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Keahna Akins, Student

Dr. Sarah Wackerbarth, Committee Chair

Dr. Sarah Wackerbarth, Director of Graduate Studies

Prospective Policy Analysis of the Kentucky HEALTH Demonstration Waiver

CAPSTONE PROJECT PAPER

A paper submitted in partial fulfillment of the
requirements for the degree of
Master of Public Health
in the
University of Kentucky College of Public Health
By

Keahna Akins
Chicago, IL

Final Examination
Lexington, Kentucky
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To all of my family and friends, thank you for your prayer and your encouragement.

ABSTRACT

In January 2018, the Centers for Medicare & Medicaid Services approved Kentucky's Section 1115 Medicaid demonstration waiver, which gave the state approval to require work/community engagement as a condition of Medicaid eligibility, charge premiums of up to 4% household income, and add an incentive account for dental and vison services. The waiver projected nearly 100,000 fewer enrollees and $2.4 billion less in spending over the five-year demonstration period. Two days short of the waiver July 1st implementation date a federal judge ruled the waiver invalid. This finding held that the Health and Human Services Secretary's judgement was arbitrary and capricious.

This capstone project was a prospective policy analysis to determine the potential impact of the Kentucky HEALTH demonstration waiver and assess alternatives to the policy. A criteria-alternatives matrix was used to evaluate the policy alternatives. The most viable policy option at this time is for the state to continue Medicaid expansion. While the results are subjective the analytic method can be adjusted as data becomes available.

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I. Introduction

On January 12, 2018, the Centers for Medicare and Medicaid Services (CMS) approved Kentucky's section 1115 waiver, entitled Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH) (Musumeci, Rudowitz, & Hinton, 2018). KY HEALTH encompassed provisions that some suggest encouraged personal responsibility in the form of incentives as a means to transition beneficiaries to private insurance. The waiver projects nearly 100,000 fewer enrollees and $2.4 billion less in spending over five years (Kentucky HEALTH 1115 Demonstration Modification Request, 2017). Following approval of the waiver, lawsuits were filed by several advocacy groups opposing the provisions of the waiver (Hundreds of Thousands of Kentucky Residents Could Lose Medicaid under the Work Demonstration Project Approved by the Trump Administration, 2018). On June 29, 2018 a federal judge invalidated the KY HEALTH waiver, two days short of the waiver July 1st implementation date (Goodnough, 2018). The judge said the secretary of the U.S. Department of Health and Human Services "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid," (Goodnough, 2018). In this capstone, I conducted a policy analysis of KY HEALTH.

II. Background

Kentucky's Pre-Waiver Medicaid Expansion Success

In 2014, as part of the Patient Protection and Affordable Care Act (ACA), the Commonwealth of Kentucky expanded its Medicaid program and created a state-based marketplace called kynect. Within one year of implementation, the state experienced one of the largest reductions in uninsured rates in the country, dropping from 16% in 2013 to 8% in 2014 (Artiga, Tolbert & Rudowitz 2016). Sommers et al. (2016) assessed changes in access to care in

three states that took alternative approaches to the ACA. The study compared Medicaid expansion in Kentucky, the use of Medicaid funds to purchase private insurance for low-income adults in Arkansas (private option), and no expansion in Texas. The findings showed that Kentucky's Medicaid expansion was associated with significant increases in outpatient utilization, preventive care, and improved health care quality; reductions in emergency department use; and improved self-reported health (Sommers, Blendon, & Epstein, 2016). Kentucky had one of the most successful ACA implementation experiences among the states.

Medicaid's Role in Kentucky

As shown in Table 1, Medicaid plays a large role in Kentucky. Approximately a quarter of Kentucky's population are covered by Medicaid (Artiga, Tolbert & Rudowitz 2016). Children make up 54.2 percent of Kentucky's Medicaid population ("Medicaid's Role in Kentucky", 2017). Although 74% of enrollees are children and working-age adults, nearly one-third of the state Medicaid spending is for the elderly; as 25% of Kentucky's Medicare enrollees are also covered by Medicaid. Additionally, people who live in rural communities are more likely to be covered by Medicaid than those in urban areas. Roughly one-half of Kentucky residents live in rural areas ("Medicaid's Role in Kentucky", 2017).

Dismantling of Kynect

In December 2015 Governor Matt Bevin won the gubernatorial election on a platform to disband kynect and move from a state-based exchange to a federal exchange (Issues, n.d.). Despite pleas from health officials and other stakeholders in Kentucky, Governor Bevin dismantled kynect. Kentucky residents now use the federal health care exchange to purchase health insurance.

Following the dismantlement of kynect, Governor Bevin proposed a Section 1115 waiver: Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH), to modify the current terms of the Medicaid program. On January 12, 2018 CMS approved the demonstration waiver, and two days short of the waiver July 1st implementation date a federal judge ruled the waiver invalid.

Section 1115 Medicaid Waivers

Since 1962, Section 1115 of the Social Security Act has allowed the federal government to approve state-level "experimental, pilot or demonstration projects" that promote the objectives of the program (Section 1115 Demonstrations, n.d.). Section 1115 Medicaid demonstration waivers are approved at the discretion of the Department of Health and Human Services Secretary through negotiations between a state and the CMS (Centers for Medicare and Medicaid Services). Section 1115 waivers are approved for a five-year period, after which new applications must be submitted and renewed. The Affordable Care Act created additional waiver authority that requires public input into the development and approval of section 1115 demonstrations, and required the Center for Medicare and Medicaid Innovation (CMMI) to evaluate demonstrations to ensure they provide patient-centered care, improve quality, and to slow cost growth in Medicare, Medicaid, and Children's Health Insurance Program (CHIP) (Section 1115 Demonstrations, n.d.).

Section 1115 waiver applications have included provisions such as premiums or premium-like contributions; disenrollment of beneficiaries for nonpayment of premiums; or elimination of coverage for non-emergency transportation to obtain medical care (Musumeci, Rudowitz, Hinton, Antonisse, & Hall, 2018).

