MILLIMAN REPORT

Medicaid Reimbursement Options to Address Social Risks and Health Related Social Needs

Kentucky Department for Medicaid Services

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Table of Contents

EXECUTIVE SUMMARY

This legislative report fulfills the requirements outlined in Section 1 of SJR 54, mandating that the Kentucky Department for Medicaid Services (DMS) assess various aspects related to Medicaid payment models, federal regulations, and the Area Deprivation Index (ADI). While the report does not endorse specific plan elements, it offers a range of research-based options that may meet SJR 54's objectives, as well as more broadly discussing programmatic and payment options that many states are using within their Medicaid programs to address unmet social needs and healthcare disparities. The options presented vary in terms of how directly (or if at all) they may increase reimbursement to Medicaid providers, as well as the degree of difficulty for DMS to implement (i.e., whether they are permissible under the current program or would require new federal authority). The options also vary in terms of the potential impact on different levels of social need – be it community-based needs ("social determinants of health" or SDOH) or individual risks ("health related social needs" or HRSN) or the addition of specific new covered benefits to address a member's risks. Clarification of the specific goals and outcomes desired, as well as considering the administrative lift and timing desired for implementation, will be useful to assist Kentucky policymakers in selecting from among the wide range of options.

Within the context of federal Medicaid regulations and CMS guidelines, numerous options exist to leverage Kentucky's Medicaid managed care organization (MCO) contracts or make fee schedule or covered benefit changes which may serve the goals of SJR 54. While ADI is a commonly used tool to guide reimbursement variances across different geographies in a way that targets areas of higher social risk, ADI also has documented limitations, including its data lag and lack of insight into the social determinants of health domains that are driving neighborhood disadvantage rankings. Custom models that incorporate more recent data and are calibrated to Kentucky's Medicaid population may be useful alternatives to designing more strategically tailored payment or benefits solutions in support of those Kentuckians most in need.

Nonetheless, analysis of Kentucky's regional ADI scores confirms that the Commonwealth's geographic areas with high (worse) ADI scores also tend to experience underutilization of certain Medicaid benefits such as primary care and preventive dental services. Given this correlation, increasing reimbursement to particular Medicaid provider types in High-ADI areas may be one useful strategy to increase access and utilization of preventive care. At the same time, if lack of provider access is not the primary reason for the low utilization of services, or if other compounding SDOH factors may be contributing to an area's poorer health outcomes in the Medicaid population, then Kentucky may wish to consider aligning multiple Medicaid payment and program strategies to address both individual HRSN and community conditions impacting SDOH, as a way to create even greater support for disadvantaged communities across the Commonwealth.

INTRODUCTION

The Kentucky General Assembly passed Senate Joint Resolution 54 during its 2023 Regular Session, which instructs the Department for Medicaid Services (DMS) "to develop a proposal to link Medicaid reimbursements to the Area Deprivation Index (ADI) scores" and submit findings and the proposal to the Legislative Research Commission by November 1, 2023.[1] The bill requests that several areas be explored:

1. **National Landscape.** Study what other states have done to account for social risks and health-related social needs (HRSN) in Medicaid payment models.

   The legislation specifically mentions four states, Hawaii, Massachusetts, Maine, and Washington, that have taken steps to address HRSNs using various payments models. This report explores the details of payment models in use by each of these states, as well as several other relevant state examples (see Appendix A).

2. **Review of Federal Guidance and Regulations.** Review federal regulations related to Medicaid reimbursements and ability for states to address HRSN.

3. **ADI Analysis.** Assess appropriateness of the ADI as a valid measure of social risks and HRSNs in Kentucky.

   The legislation notes that the ADI can be used to inform "risk-adjustment strategies, financial incentives, payment reform, infrastructure targeting, benefit decisions, and program eligibility." Options within each of these categories are explored in this report.

4. **Options for Consideration.** Develop a proposal to modify Kentucky's Medicaid reimbursement model to better account for social risk and HRSNs at a community level by modifying reimbursement rates for providers based on the ADI score of where the provider practices.

This report has been organized according to the four areas of study directed by SJR 54, as noted above.

Kentucky DMS requested Milliman to provide an actuarial analysis of the ADI, review federal regulations surrounding Medicaid payment models, and research approaches other states have taken to utilize alternative payment methods to effectively address social risk and health-related social needs. This report provides support to DMS as it considers options to amend and update its Medicaid payment models to increase access to care and achieve the goals of the program.

While SJR 54 describes the basic framework for the research requested to propose a modification to Kentucky's current Medicaid reimbursement model, many elements of HRSN-related Medicaid payment models that the Commonwealth could choose to mirror were not specified in the language of the resolution. As a result, Milliman and Kentucky DMS met several times to establish a framework and identify several options to present to the legislature for consideration that the Commonwealth could pursue in order achieve the goals of addressing social risk and health-related social needs utilizing a tool such as the Area Deprivation Index.

BACKGROUND

While reviewing this report, it is important to understand the delivery system used to provide services to Medicaid members in Kentucky to better understand the options available to the state to address HRSN via payment and reimbursement methodologies. As of September 2023, over 1.6 million individuals in Kentucky are enrolled in Medicaid, with approximately 90% of individuals receiving services through a managed care organization (MCO).[2] Kentucky currently contracts with six MCOs operating under comprehensive, risk-based arrangements to provide services to Medicaid members under a 1915(b) waiver authority.[3] This means that DMS pays the MCO a predetermined amount per member, per month to cover all services under that contract. There are some limited exceptions for member types that are not included in this payment model, namely that persons needing long-term

[1] KYSJR54. (March 22, 2023). https://apps.legislature.ky.gov/law/acts/23RS/documents/0046.pdf

[2] Kentucky Department for Medicaid Services. Monthly Membership Counts by County. (September 4, 2023.). https://www.chfs.ky.gov/agencies/dms/stats/MCO%20Member%20Counts%20by%20County-%20Sept.%202023.pdf

[3] Kentucky Managed Care Program Features. (2021). https://www.medicaid.gov/sites/default/files/2023-07/ky-2021-mmcdcs.pdf

services and supports (LTSS), which includes nursing facility and home and community-based services (HCBS), are excluded from risk-based managed care in Kentucky.[4] Because of this delivery system structure, the vast majority of provider payments under Kentucky Medicaid are made to providers by the contracted MCOs.

Under traditional fee-for-service models, state Medicaid agencies can work directly to increase provider reimbursement (i.e., increase base state plan fee schedule rates) or implement supplemental payment or value-based payment models that may address state program goals such as HRSN. However, federal regulations prohibit state Medicaid agencies from directly paying managed care network providers for services covered under the contract between the state and the MCO.[5] Due to this restriction, there are a limited number of ways in which state Medicaid agencies can use reimbursement methods to incentivize managed care network providers. Therefore, since the majority of Kentucky's Medicaid population is served within a managed care delivery system, DMS will likely need to utilize its MCO contracts to design a reimbursement model that effectively addresses social risks and HRSN of Medicaid members. More information regarding these rules is provided below in the Review of Federal Guidance and Regulations section.

[4] See Section 26.11 of the managed care contract (https://www.chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx) for a full list of persons ineligible for managed care enrollment.

[5] 42 CFR § 438.60. The only permitted exception to this rule is for disproportionate share hospital (DSH) and graduate medical education (GME) payments.

NATIONAL LANDSCAPE

HRSN AND SOCIAL DETERMINANTS OF HEALTH (SDOH) CONCEPTS

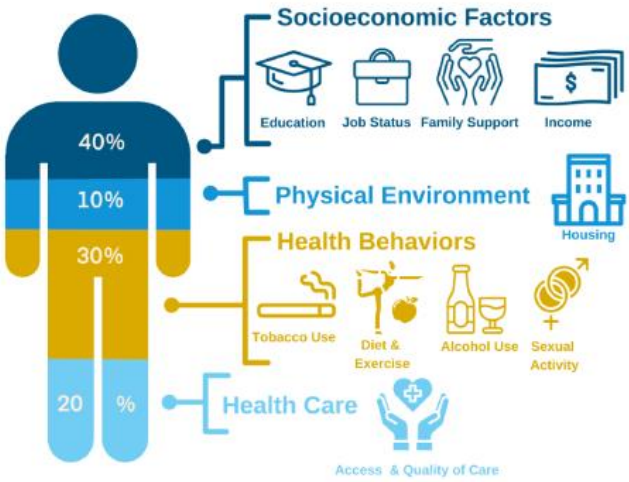
To understand how policymakers across the country are seeking to address social risks and HRSN using methods like the ADI, it is first important to understand the distinction and relationship between terms.

- **Health related social needs (HRSN)**: HRSN are best described as social and economic needs that individuals experience that affect their ability to maintain their health and well-being. This may include things like housing stability and quality, food security, employment, personal safety, transportation access, affordable utilities, etc.[6]
- **Health disparities**: Health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities.[7]
- **Health equity:** HRSN and health disparities should be addressed with a health equity lens which means when every person has the opportunity to "attain her, his, or their full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[8]
- **Social determinants of health (SDOH):** "Disparities in HRSN can be understood as a result of Social Determinants of health (SDOH)" which are defined as the conditions in which people are born, grow, work, live, and age that are impacted by various factors that affect health.[9] Access and quality of health care services only represents a small proportion of SDOH, as shown in Figure 1.[10]

The policy levers likely to address a particular SDOH or HRSN challenge may vary based on the specific needs of the individual or community. For example, a new Medicaid nutrition benefit for fruit and vegetable prescriptions may be a useful solution to support an area with a low food security rate while enhanced physician payments under Medicaid may be a more effective solution for an area facing a primary care shortage.[11]

It should also be understood that each of these terms (HRSN, SDOH, etc.) do not exist in a vacuum; rather, they can lead to one another. Community conditions may exacerbate individual social and healthcare conditions; likewise increased services for individual conditions will not be effective if the community conditions remain insufficient. For this reason, many states are pairing strategies at multiple levels. For instance, a state may elect to pay for housing supports for Medicaid members whose lack of safe, affordable housing may be exacerbating their healthcare conditions and

FIGURE 1: SOCIAL DETERMINANTS OF HEALTH[10]



[6] Medicaid.gov. Health Related Social Needs. (n.d.). https://www.medicaid.gov/health-related-social-needs/index.html

[7] Centers for Disease Control and Prevention (CDC). Promoting Health Equity, A Resource to Help Communities Address Social Determinants of Health. (2008). https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf

[8] Centers for Disease Control and Prevention (CDC). Using a Health Equity Lens. (n.d.). https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html#:~:text=What%20is%20a%20health%20equity%20lens%3F%20It%20means,bias%20and%20stigmatization%2C%20and%20effectively%20reach%20intended%20audiences.

[9] Oregon Health Authority. Health-Related Social Needs vs. The Social Determinants of Health. (n.d.) https://www.oregon.gov/oha/HPA/dsi-pcpch/AdditionalResources/Health-related%20Social%20Needs%20vs%20the%20Social%20Determinants%20of%20Health.pdf

[10] UCLA Health. Social Determinants of Health. (n.d.). https://www.uclahealth.org/sustainability/our-commitment/social-determinants-health

[11] Center for Health Care Strategies, Inc. Building a Medicaid Strategy to Address Health-Related Social Needs. (April 2021). https://www.chcs.org/media/Tool-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921v3.pdf

potentially leading to preventable hospitalizations, while also making infrastructure investments to help Medicaid providers in disadvantaged communities to increase access to primary care, screenings, or chronic disease management services. Figure 2 provides a visual depiction of how policy and payment interventions at various levels – SDOH (community condition), HRSN (individual needs), and specific healthcare services (that may help improve disparate outcomes for an individual) – may be used to complement and support each other.[12]

FIGURE 2: ADDRESSING SOCIAL NEEDS AND SOCIAL DETERMINANTS OF HEALTH[12]

THEMES IN STATE EFFORTS TO ADDRESS SOCIAL RISKS AND HRSN

Particularly since the onset of the COVID-19 pandemic, many have recognized the wide disparities in health experienced by those with social inequalities and unmet HRSN.[13] As a result, the Centers for Disease Control and Prevention (CDC) has established SDOH as one of its three priority areas for Healthy People 2030[14], including a focus on healthcare access, education, economic stability, and neighborhood and built environment, among others. Likewise, the Centers for Medicare & Medicaid Services (CMS) has outlined its policy goals for how state Medicaid programs can be used to support SDOH and HRSN, given that SDOH has been shown to impact healthcare utilization and disparities, while also noting that Medicaid must remain the payor of last resort and cannot be used to

[12] Castrucci, B., Auerbach, J. Health Affairs. Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health. (January 16, 2019). https://www.healthaffairs.org/content/forefront/meeting-individual-social-needs-falls-short-addressing-social-determinants-health

[13] Abrams, E., Szefler, St. COVID-19 and the Impacts of Social Determinants of Health. (May 18, 2020). https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30234-4/fulltext

[14] Office of Disease Prevention and Health Promotion (ODPHP). Healthy People 2030. (Octobe 11, 2023). https://health.gov/healthypeople

supplant other available funding sources for items like housing, nutrition, employment, education, and transportation.[15] In the context of these national efforts to raise awareness and promote solutions to address unmet social risks, many states have implemented initiatives to address social risk and HRSN.

