal exemptions an applicant claims on their tax return (i.e., the IRS tax household definition). Under this system, a household includes the taxpayer, his/her spouse, and any child or other person whom the applicant claims as a tax dependent.¹⁰⁵ The total income of a household will therefore equal the MAGI of all individuals in the tax filing unit. Under the current Medicaid system, states differ in their approach to determining household size and determining whose income to include when calculating eligibility.

Changes in the Application and Redetermination Process

The PPACA establishes a 12-month renewal period for MAGI-based Medicaid enrollees. The Medicaid Agency is required to pre-populate and electronically verify as much of the renewal application as possible in order to minimize the burden on the applicant. Self-attestation for most eligibility criteria is encouraged, except for proof of citizenship or immigration status. Citizenship and immigration status must be verified through federal electronic verification data sources. Medicaid Agencies may not require applicants to submit information not needed for eligibility, and paper documentation cannot be required if electronic information is available. Agencies may also not require individuals to complete an in-person interview as part of the application or redetermination process.

Coordination of Eligibility Determinations

Under the PPACA, states are required to provide a standard application form, accessible through a health insurance exchange, for all state health subsidy programs starting in 2014.¹⁰⁶ Based on this application, the exchange will electronically assess whether the individual is eligible for Medicaid, CHIP, or APTCs. States may allow the exchange to make final Medicaid eligibility determinations (based on federal verification data sources) or make an initial assessment and refer the applicant to the state Medicaid agency. If the applicant is determined to be ineligible for Medicaid and/or CHIP, the state must ensure that the individual is screened for APTC eligibility without having to submit another application.

While MAGI will also be used for determining the amount of APTCs a person is eligible for through the exchange, the income rules for the two programs do not perfectly align. Medicaid eligibility is based on current monthly income whereas eligibility for premium tax credits is based on annual income. Processes have been established to provide seamless transitions between the two systems; however, there may be persons who are income-eligible for both programs at the same time and persons who have income just above the Medicaid threshold and just below the APTC threshold.

¹⁰³ States may pursue additional eligibility tests if the individual indicates on the application: 1) a potential for eligibility based on another basis; 2) submits an application designed for MAGI-excepted eligibility; 3) requests a MAGI-excepted determination; and/or 4) the Agency has information indicating such potential eligibility.

¹⁰⁴ "Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline," Congressional Research Service (January 18, 2012).

¹⁰⁵ "Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014," Kaiser Commission on Medicaid and the Uninsured (June 2011).

¹⁰⁶ Starting 2014, states are required to establish a website that links Medicaid to the state's exchanges.

Benefit Package Requirements

The PPACA requires states to provide most people who become newly eligible for Medicaid with “benchmark” benefits. The benchmark package must: 1) meet existing rules set forth in the Deficit Reduction Act of 2005; 2) be equal to one of the three available benchmark plans or be Secretary-approved coverage; 3) meet additional Medicaid requirements; and 4) provide all Essential Health Benefits.

Deficit Reduction Act of 2005

The Deficit Reduction Act (DRA) gave states the option to provide select Medicaid groups an alternative benefit package. Prior to the Act, states were required to offer all federally mandated services to all Medicaid enrollees (although states retained the discretion to offer optional benefits). All federally mandated traditional Medicaid benefits are listed in Figure 30. The PPACA added two new mandatory benefits (free-standing birth clinics and tobacco cessation services for pregnant woman) as well as new optional benefits to the Medicaid program (preventive services for adults, health home services for persons with chronic conditions, and the expansion of home and community-based services as an alternative to institutional care).

Figure 30

Federally Mandated Traditional Medicaid Benefits		
Inpatient hospital services	Federally qualified health center services	Nurse midwife services
Outpatient hospital services	Non-emergency transportation	Nurse practitioner services
Physician services	Home health services	Rural health clinic services
Early and Periodic Screening, Diagnostic, and Treatment services for individuals under 21	Laboratory and X-ray services	Tobacco cessation counseling and pharmacotherapy for pregnant women
Family planning services and supplies	Nursing facility services (for ages 21 and over)	Freestanding birth center services

Health Home Provision: The purpose of including the health home provision in the PPACA was to provide states with “an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for state Medicaid programs.”¹⁰⁷ The option is available to individuals with chronic conditions who select a designated health home provider.¹⁰⁸

¹⁰⁷ Letter to State Medicaid Directors Regarding Health Homes for Enrollees with Chronic Conditions, CMS (November 16, 2010).

¹⁰⁸ The chronic conditions described in section 1945(h)(2) of the Social Security Act include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a body mass index over 25). However, the Act also authorizes the Secretary to expand the list of chronic conditions.

Individuals must have at least “two qualified chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition to participate in the health home.” Chronic conditions include asthma, diabetes, heart disease, obesity, substance abuse, and mental health conditions.

All categorically needy individuals, individuals receiving care through a home and community-based services waiver, and individuals in any medically needy group or section 1115 demonstration population are eligible to be enrolled in home health services. Dual eligible enrollees and children cannot be excluded if they are eligible. Home health services may be provided in a different amount, duration, and scope than services provided to individuals who are not in the health home population.

Health Home Services: States that implement a Health Home State Plan Amendment will receive a 90% federal match rate for all health home services for the first eight fiscal quarters the amendment is in effect. The states have been given flexibility in determining payment structure and targeted geographic areas. Some payment methodologies include tiered payments that take into account the severity of conditions, FFS, capitation, or alternate payment arrangements, as approved by CMS. The state may spend up to \$500,000 of Medicaid funding for planning activities related to health homes, and will receive their regular FMAP rate for those costs.

Health home services are defined as “comprehensive and timely high quality services” provided by designated health home providers or health teams. These services include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.¹⁰⁹

Eleven states have received approval for Health Home State Plan Amendments and an additional 19 states are in some stage of the process.¹¹⁰ By 2017, an independent evaluation of the health home model will be performed and presented to Congress. Among other indicators, the evaluation will address the effect of the model on reducing hospital readmissions, emergency department visits, and admissions to skilled nursing facilities.

Additional chronic conditions, such as HIV/AIDS, will be considered for incorporation into health home models.
Ibid.

¹⁰⁹ Ibid.

¹¹⁰ “State Health Home Proposal Status,” CMS. Accessed June 25, 2013. Medicaid.gov.

Alternative Benefit Package

Elimination of the comparability requirements and the establishment of an alternative benefit package (i.e., benchmark or benchmark-equivalent coverage) through the DRA allow states to provide certain Medicaid populations with benefits that differ from those offered in the traditional Medicaid package.

Multiple Benchmark Benefit Packages: Multiple benchmark benefit packages may be provided to different populations based on health status or geographic region. For example, states can offer a comprehensive benchmark plan to high-risk populations while offering a more limited benchmark plan to relatively healthy populations.¹¹¹

Exempt Groups: Several Medicaid groups are excluded from being mandatorily enrolled in benchmark coverage. These groups include:¹¹²

- Pregnant women
- Persons who are blind or disabled
- The dual eligible
- Terminally ill persons who are receiving hospice care
- Individuals that qualify for long-term/institutional care services based on medical condition
- Persons who are medically frail¹¹³
- Children in foster groups or who are receiving adoption assistance
- Former foster care children
- Section 1931 parents
- Women who qualify for Medicaid due to breast or cervical cancer
- Individuals who qualify for medical assistance because of a TB-infection
- Individuals receiving only emergency services
- Medically needy

States can allow benchmark-exempt individuals to enroll in the benchmark benefit package, but their enrollment must be voluntary and the individual must retain the option to enroll in traditional standard benefits at any time.

Some Newly Eligible in Oklahoma May Not Qualify for Benchmark Coverage: The exemption rule implies that certain groups of individuals who would be considered “newly eligible” (because they don’t qualify for Medicaid under the state’s existing Medicaid eligibility rules) may not be eligible for mandatory enrollment in benchmark coverage. For example, if Oklahoma were to expand its Medicaid program under a traditional PPACA expansion, it would significantly expand eligibility for adults with

¹¹¹ While benefit design cannot discriminate “on the basis of an individual’s age, expected length of life, or on an individual’s present or predicted disability, degree of medical dependency, or quality of life or other health conditions” (PPACA 1302(b)(4)), benefit design non-discrimination policies do not prevent states from exercising Section 1937 targeting criteria.

¹¹² 42 CFR 430–781.

¹¹³ At a minimum, a state’s definition of “medically frail” and “special medical needs” must include children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly prevent them from performing one or more activities of daily living (42 CFR 440.315(f)). States have the flexibility to expand this definition.

dependent children and individuals who are blind and disabled. The State would also be adding a new eligibility group, childless adults (who do not otherwise qualify for Medicaid).

While most of these individuals would be eligible for a benchmark benefit package, a portion would be exempt from mandatory enrollment due to being disabled or “medically frail” (i.e., have “disabling mental disorders,” and/or “physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living”). As such, this population would need to retain the option to enroll in Oklahoma’s standard Medicaid plan, even though they are considered newly eligible and the State receives the increased federal match for them.

Churn Between Existing Medicaid Categories: Because so many groups are exempt from benchmark coverage, a state that decides to utilize this option for the newly eligible population will need to evaluate how to handle the churn that may occur between existing Medicaid eligibility categories. While CMS has stated that between renewal periods states do not need to track or require the reporting of any life changes that may impact the eligibility status of an enrollee, it is expected that states will still need to provide enrollees with notices of program information and benefit options, and must respond to any information they receive that impacts an enrollees’ eligibility.

Churn Between Medicaid and the Exchange: Medicaid-eligible individuals with income near the upper end of the income threshold (138% FPL) are expected to frequently transition between being eligible for Medicaid and for premium tax credits offered through a state’s federally-facilitated exchange. A study published in Health Affairs estimated that within six months, 35% of all adults with income below 200% FPL will experience churn between Medicaid and the exchange, and within a year, 50% of adults will experience such churn.¹¹⁴ One strategy states can use to help minimize the impact of this churn the utilization of premium assistance programs.

Premium Assistance Programs: States can use premium assistance to help individuals and families purchase commercial insurance (either individual insurance or employer-based coverage). Under the existing premium assistance Medicaid statute, the purchase of premium assistance must be “cost-effective,” meaning “Medicaid’s premium payment to private plans plus the cost of additional services and cost-sharing assistance ... would be comparable to what it would otherwise pay for the same services.”¹¹⁵ The premium assistance arrangements must also provide Medicaid-eligible enrollees with access to all Medicaid benefits and cost-sharing protections. In purchasing insurance through the exchange, the premium assistance can be used in coordination with premium tax credits for individuals who are not eligible for Medicaid or CHIP.

However, HHS has indicated that it will consider a limited number of premium assistance demonstrations for the individual market that may exempt states from some of the premium assistance statutory requirements. It has stated that it will only consider proposals that:

- “Provide beneficiaries with a choice of at least two qualified health plans (QHPs);
- Make arrangements with the QHPs to provide any necessary wrap-around benefits and cost sharing along with appropriate data ...;

¹¹⁴ “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges,” Health Affairs, 30 No. 2 (2011).

¹¹⁵ “Medicaid and the Affordable care Act: Premium Assistance,” CMS (March 2013).

- Are limited to individuals ... in the new Medicaid adult group who must enroll in benchmark coverage and are not described in SSA 1937(a)(2)(B)(i.e., the medically frail)...; and
- End no later than December 31, 2016. Starting in 2017, State Innovation Waiver authority begins which could allow a range of State-designed initiatives.”¹¹⁶

Available Benchmark Plans and Additional Medicaid Requirements

The Medicaid benchmark benefits must be equal to one of the three following benchmarks:¹¹⁷

- The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP)
- Any state employee plan generally available in the state
- The state HMO plan that has the largest commercial, non-Medicaid enrollment

States can select a benefit package different from the ones listed above, as long as it is approved by the HHS Secretary. HHS has indicated that a state’s traditional Medicaid benefit package will be a Secretary-approved option.

Required Benefits: The benchmark benefit options represent the minimum benefits to be provided to the newly eligible population and states can augment coverage with additional benefits. However, a base set of benefits must be provided, including:¹¹⁸

- Inpatient and outpatient hospital services
- Physician services
- Lab/x-ray
- Well-child care including immunization
- Other appropriate preventive services designated by the Secretary
- Non-emergency transportation services
- Family planning services and supplies
- EPSDT for persons under age 21 covered under the State Plan
- Care provided by rural health clinics and federally qualified health centers.
- Prescription drugs
- Mental health and substance abuse services
- Essential Health Benefit requirements¹¹⁹

The benefit package must comply with Medicaid managed care requirements, and the state must allow for public input on the benefit package before filing a proposal with HHS.¹²⁰

¹¹⁶ Ibid.

¹¹⁷ Equal can also mean “equivalent in actuarial value.” States can reduce the actuarial value of coverage of some services in the benchmark plan by 25% of what is covered in the comparison plan.

¹¹⁸ “Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline,” Congressional Research Service (August 19, 2010).

¹¹⁹ “Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries,” Kaiser Family Foundation (August 2010).

¹²⁰ Ibid.