Kentucky HEALTH Program Overview

The stated purpose of the demonstration waiver was to continue health coverage for the existing Medicaid population while evaluating new policies and programs designed to prepare individuals for self-sufficiency and private market insurance, as well as to ensure long term sustainability of the Medicaid program through cost savings.

Kentucky's proposed section 1115 Medicaid expansion demonstration waiver modifies the state's existing Medicaid expansion by:

- eliminating coverage for dental, vision care and non-emergency medical transportation;
- adding an annual $1,000 deductible (regular Medicaid has no deductible) which the state will cover;
- adding an incentive account, My Rewards, into which the state would make deposits if enrollee participated in health, community engagement and job training activities; account funds could be used to purchase enhanced benefits such as vision and dental care;
- disenrolling beneficiaries above 100% of the federal poverty level (FPL) for failure to pay a premium after 60 days;
- locking out of coverage enrollees above 100% FPL for six months if they fall 60 days behind on their premium payments unless the beneficiary pays past due premiums, for the past-due period and the reinstatement month, and completes a financial or health literacy course;
- imposing premiums on non-disabled adults on a sliding scale from $1 to $15 per month in lieu of copayments; and

- requiring “able-bodied” working age adults to participate in work activities, such as volunteer work, employment, job search, job training, education, as a condition of eligibility. (Amendment Request to Kentucky HEALTH, submitted July 3, 2017)

Lawsuits and Invalidation of KY HEALTH

On January 24, 2018 the National Health Law Program, the Kentucky Equal Justice Center, and the Southern Poverty Law Center filed a lawsuit, on behalf of 16 KY Medicaid beneficiaries, in the United States District Court for the District of Columbia challenging the federal government’s legal authority to issue Medicaid work requirements and its approval of the Kentucky Medicaid waiver, KY HEALTH (Musumeci, 2018). The lawsuit seeks to block not only the implementation of KY HEALTH, but any implementation of Medicaid waiver work requirements.

On April 6, 2018, 43 public health scholars filed a public health “friend of the court” amicus brief in support of the 16 Medicaid beneficiaries (Hundreds of Thousands of Kentucky Residents Could Lose Medicaid under the Work Demonstration Project Approved by the Trump Administration, 2018). The brief identifies a gross underestimate of the number of people who would be adversely affected by Medicaid work requirements. The waiver application states that nearly 100,000 Medicaid beneficiaries would lose coverage over five years. However, an analysis by researchers at George Washington University’s Milken Institute School of Public Health point towards an estimated loss of coverage for 175,000 to 300,000 Medicaid beneficiaries in the first year of implementation alone (Hundreds of Thousands of Kentucky Residents Could Lose Medicaid under the Work Demonstration Project Approved by the Trump Administration, 2018). This estimate is based on evidence from the imposition of work requirements on recipients of food stamps.

Judicial review from the United States District Court for the District of Columbia found that "the Secretary never adequately considered whether KY HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid" (Goodnough, 2018). This finding held that the HHS Secretary's judgement was arbitrary and capricious. Consequently, on June 29, 2018 the Court invalidated the KY HEALTH demonstration waiver.

III. Methodology

I used Bardach's (2012) Eightfold Path as a guide while conducting the policy analysis. The first step in Bardach's (2012) problem solving process is to define the problem. By providing background information about Kentucky Medicaid population I established that the problem is that Kentucky's Medicaid changes would result in many Medicaid beneficiaries losing health care coverage.

The second step in the Eightfold Path is to assemble some evidence. This requires the gathering of data and information on the topic in order to assess the nature and extent of the problem, the features of the policy situation, and policies that have been enacted to solve similar problems (Bardach, 2012, p. 12) I assembled evidence regarding Indiana's Medicaid expansion program, Healthy Indiana Plan (HIP 2.0), which the Kentucky waiver is modeled after, and evaluation of waivers with similar provisions.

The third step in the Eightfold Path is to construct alternatives for solving the problem. By alternatives Bardach (2012, p 16) means policy options to solve or mitigate the problem. The fourth step is to select criteria for evaluating the projected outcomes of these alternatives. Commonly used criteria include efficiency, equality, equity, fairness, justice, freedom, process values, and political acceptability (Bardach, 2012, pp. 33-44).

The fifth step is to project the possible outcomes of the alternatives (Bardach, 2012, p.

47). I used a criteria-alternatives matrix (CAM) to do this. The CAM organizes a comparison of the performance of alternatives in satisfying the different evaluative criteria (Munger, n.d.).

The sixth step is to confront the tradeoffs (Bardach, 2012, p. 63). According to Bardach (2005), one must always clarify the tradeoffs because rarely does one policy option have a better outcome than the other options on all selected criteria (p. 63). To do this I weighed the importance of each criterion.

Bardach's (2012, p.69) seventh step is after assessing the possible outcomes across criteria and confronting the tradeoffs, to decide which policy option is best. The eighth step is to tell your story, meaning to present the findings from completing the previous seven steps (Bardach, 2012, p. 70).

IV. Assemble Evidence

Table 1 compares Kentucky's demographics to states that have previously implemented similar provisions to those listed in the waiver.