Emerging evidence underscores the impact of HRSN on the well-being of Medicaid and Children's Health Insurance Program (CHIP) members, and thus, many states have turned to their Medicaid programs to establish both payment methodologies and innovative program design features to address this need.[16] HRSN challenges are also understood to disproportionately impact diverse populations including individuals with disabilities, pregnant and postpartum women, individuals with mental and substance use disorders, rural residents, people experiencing homelessness, and more.[17] This knowledge has caused many states to pursue SDOH and HRSN-related initiatives with common goals including addressing health disparities, improving health outcomes, reducing health care spending, advancing health equity, and increasing access to care.[18] However, states should monitor the specific impacts of particular programs over time, because experience may vary from the intended goals. Also, as noted above, different program or payment strategies may be more appropriate to meet certain policy goals than others.

HRSN-Related State Payment Initiatives

In the current landscape, state payment strategies to address HRSN can generally be divided into two categories: (1) payments made to Medicaid MCOs; and (2) reimbursement directly to Medicaid-enrolled providers. The first model of "payment to MCOs" is used to adjust premium payments to MCOs (premium payments in Medicaid managed care are referred to as "capitation payments"). Under risk-based managed care, states are permitted to adjust capitation payments to contracted MCOs based on variation in health status or relative risk among the MCOs through a process called "risk adjustment".[19] As described in Figure 3, several states have incorporated social risk factors into the risk adjustment payment model. It should be noted that this payment adjustment is applied at the overall cost of care level for the Medicaid member (potentially due to increased use of services or other increased risk factors) and may not result in increased reimbursement to any particular provider who delivers services to that member. In addition, risk adjustment is generally required to be budget neutral to the managed care program in aggregate. Therefore, to the extent MCOs receive higher risk adjusted capitation payments for members with greater social risk factors, MCOs will conversely receive lower risk adjusted capitation payments for members with lower social risk factors (all else equal).

In contrast, the "reimbursement to providers" model is used to adjust provider reimbursement more directly. Under this approach, enhanced reimbursement is made to the specific provider or entities providing services to Medicaid members. These reimbursement models can vary significantly depending on what services are being incentivized. For example, this may include enhanced rates for providers located in a specific geographic area, bonus payments for achieving quality goals related to HRSN-related metrics, or even risk adjustment for providers that participate in more advanced value-based care payment (VBP) models, such as accountable care organizations (ACOs) where providers take overall responsibility for a member's care and outcomes.

[15] Centers for Medicare and Medicaid Services (CMS). SHO#21-001. (January 7, 2021). https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf

[16] Medicaid and CHIP Payment Access Commission (MACPAC). Financing Strategies to Address the Social Determinants of Health in Medicaid. (May 2022). https://www.macpac.gov/wp-content/uploads/2022/05/SDOH-Issue-Brief_May-2022.pdf

[17] Centers for Medicare and Medicaid Services. CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based strategies. (January 7, 2021). https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs#:~:text=Growing%20evidence%20indicates%20that%20these%20challenges%20can%20lead,use%20disorders%2C%20and%20individuals%20living%20in%20rural%20communities.

[18] Center for Health Care Strategies, Inc. Building a Medicaid Strategy to Address Health-Related Social Needs. (April 2021). https://www.chcs.org/media/Tool-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921v3.pdf

[19] 42 C.F.R. § 438.5. Rate Development Standards. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5

FIGURE 3: STATE EXAMPLES OF REIMBURSEMENT-RELATED STRATEGIES TO ADDRESS HRSN

PAYMENT TO MCOS	MECHANISM	PROVIDER REIMBURSEMENT	MECHANISM
MassHealth payments to MCOs	Adjusts capitation payments to MCOs incorporating social risk levels	MassHealth payments to ACOs	Adjusts capitation rates across 3 ACO models based on adjusted total cost of care target accounting for social risk
Arizona Health Care Cost Containment (AHCCCS) Complete Care payments to MCOs	Adjusts capitation payments to MCOs incorporating social risk levels and area risk levels	Minnesota Integrated Health Partnership quarterly population-based payments (PBPs)	PBPs account for social risk level to determine share of profits and loss
Washington Medicaid agency payments to MCOs	Adjusts capitation payments to MCOs for homeless members	New York Health Homes Serving Adults	Adjusts provider reimbursement for high-risk members
Hawaii Medicaid agency payments to MCOs	Adjusts capitation payments to MCOs for homeless members	MaineCare permanent supportive housing Community Care Teams	Permanent housing support provided in addition to PMPM payments varying across risk levels

See Appendix A for additional information on each of the state programs described above.

Other HRSN-Related State Program Initiatives

Another prevalent theme in state efforts to address HRSN through Medicaid is through mechanisms such as benefits strategies and MCO contract strategies. Examples may include offering additional Medicaid benefits that are intended to directly support HRSN (sometimes limited to members who meet certain criteria or have certain needs). For instance, a Medicaid program may choose to provide housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, or case management. Other examples leverage MCO contract terms to require the MCOs to provide additional supports for individuals with unmet social needs that may impact health, such as a requirement that the MCO offer enhanced care management services to connect members with non-Medicaid services like food banks, housing services. Other options through MCO contracts may be to impose specific quality improvement initiatives where the MCOs must take action to improve outcomes for targeted populations with unmet social needs.

How Kentucky could consider each of these strategies is further explored later in this report as we describe the regulatory options for states to address HRSN.

REVIEW OF FEDERAL GUIDANCE AND REGULATIONS

FEDERAL REGULATIONS RELATED TO MEDICAID REIMBURSEMENT

State Medicaid agencies are responsible for setting provider reimbursement rates for services under their Medicaid state plan. These fee schedules, the parameters of which must be documented in the Medicaid state plan, are the basis for reimbursing providers who deliver services to Medicaid members in the fee-for-service (non-managed care) portion of the Medicaid program. Federal regulations require that state payments to providers meet standards of economy, efficiency, and sufficiency to ensure access to care for members, but Medicaid agencies have great latitude to adjust state plan rates over time through state plan amendments.[20]

When developing provider fee schedules, state Medicaid agencies start by establishing a base rate that applies for all providers who are eligible to provide that service. Once the base rate has been established, states can make a number of adjustments to the base payment based on factors such as, but not limited to,[21] provider type, site of service, or geography. For example, some states have adjusted provider rates geographically to account for rural areas, such as Alabama that pays certain specialists (OB/GYN, Family Practice, General Practice, and Pediatric providers) an enhanced rate in rural counties and Utah which pays all physicians providing services in rural areas of the state at a rate of 112% of the standard fee schedule.[22] Similarly, **Kentucky could consider establishing reimbursement adjustments to recognize geographic differences accounting for High-ADI areas**.

There are several additional payment methodology options that are permissible under federal regulations that can be utilized to achieve the state's HRSN goals. For example, states can create provider incentives through their reimbursement models and federal managed care regulations allow flexibility for states to create additional incentives for addressing social risk and HRSN. More information about federal regulations and permitted flexibilities related to Medicaid reimbursement are outlined below.

DELIVERY SYSTEM CONSIDERATIONS

The state plan fee schedule is used to pay providers in the FFS delivery system. Conversely, under a managed care delivery system, the state contracts with managed care organizations (MCOs) to provide Medicaid services to members and pays the MCO a capitated payment for each enrolled member (usually on a per member per month basis). It is then the responsibility of the MCO to pay its network providers for any service rendered to a member as outlined in the MCO contract.

As stated previously, state Medicaid agencies have great latitude to update the rates paid to providers with a state plan amendment; however, updating the Medicaid state plan rates only impacts providers delivering services to FFS members directly. According to federal regulations, state Medicaid agencies may not directly pay managed care network providers for services covered under the MCO contract. In addition, states are also prohibited from directing the MCOs to make specific expenditures (e.g., pay providers a certain way) under a managed care contract unless specific conditions and requirements are met.

While adjusting state plan fee schedules rates may only impact fee-for-service providers directly, managed care organizations often base network provider contract rates on approved state plan rates which may lead to managed care network provider rates being amended based on state plan fee schedule changes. Some states prefer this flexibility because it allows the MCOs to pay providers in low-access areas a higher rate than the state could pay under FFS, resulting in improved access for those areas. At the same time, **states should not rely on the assumption that MCOs will update network provider contract rates when state plan rates are revised, as MCOs are not required to pay state plan rates unless explicitly required by the state**.

Due to the limitations Medicaid agencies face under managed care delivery systems to directly impact managed care network provider reimbursement, states like Kentucky that operate Medicaid programs under a majority managed

[20] Social Security Act Section 1902(a)(30). https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[21] Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Physician Fee-for-Service Payment Policy. (February 2017). https://www.macpac.gov/wp-content/uploads/2017/02/Medicaid-Physician-Fee-for-Service-Payment-Policy.pdf

[22] Medicaid and CHIP Payment and Access Commission (MACPAC). State Medicaid Fee-for-Service Physician Payment Policies. (February 2017). https://www.macpac.gov/publication/states-medicaid-fee-for-service-physician-payment-policies/

care system must work within the rules for permitted MCO contract structures to implement system reforms aimed at addressing social determinants of health and HRSN. The remainder of this section will address potential payment and provider reimbursement opportunities that state Medicaid programs can use to address social risks and HRSN within the managed care delivery system.

MANAGED CARE REIMBURSEMENT OPPORTUNITIES

Addressing HRSN through MCO Capitation Rates

In Medicaid managed care delivery systems, state Medicaid agencies pay MCOs a monthly, set amount for each covered member, called a capitation payment.[23] Capitation payments are paid to the MCO on a per member per month basis, based on the specific members enrolled in the plan for that time period by rate cell (rate cells generally reflect the age and/or gender, geographic location, and Medicaid population of the member – as structured currently in the Kentucky Medicaid managed care program). To establish capitation payments, states develop "actuarially sound" rates by rate cell, accounting for the estimated cost of providing all covered benefits for the covered population.[24] Capitation rates for individual rate cells must reflect the specific estimated cost of benefits for members in the given rate cell and cannot result in any cross-subsidization of payments from one rate cell to another.

Base experience considerations. For established managed care programs, Medicaid capitation rates are developed from historical experience for the Medicaid program. As stated above, capitation rates should account for all covered benefits and the covered population. To the extent a state has identified historical underutilization of services in a particular region, it may be appropriate for the actuary developing the capitation rates to increase funding in the capitation rates to reflect such inequities being addressed in the future rating period.[25] However, to ensure that the additional funding results in an appropriate level of service, a state should consider the appropriate contract requirements to ensure MCOs achieve the target level of utilization rather than the increased funds flowing into MCO's financial margins.

Regional capitation rates or variation based on member demographics. As mentioned above, federal regulations for developing actuarially sound rates allow for the creation of rate cells, or subgroups of the enrolled population who have similar characteristics. States may choose to implement regional capitation rates that factor in social determinants of health. Note, Kentucky's current managed care rate cell structure uses two broad regions.

For example, the state may decide to use ADI data to create a geographic rate cell for areas with High-ADI. Based on available data, capitation rates may be set at a higher amount for these High-ADI areas to account for needs of the population (to the extent unmet needs were clearly identified in the base experience as discussed above). States can also choose to set capitation rates based on the experience of a particular sub-population. For example, some states set different capitation rates for individuals who are documented as experiencing homelessness. When developing a rate cell structure, the state Medicaid agency should also consider administrative and operational issues with implementing and maintaining a rate cell structure. For example, using ADI scores to assign members to a specific rating "region" may result in members located within the same county being assigned to different rating regions which likely would be administratively burdensome. Therefore, to the extent such an ADI-rating region approach was considered, ADI would likely need to be calculated at the county or a larger geographic area level, such as Kentucky's area development districts, with geographies having similar ADI scores grouped together.[26]

Risk adjustment. Risk adjustment has historically focused primarily on member medical history,[27] but opportunities exist for states to consider member's HRSNs in the selected risk adjustment methodology. Traditionally, risk adjustment has been based on the identification of clinical risk factors through evidence of certain diagnoses or

[23] Medicaid and CHIP Payment Access Commission (MACPAC). Medicaid Managed Care Capitation Rate Setting. (March 2022). https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf

[24] Center for Health Care Strategies (CHCS). Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports. (August 22, 2016). http://www.chcs.org/media/CHCS-Look-Before-You-Leap-08-22-16.pdf

[25] Medicaid and CHIP Payment Access Commission (MACPAC). Medicaid's Role in Advancing Health Equity. (June 2022). https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-6-Medicaids-Role-in-Advancing-Health-Equity.pdf, page 148.

