

**ALTERNATIVE CONCEPTS FOR MEDICAID PROGRAM SUSTAINABILITY THROUGH  
STATE REFORM AND FINANCING REDESIGN**

December 1, 2012

Thomas Jefferson Program in Public Policy  
College of William & Mary

Kerry Casey, MPP '13  
Emily Grimes, MPP '13  
Ashley Heilprin, JD/MPP '13  
Brooke Wanlass, MPP '13

## **ACKNOWLEDGEMENTS**

It is our pleasure to thank those who made this research possible:  
Ms. Maureen McDonnell and Ms. Claire Winiarek, Amerigroup Corporation

Professor Louis Rossiter and Professor Sarah Stafford, College of William & Mary

Special thanks our research assistant, Teresa DeAtley, for her diligent work on this project.

*The views expressed herein are the sole responsibility of the authors and not the Amerigroup Corporation. Any errors and omissions are the sole responsibility of the authors.*

# Alternative Concepts for Medicaid Program Sustainability Through State Reform and Financing Redesign

---

## Table of Contents

<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>INTRODUCTION</b>	<b>3</b>
<b>SHIFTING STATE INCENTIVES</b>	<b>6</b>
BLOCK GRANTS	6
STRATEGIES FOR SHARED SAVINGS	13
<b>SHIFTING PROVIDER INCENTIVES</b>	<b>20</b>
MANAGED CARE	20
CHANGES TO SUPPLEMENTAL PAYMENTS	27
<b>SHIFTING RECIPIENT INCENTIVES</b>	<b>37</b>
TARGETED BEHAVIOR INTERVENTIONS	37
HEALTH SAVINGS ACCOUNTS	43
<b>STATUTORY AND WAIVER AUTHORITY</b>	<b>50</b>
<b>FINAL RECOMMENDATIONS</b>	<b>53</b>
<b>BIBLIOGRAPHY</b>	<b>56</b>

## Executive Summary

The cost of Medicaid is a serious concern at both the state and federal level. Medicaid is the third largest domestic program in the federal budget, while 16% of state budgets are allocated to it. Many believe that the high and rising cost of Medicaid is not sustainable. This paper explores six policies that attempt to reduce Medicaid costs through financial reforms.

Aside from the federal government, there are three groups that have a role in Medicaid financing: states, providers, and Medicaid recipients. Due to incentives inherent in the Medicaid structure, each of these groups has less incentive to control costs than is most efficient. The policies described in this paper are designed to shift incentives so that reducing Medicaid spending will provide greater benefits to states, providers, and recipients, as well as the federal government.

### *Shifting State Incentives: Block Grants and Shared Savings*

States have a reduced incentive to decrease Medicaid expenditures because state spending on Medicaid is matched by the federal government by at least 50%, and frequently more. Therefore, states do not experience the full benefits of reducing spending, because it also comes with a reduction in federal matching funds. The two policy options offered to better align state incentives are block grants and a shared savings agreement between states and the federal government.

A Medicaid block grant would be a specified allotment of money from the federal government sent to the states for Medicaid costs. States would be responsible for any costs above the amount of the block grant. States interested in block grants should consider pursuing per capita grants where federal funding is based on state Medicaid enrollment. States should also consider having emergency funding in place to cover unexpected spikes in Medicaid costs.

Shared savings is another plan that targets state incentives, in which an agreement is made between the federal government and the states that if a state achieves a certain level of savings in Medicaid the federal government will return a previously agreed upon percentage of its savings to the state. States would also be obligated to meet quality indicators in order to be eligible to receive shared savings. At the provider level shared savings programs have shown mixed results at achieving cost savings, but have been effective at increasing quality of care. Shared savings is a useful strategy for achieving some reduction in costs while increasing quality.

### *Shifting Provider Incentives: Managed Care and Supplemental Payment Reforms*

The second set of policies endeavors to reform provider incentives, by incentivizing providers to provide more cost-efficient services by decreasing the use of high cost but low value services and increasing high value services. Risk-based managed care and reforms to supplemental payments are two options that encourage providers to be more considerate of the cost of care and improve quality.

Risk-based managed care is a prominent form of care for Medicaid recipients; however, high-risk populations such as those over 65 and the disabled are disproportionately left out. Increasing

enrollment in managed care to include more of the high-risk population may reduce costs and increase coordination of care, but managed care organizations (MCOs) will need to develop appropriate tactics to care for this population, which they are less accustomed to.

Supplemental payments are lump sum payments made to providers that are not associated with the provision of specific services. They assist providers with large numbers of Medicaid and uninsured patients by augmenting Medicaid's low reimbursement rates. Two reforms are recommended: linking supplemental payments with measurable goals, such as quality measures or infrastructural investments, and decreasing supplemental payments in order to increase reimbursement rates for specific services disproportionately delivered by providers serving large Medicaid and uninsured populations.

### *Shifting Recipient Incentives: Targeted Behavior Interventions and Health Savings Accounts*

Since recipients receive medical services with little to no financial investment themselves, they can utilize services without regard to price. This incentive is challenging to correct because individuals eligible for Medicaid have limited resources. Two strategies for increasing recipient investment in the cost of care are explored: targeted behavior interventions and Health Savings Accounts.

States are exploring targeted behavior interventions to either encourage recipients to engage in beneficial health-related activities, or to discourage them from participating in detrimental activities. States which implement this approach need to have a well-developed outreach program in place to ensure recipients are aware of the benefits they could receive. The long-term effects of behavior interventions are unclear, so states would also need to stay informed as new research is done on this topic and adjust program accordingly.

Health Savings Accounts (HSAs) consist of two parts: a savings account where funds are designated for medical expenses and a high deductible health insurance plan (HDHP) to cover catastrophic health costs. Both Medicaid recipients and the state contribute to a recipient's HSA. States that want to implement HSAs need to develop strategies for ensuring a balanced risk pool, as individuals who value health care enough to make a monthly deposit may be high-risk. States participating in the Medicaid expansion should consider this for the newly enrolled population.

### *Conclusions*

To implement any of these proposals states would need federal cooperation. The most straightforward way to accomplish this is through Medicaid waivers, as most of the policies described are already being pursued through waivers in some states. Waivers provide flexibility, but also allow for semi-permanent changes to be implemented, while at the same time increasing transparency and accountability.

States are diverse and no single Medicaid financial reform is appropriate for every state. The six policies evaluated here should be considered in light of the specific needs of individual states, their populations, current health care infrastructure, and financing structures.

## Introduction

Medicaid financing is a serious concern for both the states and the federal government. In 2010 Medicaid spending totaled \$390 billion for both levels of government (Kaiser, Medicaid Program at a Glance, 2012). Medicaid amounts to one sixth of total health care spending in the United States, and is the third largest domestic program in the federal budget. Typically, states spend around 16% of their budget on Medicaid (Kaiser, 5 Key Questions about Medicaid and Its Role in State/Federal Budgets & Health Reform, 2012). As the federal government and states face budget challenges, the high cost of Medicaid is a natural cause for concern, particularly as the cost of Medicaid tends to rise during economic downturns when more individuals become eligible for the program (Kaiser, 5 Key Questions about Medicaid and Its Role in State/Federal Budgets & Health Reform, 2012). The Affordable Care Act will bring a number of changes to Medicaid programs, including substantially expanding eligibility. While the federal government will be responsible for the vast majority of the costs of the newly eligible, there is concern that such an expansion will lead individuals who were previously eligible to also enroll. Those new enrollees will be covered under the normal federal match rate, increasing state budget concerns (Deloitte, The Fiscal Impact to States of the Affordable Care Act, 2011).

A variety of strategies have been proposed to slow the growth in Medicaid costs. This paper will explore six policies, each with the goal of changing incentives for one or more of the participants in the Medicaid financing structure: states, providers, and recipients.

### State Incentives

We begin with two policies that attempt to shift state incentives regarding Medicaid financing. States pay on average 43% of Medicaid costs – in 2012 the federal matching rate ranged from 50% to 74% of the cost of Medicaid (Kaiser, 5 Key Questions about Medicaid and Its Role in State/Federal Budgets & Health Reform, 2012). The federal matching structure means that a state receiving a 50% match would have to save \$2 in total Medicaid costs to receive \$1 in savings. States receiving the highest federal matching rates have to save as much as \$4 to receive \$1 in savings. Given the challenges of reducing health care spending, it is apparent that states have less incentive to decrease spending than they otherwise would due to the federal matching structure. The two policies that will be discussed to increase state incentives to cut costs are block grants and a shared savings program between states and the federal government.

### *Block Grants*

Converting Medicaid to a block grant has been proposed a number of times and continues to be a strategy for stabilizing federal costs while offering states increased flexibility to design Medicaid programs best suited to their needs. There are also significant concerns related to restructuring Medicaid as a block grant program that will also be described.

### *Shared Savings*

Shared savings has been studied primarily at the provider level. In those cases providers and payers make an agreement that if the provider saves a certain amount of money in comparison to a baseline budget, the provider will receive a portion of those savings as a bonus. There has been some exploration of shared savings with Medicare. Implementing shared savings between states and the federal government would increase states' incentive to reduce Medicaid costs because they will receive a greater financial reward for doing so.

### Provider Incentives

The second set of policies target reforms to provider incentives. The challenge of creating incentives to increase the cost efficiency of services, by decreasing high cost and low value services and increasing preventive care is a perennial problem. Risk-based managed care and reforms to supplemental payments will be discussed in this section.

### *Managed Care*

Traditionally, risk-based managed care has involved a flat payment per enrolled individual regardless of the number of services an individual requires. Approximately 74% of the Medicaid population is already enrolled in some form of managed care (CMS, Medicaid Managed Care Enrollment Report, 2011). Medicaid recipients not enrolled in managed care are disproportionately high-risk populations such as those over 65 and the disabled, although this has been changing through the Medicare Special Needs Plan (SNP) option and other state initiatives (MACPAC, Report to Congress: The Evolution of Managed Care in Medicaid, 2011). Increasing enrollment in Managed Care to include more of the high-risk population has the potential to cut costs and increase care coordination, but managed care organizations (MCOs) may not currently have the appropriate infrastructure to treat those populations.

### *Supplemental Payments*

Supplemental payments are lump sum payments made to providers that are not associated with the provision of specific services. They are intended to assist providers with large proportions of Medicaid and uninsured patients by offsetting low Medicaid reimbursement rates and uncompensated care costs. Two reforms are explored: linking supplemental payments with measurable goals, such as quality measures or infrastructural investments, and decreasing supplemental payments in order to increase reimbursement rates for specific services.

### Recipient Incentives

Since recipients receive health care with little to no out-of-pocket costs, they can consume services without regard to price. Correcting this incentive to consume expensive or low-value services is challenging because individuals eligible for Medicaid have limited resources. For instance, currently thirty-three states limit parent eligibility to 100% of the federal poverty level (FPL) and seventeen states limit parent eligibility to 50% of the FPL. States that choose to participate in the Medicaid expansion will be required to extend eligibility to 133% of the FPL

(Kaiser, How will the Medicaid Expansion for Adults Impact Eligibility and Coverage? 2012). This newly eligible population might be better candidates to bear a small portion of the cost of their health care. Two possibilities we will explore to shift recipient incentives are targeted behavioral interventions and Health Savings Accounts.