Table 1 Comparison of State Demographics

	Kentucky	Arkansas	Iowa	Indiana	Michigan	California
Health Insurance Coverage of the Total Population, 2016						
Employer	44%	44%	54%	52%	51%	46%
Non-Group	10%	9%	6%	6%	5%	8%
Medicaid	21%	21%	18%	20%	22%	25%
Medicare	16%	17%	15%	14%	15%	11%
Other Public	N/A	2%	1%	1%	1%	1%
Uninsured	6%	8%	5%	7%	6%	8%
Total	100%	100%	100%	100%	100%	100%
Status of State Action on the Medicaid Expansion Decision, as of November 7, 2018						
Current Status of Medicaid Expansion Decision	Adopted	Adopted	Adopted	Adopted	Adopted	Adopted
Poverty Rate by Age, 2016						
Children 0-18	21%	22%	14%	14%	18%	19%
Adults 19-64	14%	16%	10%	11%	10%	12%
65+	10%	10%	N/A	12%	6%	12%
Total	15%	16%	10%	12%	11%	14%
Poverty Rate by Race/Ethnicity, 2016						
White	13%	12%	9%	10%	8%	10%
Black	25%	29%	N/A	29%	24%	23%
Hispanic	N/A	25%	N/A	N/A	23%	19%
Other	31%	22%	N/A	N/A	11%	10%
Total	15%	16%	10%	12%	11%	14%
Poverty Rate by Metropolitan Status, 2016						
Metropolitan	12%	16%	8%	12%	11%	14%
Nonmetropolitan	20%	17%	13%	12%	10%	16%
Total	15%	16%	10%	12%	11%	14%
Unemployment Rate (Seasonally Adjusted), Sept 2018						
Unemployed	4.50%	3.50%	2.50%	3.50%	4.00%	4.10%

Custom State Reports. (2018). Retrieved from https://www.kff.org/statedata/custom-state-report/?view=3&i=32234~69196~32132~32136~32135~32141&g=ar~ia~in~ky~mi~ca

Premiums

Kentucky, under the waiver, would have the highest Medicaid premiums and copayments in the nation, with premiums ranging up to 4% of household income. Enrollees from 100-138% of the federal poverty line (FPL) were required to pay the first premium before coverage was effective (Kentucky HEALTH Overview, n.d.). If premium payments were not received within 60 days, these individuals were removed from coverage for six months. Enrollees can return to the program before the six-month lockout if they pay two months of missed premiums and make one new premium payment, in addition to taking a financial or health literacy course. For those below 100% FPL who did not pay a premium coverage became effective after the expiration of the 60-day premium payment period for those below.

Previous research has shown premiums serve as a barrier to obtaining and maintaining Medicaid coverage among low income individuals (Artiga, Ubri, & Zur, 2017). Studies find that premiums shorten length of Medicaid enrollment, increase disenrollment from Medicaid, and discourage eligible individuals from enrolling in Medicaid (Artiga, Ubri, & Zur, 2017). Supporters of this provision assert that financial contribution by enrollees increases individual responsibility for health care utilization. I was unable to find any evidence supporting this. Conversely, research shows that charging premiums will likely lead to a reduction in enrollment, thus countering the goal of expanding coverage to all eligible adults (Guy, et. al., 2012, Guy, et. al., 2017, Impact of Premium Changes in the Oregon Health Plan, 2004, Wright, et.al, 2005). For example, Oregon increased Medicaid premiums to a maximum amount of $20 (Artiga, Ubri, & Zur, 2017). Following the increase nearly half of adults disenrolled (LeCouteur, Perry, Artiga, & Rousseau, 2004). Individuals who disenroll from Medicaid following premium increases and do

not receive coverage from other sources become uninsured and their access to healthcare is negatively impacted.

Indiana's Medicaid expansion program HIP 2.0, which KY HEALTH is modeled after, yielded similar results. An evaluation of HIP 2.0 conducted by the Lewin Group showed that charging enrollees premiums created barriers to care (The Lewin Group, 2017). HIP 2.0 enrollees receive a type of health savings account (HSA) — called a "Personal Wellness and Responsibility" or " POWER" Account Contribution (PAC) (Solomon, 2017). Enrollees are required to make monthly contributions to PACs that are indexed to two percent of household income. Members who do not make these contributions and whose incomes are at or below 100 percent of the FPL are either moved from HIP Plus into a more limited benefit plan, HIP Basic or are not enrolled in HIP 2.0 coverage. Members whose income is above 100 percent of the FPL are disenrolled from HIP 2.0 coverage if they fail to make these contributions.

Among individuals who qualified and applied for Medicaid with incomes above the poverty line, 29 percent were either not enrolled because they did not make a payment or disenrolled from the program by the state (The Lewin Group, 2017). During the first 21 months of the waiver, 55 percent of people eligible to pay PACs did not make a required payment at some point (Pugel, 2017). All of these individuals were then removed from Medicaid or were left with inferior coverage. In Kentucky all nondisabled adults were, under the waiver, required to pay premiums. In 2016 325,000 nondisabled adults were enrolled in Kentucky's Medicaid program during 2016-2017 (Haught, Dobson & Luu, 2018). Based on Indiana's experience 178,750 beneficiaries will be locked out of coverage.

Work Requirement

Kentucky was the first state to win federal approval to test work requirements in Medicaid (Kentucky HEALTH Overview, n.d.). KY HEALTH required non-disabled adults to participate in 80 hours per month of work, job training, education or other qualified community engagement. According to a study by the Kaiser Family Foundation, six in ten non-disabled adults on Medicaid already work at least part time (Figure 1), although part time positions often do not provide health benefits. In recent years, Target, Walmart, Home Depot and Trader Joe's have all discontinued health plans for part time employees (O'Connor, 2014). For health, dental, and vision coverage, individuals who do not work fulltime must turn to state or federal insurance exchanges if they are not eligible for Medicaid.

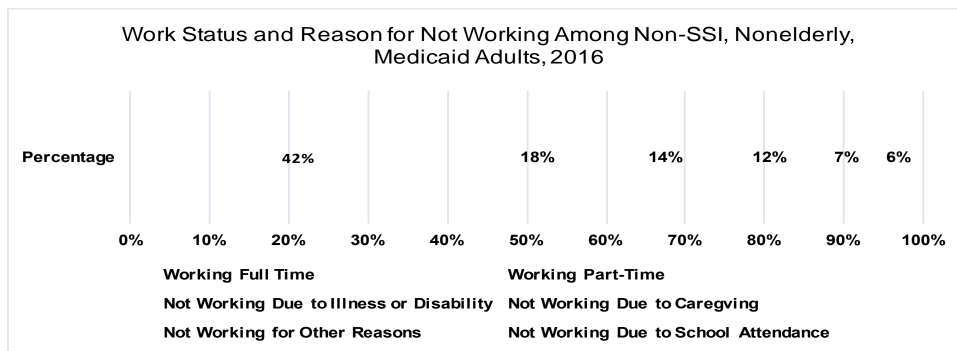

Figure 1 *Not working for Other Reasons include the following: could not find work, or other reasons. "Working Full time is at least 35 hours per week. Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.*

Among Medicaid beneficiaries who are not working, a majority report not working due to illness or disability, attending school or providing caregiving services. These reasons could exempt these individuals from work requirements, focusing the work requirements on the remaining 7% of the population who are not working for other reasons (Musumeci, Garfield, & Rudowitz, 2018). Enrollees who are already employed are still required to document and verify their compliance. Individuals who are exempt from this provision are also required to document and verify their exempt status, as often as monthly (Kentucky HEALTH Overview, n.d.).

