



**LOUISVILLE, KENTUCKY  
LOUISVILLE METRO BOARD OF HEALTH**

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**Evaluation of Affordable Care Act Implementation at the Local Level in Metro Louisville**

**Louisville Metro Board of Health  
December 2014**

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**Louisville Metro Board of Health**  
**Local Implementation of the Affordable Care Act: Annual Progress Report**  
**December, 2014**

**I. Introduction and Executive Summary**

In August 2013, the Louisville Metro Board of Health (BOH) began a unique and proactive process to facilitate the implementation of the Patient Protection and Affordable Care Act (ACA) in Louisville, Kentucky. Recognizing a gap between activity at the federal, state, and local levels, the BOH sought to provide a mechanism for coordination and communication between the agencies and community members working on ACA implementation at the local level in Metro Louisville. The BOH's goals for organizing local efforts and convening stakeholders were to ensure successful implementation of ACA, discover and overcome any barriers to success, and examine the potential for a sustained infrastructure for local health planning and policy development to improve community health. The project description can be found in Appendix A. Since its inception, this project has mobilized local community partners to engage with each other and representatives of state agencies in routine meetings designed to identify key issues and generate solutions to improve the health system and health outcomes for residents of Metro Louisville while navigating health care reform. This project has been supported by funding from Kindred Healthcare, Inc., the Foundation for a Healthy Kentucky, KentuckyOne Health, Friends of Louisville Health and Wellness, Norton Healthcare, and the University of Louisville School of Public Health and Information Sciences. A full list of stakeholders who engaged in activities convened by the BOH committees can be found in Appendix B.

To focus on specific issues related to ACA implementation, the BOH commissioned five committees, each charged with a different aspect of the implementation. The Steering Committee, chaired by William M. Altman, Executive Vice President for Strategy, Policy and Integrated Care at Kindred Healthcare, Inc. and former Chair of the BOH, defined the initial vision of this project and has continued to provide oversight. The purpose of this committee is to serve as an entity for health planning and policy development by defining the vision of how Louisville stakeholders can, in the short term, implement ACA successfully and, in the long term, improve the health of the community.

The Enrollment Committee, chaired by Bill Wagner, Executive Director of Family Health Centers, was charged with convening a range of stakeholders in the Louisville community to identify areas of collaboration and coordination to ensure successful enrollment of people into health benefit plans through kynect and Medicaid. This committee began meeting September 2013 as the community prepared for the first open enrollment period.

The Health Literacy and Education Committee, chaired by Dr. LaQuandra Nesbitt, Director of Louisville Metro Public Health and Wellness, has focused on educating the public on the appropriate uses of the health care system. This committee has designed and produced educational materials, and continues to convene stakeholders who engage consumers to increase their health literacy.

The Workforce Capacity Committee was charged with ensuring that the Louisville health care community has the capacity to care for the newly enrolled population. This work entails assessing the current workforce capacity and anticipating workforce needs based on increased population coverage to inform strategies for educating, recruiting, and retaining health professionals to serve Metro Louisville.

The Measurement and Outcomes Committee, chaired by Dr. Craig Blakely, Dean of the University of Louisville School of Public Health and Information Sciences, was asked to measure the efficacy of all committee efforts by tracking and compiling data related to Metro Louisville's implementation of ACA. The Measurement and Outcomes Committee was additionally responsible for reporting findings.

The first year of implementation of ACA at the local level in Metro Louisville was viewed as a success by a variety of process and outcome measures:

- The BOH-convened stakeholder groups were viewed as a critical component of ACA implementation success as well as a model for collaboration on public health issues in the future.
- The number of people newly enrolled in insurance coverage exceeded expectations in Metro Louisville, particularly for enrollment in the Medicaid program. The enrollment success was attributable, in part, to the collaboration and outreach of local stakeholders working to develop a highly publicized and accessible enrollment process.
- All parties have recognized that Kentucky has done well implementing ACA with the kynect system. Additionally, stakeholders have consistently reported that KOHBHIE has been responsive to requests for changes and has made significant system improvements during the first year.

Despite these early successes, many challenges remain to ensure Louisville residents can access health care. As we enter into the second year of ACA implementation in Metro Louisville, the BOH ACA Steering Committee makes the following recommendations:

1. **Stakeholder Collaboration and Engagement:** The ACA Steering Committee and its Workgroups should continue to remain active and engaged to ensure continued successful implementation of the ACA in Metro Louisville.
2. **Policy Recommendations:** The Committee recommends a series of improvements to the enrollment process detailed in the report to improve the efficiency and the effectiveness of the system to enroll people in both Medicaid and Qualified Health Plans (QHPs). Many of these recommendations require close coordination with the State and with private insurance brokers.
3. **Research Recommendations:** The Committee recommends a robust research agenda to evaluate the ongoing effectiveness and efficiency of the system to expand access to health insurance for the community as well as the impact on health status and well-being. This research agenda should include at a minimum the following: barriers to enrollment in Medicaid and QHPs; consumer experiences with enrollment and with the health care system from a care standpoint; the capacity of the workforce in Metro Louisville to meet the increased demand for health care services; the experience and perspective of the

health care workforce; and the long-term impact on health status and health outcomes for the Metro Louisville community.

4. **Education and Engagement Recommendations:** The Committee recommends an expanded effort to educate Louisville community members, health care providers, and other key stakeholders regarding enrollment, appropriate use of the health care system, healthy living, and health care best practices.

## **II. Overview and Methodology**

To date, ACA implementation has gone through one complete cycle of open enrollment for the QHPs, while enrollment for Medicaid ended its first year of ongoing enrollment on September 30, 2014. This report summarizes the findings of the Measurement and Outcomes Committee related to the first year of ACA implementation activity. Specifically, the report highlights various aspects of the implementation process as well as the numbers of new Metro Louisville enrollees in Medicaid and QHPs. The report concludes with recommendations for how to strengthen implementation going forward.

A variety of data were used to monitor and evaluate the process. Enrollment data were provided by the Kentucky Office of Health Benefit and Health Information Exchange (KOHBHIE) and the Office of the Secretary of the Kentucky Cabinet of Health and Family Services (CHFS). Qualitative data collection included targeted interviews with eleven community leaders who routinely attended the Enrollment Committee meetings throughout the past year. Fourteen local insurance agents (agents) attended two focus groups to provide their feedback on the enrollment process. Fifteen kynectors from seven unique community agencies also attended focus groups to report on their experiences. Additionally, Enrollment Committee minutes were reviewed for relevant themes that emerged throughout the process. To date, this evaluation process has not included the voices of consumers or health care professionals, both of which are recognized as imperative to the successful implementation of ACA.