[26] Kentucky Council of Area Developmental Districts. (n.d.). https://www.kcadd.org/

[27] State Health & Value Strategies. Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps. (August 2020). https://www.shvs.org/wp-content/uploads/2020/08/FINAL_SHVS-Risk-Adjustment-Brief.pdf

prescription drug history but has not taken socioeconomic factors into account. However, as interest in the impact of social risk on health has grown, some states have sought to incorporate various factors related to income, housing, and other key social characteristics that may impact a member's health outcomes into the risk adjustment process. To identify whether members have select social risk factors, states have looked to enrollment, administrative or claims data, or survey findings.[28] Typical social risk factors identified by states through these means have included homelessness, incarceration, substance use disorder (SUD) or serious mental illness (SMI) diagnosis, and rural area.[29]

Under one such approach, Kentucky could choose to use a social risk factor measure, such as the ADI of an individual's area of residence as a consideration in risk adjustment. Utilizing social risk factors in the risk adjustment process may be simpler than other approaches as it would be integrated into a process that is already occurring. Current Medicaid regulations permit states to pursue these approaches, and as such, Kentucky would not need to implement a new authority or program to pursue this approach.

However, it is also important to note that social risk adjustment does not result in any additional funding being offered to specific providers or the managed care program as a whole (because of the previously discussed budget neutrality requirements for risk adjustment). Changes to risk adjustment would only affect the relative capitation payments provided to MCOs. Further, to the extent that each contracted MCO enrolls members with similar social risk, it is unlikely that the relative risk adjustment scores and capitation payments would materially change for each MCO. In addition, this approach may not achieve Kentucky's goals of increasing individual provider reimbursement rates, as again, risk adjustment does not by itself result in additional funding for the managed care program. However, states could implement risk adjustment along with increased contractual requirements. Kentucky could also evaluate the various managed care payment tools and consider complementary contract requirements such that a MCO that receives an increase in incremental funding from a risk adjustment approach would also be required to use such funds to offer additional supports and resources to members with higher social needs.

Addressing HRSN through State Directed Payments

As previously stated, federal regulations prohibit state Medicaid agencies from directly paying managed care network providers for services covered under the contract between the state and the MCO, as well as prohibiting the state from directing the MCO's expenditures under a managed care contract unless specific conditions and requirements are met. Under 42 Code of Federal Regulations (CFR) 438.6(c), states may request CMS approval for a "directed payment" arrangement that would permit the state to direct reimbursement to MCO network providers under certain circumstances. CMS regulations permit state directed payments of the following types:

- **Minimum or maximum fee schedules:** a type of directed payment that sets parameters for the base payment rates that MCOs pay for specified services.
- **Uniform rate increases:** a type of directed payment that requires MCOs to pay a uniform dollar or uniform percentage increase in payments above negotiated base reimbursement rates.
- **Value-based payment (VBP) arrangements:** a type of directed payment that requires MCOs to implement VBP models or participate in broader delivery system reform initiatives.[30]

To receive CMS approval, a state directed payment must be expected to advance the state Medicaid agency's quality goals and priorities for its programs through one of the arrangements listed above. Figure 4 shows a hypothetical scenario for how a state could establish a directed payment arrangement intended to address members' HRSN.

[28] Ibid.

[29] Ibid.

[30] Medicaid and CHIP Payment and Access Commission (MACPAC). Directed Payments in Medicaid Managed Care. (June 2023). https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf

FIGURE 4: HYPOTHETICAL STATE DIRECTED PAYMENT SCENARIO TO SUPPORT HRSN

One example of a potential state directed payment design:

- The state could identify and define the providers to receive payment under the program as a generic class of all providers practicing in underserved areas, or as a subset of providers in those area (e.g., physicians or certain specialties of physicians).
- The directed payment arrangement could be targeted to increase reimbursement to providers located in the regions defined as underserved (e.g., High-ADI areas).
- The stated goal of the directed payment would need to be tied to the state's managed care quality strategy and have an evaluation plan to measure the payment arrangement against the quality strategy goals and objectives.[31] For example, specific HEDIS measures might be tracked to assess the impact of the directed payment on care delivered in the defined underserved areas.
- A preprint (application form) describing the payment arrangement must be approved by CMS prior to implementation and reviewed annually.
- The state directed payment must be documented in MCO contracts and the actuarial capitation rate certification.

CMS has established an administrative process for submitting and receiving approval for a state directed payment. The only type of state directed payment that does not require prior written approval from CMS is a directed payment that requires an MCO to adopt a minimum fee schedule using state plan approved rates. Designing, drafting, submitting, and negotiating with CMS about a preprint requires time and state resources to complete. The state directed payment model may also require buy-in from various stakeholders (e.g., MCOs and providers) prior to implementation. As stated above, MCO contracts may need to be amended which will require additional state time and resources to complete. In addition, revisions to MCO capitation rates will require additional work from vendors that are contracted to provide actuarially sound rates. Further, these required capitation rate adjustments are not budget neutral, and additional funding may be required. As such, the preprint application requires states to identify and detail the source of the non-federal share (e.g., state general fund, provider assessment, intergovernmental transfer) used to finance the state directed payment.

Kentucky could implement a state directed payment to specifically address HRSN and directly affect provider reimbursement rates under managed care by targeting specific providers who are serving members in areas with high ADI. The state can define the payment criteria in a manner that provides funds to the provider types most likely to be working with high-need populations. For example, Kentucky recently added community health worker services to its state plan which provides preventive health services including health system navigation, health promotion and coaching, and health education and training. The state could complement this benefit addition by implementing a state directed payment that directs MCOs to increase reimbursement to qualified community health workers in High-ADI areas. While this option may be viable in terms of providing additional reimbursement directly to targeted providers, it does not necessarily increase quality of care or ensure covered services are addressing HRSN.

Additionally, **Kentucky should consider the potential for overlapping impact with its existing state directed payments in use today**. In setting the rules for which providers are eligible for the directed payment, states with multiple approved state directed payments must appropriately define the provider class for each arrangement to ensure any overlap between state directed payments allows for effective and delineated evaluation of the directed payment against state goals and priorities. For example, if there are several state directed payments associated with the same class of providers, it will be important for the state to be able to distinguish which payment arrangement advanced or impacted a quality measure compared to another payment arrangement.

Value Based Payment Arrangements and Quality Incentives Targeting HRSN

In an effort to improve service delivery outcomes, MCOs have begun to implement value-based payment (VBP) arrangements to reimburse network providers based upon quality rather than volume of services; states are more frequently requiring MCOs to implement VBP programs as well. VBP arrangements can be used to improve quality of care, reduce costs to the Medicaid program, and are an advanced mechanism through which states can address

[31] Centers for Medicare and Medicaid Services (CMS). SHO#21-001. (January 7, 2021). https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf

HRSNs. The following section outlines some VBP options states may choose to implement within a managed care delivery system.

Pay-for-Outcomes (P4O). States may implement quality incentive arrangements to provide MCOs with additional funds beyond capitation payments (e.g., a bonus payment) or deduct a portion of the MCO capitation payment (e.g., a payment withhold), payment of which is then tied to performance on quality measures or activities that relate to advanced primary care. MCO contract payments that include incentives may be as much as 105% of a plan's total approved capitation payments.[32] While there is no regulatory limit on incentives structured as a withhold amount, in practice these arrangements are also generally less than 5% of the plan's total capitation revenue.

To implement quality incentive arrangements, states generally select specific quality measures that MCOs must address and establish minimum desired performance standards for those measures. Quality measures selected by states may include basic primary care utilization measures such as well-child, well-care, or dental visits, or can include more specialized categories of measures like substance use or maternity care. Once measures are selected and targets are set, states require MCO performance reporting and pay out the incentive to MCOs who satisfactorily achieve the targets. States sometimes also establish contractual requirements for how incentive money can be used by the MCO, such as requiring the MCO to submit a plan for spending its incentive dollars; or mandating that the MCO must pay out a portion of any earned dollars to the providers who helped achieve the measures. In this way, states can create financial incentives for MCOs that can be shared with providers through aligned VBP initiatives between the MCO and the provider. For example, **Kentucky could set the expectation that quality incentive funding be used to support providers delivering care in underserved areas or High-ADI regions**. The MCO may be required to create a VBP arrangement with its network providers and design a program that aims to address HRSN in the underserved area. If quality targets are met by the provider and the MCO, the MCO is then required to share a portion of the quality incentive dollars provided by the state with the provider.

One advantage of this approach is that it does not require a waiver or preprint and can be implemented through the managed care contract. Additionally, states have significant authority to design their quality incentive arrangements and can select the measures and targets most useful for their state.

Provider Network VBP Goals. States may establish provider contracting goals that require MCOs to implement alternative payment models (APMs) with their network providers. Without triggering directed payment regulations, states can outline the general nature of the program requirements, but each MCO would have flexibility to design specific VBP payment arrangements with its network providers. This option offers less direct influence by the state Medicaid agency, but still can be tailored to meet a state's quality goals and can address HRSN. Under this type of VBP arrangement, the state could require that a certain percentage of MCO network provider contracts have reimbursement structures based on quality rather than quantity. These APMs may fall within a continuum ranging from arrangements with no provider financial risk (pay-for-performance) to substantial provider risk (shared savings or global capitation payments), and national best practices have been established to define the common provider payment models.[33] Using this type of arrangement, the state could specify goals for MCO APM targets for providers located in a High-ADI region. However, under this approach, the MCOs would then each design their own unique approach to meet these targets, such as by paying quality infrastructure-building dollars to providers located in a High-ADI region, or setting outcomes-based payment structures for providers in High-ADI regions who improve primary care utilization for their members. While this option may be simpler for DMS to implement, it may result in widely different approaches by MCO that could be confusing or administratively burdensome for providers who work with multiple plans.

VBP arrangements may enable Kentucky to customize a program based on specific HRSN considerations, but as described above, the MCOs would retain flexibility in how specific provider payments may or may not change. Depending upon the model selected, providers can be engaged in improving performance on meeting

[32] Medicaid and CHIP Payment Access Coalition. Financing Strategies to Address the Social Determinants of Health in Medicaid. (May 2022). https://www.macpac.gov/publication/financing-strategies-to-address-the-social-determinants-of-health-in-medicaid/

[33] Health Care Payment Learning & Action Network. Alternative Payment Model (APM) Framework. (July 11, 2017). http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

unmet social and healthcare needs, and as such, programs can be designed to assure the providers also reap financial rewards for achieving quality goals.

Payment for HRSN-Related Services

Adding coverage of new Medicaid services may represent an additional avenue for states to increase the available reimbursement for providers offering services to individuals in a High-ADI region. Changes to the benefit package are typically accomplished through a Medicaid state plan amendment. **Covered benefits can be added to address member's HRSNs specifically, and eligibility for these services can be limited to individuals who meet certain criteria**. For instance, support services could be made available only to members who meet a certain level of care need. State plan service additions are limited to the list of optional benefits under federal law. Generally, service eligibility restrictions must be based on member need and cannot be limited to individuals in a particular geography.

However, states can seek an 1115 demonstration waiver to cover new types of services not normally permitted under a Medicaid state plan. Through a waiver development and CMS approval process, states may request federal approval to add new benefits. In some cases, states can seek to provide new services only for certain geographical regions by seeking a waiver of federal statewideness requirements. **Generally, states cannot exclude members or providers from a benefit or program based on where they live or work, but states can seek a waiver of the statewideness requirement to implement a pilot in certain areas of the state or to phase-in a new program**.[34]

Additionally, the managed care delivery system offers greater flexibility for the provision of expanded services. MCOs have several pathways by which they can provide additional benefits to members above and beyond what is offered in the Medicaid state plan. Many of these pathways can be designed to address HRSN, as outlined below.

Optional Managed Care Services

While the in lieu of services and value-added services outlined below are not required to be offered by MCOs, states can work collaboratively with their MCOs to signal their quality goals, encourage use of these additional flexibilities, and implement benefits that address HRSN.

In Lieu of Services (ILOS). ILOS are services or settings that can be utilized as an immediate or long-term substitute for a state plan-covered service or setting.[35] ILOS must be authorized through the state's MCO contract. However, it is optional for the MCO to offer the ILOS and optional for the member to elect to receive the service. ILOS must be medically appropriate and made available only to a clinically defined target population.[36] Additionally, ILOS must be a cost-effective substitute for the state plan service and must be outlined in the capitation rate letter as utilization and costs associated with ILOS are considered in the capitation rate development process. CMS recently released guidance and a subsequent proposed rule recommending the use of ILOS to address HRSN and imposing new administrative requirements. Examples of ILOS targeted at HRSN include, but are not limited to: housing services (transition navigation services, housing deposits, tenancy/tenancy sustaining services, environmental accessibility adaptations), respite services, medically tailored meals, and post-hospitalization recuperative care.[37] State Medicaid programs can select and authorize one or more ILOS that are most suitable for members in managed care in their state but must ensure that service eligibility is appropriately defined based on member need.