### *Targeted Behavior Interventions*

States have been experimenting with policies to either encourage recipients to engage in positive health-related behaviors, or to discourage them from participating in detrimental behaviors. This is a tactic employers have been utilizing for years with their employees. Incentives can take a variety of forms, such as cash, gift cards, or credits. Alternatively, recipients who participate in negative health behaviors could have their benefits reduced.

### *Health Savings Accounts*

Health Savings Accounts (HSAs) consist of two parts: a savings account where funds are designated for medical expenses and a high deductible health insurance plan (HDHP) to cover catastrophic health costs. Both Medicaid recipients and the state make deposits into the recipients HSA. Since a recipient's money will be spent when they use medical services, the hope is that they will choose more cost-efficient care. Any extra funds left in a recipient's account can be rolled over to the next year, reducing the amount states will contribute the following year, thereby saving money. HSAs originated in the private market and there are some unique challenges to implementing them for Medicaid, such as the more limited range of providers available to Medicaid recipients, which constrains their ability to shop around for the best price. However, HSAs increase financial risk to recipients, making them an important policy to consider for controlling Medicaid costs.

After exploring the policies described above there will be an overview of how states can implement these plans given the current regulatory structure for Medicaid. We will close with recommendations regarding how these various reforms might be implemented to more effectively reduce Medicaid costs.

## Shifting State Incentives

### Block Grants

#### I. Overview

One approach to changing state incentives with respect to Medicaid spending is to convert the Medicaid program into a block grant to states. Presently, states have very little incentive to save, because based on the matching grant, states essentially have to cut \$2 from their budgets in order to save \$1. Generally, a block grant is a lump sum payment from the federal government to the states, determined in advance through a formula based on current expenditures and a pre-determined growth rate. “Federal requirements regarding eligibility rules, covered benefits, and provider payment rates could be preserved (which would cause the states to object) or eliminated (which would cause advocates for Medicaid recipients to object)” (Weil & Rossiter). While a block grant could be structured in a number of different ways, block grant proposals typically fall in one of two categories; either the funds are allocated under a “global” cap, or they may be allocated on a per capita basis. The goal of converting Medicaid to a block grant program is to lower spending and address state and federal budget shortfalls and deficits.

#### II. Case Study: Rhode Island Global Waiver

Beginning in 2009, Rhode Island accepted a five-year cap on combined state and federal Medicaid spending of \$12.075 billion as part of a global waiver from CMS (Howard, 2012). This cap was based on data that took into account historical spending trends and projections of the future rate of spending growth (Howard, 2012). The state accepted full responsibility for any spending above its cap (Howard, 2012).

“To date, the state projects that it has saved \$100 million through changes related to the global waiver and that the waiver helped reduce the projected Medicaid spending rate from 8 percent to 3 percent annually” (Howard, 2012). Shifting patients from nursing home care to home-and-community based services saved the state an estimated \$35.7 million (The Lewin Group, An Independent Evaluation of Rhode Island’s Global Waiver, 2011). New rate setting and acuity adjustments for nursing home care saved Rhode Island an additional \$15 million (The Lewin Group, An Independent Evaluation of Rhode Island’s Global Waiver, 2011). Care management for children with special needs and adults with disabilities reduced total expenditures for fee-for-service care and emergency room use while improving access to physician care, resulting in an estimated savings of \$5 million (The Lewin Group, An Independent Evaluation of Rhode Island’s Global Waiver, 2011).

Rhode Island’s Global Waiver has been pointed to as a model Medicaid block grant that can provide additional flexibility and yield savings for both the federal government and state. However, a December 2011 independent assessment of the Rhode Island Global Waiver Program by the Lewin Group found that in reality, the change in financing resulted in only modest savings to the state (The Lewin Group, An Independent Evaluation of Rhode Island’s Global Waiver, 2011). First, the Rhode Island Global Waiver set federal Medicaid payments above anticipated levels. As a result, Rhode Island received more federal financing than was

projected in the absence of the waiver. If all states were able to get the Rhode Island deal, this could significantly increase federal costs, not generate savings. In contrast to Rhode Island's Global Waiver, most federal block-grant proposals aim to reduce federal expenditures by giving states substantially less funding that they would otherwise receive. Thus, while Rhode Island's Global Waiver places a total limit on federal Medicaid funding for activities covered by the waiver, this is not a good model to follow for federal block grant proposals because the caps were set at a generous level, above the projected amount, and allow for funding greater than Rhode Island would have received in the absence of the waiver. This is a stark comparison to other block grant proposals, such as FY2013 House Budget Resolution ("the Ryan Plan"), which focused on federal deficit reduction and lowering federal Medicaid funding provided to the states.

Further, Rhode Island's global cap places a total limit on federal funding for waiver-related expenditures and does not adjust for higher than projected enrollment or increases in per person costs. Given that Rhode Island's program has only been in place for a short amount of time, there is not enough evidence yet to know how the state will fair should it have unanticipated increases in enrollment or per capita health care costs, and how such potential increases in costs or enrollment could affect the provision of services and eligibility criteria.

Finally, analysis also shows that the state could have achieved most of the policy objectives (such as moving individuals from nursing homes to community-based care) under current law without the waiver and spending cap (Kaiser, Implications of a Federal Block Grant for Medicaid (2011)). Thus, a state could implement programmatic changes similar to those instituted in Rhode Island, without a global block grant waiver, reap savings, and not have to assume the same level of risk for covering people should per capita health care cost costs rise or enrollment increase.

### **III. Children's Health Insurance Program (CHIP)**

Another frequently cited example of block grant success is the Children's Health Insurance Program (CHIP). Some lawmakers have argued in favor of converting Medicaid into a block grant, due to the success of this program. CHIP was created in 1997 to provide health coverage to low-income families that earn too much to qualify for Medicaid but too little to afford private insurance. All states have a CHIP program, with each state designing their own program and determining policies and eligibility requirements within broad federal guidelines. States can choose to use CHIP funds in different ways to expand coverage for uninsured children; some states do so through Medicaid or by creating a separate state CHIP program (Heberlein & Alker, 2011). State funding is matched by federal funds, up to a capped allotment. Within the capped allotment, states receive an "enhanced" federal matching rate that is higher than the matching rate for their Medicaid program (Heberlein & Alker, 2011).<sup>1</sup> Annual allotments are distributed to states according to a formula that takes into account how much each state actually spends on CHIP. This program was reauthorized in the Children's Health Insurance Program Reauthorization Act (CHIPRA), and signed into law on February 4, 2009 by President Obama (Public Law 111-3). Under CHIPRA, states now have a two-year time limit to spend their annual

---

<sup>1</sup> On average, the federal government's share of Medicaid spending is 57%, but it is much higher at 70% under CHIP.

CHIP allotment. Any amounts not used will revert back to the federal government and be redistributed to other states that demonstrate need for more CHIP funds. CHIPRA also created new enrollment strategies and incentives for states to expand eligibility and receive increased federal funds.

While CHIP has been successful, there are several key limitations in relying on CHIP as a model for converting Medicaid into a block grant program. First, CHIP plays a much more limited role in the health care system than Medicaid. CHIP is a far smaller program than Medicaid and its role in the health care system is simply “more circumscribed...providing coverage to mostly healthy children in families with income somewhat above Medicaid thresholds. In comparison, Medicaid covers eight out of ten children with public coverage in the United States and finances 34 times as much care as CHIP” (Heberlein & Alker, 2011). Moreover, the scope of services provided by Medicaid is much greater than CHIP; Medicaid provides long-term care services as well as other complex and expensive services to seniors and people with disabilities, which CHIP does not need to provide (Medicaid and CHIP Payment and Access Commission, Report on Medicaid and Chip, 2011).

Additionally, much of the success of CHIP is attributable to a difference in federal funding. With the reauthorization of CHIP, federal funding dramatically increased in FY 2009. On average, states received an average of 96% more in their FY 2009 allotments under CHIPRA than under the original CHIP formula. (Medicaid and CHIP Payment and Access Commission, Report on Medicaid and Chip, 2011). This increased funding gives every state the incentive and opportunity to enroll more eligible children.

CHIP success is attributable in part to the rapid increase in federal funding. If Medicaid were turned into a block grant and allowed to grow at the same rate, it would actually cost the federal government an additional \$514 billion dollars over the next ten years (Heberlein & Alker, 2011). In comparison, when CHIP was reauthorized in 2009, the program received additional federal funding from an increase in the tobacco tax through FY2013, and under the Affordable Care Act, CHIP funding was extended for an additional two years, with allotment levels set in excess of what states are expected to be able to use.

Finally, CHIP differs from global block grant proposals in that funding formal takes into account both the growth in per capita health care expenditures and the growth in the number of children in each state. States which enroll more children, by taking advantage of new funding strategies with CHIPRA and expanding eligibility by doing things such as investing in outreach, simplifying the enrollment and renewal procedures, will receive increasing amounts of federal funding (Public Law 111-3). A per capita block grant program with similar funding support has the potential to provide great savings and flexibility to states, while avoiding the increased risk associated with global block grants.

#### **IV. FY2013 Budget Resolution**

The FY2013 proposed Budget Resolution (“the Ryan plan”) includes significant savings in Medicaid related to converting the program to a block grant and repealing health reform. This proposal is a fairly typical block grant proposal where the federal cap is made on a global basis rather than per capita.

Under the FY2013 Budget Resolution, states would no longer receive a fixed share of state’s Medicaid costs (House of Representatives Committee on the Budget, 2012). The FY2013 Budget Resolution does not provide much detail about its Medicaid block grant proposal, however, assuming that it is the same as the FY2012 house budget resolution proposed by Chairman Paul Ryan, each state would receive a fixed dollar amount starting in FY2014 and thereafter based on the federal funding received in FY2011, adjusted for inflation and population growth (House of Representatives Committee on the Budget, 2012). States would also be given greater flexibility in the design of their programs (Congressional Budget Office, Long-Term Analysis of a Budget Proposal by Chairman Ryan, 2011). Additionally, starting in 2022, Medicaid block grant payments would be reduced to exclude projected spending for acute care services for elderly Medicaid beneficiaries (Congressional Budget Office, Long-Term Analysis of a Budget Proposal by Chairman Ryan, 2011).

The annual increase in block grant funding from year to year under this plan would average more than 3.5 percentage points below what the Congressional Budget Office (CBO) expects to be the average growth rate of the Medicaid program over the coming decade under current law (Congressional Budget Office, Long-Term Analysis of a Budget Proposal by Chairman Ryan, 2011). By 2022, federal funding of Medicaid would be reduced by 35 percent relative to current law (after excluding the effects of repealing the Medicaid Expansion associated with the ACA) (Congressional Budget Office, Long-Term Analysis of a Budget Proposal by Chairman Ryan, 2011). The FY2013 Budget Resolution marks a major shift from the current health system; one consequence is that states will bear a larger burden of the cost of Medicaid, and as result they may have to increase taxes, or reduce eligibility or service coverage in order to control costs.