## **III. Key Findings**

### **A. Findings Regarding ACA Implementation Process**

#### *1. Training and Preparation*

Preparation for this process was challenging, as is the implementation of any new policy that impacts the population. In some instances, contracts between local agencies and KOHBHIE were not finalized until September 2013. Training on the kynect system did not include practice with live screens, which were not introduced until October 1<sup>st</sup> when enrollment actually began. kynectors, who have been certified by KOHBHIE to aid consumers with enrollment, found that they learned the most on the job. Leaders, kynectors, and agents all vocalized that they have learned and benefited from each other when they collaborated. Specifically, kynectors have networked when they attended outreach and enrollment events together. kynectors also stated that the kynect blog has been a helpful tool during this first year.

The Department of Community Based Services (DCBS) reported the agency has corrected errors made by kynectors, specifically as they counted income and determined eligibility. These errors

may be prevented with additional training. kynectors struggled assisting small businesses and expressed a need for training on the Small Business Health Options Program (SHOP). Additionally, kynectors might benefit from training on federal benefit programs to increase their understanding of how DCBS determines eligibility for Medicaid or Advanced Premium Tax Credits (APTCs). Agents reported that they have not received training on Medicaid or Kentucky Children's Health Insurance Plan (KCHIP) eligibility, despite their frequent work with this population. However, they also voiced they are unwilling to invest time into learning more about Medicaid, since it does not positively impact their businesses to do so.

## *2. Outreach and Advertising*

Metro Louisville has demonstrated success by implementing this fundamental change to the health system through tremendous community outreach. Hundreds of outreach events were held both statewide and focused in Metro Louisville. At the state level, Kentucky did well by choosing to advertise for kynect as health coverage for Kentuckians, rather than connecting the reform tool to ACA or Obamacare, which has a political connotation. KOHBHIE hosted a booth at the Kentucky State Fair in both 2013 and 2014. In October 2013, Get Covered Kentucky sponsored news spots on WHAS11, and then hosted open phone lines to answer questions, receiving 15,000 calls on each of four days.

Local agency strategies for enrollment included housing kynectors within care settings, visiting popular community locations, and use of social media. Insurance agents preferred to work one-on-one with consumers, finding that their independently arranged events were not cost-effective methods of gaining business. When agents and kynectors did work together during enrollment events, they found that the collaboration enabled each party to reach consumers more effectively. However, when KOHBHIE requested assistance with enrollment events beyond original contracts, this strained kynector capacity.

A range of stakeholders has created educational resources to inform consumers about health insurance and the health care system. Additionally, the Greater Louisville Medical Society worked to educate providers and physician groups about ACA implementation and how patient coverage might impact their practices. Agents and kynectors reported that consumers have presented misperceptions about the enrollment period and kynect's role as a marketplace rather than an insurance carrier, as well as a lack of knowledge about health insurance terminology.

## *3. Customer Service*

A primary concern of kynectors and insurance agents has been the ability to provide good customer service. Although the system was designed with an initial screening process to enable consumers to approach either kynectors for help with the kynect eligibility process or insurance agents to receive in-depth assistance with purchasing QHPs, agents and kynectors both found that the screening results did not always match consumers' eligibility results after all information was entered. Additionally, consumers reach out to either resource without differentiation between their areas of expertise. This has posed a problem for providing the best customer service, since kynectors are prohibited from advising consumers in making a plan choice that best meets the consumer's needs, agents are not versed in Medicaid, and some cases require DCBS assistance. Both agents and kynectors are hesitant to refer consumers elsewhere because it places excessive burden on the consumer to seek assistance from multiple resources.

Furthermore, regulations prohibited kynectors from linking consumers to specific agents, instead requiring them to present a list of local options to prevent biased recommendations. Consumers were less likely to follow up with initiating a second appointment.

Both agents and kynectors reported that they encountered consumers who had started the enrollment process independently, but then required assistance. However, when these consumers approached them, they had difficulty gaining access to the consumer's account. Once assisting consumers, they spent time correcting consumer errors in the system, which took significant time or required assistance from DCBS or the kynect call center. Agents and kynectors also stated that if they required technical assistance from KOHBHIE to process a case, it may take several days to determine if a problem had been resolved, and they could not rely on KOHBHIE staff members to alert them to an updated status.

Insurance agents verbalized some specific concerns about their ability to provide customer service as part of their business models. They compared their enrollment experiences using kynect, which may take more than two hours, to those when enrolling consumers in plans outside the exchange, which typically takes 20 minutes. Agents expressed frustration that only their agency's licensed staff members were authorized to speak with the kynect call center to assist consumers, which limited their ability to assist consumers effectively and efficiently. They stated that when they have used a subsidy calculator, any inaccuracies in the calculation reinforced consumers' suspicions that the agents may not be trustworthy. Agents also voiced concern that kynectors may not assist consumers to match insurance plans to network preferences and coverage needs due to their lack of licensure and inability to present bias.

#### *4. Communication*

There were many systemic complications observed with communication from KOHBHIE. kynectors and agency leaders expressed concern that communication from KOHBHIE was delayed relative to implementation of system changes. Communication was also sporadic, such that one agency might learn news from one another rather than from KOHBHIE directly. Agents and kynectors noted that identifying someone who could assist with a case was difficult, both through the kynect call center and within DCBS. They also stated that there appeared to be inconsistencies in the instructions or answers they received from any given person within these state agencies. Due to the call volume, they might hold on a call for hours while waiting for assistance, or never receive the return call they were promised. kynectors working with immigrants reported that there were significant barriers to the use of interpreters.

#### *5. The State's System for Enrollment: kynect*

Despite glitches and challenges in the kynect website, all parties have recognized that Kentucky has done well implementing ACA with the kynect system. Additionally, stakeholders have consistently reported that KOHBHIE has been responsive to requests for changes and has made significant system improvements during the first year.

Agents and kynectors found that consumers had attempted to enroll independently, but had become frustrated using kynect and had reached out for assistance. However when working to assist consumers, they found that the kynect dashboard is not user-friendly, nor can kynectors view every screen on an account to communicate effectively with DCBS. Additionally, agents

and kynectors expressed concern that consumers cannot view their own accounts online once a professional initiates the account. On the occasion that a consumer transferred from one source of assistance to another (i.e., a kynector to an agent, a kynector to DCBS, etc.), assisters found that it was difficult to become authorized representatives on an account, and the system for documenting case notes is not visible for every user.