Implementing ILOS allows states to expand and customize setting options and strengthen access to care under their managed care contracts. There are specific guardrails enforced by CMS when implementing ILOS that states must take into consideration. In addition to the previously stated requirements that ILOS must be medically appropriate and cost effective, ILOS must also advance the objectives of the Medicaid program, be provided in a manner that preserves member rights and protections, be subject to appropriate monitoring and oversight, and be subject to

[34] Medicaid and CHIP Payment Access Commission. Waivers. (n.d.). https://www.macpac.gov/subtopic/overview/

[35] Centers for Medicare and Medicaid Services (CMS). Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality. (May 3, 2023). https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

[36] Health Foundation of South Florida. Bailit Health. Addressing Health-Related Social Needs Through Medicaid Managed Care. (October 2022). https://www.shvs.org/wp-content/uploads/2022/11/Addressing-HRSN-Through-Medicaid-Managed-Care_October-2022.pdf

[37] Ibid.

retrospective evaluation.[38] **Adding ILOS to the managed care contract would require limited resources to implement and could be made effective quickly through existing Medicaid pathways; however, because states cannot mandate MCOs to offer them or members to use them, they may be limited in their effectiveness**.

*Value-Added Benefits***.** Federal regulations provide MCOs with the opportunity to offer services to members in addition to those covered under the Medicaid state plan. These are referred to as value-added benefits and are typically funded by MCO administrative funds and therefore are not considered in the development of the capitation rates. **State Medicaid agencies cannot require MCOs to offer value-added benefits, but increasingly, MCOs have been using this flexibility to provide services that address HRSN** and social determinants of heath in alignment with state quality goals. These value-added benefits are often non-medical services which lends them to being a viable option to use to address HRSN.

State-Required Covered Benefits

Although MCOs have the option to implement additional services without prior state approval (i.e., value-added benefits), states may elect to mandate new coverage of certain services or require MCOs to implement processes to address social risk and HRSN, which are outlined below. Adding services is likely a low-barrier approach for the state to pursue to address HRSNs. For instance, creating a new case management service under the state plan as described below would require limited resources to implement and would be effective quickly through existing Medicaid pathways. In reviewing the options outlined in this section, the state should consider the additional administrative lift to draft and submit new federal authorities, as well as the potential budget impact of adding new mandated Medicaid benefits. Unlike options, such as state directed payments, that create increased reimbursement for existing services, these options create increased reimbursement opportunities for providers through introducing new services eligible for reimbursement, such as HRSN screening or enhanced case management.

Contract Requirements. There are several ways that states can utilize their managed care contracts to impose requirements on MCOs to directly address member's HRSNs through increased investments and expanded services. States have authority to design their managed care contracts in a manner that reflects the state's goals and the expectations it seeks to impose on MCOs. Requiring MCOs to commit to addressing HRSNs and improving health outcomes, including for individuals in areas with a high ADI, can start as early as the procurement process and carry throughout the contract period through strategies like community reinvestment and expanded care management requirements. As discussed above, MCO contract strategies can be implemented independently or in concert with other approaches to account for HRSNs, like social risk adjustment.

Potentially applicable contract requirements in this context include community reinvestment requirements and expanded care management requirements.

- **Community reinvestment** is a term used to describe a requirement that MCOs spend a portion of their profits or reserves on the local community.[39] States can elect what amount MCOs will be required to invest. To ensure that strategies like community reinvestment have the intended effect, it would be important for the state to carefully define the contract requirement, including the amount of money to commit, any priority areas, and specific community organizations, if applicable.
- **Care management program requirements** refers to a state's parameters for how MCOs must screen for and conduct coordination of services to address a member's healthcare needs. For example, MCOs can be required to screen for HRSNs when conducting health risk assessments to determine whether a member requires additional support and what kind. In addition, MCOs can be required to offer a greater level of care management supports to those individuals who have been identified as experiencing HRSNs (e.g., by designating those individuals as higher risk and in need of complex care). An example of this could be

[38] Center for Medicaid and CHIP Services. SMD#23-001. Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. (January 4, 2023). https://www.medicaid.gov/sites/default/files/2023-01/smd23001.pdf

[39] Center for Health Care Strategies (CHCS). Promote Accountability Mechanisms for Managed Care Organizations: Advancing Primary Care Innovation in Medicaid Managed Care. (November 17, 2020). https://www.chcs.org/media/PCI-Toolkit-MCO-Accountability-Tool_111720.pdf

requiring MCO care managers to direct individuals with HRSNs to community health workers or community-based services to address their identified needs, including tracking referrals to ensure fulfillment.[40]

Implementing specific requirements for MCOs to address HRSNs through the managed care contract requires limited time and resource commitment from the state and targets member's HRSNs directly, especially through care management. Kentucky could add these requirements through a contract update or amendment and the burden would largely be on the MCOs to abide by the state's expectations. Notably, **increasing MCO care management expectations does not provide new reimbursement to providers, but rather creates expectations for the activities that the MCOs must provide to better address HRSN and hopefully to improve outcomes as well**.

Additionally, it is unclear if an MCO could be required to provide enhanced services, such as care management, based on the ADI score of the region where a member lives. Such requirements are typically targeted at a member's individual need, not based upon the overall conditions of a specific area.

FIGURE 5. EXAMPLES OF MCO CONTRACT REQUIREMENTS TO ADDRESS HRSN

STATE	CONTRACT REQUIREMENT	STATE GOAL
Arizona[41]	Added a new managed care service for permanent supportive housing coordination	Safe, stable, and affordable housing aligned and coordinated with an individual's behavioral health, medical, and other supportive services.
North Carolina[42]	MCO to conduct care needs screening	Contractor must conduct a care needs screening including unmet health-related social need questions, such as housing.
Texas[43]	MCO permitted to include housing services in MLR numerator	Including housing services in the MLR numerator will help ensure these services are properly funded
Colorado[44]	MCO staff required to be knowledgeable of health disparities and inequities in their region	Demonstrating knowledge of the region's health inequities will allow stakeholders to optimize the physical and behavioral health of its members.
Oregon[45]	MCO required to have extensive involvement with the community to address SDOH	Contracting with organizations that are already involved in the community addressing SDOH will improve health outcomes and decrease health inequities in the impacted region

1915(i) State Plan Amendment. 1915(i) is a state plan option that allows states to offer home and community-based service (HCBS) to Medicaid-eligible individuals who meet state-defined minimum needs-based criteria that are less stringent than institutional criteria.[46] This is unlike 1915(c) HCBS waivers, which are only available to individuals who are at-risk of institutional care.[47] 1915(i) authorities can waive or disregard comparability,[48] allowing states to target the benefit by factors such as age, diagnosis, disability, or Medicaid eligibility group. Examples of 1915(i) authorities include those targeted to persons with intellectual or developmental disabilities or with mental illness or substance

[40] Health Foundation of South Florida. Bailit Health. Addressing Health-Related Social Needs Through Medicaid Managed Care. (October 2022). https://www.shvs.org/wp-content/uploads/2022/11/Addressing-HRSN-Through-Medicaid-Managed-Care_October-2022.pdf

[41] Center for Health Care Strategies. Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review. (February 2023). https://www.chcs.org/media/Financing-Approaches-to-Address-Health-Related-Social-Needs-via-Medicaid-Managed-Care.docx.pdf

[42] Ibid.

[43] Ibid.

[44] Colorado Managed Care Contract. p. 126. (2020). https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Health%20Partnership%20%20Base%20Contract.pdf

[45] Oregon Coordinated Care Contract. p. 83. (2023). https://www.oregon.gov/oha/HSD/OHP/CCO/2023-CCO-Contract-Template.pdf

[46] Centers for Medicare and Medicaid Services (CMS). 1915(i) State Plan Home and Community Based Services. (n.d.) https://www.hcbs-ta.org/node/83

[47] U.S. Department of Health and Human Services. The Use of 1915(i) Medicaid Plan Option for Individuals With Mental Health and Substance Use Disorders. (November 2016). https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//173071/1915iSPA.pdf

[48] Centers for Medicare and Medicaid Services (CMS). 1915(i) State Plan Home and Community Based Services. (n.d.) https://www.hcbs-ta.org/node/83

use disorder. While states cannot cap the number of members eligible for a 1915(i), states can tighten eligibility criteria "if projected enrollment appears likely to exceed state estimates."[49]

A 1915(i) state plan option could be utilized to target services addressing HRSN for a specific population. 1915(i) authorities are utilized to provide HCBS services to individuals who do not require institutionalization, but who do have a significant level of care need. Services targeted at HRSN can enhance an HCBS service array to address the whole person care needs of qualifying members. For example, a 1915(i) authority could be targeted at members with serious mental illness (SMI). In addition to other HCBS, a state could include pre-tenancy and tenancy sustaining services as a service under the authority. Therefore, in addition to receiving other medically necessary treatment services, individuals with SMI could receive critical supportive services that allow them to remain housed while in treatment.

In response to Senate Joint Resolution 72, Kentucky has taken steps to implement a 1915(i) state plan amendment to help address the needs of individuals living with SMI. The state has included certain risk factors as an eligibility requirement for services, including individuals needing to demonstrate homelessness or being at-risk of homelessness to receive housing-related services. Under the proposed 1915(i) state plan amendment, Kentucky will provide eligible individuals with supportive services including, but not limited to, supported education and training, transportation, medication management, respite, assistive technology, case management, and housing related services (supervised residential care, tenancy supports, and in-home independent living supports).[50] Additional services to address HRSN could be added to the proposed 1915(i) state plan amendment, and the state may choose to evaluate other populations that could benefit from this type of program moving forward.

Section 1115 Waivers. 1115 waivers, or research and demonstration waivers, can be used to authorize experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program.[51] Generally, 1115 waivers are used to test new and novel approaches to Medicaid eligibility, service delivery, or other functions of the program. Under a 1115, states can waive rules regarding freedom of choice of provider, comparability, and/or statewideness.[52] States must submit a formal, narrative application request to CMS to obtain 1115 authority and must demonstrate that the requests will be budget neutral.[53]

Many opportunities exist for states to address HRSNs through 1115 waivers. **CMS has signaled its strong encouragement for states to consider novel ways to address HRSNs through 1115 waivers by approving several new HRSN-related requests over the last year**. Funding is available both for new HRSN services and for service infrastructure costs.[54] States have received approval to provide:

- **Housing services** – Rent/temporary housing and utility costs (for six months for individuals exiting institutional settings); pre-tenancy/tenancy sustaining services, housing transition navigation services, one-time transition and moving costs, housing deposits, medically necessary air conditioners/other appliances, medically necessary home accessibility modifications/remediation.
- **Nutrition services** – Nutrition counseling and education, medically-tailored meals (up to three meals a day for up to six months), meals or pantry stocking (up to three meals a day for up to six months), fruit and vegetable prescriptions (for up to six months), cooking supplies.

[49] U.S. Department of Health and Human Services. The Use of 1915(i) Medicaid Plan Option for Individuals With Mental Health and Substance Use Disorders. (November 2016). https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//173071/1915iSPA.pdf

[50] Kentucky Cabinet for Health and Family Services. 1915i SPA Informational Webinar. (September 25, 2023). https://www.chfs.ky.gov/agencies/dms/dca/Documents/1915iSPAInformationalWebinar.pdf

[51] Medicaid.gov. About Section 1115 Demonstrations. (n.d.). https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

[52] Ibid.

[53] Ibid.

[54] The Commonwealth Fund. CMS Approves Groundbreaking Section 1115 Demonstrations. (December 7, 2022). https://www.commonwealthfund.org/blog/2022/cms-approves-groundbreaking-section-1115-demonstrations

- **Case management services**, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.[55]

In its recent waiver approvals, CMS has laid out a framework for how HRSN expenditures will be treated as part of the required budget neutrality test for 1115 waivers. (Budget neutrality in this context means that federal spending under the waiver may not exceed what federal costs would have occurred if the waiver were not granted.) HRSN expenditures will be treated as a capped hypothetical. This means that states can implement HRSN services without needing to require on banked budget neutrality savings.[56] However, under this framework, CMS has stated that HRSN expenditures must be limited to 3% of a state total Medicaid spending. Additionally, CMS will require states to meet certain provider payment rate standards as a condition of approving HRSN services.[57]

Case Management Services. Case management is a Medicaid service that can be provided to a variety of members who may benefit from enhanced service coordination. The Social Security Act defines case management as services which will assist Medicaid enrolled individuals gain access to needed medical, social, educational, and other services.[58] Case management can be authorized through the Medicaid state plan or as a service under the other types of authorities discussed in this section, such as a 1915(i) state plan option or 1115 waiver.