Tracking and verifying each enrollee's compliance or exemption status will bring about additional administrative challenges and cost for the state. Kentucky would have to build an IT infrastructure and hire additional support staff. Kentucky budgeted $186 million for fiscal year 2018 to implement the Medicaid work requirements, the federal government covered more than $167 million of this cost, and plans to spend an additional $187 million in 2019 (Wagner & Solomon, 2018).

On June 1, 2018, Arkansas became the first state to implement a work requirement in its Medicaid program. The work requirements are being phased in for enrollees beginning with an initial group of Medicaid expansion recipients aged 30-49 who had no children under 18 in the home, did not have a disability, and who did not meet other exemption criteria (Greene, 2018). Beneficiaries aged 18-29 will become subject to the policy in 2019. Unless exempt from the policy, enrollees must engage in 80 hours per month of working, volunteering, attending school, searching for work or attending health education classes, and report the hours to the Arkansas Department of Human Services (DHS) through an online portal. Recipients need to report hours by the 5th of the following month. If hours are not reported any three months out of the year recipients will lose Medicaid health coverage until the following calendar year.

The work requirements took effect for the initial group of beneficiaries on June 1, 2018. State data shows that as of October 8, 2018, a total of 8,462 —29 % of the targeted population— individuals have lost Medicaid coverage until January 2019 due to non-compliance with the reporting requirements (Rudowitz, & Musumeci, 2018). This includes cases that were closed on September, 4,353, and cases closed on October, 4,109 (Rudowitz, & Musumeci, 2018).

Arkansas and Kentucky both require 80 hours per month of a qualifying work activity among non-exempt beneficiaries. A major difference in the two states work requirements is that

Kentucky requires work as a condition of eligibility for expansion adults and their traditional Medicaid population (Musumeci, Garfield, & Rudowitz, 2018). Also, Kentucky's work requirement requires more reporting from participants than the Arkansas work requirement. Based on Arkansas's experience about 94,240 beneficiaries will fail to meet the requirements and lose their Medicaid coverage.

Removal of Dental and Vision Coverage

KY HEALTH eliminated coverage of dental and vision services, and waived non-emergency medical transportation (NEMT), all of which were covered under Kentucky Medicaid (Kentucky HEALTH Overview, n.d.). Visits to the dentist and eye doctor are often the first step in identifying health conditions such as diabetes, multiple sclerosis, hypertension, stroke and heart disease (Chous & Christopher, n.d., Nasseh, Greenberg, Vujicic, & Glick, 2014). Removal of these services could lead to higher healthcare cost by increased emergency room use and poorer health outcomes as a result of untreated illness.

In 2009 California eliminated comprehensive adult dental coverage from its Medicaid program (Wides, Alam, & Mertz, 2014). A 2015 study examined the impact of California's removal of adult dental coverage on emergency department (ED) visits by Medicaid-enrolled adults for dental problems in the period 2006–2011 (Singhal, Caplan, Jones, Momany, Kuthy, Buresh, & Damiano, 2015). Researchers found a significant and immediate increase in dental ED use, a 68 percent increase in average yearly costs associated with dental ED visits. This policy change was associated with more than 1,800 additional dental ED visits. These findings suggest that removal of Medicaid adult dental benefits may result in costly ED visits that do not provide definitive dental care.

Elimination of non-emergency medical transportation

Since 1966, non-emergency medical transportation (NEMT) has been a part of Medicaid (Adelberg & Simon, 2017). Lack of transportation to and from medical services is one of the socioeconomic disadvantages that prevent Medicaid beneficiaries from accessing health care services (Adelberg & Simon, 2017). Lack of transportation leads to rescheduled or missed medical appointments, delayed care, and missed or delayed medication use (Syed, Gerber & Sharp, 2014). It is suggested that 3.6 million Americans "miss or delay care" annually due to transportation problems (Komenda, 2017). For individuals with chronic illness transportation barriers can lead to poorer management of their illness and consequently poorer health outcomes (Syed, Gerber & Sharp, 2014).

Incentive Account

Enrollees had an incentive account, My Rewards, to purchase vision and dental services, and other services not covered by the KY HEALTH plan (Kentucky HEALTH Overview, n.d.). Enrollees could earn rewards by participating in health, community engagement and job training activities (Kentucky HEALTH Overview, n.d.). Evaluations of similar incentive programs show that few Kentucky enrollees are likely to earn rewards (Blumenthal, et. al., 2013, Solomon, 2018).

Iowa was the first state to offer an incentive to Medicaid expansion enrollees who engage in healthy behaviors. Iowa Medicaid enrollees with income at or above 50 percent of the FPL pay premiums after they have been enrolled in the program for a year; however, premiums can be waived if the enrollee participates in a wellness exam and completes health risk assessment (HRA) (Soloman, 2016). Providers are also incentivized to help enrollees complete their HRA. In spite of these incentives, in 2015 only 8 percent of enrollees with incomes above the FPL and

17 percent below the FPL completed both the wellness exam and HRA to gain the premium waiver (Askelson, Momany, Wright, Bentler, McInory, Heeren & Damiano, 2016). In a survey, clinic managers reported having limited awareness and knowledge of the incentive program (Askelson, Wright, Bentler, Momany, & Damiano, 2017). Evaluators concluded that the proportion of enrollees who participated in either the wellness exam or the HRA is suboptimal (Askelson, Momany, Wright, Bentler, McInory, Heeren, & Damiano, 2016).