#### *6. Role of the Department of Community Based Services*

DCBS enrolls and certifies individuals in Medicaid and other assistance programs, and therefore DCBS staff members have more training in Medicaid eligibility than kynectors who were newly introduced to this role. Medicaid enrollees might seek benefits directly through DCBS, or kynectors might refer pending applications to DCBS to correct problems that might keep an application from processing. However, DCBS introduced a new operational design and an electronic case file system simultaneous to the process of ACA implementation. The agency reports high turnover which impacts service provision by qualified staff members. Additionally, DCBS did not have access to kynect until December 15, 2013, months after other agencies began to use it. The agency continues to rely on its older computer system for processing non-medical benefits as well, which has slowed on-site interviews for DCBS staff. This has complicated the agency's ability to assist with the enrollment process efficiently and effectively.

#### *7. Role of the Enrollment Committee*

Leaders of local agencies expressed confidence that the Enrollment Committee was instrumental in the successful enrollment of so many residents of Metro Louisville. Committee meeting attendees have voiced the value the communication and collaboration facilitated by the Enrollment Committee, especially with KOHBHIE. Monthly meetings have been a source of information, learning, and problem-solving. Members of the Enrollment Committee have shared information as it has come to them, and have created new resources to benefit the community. Enrollment Committee meetings have also provided agencies an opportunity to provide feedback to KOHBHIE regarding problems with kynect and the KOHBHIE call center. KOHBHIE representation at the meetings provided local agencies with a point person who could address concerns and assist with problem-solving, which has meant less navigation through the complex system as problems have arisen.

The Enrollment Committee generated ideas to reach underserved populations, such as immigrants, incarcerated individuals, and the homeless population. Specifically, members of the committee developed and distributed a chart to designate immigrant eligibility, which has served as an aid for kynectors statewide. Members of the committee have also initiated the Healthy Reentry Coalition for Kentucky, which works toward health reform within the criminal justice system. This discussion has resulted in recognition that Kentucky regulations require the termination of Medicaid benefits for incarcerated individuals, which creates cyclical churning, increasing the workload for DCBS, disrupting the continuity of care for consumers, and creating reimbursement inefficiencies for providers. One larger systemic problem identified was the Federal Data Service Hub's inability to provide correct information, resulting in pending cases, particularly for immigrants and individuals who were recently released from incarceration.

## **B. Outcomes: New Metro Louisville Enrollees**

### *1. Medicaid Enrollment*

The open enrollment process for expanded Medicaid began October 1, 2013. Individuals can now apply for Medicaid under traditional or Modified Adjusted Gross Income (MAGI) terms throughout the year. Open enrollment for QHPs lasted October 1, 2013, through April 15, 2014. Prior to the start of open enrollment, it was estimated that 101,366 Metro Louisville residents were uninsured, 47% of whom were eligible for benefits covered by Medicaid expansion.

In Metro Louisville, a total of 70,281 new members were enrolled in Medicaid by July 29, 2014, 52,549 of whom were eligible under the provisions for Medicaid expansion. This exceeded not only the goal set by the BOH Enrollment Committee, but also the estimated number of uninsured generated by the Office of Kentucky Governor Steven Beshear (Commonwealth of Kentucky, 2014). By the end of July 2014, 11,976 consumers had been enrolled in QHPs through kynect, 22% of those estimated to be eligible for these products. Over 15,000 children and youth were enrolled in Medicaid throughout the past year, despite Kentucky's push to increase enrollment in the Kentucky Children's Health Insurance Plan (KCHIP) in the past five years. The enrollment of 16,617 individuals ages 26 through 34 in both Medicaid and QHPs is indicative of successful outreach to the population of young adults termed "young invincibles." Appendix C provides detailed enrollment data.

Enrollment in health insurance has positively impacted members of the Louisville community. Individuals who could not be covered previously (due to pre-existing conditions or financial constraints) expressed gratitude and relief to enrollment agents and kynectors that they have coverage and the ability to access care.

### *2. Enrollment in Qualified Health Plans*

Agents and kynectors found a variety of reasons that QHP enrollment was low. First, QHPs are associated with the stigma of Obamacare; consumers expressed apprehension toward health reform, wondering if the act might be repealed as the politics surrounding health reform continue in national news. Additionally, consumers presented with misperceptions and a lack of knowledge about the penalty for being uninsured and the need for health insurance. They faced high premiums, deductibles, and out of pocket costs. Agents also noted that because subsidies are based on a premium to income ratio, younger consumers often do not qualify for assistance. Family subsidies are impacted when children qualify for KCHIP.

### *3. Post-Enrollment Support*

Enrollment professionals have also provided post-enrollment support in the past year. Consumers return to their initial assister for help with problems using their insurance, finding in-network providers, and resolving claims issues. As the Open Enrollment 2014 approached, Enrollment Committee conversations centered on concern regarding the actions consumers and kynectors need to take in order to maintain coverage.

Following initial Medicaid enrollment, consumers must be recertified annually to ensure continued Medicaid eligibility. While kynect enables passive recertification for some consumers,

this is an active process for others, requiring that they must present to DCBS or a kynector with documentation to verify current income and prevent automatic termination of coverage. Without this action, Medicaid coverage is terminated after 12 months. Termination can be reactivated retrospectively up to three months, but only with system overrides or reapplication through kynect. This current process poses multiple reasons for concern by creating both the potential for consumer churning and considerable additional work at the expense of the state, consumers, and providers. Stakeholders have expressed concern about the recertification process, as well as the unclear communication around this process. Recertification notifications may not reach consumers due to the transient nature of the Medicaid population. kynectors have not received training specific to recertification, and agencies have not received clarification about their roles and responsibilities associated with consumers who return to them for eligibility determination. Furthermore, coverage gaps mean that consumers may not receive timely treatment or medication, and providers experience a delay or denial for reimbursement.

Enrollment data indicate fewer QHP enrollees in June, July, and August 2014. This decline of consumers could possibly represent individuals who have not maintained premium payments and have lost health insurance coverage, but this issue will need to be researched more closely as data become available. Understanding the needs of enrolled consumers to maintain eligibility and coverage requires further study.

### **C. Health Literacy and Education**

Education to increase health literacy has occurred simultaneously to outreach and enrollment. The work of the Health Literacy and Education Committee has resulted in collaboration of both state and local agencies that have been willing to share their ideas and resources. Initially, the Health Literacy and Education Committee met to create a brochure with four core messages: 1) get health insurance if you don't have it, 2) choose healthy behaviors, 3) identify a medical home, and 4) know where to go for appropriate care. Thirty-five thousand brochures were produced in both English and Spanish with grant funding, then distributed throughout the community in Fall 2013.