While the block grant would give states additional flexibility to improve the efficiency of Medicaid programs, in order to exercise such flexibility, states would either need to increase their spending or make cutbacks. “CBO has written that unless states increased their own Medicaid funding very substantially to make up for the Ryan plan’s deep Medicaid funding cuts, they would have to take such steps as cutting eligibility (leading to more uninsured low-income people), cutting covered health services (leading to more underinsured low-income people), and/or cutting the already-low payment rates to health care providers, likely inducing more doctors, hospitals, and nursing homes to withdraw from Medicaid (and thereby reducing beneficiaries’ access to care.) Last year, when Chairman Ryan included a similar Medicaid block-grant proposal in his budget, the Urban Institute estimated it would lead states to drop between 14 million and 27 million people from Medicaid by 2021 (in addition to the 17 million people who would no longer gain coverage because of the repeal of the health reform law’s Medicaid expansion)” (Park & Broaddus, 2012).

## V. Fiscal Impact

First and foremost, block grant proposals give states greater incentives to save money because states could keep all of the savings. The present Medicaid matching structure makes it less advantageous for states to restrain Medicaid spending, since they have to cut at least \$2 of Medicaid spending to gain \$1 in savings, depending on their federal match rate (Howard, 2012).

The second financial advantage of funding Medicaid through block grants is the greater budget predictability, savings and deficit reduction it would provide to the federal government. The level of budget predictability would depend on whether the block grant program allocated funds on a global basis or per capita basis. When block grants are made on a global basis, such as in the case of Rhode Island's global waiver, the federal government's financial exposure is limited to the pre-set allotment amounts, and the state assumes the risk for any costs incurred above that cap. In contrast, per capita block grants, like CHIP, could result in increases in federal spending if enrollment in Medicaid increases. Nevertheless, block grant funding provides a simpler way for the federal government to control future spending. While a block grant would initially reduce federal financing and shift costs and risk to states, the evidence is unclear as to whether underlying program costs would be reduced.

While a block grant provides key financial benefits to the federal government, and incentives for states to create greater savings, there are also serious ramifications that must be weighed. States would have more programmatic flexibility with respect to eligibility, benefits, and provider payments, but states' financial risk would not be limited as it is under current policies.

The current funding levels are based on a federal matching program, which assists states with fluctuation in costs that are difficult to predict. A global block grant program could face difficulty in addressing program needs such as economic downturns, health care inflation, increased demand of long-term care, or costs related to epidemics (such as HIV/AIDS) and emergencies (such as hurricanes or terrorist attacks) (Kaiser, Implications of a Federal Block Grant for Medicaid, 2011). "Often, the only tool that states can use to restrain spending (particularly during economic downturns) is to slash reimbursements to providers—leaving Medicaid enrollees struggling to find doctors who accept Medicaid coverage. And delayed or denied health-care access leads to worse health care outcomes for American's most vulnerable citizens" (Howard, 2012) Accordingly, the programmatic flexibility available to states under a block grant scheme could lead to significant reductions in benefits and eligibility criteria as costs rise.

"Under a Medicaid block grant with limited financing, states could limit eligibility, extend waiting lists to nursing home services and impose longer wait lists for home-and-community based services" (Kaiser, Implications of a Federal Block Grant for Medicaid, 2011). Experience from CHIP and TANF shows that in exchange for limited liability and predictable funding levels, capped federal financing can result in discordance between funding and needs, as well as problems distributing funds across states. This is a serious danger with global block grant programs. "By reducing the amount of federal funds flowing to states, a Medicaid block grant could have a dampening effect on state revenues, state economic growth, and employment. The current matching structure allows states to share the risks related to increased enrollment during

an economic downturn, medical inflation costs, as well as the growing costs related to providing long-term services and supports for the elderly and individuals with disabilities. Reducing federal funds to states would not reduce these needs or costs, but could shift additional costs to the states. The current matching structure also supports state choices and flexibility. All states have expanded eligibility levels (especially for children) and benefits (like prescription drugs) beyond those required by federal law and are able to receive federal matching payments to do so. States that have limited programs with few optional services would have a harder time making program reductions or expanding their programs in the future if federal support were capped based on current funding levels” (Kaiser, Implications of a Federal Block Grant for Medicaid, 2011). States must plan carefully for the future of their Medicaid programs in both good times and times of economic downturn. It is possible that the federal government could make supplemental payments to states in the case of economic downturn in the future, as was the case in the 2009 Stimulus Bill, however, in the interest of long-term sustainability, states opting to pursue a global block grant will have to take proactive steps to ensure that they have an adequate safety net, in the event that the federal government does not provide similarly-sized supplemental payments to states.

## **VI. Political Feasibility**

Medicaid block grant proposals were proposed and subsequently rejected by Congress in 1981, 1995, 2003, 2011 and 2012. The issue of block This highlights not only the difficulty in determining pre-set allotments that will address state needs, but also the significant obstacles to instituting block grants as a broad Medicaid reform measure. Moreover, Medicaid block grants are not consistent with the expansion of Medicaid eligibility under the Affordable Care Act that would help reduce the number of uninsured Americans. As such, recent block grant proposals, like the Ryan Plan’s call for invalidating health reform *and* a shift to block grant funding, are likely to pose insurmountable political obstacles unless the balance of power in Congress and the White House shifts. From the perspective of state leaders, a state’s reaction “to a block grant depend on how large the grant is in the first year, what factors are used to increase the grant over time, how much flexibility it actually gives states to modify their programs, how high a priority the states place on meeting the needs of the Medicaid population, and how the states feel about bearing the risk of filling in the gap between the cost of meeting their populations’ needs and the amount the federal government gives them to do so” (Weil & Rossiter).

## **VII. Recommendations**

While a block grant proposal would allow states to tailor their Medicaid programs to their individual needs, and the potential for states to provide more choices to beneficiaries as well as increase access to care, the viability of a the proposal would heavily depend on the funding level.

A state wishing to implement a block grant as a part of their Medicaid program should opt for a per capita cap, as opposed to a global waiver like Rhode Island, or the FY2013 Budget Resolution’s global allotment. “Under a per capita cap, federal matching funds automatically adjust for enrollment levels but not for higher than projected per person costs” (KFF, Section 1115 Waivers, 2011). This will help to insulate the state during economic downturns and ensure that the most vulnerable citizens are able to maintain coverage.

States wishing to pursue block grant proposals can also protect against potential harms to their sustainability by establishing a mandatory “rainy day” fund, which a portion of the savings would go into. This proactive effort would mitigate the potential for changing eligibility criteria for states that currently have criteria above the federal minimums as well as enrollment caps, waiting lists, changes in services, or increased taxes to cover the shortfall in the event of economic downturn or increases in per capita health care costs.

## Strategies for Shared Savings

### I. Overview

One strategy to incentivize states to reduce Medicaid costs is to implement shared savings between the states and the federal government. Currently, a state spending \$10 billion on Medicaid with a 60% federal match rate only pays \$4 billion on Medicaid, while the federal government provides \$6 billion. However, since states administer the Medicaid program, they have greater control over how much money is spent. Therefore, states need an increased incentive to reduce Medicaid costs. In a shared savings program, the federal government would send some of its savings back to the state in order to make it more beneficial for states to reduce spending on Medicaid.

The strategy of shared savings rests on two principles. First is the assumption that states have spent Medicaid money unnecessarily due to the availability of federal funding. There is substantial evidence, for example, of extensive Medicaid fraud that states have less interest in resolving due to the unlimited nature of the federal match (Committee on Government Oversight and Reform, *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*, 2012). Shared Savings would increase state motivation to decrease fraud and other unnecessary expenses because states would receive increased savings. Second, if the additional money from shared savings were required to be spent on strategies for improving health care infrastructure, it could become a tool for creating a more efficient health care system in the state, thereby reducing costs further.

Shared savings does benefit states at the expense of the federal government. All the risk of shared savings would be imposed at the federal level, which raises the question of why the federal government would be interested in such a program. One solution would be adopting a variation on shared savings, shared savings/shared losses. In this manifestation, a target expenditure level is set and states receive money if they save, but are also responsible for losses if they exceed the budget. This substantially increases the risk to states, and would need to be phased in to prepare states for the new responsibility. Shared savings/shared losses would be similar to a block grant by putting financial risk on the states, but has an important distinction. While block grants normally have relatively little federal regulations, shared savings programs typically include quality requirements that would prevent states from reducing services to cut costs.

## **II. Elements of Shared Savings**

The idea of shared savings has been most prominent at the provider level, where payers agree to pay providers a bonus if the provider achieves a certain level of savings. Most shared savings programs have begun relatively recently – one study found that two-thirds of them were first implemented in 2010 or 2011 (Bailit and Hughes, 2011). A 2011 study by Michael Bailit and Christine Hughes noted a number of design elements are common across the programs:

- A definition of services included in the savings calculation.
- A formula for calculating the baseline budget to compare with actual expenditures.
- A technique for reducing the likelihood that savings are due to natural variation.
- A series of quality indicators that providers must meet in addition to savings.
- A plan defining what percentage of savings will go to the provider.

Most existing shared savings programs include all services covered under a given medical plan, although some programs exclude costs such as prescription drugs and laboratory fees that may involve a third party provider. Other plans exclude non-preventable inpatient and emergency department use, since this involves circumstances outside of the medical provider's control. The cost of services not directly related to provision of care is also excluded from savings calculations, as are outliers, typically by determining a flat dollar amount and excluding patients whose costs exceed that threshold. (Weissman et al, 2012).

Once the costs that will be included in the calculation are determined, a formula must be developed to calculate baseline expenditures to which actual expenditures can be compared. In most cases savings are determined by comparing expenditures over a twelve-month period to a pre-set budget. The prior cost of care for the patient group is forecasted out to determine the budget, while accounting for other factors that may influence the cost of care, such as changes to plan benefits (Bailit and Hughes, 2011). It is also necessary to minimize the possibility that savings result from natural variation in costs, rather than the behavior of providers. In some cases, a minimum number of patients must be involved to reduce the possibility of random variation in health care costs being incorrectly identified as savings. Another step some programs take is allowing the payer to retain some percent of initial savings, frequently 2%, before providers are eligible for shared savings. Some programs also set a cap as to what percent of savings will be shared (Weissman et al., 2012). There are a number of different strategies for determining how the savings are divided between the payer and the provider. In addition, there is often a corresponding set of non-financial targets related to provider quality, service utilization, or access to care that the provider must meet in order to be eligible for the shared savings (Bailit and Hughes, 2011).

Two CMS shared savings programs below will demonstrate how these elements of shared savings programs have been implemented in practice.

## **III. Physician Group Practice Demonstration**

One early shared savings pilot was the Center for Medicare and Medicaid's Physician Group Practice Demonstration (PGPD), which ran from 2005 to 2010 and was mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

(BIPA). The 10 participants in the demonstration were all large medical practices, with between 232 to 1,291 affiliated physicians. The goal was to observe the effect of performance payments drawn from Medicare savings on participants' expenditures, as well as access to care and quality of care (CMS, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009).

The demonstration included all the elements of shared savings programs described above. The services included in the calculation were all Medicare Part A and B expenses, excluding deductibles and co-insurance. A baseline of expenditures was created by taking the expenditures of participating groups from the base year and multiplying it by the growth of comparable non-participating organizations. To account for natural variation, savings had to exceed 2% of target expenditures before groups were eligible for shared savings. If that benchmark was met, groups were eligible for up to 80% of savings from the first dollar. This bonus was termed a performance payment. Groups had to achieve quality indicators to be eligible for the full performance payment, and the percent of the performance payment tied to quality indicators increased each year of the study. In the first year, only 30% of the payment was dependent upon achieving quality indicators, but by the third year, 50% of the payment was based on quality. (Center for Medicare & Medicaid Services, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009).