Essential Health Benefits: 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. All 10 EHB categories must also be offered in the Medicaid benefit package. If the selected benchmark plan does not cover all of the required benefits, the state must supplement the benefits. The 10 EHB categories are listed in Figure 31; however, specific benefits and services to be offered within each of the categories have not been defined. That decision has been left to the states by allowing them to select their benchmark EHB benefit packages.¹²¹

Figure 31

Essential Health Benefit Categories	
Ambulatory patient services	Prescription Drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance abuse disorder services	Pediatric services, including oral and vision care
Benefits Required Under Section 1937	
Early and Periodic Screening and Diagnostic Treatment (EPSDT)	Non-Emergency Transportation
Federally Qualified Health Centers & Rural Health Clinics	Family Planning Services

Pharmacy: Similar to Medicare Part D, CMS intends to allow states to choose the specific drugs that are covered within the categories and classes of pharmacy benefits offered in the exchange’s essential health benefit benchmark plan. If the benchmark plan offers a drug in a certain category or class, the state’s benefit design must cover the greater of 1) one drug in that same category or class, or 2) the same number of drugs in each category or class as the EHB reference plan (the specific drugs on the formulary may vary).¹²² Unlike Medicare Part D, there are no protected drug classes. It is not clear

¹²¹ The final rule on Essential Health Benefits requires that all EHB Benchmark plans cover a broad range of preventive services, including: “A” or “B” services recommended by the United States Preventive Services Task Force; vaccines recommended by the Advisory Committee for Immunization Practices (ACIP); preventive care and screening for infants, children, and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by Institute of Medicine (IOM). U.S. Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule 45 CFR Parts 147, 155, and 156 (February 25, 2013).

¹²² “Essential Health Benefits Bulletin,” Centers for Consumer Information and Insurance Oversight (December 16, 2011).

whether the same standard will apply to the Medicaid benchmark plan. However, it is assumed that a state will be able to maintain its current preferred drug list when setting the benchmark plan, as long as the list complies with other Medicaid statutory requirements and the coverage has an aggregate actuarial value equivalent to the benchmark.¹²³ In addition, states will also have the flexibility to adopt prior authorization, other utilization control measures, and policies that promote the use of generic drugs as are currently allowed in the Medicaid drug rebate program.¹²⁴

Mental Health Parity and Addiction Equity Act: The PPACA extends federal Mental Health Parity and Addiction Equity Act (MHP) requirements to benchmark plans. Previously, the MHP only applied to Medicaid MCOs; however, under the PPACA, all benchmark plans must offer mental health and substance abuse benefits in parity with medical and surgical benefits, regardless of whether it is delivered through a Medicaid managed care system. Parity must be achieved with respect to both financial requirements (e.g., deductibles, copays, and coinsurance) as well as treatment limitations. Because all benchmark plans must cover EPSDT for persons under 21, they should already meet MHP requirements for children.¹²⁵

Because mental health and substance abuse disorder services are one of the 10 required EHB categories, all benchmark plans must offer some services within this category—and, as specified by the MHP, the services must be offered in parity with medical and surgical benefits. This implies that both the amount of services and the associated costs of providing mental health services through Medicaid could dramatically increase in order to meet the MHP requirements. The issue of cost may be somewhat mitigated by creating separate benefit packages that target specific populations with greater mental health needs. This would allow states to limit the effects of the MHP requirements by targeting necessary services to a specific population.

Cost Sharing: The cost-sharing amounts states can charge the Medicaid population depends on both the enrollees' income and the service being provided.¹²⁶ For adults below 100% FPL, states cannot charge more than a nominal amount for most services and cannot charge a premium or copay for emergency services or family planning services. Above 100% FPL, however, the amount of cost sharing allowed increases as the enrollee's income increases.

Certain groups are exempt from any cost sharing, regardless of income (pregnant women, certain children, and individuals with special needs), and certain services are exempt from cost sharing as well (preventive care for children, emergency care, and family planning services). Medicaid regulations allow for cost sharing to be adjusted for medical inflation over time as well as for states to condition continuing Medicaid eligibility on the payment of premiums. Providers can also refuse care for failure to pay service-related cost sharing.¹²⁷

¹²³ "States may now choose whether to include prescription drugs in managed care contracts or carve drugs out separately without losing the rebates paid by manufacturers" (PPACA 2501)—meaning drug manufacturers are now required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid MCO.

¹²⁴ Letter to State Medicaid Directors Regarding Essential Health Benefits in the Medicaid Program, CMS (November 20, 2012).

¹²⁵ "Frequently Asked Questions on Essential Health Benefits Bulletin," CMS (February 17, 2012).

¹²⁶ "Medicaid: A Primer," Congressional Research Service (July 15, 2010).

¹²⁷ Ibid.

CMS Proposed Rule on Cost Sharing: CMS' proposed rule on Medicaid Premiums and Cost Sharing recommends increasing the maximum nominal cost-sharing amounts and providing new flexibility to impose higher cost sharing for non-preferred drugs and for non-emergency use of the emergency department. These changes are highlighted in Figure 32. In terms of outpatient visits, CMS proposes increasing the copay to \$4 for individuals with incomes under 100% FPL (individuals between 100% and 150% FPL would be charged up to 10% of the cost of the service). In terms of institutional care, current rules allow for charging up to 50% of the cost of the 1st day of an inpatient visit for individuals with income below 100% FPL. CMS is considering alternatives to this such as the \$4 maximum applied to outpatient services, \$50, or \$100.¹²⁸

In terms of non-emergency use of the emergency department, CMS proposes increasing the cost sharing to up to \$8 per visit for individuals with incomes below 150% FPL. However, before cost sharing is imposed, the hospital must provide screening and referral to ensure that enrollees have appropriate access to other sources of care.

In terms of prescription drugs, the proposed rule recommends allowing states to implement cost sharing of up to \$8 for non-preferred drugs and \$4 for preferred drugs for individuals with income less than 150% FPL (this is in addition to any other cost-sharing requirements).¹²⁹ For individuals with income above 150% FPL, the cost sharing for non-preferred drugs may not exceed 20% of the cost the agency pays for the drug.

The proposed rule also recommends allowing states to utilize targeted cost sharing for individuals with family income above 100% FPL, meaning they may have differential cost-sharing levels for different groups of individuals. Targeting must be based on reasonable categories of enrollees, such as a specific income group or population.

Some other key points related to cost sharing and premiums outlined in the proposed rule include: 1) providing states with the flexibility to determine a sliding scale for establishing premiums up to \$20 (currently \$19) for medically needy individuals with income below 150% FPL; 2) exempting spend-down individuals receiving Home and Community Based Services from premiums; and 3) exempting American Indians currently receiving, or who have ever received, an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization from all cost sharing.

¹²⁸ CMS is considering establishing distinct levels of cost sharing for community-based long-term services and supports, which include services such as personal care, home health, and rehabilitative services furnished over an extended period of time.

¹²⁹ If a doctor specifies that a non-preferred medication is in the best interests of the consumer, the consumer will be able to receive the medication at the preferred drug rate.

Figure 32

Medicaid Premium and Cost-Sharing Limits for Adults				
	Current		Proposed Rule, 2013	
	≤100% FPL	101% – 150% FPL	≤100% FPL	101% – 150% FPL
Premiums	Not allowed	Not allowed	Not allowed	Not allowed
Cost Sharing (may include deductibles, copayments, or coinsurance)				
Most Services	Nominal	Up to 10% of the cost of the service or a nominal charge	\$4 for outpatient services Nominal for other services	Up to 10% of the cost of the service
Prescription Drugs:	Nominal	Nominal	\$4.00	\$4.00
• Preferred	Nominal	Nominal	\$8.00	\$8.00
• Non-preferred				
Non-emergency use of emergency department	Nominal	Up to twice the nominal amount	\$8.00	\$8.00
Preventive Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Nominal	Up to 10% of the cost of the service or a nominal charge
Cap on total premiums, deductibles, and cost-sharing charges for all family members	5% of family income			
Service may be denied for non-payment of cost sharing	No	Yes	No	Yes

Note: Some groups are exempt from premium and cost-sharing limits described in this table. These groups include pregnant women (those above 150% FPL can be charged minimal premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. However, these groups can currently be charged cost sharing for non-emergency use of an emergency department and for non-preferred prescription drug use.

Source: Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser (August 2010). CMS, Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, Proposed Rule 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457 (January 22, 2013).

Appendix 2: State Medicaid Delivery System Reforms

Alabama: Accountable and Coordinated Care Model

During its 2013 legislative session, the Alabama Legislature enacted Senate Bill 340.¹³⁰ The bill is based on recommendations from the Alabama Medicaid Advisory Commission which was convened by the Governor in October 2012. Governor Bentley signed the bill in June 2013.

The legislation directs that the State be divided into regions and that a community-led network of providers, referred to as “regional care organizations” (RCO), coordinate the care of Medicaid recipients within each region. RCOs will be responsible for managing and coordinating the full range of Medicaid benefits, including physical health, behavioral health, and pharmacy services. RCOs will be risk-bearing entities. The Medicaid agency is required to draw the regional boundaries by October 1, 2013 and RCOs must have contracts in place with the Medicaid Agency and be ready to operate by October 1, 2016.

Implementation of this model will require an 1115 waiver. On May 17th, 2013 Alabama submitted an 1115 waiver concept paper to CMS.¹³¹ In addition to requests related to the establishment of the RCO model, the State is proposing that CMS make additional funding available for items that would not otherwise be eligible for a federal match, including:

- Investments in RCOs to build delivery system reform infrastructure.
- Investments to enhance the infrastructure of the State’s behavioral health safety-net system to support RCOs in their efforts to provide coordinated care for individuals who have mental illnesses and substance use disorders.
- A Provider Payment Transition Pool to support hospitals in the transition from a per diem to an APR-DRG payment system.
- A Quality of Care Pool to fund incentive payments to RCOs outside of the capitation rate for achieving target quality outcomes.
- Designated State Health Programs (DSHP) that would not otherwise be eligible for the Medicaid match.

These requests mirror those that are included in several previously approved 1115 waivers including Texas, California, and Oregon.

Arizona: Managed Care Model

The Arizona Medicaid program, administered by Arizona Health Care Cost Containment System (AHCCCS), largely operates on a managed care basis under an 1115 waiver. The State currently utilizes three different models of managed care: acute care, long-term care, and behavioral health. This system

¹³⁰ Alabama Legislature, “Relating to the Medicaid Agency; to provide for the, delivery of medical services to Medicaid eligible persons through regional care organizations or alternate care providers,” 2013 Regular Session, SB340.

¹³¹ Letter to Cindy Mann Regarding the Alabama 1115 Waiver Concept Paper, Alabama Medicaid Agency (May 17, 2013).

operates through MCOs that assign each member to a participating PCP. Case management and behavioral health services are provided to identified members.¹³²

The AHCCCS contracts with 19 different pre-paid, capitated, managed care entities. Two of the entities are run by state agencies. The Department of Economic Security/Division of Developmental Disabilities runs an MCO, while the Department of Health Services/Division of Behavioral Health Services operates a prepaid inpatient health plan (PIHP).¹³³ Close to 90% of all Arizona Medicaid recipients are mandatorily enrolled in either an MCO or PIHP, including the dual eligible population and childless adults.¹³⁴ In 2011, the State received a new 1115 waiver that allows it to extend its managed care delivery model.¹³⁵

AHCCCS carves behavioral health services out of its MCO contracts and provides it through a contract with the Division of Behavioral Health Services (DBHS). DBHS plans, administers, and monitors behavioral health services available to all state-supported programs.¹³⁶ It subcontracts with four Regional Behavioral Health Authorities (RBHAs) who deliver the managed behavioral health services to Medicaid enrollees. The RBHAs are responsible for ensuring provider accountability and that they meet certain quality measures related to the delivery of care.¹³⁷

The AHCCCS model requires every Medicaid member to enroll with an MCO. The only exception is the American Indian population, which has the option of enrolling with an MCO or receiving services through the FFS program. American Indians who enroll in the FFS program receive care through IHS facilities and facilities operated under PL 93-638 (638 facilities).¹³⁸ As such, Arizona is requesting a waiver amendment that would allow the State to provide and pay for services that support a medical home for American Indians receiving services through these facilities (services such as PCCM, after-hospital care coordination, and 24-hour call lines).¹³⁹

On April 8, 2013, CMS renewed Arizona's 1115 waiver, which allows the State to impose mandatory copayments for the childless adult expansion population (authority expires on December 31, 2013) as well as other copayments such as \$3 fees for parents and childless adults who miss scheduled appointments (and live outside of certain counties). CMS justifies the mandatory copayments by stating that the demonstration will test the effects of copayments on the utilization of needed preventive, primary care and treatment services as well as appropriate utilization of emergency department care and generic and brand name drugs.¹⁴⁰

¹³² Letter to Cindy Mann Regarding the Arizona 1115 Waiver Amendment Request, AHCCCS (November 9, 2012).

¹³³ "AHCCCS Available Health Plans," AHCCCS. Accessed June 17, 2013.

<http://www.azahcccs.gov/applicants/healthplans/available.aspx>.

¹³⁴ "2011 Medicaid Managed Care Enrollment Report," CMS (November 8, 2012).

¹³⁵ "Arizona Health Care Cost Containment System 1115 Demonstration Fact Sheet," CMS (April 24, 2012).

¹³⁶ "Behavioral Health Services Annual External Quality Review Report for Contract Year Ending 2011," Arizona Department of Health Services (May 29, 2012).

¹³⁷ Arizona Section 1115 Waiver Amendment Request, Medical Homes for American Indians," Draft Request, AHCCS (July 2011).

¹³⁸ Letter to Cindy Mann Regarding the Arizona 1115 Waiver Amendment Request, AHCCCS (November 9, 2012).

¹³⁹ "Arizona Section 1115 Waiver Amendment Request, Medical Homes for American Indians," Draft Request, AHCCS (July 2011).

¹⁴⁰ Letter to Mr. Thomas Betlach, Director of the Arizona Health Care Cost Containment System, CMS (Apr. 8, 2013).