In 2014, Louisville Metro Public Health and Wellness has collaborated with the Health Literacy and Education Committee to devise a health literacy campaign. Through committee meetings, the group has distinguished and defined health benefits literacy, health systems literacy, and health behavior literacy. To this end, the committee has asked that partner agencies present on the content areas they address when engaging community members in health literacy, with the long-term plan to create a health literacy curriculum available to any partner interested in one of the topic areas. The group's continued work empowers members to share resources and ensure outreach to all Louisville residents while providing consistent messaging.

### **D. Workforce Capacity**

One missing link in ensuring that the ACA is well implemented in Louisville has been the ability of the health care community to ensure its workforce capacity to care for the newly enrolled population. This entails assessment of the current workforce capacity and anticipating workforce needs based on increased population coverage to inform strategies for educating, recruiting, and

retaining health professionals to serve Metro Louisville. Several reports have been published within the past decade, each with differing methodologies: in 2007, the Kentucky Institute of Medicine published information about the statewide physician workforce (Kentucky Institute of Medicine, 2007); the Louisville Primary Care Association examined local primary care and oral health in 2011 (REACH of Louisville, 2011); the Foundation for a Healthy Kentucky commissioned a health care market report in 2012 (Davis, 2012); and Deloitte, in partnership with KOHBHIE, investigated state level facility capacity and health care workforce, including numbers of physicians, dentists, advanced practice registered nurses (APRNs), physician assistants (PAs), registered nurses (RNs), licensed practical nurses (LPNs), optometrists, and mental health providers in their study in 2013 (Deloitte Consulting, 2013).

As the Workforce Capacity Committee began to explore methodologies for understanding the current workforce capacity and the current system needs, it became clear that the information available for analysis is unreliable and incomplete. Each available database collects different fields of information, which impacts the uniformity and accuracy of the information across provider type. For example, physician availability has been determined based on each individual's report during licensure renewal. It does not account for multiple designations of time and responsibility, such as teaching or administrative duties, nor for multiple practice locations, such as when a physician has offices in both Louisville and southern Indiana. Additionally, traditional measurements of workforce capacity may not truly reflect population needs, since this metric has typically been calculated using the number of professionals given the total population, without accounting for context. As an urban environment, Louisville serves as a resource hub and a regional trauma center. The population that uses Metro Louisville practitioners is not limited to Metro Louisville residents, particularly for specialty practitioners. Bullitt and Spencer Counties, which both neighbor Metro Louisville, have been identified as the neediest for increased primary care. Their deficits impact Metro Louisville. Finally, workforce capacity is reported in terms of gross numbers, and not by provider acceptance of specific insurance plans, which may influence the capacity of the Louisville health care community to service the newest insured consumers.

In 2014, Kentucky was invited as one of seven states to participate in the Health Workforce Policy Academy sponsored by the National Governors Association (NGA). The Kentucky Office of Health Policy is engaged in the initial stages of investigating new models that would aid the state in reaching a better understanding of the current workforce capacity and workforce needs.

#### **IV. Summary**

As a community, Metro Louisville capitalized on the opportunity to utilize the new features of ACA and work toward a healthier Kentucky. Under the leadership of the BOH, community stakeholders collaborated to ensure a successful enrollment process. Louisville has demonstrated the benefits of both Medicaid expansion and a state-run benefit exchange, enrolling over 80,000 residents in health insurance plans. The collaborative efforts in Louisville have included iterative feedback to KOHBHIE during the past year, which has been invaluable for refining the statewide system. Throughout the county, work continues to educate residents regarding effective use of their health insurance and the recertification process to ensure maintenance of coverage, as well as efficient use of the health care system for long-term positive outcomes. Community

stakeholders are prepared to address the ongoing challenge of reaching consumers who remain uninsured in the continued effort to lower Kentucky's uninsurance rate. Questions remain about the capacity of the health care system and whether there is enough provider capacity to meet the increased demand resulting from the newly insured residents. In addition, a few systemic improvements may make the process of enrollment even more successful. However, Louisville has exceeded its expectations for the first year of implementing significant health care reform.

## **V. Recommendations**

### *A. Policy Recommendations*

#### *1. Enrollment*

- Improve preparation of enrollment professionals for annual recertification and open enrollment.
  - Responsible party: KOHBHIE
  - Timeframe: Annually, 30 days prior to open enrollment
- Increase training on SHOP and eligibility determination for kynectors.
  - Responsible party: KOHBHIE
  - Timeframe: Annually, 30 days prior to open enrollment

#### *2. Medicaid*

- Suspend Medicaid benefits for incarcerated individuals rather than terminate them to eliminate churning and the resultant systematic inefficiencies and gaps in consumer coverage.
  - Responsible party: Kentucky Department for Medicaid Services
  - Timeframe: January 2016
- Establish passive recertification for all Medicaid consumers to eliminate churning and the resultant systematic inefficiencies and gaps in consumer coverage.
  - Responsible party: Kentucky Department for Medicaid Services
  - Timeframe: Prior to Open Enrollment 2015

### *B. Research Recommendations*

#### *1. Outcomes and Health Status Research*

- Evaluate long-term health outcomes of Louisville residents.
  - Responsible party: Louisville Metro Public Health and Wellness
  - Timeframe: Annually

#### *2. Workforce Capacity Research*

- Short-Term: Analyze the local workforce capacity to accommodate new Medicaid consumers in primary care and specialized practices.
  - Responsible party: The Commonwealth Institute, Kentucky Office of Health Policy, Kentucky Department for Medicaid Services
  - Timeframe: October 2015

- Longer Term: Establish reliable mechanisms for collecting data and completing research regarding workforce capacity.
  - Responsible party: Kentucky Office of Health Policy
  - Timeframe: April 2016

### 3. *Research Regarding Consumer and Provider Perspectives and Experience*

- Understand consumers' hesitancy to enroll in QHPs and perceptions of affordability, and analyze strategies for outreach to individuals who remain uninsured.
  - Responsible party: The Commonwealth Institute
  - Timeframe: October 2015
- Evaluate health care practitioners' experiences of caregiving and administration due to policy changes as a result of ACA.
  - Responsible party: The Commonwealth Institute, Greater Louisville Medical Society
  - Timeframe: October 2015
- Evaluate consumers' experiences of kynect, health insurance, and health care systems post-ACA implementation.
  - Responsible party: The Commonwealth Institute, Kentucky Voices for Health
  - Timeframe: March 2016