Michigan's waiver program offers incentive payments that reduce enrollees' liability for cost-sharing if they complete an HRA and agree to address or maintain healthy behaviors (Healthy Michigan Demonstration Section 1115 Annual Report Demonstration Year: 7 (01/01/2016 – 12/31/2016), 2017, p. 6). The first part of the HRA is completed with the help of the state's enrollment broker and the second part must be completed with the enrollee's health care provider. Both parts have to be completed to earn an incentive. Although the vast majority of enrollees completed the first part, only 14.9 percent of enrollees who were in a health plan for at least six months qualified as of December 2015 (Solomon, 2016). Enrollee interviews showed that beneficiaries did not know that completion of an HRA earns them a healthy behavior award (Michigan Adult Coverage Demonstration Section 1115 Annual Report, 2016).

Iowa and Michigan utilized financial incentives to encourage their Medicaid enrollees to engage in healthy behaviors. Evaluation of both programs revealed suboptimal results. Kentucky's waiver incentive account, My Rewards, is used not only to influence healthy behaviors, but to purchase enhanced benefits such as vision and dental care. Based on Iowa's and Michigan's experience, Kentucky's incentives are likely to fall short in influencing health behaviors among enrollees and therefore few enrollees will receive rewards to purchase dental and vision care.

Social Construction and the Medicaid Population

The social construction of target populations is important to the analysis of public policy. Policy implementation depends partly on the power of the population targeted by the policy, but also on the extent to which others approve or disapprove of the policy being directed towards a specific population. According to Schneider & Ingram:

> *The social construction of a target population refers to (1) the recognition of the shared characteristics that distinguish a target population as socially meaningful, and (2) the attribution of specific, valence-oriented values, symbols, and images to the characteristics. Social constructions are stereotypes about particular groups of people that have been created by politics, culture, socialization, history, the media, literature, religion, and the like.*

There are four types of target populations that have been created by the convergence of power and social constructions (Table 1). The four types of target populations are advantaged, contenders, dependents and deviants. Low income individuals fall under the deviant target population. Historically, low income individuals have been construed negatively in the public and punished in policy. Stereotypes about low income individuals are that they are lazy, they are taking advantage of the system, are non-white, and that their impoverishment is due to their individual behavior or character flaws (Weinstein, 2018). Janel George of the National Women's Law Center wrote, "…the caricature of an 'able-bodied' single mother of color 'collecting' public benefits and willfully refusing to work while living a lavish lifestyle—has long been resurrected in false narratives to support 'reforms' that would slash federal contributions to many benefit programs like Medicaid" (George, 2017). In the *Assemble Evidence* section of this paper I provide facts to undercut this stereotype.

Table 2 Convergence of Power and Social Constructions

Power		Constructions: Described positively	Constructions: Described negatively
Power	Powerful	***Advantaged***, treated positively in public and receiving benefits publically	***Contenders***, treated negatively in public but negotiating benefits privately
	Powerless	***Dependents***, treated positively in public but unable to mobilize to negotiate benefits	***Deviants***, treated negatively in the public and punished by policy

Source: "Policy Concepts in 500 Words: Social Construction and Policy Design. ", 2017.

Policies are often targeted to a specific group, and often seek to address specific issues through changing behavior (Schneider & Ingram, 1993). The stated purposes of the KY HEALTH waiver were to 1) prepare individuals for self-sufficiency and private market insurance, and 2) ensure long term sustainability of the Medicaid program. The waiver is pursuing these purposes through behavior change. Provisions of the waiver, such as the incentive account and work requirements, enable and coerce Medicaid beneficiaries, to do things they would not have done otherwise. The policy is designed to "provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance" (KY HEALTH Overview, n.d., p.4). However, the policy provisions are further perpetuating myths that stereotype people of low income as not demonstrating these characteristics.

V. The Alternatives

Alternative 1: The Status Quo

As stated by Bardach (2012), one should always include the alternative "let present trends (or 'business-as-usual') continue undisturbed" (p. 18). The first alternative I evaluated was to continue with current practices, specifically, to keep things as they are and take no action in regards to the invalidation of the KY HEALTH waiver. This means that Kentuckians will continue to enroll in exchange coverage through Healthcare.gov.

Alternative 2: Appeals Court Ruling

The second policy alternative is the appeal of the Court ruling to the federal Court of Appeals for the District of Columbia Circuit by CMS and the State of Kentucky. This alternative was evaluated as if the court ruling was appealed and won.

Alternative 3: Private Option

The third policy alternative is the "private option". The Medicaid "private option" pioneered by Arkansas uses Medicaid funds to purchase private insurance to cover low-income people (Maylone & Sommers, 2017).

Alternative 4: End Medicaid Expansion

The last alternative is to end Medicaid expansion. Prior to the approval of KY HEALTH Governor Matt Bevin stated that he would end the state's Medicaid expansion if any part of the waiver was overruled (Ky. Governor's Ultimatum: If Courts Touch Work Requirements, State Will Roll Back Expansion Completely, 2018). With the Court invalidating the demonstration waiver as a whole, the end of Medicaid expansion is very much a possibility for the state.

VI. Criteria for Evaluating Alternatives

The fourth step, according to Bardach (2012), "is the most important step for introducing values and philosophy into the policy analysis, because some possible criteria are evaluative standards used to judge the goodness of the projected policy outcomes that are associated with each of the alternatives" (p.32). The evaluative criteria I applied to the projected outcomes are cost-effectiveness, population health benefit, and equity in health. These criteria were used to identify, measure and compare the alternative policies.