#### *Fiscal Outcomes*

In the first two years of the study, the Medicare Trust Fund saved \$2.26 million, and only four of the participating groups were able to reduce spending enough to receive shared savings. These practices earned a combined \$21.2 million in shared savings. (CMS, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009) In the fifth year, the PGPD saved the Medicare Trust Fund \$36.2 million, \$29.4 million of which was returned to four participating groups in performance payments. Over the course of the demonstration, the practices received \$110 million in payments, and Medicare saved approximately \$134 million. As a result, Medicare's savings totaled near \$24 million after making the performance payments (CMS, Physician Group Practice Demonstration Succeeds in Improving Quality and Reducing Cost, 2011). Over the five years, three of the ten practices never received a performance payment (CMS, Summary Results, 2011). An earlier report found that the differences between the practices which received shared savings and those that did not were associated with pre-existing spending trends (CMS, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009).

#### *Access Outcomes*

There are conflicting analyses of the effect of PGPD on access to care. The 2009 report to Congress says access to care did not decline and may have increased during the first two years of the demonstration, based on the number of recipients and visits (CMS, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009). A contrasting study of the PGPD asserted that quality measures indicated lack of access to care was a problem (Trisolini et al, 2008). These reports differ in that the report to Congress evaluated access in the total number

of visits, whereas the other study evaluated access in terms of patients being referred to or receiving appropriate care for their health concerns during those visits.

*Quality Outcomes*

In the PGPD practices were required to meet quality standards, in addition to saving money, to be eligible for the bonus. In the first year, all groups met at least twenty-five of the twenty-seven measures (CMS, Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009). By the fifth year, seven groups actually met all thirty-two of the indicators. In addition, groups improved their quality scores by an average of 12 percentage points on coronary artery disease measures and 11 percentage points on diabetes measures, among other improvements (CMS, Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration, 2011).

*Discussion*

The results of the PGPD were quite mixed, despite CMS’ enthusiastic descriptions of the results (Wilensky, 2011). The most promising element of the results was the consistently positive increases in quality measurements. One issue that can arise when reducing health care costs is that providers will simply reduce services. Instead, the PGPD appears to have encouraged participating organizations to continually improve the quality of their care. However, the primary goal of shared savings is to reduce costs, and in that regard, the program was less successful, as most savings was paid back to providers. As more studies of this demonstration are produced, it may be easier to determine which parts of the demonstration should be emulated to maintain high quality, while altering other aspects to achieve more savings.

**Figure 1: Results of Physician Group Demonstration Project**

<b>Results</b>	<b>Year 1</b>	<b>Year 5</b>
<b>Number of Participants Receiving Shared Savings</b>	4 of 10.	4 out of 10.
<b>Savings Results</b>	Total savings of \$26.9 million.  Medicare Trust Fund saved \$2.26 million.	Total savings of \$29.4 million.  Medicare Trust Fund saved \$6.8 million.
<b>Quality Results</b>	All 10 met at least 25 of 27 indicators.	All 10 met at least 30 of 32 indicators.

CMS is currently involved in another shared savings plan, the Medicare Shared Savings Program (MSSP), which is one of the programs implementing Accountable Care Organizations. MSSP originated in Section 3022 of the Affordable Care Act, which required Medicare to create a shared savings program. ACOs are groups of providers that agree to coordinate care across a variety of settings for a patient population, in this case Medicare fee-for-service recipients. To be eligible, the ACO must serve at least 5,000 Medicare patients. ACOs will continue to receive the same fees as they do currently, but will also be eligible for shared savings if they meet certain quality measures (CMS, Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program, 2011).

There are two models within the program. In the first model, ACOs will be eligible for bonuses of up to 50% of savings if they achieve savings and meet quality measures. In the second model, ACOs will be eligible for up to 60% of savings, but will also be responsible for any losses incurred. The one sided model is designed to help smaller organizations and other groups less familiar with risk models (CMS, ACO: What Providers Need to Know, 2011).

To establish if ACOs have achieved sufficient savings to receive a bonus, CMS will use recipients' claims information from the three years prior to the creation of the ACO to create a benchmark for expenditures. All Medicare Part A and B costs will be included in the calculation. CMS will then determine a Minimum Savings Rate (MSR) and a Minimum Loss Rate (MLR). For organizations in the one sided model, the MSR will be on a sliding scale and dependent upon the size of the ACO. To receive the bonus, organizations must achieve savings at or above the MSR (CMS, ACO: What Providers Need to Know, 2011). Groups in the second model will also be responsible for losses at or above the MLR, but losses will be capped at a certain percentage of the expenditure baseline (CMS, ACO: What Providers Need to Know, 2011).

There are some doubts as to whether this program will be successful at reducing costs. A simulation of the MSSP under which ACOs are being formed found that a 10 percentage point improvement in measures of diabetes care would only result in savings of 1% (Eddy and Shah, 2012). The original regulations governing the MSSP were regarded as overly burdensome by many potential participants, and the financial incentives were insufficient to encourage participation despite the regulations (Meyer, 2012). Even with revisions to the regulations, skepticism remained among providers, with only twenty-seven organizations participating in the first start date for MSSP – although the subsequent start dates had more participants (Ballard, 2012). Data regarding the outcomes of this program will be invaluable to understanding the effects of shared savings and if it should be implemented on a larger scale.

**Figure 2. Elements of Two CMS Shared Savings Programs**

<b>Elements of Shared Savings Plan</b>	<b>Physician Group Practice Demonstration</b>	<b>Accountable Care Organizations (Shared Savings &amp; Shared Savings/Shared Losses)</b>
<b>Services Included in Savings Calculation</b>	All Medicare Part A & B expenditures except hospice.	Medicare Parts A & B.
<b>Payment Method</b>	Fee-for-Service	Fee-for-Service
<b>Formula for Baseline Expenditure Calculation</b>	Base year expenditures are trended forward based on growth rate of comparison groups and risk scores of patients.	Benchmark based on recipients' claims in 3 prior years.
<b>Formula for Savings Calculation</b>	Actual Expenditures are compared with Target Expenditures $\pm$ 2%.	Must achieve Minimum Savings Rate (MSR), a percentage of benchmark expenditures.  Participants in Shared Savings/Shared Losses are responsible for losses at or above Minimum Loss Rate (MLR).
<b>Reward for Savings</b>	Performance payments up to 80% of total savings based on number of quality indicators met.	For Shared Savings, up to 50% based on quality indicators.  For Shared Savings/Losses, up to 60% based on quality indicators

#### **IV. Shared Savings Effects on Medicaid Costs, Access, and Quality**

Drawing on the results of PGPD, it appears that a shared savings program between the states and federal government would achieve minimal savings at the federal level, but would benefit states significantly more. However, given the rapid rise in Medicaid costs, even slowing the growth of expenditures would be advantageous to the federal government. Shared savings is best viewed as a temporary measure to change state behavior, rather than a permanent solution to the rising costs of Medicaid.

The achievement of quality indicators in PGPD is promising. It appears that tying receipt of the bonus to quality is very successful and could be duplicated in a state-federal shared savings agreement. The relationship between shared savings and access has not been explored closely. The official PGPD report indicates that access was not reduced; another study offers a conflicting analysis. However, given that quality indicators were successfully met, it seems that if access was a factor in whether or not states received a shared savings payment it would likely be effective.

When results of the MSSP are available, states will be able to make much more informed decisions regarding the advantages and disadvantages of creating a shared savings agreement with the federal government.

## **V. Recommendations**

For states that are interested in pursuing a shared savings program, either between themselves and the federal government or with providers in their state, the following recommendations are offered:

*Shared Savings/Shared Losses Is a More Sustainable Model.* Shared savings alone is not sustainable in the long run due to the disadvantage it places on the payer. The MSSP model of allowing organizations capable of handling increased risk to enter a shared savings/shared losses model is an appropriate strategy. In a federal-state shared savings arrangement, states with greater ability to take on risk could begin in the two-sided model, and other states could switch to that model when they become more confident in their capacity to be successful. If states were to create shared savings programs with providers, then they could also use the MSSP as a model, where providers are able to take on greater risk.

*Quality Indicators Are Critical to a Successful Program.* One of the most notable findings regarding previous shared savings programs is that quality indicators improve even while providers are attempting to reduce costs. Without quality indicators, the temptation to cut services in order to achieve savings is simply too high.

*Reinvest Savings in Health Infrastructure.* Over the long term, the most effective way to reduce Medicaid costs is to provide medical services more efficiently. Given the challenging fiscal environment most states face, it would be tempting to use a performance payment to fund more urgent expenses. However, that would be detrimental to health care costs in the long run. In either a federal-state or state-provider shared savings arrangement it would be most beneficial for savings to be reinvested in health infrastructure.

## Shifting Provider Incentives

### Managed Care

#### I. Overview

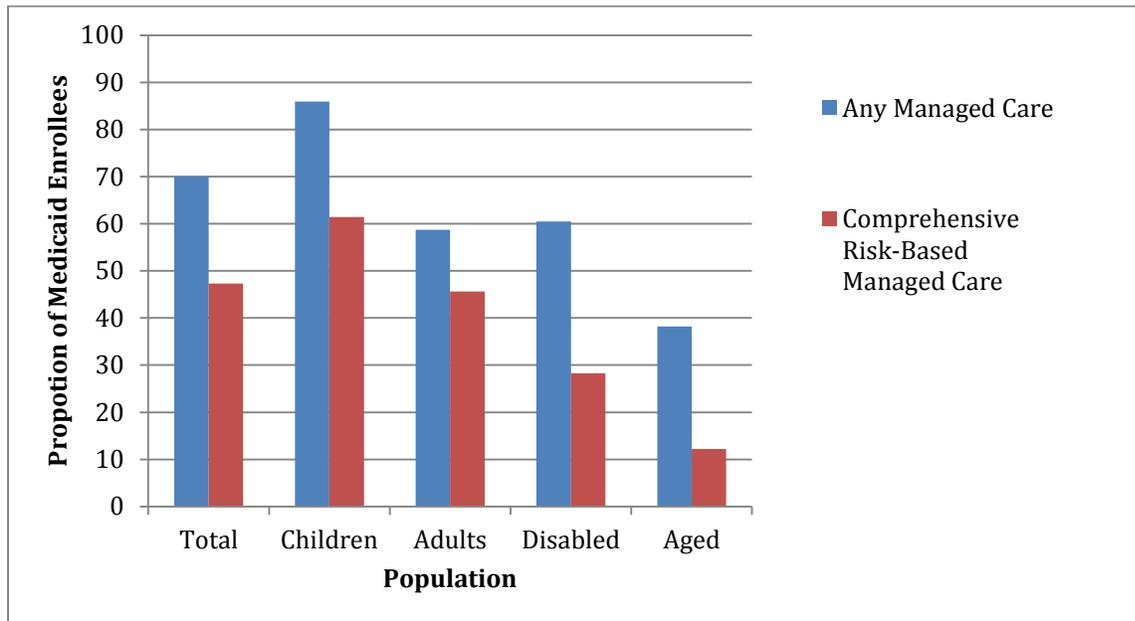
Managed care has grown dramatically over the past few decades as a means for states to provide health benefits to Medicaid enrollees. On average, 74% of Medicaid recipients received some or all of their health care benefits through a form of managed care in 2011 (CMS, 2011). States have turned to managed care to control costs, promote management and coordination of care, and provide more predictable spending, as well as to increase accountability, performance, access, and care quality. There are three types of managed care: risk-based, primary care case management, and limited benefit plans. Risk-based managed care is the focus below because it is the most fundamental change in financing and incentives, but it is important to note that many studies do not differentiate between types of managed care arrangements.