### 4. *Enrollment-related Research*

- Evaluate churning as enrollment numbers fluctuate over time.
  - Responsible party: The Commonwealth Institute, KOHBHIE, Kentucky Office of Health Policy, Kentucky Department for Medicaid Services
  - Timeframe: October 2015
- Reforecast the number of eligible uninsured and provide more detailed information about identity and contact information to support outreach efforts.
  - Responsible party: KOHBHIE
  - Timeframe: Annually, 60 days prior to open enrollment

### C. *Engagement and Education Research*

- The BOH ACA Implementation Committees should continue to convene key stakeholders to sustain community engagement in health planning and health policy development and at a local level.
  - Responsible party: BOH
  - Timeframe: Ongoing

- Create a website forum or clearinghouse that allows for communication between enrollment professionals to improve the efficiency of the enrollment system by reducing the inconsistencies in both the timing and content of messages from KOHBHIE, enabling feedback from individuals working with consumers, quickly identifying problems, answering questions about policy, sharing best practices, and providing reports to KOHBHIE and insurance providers. This clearinghouse should include the financial investment of KOHBHIE and insurance providers. One specific model for a website forum is In the Loop at [enrollmentloop.org](http://enrollmentloop.org).
  - Responsible party: Kentucky Voices for Health
  - Timeframe: March 2015
  
- Increase advertising and media efforts to clarifying enrollment dates. Medicaid enrollment is ongoing, as is QHP enrollment for qualifying events, which merits advertising throughout the year.
  - Responsible party: KOHBHIE, Insurance Providers, Kentucky Department of Medicaid Services, BOH Health Literacy and Education Committee, BOH Enrollment Committee
  - Timeframe: Annually between Open Enrollment Periods
  
- Increase collaboration between kynectors and insurance agents to capitalize on each discipline's expertise, which includes representation of insurance agents in the Enrollment and Health Literacy and Education Committee meetings.
  - Responsible party: KOHBHIE, BOH Enrollment Committee, BOH Health Literacy and Education Committee
  - Timeframe: November 2014
  
- Provide focused health insurance literacy to prevent loss of consumer coverage.
  - Responsible party: Insurance Providers, Health Care Systems, BOH Health Literacy and Education Committee
  - Timeframe: Ongoing

## Glossary of Terms

**Advanced Premium Tax Credits (APTCs):** APTCs reduce monthly premium costs for individuals who qualify with based on the expected tax filing status for the coverage year.

**Brokers:** Also called *insurance agents*, brokers are licensed to sell insurance plans for compensation. Although the broker is paid by the insurance provider, an agent represents the consumer and can match the consumer to the plan or product that best meets the consumer's needs.

**Department of Community Based Services (DCBS):** DCBS is housed within the Kentucky CHFS, and provides services and programs to enhance the self-sufficiency of families; improve safety and permanency for children and vulnerable adults; and, engage families and community partners in a collaborative decision-making process. Among other things, DCBS is responsible for eligibility determinations for Medicaid and food benefits (CHFS, 2014b).

**Get Covered Kentucky:** Get Covered Kentucky is a coalition effort spearheaded by Kentucky Voices for Health (KVH). KVH is a coalition of concerned Kentuckians who believe that the best health care solutions are found when everyone works together to build them.

**Insurance Agents (agents):** Also called *brokers*, insurance agents are licensed to sell insurance plans for compensation. Although the agent is paid by the insurance provider, an agent represents the consumer and can match the consumer to the plan or product that best meets the consumer's needs.

**Insurance Providers:** Health insurance providers are companies whose businesses offer health insurance plans.

**kynect:** kynect, "Kentucky's Healthcare Connection," is Kentucky's online health benefit exchange, found at [kynect.ky.gov](http://kynect.ky.gov). Through kynect, individuals and small-business employees in Kentucky can shop for health insurance, compare plan costs, benefits, and quality. Additionally, Kentucky residents can determine their eligibility and apply for Medicaid, KCHIP, and premium subsidies and tax credits to assist with the costs associated with health insurance (CHFS, 2014c).

**kynector:** An individual that is trained and certified through KOHBHIE to facilitate consumer enrollment in health coverage through kynect, including helping to complete eligibility and enrollment forms. kynectors are required to be unbiased, and their services are free to consumers. Under ACA, the kynector program includes the Navigator Program, the In-Person Assistor Program, and the Certified Application Counselor Program, which differ by funding sources and community roles. (kynect, 2013)

**Kentucky Cabinet for Health and Family Services (CHFS):** CHFS is the state agency responsible for human services and health care programs (CHFS, 2014a).

**Kentucky Children’s Health Insurance Plan (KCHIP):** KCHIP is free or low-cost health insurance for children younger than 19 whose family income is less than 213% of the federal poverty level. KCHIP was offered prior to ACA.

**Kentucky Office of Health Benefit and Health Information Exchange (KOHBHIE):** The KOHBHIE exists within the CHFS to oversee kynect. The office includes five divisions: Health Care Policy Administration, Education and Outreach, Financial and Operations Administration, Kentucky Access and Kentucky Electronic Health Information (CHFS, 2014c).

**Louisville Metro Board of Health (BOH):** The mission of the BOH is to act as an independent voice to promote and protect equitable physical, mental, and environmental health in the Louisville community through advocacy, education, regulation, and collaboration with public and private entities. (<http://louisvilleky.gov/government/health-wellness/about-board-health>)

**Medicaid Expansion:** ACA allows states to choose to expand Medicaid coverage for most low-income adults whose income is under 138% of the federal poverty level (FPL).

**Modified Adjusted Gross Income (MAGI):** MAGI is a simplified method for calculating income eligibility for Medicaid, CHIP, and financial assistance available through kynect.

**Obamacare:** A nickname for ACA, given because the law was an agenda item of President Barack Obama.

**Patient Protection and Affordable Care Act (ACA):** ACA is a comprehensive health reform law passed by Congress and signed by President Obama in March 2010, with the primary intent to increase access to quality and affordable health care by reducing the number of uninsured individuals.

**Qualified Health Plan (QHP):** A QHP is an insurance plan that is certified by the Health Insurance Marketplace, because it provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other regulation requirements. Plans offered on kynect must be QHPs.

**Small Business Health Options Program (SHOP):** SHOP is a program to provide health insurance options to small businesses (defined as 2-50 employees in Kentucky). SHOP is a required feature of state-run health benefit exchanges per ACA regulations.