Criterion I: Cost Effectiveness

The purpose of this criterion was to show the relationship between resources used (costs) and the health benefits achieved (effects) of the policy (Neumann & Johannesson, 1994). It is important to gain value from the resources we use as we do not live in a society with unlimited resources. A high ranking of this criterion would have the policy produce greater benefits than costs, and a low ranking on this criterion would be an outcome that costs more than the benefits it generates.

Criterion II: Population Health Benefit

This criterion's purpose was to answer the question; *Does this alternative improve quality of life and health outcomes*? A high ranking on this criterion means that the outcomes produce an increase in quality of life and health outcomes for the Medicaid population. A low ranking would mean the outcomes produce reductions in those areas.

Criterion III: Equity in Health

The 1995–1998 World Health Organization initiative on Equity in Health and Health Care defined equity in health as "minimizing avoidable disparities in health and its determinants–including but not limited to health care–between groups of people who have different levels of underlying social advantage or privilege, i.e., different levels of power, wealth, or prestige due to their positions in society relative to other groups," (Braveman, n.d.). Using this definition of health equity, the purpose of this criterion was to answer the question; *Will implementation of this alternative minimize avoidable disparities in health and its determinants?* A high ranking on this criterion means that the policy provisions may reduce health disparities and its determinants of target population. A low ranking means that the alternative has the potential to increase avoidable disparities in health and its determinants.

VII. Criteria Weights

These criteria were chosen because I found them to be essential in evaluating the projected outcomes of the policy alternatives. I applied weights to the criteria as some criteria are more important than others in determining which policy alternative has the best outcome. Criterion I is weighted most heavily relatively to the other criteria because of the state of Kentucky's economy. According to *Kentucky Annual Economic Report 2017* Kentucky ranked in the bottom ten states for per capita personal income. Kentucky is also lagging behind the U.S. and competitor state averages in the growth of private wages and employment. In addition, the underlying economic vitality of the state is of concern as Kentucky's earned income per capita ranks 47th among the states (Bollinger, Hoyt, Blackwell & Childress, n.d.). Therefore, the state is in great need of a policy that is fiscally sustainable and cost effective. A healthy population and workforce is vital for economic growth. Lack of access to care is not only a public health issue but an economic one as well. Thus I think it is important to weigh cost effectiveness more heavily than the other criteria.

Criterion II, population health benefit, was also weighted heavily. Health care coverage has the potential to maintain or restore functioning enabling individuals, and therefore, improving their quality of life, and health outcomes, as well as giving these individuals the opportunity to compete for social positions. Additionally, nearly 6 in 10 Americans say Medicaid was important for them and their family (Kaiser Health Tracking Poll-May 2017). Criterion III, equity in health, is also a very important criterion. Disadvantaged social groups systematically experience worse health or greater health risks than more advantaged social groups (Braveman, n.d.). Health disparities not only affect affected groups, but limit overall quality for the broader community.

Table 3 quantitatively demonstrates the weights assigned to the different criteria. Table 3.1 displays the qualitative value of each rating given to the alternatives against the criteria. The rating value multiplied by the weight of the criteria produced a score. The total score for each alternative was then compared to determine the most attractive policy option.

Table 3

Weighting of Criteria

Criterion	*Weighting*
Cost Effectiveness	**.40**
Population Health Benefit	**.35**
Equity in Health	**.25**

Table 3.1

Rating Value

Rating	*Value*
Does Not Satisfy Criteria	**1**
Minimally Satisfies Criteria	**2**
Moderately Satisfies Criteria	**3**
Satisfies Criteria	**4**

VIII. Evaluation of Alternatives

In this section I evaluated the alternatives against the criteria. I provided a brief description of each alternative again, and then I evaluated each alternative in terms of three criteria: cost effectiveness, population health benefit, and equity in health. I then summarized the evaluation in a qualitative matrix. Lastly, I utilized a qualitative matrix to calculate the score for each alternative.

- *Alternative 1: The Status Quo*

Description

Continuing with current practices would mean taking no action in regard to the Court ruling invalidating KY HEALTH. Therefore, Kentuckians would continue to enroll in exchange coverage through Healthcare.gov.

Cost Effectiveness

Under the ACA, states that expanded Medicaid received a 100% federal match rate for the first three years of the program. Beginning in calendar year 2017 states began paying a share of the costs for new enrollees. States share is expected to rise to 10% by the year 2020. Thus far federal funding has insulated state budgets from increased spending related to Medicaid expansion (Sommers, & Gruber, 2017).

The cost effectiveness criterion consider more than the spending from state funds as a result of the expansion. This criterion takes into account the impact on beneficiary access to care, healthcare utilization, preventative care, and population health benefit as well. Studies have shown that Kentucky's Medicaid expansion is associated with significant increases in access to care, outpatient utilization, preventive care, and improved health care quality (Sommers, Blendon & Epstein, 2016; Sommers, Maylone, Blendon, Orav, & Epstein, 2017). According to the Kentucky Center for Economic Policy, Medicaid expansion has improved hospital finances, created jobs, and is growing the economy as a whole in Kentucky (Pugel, 2018). From 2012 to 2015 past due medical debt in Kentucky has declined nearly 27 percent (Karpman, M., & Caswell, K. J., 2017). The state has also experienced an increase in labor market demand through health care and social assistance job growth which increased 7.1 percent while the rest of the private labor force grew 5 percent (Bailey, 2016; Pugel, 2018).

The state is also leveraging additional dollars from the federal government. This fiscal year Kentucky will spend over $11 billion on health care through Medicaid (Pugel, 2018). The federal government will be paying $8.6 billion of this budget, leaving the state responsible for $1.9 billion General Fund monies. Therefore, the state leverages four federal dollars for every dollar it invests in the expansion. Despite this, the program is expected to be $296 million short by 2020. For that reason, this alternative grades as – Moderately Satisfies Criterion.

Population Health Benefit

According to Milken Institute School of Public Health, the implementation of KY HEALTH would have led to an estimated loss of coverage for 175,000 to 300,000 Medicaid beneficiaries in the first year of implementation alone (Hundreds of Thousands of Kentucky Residents Could Lose Medicaid under the Work Demonstration Project Approved by the Trump Administration, n.d.), adversely impacting the quality of life and health outcomes of Kentucky residents. The court ruling invalidating the demonstration waiver blocks the many provisions in the waiver associated with this loss in access to care.