Arkansas: Alternative Expansion

Arkansas recently proposed a more market-driven approach to the Medicaid expansion. The legislation, which was passed on April 17, 2013, instructs 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 utilizing 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.”¹⁴¹

Specifically, the law directs that the Department utilize a private insurance option to cover “low-risk” uninsured adults. In order to accomplish this task, the Department will provide premium assistance, paid for with enhanced federal funds, to eligible individuals to “enable their enrollment in a qualified health plan” through the State’s health insurance exchange.

The Arkansas proposal will include “allowable 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.”¹⁴² However, the law restricts this cost sharing to amounts that do not exceed Medicaid cost-sharing limitations, keeping it within the restrictions sent by current Medicaid rules and the provisions outlined by HHS.

Other key points in the Arkansas proposal include:

- Children are to be enrolled in same plans as parents to extent possible.
- The program will be terminated 120 days after any reduction in the Medicaid expansion FMAP rates specified in the PPACA.
- The Department is to develop a model and seek a federal waiver to allow non-aged, non-disabled individuals to enroll in a program that utilizes Health Saving Accounts (HSA) and provides participants rewards for “healthy living and self-sufficiency.”
- The overall plan sunsets on June 30, 2017 unless extended by the Legislature.
- Eligible individuals enrolled in the program must affirmatively acknowledge that: 1) the program is not a perpetual federal or state right or a guaranteed entitlement; 2) the program is subject to cancellation upon appropriate notice; and 3) the program is not an entitlement program.

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 having to

¹⁴¹ Arkansas State Legislature, “The Health Care Independence Act of 2013,” 2013 Regular Session, SB1020.

¹⁴² Ibid.

increase rates in order to incentivize more providers to treat Medicaid patients.¹⁴³ Costs would be further reduced by increased competition on the exchange, aggressive private-plan management, increased cost sharing, more conscientious consumer health care decision making, and selective population management (i.e., enrolling healthier, less costly Medicaid recipients in commercial plans).

On March 29, 2013, HHS 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 ‘wrap-around’ private coverage to the extent that benefits are less and cost-sharing requirements are greater than those in Medicaid.”

Proposals must also meet the parameters outlined by HHS, which includes 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., the medically frail).¹⁴⁴ 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 138% FPL. 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 138% FPL.”¹⁴⁵

Florida: Managed Care Model

In 2013, Florida received approval for an amendment to its 1115 demonstration waiver for a Statewide Managed Medical Assistance (MMA) Program.¹⁴⁶ Since 2005, it has been running the program through an approved demonstration waiver in five pilot counties. The amendment will allow the State to operate the program in all counties, with some key program improvements. The 1115 waiver, effective through June 2014, seeks to improve the value of the Medicaid delivery system and allow the State to implement Medicaid managed care. It requires most Medicaid eligible individuals to enroll in a managed care plan. Participation is mandatory for TANF-related populations and the aged and disabled, with some exceptions. This demonstration does not expand or reduce Medicaid eligibility.

Four key components of Florida’s MMA program include comprehensive Choice Counseling, customized benefit packages with risk-adjusted premiums, an Enhanced Benefits Account Program, and a Low Income Funding Pool.¹⁴⁷

Comprehensive Choice Counseling provides enrollees with support in choosing a managed care health plan. Enrollees are given the opportunity to speak with a counselor and receive additional information

¹⁴³ “Financial Impact of Arkansas’ Private Option Plan for Insurance Premium Assistance,” Arkansas Insurance Department (2013).

¹⁴⁴ 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 (Mar. 2013).

¹⁴⁵ Ibid.

¹⁴⁶ Letter to Justin Senior, Deputy Secretary of Florida Medicaid from Cindy Mann, CMS (June 14, 2013).

¹⁴⁷ “Statewide Managed Medical Assistance Program, 1115 Research and Demonstration Waiver Replacement,” AHCA. Accessed June 17, 2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-pa.pdf>.

so they fully understand their choices and can make an informed decision. Information provided to the enrollees includes benefits and benefit limitations, cost-sharing reductions, network information, performance measures, and available access to preventive services.

Under the pilot demonstration, enrollees were able to enroll in either a capitated HMO or a Provider Service Network (PSN, which was FFS or capitated).¹⁴⁸ The amended waiver offers additional managed care plan types to enrollees, including ACOs, EPOs (Exclusive Provider Organizations), or CMS Networks (Children’s Medical Services). While FFS plans are not permitted to vary the benefits from those set in the State Plan, all capitated plans have the flexibility to develop customized benefit packages. At a minimum, they must cover the services in the State Plan, but may alter the amount, duration, and scope of coverage for non-pregnant adults to better reflect the needs of the plan’s population. These customized plans will be evaluated on actuarial equivalence and sufficiency. They are intended to more closely resemble commercial plans, creating a bridge between private and public coverage.

The Enhanced Benefits Account Program provides incentives to MMA enrollees to participate in activities that promote healthy behaviors, such as health screenings, preventive care services, and disease or weight management programs. Enrollees may earn up to \$125 in credits per year, and may use those credits to purchase approved products and supplies at participating pharmacies.

The Low Income Pool (Pool) supports safety net providers that furnish uncompensated care to the Medicaid, underinsured, and uninsured populations. The Pool has a maximum allotment of \$1 billion for each year of the demonstration. Two tiers of milestones must be met during each year for the State and providers to receive 100% of the available federal funds for the Pool.

During the first five years of operation, the pilot program demonstrated its ability to improve the health of enrolled patients, achieve high patient satisfaction, and keep cost increases below average—saving Florida up to \$161 million annually. It is estimated that once the program is implemented statewide, it could reduce Medicaid spending by up to \$1.9 billion annually.¹⁴⁹ Full MMA program implementation is scheduled to be completed by October 1, 2014.

The MMA program is one part of Florida’s Statewide Medicaid Managed Care program. The second part is a long-term care managed care program, scheduled to begin implementation in the fall of 2013.

Indiana: Alternative Expansion

Close to 70% of Indiana’s Medicaid population is enrolled in managed care, either through a traditional Medicaid MCO or a PCCM. Its Care Select program is a PCCM program in which high-risk recipients are enrolled in one of the State’s Care Management Organizations (CMOs). These organizations work with the enrollees’ selected PCP to coordinate their health care services and needs.¹⁵⁰ Individuals served by Care Select may be aged, blind, disabled, wards of the court and foster children, or children receiving

¹⁴⁸ Although PSNs may either be capitated or FFS, all PSN plans currently operating in the pilot counties are FFS.

¹⁴⁹ “Florida’s Medicaid Reform Shows the Way to Improve Health, Increase Satisfaction, and Control Costs,” Backgrounder #2620, The Heritage Foundation (November 9, 2011).

¹⁵⁰ “Care Select,” Indiana Medicaid. Accessed June 17, 2013. <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/care-select.aspx>.

adoptive services, or have a chronic condition, such as asthma, diabetes, heart failure, severe mental illness, depression, etc.¹⁵¹

Hoosier Healthwise is Indiana's health care program for low-income families, pregnant women, and children. Based on family income, children up to age 19 may also be eligible for coverage. The program covers medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning. There are four benefit packages in Hoosier Healthwise that are provided based on an applicant's eligibility. For example, Package A is a full-service plan for children, pregnant women, and families. Members have no premiums but may have nominal copays for pharmacy, transportation, and emergency services.¹⁵² Hoosier Healthwise enrollees select one of three available MCO options to manage their care.

In 2008, Indiana expanded its Medicaid program through an 1115 waiver to two additional 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). This expansion program is known as the Healthy Indiana Plan (HIP). The goals of the program include: 1) reducing the number of uninsured, low-income residents; 2) reducing barriers and improving statewide access to health care services for these residents; 3) promoting value-based decisions making and personal health responsibility; 4) promoting primary care prevention; 5) preventing chronic disease progression with secondary prevention; 6) providing appropriate and quality-based health care services; and 7) assuring state fiscal responsibility and efficient management of the program.¹⁵³

HIP does not cover vision, dental, or maternity services. HIP enrollees have access to most services that are available in the State's traditional Medicaid program and are currently enrolled in one of three health plans: Anthem, MDWise (both pre-paid, capitated plans), or the Enhanced Service Plan (ESP), which is designed for enrollees with significant medical needs.¹⁵⁴

Enrollees are also provided with HSA accounts to pay for deductibles. The Personal Wellness Responsibility (POWER) accounts are funded through a combination of enrollee, state, and federal contributions. Enrollees' contribution amounts are scaled by household income and range from 0% to 5%, based on the enrollees' income. Unused POWER account funds roll over year-to-year (assuming the enrollee has met all program requirements), providing incentives for members to obtain annual preventive care requirements first (which are provided at no charge to enrollees). Because POWER accounts are capped at \$1,100, any funds that are rolled over effectively reduce the enrollee's account contribution amount in the following year. If an enrollee 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.¹⁵⁵

¹⁵¹ "Medicaid Programs," Indiana Medicaid. Accessed June 17, 2013.

<http://member.indianamedicaid.com/programs--benefits/medicaid-programs.aspx>.

¹⁵² "Hoosier Healthwise," Indiana Medicaid. Accessed June 17, 2013.

<http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise.aspx>.

¹⁵³ "Healthy Indiana Plan 1115 Waiver Extension Application," Indiana Family and Social Services Administration (April 12, 2013).

¹⁵⁴ "Healthy Indiana Plan Gets Mixed Reviews at Hearing," Associated Press (March 20, 2013).

¹⁵⁵ "Experience under the Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured," Milliman (August 2009).

The State recently proposed using this program as the basis for Medicaid expansion. In February 2013, the State sent Secretary Sebelius a letter applying for a waiver to extend the program through 2016 and to use HIP as a vehicle for expansion.¹⁵⁶ Governor Pence has also indicated his desire to see the Medicaid program converted to a block grant.

Iowa: Alternative Expansion

In May 2013, Iowa Governor Branstad agreed to expand Medicaid through the State's "Iowa Health and Wellness Plan." The plan will cover individuals age 19–64 with incomes under 138% FPL using a two-fold approach: 1) a coordinated care program; and 2) a premium assistance program. The coordinated care program will provide a comprehensive benefit package to the new enrollees, which will be equivalent to the State Employee Health Benefit Package. It will include services such as physician services, emergency services, mental health and substance use disorder services (including behavioral health treatment), rehabilitative and habilitative services and devices, home and community based services for persons with chronic mental illness (equivalent to the State's Medicaid benefit), and dental services.¹⁵⁷

Under the program, enrollees will be charged \$10 copays for non-emergency use of the emergency department. After the first year, monthly premiums will be charged to adults with incomes greater than 50% FPL if certain preventative services are not accessed or wellness activities are not completed. Total out-of-pocket costs will never exceed 5% of income.

The coordinated care program will also include care management activities conducted by ACOs. These organizations will be responsible for meeting a set of quality and cost outcomes for their assigned populations.¹⁵⁸ 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 can receive a share of the savings that was achieved through greater care coordination if they are successful in meeting quality and cost measures. As indicated above, the program will incentivize the use of health and wellness activities by waiving monthly premiums.

Enrollees with income between 100% and 138% FPL will be eligible for the premium assistance program and will select a qualified commercial health plan through the State's exchange. The Medicaid program will pay the enrollees' premiums and ensure that the health plan options provide the required benefits, provider network, and out-of-pocket costs.¹⁵⁹ The benefit categories covered and cost-sharing requirements are the same as those covered under the coordinated care program.

The Iowa Department of Human Services has already started the 1115 waiver application process. It is expected the amended waiver will be submitted to CMS on June 28, 2013.¹⁶⁰

¹⁵⁶ 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).

¹⁵⁷ "Iowa Health and Wellness Plan," Iowa Department of Human Services (June 2013).

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

Louisiana: Managed Care Model

Since the 1990s, Louisiana Medicaid had been utilizing CommunityCARE, a PCCM program. However, recognizing some of the system's inadequacies and service gaps, the State initiated the development of an improved Medicaid service delivery system. In 2012, Louisiana implemented a coordinated care network (CCN) program, known as Bayou Health.

Bayou Health offers two types of health plans to enrollees: a prepaid plan and a shared savings plan. The two models are being implemented simultaneously, and enrollees may choose the type of model as well as the provider from which to receive services. Services are offered statewide, and most Medicaid enrollees are required to participate in the CCN program (with some exceptions). As of May 2013, 52% of enrollees were auto-enrolled in a health plan instead of proactively choosing one themselves. Enrollment in the prepaid plans compared to the shared savings plans is split evenly among enrollees.

The prepaid plan is a traditional capitated MCO model, in which plans establish a network of providers, guarantee access to specified services, and receive a monthly payment for each enrollee. Prescription and pharmacy services are managed through the health plan, and additional services are also provided, as well as provider incentive programs. There is a "prompt payment" process included requiring 90% of claims to be paid by the plan within 15 business days and 99% within 30 calendar days. Plans may set their rates, but they may not be lower than the state Medicaid rate. Certain services are excluded from the plan, but will still be reimbursed on a FFS basis. Some of these include dental, behavioral health, hospice, and nursing facility services.

The shared savings plan is an enhanced PCCM model, in which the plan receives a monthly fee to provide enhanced PCCM services and PCP care management. Prescription drugs and visits to specialists are available through Medicaid contracted providers. Plans are required to share a portion of the savings with the providers.

North Carolina: Accountable and Coordinated Care Model

Due to rising costs and spending which consistently outstrips projected funding, North Carolina is currently in the process of revising its Medicaid program. The current program uses medical homes, managed under the Community Care of North Carolina program, to provide care to Medicaid enrollees. Fourteen nonprofit, physician-directed regional networks participate in the program, which covers about two-thirds of the State's Medicaid population.¹⁶¹ Participating doctors are paid on a PMPM basis as well as receive a care coordination fee.