## Appendix A



# Louisville Metro Board of Health

## Affordable Care Act Implementation in Metro Louisville

### *The Mission of the Board of Health*

*The Board of Health acts as an independent voice to promote and protect equitable physical, mental, and environmental health in the Louisville community through advocacy, education, regulation, and collaboration with public and private entities.*



## Role of Louisville Metro Board of Health

- Every County in Kentucky has a Board of Health.
- Louisville Metro Board of Health Mission:
  - *The Board of Health acts as an independent voice to promote and protect equitable physical, mental, and environmental health in the Louisville community through advocacy, education, regulation, and collaboration with public and private entities.*
- Board of Health Core Functions:
  - Inform
  - Engage / Act as Community Convener
  - Assess
  - Develop Recommendations
  - Assure Health Equity and Access to Public Health Services

The Board of Health seeks to Educate the Community about Important Public Health Issues, Give Voice to Community Concerns, and Assure Health Equity and Access for all Louisville Citizens.

2



In September 2013, the Louisville Metro Board of Health invited key stakeholders in (Louisville's) community health and health care communities to discuss opportunities and challenges regarding ACA implementation.

3



## Why did the Board of Health form the ACA Implementation Steering Committee?

- Dramatic and immediate changes in the Health Care Delivery and Payment System are upon us – success or failure will depend on what we do locally.
- Need for a safe forum to discuss opportunities, barriers and solutions to ACA implementation – *community health planning function*.
- Identify specific action items that can help the community – and each of the involved organizations – benefit from expanded access to insurance and (we hope) care.
- Unique opportunity to improve the health of our community.
- Kentucky (and Louisville) are being watched by the rest of the country.

4



## Key Provisions of ACA

Increasing Coverage and Access	Essential Health Benefits (EHB)	Preventive Care
Coverage for young adults up to age 26 on parent's plan	Ambulatory patient services	Private health plans required to cover preventive services without any cost-sharing
Removal of lifetime limits on coverage; annual limits are restricted until 2014, when they are totally removed	Emergency services and Hospitalization	Certain women's and children's preventive services must be covered without cost-sharing by all plans created or sold after March 23, 2010
No out-of-pocket costs for preventive care	Maternity and newborn care	By eliminating cost-sharing for preventive services, it reduces barriers to prevention for low-income communities
Care cannot be denied and premium costs cannot be increased based on a person's pre-existing health condition	Mental health and substance use disorder services	
Premium costs cannot be higher based on gender	Prescription drugs	
	Rehabilitative services and devices	
	Laboratory services	
	Preventive and chronic disease management	
	Pediatric services, including oral and vision care	

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## High Level ACA Timeline

2010-2013	2013	2014
Consumer protections: 2010	Increase payments for primary care doctors	Prohibits discrimination due to pre-existing conditions or gender: 1/1/14
Small business health insurance tax credits: effective now	Open enrollment in Exchanges <a href="http://www.kynet.ky.gov">www.kynet.ky.gov</a> : 10/1/13	Eliminates annual limits on insurance coverage: 1/14
Free preventive care: 2010		Tax credits for purchasing health insurance 1/14
Pre-existing condition insurance plan: 2010		Health benefits exchange open and running 1/1/14
Incentives for primary care workforce: 2010		Medicaid expansion: 1/1/14
Medicaid expansion (optional): starting 2010		Individual mandate: 1/1/14
Increase payments to rural health providers: 2010		
New funding for community health centers: 2010		
Increased access to services at home and community disables: 2010		

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## ACA Roles and Responsibilities

	Federal	State	Local
Define Benefits / Rules	✓		
Enforcement	✓	✓	
Interpret Benefit Definitions		✓	
Set up Exchanges	✓	✓ (Kentucky)	
Enrollment		✓	✓
Expand Medicaid		✓ (Kentucky)	
Community Needs Assessment / QI Plans			✓
Ensure Adequate Workforce			✓
Deliver Care			✓
Reconfigure Health Care Delivery System to Improve Population Health			✓

7



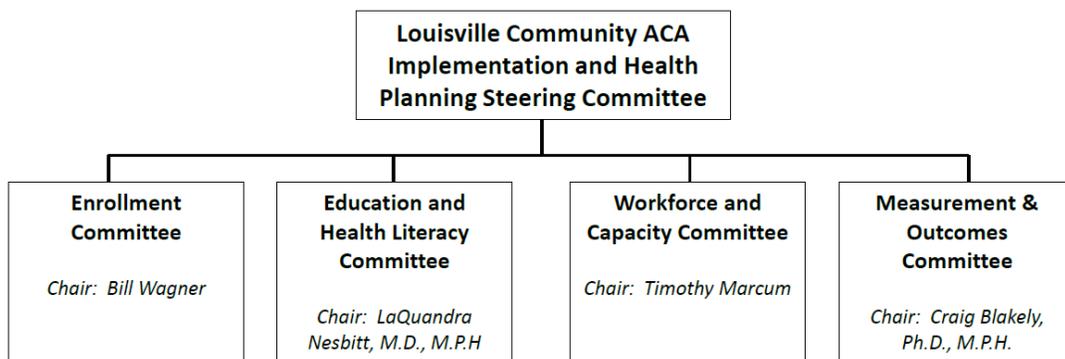
# Members of the Steering Committee

- Baptist Healthcare System
- Board of Health
- Kentucky Office for Health Policy
- Congressman Yarmuth's Office
- Family Health Centers (FQHC)
- Foundation for a Healthy Kentucky
- Louisville Metro Dept. of Public Health & Wellness
- Greater Louisville Medical Society
- Kynect--Kentucky Health Benefit Exchange
- KentuckyOne Health
- Kindred Healthcare
- Norton Healthcare
- Park DuValle Community Health Center (FQHC)
- UL School of Medicine
- UL School of Public Health & Information Sciences

8



# Collaborative Community Engagement on ACA Implementation in Metro Louisville



- 640,000 Uninsured Kentuckians
- 101,000 Uninsured in Jefferson County
  - 53,915 (53%) eligible for insurance
  - 47,451 (45%) eligible for Medicaid

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## Discussion Questions

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1. What would success look like if ACA were implemented successfully in Louisville? How would we know whether we have succeeded?
2. What worries you most about ACA implementation? What do you see as the principal challenges and obstacles?
3. Are there concrete things we can do to overcome these obstacles by working together?
4. What are the biggest opportunities you see? How can we take full advantage of these opportunities?
5. Are there areas we should identify where we can't work together because of "competition"?