Although numerous studies have identified significant increases in access to care, outpatient utilization, preventive care, and improved health care quality, there is a lack of research detailing the physical health outcomes of the Kentucky Medicaid expansion population. Findings from the Oregon Health Insurance Experiment failed to show improvements in major health outcomes. Measures of blood pressure, cholesterol, blood sugar, blood pressure and cholesterol all showed no significant signs of improvement for the population covered by Medicaid (James, 2015) Therefore, this alternative grades as – Moderately Satisfies Criterion

Equity in Health

Blocking the implementation of KY HEALTH minimizes avoidable disparities in health and its determinants. The *Assemble Evidence* section of this capstone reports that other states have implemented the key provisions of the demonstration waiver. Previous studies have shown that each provision has resulted in avoidable negative outcomes for its targeted population. For this reason, this alternative grades as –Satisfies Criterion.

- *Alternative 2: Appeal Court Ruling*

Description

This involves an appeal of the court ruling to the federal Court of Appeals for the District of Columbia Circuit by CMS and the State of Kentucky.

Cost Effectiveness

This alternative, if the appeal is successful, will incur major costs due to administrative expenses. The provisions of the waiver could cost nearly $186 million in the first six months alone (Wagner & Soloman, 2018). This demonstration requires thorough tracking of beneficiaries' work requirements, monthly premium payments, incentive account rewards, and other components of the waiver. If Kentucky is allowed to proceed with the work requirement it is likely that many beneficiaries will fail to meet the requirements and lose their Medicaid coverage as seen in the first phase of the Arkansas Medicaid work requirement roll out. Also, there is cost associated with appealing the court ruling that need to be taken into consideration. Therefore, this alternative grades as – Does Not Satisfy Criterion.

Population Health Benefit

There is a lack of evidence that threats of future punishment, incentives, and work requirements are effective in motivating people to change their behaviors. In addition, the

Milken Institute School of Public Health identifies a gross underestimate of the number of people who would be adversely affected by Medicaid work requirements. The provisions of the demonstration waiver put thousands of Medicaid beneficiaries at risk of losing health insurance. For this reason, this alternative grades as - Does Not Satisfy Criterion.

Equity in Health

In terms of equity in health, this alternative is very weak. Key provisions of the demonstration waiver have been proven to be barriers to accessing health care. Utilization of health care services can help individuals to improve their health status; which in turn impacts individual's social participation within their current environments. Social participation involves education, employment, and involvement in leisure and social activities. The demonstration waiver is perpetuating the inequities in health by withholding the distribution of health resources to able bodied low income individuals. For these reasons this alternative grades as - Does Not Satisfy Criterion.

Alternative 3: The Private Option

Description

The policy option involves using Medicaid funds to purchase private insurance to cover low-income people (Sommers, Maylone, Blendon, Orav & Epstein,2017).

Cost Effectiveness

Although Arkansas has been able to significantly lower the state uninsured rate and reduce uncompensated care costs for hospitals and clinics through the private option, studies indicate mixed results on the cost effectiveness of this alternative (Beeuwkes Buntin, Graves & Viverette, 2017; Guyer, Shine, Musumeci, & Rudowitz, 2016; Office, 2018; "Arkansas Health

Reform Legislative Task Force Final Report", 2016). For this reason, this alternative grades as - Minimally Satisfies Criterion.

Population Health Benefit

Previous studies of Arkansas's private option indicate improved access to primary care, significant gains in chronic disease management, reduced reliance on the emergency department, and improved perceptions of quality and health among low-income adults in the state. Again, there is a lack of data showing improvements in major health outcomes as a result of these significant gains in access to health care services. Therefore, this alternative grades as – Moderately Satisfies Criterion.

Equity in Health

Previous studies have documented disparities in health care delivered to patients who are uninsured, are underinsured, or have Medicaid. By providing private insurance to cover low-income individuals the private option improves access to high quality providers and hospitals because uninsured and Medicaid patients tend to use different hospitals than privately insured and Medicare patients do. Therefore, this alternative grades as – Satisfies Criterion.

- *Alternative 4: End Medicaid Expansion*

Description

This alternative involves ending Medicaid expansion and reverting to traditional Medicaid eligibility requirements.

Cost Effectiveness

By not expanding care to all low income individuals with incomes at or below 138 percent of poverty, this alternative eliminates an opportunity to provide preventive medicine and early interventions. Ending Medicaid expansion will likely lead to a financial strain on providers

and government programs because individuals who previously gained insurance coverage through the expansion will now become uninsured with many individuals falling into a coverage gap and likely remaining uninsured. Although the state would no longer incur the cost of covering the expansion population, there are cost associated with increasing the uninsured population. Kentucky will likely be increasing providers' uncompensated care costs and reducing federal funding. For these reasons this alternative grades as – Does Not Satisfy Criterion.

Population Health Benefit

This alternative does not produce an increase in quality of life and health outcomes because thousands of individuals who have health insurance through Medicaid expansion now will become uninsured. Therefore, this alternative grades as – Does Not Satisfy Criterion.

Equity in Health

This alternative fails to address disparities in health and its determinants. This alternative does not tackle the increased barriers that low income individuals face such as lack of access to health care services, lower quality health care, and poorer health outcomes. Therefore, this alternative grades as – Does Not Satisfy Criterion.