Targeted case management is a specific type of case management provided under the state plan that can be offered to targeted groups and in any defined location of the state. In other words, the service does not have to comply with federal comparability or statewideness requirements.[59] **Kentucky currently provides targeted case management to many groups**, including:

- Certain disabled children, including those with a diagnosis of hemophilia;
- Children in custody or at risk of being in custody of the state or in under the supervision of the state; adults in need of protective services;
- Children ages birth to three years who have developmental disabilities and are participating in the Kentucky Early Intervention Program;
- Certain pregnant women age 20 and younger or who qualify for home visitation services and their children; pregnant or postpartum women up to the end of the month of 60 days following the date of delivery who have applied for or are receiving substance abuse services;
- Certain adults and children with moderate or severe substance use disorder who meet other risk factors;
- Certain adults and children with co-occurring mental health or substance use disorders and chronic or complex physical health issues; and
- Certain adults and children with severe emotional disability or severe mental illness.[60]

Case management can be provided to assist Medicaid members in obtaining access to necessary services and supports that address HRSN. For example, through case management services, a member could be connected with a local housing agency to learn more about obtaining a rental subsidy or be linked to a transportation service that can provide them with rides.[61] States can assess a member's need for HRSN case management through MCO

[55] Summarized based on the following waiver approvals: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca1.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ca-11012022.pdf

[56] State Health and Value Strategies. Recent Updates to Section 1115 Waiver Budget Neutrality Policy. (December 2022). https://www.shvs.org/wp-content/uploads/2022/12/SHVS_Recent-Updates-to-Section-1115-Waiver-Budget-Neutrality-Policy.pdf

[57] The Commonwealth Fund. CMS' New Policy Framework for Section 1115 Medicaid Demonstrations. (January 10, 2023). https://www.commonwealthfund.org/blog/2023/cms-new-policy-framework-section-1115-medicaid-demonstrations

[58] Social Security Act, § 1915(g)(2). https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

[59] 42 CFR § 440.169. https://www.law.cornell.edu/cfr/text/42/440.169

[60] https://www.chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf

[61] Kaiser Family Foundation (KFF). Hinton, E., Stolyar, L. Medicaid Authorities and Options to Address Social Determinants of Health (SDOH). (August 5, 2021). https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

assessment tools or by requiring providers to capture certain Z codes to identify members in need.[62] A state can also narrowly define the eligibility for case management or provide it to groups in a specific area of the state by using targeted case management.

[62] Ibid.

ADI ANALYSIS

OVERVIEW OF ADI

Based on a measure created by the federal Health Resources and Services Administration (HRSA), and further enhanced by the researchers at the University of Wisconsin-Madison,[63] the Area Deprivation Index (ADI) is a social risk factor model to rank neighborhoods (defined at the census block level[64]) according to socioeconomic disadvantage. The neighborhood rankings account for factors including income, education, employment, household characteristics, and housing quality variation across neighborhoods.[65] The ADI is intended to allow "health systems and health care providers to target program delivery by geographic location based on the area of greatest disadvantage."[66] The ADI was last updated in 2023 based on American Community Survey data from 2017 through 2021.[67] Therefore, the ADI will not fully consider any socioeconomic changes that have occurred since the onset of the COVID-19 pandemic.

The ADI provides two ranking methodologies: national methodology and state methodology. Under the "national methodology", the ADI ranks neighborhoods on a scale from 1 to 100.[68] A lower value indicates a lower level of "disadvantage", meaning that theoretically one would find lower (better) HRSN among the residents of that neighborhood on average. A higher ADI value indicates a greater level of disadvantage and means that theoretically one would find higher (worse) HRSN among the residents of that neighborhood on average. It should be recognized that the **ADI is a community-based ranking which has inherent limitations in identifying the specific HRSN for individual residents within a community**. To the extent that individual or household HRSN were sampled from a community, it is likely that significant variation in HRSN would be observed within such a sample across households.

USAGE OF ADI IN HEALTHCARE PAYMENT POLICY

The ADI is among the most widely recognized tools for measuring social risk in the United States and has been incorporated into healthcare payment policy by several payers and markets. A September 2022 report commissioned by the Department of Health and Human Services (HHS) states, "**For immediate policy development addressing HRSNs, the Area Deprivation Index (ADI) and Social Vulnerability Index (SVI)[69] are the best choices given our selection criteria** (validity, the SDOH and HRSN components they reflect, their availability and timeliness, the geographic level for which they are calculated, and usefulness for focusing funding in communities with the greatest need)."[70] Selected examples of ADI usage in healthcare payment policy are listed below.

- **ACO REACH Model**. In the Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model, the Center for Medicare and Medicaid Innovation (CMMI) has incorporated the ADI into its health equity benchmark adjustment (HEBA), resulting in ACOs receiving greater payment for serving the most disadvantaged neighborhoods.[71]

[63] Center for Health Disparities Research. Neighborhood Atlas. (2021). https://www.neighborhoodatlas.medicine.wisc.edu/

[64] For more information regarding census blocks, please see https://www.census.gov/newsroom/blogs/random-samplings/2011/07/what-are-census-blocks.html.

[65] Neighborhood Atlas. Center for Health Disparities Research. About the Area Deprivation Index. (n.d.). https://www.neighborhoodatlas.medicine.wisc.edu/

[66] Center for Health Disparities Research. Neighborhood Atlas. (2021). https://www.neighborhoodatlas.medicine.wisc.edu/

[67] Department of Health and Human Services. Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments. (September 2022). https://aspe.hhs.gov/sites/default/files/documents/ce8cdc5da7d1b92314eab263a06efd03/Area-Level-SDOH-Indices-Report.pdf, Table 2.4.

[68] Ibid.

[69] The SVI was developed to support the identification of communities and geographic areas most likely to need support of the course of a disaster. Unlike the ADI, it does permit the ability to review scores for the components (socioeconomic status, household composition and disability, minority status and language, and housing type and transportation). For more information on the SVI, please see: https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html.

[70] Department of Health and Human Services. Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments. (September 2022). https://aspe.hhs.gov/sites/default/files/documents/ce8cdc5da7d1b92314eab263a06efd03/Area-Level-SDOH-Indices-Report.pdf

[71] Health Affairs. The Area Deprivation Index is the Most Scientifically Validated Social Exposome Tool Available. (July 20, 2023). https://www.healthaffairs.org/content/forefront/area-deprivation-index-most-scientifically-validated-social-exposome-tool-available

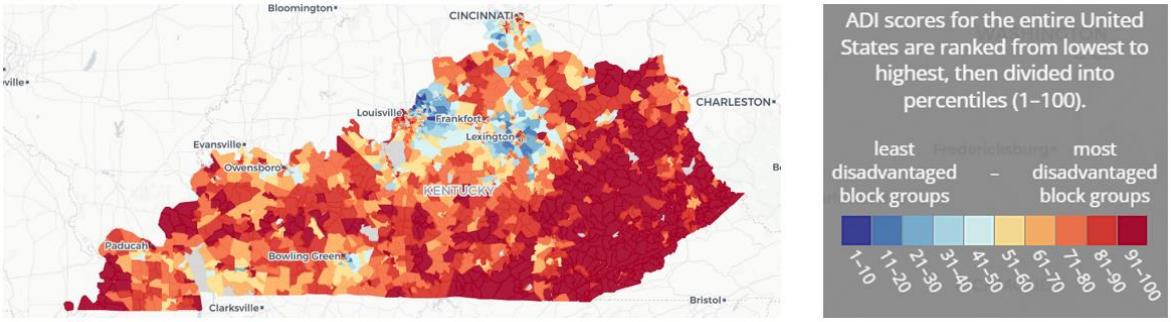
- **Medicare Shared Savings Program (MSSP)**. Beginning on January 1, 2024, advanced payments will be made to new ACOs joining the MSSP to "build the infrastructure needed to succeed in the program, and promote equity by holistically addressing member needs, including social needs".[72] Advanced payments will be partially based on assigned member's ADI national percentile rank (with no payment made for members with a ranking score below 25).[73]
- **Everybody with Diabetes Counts (EDC)**. The Centers for Medicare & Medicaid Services (CMS) EDC program uses the ADI to target diabetes education efforts in disadvantaged neighborhoods.[74]

ADI ANALYSIS FOR KENTUCKY

Using the ADI mapping features provided on the Neighborhood Atlas® website, which reflects the total Kentucky population (not limited to Medicaid members), Figure 6 illustrates that **a significant portion of Kentucky's geography is classified as having a national ADI score more than 91 (which is the darkest red shade shown on the map), with most of eastern Kentucky falling in this cohort**. This means that, were Kentucky to utilize the national methodology, a Medicaid payment strategy to target High-ADI areas would require implementation in vast areas of the state.

Again, using the national methodology, **Kentucky's geographic areas with lower ADI rankings (blue-shaded areas) are clustered around the Louisville, Lexington, and Cincinnati metropolitan areas**. However, as we will discuss below, even with these metropolitan areas, significant ADI variation across neighborhoods can be observed.

FIGURE 6. KENTUCKY ADI MAPPING FROM NEIGHBORHOOD ATLAS – NATIONAL METHODOLOGY



Under the "state methodology", the ADI for each neighborhood is assigned to a decile ranging from 1 to 10 (with 1 being the least disadvantaged cohort of neighborhoods and 10 being the most disadvantaged neighborhood cohort).[75] As seen by the greater color variation relative to the national methodology, the state methodology mapping shown in Figure 7 allows the variance in ADI scores across the Commonwealth to be more discernable as it ranks neighborhoods in Kentucky relative to only other communities in the Commonwealth. However, consistent with the national methodology, the state methodology also illustrates the most disadvantaged neighborhoods are largely in eastern Kentucky.

Using the state methodology, it may be possible for Kentucky to more strategically tailor a Medicaid payment approach to target the areas of greatest need (based upon having a High-ADI) within the Commonwealth.

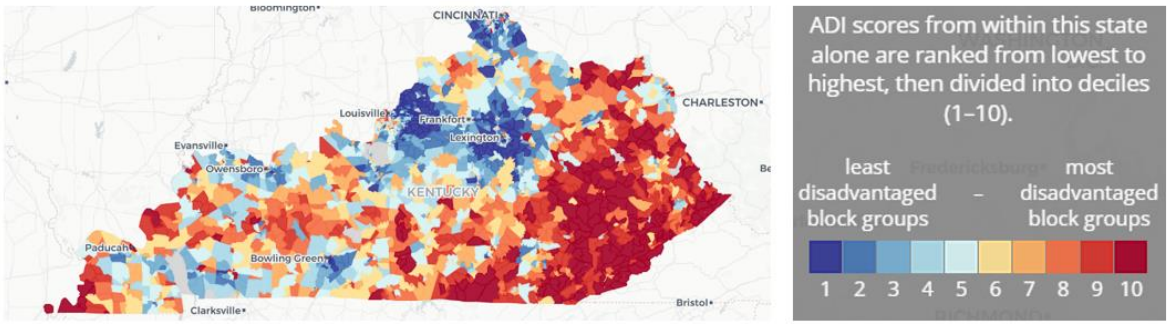
[72] Center for Medicare and Medicaid Services. Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule – Medicare Shared Savings Program. (2023). https://www.cms.gov/files/document/mssp-fact-sheet-cy-2023-pfs-final-rule.pdf

[73] Ibid.

[74] National Institute on Minority Health and Health Disparities. Research Examines Effects of Disadvantaged Neighborhoods on Long-Term Health. (July 10, 2018). https://www.nimhd.nih.gov/news-events/features/community-health/disadvantaged-neighborhoods.html

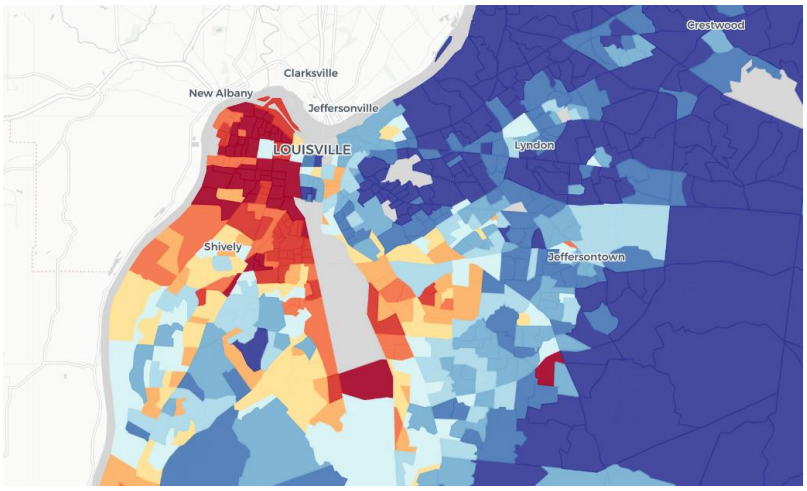
[75] Ibid.

FIGURE 7. KENTUCKY ADI MAPPING FROM NEIGHBORHOOD ATLAS – STATE METHODOLOGY



However, even utilizing the state methodology presents limitations. As mentioned above, the ADI scores within a metropolitan area can vary significantly by neighborhood. Using the Neighborhood Atlas mapping tool to zoom into the Louisville metropolitan area (using the state methodology), Figure 8 indicates there are neighborhoods in close geographic proximity that are in decile 1 (i.e., low ADI, or least disadvantaged) as well as decile 10 (i.e., high ADI, or most disadvantaged). **State payment strategies that rely upon a county-weighted ADI score may not fully account for the ADI variances that commonly exist within the county**.