"Partnership for a Healthy North Carolina" was announced by Governor McCrory on April 3, 2013 and is described as "a bold framework to improve mental and physical health care and outcomes for North Carolina's most vulnerable citizens. This reform plan seeks to build on—not undo—the significant gains and innovations in community-based care in our state and take them to the next level."¹⁶² No "reduction in needed services" or eligibility changes are included in the reform framework.¹⁶³

¹⁶¹ "Medicaid Medical Homes Saved \$1 billion in North Carolina," American Medical News (January 23, 2012).

¹⁶² "Partnership for a Healthy North Carolina," North Carolina Department of Health and Human Services. Accessed June 17, 2013. <http://www.ncdhhs.gov/medicaidreform/>.

¹⁶³ Ibid.

The reform plan includes elements of delivery system reforms implemented in Oregon and recently enacted in Alabama. As outlined in the press release announcing the Partnership, the State plans to implement Comprehensive Care Entities (CCEs) as a “single place” for recipients to receive coordinated care. These entities will be statewide organizations (public and private, not-for-profit or for-profit organizations) responsible for coordinating the entire system of care for Medicaid enrollees, including physical and behavioral health.¹⁶⁴

CCEs will be responsible for conducting individualized comprehensive “functional needs assessments” and engaging a “Comprehensive Care Network of providers” to deliver necessary care.¹⁶⁵ A PMPM payment model is proposed. The State plans to issue an RFP for entities to apply to serve as statewide CCEs and anticipates contracting with three or four entities. The State is currently conducting additional discussions with legislators, providers, and other stakeholders to further develop the proposal.

Oregon: Accountable and Coordinated Care Model

In July 2012, Oregon received permission from CMS to manage its Medicaid program through Coordinated Care Organizations (CCOs). A CCO is a local network of providers that work together to provide physical health care, addiction and mental health care, and, in some cases, dental care to Medicaid enrollees. CCOs are focused on prevention and managing chronic conditions in order to improve care and reduce unnecessary utilization of the health care system, such as emergency department visits. Since August 1, 2012, 15 CCOs have begun operating in communities in Oregon.¹⁶⁶

CCOs are patient-centered and team-focused, and are accountable for the health care outcomes of the populations they serve. They are governed by a partnership among the participating health care providers, community members, and health care system stakeholders.

These partnerships are financially responsible for their patients’ care and, as such, are risk-bearing entities. Each CCO is paid a lump sum to provide care to the Medicaid enrollees in its region. The providers that comprise each CCO operate under one budget that grows at a fixed rate for mental, physical, and dental care. The CCO global budget includes three components: 1) a capitated rate; 2) payments for optional services; and 3) incentive payments. The capitated rate generally consists of a PMPM fee paid to each CCO for providing physical and mental health care. Some CCOs also receive additional funds to provide optional services, such as residential alcohol and drug treatment services, dental care, and targeted case management programs.

Incentive payments are also paid outside of the capitated portion in order to incentivize providers to meet both cost and health outcome metrics. CCOs must comply with 17 quality metrics and are able to receive a financial reward from a Quality Pool based on their performance.

The State is projecting savings of \$3.1 billion over five years and close to \$11 billion over the next decade. These savings are expected to come from the risk-based payments as well as increased care

¹⁶⁴ “Governor McCrory Announces “Partnership for a Healthy North Carolina,” Office of Governor Pat McCrory, Press Release (April 3, 2013).

¹⁶⁵ “Partnership for a Healthy North Carolina,” N.C. Department of Health and Human Services Presentation to Western NC. Accessed June 17, 2013. http://www.ncdhhs.gov/medicaidreform/partnership_healthy_NC.pdf.

¹⁶⁶ “Coordinated Care Organizations,” Oregon.gov. Accessed June 17, 2013. <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>.

coordination between the providers.¹⁶⁷ Through an 1115 waiver, the State received a \$1.9 billion investment from CMS to support the coordinated care model. As part of the agreement, the State must show that state Medicaid spending is 2% slower than the rest of the country, or it will lose the federal funds. This waiver is considered an “expansion” 1115 waiver, meaning it is being used to prepare the State to provide care for the Medicaid expansion population.

Utah: Accountable and Coordinated Care Model

In 2011, Utah’s Legislature passed a Medicaid Reform bill requiring the Department of Health to “develop a proposal to modify the Medicaid program in a way that maximizes the replacement of the FFS delivery model with one or more risk-based delivery models.”¹⁶⁸ As such, the Department of Health proposed converting its current managed care contracts to an ACO model.¹⁶⁹ It is envisioned that the model will: 1) provide incentives for providers to collaborate; 2) pay providers under a risk-based methodology; 3) restructure cost sharing and provide new incentives to reward enrollees for personal efforts to maintain or improve their health; and 4) keep the same funding amount in the system. The ultimate goals of the model are to better align financial incentives to control costs and deliver appropriate care to Medicaid enrollees.¹⁷⁰

The model is largely still in the implementation phase and the Department is currently seeking stakeholder input on how it will be developed over time. However, on January 1, 2013 over 170,000 Medicaid enrollees were moved to “ACO” contracts. The contracts are with four Medicaid MCOs that are paid on a risk-adjusted, PMPM amount. ACOs have the flexibility to distribute payments throughout their provider network and, rather than reimbursing providers based on the units of service delivered, are encouraged to pay providers an amount equal to delivering the necessary care to a group of Medicaid enrollees for a specified period of time.¹⁷¹ Currently, base reimbursements are made on a sub-capitation basis with some FFS payments. Each ACO must ensure a sufficient provider network and enrollees have the option of selecting from at least two ACOs at their time of program enrollment.

The ACO model implements a medical home system in which each enrollee has access to a group of PCPs who coordinate the enrollee’s use of medical services. By better coordinating care and reducing costs, providers can also share in the savings paid from the risk-based, capitated payment.¹⁷²

The contracts also establish mandatory quality targets (such as HEDIS, CAHPS, and Utah-specific quality targets), incorporate limited pharmacy benefits, and provide incentives for enrollees to engage in personal accountability and wellness activities. ACOs may waive or charge differential cost sharing based on the services being provided.¹⁷³

¹⁶⁷ “Oregon Coordinated Care to Receive \$1.9 Billion from Feds,” *Modern Healthcare* (May 3, 2012).

¹⁶⁸ Utah State Legislature, “Medicaid Reform,” 2011 General Session, SB 180.

¹⁶⁹ This model is not affiliated with the Medicare ACO model.

¹⁷⁰ “Successful ACO Implementation,” Utah Medicaid Office Presentation to Utah Medicaid ACO Alliance Meeting (March 20, 2013).

¹⁷¹ “Utah Medicaid Reform Proposal” Draft Proposal, Utah Department of Health (2011).

¹⁷² “Successful ACO Implementation,” Utah Medicaid Office Presentation to Utah Medicaid ACO Alliance Meeting (March 20, 2013).

¹⁷³ *Ibid.*

Plans for future phases of Utah’s ACO model include: 1) integrating mental health; 2) integrating the long-term care benefit; 3) integrating the dental benefit; 4) expanding the ACO model into rural counties; and 5) eventually transferring the model to the commercial market.¹⁷⁴

Texas: Managed Care Model

On December 12, 2011, CMS approved the Texas Health and Human Services Commission’s (HHSC) 1115 waiver request. As articulated by the HHSC, the goals of the 1115 waiver are to: 1) expand risk-based managed care statewide; 2) support the development and maintenance of a coordinated care delivery system; 3) improve outcomes while containing cost growth; 4) protect and leverage financing to improve and prepare the health care infrastructure to increase access to services; and 5) transition to quality based payment systems in managed care and in hospitals.¹⁷⁵

Under the 1115 waiver, Texas seeks to capture the savings generated from the expansion of Medicaid managed care statewide and reinvest those savings in health delivery system reform. The waiver will allow the State to replace some of the current hospital funding mechanisms with a “funding pool” made up of federal funding and IGT transfers.¹⁷⁶ Total federal funding received by the end of 2016 is expected to reach \$29 billion.¹⁷⁷ The funding pool will include two specific components:

Uncompensated Care (UC) Pool: Funding from this pool will be used to compensate hospitals and other eligible providers for uncompensated costs related to: 1) delivering services to Medicaid managed care enrollees who are not otherwise covered by DSH payments; 2) delivering services to uninsured individuals who are not otherwise covered by DSH payments; and 3) delivering non-hospital services to Medicaid enrollees and uninsured individuals. Maintaining DSH payments is important in Texas, which is estimated to receive \$39 DSH dollars per resident.

Delivery System Reform Incentive Payment (DSRIP) Pool: The DSRIP Pool is used to support “hospitals’ efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.” Funding from this pool is used to support health reform efforts channeled through Regional Healthcare Partnerships (RHP). RHPs are led by public hospitals and local governments who elect to use their local resources in the form of IGTs to fund the non-federal portion of reform effort financing.¹⁷⁸

To achieve these goals, each RHP allocates DSRIP funding for projects in the following four categories:

1. Infrastructure Development: Investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services.
2. Program Innovation and Redesign: Piloting, testing, and replicating of innovative care models.

¹⁷⁴ Ibid.

¹⁷⁵ “Texas Health Care Transformation and Quality Improvement Program 1115 Waiver,” Briefing Document, Texas HHSC (August 4, 2011).

¹⁷⁶ “Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Proposal” Texas HHSC (July 13, 2011).

¹⁷⁷ Letter to Billy Millwee Regarding CMS’ Approval of Texas’ Request for a new 1115(a) Demonstration, CMS (December 12, 2011).

¹⁷⁸ “Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Proposal” Texas HHSC (July 13, 2011).

3. Quality Improvements: Hospital-specific initiatives jointly developed by hospitals, the State, and CMS (involves the broad dissemination of up to four interventions from a list of 7-10 interventions in which major improvements in care can be achieved within four years).
4. Population Focused Improvements: Reporting measures from domains that demonstrate the impact of delivery system reform investments made in previous years. Domains may include patient experience, preventative health, care coordination, and at-risk groups.

Only projects specified in RHP plan proposals are considered for funding and all RHP plans require approval from both HHSC and CMS.¹⁷⁹

During the first year of the demonstration, the State worked with CMS and providers to organize the RHPs, identify the projects under the four categories, and determine the amount of incentive payments associated with performance metrics.¹⁸⁰ Twenty RHPs were organized and each RHP has developed and submitted a list of projects to be reviewed by CMS. Over 1,500 projects were developed in total by the RHPs. While the overall goals of the projects are the same, the projects being proposed have a range of scope—from enhancing access by increasing the number of PCPs and support staff and utilizing telemedicine services, to establishing a registry of patients with chronic care conditions. Many of the projects include a public health and social service component such as funding a Center for Healthy Living focusing on chronic disease prevention and education and refurbishing buildings to create apartments for behavioral health enrollees who are at risk of being homeless.¹⁸¹

Wisconsin: Alternative Expansion

Wisconsin's BadgerCare Plus Plans currently offer services to adults with income below 200% FPL. The BadgerCare Plus Standard Plan provides services to parents, while the BadgerCare Plus Core Plan provides a more limited benefit package to childless adults. The State also offered a state-funded BadgerCare Plus Basic Plan which provided temporary, unsubsidized health insurance to adults on the BadgerCare Plus Core Plan waiting list. Enrollment closed in the BadgerCare Plus Core Plan in 2010 and the BadgerCare Plus Basic Plan in 2011.

The BadgerCare Standard Plan benefit package is a broad Medicaid benefit package; while the benefits offered in the Core Plan and Basic Plan are more limited. Cost-sharing in the Core Plan and Basic Plan is also higher than the Standard Plan. Within the Core Plan, service-specific copayments are scaled by income levels. For example the copayment for emergency department visits is \$3 for enrollees with income less than 100% FPL and \$60 for enrollees with income between 100% and 200% FPL. In order to reduce program costs, Wisconsin also received approval from CMS to increase premiums for enrollees with income above 138% FPL. Adults who fail to make their monthly premium payment without a valid excuse are dropped from the program for one year.¹⁸²

¹⁷⁹ Ibid.

¹⁸⁰ Letter to Billy Millwee Regarding CMS' Approval of Texas' Request for a new 1115(a) Demonstration, CMS (December 12, 2011).

¹⁸¹ "Summaries of Proposed Delivery System Reform Incentive Payment (DSRIP) Projects" HHSC (April 24, 2013).

¹⁸² "Feds OK Walker Plans to Cut Medicaid Costs," Milwaukee Wisconsin Journal Sentinel (April 27, 2012).

Core Plan enrollees receive services through pre-paid, capitated health plans. A health needs assessment form is completed by every BadgerCare Plus enrollee as part of the application process. This assessment allows the State to analyze the applicant's health care needs and match them to appropriate managed care plans. The program also requires enrollees to receive a physical examination during their first year of participation.

Governor Walker has rejected a traditional Medicaid expansion, but is proposing scaling back the State's current expansion program, opening enrollment, and utilizing the federally-facilitated exchange to provide coverage to the State's low-income, uninsured population.

The Governor's proposal includes reducing eligibility for BadgerCare to 100% FPL for adults, while keeping the program unchanged for children, the disabled, and the elderly. Reducing program eligibility would allow the Medicaid agency to lift the enrollment cap—expanding coverage to those with income below 100% FPL. Those with income above 100% FPL would be removed from the program as they would be eligible to receive APTCs through the exchange.