Comprehensive risk-based managed care involves a fixed payment, called a capitation rate, to a managed care organization (MCO) to cover all medical care for enrollees, regardless of the cost or quantity of services enrollees ultimately utilize (although several states mitigate some of these risks through risk corridors or other arrangements) (MACPAC, 2011). In this way, financial risk is shifted from the state Medicaid program to the managed care organization. As a result, states have highly predictable costs and managed care organizations are incentivized to control spending.

The proportion of Medicaid enrollees in comprehensive risk-based programs increased from 15% in 1995 to 47% in 2009, with more non-disabled children and adults under 65 enrolled in these plans than those with disabilities and the elderly (see Figure 3). Thirty-four states, including the District of Columbia, have these plans (MACPAC, 2011).

The Medicaid managed care population is expected to continue to increase in the near future. This is due to states expanding their eligibility requirements in line with the ACA, along with increasing enrollment among populations that have traditionally been carved out of managed care, such as the elderly and disabled (MACPAC, Report to Congress, 2011; Iglehart, 2011). Twenty states expanded their use of managed care in FY 2012 and thirty-five states are expanding managed care in FY 2013, a testament to the continued expansion of Medicaid managed care (Smith et al., 2012).

**Figure 3. Proportion of Medicaid Enrollees in Managed Care by Population, FY 2009**



Source: MACPAC, 2012

## II. Fiscal Impact

In theory, a flat rate paid to a MCO could change health care and costs in a number of ways. The intent is that providers will choose more cost-efficient treatment options, such as focusing on preventive care and not providing expensive treatments that produce little marginal value. When patients have multiple plans from which to choose, competition between plans may also lead to increased quality and decreased costs. However, the incentives created by managed care could also potentially discourage organizations from providing high-quality care and access to services to decrease costs, or encourage managed care organizations to ask for higher payments than necessary when there are few competitors.

There is no consensus in the research on the effects of states utilizing MCOs as opposed to fee-for-service care. Some studies find overall cost savings, but many find no difference in cost, and even a few find increased costs (Sparer, 2012). The majority of the evidence seems to indicate no cost differences or modest savings (Sparer, 2012; Lewin Group, 2009). However, it is extremely difficult to make generalizations about the effects of managed care, because state Medicaid plans and managed care models are so diverse.

One of the most comprehensive and methodologically sound studies on shifting state Medicaid populations from fee-for-services to managed care found differential financial effects based on states' preexisting reimbursement levels. Duggan and Hayford did this study in 2011, which utilized data across the country and exploited state and local mandates shifting recipients to managed care. On average, the study found no reductions in Medicaid spending. However, the effects of managed care differed depending on the existing state Medicaid reimbursement rates.

In states with relatively generous fee-for-service Medicaid reimbursement rates, shifting to managed care produced cost savings on average. The reverse was also the case; states with very low reimbursement rates in comparison to private reimbursement rates tended to experience increased Medicaid costs as managed care populations expanded. This may explain the wide variation in findings on costs among different studies, since most studies examine a concise geographic area. Therefore, some studies are bound to look at high reimbursement areas and see savings with managed care and others are likely to see the opposite in areas of low reimbursement.

### **III. Access and Quality**

Some studies have found that managed care is associated with increased access to medical care. Improvement in measures of access and quality, such as recipients possessing a usual source of primary care and decreases in emergency department or hospital utilization, have been found by many sources. However, there are other sources that find no differences between fee-for-service and managed care, and some that find decreased access (Sparer, 2012). One possible reason for these divergent findings is that many states' fee-for-service programs have incorporated prior authorization and utilization review, which may change utilization patterns in fee-for-service in similar ways as managed care (Sparer, 2012). Also, like state Medicaid programs, there is great diversity in managed care plans and contracts.

One advantage of managed care is that state contracts with MCOs can require standards of access and quality of care. Even though some states face challenges with low provider participation in the state's fee-for-service program, especially among specialists, they can require managed care plans to create large provider networks (MACPAC June 2011). All states require managed care organizations to report some kind of performance measure and survey of patient experience, offering states the opportunity to monitor enrollees' access and quality of care (Kaiser Family Foundation, Medicaid Managed Care, 2012). There are also federal requirements states and managed care organizations must meet in terms of monitoring care quality, including having an ongoing quality assessment and performance improvement program for each risk-based managed care plan (MACPAC, June 2011).

### **IV. Case Study: California**

California offers an interesting case study because the state has made transitions to managed care mandatory at various points in time, mitigating concerns of adverse selection that can produce unrepresentative results. Furthermore, California has had one of the most competitive marketplaces for managed care organizations, which would foster lower costs and higher quality as organizations compete for business (Duggan, 2004).

The county of San Mateo in California has one of the longest-running waiver programs for managed care in the country. Its risk-based managed care plan has been operating since 1987 and incorporates mandatory enrollment for all Medicaid populations, including the elderly and disabled. A study by Lo Sasso and Freund (2000) compared costs and medical care received among recipients in San Mateo and a similar California county, Ventura, with only fee-for-service Medicaid services available. Capitation rates were originally established at 95% of prior

fee-for-service expenditures, setting the county up for modest cost savings. About 70% of primary care practitioners in the county participated in the plan, a good sign of access for enrollees. Lo Sasso and Freund found that between 1989 and 1992 Medicaid nonelderly managed care enrollees generally had lower expenditures than those in the fee-for-service county, but evidence was mixed on indications of access to care. Some populations received more ambulatory care visits while other received less, and overall enrollees experienced more emergency room visits and hospitalizations.

A much broader mandatory transition from fee-for-service to managed care occurred in California throughout the 1990s. During this time, the state saw an increase in Medicaid expenditures, but no evidence of improved health outcomes (Duggan, 2004). Between 1992 and 1999, California's Medicaid managed care program transformed from covering only 12% of Medicaid recipients who voluntarily enrolled to providing care to 51% of recipients, with mandatory enrollment of certain groups. This transition was representative of what happened in the nation as a whole over the time period. A study by Mark Duggan (2004) examined the financial effects of the transition to managed care in California during these years among Medicaid recipients who qualified for Medicaid through the welfare program Aid to Families with Dependent Children (AFDC). There was a substantial increase in total Medicaid spending among this population as they moved from fee-for-service to managed care. The AFDC population was examined because not all Medicaid populations were required to transition to managed care, as is true in most states, and AFDC enrollees represent a population most frequently mandated to transition. Duggan also analyzed the effects of managed care on health outcomes as represented by infant health, which is frequently used as a representation of health outcomes for Medicaid due to greater availability of data. As the Medicaid population in managed care and total Medicaid spending increased in California, infant health outcomes remained unchanged, suggesting that the additional Medicaid expenditures associated with managed care were due to inefficiencies rather than improved health care.

In an effort to adapt its Medicaid program to cover the ACA expansion population, California received a waiver called the "Bridge to Reform" that expands coverage to low-income adults and incorporates mandatory enrollment in managed care plans, including the elderly and disabled (California Department of Health Care Services, May 2010).

An estimated 380,000 seniors and people with disabilities will newly enroll in managed care. Since demonstration waivers must be budget neutral and California's plan increases costs by expanding coverage, the difference is made up mostly from savings from managed care and the mandatory enrollment of seniors and people with disabilities previously in fee-for-service. To ensure budget neutrality, the amount paid per recipient to managed care plans is limited, and cuts are made from other areas if actual managed care enrollment and savings is significantly lower than expected (California Department of Health Care Services, May 2010).

As seen in California, the effects of managed care transitions are mixed in terms of costs, indicators of access, and quality of care.

## **V. Elderly and Disabled Populations**

The impact of managed care on elderly and disabled populations in particular is also important to note. These populations have the largest and costliest medical needs and account for a disproportionate share of Medicaid expenditures, so addressing their costs is important to solving the larger issue of Medicaid financial sustainability. While 47% of Medicaid enrollees were in comprehensive risk-based care in 2008, they only accounted for 18% of Medicaid benefit spending, indicating the extent to which most costs still remain under fee-for-service reimbursement due to differences in medical needs among populations in fee-for-service and managed care (MACPAC June 2011).

The elderly and disabled are often some of the last recipients to be transferred from Medicaid fee-for-service to managed care plans due to their complex needs and high demand. The number of states offering risk-based managed care for disabled adults increased 170% between 1990 and 2002 and 100% for the elderly in the non-institutionalized population (Kaye 2005). Still, only 11% of seniors and 28% of disabled individuals were enrolled in risk-based managed care in FY 2008 (MACPAC Managed Care, June 2011). The presence of a Medicaid managed care program for these populations, however, does not necessarily mean they will be enrolled, with many states allowing enrollment to be voluntary for the elderly and disabled.

As with managed care in the general population, the results for cost savings with the elderly and disabled populations are also mixed. Some studies have found savings from managed care in the adult disabled population; however, most have compared fee-for-service spending with Medicaid managed care plans for which disabled adults voluntarily choose managed care, which presents the opportunity for selection bias (Burns, 2009). A relatively recent study found no differences in costs with a mandatory managed care expansion in Florida among those qualifying for Medicaid through Supplemental Security Income. (Harman et al, 2011).

The need for more coordinated care for the elderly and disabled populations to improve both quality and cost efficiency is a growing concern. Dual eligible beneficiaries, with both Medicare and Medicaid benefits, particularly face integration and coordination obstacles both from the disjointedness between Medicare and Medicaid as well as the fee-for-service system. Risk-based managed care plans are one of the solutions that both CMS and individual states are pursuing to address this need. However, the dual eligible population itself is very diverse, with wide-ranging needs especially since beneficiaries can qualify for Medicare either by age or permanent disability. Further, many of those under age sixty-five have a mental or cognitive impairment, have multiple chronic conditions, or live in institutional facilities, which makes their medical needs extremely diverse (Neuman et al., 2012).

One reason the elderly and disabled may be good candidates for managed care is that they have longer periods of continuous Medicaid coverage, which can decrease administrative costs as well as the costs of care. Longer periods of continuous enrollment may increase the chances of managed care organizations reaping the benefits of investing in care coordination and preventive care capable of saving money in the long run. Within the Medicaid population, the disabled have the highest continuity ratio of 90% in 2006, followed by the aged (82 %), children (80%), and adults (68%) (Ku et al., 2009). They also have more complex needs which may benefit from

coordination services available in many managed care contracts; however, these needs may also be significantly different than other Medicaid populations that managed care organizations are used to serving (MACPAC Managed Care June 2011; Neuman et al, 2012). Any attempt to transition these populations into managed care will need to ensure that the MCO is capable of caring for the specific needs of these new populations.

The setting of reasonable capitation rates is important to ensure managed care organizations are willing to take these recipients as well as maintaining access and quality of care in addition to equity across MCOs (MACPAC June 2011; Kaiser Family Foundation People with Disabilities and Medicaid Managed Care, 2012). Managed care plans must be financially able to recruit the necessary providers and compensate for more expensive and specialized medical services and care management that they require.