FIGURE 8. LOUISVILLE METROPOLITAN AREA, ADI MAPPING FROM NEIGHBORHOOD ATLAS – STATE METHODOLOGY



ADI THEMES WITHIN THE KENTUCKY MEDICAID POPULATION

To provide an initial assessment of the relationship between ADI and healthcare utilization specifically within the Kentucky Medicaid managed care delivery system, we developed several metrics based on Medicaid eligibility and managed care encounter data from calendar year 2022 coverage periods. ADI scores were mapped onto each member's eligibility month based on the member's 9-digit zip code. For the Families and Children and Expansion populations, approximately 80% of members had an available 9-digit zip code that allowed the ADI mapping to occur. For the other Medicaid populations, the availability of the 9-digit zip code on the eligibility file was more limited, ranging from approximately 10% to 60% complete among the other populations. Because of the zip code data limitations for these other Medicaid populations, we elected to exclude them from the ADI analysis.[76]

Utilizing Medicaid eligibility and managed care encounter data submitted to DMS through July 31, 2023, we developed the following metrics related to the Medicaid population and ADI rankings for CY 2022 coverage periods:

[76] Based on discussions with DMS, it may be possible to receive more complete 9-digit zip code information for other populations with additional follow-up with the Office of Application Technology Services (OATS).

- Medicaid enrollment distribution by the member's ADI state decile (1 to 10), limited to members with a valid 9-digit zip code in the Families & Children and Expansion populations.
- Medicaid enrollment distribution by the member's ADI national percentile (bucketed into deciles), limited to members with a valid 9-digit zip code in the Families & Children and Expansion populations.
- Calendar year 2022 (CY 2022) utilization per 1,000 for the Expansion Adult, Families and Children – Child, and Families and Children – Adult populations, stratified by the member's ADI state decile, for the following services:
    - Physical exams
    - Professional emergency room
    - Professional office visits
    - Dental services, split between cleanings and higher level services, limited to the Families and Children – Child population.

These services were chosen for our analysis because utilization levels for these services may be influenced by variances in provider access levels across the Commonwealth. Utilization levels are presented on a 'Utilization per 1,000' basis. The utilization per 1,000 metric represents the number of services a population of 1,000 individuals is expected to incur during a 12-month period.

As shown in the below utilization per 1,000 charts for the above listed services, we observed utilization patterns that indicated a correlation with the member's ADI ranking. For physical exams, professional office visits, and dental cleanings, we observed utilization rates decreasing as the ADI ranking increased. For professional emergency room visits and higher-level dental services, we observed greater utilization as the ADI increased, suggesting that access to preventive and primary care services may be more limited as the ADI of a neighborhood increases. There are several aspects of these analyses that warrant further study before implementing a payment reform.

A sample of areas for possible future research include:

- Social risk adjustment is a rapidly evolving area of research. **While the ADI is a widely recognized tool for undertaking social risk adjustment, the ADI (and other social risk measures) have not been calibrated to reflect Kentucky's specific policy objectives around social determinants of health, HRSN, or health outcomes.**[77] In addition, because the ADI only provides a composite disadvantage ranking for a community, it is not possible to immediately understand the primary components (education, income, housing, employment, and household characteristics) contributing to the ranking value. As previously mentioned, the data lag (current ADI rankings are based on 2017 through 2021 values) is also a potential concern with using the ADI for payment reforms. Using actuarial and/or data science models, it may be possible to build a custom social risk adjustment index specific to Kentucky's socioeconomic characteristics and health outcomes that would allow better targeting of public investment and reflect more recent data. In addition, having person-level data on HRSN (such as through a member assessment) may provide better insight to Medicaid members' actual HRSN needs.
- For these analyses, we did not assess or quantify provider access by ADI state decile. For example, we did not calculate the average driving time and distance from a member's residence to a primary care physician's office. Differences in transportation access, rather than solely medical provider availability, may contribute to the observed utilization differences. **As options for reform are evaluated by the Commonwealth, it is important to remember that provider payment adjustments may not target the root cause of observed utilization differences**.

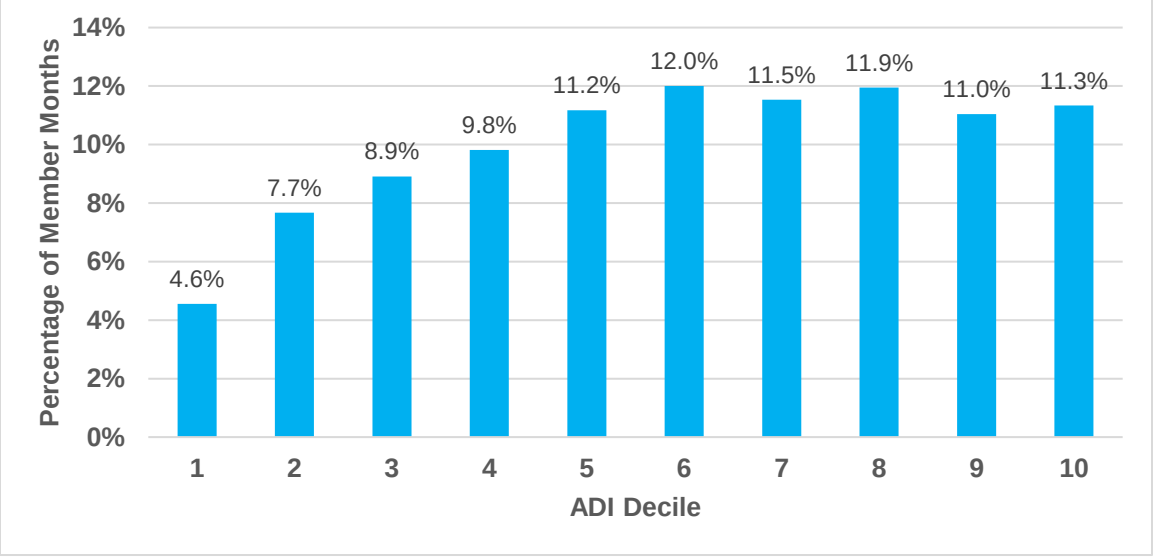
[77] Department of Health and Human Services. Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments. (September 2022). https://aspe.hhs.gov/sites/default/files/documents/ce8cdc5da7d1b92314eab263a06efd03/Area-Level-SDOH-Indices-Report.pdf

- Further analyses could also examine utilization differences within the same ADI decile. While we have presented composite utilization rates by ADI decile, there is also likely variance in utilization statistics among communities classified in the same ADI decile.
- Observed utilization variances by ADI state decile may be caused by factors other than community-level SDOH or HRSN that include MCO utilization and care management practices, population morbidity, member preferences, and a multitude of other factors. Further analysis may be useful to identify the primary factors resulting in the observed relationships between ADI and healthcare utilization shown in the below charts.
- SJR 54 directs DMS to study payment reforms that would vary provider reimbursement based on the ADI ranking of the provider's location, rather than the member's location which is the basis for the below figures. We have not quantified utilization variances by provider location, as it would require a considerable amount of time and effort to review and clean provider address information. While we would not anticipate large differences in the results presented in this report if provider location was used, some changes would be anticipated. In particular, there may be greater differences for urban areas where neighborhoods of highly varying ADI ranking are in close proximity.

Enrollment Distribution by ADI State Decile

Figure 9 illustrates the distribution of Kentucky's Medicaid population by ADI state decile. In theory, if this chart illustrated the overall state population, we would observe the population uniformly distributed across the ten deciles (10% in each decile). However, we observe that Medicaid enrollment is skewed (above 10%) towards the higher (representing more disadvantaged neighborhoods) deciles. Intuitively, this is an expected result because the composition of the ADI ranking includes employment and household income measures. Greater access to employment opportunities for residents in a neighborhood should result in higher household income on average and a lower proportion of residents qualifying for Medicaid based on income standards.

FIGURE 9. DISTRIBUTION OF CY 2022 KENTUCKY MEDICAID MANAGED CARE ENROLLMENT BY ADI DECILE – STATE METHODOLOGY

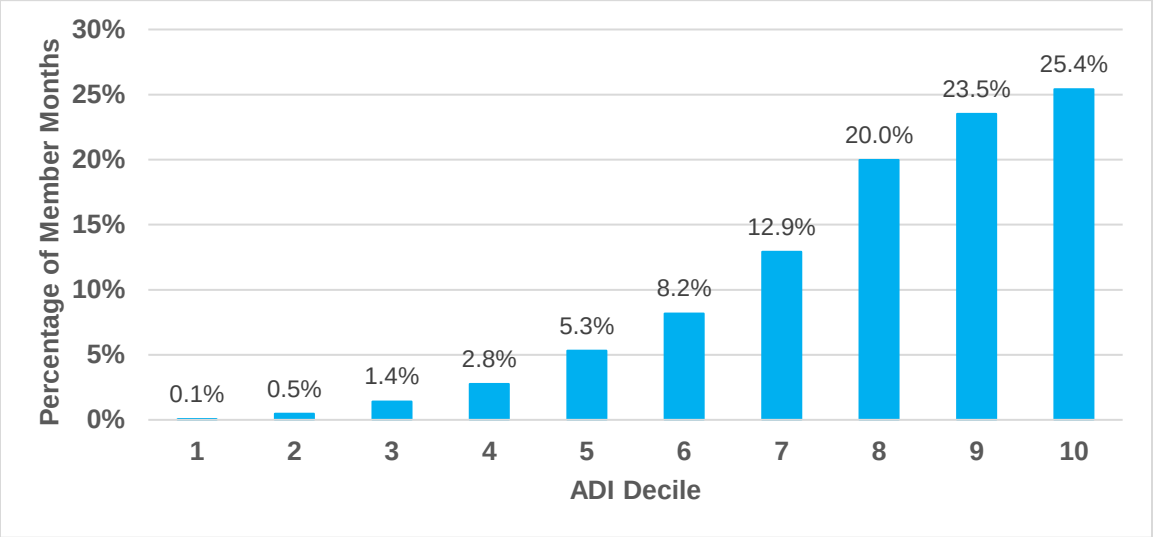


Notes:
1. Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children or Expansion populations.
2. Percentage values are rounded to the nearest tenth of a percent.

Enrollment Distribution by ADI National Decile

Figure 10 provides the distribution of Kentucky's Medicaid population using the ADI national scores (grouped into 10 deciles). To the extent the entire United State population was illustrated in this chart, we should observe a uniform distribution across the deciles (10% in each decile). Using the ADI national scores, Medicaid enrollment is skewed heavily towards deciles 8, 9, and 10, with nearly 70% of Medicaid enrollment identified as residing in a neighborhood that has a national ADI score of 70 or higher. Conversely, less than 5% of Medicaid enrollment is in deciles 1 through 4 (less than 5% of Medicaid enrollment resides in a neighborhood with a national ADI score of 40 or less).

FIGURE 10. DISTRIBUTION OF CY 2022 KENTUCKY MEDICAID MANAGED CARE ENROLLMENT BY ADI DECILE – NATIONAL METHODOLOGY

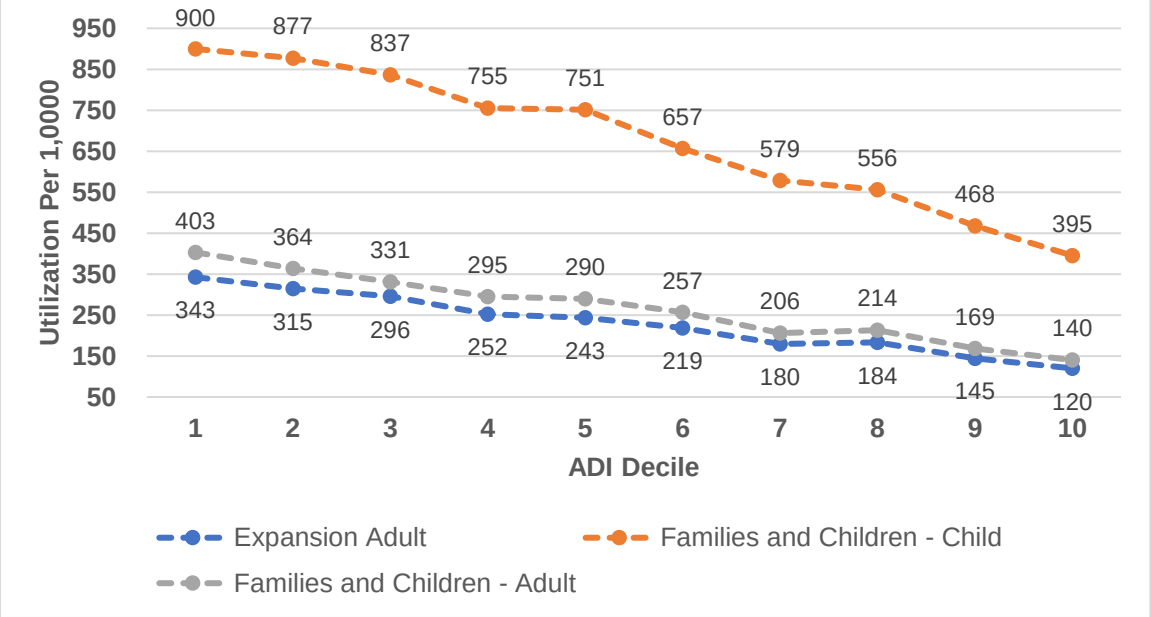


Notes:
1. *Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children or Expansion populations.*
2. *Percentage values are rounded to the nearest tenth of a percent.*

Physical Exam Utilization per 1,000 - State ADI Decile

The 'physical exam' service category includes annual check-ups, preventive counseling, and vaccine administration. Physical exam utilization is one metric for measuring the utilization of preventive care services, which reduce the risk for diseases, disabilities, and death.[78] For each of the three populations, Figure 11 illustrates that there is a steady decline in physical exam utilization as the ADI decile increases, with the utilization rate in the first decile more than double the utilization rate in the tenth decile.