Republicans on a State Legislative Budget Committee also voted to provide hospitals with up to \$73.5 million over two years to offset an expected increase in uncompensated care costs from uninsured patients accessing emergency departments. It is expected the State would cover \$30 million of the total amount, with the remaining being paid for with federal dollars. The size of the payments given to each hospital would be determined by the hospital's level of uncompensated care.¹⁸³

Calculations from the Department of Health Services show Governor Walker's plan would reduce the uninsured by an amount comparable to a traditional PPACA Medicaid expansion, while simultaneously reducing the number of persons enrolled in Medicaid—saving the State additional funds.¹⁸⁴ However, other studies have shown the proposal to not be as cost effective as a traditional expansion. HHS has not formally signed off of this option.

Washington: Traditional Expansion

Washington is one of many states that will expand Medicaid under the comprehensive provisions outlined in the PPACA. With respect to implementation of the Medicaid expansion, the Washington Health Care Authority has expressed the following goals: 1) leverage new federal financing opportunities to ensure that the Medicaid expansion is sustainable; 2) maximize use of technology to create a consumer-friendly application/ enrollment/ renewal experience; 3) maximize continuity of coverage and care as individuals move between subsidized coverage options; and 4) reform the Washington way—comply with, or seek waiver from specific PPACA requirements related to coverage and eligibility, as needs are identified.¹⁸⁵

In 2011, the State received approval to transform its state-funded programs (Basic Health Plan and the Medical Care Services program for Disability Lifeline) to waiver coverage. The waiver provides the State with a bridge to national healthcare reform and, as such, changes eligibility for these programs to 138%

¹⁸³ "State budget panel votes to pay hospitals \$73.5 million for uninsured patients," *Journal Sentinel* (June 4, 2013).

¹⁸⁴ "On, Wisconsin: Scott Walker's Rejection of Obamacare's Medicaid Expansion is a Model for the Nation," *Forbes* (February 15, 2013).

¹⁸⁵ "2014 Medicaid Expansion Progress," HCA Presentation to House Health Care and Wellness Committee (January 18, 2013).

FPL for all adult populations (jobless and working parents and other non-disabled adults). In 2014, these individuals will be transitioned to coverage under the Medicaid State Plan¹⁸⁶ and may be enrolled in an alternative, or benchmark benefit package.

Washington also elected to establish a state-based exchange and is in the process of modifying existing Medicaid eligibility determination systems to coordinate with the exchange and meet new eligibility rules. The goal is to develop an interface between the exchange, Medicaid, and other programs, which will allow for seamless eligibility determinations across the State's multiple public assistance programs.

By implementing a Medicaid expansion and leveraging the state-based exchange, the State is expecting to realize savings from streamlining programs and processes. For example, moving the state-funded general assistance program populations to Medicaid and the exchange will result in significant savings for the State as costs are shifted to the federal government. Streamlining and simplifying existing Medicaid programs, by moving populations enrolled in programs such as the Breast & Cervical Cancer Treatment and Family Planning to the standard Medicaid benefit, Medicaid benchmark benefit, or the exchange (depending on income) may result in some savings as well.

Additional administrative savings may also be realized. For example, Washington has decided to have Medicaid determinations based on MAGI be conducted through the exchange (all newly eligible at time of application and currently eligible at time of renewal). The State is also adopting self-attestation to reduce pre-eligibility verification administrative requirements. Both of these changes will reduce the staff needed for eligibility determinations (although there will be an increase in the number of post-eligibility program integrity staff). The State will also be able to reduce staff needed to determine the eligibility for its state-funded general assistance programs, since eligibility for these individuals will be based on income. Finally, once Exchange Navigators and In-Person Assisters are employed, the number of out-stationed eligibility workers will decrease as well. Potential savings may be used to restore optional Medicaid benefits or go into the state general fund.

While the 2013 Legislature has yet to make a final budgetary determination authorizing the official expansion of Medicaid, all indications are that the final 2013-15 Biennial Budget will include this authorization. House and Senate Democratic and Republican leadership have publicly expressed support for the expansion and it is included in the initial budgets passed by both chambers.

State Innovation Models

On February 21, 2013, CMMI awarded State Innovation Model¹⁸⁷ grants to a total of 25 states. Six states (Arkansas¹⁸⁸, Maine¹⁸⁹, Massachusetts¹⁹⁰, Minnesota¹⁹¹, Oregon¹⁹², and Vermont¹⁹³) received funding

¹⁸⁶ Letter to Cindy Mann Regarding Washington's 1115 Demonstration Waiver Proposal: Transitional Bridge for Low-Income Adults, Department of Social and Health Services (July 7, 2010).

¹⁸⁷ CMMI State Innovation Models are designed to "...test innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of beneficiaries. The goal is to create multi-payer models with a broad mission to raise community health status and reduce long-term health risks..." "State Innovation Models Initiative: General Information," CMS.gov. Accessed June 17, 2013. <http://innovation.cms.gov/initiatives/State-Innovations/index.html>.

¹⁸⁸ "Arkansas Plan," Health Care Payment Improvement Initiative. Accessed June 17, 2013. <http://www.paymentinitiative.org/Pages/default.aspx>.

ranging from \$33 to \$45 million, awarded over the next 42 months, to test models they outlined in their State Health Care Innovation Plans. Three states (Colorado, New York, and Washington State) received awards of \$1 to \$2 million for pre-testing assistance over the next six months to further develop and refine their proposed models to be considered for a future testing award. Sixteen additional states¹⁹⁴ received six-month awards ranging from \$1 to \$3 million to develop State Health Care Innovation Plans for future testing or pre-testing award consideration.

While each State Health Care Innovation Plan is unique and designed to meet the goals of the state, some common themes and strategies have emerged from the nine models currently in the testing and pre-testing phase.

Alignment of Strategies across Multiple Public and Commercial Payers

States that have already implemented care delivery and financing innovations in their Medicaid programs over the past several years are now seeking to expand and align those innovations with other publicly funded health benefit programs as well as with commercial payers. Examples include efforts by Maine to align MaineCare (Medicaid), Medicare, and commercial payers by supporting formation of “multi-payer Accountable Care Organizations” and implementation of “payment reform across public/private payers.” Oregon is seeking to spread adoption of its regional CCOs to additional covered populations and payers such as Medicare and private plans covering state employees. To assist in the adoption of this model, Oregon will use innovation funding to create a “Transformation Center” to “spread the model across payers and into the qualified health plans of the exchange in 2014.”

Alternative Payment Models

States have been implementing various alternative payment methodologies as they seek to transition from traditional and outdated FFS payment systems. These alternative methodologies have been piloted in Medicaid-only models, in Medicaid and Medicare financial alignment models, and in multi-payer models involving Medicaid, Medicare, and/or commercial payers. Similar efforts being tested in the State Innovation Models Initiatives include those in Arkansas that will further institute and expand a system of episode of care payments for “acute, procedural or ongoing specialty care conditions.” Arkansas Medicaid has already implemented episode of care payment methodologies in five areas.¹⁹⁵ In addition, Vermont will further test three payment models—shared savings, bundled payments, and a pay-for-performance model.

Integration of Acute, Behavioral Health, Long Term, and Other Services and Support

A key element of most health care delivery model transformations is the development and use of patient-centered medical homes to better integrate primary, acute and specialty health care. Use of broader based “health homes” to further integrate primary and acute health care with behavioral health

¹⁸⁹ “Maine Plan,” Maine.gov. Accessed June 17, 2013. <http://www.maine.gov/dhhs/oms/vbp/sim.html>.

¹⁹⁰ “Massachusetts Plan,” Mass.gov. Accessed June 17, 2013. <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/state-innovation-model-grant.html>.

¹⁹¹ “Minnesota Plan,” MN.gov. Accessed June 17, 2013. <http://mn.gov/health-reform/health-reform-in-Minnesota/index.jsp>.

¹⁹² “Oregon Plan,” Oregon.gov. Accessed June 17, 2013. <http://www.oregon.gov/oha/news/Pages/Resources.aspx>.

¹⁹³ “Vermont Plan,” Vermont.gov. Accessed June 17, 2013. <http://hcr.vermont.gov/blueprint>.

¹⁹⁴ The 16 states include California, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Maryland, Michigan, New Hampshire, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, and Utah.

¹⁹⁵ “Episodes of Care,” Health Care Payment Improvement Initiative. Accessed June 17, 2013. <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx>.

and long-term care are gaining momentum in many states, as are efforts to integrate oral health and population/public health strategies. Several of the State Innovation Model testing and pre-testing awards will support these efforts, including alignments between primary care, behavioral health, public health, and long-term care services in Maine and integration of physical and behavioral health at the practice level in Colorado. Colorado is implementing this integration within the framework of its existing “Medicaid Accountable Care Collaboratives.” In addition, a component of the innovation testing award given to Massachusetts will assist primary care practices continue to transition to patient-centered medical homes including “enhanced access to primary care, coordination with community and public health resources, and population health management.”

Health Data Infrastructure and Analytics

As outlined in its *Blueprint for Health*, Vermont is seeking to develop a health care system that “achieves full coordination and integration of care throughout a person’s lifespan.” Vermont’s State Innovation Award includes infrastructure funding for “...improved clinical and claims data transmission, integration, and analytics, and modeling; [and] expanded measurement of patient experience of care...” New York’s Health Care Innovation Plan includes health data and information technology improvement targeted at areas such as “expanding provider access to data” and “monitoring systems that will collect and aggregate health, quality, and cost indicators for each care model.” In its Innovation Plan that secured pre-testing support, Washington proposes to utilize its existing quality collaboratives (Puget Sound Health Alliance and Bree Collaborative) to “convene multiple payers, providers and others to develop and promote the adoption of a common set of transparent, evidence-based quality and utilization metrics and evaluation criteria.”

Development and Utilization of Regional/Community Collaboratives

Recent efforts by states to re-design health care systems at a community or regional level in order to achieve greater coordination as well as test new delivery and payment models have received additional support through the State Innovation Models Initiative. As previously mentioned, Oregon has already transformed its Oregon Health Plan (Medicaid) to Coordinated Care Organizations. CCOs are “risk-bearing, community-based entities governed by a partnership among providers of care, community members, and entities taking financial risk for the cost of health care.”¹⁹⁶ In its testing award, Minnesota will support the development of up to 15 “Accountable Communities for Health.” As a part of its Innovation Plan, Washington proposes “leveraging and integrating Regional Collaborative community health and community prevention activities;” Washington’s proposal was supported by the recently formed Health Philanthropy Partners of Washington “a coalition of foundations working to collectively influence a rapidly changing health care system” including efforts to “support communities to construct local or regional collaboratives” to “break down silo walls to better integrate systems of care.”¹⁹⁷

¹⁹⁶ “State Innovation Models Initiative: Model Testing Awards,” CMS.gov. Accessed June 17, 2013. <http://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html>.

¹⁹⁷ “Goals,” Health Philanthropy Partners. Accessed June 17, 2013. <http://hppwa.net/goals/>.

Appendix 3: Characteristics of Oklahoma’s Low-Income, Uninsured Populations

Overall Health of the State

Oklahoma rates positively on several health indicators. Its strengths include a low prevalence of binge drinking, low incidence of infectious diseases, and high immunization rates. Despite some of these positive factors, however, the high prevalence of negative factors has contributed to the state’s high rates of diseases and higher mortality rate.

Since 2007, Oklahoma has ranked as one of the bottom five states in terms of overall health status, and in the bottom 10 since 1997.¹⁹⁸ Despite its rise to 43rd in the nation in 2012, the State still has many health challenges and concerning health indicators. For example, Oklahoma has some of the highest rates in the nation for smoking, sedentary lifestyle, low consumption of fruit, obesity, and high cholesterol. Its smoking rate is almost 25% higher than the national average. This continued dependency on tobacco has led to chronic lower respiratory diseases that affect Oklahoma at higher rates than most of the nation. Sedentary lifestyle, unhealthy eating, and obesity have led to diabetes and cardiovascular disease rates that are 17% to 20% higher than the national average—and Oklahoma ranks near the top of the nation in terms of deaths due to cardiovascular disease. Altogether, these conditions result in a much higher mortality rate in Oklahoma. Data indicate that if improvements are made in the underlying risk factors, such as physical activity, consumption of fruits and vegetables, and lower smoking rates, improvements can be seen in the overall health of the State.

Figure 33

Oklahoma State Health Ranking by Health Indicator				
Health Indicator	National 2012 Rate	Oklahoma 2012 Rate	Oklahoma State Rank	Oklahoma Trend
Smoking	21.2%	26.1%	47	
High Cholesterol	38.4%	41.8%	46	
Fruits Consumed per Day	0.99	0.74	46	
Physical Inactivity	26.2%	31.2%	45	
Obesity	27.8%	31.1%	45	
Diabetes	9.5%	11.1%	43	
Immunizations ¹	90.3%	91.2%	20	
Binge Drinking	18.3%	16.5%	12	
Infectious Disease ²	12.4	7.1	11	

¹ Average percentage of children ages 19 to 35 who have received specific vaccinations.

² Number of reported measles, pertussis, syphilis, and Hepatitis A cases per 100,000 population. Two-year average.

Source: National Association of Community Health Centers.

¹⁹⁸ “America’s Health Rankings,” United Health Foundation (2012).