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## Enrollment

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- Chaired by Bill Wagner and charged with convening a range of stakeholders in the Louisville community to identify areas of collaboration and coordination to ensure successful enrollment of people into health benefit plans through kynect or Medicaid. Meets regularly.
- As of April 9, 2014:
  - Medicaid enrolled: 45,942 (total eligible 47,451)
  - QHP enrolled: 12,096 (total eligible 53,915)

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## Workforce

### Goals:

- To inventory health care professionals and facilities in Jefferson county to ensure an adequate supply is available to meet the health care needs of newly enrolled persons in health care plans through Kynect and Medicaid.
- To develop strategies for increasing appropriate access to newly insured patients in Jefferson County.

### Types of Information:

- Number of physicians by specialty by zip code who are accepting new Medicaid patients and who are accepting new Exchange-insured patients.
- Number of physicians by specialty by zip code in total.
- Number of hospital visits by type (ED, Outpatient Surgery, Inpatient) by payor for newly insured patients.
- Number of office visits by specialty by payor (may only be available for hospital-employed physicians) for newly insured patients.
- Capacity analysis of local health care facilities to determine if there are bottlenecks in any services.

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## Education and Health Literacy

- Goal is to collaborate on ways to educate new users of the health care system and individuals who over-utilize emergency services.
- Comprised of healthcare providers, health educators, social service providers, and other stakeholders, was convened and continues to meet under the leadership of Dr. LaQuandra Nesbitt, Director of the Louisville Metro Department of Public Health and Wellness (LMPHW).
- The LMPHW has committed \$35,000 to the development of educational materials including brochures and posters. As the campaign grows, additional funds will be sought from foundations and other sources to expand education and outreach efforts.

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# Evaluation

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- Committee formed to track and assess the work of steering committee as well as subcommittees.
- Organized by topic: enrollment; workforce; and education.
- Identifying questions and metrics necessary for a complete picture of our efforts and to inform our ongoing work to improve local community health.
- Identifying potential data sources: emergency depts.; kynect; MCOs; Office of Health Policy; others?

## **Appendix B: Engaged Stakeholders**

### *Health care Systems and Providers*

Baptist Health  
Family Health Centers  
KentuckyOne Health  
Kindred Healthcare  
Kosair Children's Hospital  
Norton Healthcare  
Park DuValle Community Health Center  
Seven Counties Services  
Shawnee Christian Health Center  
UofL Psychiatry  
Walgreens

### *State Level Organizations*

Commission for Children with Special Health Care Needs  
Foundation for a Healthy Kentucky  
Get Covered Kentucky  
Health Literacy Kentucky  
Kentuckiana Regional Planning & Development Agency (KIPDA)  
Kentucky Cancer Program  
Kentucky Department of Community Based Services (DCBS)  
Kentucky Office of Health Benefit and Health Information Exchange (KOHBHIE)  
Kentucky Primary Care Association  
Kentucky Office of Health Policy  
Kentucky Office for Refugees  
Kentucky Voices for Health  
Kentucky Youth Advocates  
Office of Congressman John Yarmuth at House of Representatives

### *Public Services*

Jefferson County Public Schools  
Louisville Metro Department of Corrections  
Louisville Metro Department of Community Services  
Louisville Metro Public Health & Wellness  
The Center for Health Equity

*Local Organizations*

AARP

Legal Aid Society Louisville

Greater Louisville Medical Society

Luken Associates

St. John Center

University of Louisville Kent School of Social Work

University of Louisville School of Public Health and Information Sciences

*Insurance Providers*

WellCare Health Plans

Humana Care-Source

Passport Health Plan

Kentucky Health Cooperative

*Insurance Agents*

Aflac

Agentlink

AM Warner Insurance, Inc.

Conliffe Hickey Insurance

Garrett-Stotz Company

Health Insurance Choice Centers

Kentucky Farm Bureau Insurance

MC Financial Services

The Benefits Firm

The Insurance Lady

## Appendix C: Outcomes

Jefferson County, KY: Estimated Eligible & Actual Enrollment, through July 29, 2014

	<b>Estimated Eligible</b>	<b>Jeff Co Enrollment</b>	<b>Kentucky Enrollment</b>
<b>Medicaid</b>	47,451	70,281	441,607
<b>QHP*</b>	53,915	11,976	79,416
<b>Grand Total</b>	101,366	82,257	521,014