FIGURE 11. CY 2022 KENTUCKY MEDICAID MANAGED CARE PHYSICAL EXAM UTILIZATION PER 1,000 BY MANAGED CARE POPULATION AND ADI DECILE – STATE METHODOLOGY



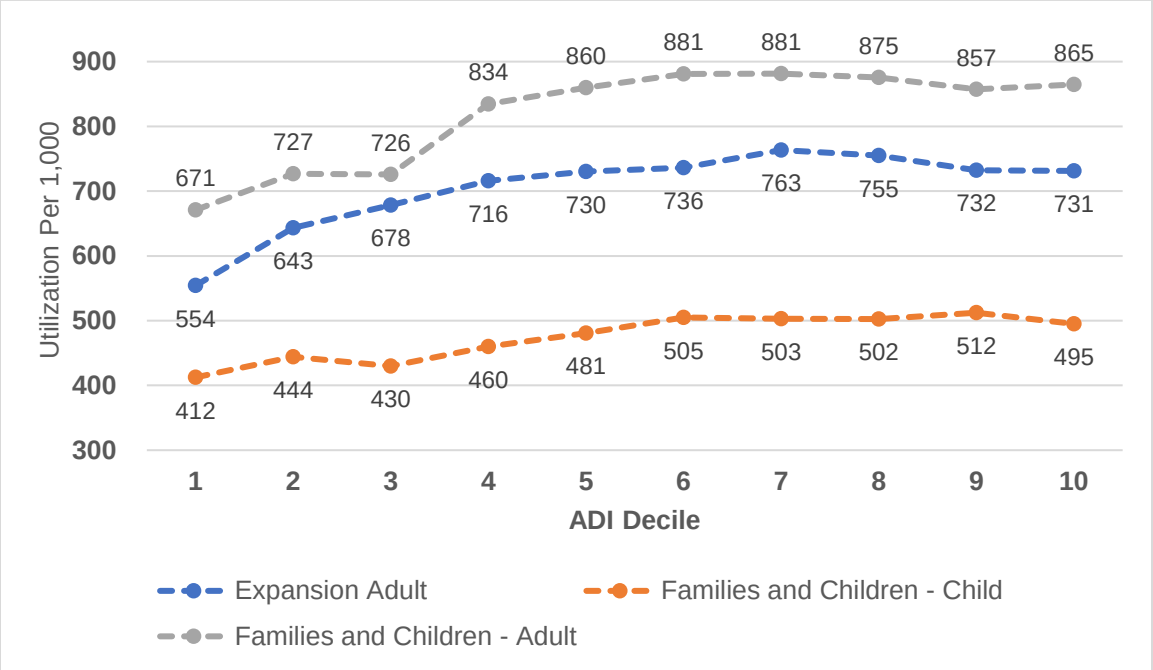
Notes:
1. *Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children or Expansion populations.*
2. *Utilization rates developed from unadjusted managed care encounter submissions.*

[78] Office of Disease Prevention and Health Promotion (ODPHP). Healthy People. Preventive Care. (October 11, 2023). https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care

Professional Emergency Room Utilization per 1,000 - State ADI Decile

A high rate of emergency room utilization may indicate poor care management or lack of access to primary care services that may result in some emergency room visits being preventable.[79] Figure 12 shows that professional emergency room utilization is materially lower for Medicaid members residing in state ADI deciles 1 through 4; however, there is less variation in emergency room utilization among deciles 5 through 10.

FIGURE 12. CY 2022 KENTUCKY MEDICAID MANAGED CARE PROFESSIONAL EMERGENCY ROOM UTILIZATION PER 1,000 BY MANAGED CARE POPULATION AND ADI DECILE – STATE METHODOLOGY



Notes:
1. Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children or Expansion populations.
2. Utilization rates developed from unadjusted managed care encounter submissions.

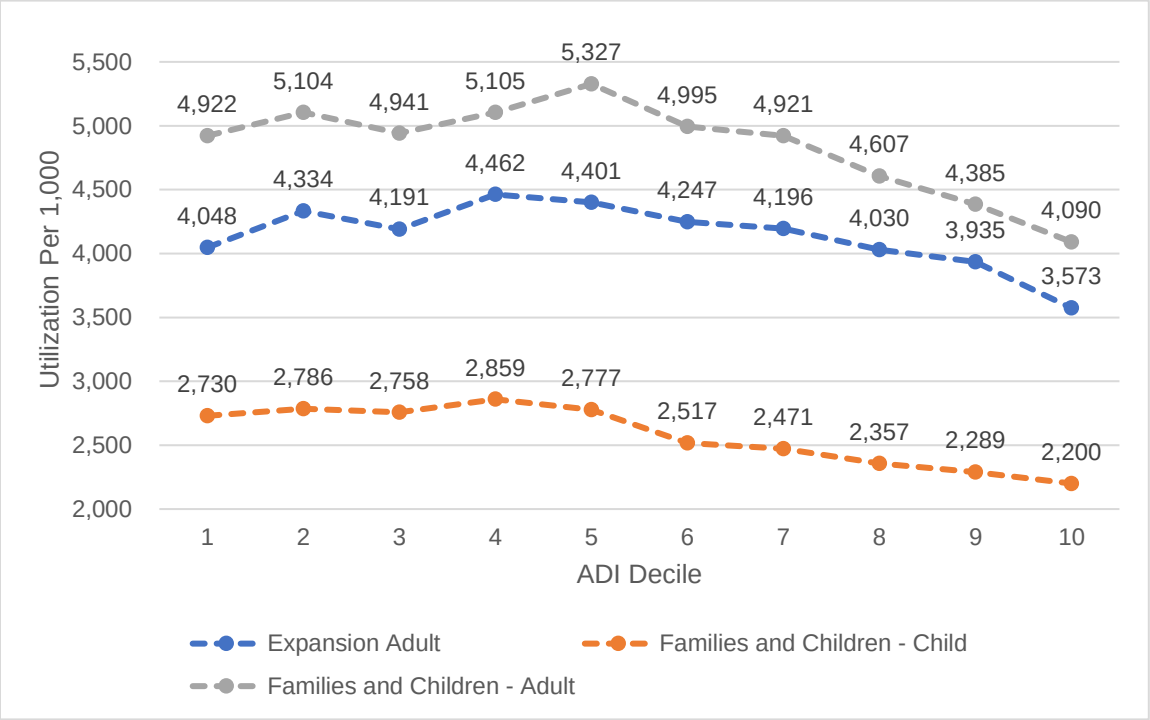
[79] NCQUA. Emergency Department Utilization. (n.d.). https://www.ncqa.org/hedis/measures/emergency-department-utilization/

Professional Office Visit Utilization per 1,000 - State ADI Decile

In contrast to emergency room utilization, higher rates of professional office visit utilization are generally associated with improved care management practices in a healthcare delivery system. For example, primary care or specialty office visits should appropriately treat the condition or illness, reducing the likelihood of a subsequent hospitalization or emergency room visit.

As shown in Figure 13, in all three population cohorts, we observe declines in office visit utilization in deciles 6 through 10. Note, we have not adjusted the utilization metrics for the underlying morbidity of the Medicaid members in each decile. As population morbidity or illness burden increases, it is expected that the need for professional office visit services would increase. Therefore, to the extent the Medicaid members residing in decile 10 have a greater average morbidity or illness burden relative to decile 1, it is possible that the morbidity-adjusted utilization disparity between the two deciles is greater than the values illustrated in the below chart.

FIGURE 13. CY 2022 KENTUCKY MEDICAID MANAGED CARE PROFESSIONAL OFFICE VISIT UTILIZATION PER 1,000 BY MANAGED CARE POPULATION AND ADI DECILE – STATE METHODOLOGY



Notes:
1. *Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children or Expansion populations.*
2. *Utilization rates developed from unadjusted managed care encounter submissions.*

Dental Service Utilization per 1,000 - State ADI Decile

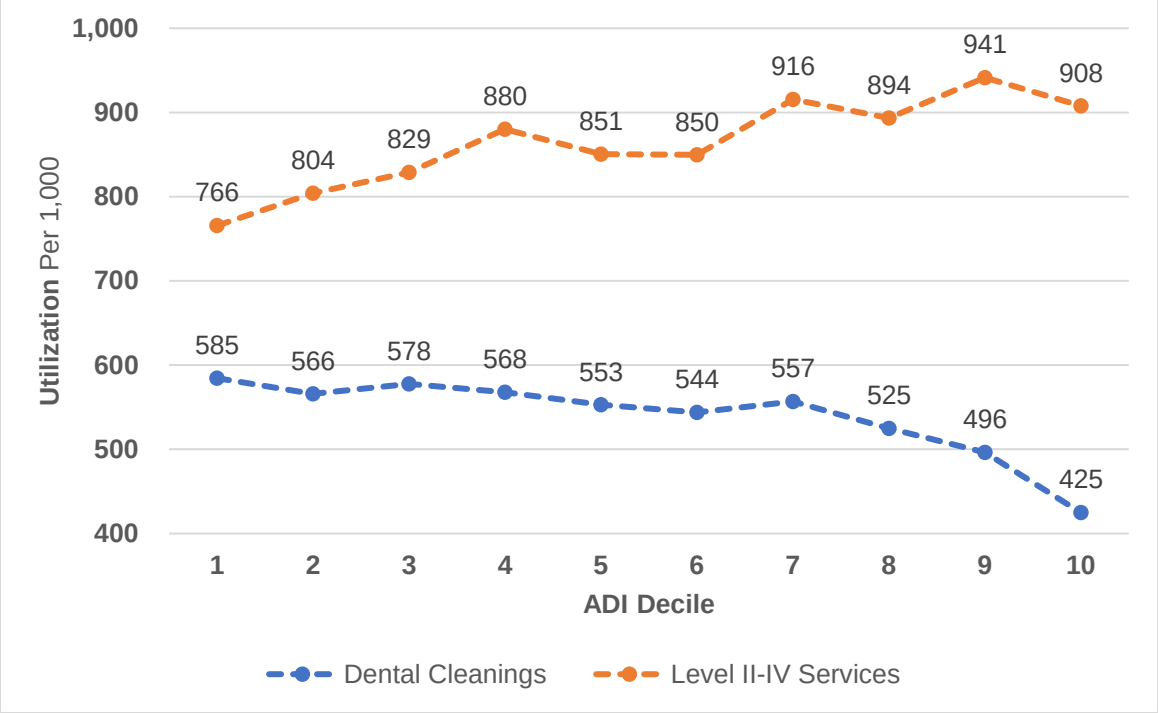
Dental services can be classified into 4 levels[80]:

- Level I: Diagnostic and Preventive (oral evaluations, fluoride treatments, X-rays, sealants, other preventive services)
- Level II: Basic Dental (emergency treatment, space maintainers, extractions, periodontics, endodontics)
- Level III: Major Dental Services (inlays, onlays, crowns)
- Level IV: Orthodontics

It is well established that preventive dental care reduces the risk of cavities or tooth decay in children.[81] For this reason, populations that have higher utilization of Level I dental services should have lower utilization of Level II through IV services.

To study this relationship with the Kentucky Families & Children – Child population[82], we summarized in Figure 14 the dental utilization for both dental cleanings and Level II – IV services, by ADI state decile. The cleaning utilization rate exhibited only a slight decline from deciles 1 through 7 until it decreased more significantly in deciles 8, 9, and 10. Conversely, utilization of Level II – IV services increased steadily across the 10 ADI state deciles.

FIGURE 14. CY 2022 KENTUCKY MEDICAID MANAGED CARE FAMILIES AND CHILDREN – CHILD POPULATION, DENTAL UTILIZATION PER 1,000 AND ADI DECILE – STATE METHODOLOGY



Notes:
1. *Managed care enrollment limited to members with a valid 9-digit zip code classified in the Families & Children – Child population.*
2. *Utilization rates developed from unadjusted managed care encounter submissions.*

[80] Milliman Health Cost Guidelines – Dental™

[81] Centers for Disease Control and Prevention (CDC). Children's Oral Health Index. (n.d.). https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html

[82] Comprehensive dental services were not provided to the adult Medicaid population during CY 2022.