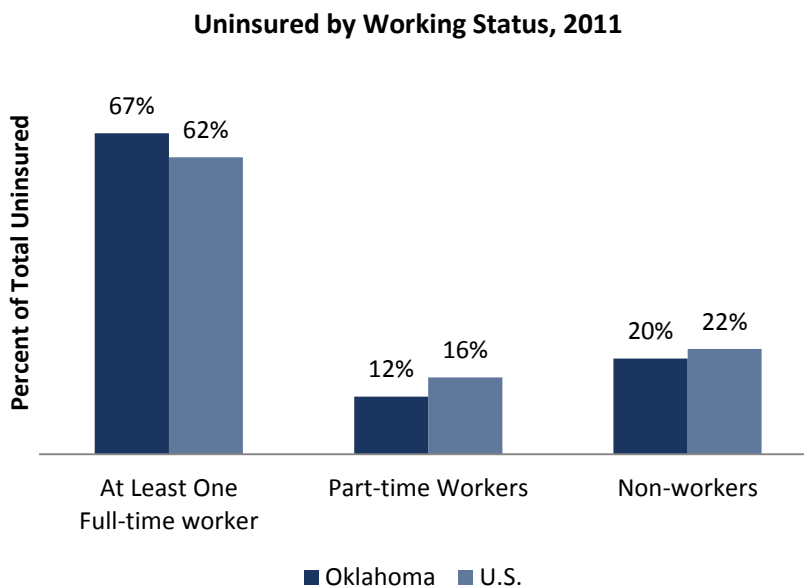
Target Population Characteristics

The negative health factors that contribute to Oklahoma's poor health are exacerbated in the low-income, uninsured population. Several surveys and studies have been used to provide information on the characteristics of this population. One of these data sources is Oklahoma's Essential Community Health Centers. While these centers do not cover strictly uninsured or low-income individuals, 40% of their patients are uninsured and 36% are covered by Medicaid; 70% of the patients have incomes below 100% FPL and an additional 22% have incomes between 100% and 200% FPL. These centers serve communities who confront financial, geographic, language, or other barriers, and are often located in high-need areas that have more poverty, higher-than-average infant mortality, and few providers. Because each center tailors their services to the needs of their communities, the needs of their patient population is a good indicator of the needs of the target low-income, uninsured population.

In addition to Essential Community Health Center data that outline low-income population needs, other surveys have been used to characterize the uninsured population, including the U.S. Census Bureau. While some data points characterize only Oklahoma's population, some compare Oklahoma with national estimates. Examining these comparisons can be important in determining whether Oklahoma has the same general characteristics found at the national level, or if there are key differences that may impact Oklahoma's program. Some characteristics of the uninsured and low-income populations that emerge from these data points are outlined in this section.

Most uninsured families have full-time jobs. About 67% of Oklahoma’s uninsured population has at least one full-time worker in the home.¹⁹⁹ Of the remaining, most are unemployed. This is comparable to national estimates, but Oklahoma does have a higher rate of full-time, uninsured workers. Oklahoma also has a higher rate of businesses who do not offer insurance. Only 32.4% of Oklahoma’s small businesses, with 50 or fewer employees, offer health insurance benefits compared to 35.7% nationally. In addition, only 92.7% of large Oklahoma businesses offer health insurance benefits compared to 95.7% nationally.²⁰⁰

Figure 34



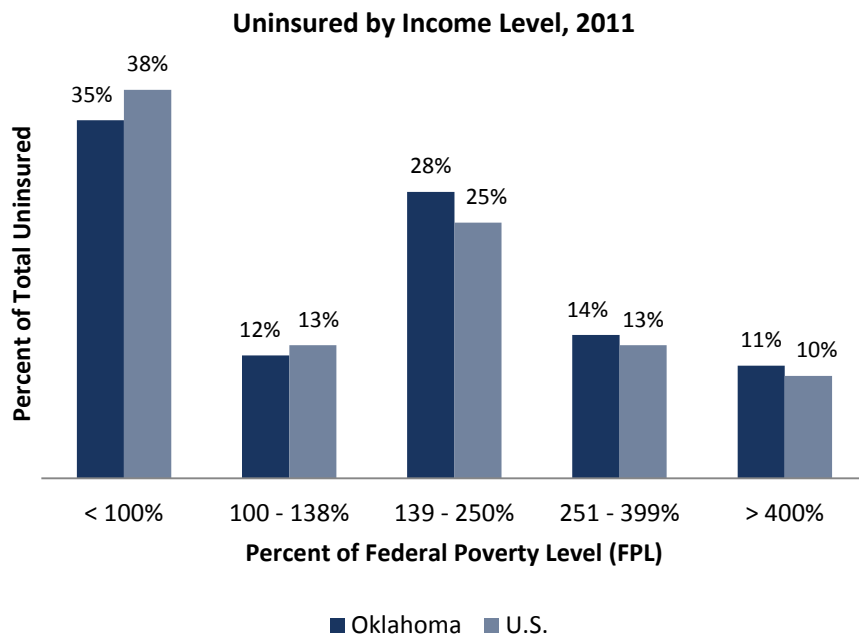
Source: Kaiser State Health Facts. Based on the U.S. Census Bureau Current Population Survey, 2010-2011.

¹⁹⁹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey. Available from Kaiser Family Foundation's State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

²⁰⁰ "Table II.A.2." Medical Expenditure Panel Survey, 2011. Accessed June 17, 2013. meps.ahrq.gov.

Half of the uninsured are part of the target population. In Oklahoma, 47% of the uninsured have income below 138% FPL (the income threshold for which enhanced federal funds are available), compared to 51% at national levels.²⁰¹ While still comparable, Oklahoma’s uninsured tend to have slightly higher incomes than the national average. One contributing factor to this percentage could be the low number of businesses in Oklahoma offering health insurance benefits, creating a greater number of uninsured with higher income.

Figure 35



Source: Kaiser State Health Facts. Based on the U.S. Census Bureau Current Population Survey, 2010-2011.

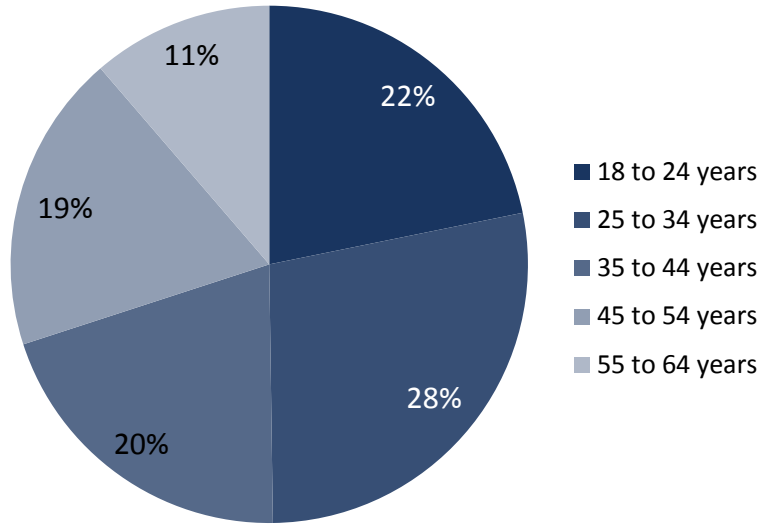
Most uninsured are below age 45. 70% of Oklahoma’s uninsured adults are below age 45. The population between 25 and 34 years old not only has the largest number among the uninsured (28%), they are also the age segment with one of the highest uninsured rates in the State (34% compared to 35% for 18-24 year olds).²⁰²

²⁰¹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey. Available from Kaiser Family Foundation’s State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

²⁰² “American Community Survey,” American Community Survey Office. Accessed June 5, 2013. <http://www.census.gov/acs/www/>.

Figure 36

Oklahoma’s Uninsured Population by Age, 2011



Source: U.S. Census Bureau, American Community Survey, 2009-2011.

Figure 37

Percentage of Oklahoma’s Population that is Uninsured by Age, 2011			
Age	Estimated Population	Uninsured	Uninsured Rate
18 to 24 years	369,173	127,991	35%
25 to 34 years	484,886	164,219	34%
35 to 44 years	446,828	118,690	27%
45 to 54 years	513,115	109,724	21%
55 to 64 years	438,600	66,410	15%
Total	2,252,602	587,034	26%

Source: U.S. Census Bureau, American Community Survey, 2009-2011.

The most prevalent chronic primary diagnosis among the low income is hypertension. More than 11% of patients have a primary diagnosis of hypertension, which is a risk factor for more serious chronic conditions, including diabetes.

Low-income patients with a primary diagnosis of a mood disorder have a higher utilization of services than other chronic primary-diagnosed conditions. Patients diagnosed with depression or other mood disorders show an average of 2.9 visits per patient at the Community Health Centers, the next highest being 2.2 visits for patients whose primary diagnosis is diabetes and 1.1 visits per patient for those with asthma.

Well-child visits are the most-used preventive service among the low-income population. The available data from the Essential Community Health Centers do not provide an indication of patients' age, but it is likely that many patients are children in the Medicaid program. The second highest preventive service utilized is oral dental exams.

Figure 38

Patients and Patient Visits by Diagnoses and Services, 2011				
	# of Patients	% of Patients	Patient Visits	Visits per Patient
Chronic Condition (Primary Diagnosis)				
Hypertension	15,653	11.6%	25,407	1.6
Diabetes	8,842	6.5%	19,565	2.2
Depression & Other Mood Disorders	6,357	4.7%	18,672	2.9
Asthma	3,133	2.3%	4,768	1.5
Preventive Services				
Well-Child Visits	14,875	11.0%	23,647	1.6
Oral Dental Exams	14,259	10.5%	17,619	1.2
Pap Test	10,904	8.1%	11,435	1.0
Selected Immunizations	9,313	6.9%	12,777	1.4

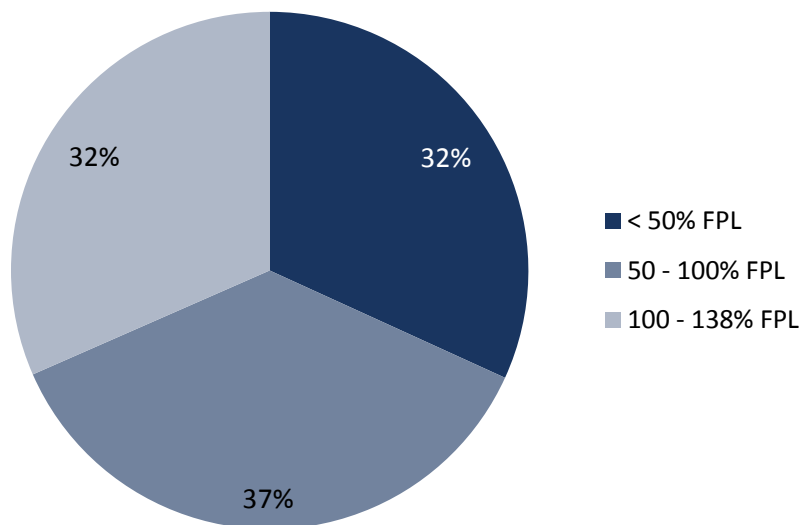
Source: National Association of Community Health Centers.

While the data presented above helps to create a high-level picture of Oklahoma’s uninsured and low-income populations, it is possible to create a more detailed picture of the target population, and some of their specific needs using the Behavioral Risk Factor Surveillance System (BRFSS). While this survey is not intended to highlight the needs of low-income, uninsured population, data related to this population can be extrapolated by filtering the income level and uninsured status of the survey participants. A maximum annual income of \$25,000 was used to represent the target population.²⁰³ Some of the characteristics and key points from these data include:

Most are young and middle-aged, and split evenly among income levels. 18-40 year olds account for 63% of the low-income, uninsured adults, while those aged 40-64 years account for 37%.²⁰⁴ This is roughly equal to the distribution of all uninsured in Oklahoma. In addition, they are split fairly evenly among income levels, the largest group being between 50% and 100% FPL.²⁰⁵

Figure 39

Oklahoma’s Low-Income, Uninsured Population by Income Level, 2011



Source: U.S. Census Bureau, American Community Survey, 2009-2011.

²⁰³ \$25,000 is roughly equal to the annual income for a family of three at 138% FPL.

²⁰⁴ “Small Area Health Estimates 2010,” U.S. Census Bureau. Accessed June 5, 2013. <http://www.census.gov/>.

²⁰⁵ “American Community Survey,” American Community Survey Office. Accessed June 5, 2013. <http://www.census.gov/acs/www/>.

The prevalence of risk factors is higher among the target population. Uninsured individuals earning less than \$25,000 per year are much more likely to report poor health, smoke, and have diabetes, heart disease, and asthma than those with annual wages over \$50,000.²⁰⁶ Each of these risk factors is an indicator of more serious and future chronic conditions.

Figure 40

Prevalence of Select Risk Factors Among Oklahoma Adults Age 18–64, 2010			
Select Risk Factor	Annual Wage < \$25,000	Annual Wage > \$50,000	Increased likeliness <\$25,000 has risk factor
Don't Have Health Coverage	46.7%	6.0%	7.8
Health is Fair or Poor ¹	37.3%	6.0%	6.2
Current Smoker	46.2%	14.0%	3.3
Diabetes	13.7%	5.5%	2.5
Heart Disease	4.7%	2.0%	2.3
Asthma	13.9%	7.4%	1.9
Obesity	40.7%	28.6%	1.4
Heavy Drinking ²	4.1%	3.5%	1.2
High Blood Pressure ³	32.4%	27.7%	1.2
High Cholesterol ⁴	38.3%	34.1%	1.1

¹ Self-reported health status.

² Heavy drinking is defined as men having 2+ drinks per day and women having 1+ drinks per day.

³ This measure is taken from 2009 data.

⁴ This measure is taken from 2009 data.

Source: Oklahoma's Behavioral Risk Factor Surveillance System Data, 2010.

²⁰⁶ Oklahoma's Behavioral Risk Factor Surveillance System Data (2010).

The prevalence of risk factors has increased in the last 5 years. Almost all risk factors for the low-income, uninsured population in Oklahoma have increased in prevalence since 2005.²⁰⁷ The only exception is heavy drinking. Obesity increased by almost 9 percentage points. Not only has the rate of these risk factors increased, but the estimated population affected has also increased in every case.