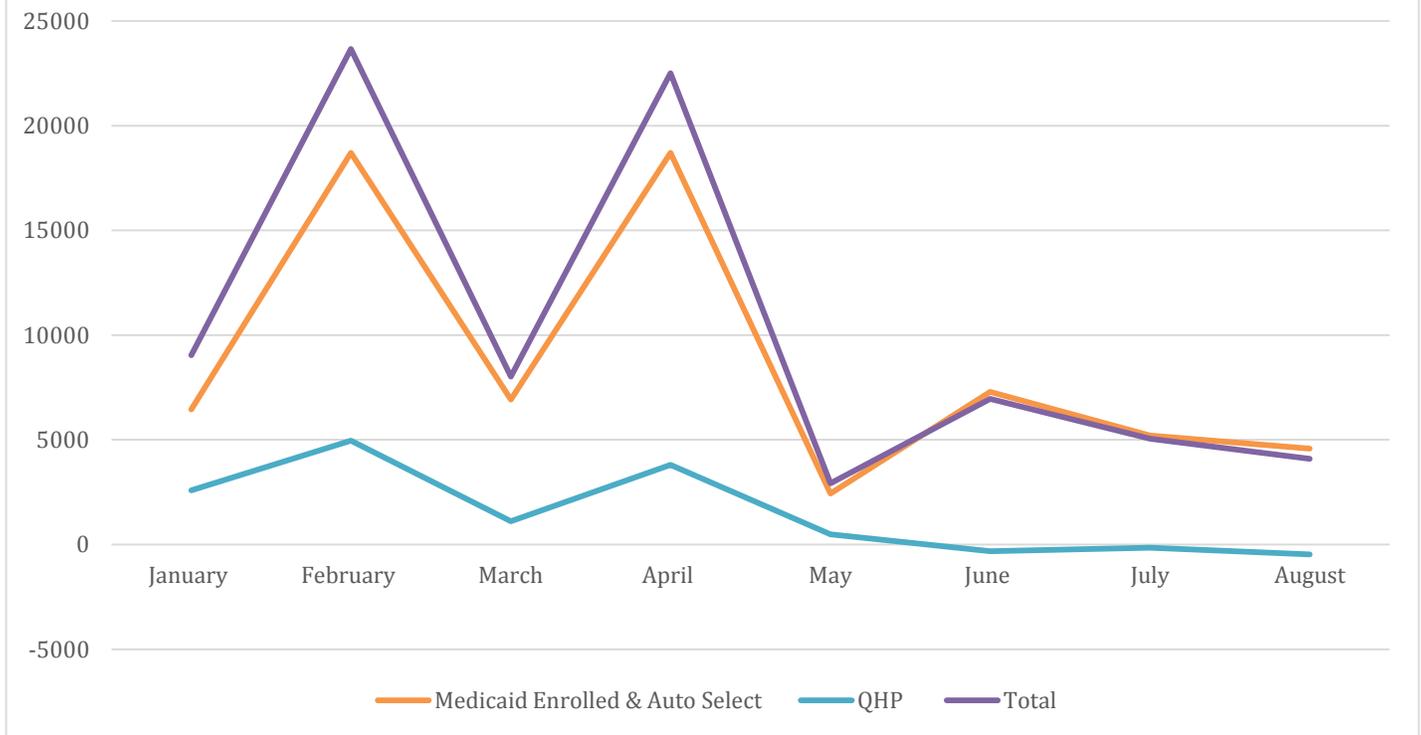
\*Qualified Health Plans

Jefferson County, KY: By Program & Age Group, through July 29, 2014

<b>Program Type</b>	<b>&lt;18</b>	<b>18-25</b>	<b>26-34</b>	<b>35-44</b>	<b>45-54</b>	<b>55-64</b>	<b>≥65</b>	<b>Total</b>
Medicaid Enrolled & Auto Select	15075	11864	14447	11927	10414	6733	1	70281
QHP Enrolled without APTC**	768	369	988	850	792	747	42	4556
QHP with APTC	493	507	1182	1171	1647	2391	29	7420
<b>Total</b>	<b>16336</b>	<b>12560</b>	<b>16617</b>	<b>13948</b>	<b>12853</b>	<b>9871</b>	<b>72</b>	<b>82257</b>

\*\*Advanced Premium Tax Credits

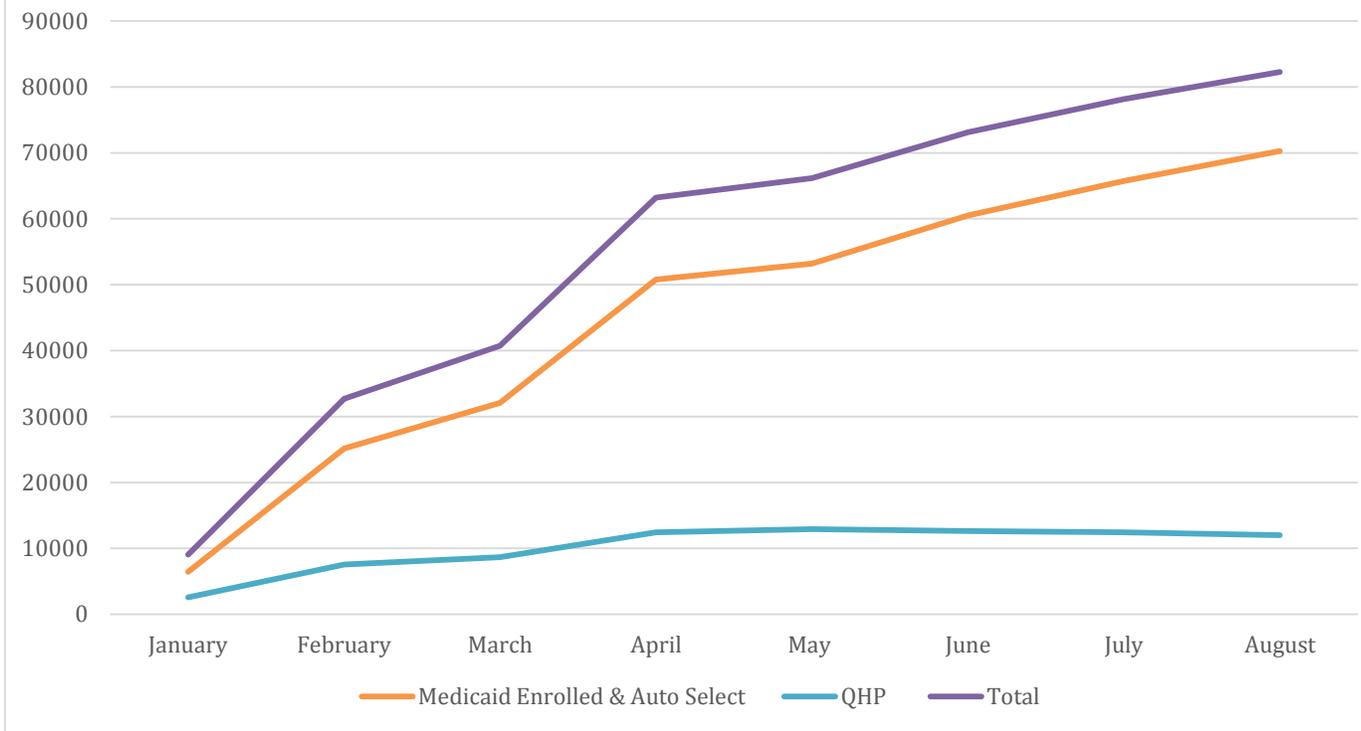
### Jefferson County 2014 Monthly Unique Enrollments



<b>Program Type</b>	January	February	March	April	May	June	July	August	Grand Total
Medicaid & Auto Select	6453	18695	6918	18708	2440	7283	5208	4576	70281
QHP	2585	4962	1105	3802	485	-326	-159	-478	11976
<b>Total</b>	<b>9038</b>	<b>23657</b>	<b>8023</b>	<b>22510</b>	<b>2925</b>	<b>6957</b>	<b>5049</b>	<b>4098</b>	<b>82257</b>

\* Monthly numbers based on date data was presented to the Enrollment Committee and usually reflect data collected the previous month.

### Jefferson County 2014 Total Enrollments



<b>Program Type</b>	January	February	March	April	May	June	July	August
Medicaid & Auto Select	6453	25148	32066	50774	53214	60497	65705	70281
QHP	2585	7547	8652	12454	12939	12613	12454	11976
Grand Total	9038	32695	40718	63228	66153	73110	78159	82257

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