SUMMARY OF ADI OBSERVATIONS

The analysis of ADI and healthcare utilization for select services indicates there are distinct differences in utilization patterns across the Commonwealth based on the Medicaid member's ADI ranking. **While this analysis demonstrates correlation between the ADI and healthcare utilization for the selected services, Kentucky may wish to conduct further analysis to assess the causality of the observed utilization variation and whether the utilization variation is consistent within the ADI decile cohorts**.

Additionally, while variance in provider access may be a contributing factor, or even the primary factor, other potential HRSN factors should be considered in the development of any payment reforms or other programmatic changes to Kentucky's Medicaid program.

OPTIONS FOR CONSIDERATION

ASSESSMENT OF OPTIONS

SJR 54 instructs DMS to "develop a proposal to modify Kentucky's current Medicaid reimbursement model to better account for the social risks and health-related social needs at the community level by modifying reimbursement rates for providers based on the Area Deprivation Index (ADI) score of the location in which the provider practices." However, as previously discussed in this report, the factors contributing to ADI scores in a particular geographic area are multi-faceted and likely require a targeted multi-faceted approach to be addressed effectively. While there are several programmatic and payment-based strategies available to state Medicaid agencies, selecting the appropriate tool(s) requires careful consideration of the interaction with existing reimbursement structures and the impact of the proposal on fee-for-service versus managed care populations, as well as an analysis of the ultimate policy goals of the proposal.

Potential for Interaction with Other Payment Programs

An overall consideration for Kentucky to assess is the potential for interplay between an ADI payment strategy and other Medicaid payment programs established by the Commonwealth. For instance, Kentucky currently operates the Hospital Rate Improvement Program (HRIP) which provides qualifying hospitals with supplemental payments to increase reimbursement for inpatient services provided through Medicaid fee for service and inpatient and outpatient services provided through Medicaid managed care.[83] Because HRIP pays the difference between Medicaid managed care payments and average commercial rates (in part due to whether the provider meetings required quality metrics), adding a new program that increases Medicaid payment rates to HRIP-eligible hospitals would merely reduce the HRIP payment, not provide new payment to those providers. Additionally, the HRIP program is funded by an assessment on hospitals to provide state matching dollars for federal Medicaid funds required for implementation of the program, whereas a funding source for an ADI payment program has not yet been identified. In general, **if an ADI-related provider reimbursement program were to be established that required new state dollars as part of the funding strategy, Kentucky should evaluate whether this change would shift the funding source away from an existing funding source** (e.g., a provider tax-funded program) to a program that would require the state to wholly fund the Medicaid state share of the cost.

Scope of Potential Impact

As discussed earlier in this report, Kentucky primarily operates its Medicaid program under a managed care delivery system, with more than 90% of membership and 75% of expenditures being in managed care. As such, **DMS cannot directly make payments to providers for services provided to managed care members, and therefore a fee schedule change alone would not impact payment rates to managed care providers in Kentucky**. Instead, Kentucky would need to leverage available tools under its MCO contracts to encourage or require certain levels of provider payments to be made by the MCO, or to require the MCO to make other investments in providers who deliver desired services.

However, certain services (e.g., long term services and supports) remain operated under the fee-for-service (FFS) delivery system, meaning that FFS payment changes can impact overall reimbursement to those providers. DMS can (and regularly does) make changes to its fee schedule and other supplemental payments to providers for services provided to FFS members. If DMS wanted a fee schedule change to be mandated for application to the managed care population, this would require changes to the MCO contracts and imposition of a minimum fee schedule requirement for the plans. **Selection of the most effective provider reimbursement mechanisms will depend on which services it wishes to encourage and in which delivery system those services are delivered**.

Likewise, the ability to impact performance on quality improvement goals (such as reduction of health disparities) will be generally greater if the strategy selected aligns with the program (managed care or FFS) where financial levers are available. A policy goal to improve quality outcomes for Kentucky Medicaid members would also require MCO contract terms to support their participation in that effort, and can be further enhanced if financial incentives for the MCO's participating providers are also put in place (such as through value-based payment).

[83] Kentucky Revised Statutes 205.6405 to 205.6408; 907 Kentucky Administrative Regulations 10:840.

Alignment with Goals

Each of the various options discussed in this report have the ability to address different aspects that may be driving underlying ADI scores. For example, increasing Medicaid reimbursement for certain providers located in targeted geographic areas (High-ADI areas) may be helpful to address lack of provider access in the given geographic area but may not be impactful as a standalone strategy if other social risk factors are driving the High ADI score.

Other strategies like MCO risk adjustment or requirements for community reinvestment can be useful tools to broadly infuse additional resources into the MCOs serving members with high HRSN and the communities with increased need but are not directly targeted at a provider or member level. Conversely, adding new benefits could directly target HRSN services to individual members in need but still may not address the underlying community needs driving high ADI scores in a given area. Careful consideration must be given to ensure the selected proposal aligns with the specific overarching goals.

SUMMARY OF OPTIONS

Given these factors, below is a summary of the high level considerations for the various managed care options discussed in this report. Depending on the goals, Kentucky may choose to pursue one or more strategies from the list below. Ultimately, effectively addressing social risk and HRSN at the community level is a multi-faceted challenge that likely requires a more comprehensive solution.

FIGURE 15. SUMMARY OF OPTIONS AND POTENTIAL APPLICABILITY TO ADDRESS HRSN

STRATEGY	CONSIDERATIONS
State Plan Fee Schedule Update Increase reimbursement for some or all providers and/or services in a High-ADI region	▪ Permissible under current Medicaid state plan authority, using a state plan amendment (SPA) ▪ On its own, this strategy will only impact reimbursement for FFS services. However, MCO contracts can include a requirement to pay providers per a minimum fee schedule (such as the FFS fee schedule). This would require a state directed payment to be implemented (see below), but would not require CMS approval of a preprint.
State Directed Payment Seek federal approval to mandate that MCOs pay certain providers (such as those in a High-ADI region) according to certain payment terms.	▪ Requires federal approval and must meet federal criteria for state directed payments. Most preprints must be renewed on an annual basis. ▪ A class of providers to receive these payments could be designed to target High-ADI regions, or even specific providers located within those regions ▪ Targets payments only within managed care, which may be useful given the large proportion of managed care within the Medicaid program.
Value Based Payment (VBP) Arrangements Pay an incentive to MCOs that meet quality performance goals related to improving outcomes in High-ADI regions or for meeting network contracting goals related to including VBP terms in provider contracts in High-ADI regions.	▪ In general, can be implemented under existing Medicaid authority by incorporating new contract terms with MCOs ▪ MCO performance incentives are capped at 5% of total capitation paid to the MCO. Although these incentives alone do not directly result in increased reimbursement to providers, states can require MCOs to share incentive earnings with the providers who helped achieve the results. ▪ Quality goals for MCOs and provider VBPs could be aligned to specifically target improved access in High-ADI areas. Depending upon the VBP model selected, providers can be engaged to improve their performance and share in any rewards for achieving VBP goals.
New Medicaid Covered Services and Authorities Add new targeted Medicaid services that directly address HRSN of members, such as enhanced case management, housing supports, or nutrition services.	▪ States can add most new services, including targeted case management services, under current Medicaid state plan authority, using a state plan amendment (SPA). ▪ By contrast, some new HRSN services, such as housing and nutrition supports, require 1115 waiver authority that may impose a significant administrative burden to obtain. However, waiver services can typically be targeted to a more defined population, including limited to specific geographic regions. ▪ These options do not increase reimbursement for current services delivered by providers. However, it offers the ability for providers to access and receive reimbursement for new services that address individual HRSN.

STRATEGY	CONSIDERATIONS
In Lieu of Services Through Managed Care Flexibilities Include authorized list of services to support HRSN that MCOs may opt to cover under their contract.	▪ Can be implemented under existing Medicaid authority by incorporating new contract terms with MCOs. ▪ Requires limited time and DMS resource commitment to implement. ▪ ILOS must advance the objectives of the Medicaid program, be cost effective, be medically appropriate, be provided in a manner that preserves member rights and protections, be subject to appropriate monitoring and oversight, and be subject to retrospective evaluation. ▪ Cannot mandate MCOs to offer ILOS and cannot require members to use them, which may limit the effectiveness of this strategy on its own (but could be paired with other strategies such as quality incentives, to encourage their use)
Risk Adjustment Use the ADI of a member's area of residence as a consideration in risk adjustment for MCO capitation payments.	▪ Can be implemented under existing Medicaid authority by incorporating new contract terms with MCOs ▪ Requires limited time and DMS resource commitment to implement, as it would be integrated into a process that is already occurring at DMS. ▪ This approach could be designed to consider the overall SDOH in a given area (e.g., High-ADI region). ▪ Changes to risk adjustment would only affect the relative capitation payments provided to MCOs and may not result in additional funding being offered to providers or the MCOs in aggregate. ▪ Adjusting capitation payments alone is likely not enough to measurably move the needle on health equity, therefore, states utilizing this approach may wish to combine this strategy with other contract tools to mandate plans to offer additional supports and resources to members with higher social needs.

Add Other Types of MCO Contract Requirements
Include contract requirements for MCOs to provide staffing or special programs to address HRSN.
	▪ Can be implemented under existing Medicaid authority by incorporating new contract terms with MCOs.
	▪ Requires limited time and DMS resource commitment to implement.
	▪ Possible to implement within current managed care funding levels, depending on design. Examples may include:
	  ▪ Define MCO care management program requirements to include required screenings for HRSN and referrals/coordination with HRSN-related services.
	  ▪ Use auto-assignment algorithms to incentivize value-added services or other MCO investment in HRSN.
	  ▪ Require MCOs that fail to meet the minimum medical loss ratio target to make community investments in geographic areas of need, such as High-ADI regions.

LIMITATIONS

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services (DMS).

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In performing this analysis, we relied on data and other information provided by DMS and participating MCOs. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Qualifications:

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens and Michael Kornhauser are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this presentation.

APPENDIX A

STATE EXAMPLES OF PAYMENT MECHANISMS[84]

STATE	PAYMENT TYPE	SOCIAL RISK FACTORS	DATA SOURCE	DETAILS
Arizona	Payment to MCO	• Housing instability • Parental relationship instability • Family instability • Criminal justice involvement	• Claims • U.S. Census Data	• Capitation payments to participating MCOs • Adjustment incorporates four member-level social risk factors and one area-level measure
Hawaii*	Payment to MCO	• Homelessness	• Claims (Z Codes)	• Higher capitation payments to MCOs for Medicaid members who are experiencing homelessness
Maine*	Provider reimbursement	• Homelessness • Experience of abuse or trauma • Legal issues • Social networks	• Service Prioritization Decision Assistance Tool (SDPAT)	• Provides permanent supportive housing support • Community Care Teams are paid on a per-member per-month (PMPM) basis that varies across three service tiers
Massachusetts ACOs*	Payment to provider ACOs	• Housing instability • Disability • NSS7** • SMI • Opioid use disorder (OUD)	• Claims • State administrative data • U.S. Census	• Adjusted payments (see additional details below)***
Massachusetts MCOs*	Payment to MCO	• Housing instability • Disability • NSS7** • SMI • OUD	• Claims • State administrative data • U.S. Census	• Adjusts capitation payments to MCOs to incorporate three member-level social risk factors and two area-level measures of social risk
Minnesota	Payment to provider ACOs	• Deep poverty**** • Homelessness • Past incarceration • SMI or SUD	• Self-reported member address • State Department of Corrections data	• Population based payments (PBPs) directed to Integrated Health Partnerships (IHP) • PBPs account for social risk to determine IHP's share of profits and loss
New York	Provider reimbursement	• Homelessness • Criminal justice involvement	• Health Home Tracking System High, Medium, Low (HML) Assessment	• Higher provider reimbursement for high-value services such as outreach and care management for members who are identified as high risk
Washington*	Payment to MCO	• Homelessness	• Claims	• Higher capitation payments to MCOs for Medicaid members who are experiencing homelessness

[84] Department of Health and Human Services. Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments. (September 2022). https://aspe.hhs.gov/sites/default/files/documents/ce8cdc5da7d1b92314eab263a06efd03/Area-Level-SDOH-Indices-Report.pdf

Notes:

**Specifically requested for review in SJR54*

**NSS7: Neighborhood stress score

***Nature of payment varies across 3 ACO models in MassHealth:

- Accountable Care Partnership Plan: adjusted capitation payments are made to each partnership involving a provider-led ACO and a single MCO (as of 2018, 13 ACOs)
- Primary Care ACO: FFS payments are made to ACO providers and savings/losses are determined by comparison with an adjusted total cost-of-care target (as of 2018, 3 ACOs)
- MCO-Administered ACO: Adjusted capitation payments are made to MCO(s) and then MCOs pay the ACO based on approved state payment arrangement (as of 2018, 1 ACO)

****Minnesota defines deep poverty as below 50% FPL

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