## **VI. Managed Care Organizations**

The vitality of the Medicaid managed care market is a concern as states continue to expand managed care. The number of health plans participating in Medicaid initially rose in the early 1990s and then fell as many exited the market. The most likely reason that managed care organizations have exited from state Medicaid programs is believed to be financial (Kaye 2005; Long and Yemane, 2005). Many plans are losing money; especially those that do not specialize in Medicaid and even many specializing in Medicaid are facing very small profit margins (McCue, 2012). MCOs specializing in Medicaid are able to mitigate this loss, in part, because they develop expertise in the distinct Medicaid population and make investments in programs and information systems that lead to more cost-efficient use of medical services from increased care coordination (McCue, 2012; Hurley and McCue, 2000).

Most concerning, given recent trends of mandatory enrollment of Medicaid recipients, including the elderly and disabled, are findings that this may decrease the participation of MCOs in the Medicaid market. Requiring the SSI disabled population to enroll in managed care was associated with almost a ten percentage point increase in the probability that commercial plans would exit the market (Long and Yemane, 2005).

States need ensure that they create environments conducive to MCOs as they continue to expand managed care populations, or they will to face turmoil as organizations exit the market. States and MCOs need to communicate and work together with mutual understanding of each other's needs, especially as elderly and disabled populations continue to be transitioned to managed care.

## **VII. Recommendation**

While there is not clear evidence of drastic cost savings with risk-based managed care, it is a viable option for states to provide Medicaid recipients with coordinated care and guaranteed access. States with relatively high fee-for-service reimbursement rates have the most potential for cost savings from managed care and should consider whether shifting recipients is appropriate, based on their market and other unique features. States should also keep in mind that for managed care expansions to work, MCOs must have the capacity to serve the new

population's size and particular medical needs. Therefore, shifting elderly and disabled populations to managed care must be thoughtfully done by providing capitation rates that allow MCOs to meet their needs in addition to any investments that may be necessary to serve a very different population than many are accustomed to. Strong contracts and monitoring on the part of the state is also important to ensure that managed care arrangements work well, and as a result increased reliance on managed care may not decrease state's administrative burden, but instead change administrative goals.

## Changes to Supplemental Payments

Medicaid supplemental payments are funds given to providers outside of the usual reimbursement process, which are intended to subsidize the provision of uncompensated care to uninsured and Medicaid patients. Therefore, they are often an important revenue source for safety-net providers. Supplemental payments are typically made to health care providers in lump sums rather than being paid to providers for specific medical services. They are often criticized for failing to incentivize quality and cost-efficient care due to their detachment from the care of specific patients. Additionally, states vary widely in their use of supplemental payments, and these payments are not reflected in fee-for-service rates, making comparisons between states and providers difficult. Further complicating matters, states normally fund supplemental payments with money garnered through a combination of intergovernmental transfers and health care related taxes. Ironically, these taxes often collect money from some of the very providers who receive supplemental payments (MACPAC, 2012).

Concerns with supplemental payments have grown over the years, including not just their effectiveness as a financing mechanism, but also due to insufficient reporting and transparency. It is difficult to determine who receives these payments and how states allocate money among different providers. As a result, their effect on provider behavior, access, and quality of care are largely unknown. They are believed to play an important role in the financial viability of safety-net providers, especially hospitals, which receive the most supplemental payments by far. Supplemental payments accounted for 41 percent of all Medicaid fee-for-service payments hospitals received in the 2011 fiscal year (MACPAC, 2012). Therefore, any reform to supplemental payment policies should consider the effect on safety-net providers and their ability to care for uninsured and Medicaid patients.

The two most important forms of supplemental payments from Medicaid programs are the Disproportionate Share Hospital (DSH) payments and Upper Payment Limit (UPL) payments. Perhaps the most prominent difference between the two is that DSH payments are required by law (42 U.S.C.A. § 1396r-4), whereas UPL payments are not. They also differ in the types of providers they may be paid to and the methods used to calculate allowable payments.

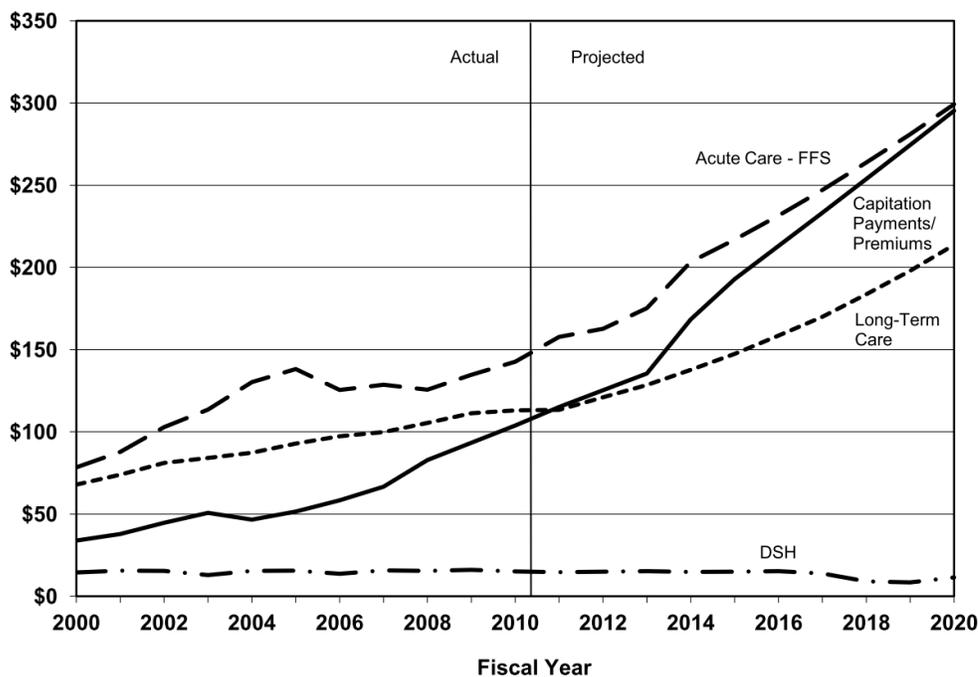
### **I. Disproportionate Share Hospital Payments**

As required by law, DSH payments go to hospitals that serve a large proportion of low-income patients. They are meant to offset uncompensated costs hospitals incur from treating uninsured patients and Medicaid patients for which state reimbursement rates do not cover total costs. States must provide DSH payments to hospitals with high Medicaid or low-income inpatient use, but can choose to provide payments to other hospitals with at least a Medicaid utilization rate of 1% (MACPAC, 2012). This comes from part of the Social Security Act that requires states to “take into account... the situation of hospitals which serve a disproportionate number of low-income patients with special needs” in their payment rates (42 U.S.C. Section 1396a (a)(13)(A)(iv)). In addition, 42 U.S.C.A. § 1396r-4 further stipulates that this requires states to develop payment methodology to identify and make payments to hospitals with disproportionate shares of low-income patients (42 U.S.C.A. § 1396r-4). Hospitals are considered to have high Medicaid or low-income inpatient use and must be designated as DSH hospitals when the Medicaid



uninsured population by the year 2019 (CBO, 2010). Consequently, DSH payments would naturally decline since they may not exceed uncompensated care amounts. Another reason for the reduction is to make states' use of DSH payments more equal. The largest proportional reductions in DSH allotments are required to come from states that have the lowest proportion of uninsured individuals and have failed to target their DSH payments to hospitals with high volumes of Medicaid inpatients and uncompensated care (P.L. 111-152 Section 1203 (7)(B)). This puts significant pressure on states to target DSH payments to safety net hospitals and encourages a more equitable distribution of DSH payments across states and providers. CMS has also stated that it anticipates the change will make distribution of DSH payments more equitable among hospitals (HHS, 2010).

**Figure 5. Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, FY 2000 – 2020 (In Billions)**



Source: Department of Health and Human Services, 2011 Actuarial Report on the Financial Outlook for Medicaid, 2012.

Another factor to consider is that even when DSH payments are included, Medicaid payments do not cover hospitals' cost of providing care to Medicaid patients, meaning hospitals are losing money by providing services to Medicaid patients (American Hospital Association, 2012). The problem with DSH payments, therefore, is not that hospitals are receiving too much money but that they are not tied to measures of quality or access to care.

## *Disproportionate Share Hospital Payments: Access and Quality*

The low payment-to-cost ratio of Medicaid payments raises questions about the incentives for hospitals to provide access and quality care to Medicaid patients. DSH payments provide an additional incentive for hospitals to continue to care for such patients, despite the fact that payments do not cover the cost of services. (Buchrach et al., 2012). Still, if payments could be tied to measures of quality and access, Medicaid programs may get more “bang for their buck” by encouraging increased quality and access for the same amount of money.

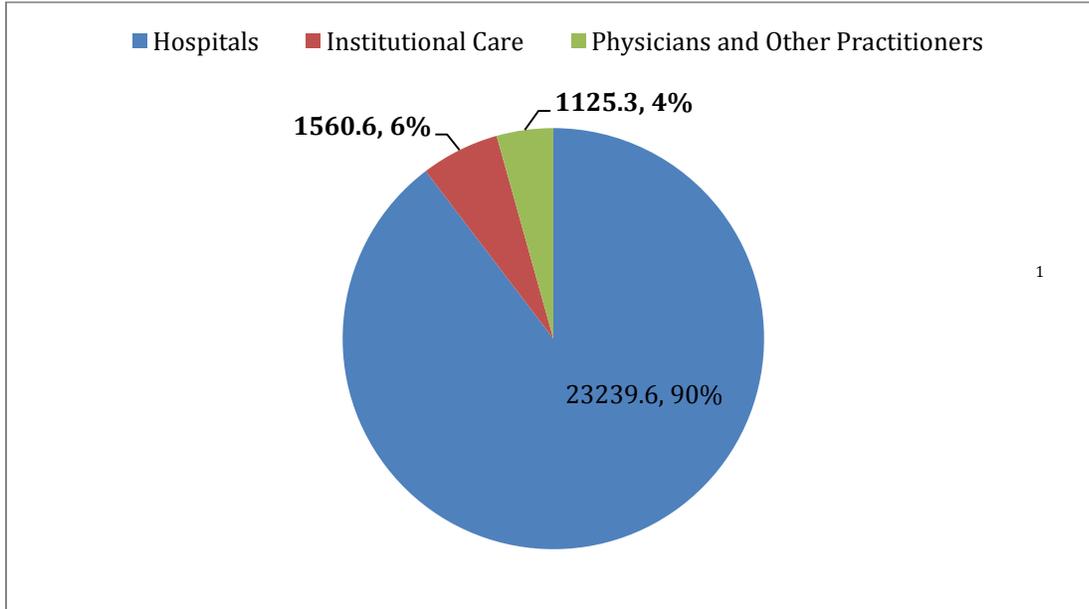
Alternatively, states can redirect money that has been cut from DSH under the ACA and put it towards higher reimbursement rates. Even reimbursement rate changes can be targeted to hospitals with large Medicaid and uninsured populations by increasing rates specifically for services that safety-net hospitals disproportionately provide for Medicaid patients. Redirecting money to higher reimbursement rates will increase providers’ incentives to treat Medicaid patients. Changes to reimbursement rates as opposed to DSH payments would also benefit states. Under the ACA states will receive a higher match rate for services provided to newly eligible Medicaid recipients, while supplemental payments will continue to be matched at the state’s normal rate (P.L. 111-148 § 2001(a)(3)).