Table 4

Qualitative Outcomes Matrix

		ALTERNATIVES			
		Alternative 1: **Status Quo**	***Alternative 2:*** **Appeal Court Ruling**	***Alternative 3:*** **The Private Option**	***Alternative 4:*** **End Medicaid Expansion**
CRITERIA	***Criterion 1:*** **Cost Effectiveness**	Moderately Satisfy Criterion	Does Not Satisfy Criterion	Minimally Satisfy Criterion	Does Not Satisfy Criterion
	Criterion 2: **Population Health Benefit**	Moderately Satisfies Criterion	Does Not Satisfy Criterion	Moderately Satisfies Criterion	Does Not Satisfy Criterion
	Criterion 3: **Health in Equity**	Satisfy Criterion	Does Not Satisfy Criterion	Satisfy Criterion	Does Not Satisfy Criterion

Table 4.1

Comprehensive Quantitative Outcomes Matrix

		ALTERNATIVES			
		Alternative 1: **Status Quo**	***Alternative 2:*** **Appeal Court Ruling**	***Alternative 3:*** **The Private Option**	***Alternative 4:*** **End Medicaid Expansion**
CRITERIA	***Criterion 1:*** **Cost Effectiveness (.40)**	3 x .4= 1.2	1 x .4= .4	2 x .4= .8	1 x .4= .4
	Criterion 2: **Population Health Benefit (.35)**	3 x .35= 1.05	1 x .35= .35	3 x .35= 1.05	1 x .35= .35
	Criterion 3: **Equity in Health(.25)**	4 x .25= 1	1 x .25= .25	4 x .25= 1	1 x .25= .25
	TOTAL SCORE:	**3.25**	**1**	**2.85**	**1**

IX. Recommendation and Conclusion:

The purpose of this capstone was to analyze the potential impact of the KY Health waiver. I assessed the nature and extent of the problem and constructed alternatives for solving the problem. I also developed evaluative criteria to determine which alternative represents the

best policy option. In this final section I discuss the results of my CAM analysis and provide a policy recommendation.

CAM Analysis Results

In this capstone, I conducted a CAM analysis to analyze four policy alternatives to determine which policy option is “best” to solve the potential problem of Kentucky Medicaid beneficiaries losing heath care coverage. These four alternatives are based on previous recommendations to mitigate this issue. To determine, the “best” policy option I compared the performance of each policy alternative in satisfying three weighted measurement criterion. Previously, I explained the importance of each criterion and their respective weights.

The results from my analysis indicate that Alternative 2: Appeal Court Ruling and Alternative 4: End Medicaid Expansion both failed to satisfy across all criterions. Alternative 3: The Private Option minimally satisfied Criterion 1: Cost Effectiveness weakening this alternative as a viable policy option. Alternative1: Status Quo emerges as the “best” policy option, scoring highest amongst all alternatives.

A limitation of the CAM analysis is its subjectivity. The results are influenced by the perceptions of the individual conducting the analysis. The weights applied to each criterion could change depending on the audience and result in different rankings of the alternatives. For that reason, it is important for future researchers to explore different weights for the criteria.

Recommendation:

Based upon the results of my research, I recommend that the state continue with Medicaid expansion. Medicaid expansion has proven successful in the state and has made progress towards helping individuals improve their health and well-being. This has been accomplished though the state expanding Medicaid coverage to individuals and families with

income up to 138 percent of the FPL. According to the Center on Budget and Policy Priorities Kentucky's Medicaid expansion has resulted in the largest coverage gains of any state, improved health of low-income Kentuckians, improved access to care and financial security of beneficiaries, and lastly state budget savings (Cross-Call, 2018).

A major benefit of Medicaid expansion is that the federal government covers no less than 90% of the cost of new Medicaid enrollees (Hall, 2018). Several evaluations have shown a reduction in state spending as a result of the expansion (Hall, 2018). As well as reductions in uncompensated care cost for hospitals and clinics, an increase in labor market demand, and growth in the Kentucky economy as a whole (Antonisse, Garfield, Rudowitz, Artiga, 2018; Bailey, 2016; Pugel, 2018).

Evidence suggests that key provisions in the KY HEALTH waiver will negatively affect Medicaid beneficiaries, and ultimately lead to a loss in coverage for many. According to Milken Institute School of Public Health, the implementation of KY HEALTH would have led to an estimated loss of coverage for 175,000 to 300,000 Medicaid beneficiaries in the first year of implementation alone ("Hundreds of Thousands of Kentucky Residents Could Lose Medicaid under the Work Demonstration Project Approved by the Trump Administration", n.d.) Previous research has shown that premiums serve as a barrier to obtaining and maintaining Medicaid coverage among low income individuals (Artiga, Ubri & Zur, 2017).

It has also been demonstrated that removal of Medicaid adult dental benefits may result in costly ED visits that do not provide definitive dental care. Lastly, research findings suggest that lack of transportation leads to rescheduled or missed medical appointments, delayed care, and missed or delayed medication use (Syed, Gerber & Sharp, 2014). These provisions do not

help individuals improve health and well-being, they instead pose barriers that will likely lead too many Medicaid beneficiaries losing coverage.

Conclusion

In this capstone I explored the potential impact of the KY HEALTH waiver. Evidence suggests the demonstration will result in a significant loss of health care coverage, negatively affecting low income Kentuckians that have benefited from the state Medicaid expansion. I constructed alternatives to mitigate the problem and conducted a CAM analysis to determine which policy alternative is "best". The results of the analysis indicate the status quo, continuing with state Medicaid expansion, as the best policy option. Again, the results of this analysis are subjective and I encourage future researchers to explore different weights for the criterion.

In conclusion, this projects purpose is to inform, educate and empower state government officials, stake holders and public health officials about the potential health impacts of this waiver and similar proposals. Medicaid is the nation's largest insurance program, for that reason efforts should be put towards strengthening instead of restricting Medicaid health coverage. I further recommend the collaboration between Medicaid and public health system as a means to mitigate the cost of health care and to achieve mutual prevention goals.

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Biographical Sketch

This capstone was completed by Keahna Akins. In December 2018, she will graduate with a Master of Public Health degree, with a concentration in Population Health Policy and Management. She has earned a Bachelor of Arts in Political Science from the University of Kentucky. She is pursuing a career in which she can make a social impact. Currently she works for a private not-for-profit organization and participates in the delivery of addiction treatment services to patients and their families.