Figure 41

Prevalence of Select Risk Factors Among Uninsured Oklahoma Adults Age 18–64 with Incomes Below \$25,000, 2005-2010						
Select Risk Factor	2005		2010		Increase	
	%	Pop. Estimate ⁵	%	Pop. Estimate	% Points	Pop. Estimate
Health is Fair or Poor ¹	30.8%	100,249	42.2%	137,349	11.3	37,100
Obesity	32.9%	103,325	41.9%	131,737	8.9	28,412
High Blood Pressure ³	31.5%	102,823	41.1%	128,678	9.5	25,855
High Cholesterol ⁴	36.5%	77,504	45.6%	98,804	9.0	21,300
Diabetes	12.4%	40,442	17.6%	57,292	5.1	16,850
Current Smoker	39.7%	129,280	44.3%	144,841	4.6	15,561
Heart Disease	6.4%	20,605	7.2%	23,324	0.9	2,719
Asthma	16.8%	54,618	17.5%	56,924	0.8	2,306
Heavy Drinking ²	2.5%	8,091	2.3%	7,452	(0.2)	(639)

¹ Self-reported health status.

² Heavy drinking is defined as men having 2+ drinks per day and women having 1+ drinks per day.

³ This measure is taken from 2009 data.

⁴ This measure is taken from 2009 data.

Source: Oklahoma’s Behavioral Risk Factor Surveillance System Data, 2010.

²⁰⁷ Oklahoma’s Behavioral Risk Factor Surveillance System Data (2010).

All Oklahoma regions are not equal in health. The BRFSS data split Oklahoma into five regions. When the low-income, uninsured population in each region is compared against one another, the southwestern region appears to have the lowest level of health, while the eastern regions have the highest levels of health. The southwestern region has the highest prevalence in four of the nine selected risk factors, while the northeast and southeast regions have the lowest prevalence in four of the nine selected risk factors.²⁰⁸

Figure 42

Prevalence of Select Risk Factors Among Oklahoma Adults Age 18–64 with Incomes Below \$25,000 by Region, 2009						
Select Risk Factor	Northeast	Northwest	Southeast	Southwest	Central	Tulsa
Health is Fair or Poor ¹	63.4%	43.2%	40.1%	54.3%	49.7%	50.3%
Current Smoker	37.4%	47.6%	43.9%	47.6%	42.1%	47.3%
Obesity	37.2%	39.6%	39.4%	45.3%	34.7%	34.3%
High Cholesterol ⁴	42.2%	38.6%	37.8%	39.4%	35.4%	40.4%
High Blood Pressure ³	31.8%	32.1%	27.4%	39.6%	29.6%	30.2%
Asthma	12.9%	21.3%	12.8%	19.5%	14.0%	13.8%
Diabetes	11.5%	12.1%	11.4%	14.2%	14.3%	12.5%
Heart Disease	2.1%	5.7%	4.8%	2.8%	6.4%	6.2%
Heavy Drinking ²	*	2.2%	*	*	2.9%	3.4%

Note: Green numbers indicate the regions with the lowest prevalence of the selected risk factor, while red numbers indicate regions with the highest prevalence. For example, the Northeast region has the lowest rate of current smokers, while the Northwest and Southwest regions have the highest prevalence.

*Sufficient data not available.

¹ Self-reported health status.

² Heavy drinking is defined as men having 2+ drinks per day and women having 1+ drinks per day.

³ This measure is taken from 2009 data.

⁴ This measure is taken from 2009 data.

Source: Oklahoma's Behavioral Risk Factor Surveillance System Data, 2010.

²⁰⁸ Oklahoma's Behavioral Risk Factor Surveillance System Data (2010).

While risk factors are higher among the target population, these factors seem to be more directly related to income than to insurance coverage status. It is common for the low-income population to have greater health needs than the average population. This is the case at both the state and national levels. Compared with all income levels, some risk factors for the low income in Oklahoma increase by as much as 20 percentage points and as by as much as 17 percentage points nationally.²⁰⁹

It is also common for the uninsured to have higher needs than the average population due to a pent-up need for care. However, the BRFSS survey seems to indicate that this is not the case in Oklahoma. When compared with the insured low-income population, the uninsured low-income population shows a lower prevalence of almost every selected risk factor. This indicates that an individual’s income is more directly related to health status and chronic conditions than to an individual’s health coverage status.

Figure 43

Prevalence of Select Risk Factors Among Adults Age 18–64, 2010					
Select Risk Factor	All Income Levels		Incomes Below \$25,000		
	National	Oklahoma	National	Oklahoma	Oklahoma Uninsured
Current Smoker	19.0%	26.6%	30.8%	46.2%	48.4%
Obesity	29.2%	33.0%	35.4%	40.7%	39.4%
Health is Fair or Poor ¹	13.9%	18.1%	30.9%	37.4%	31.9%
High Cholesterol ⁴	37.0%	35.4%	38.2%	38.3%	27.8%
High Blood Pressure ³	24.6%	29.6%	29.2%	32.4%	23.7%
Asthma	8.7%	9.7%	12.0%	13.9%	9.8%
Diabetes	8.0%	9.0%	12.1%	13.7%	9.2%
Heavy Drinking ²	5.4%	4.3%	4.7%	4.1%	6.0%
Heart Disease	2.5%	3.2%	4.1%	4.8%	1.9%

¹ Self-reported health status.

² Heavy drinking is defined as men having 2+ drinks per day and women having 1+ drinks per day.

³ This measure is taken from 2009 data.

⁴ This measure is taken from 2009 data.

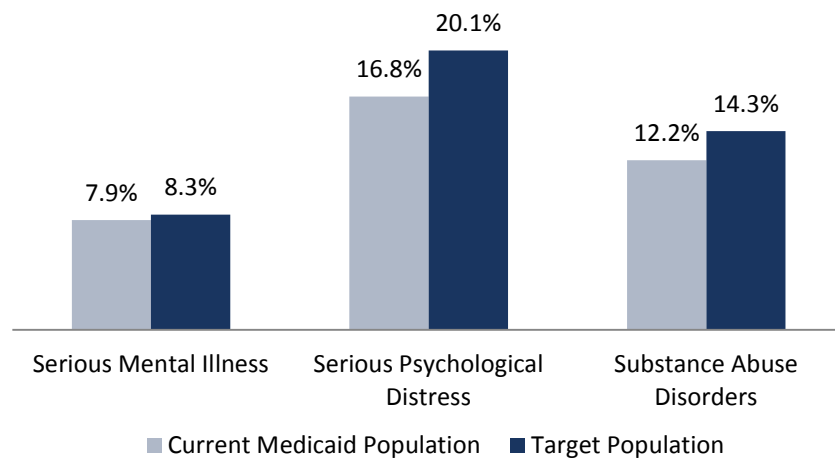
Source: Oklahoma’s Behavioral Risk Factor Surveillance System Data, 2010.

²⁰⁹ Ibid.

The need for behavioral health services is higher among the target population than the current Medicaid population. Oklahoma’s target population has a higher prevalence of serious mental illness, serious psychological distress, and substance use disorders than both the national target population as well as Oklahoma’s current Medicaid population—signifying a high need for coverage of behavioral health services. One-fifth (20%) of the target population has a history of serious psychological distress. Of those with substance abuse disorders, 74% are male and 65% are between the ages of 18 and 34. Of those with a serious mental illness, 64% are female and 55% between the ages of 18 and 34. The majority of those with behavioral health conditions are non-Hispanic whites.

Figure 44

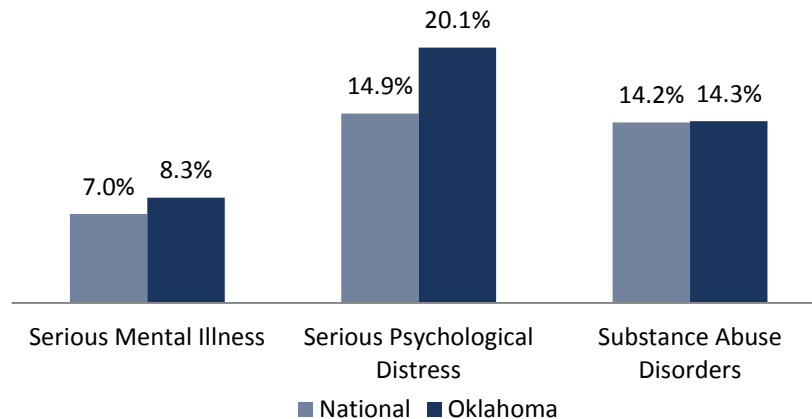
Prevalence of Behavioral Health Conditions in Oklahoma, 2010



Source: Substance Abuse and Mental Health Services Administration, 2010.

Figure 45

Prevalence of Behavioral Health Conditions in the Target Populations, 2010



Source: Substance Abuse and Mental Health Services Administration, 2010.

Appendix 4: Use of Incentives in Health Care

State Medicaid programs have started exploring different approaches to incentivize positive health-related behaviors. Florida, Idaho, and West Virginia have taken the first steps in developing incentive programs to encourage positive health behaviors in Medicaid populations. Unfortunately, only Idaho has built an evaluative component into their services, so much is still left to be learned when creating best practices. Leavitt Partners performed a literature review to address the following questions:

1. What are the most effective approaches to motivate low-income adults to make positive changes in their behavior (for themselves and children)?
2. What are the most effective approaches to motivate low-income adults to change unhealthy behaviors and maintain positive health behaviors?
3. What are the most effective approaches to motivate Medicaid recipients to engage in positive health behaviors?

Lessons Learned

State and Federal leaders, charged with holding down costs without sacrificing access to or quality of medical services, agree with data suggesting costs can be better contained if all people are practicing healthy life behaviors.²¹⁰ In an effort to encourage healthy behaviors, three states (Florida, Idaho, and West Virginia) used the 2005 Deficit Reduction Act and/or waivers to craft incentive programs. Lessons learned from these first attempts at incentivizing behaviors suggest:

- It is difficult to engage participants in complex behaviors that are not clearly delineated (e.g., smoking cessation, weight management, increased exercise, etc.) using an incentive program;²¹¹
- It is easy to engage participants in simple behaviors involving office visits (e.g., vaccinations, screenings, wellness programs, etc.);²¹²
- It is easy to engage parents in behaviors which provide benefit to their young children (however, these activities involved office visits so there may be some confounding variables);²¹³
- If money is used as an incentive it needs to be immediately available to the participant to be of value;

²¹⁰ Hale, J., Phillips C., & Jewell T., "Making the economic case for prevention – a view from Wales," *BMC Public Health*, 12 No. 1 (2012). Schroeder, S. A. "We can do better – improving the health of the American people," *New England Journal of Medicine*, 357 No. 12 (2007).

²¹¹ Kane, R. L., et. al., "A structured review of the effect of economic incentives on consumers' preventive behavior," *American Journal of Preventive Medicine*, 27 (2004). Schroeder, S. A. "We can do better – improving the health of the American people," *New England Journal of Medicine*, 357 No. 12 (2007).

²¹² Kane, R. L., et. al., "A structured review of the effect of economic incentives on consumers' preventive behavior," *American Journal of Preventive Medicine*, 27 (2004). Sutherland, et. al., "Impact of targeted financial incentives on personal health behavior: A review of the literature," *Medical Care Research and Review*, 65 Sup. 6 (2008).

²¹³ Gurley-Calvez, T., et. al., "Mountain Health Choices Beneficiary Report." West Virginia University, Bureau of Business and Economic Research (2009). Greene, J. "Using consumer incentives to increase well-child visits among low-income children," *Medical Care Research and Review*, 68 No. 5 (2011).

- Informing potential participants of the availability of the incentive program is of utmost importance;²¹⁴
- 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;²¹⁵
- Enrollment in incentivized programs requires action from the participant (as opposed to default assignment) in order to better educate and motivate the participant;²¹⁶ and
- A voucher program will not be successful if other barriers exist to prevent the participant from using the voucher (e.g., voucher provided for gym cannot be used because of difficulties regarding childcare and transportation).

Section 4108 of the PPACA granted CMS the authority to provide competitive state grants to test the effectiveness of incentivizing positive health behaviors in an effort to improve outcomes related to chronic disease. In September 2011, ten states were awarded grants to develop, test, and evaluate ways to encourage healthy behaviors in Medicaid recipients whose life habits most often lead to chronic disease. These ten states—California, Connecticut, Hawaii, Minnesota, Montana, New Hampshire, New York, Nevada, Texas, and Wisconsin—are each tackling some complex behaviors traditionally linked to reducing chronic disease, smoking cessation, weight loss, diabetes management/ prevention/ detection, and using exercise and/or nutrition to improve health.²¹⁷ As these states implement, and then evaluate, these new programs across states they will begin to produce valuable and heretofore missing information regarding the efficacy and cost efficiency of incentivized plans.

Effective Approaches to Motivating Individuals to make Positive Changes

The thread running through questions regarding how to elicit long-term commitment to healthy lifestyle choices is clearly related to motivation. Thus far, states have not succeeded in engaging and motivating participants for their wellness programs.

A review of motivational theories, as they relate to healthy lifestyle behaviors, shows Self Determination Theory to be most applicable to developing long-term exercise and weight loss motivation. Self Determination Theory has also been used, in both full and partial theory, in smoking cessation programs. Self Determination Theory is an amalgam of several extant motivation and learning theories. At its core, it postulates that needs of autonomy, perceived competence, and relatedness work together to inform magnitude of motivation and persistence.

Autonomy, operationalized, is when people engage in an activity because they find it interesting and personally beneficial. High levels of autonomy are correlated with strong persistence. In contrast, being *Controlled* involves acting with a sense of having to participate in an activity due to external forces. States of Autonomy and Controlled exist on a gradient scale in which there can be varying degrees of both applied to specific activities. In other words, a person can be exercising because she is interested in

²¹⁴ Sutherland, K., et. al., "Impact of targeted financial incentives on personal health behavior: A review of the literature," *Medical Care Research and Review*, 65 Sup. 6 (2008).