### **II. Upper Payment Limit Supplemental Payments**

Upper Payment Limit (UPL) payments, sometimes included within the term non-DSH supplemental payments, are used to make up some or all of the difference between base fee-for-service reimbursement levels and the maximum payment level for which the federal government will contribute matching funds, or the “upper payment limit.” These payments totaled almost \$26 billion in FY 2011 (MACPAC, 2012). Unlike DSH payments, states are not required to make UPL Payments. Most of UPL payments go to hospitals, although a portion also goes to nursing facilities, physicians, and other practitioners (see Figure 6). UPL payments account for 25% of Medicaid payments to hospitals, not inclusive of payments made under managed care arrangements (see Figure 7). Providing supplemental payments to services beyond hospital and institutional care is a more recent trend. In 2001 no states reported making supplemental payment outside of hospitals or nursing homes, but thirteen states reported payments to other providers by 2005 (Coughlin et al., 2007).

The upper payment limit prevents states from paying more than would be paid by Medicare for hospital or long term care services in the aggregate. It is based on an estimate of what Medicare would pay for similar services and is calculated for each different provider class and ownership type, with the limit aggregated over each type.

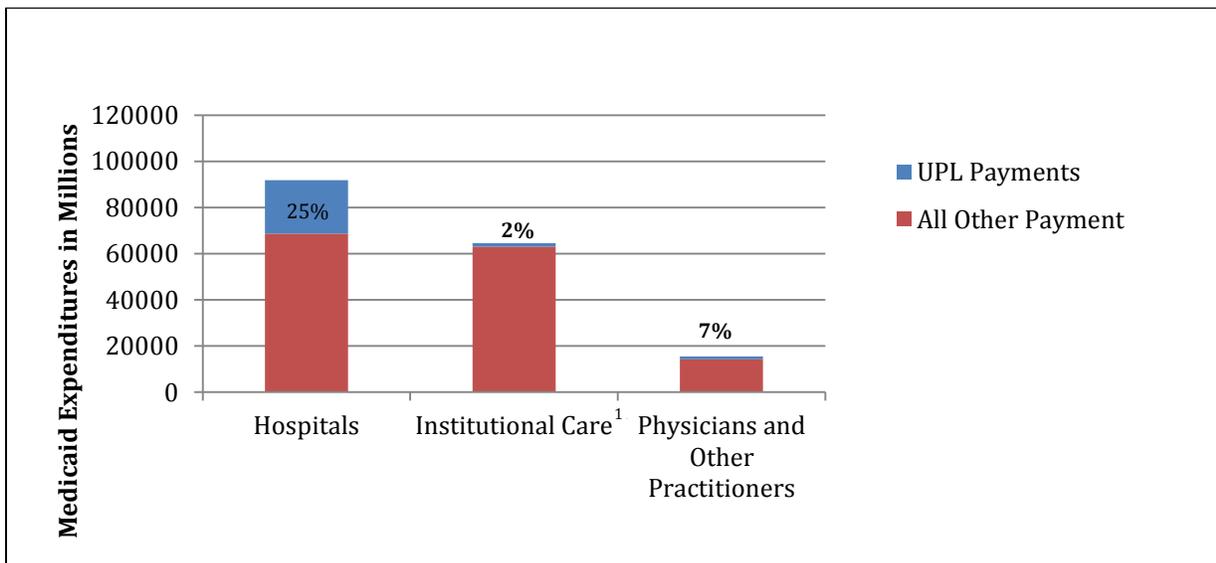
**Figure 6. UPL Supplemental Payments by Provider Type for FY 2011 in Millions**



<sup>1</sup> Institutional Care includes nursing facilities and intermediate care facilities for the intellectually disabled.

Source: MACPAC, 2012

**Figure 7. UPL Supplemental Payments as Percent of Medicaid Expenditures by Provider Type for FY 2011 in Millions**



<sup>1</sup> Institutional Care includes nursing facilities and intermediate care facilities for the intellectually disabled.

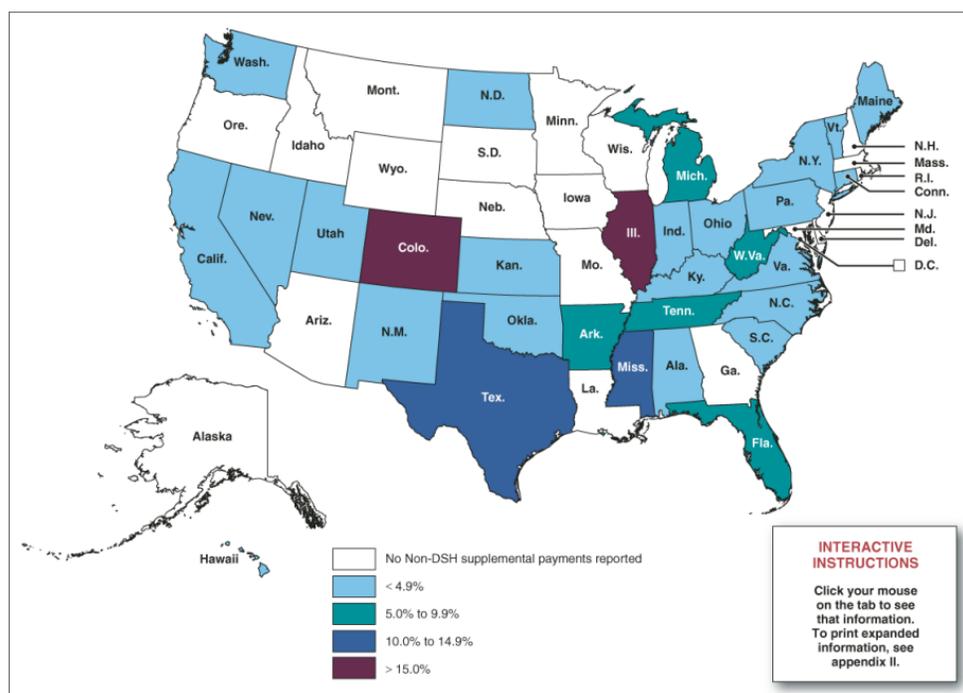
Note: DSH payments are included in total in these figures but payments under managed care arrangements are not.

Source: MACPAC, 2012

*Upper Payment Limit: Fiscal Impact*

There is wide variation among states in the use of supplemental payments. Non-DSH supplemental payments ranged from 1% to 17% of total Medicaid spending within states, although only thirty states reported whether or not they made these payments (see Figure 8). This makes UPL payments especially problematic to analyze, which the Centers for Medicare and Medicaid Services is currently remedying (GAO, 2012). States must also document their payment methodology, but payment amounts are not necessarily calculated based on Medicaid use (MACPAC, 2012). There are no caps on total state UPL payments or limits on payments to specific providers. In fact, UPL payments to individual providers may exceed an individual provider’s own upper payment limit as long as total payments to providers in that class are within the UPL.

**Figure 8. Non-DSH Supplemental Payments Separately Reported by States during Federal Fiscal Year 2010 as a Percentage of the State’s Total Medicaid Payments**



Source: GAO 2012

Despite data limitations, it is evident that states have increased spending in UPL payments between 2006 and 2010. Within this time, states reported \$8 billion more in non-DSH supplemental payments, with some of this increase due to better reporting. Among states that reported non-DSH payments in both 2006 and 2010, fifteen states reported higher payments in 2010 and only four reported lower payments, with a net change of \$7.7 billion more spent on non-DSH payments in 2010 compared to 2006 (GAO, 2012).

### *Managed Care and Alternatives to UPL Payment Methods*

An additional concern with UPL payments is that they may provide a disincentive to states and individual providers for transitioning to managed care where it may be more cost-effective, because UPL payments can only be calculated based on fee-for-service usage. Many states do not want to forego federal matching funds from UPL payments. This is especially true when high-cost populations such as the elderly and disabled, who utilize a disproportionate share of medical services, are moved to managed care. (MACPAC, 2012).

Managed care services are not calculated within the UPL because managed care organizations are themselves responsible for adequately paying providers. However, managed care payment shortfalls to providers are incorporated into DSH payment calculations. Some states have indicated that they are less likely to expand managed care to high-cost populations due to UPL policies. Although managed care already serves a majority of Medicaid populations, populations with the highest utilization remain disproportionately in fee-for-service payment methods. Individual safety net providers, many of whom receive substantial funding from UPL payments, may also be hesitant to transition from fee-for-service to payments under managed care due to their individual loss of UPL funding (Robinson and Laughton, 2012).

In response, states have utilized a variety of methods to maintain payment levels for providers and preserve federal matching funds as they expand their managed care population. These attempts have been established through Section 1115 demonstration waivers within a number of states and replace UPL payment programs either wholly or in part. States with waivers incorporating UPL changes include Florida, California, Texas, Iowa, and Massachusetts (Robinson and Laughton, 2012).

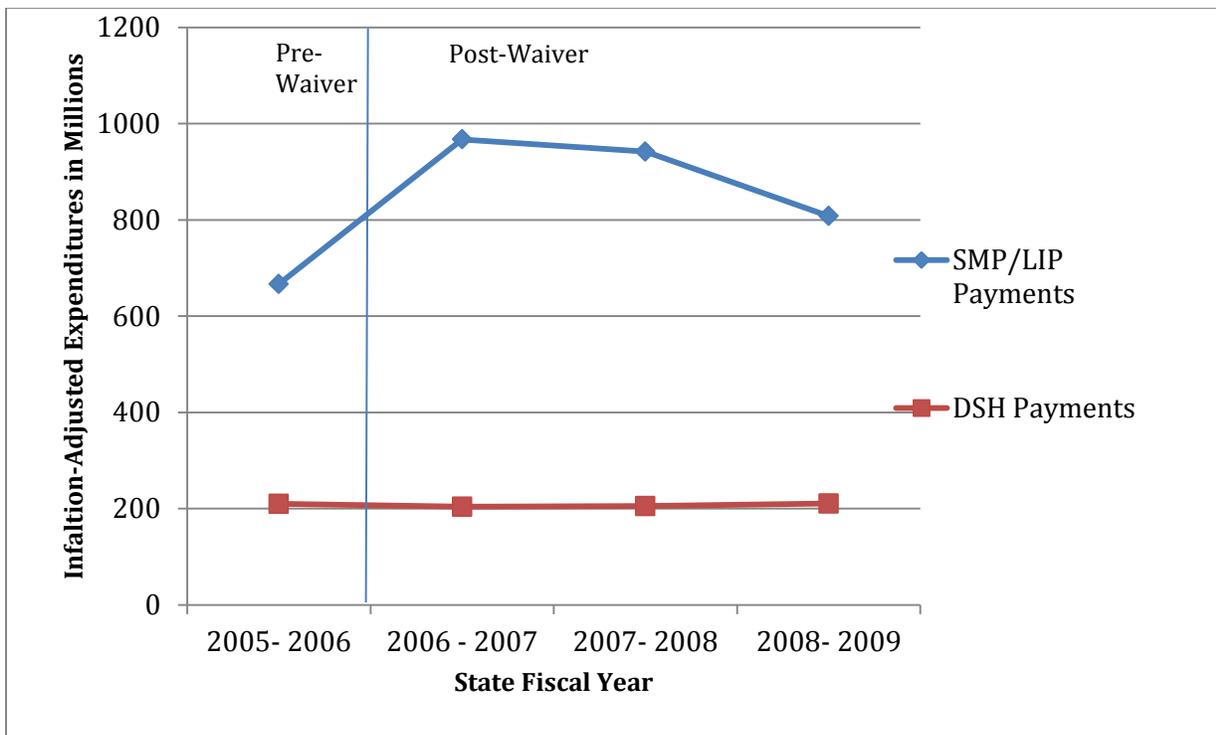
### **III. Supplemental Payment Reform in Florida, California, and Texas**

Florida utilizes a Low Income Pool (LIP) program under a CMS waiver that replaces the UPL program. Florida's initial waiver for this program was set to expire in 2011 and has been extended through June 30, 2014. The most prominent difference between LIP and UPL payments is that uncompensated costs of medical care provided to Medicaid enrollees in managed care plans may be reimbursed through the LIP program, in addition to fee-for-service uncompensated care costs. This removes the most prominent obstacle UPL policies pose to expanding managed care populations, by allowing uncompensated care from managed care enrollees to be included.