²¹⁵ Gurley-Calvez, T., et. al., "Mountain Health Choices Beneficiary Report." West Virginia University, Bureau of Business and Economic Research (2009).

²¹⁶ Blumenthal, K. J., et. al., "Medicaid incentive programs to encourage healthy behavior show missed results to date and should be studied and improved," *Health Affairs*, 32 No. 3 (2013).

²¹⁷ *Ibid.*

using the process as a means to maintaining her good health or she could be exercising because she has been told that she will lose health-related benefits if she does not do so. The person performing under Controlled circumstances will less likely be persistent. One's sense of autonomy can be mitigated by the use of rewards. Rewards can be either positive or negative and *intrinsic* or *extrinsic*.

Intrinsic motivation would be located at one end of a continuum with *amotivation* at the opposite end. Various types of extrinsic motivation would be located between the two points. Incentive programs, by their very nature, are recognized as extrinsic motivation and a meta-analysis of 128 lab experiments have confirmed that "whereas positive [verbal] feedback enhances motivation, tangible rewards significantly undermine it." Hence it is suggested that, although extrinsic rewards may be used to incentivize initial behaviors, there must be an eventual shift wherein the intrinsic rewards replace them or the persistence will fade.

It is only when the extrinsic reward is given without being tied to specific behaviors (e.g., a bonus at work) that they do not undermine the intrinsic motivation that will lead to autonomy. When creating an incentivized program it is suggested the participant will develop through three phases. First, the participant will receive an extrinsic reward in exchange for the desirable behavior (interjection) until the participant has had the chance to perform the behavior and discover how the value actually aligns with personal goals and identities (identification). At this point any extrinsic rewards may or may not be withdrawn in order to allow the participant to fully identify with the activity and integrate it into personal identification, interests, and values (integration). Once integration has occurred, the participant is deemed autonomous and would not need external rewards to continue the behavior.

Perceived competence denotes the psychological perception that one is able to effectively interact with one's environment. Often times perceived competence will differ drastically from reality. Perceived competence is associated with higher levels of persistence in a chosen behavior. It is closely tied to self-efficacy, which is a person's belief regarding whether one has the power to create change with personal actions.

Relatedness refers to one's sense of belonging and connectedness to others within a social context. This also has shown to be highly correlated to persistence.

Studies using Self Determination Theory have shown that individuals are much more likely to engage in, and continue with, an activity when the magnitude of all three components (i.e., autonomy, perceived competence, and relatedness) remains high.

Recent Approaches to Motivate Engagement in Positive Health Behaviors

Florida

The Enhanced Benefits Rewards Program was established to encourage healthy practices and personal responsibility for Florida's Medicaid population. Participants were awarded monetary credits for a range of specific behaviors including well child visits, immunizations, and cancer screenings as well as participation in alcohol or drug treatment programs and weight loss programs. Acquiring credits could be accomplished in one of two manners: 1) credits would be applied to participant's account when the provider billed via Medicaid; and 2) the participant was required to submit a form countersigned by the program provider for long-term efforts such as weight loss, exercise, and smoking cessation. Earned credits could then be redeemed at participating pharmacies for preapproved, health-related products and supplies. Participants were advised of the number of credits in their accounts via a mailed

statement. Participants were not required to sign up for this program as it was passive enrollment. Only 52% of the credits were redeemed (most of those redemptions being for diapers) indicating low interest in the redemption program. Additionally the bulk of the credits were earned for attending office visits which had been scheduled for primary care appointments, immunizations, and maintaining ongoing medications. Only 2 enrollees earned credits for smoking cessation and only 2 enrollees earned credits for participating in an exercise program. Low levels of participation have been attributed to the possibilities of too low of incentives, lack of understanding of the program, confusion of the program with Florida's Extra Services program which was being concurrently run, poor marketing of the program, or lack of need for incentivization to encourage behaviors already being performed.

Using the Self Determination Theory frame to review the Enhanced Benefits Rewards program reveals that autonomy was low and there was no perceived competence or relatedness.

Idaho

The Preventive Health Assistance program was established to encourage child wellness visits for children covered under the Children's Health Insurance Program (CHIP) and to promote healthy behaviors in Medicaid-eligible adults. Parents who were up-to-date with well child visits during each quarter were awarded with up to \$30 toward the \$10 or \$15 premiums each quarter. For long-term behavior changes, such as weight loss and smoking cessation, participants would indicate a desire to change a behavior (in an agency provided survey) and receive a \$100 in points that can be redeemed for whatever they believe they need to meet the goals for the change. For example, a smoker may use the points to purchase counseling or medication and a person working to lose weight might purchase a weight loss program or a gym pass. But first they must visit a doctor to gain an okay to participate in treatment. When a participant reaches a benchmark based on an agreed upon goal another \$100 is awarded. The program is capped at \$200 per year.

The program was successful in bringing adherence to well-child visits up (49% compliance in the incentivized group were in compliance at the time of the current measure compared to 32% of the non-incentivized group). Only 5% of eligible recipients enrolled in the weight management program and almost 2% of eligible recipients enrolled in the smoking cessation program; indicating very limited success in creating motivation to these populations. Using the Self Determination Theory frame to review the Preventive Health Assistance program reveals that autonomy and perceived competence were moderate and relatedness was low to moderate.

West Virginia

The Mountain Health Choices (MHC) program was established to encourage responsible health choices among Medicaid-eligible recipients. Recipients were assigned to the Basic Medicaid benefits plans if they did not provide a signed Responsibility Agreement and Health Improvement Plan to the MHC administration. Recipients who did provide the signed forms were extended an enhanced Medicaid benefit and were required to demonstrate compliance to the health improvement contract (or they were switched to the basic care plan). The basic care plan was a revised Medicaid plan that took away benefits that had been awarded as basic care in the past (e.g., prescription coverage was limited to 4 prescriptions per month and excluded payment for services such as inpatient psychiatric care, substance abuse programs, vision care, smoking cessation programs, etc.). Only 10% of the eligible population took actions to become eligible for the enhanced benefits program. Lack of participation was attributed to passive, default enrollment in the Basic plan; difficulty in accessing health care; possible low levels of health literacy among the target population (although that was disputed by the Gurley-Calvez report); lack of clear instructions on how to obtain enhanced care, lack of a return envelope, and significantly

low levels of understanding of plan provisions and enrollment requirements despite intensive promotional efforts prior to roll out. It is also interesting to note that exclusion from the enhanced program meant Medicaid recipients were ironically not eligible to receive some of the services (such as smoking cessation) which were behaviors targeted for improvement. Some participants were not willing to visit their doctor when there was no illness present, as illustrated by one participant's statement, "I think it's ridiculous to make an appointment just to fill out paperwork. I will be glad to sign papers whenever our next trip may be. Till then—why waste state dollars?"²¹⁸

Using the Self Determination Theory frame to review the Mountain Health Choices program reveals that autonomy and perceived competence were very low and there was no relatedness.

Motivating Low-Income Adults to Make Positive Changes

To date, there are few studies on long-term, health-related behavior changes directly aimed at people in the lower socioeconomic tiers of society. It can be assumed that there will be differences in motivators based on race, gender, and religious affiliation and that a lot of motivators for people in the higher tiers of society would be similar. However, care should be taken to ensure equality of access and equality of outcome are not negatively impacted via the use of incentives. Positive incentives for attempts at change should be considered superior when seeking to create incentivization for long-term changes as they are reported to create a higher rate of long-term persistence. However, research needs to fine-tune some of the negative and positive rewards used in studies of other populations to ensure they actually provide incentive and/or remove barriers to success for the target population. Research is suggesting that negative rewards should be used sparingly, if at all, for these populations. For example, it has been shown that a negative incentive approach is most effective in creating incentives to change behavior in general populations. However, the negative incentives used in their studies created a low-stake loss; not a high stakes loss such as access to integral health care and positive health outcomes. Utilizing negative incentives on a low-income group (as occurred in West Virginia) can lead to despair, decreased motivation, and further alienation of low-income groups. It is unfair to ask "the most vulnerable population to do more with less ability to accomplish what we ask of them." If it becomes imperative to utilize negative rewards as incentives, the program planners should explicitly acknowledge how the benefits will outweigh the burdens being placed on participants and then ensure evaluation is thorough and occurs early in the program so that rewards can be altered if needed.

Smoking

Changes to laws, public perception, and taxes have aided efforts to encourage smoking cessation. However, smoking remains concentrated in the populations with high incidences of poverty, mental illness, and substance abuse. In fact, almost half of all Americans whose deaths are attributed to smoking behaviors are people with chronic mental illness problems, substance abuse problems, or both. Advertising continues to be heavily geared toward low-income neighborhoods as health agencies battle to increase overall health by decreasing the incidents of smoking. No other medical or public health intervention approaches the degree of impact that smoking cessation could make on the health of low-income populations; and the tools are already available to accomplish the goals.

Research shows low-income smokers who carefully select the time they choose to quit and have cessation support available experience better outcomes than smokers who quit for externally motivated

²¹⁸ Gurley-Calvez, T., Bone, P. F., Pellillo, A., Plein, C., & Walsh, M., "Mountain Health Choices Beneficiary Report," West Virginia University, Bureau of Business and Economic Research (2009).

reasons. To ensure smokers who self-refer to a cessation program are truly ready to quit, an in-person counseling session would be recommended. In that session, the potential participant should be assessed as to readiness to enhance chances for success (using a tool such as The 20-item Reason for Quitting Scale); educated on different technologies available; allowed to craft a personalized treatment plan that addresses autonomy, perceived competence, and relatedness; and be assured the funding is there to support them through treatment. Providing choice minimizes pressure, creates meaningful rationale, and acknowledges the participant's feelings and perspectives; these in turn facilitate internalization and eventual integration of personal regulatory processes and thus promote effective, long-term behavioral change once the goal has been achieved. Technology concentrated in this area includes smoking cessation aids that have shown to be effective in helping smokers quit. Smokers who have access to various cessation aids and are able to augment their treatment with in-person or telephonic counseling have better long-term outcomes. Again, current research shows Self Determination Theory should be used to frame the design of any programs to augment chances for persistence.

Obesity

Obesity is a relatively new preventable cause of death and disability in the United States. It carries a social stigma and can impact health as well as quality of life and ability to secure employment. Obesity tends to start in childhood, and encouraging a healthy weight for adults in the lower socioeconomic tiers can be a challenge. Like tobacco, foods that are notoriously full of fats and sugars are intensely marketed to the poor. At the same time, low-income neighborhoods have been shown to have limited access to fresh foods and restricted opportunities for exercise.

Current research, as well as the experiences of West Virginia, Idaho, and Florida, indicates incentive programs for weight grounded solely in financial incentives are difficult to sustain. This is why Self Determination Theory has been used to try to create a balance of motivation and learning that will actually support long-term behavior changes when used within the scope of incentivized weight loss and exercise programs.

To enjoy success with programs of this complexity, program planners should acknowledge how the functions of genetics, behavior, environment, and psychology work together to establish a person's weight. Once the weight is lost, persistence will determine if the new health behaviors will be sustained over a long period of time. Self Determination Theory postulates that the weight loss itself will increase feelings of perceived competency and self-efficacy which will work to boost feelings of autonomy *if the participant has internalized both the value of the weight loss and the locus of causality.*

The development of the target goal needs to be inclusive of the participant because research has shown providing choice minimizes pressure, creates meaningful rationale, and acknowledges the participant's feelings and perspectives; these in turn facilitate internalization and eventual integration of personal regulatory processes and thus promote effective, long-term behavioral change once the goal has been achieved. It is also imperative to ensure methods to boost relatedness by providing a forum for group chats (whether virtual or in-person) so the participant has easy access to peers, support, and suggestions for self-monitoring relevant behaviors. A hosted group chat would be recommended due to the prevalence of low-income participants citing time constraints as one of their primary barriers to losing weight and keeping it off. Research shows the behavior change is more likely to be maintained if the participant's up-front autonomy is high. The peer support continues to maintain autonomy and relatedness because the participant can go to them when she chooses. It also maintains perceived competence as the participant will approach the group with questions and can also provide answers for other members of the group.

Motivating Low-Income Adults to Change Unhealthy Behaviors

Based on the experiences of Florida and Idaho, it is clear that motivating adults to start on the road to changing unhealthy behaviors is challenging. As the nation moves toward wellness models in the health arena, it is clear that proper marketing will be imperative to successfully recruiting program participants. This marketing will entail getting the word out, as well as describing the process the potential participant will need to follow to become enrolled in the program. Additionally, these processes will need to be as simple as possible, guarantee quick and adequate payments of incentives, and be supported by staff willing to support the autonomy of the participants.

Another method of motivating heretofore unmotivated adults would be to create engaging programs that support the participants socially and are fun. This may involve creating focus groups including members of the target population to determine what might build autonomy, competence, and relatedness while presenting as an enjoyable activity. One successful program was Fab and Fit. This program conceptualized an exercise program that offered different types of exercise each day, provided after-exercise refreshments to encourage relatedness, and worked to overcome the identified barriers of both cost and child care needs. It utilized social marketing techniques to recruit its initial participants and later created a buzz to draw in even more participants. The goal was to increase exercise in the low-income target population. The session leaders were encouraged to maximize fun and work to allow the participants to feel successful. Their program was successful in engaging low-income women under the age of 25, and older than the age 54, in exercise programs. Their attendant study showed that enjoyment is highly correlated with adherence to physical activity.

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