Florida's LIP program is capped at \$1 billion annually and can go to hospitals as well as other types of providers. Another noteworthy feature is that the state designated some hospitals as "transition programs," allowing them to receive payments comparable to the UPL program temporarily because of their designation as the state's "core safety-net providers" (McKay, 2010). This protected key safety-net providers as the supplemental payment program changed. The state also chose to target non-hospital LIP funding to primary care, emergency room diversion, disease management, poison control, and premium assistance programs in specific locations, which it had not done in the past (Florida Committee on Health Regulation, 2010).

There is no way to know the marginal effect of supplemental payments on access or quality of care, because providers' behavior in the absence of payments is unknown. That being said, an evaluation of Florida's LIP program found that for every \$1,000 of LIP funding, hospitals provided care to 31.1 patients that were either uninsured, underinsured, or on Medicaid (McKay, 2010). Also worth highlighting is a small portion of LIP funding that went to eleven emergency room diversion projects. One of these eleven projects alone boasted savings of \$5,293,000 in avoided emergency room visits and hospitalizations (McKay, 2010). Florida's ability to invest LIP money in non-hospital services such as primary care is important, because these services have the potential to save money overall by decreasing usage of more expensive hospital services. However, total LIP payments were considerably more than UPL payments made the year prior to reform, even after adjusting for inflation, as shown in Figure 10. DSH payments remained relatively stable over the same period (see Figure 9) (McKay, 2010).

**Figure 9. Comparison of Florida's Supplemental Payments Before and After Reform**



Note: SMP stands for Special Medicaid Payments and is the supplemental payment program under the UPL used prior to LIP

Source: McKay, 2010

A second alternative to UPL payments is known as Delivery System Reform Incentive Pools (DSRIPs). Payments from these pools are contingent on meeting specific requirements set by the state. States can utilize a variety of requirements, including measures of quality, access, population health, coordination of care, cost-effectiveness, or infrastructural investment. This puts pressure on providers because they have to meet higher standards to receive payments, particularly since meeting these requirements often necessitates upfront investments by

providers. Both California and Texas have adopted DSRIP programs as a part of waivers, which also include expansions of populations that must mandatorily enroll in managed care. Both states require public hospitals to provide the non-federal portion of funding, which is then matched by the federal government if providers meet their goals, increasing the financial risk to providers. California's program has been in existence about a year longer than Texas's DSRIP and was the model for Texas. However, Texas's DSRIP is more broad-based in terms of the providers that are eligible to receive payments and has more funding available. Some preliminary outcomes from California are now known, but not for Texas due to its short time in existence.

California created a Delivery System Reform Incentive Pool under its 2010 waiver called Bridge to Reform. The pool provides up to \$3.3 billion to public hospitals over a five year period. Each hospital individually submitted a five year plan approved by the state and federal government, which includes multiple initiatives addressing a broad base of infrastructural, quality, access, and cost-efficiency improvements. There are hundreds of associated output and outcome measures that hospitals must meet to qualify for full payment (California Health and Human Services Agency Bridge to Reform Waiver, 2012). In the first year, each of California's twenty-one public hospitals initiated between twelve and nineteen projects, which were associated with 298 milestones that hospitals had to meet to receive full funding. In the first year, hospitals met 100% of the milestones (California Association of Public Hospitals and Health Systems, 2011). This is a good indication that health care quality and access, in addition to patient health and possibly subsequent health care costs, have improved as a result of the DSRIP program.

Texas received a waiver in December 2011 that replaces the state's UPL program with two different funding pools. The two pools include an uncompensated care pool to reimburse hospitals for care they provide to Medicaid enrollees and the uninsured for which they have not been compensated and a Delivery System Reform Incentive Pool. DSRIP payments are contingent on providers meeting certain goals and are directed to improvements identified as important in Regional Healthcare Partnerships, which are led by public hospitals. However, funds may go to hospitals as well as other providers, a deviation from California's program. Texas is also able to spend twice as much over the course of the five year waiver than it was formerly under the UPL program, with \$29 billion available under the waiver (between \$11.4 and \$15.4 billion for the DSRIP program alone) compared to a total of \$14 billion previously spent under the UPL program over a five year period (Texas Hospital Association, 2011). The results of this demonstration are still unknown.

As with all waivers, changes must be budget neutral as a whole. In California and Texas savings from managed care expansions offset any increases in spending (KFF, California and Texas Section 1115 Medicaid Demonstration Waivers Compared, 2011).

#### **IV. Recommendations**

Overall, supplemental payment policies and reporting could benefit from additional transparency and predictability. In the case of DSH payments, cuts mandated by the Health Care and Education Reconciliation Act targeted at states with small, uninsured populations, in addition to states not targeting DSH payments to hospitals with the greatest need, should address these concerns to some extent. Therefore, we recommend waiting to see the effects of these changes.

States facing cuts to DSH allotments should appropriate at least some of the savings from decreased DSH payments to increase base fee-for-service reimbursement rates. Increases in reimbursement rates should be directed to services Medicaid recipients use most and that safety-net hospitals disproportionately provide. This will achieve the same goal as DSH payments by continuing to target funds to hospitals with large Medicaid and uninsured populations. It will also increase transparency and predictability, while creating greater incentives for providers to treat Medicaid patients. Further, states stand to receive more federal matching funds from increased reimbursement rates in comparison to supplemental payments because the Medicaid expansion population is eligible for a higher federal matching rate indefinitely.

Alternatives to upper payment limit programs, especially Delivery System Reform Incentive Pools may be a good option for states, particularly as Medicaid coverage expands under the Affordable Care Act. DSRIPs can be used to facilitate improvements in quality, access, cost-efficiency, and infrastructure, while ensuring that Medicaid is receiving concrete benefits for its money. DSRIPs may be used in conjunction with other pools of money for uncompensated care, but should be incorporated at least in part into any alternative supplemental payment program.

States shifting large numbers of recipients from fee-for-service to managed care can particularly benefit from alternatives to traditional UPL programs because they can continue to support safety-net providers at least during a transition period. As is the case for DSH payments, states stand to receive more federal matching money from diverting supplemental payments to increase reimbursement rates, although if this is done it is also recommended to allow safety-net providers a transition period with time to adjust to different payment methodology.

## Shifting Recipient Incentives

### Targeted Behavior Interventions

#### I. Overview

The Deficit Reduction Act (DRA) of 2005 provides individual states with additional flexibility in designing their Medicaid programs. Specifically, it allows states to make policy changes previously requiring a waiver through permanent state plan amendments. Under state plan amendments, these programs do not need to be budget neutral, benefit packages can be tailored to the needs of different groups, and states can use innovative designs to promote healthy behavior (Kenney and Pelletier, 2010).

Many states have taken advantage of this additional flexibility to design programs that attempt to control Medicaid costs by modifying individual behaviors. According to a 2007 survey, over half of the states are considering the use of financial incentives to encourage healthy behavior among Medicaid beneficiaries (Greene, 2007). As such, states may use incentives to either encourage preventative care, or discourage unhealthy conditions and behaviors such as obesity and tobacco usage.

There is a variety of literature illustrating that financial rewards for simple, one-time behaviors are effective. Kane et al. (2004) analyzed forty-seven different studies of incentive programs, and found that economic rewards are effective in incentivizing simple preventative care and well-defined behavior goals in the short run. However, how large an incentive must be to induce behavior changes remains unclear.

Through their literature review, Kane et al. also demonstrated that the effectiveness of incentives might not necessarily be correlated with their redemption rate. For example, one study demonstrated that free taxi rides were a positive incentive, despite the fact that only one of thirty-four vouchers was actually redeemed. This suggests that little is understood about how behavior changes actually work (Kane et al., 2004).

The authors found that incentives directly increasing participants' ability to purchase the preventative service were more effective than those with less direct impacts. However, they note that there isn't sufficient evidence to indicate that financial incentives can sustain healthy lifestyle changes in the long run (Kane et al., 2004).

This contention is supported by literature on weight loss and smoking cessation programs, which found that incentives rewarding participation are insufficient to alter long term behavior. Follick et al. found that, while incentives increased participation in a weight loss program, they did not significantly diminish obesity (Follick et al., 1984). Jeffery et al. (1999) determined that those who were rewarded for participation in a weight loss program had significantly less success than those who were rewarded for performance. Unfortunately, most Medicaid programs target participation, and fail to monitor progress after the program ends. This may have important implications, as Greene (2007) notes that most behavior changes disappear within a year after incentives stop.

There may be a variety of reasons for these trends. It is possible that participants lack the support systems necessary to make long-term changes. Additionally, there is evidence that the use of extrinsic motivators may actually diminish the intrinsic motivation required for long-term behavior changes. Curry et al. found that, while an extrinsic incentive improved participation in a smoking-cessation program, only those intrinsically motivated exhibited improvement after the program ended (Kane et al., 2007).

## **II. Recipient Impact**

Targeted behavior interventions are designed to impact both short-term and long-term behavior. This report will explore two approaches to achieving this goal: incentivizing healthy behavior through financial rewards, and incentivizing healthy behavior by limiting benefits.

Florida provides beneficiaries with credits in order to incentivize better health. Under the Enhanced Benefit Rewards program, part of the state's 2006 Medicaid reform, individuals can receive up to \$125 in credits each year for engaging in behaviors that improve health. These activities include preventative office visits, immunizations, flu shots, and cancer screenings. They also encompass long-term lifestyle changes, such as participating in a six-month alcohol or drug treatment program, or a comprehensive weight loss program (Alker and Hoadley, 2008).

The amounts that individuals can earn vary based upon the behavior, ranging from \$7.50 for medication compliance to \$25 for a pap smear or a child wellness visit. While the credits cannot be redeemed for cash, they can be used for approved products, including vitamins, bandages or over-the-counter medications. As of March 2008, the program enrolled 27,140 beneficiaries (Alker and Hoadley, 2008).

Despite the high enrollment, there is little evidence that participants are utilizing their credits. A study by researchers at the Georgetown Institute for Health Policy commissioned by the Jessie Ball DuPont Fund revealed that, while beneficiaries earned a total of \$12.5 million in credits within the first year and a half of the program, only 10% were redeemed. It was found that only 12% of enrollees actually used their credits (Alker and Hoadley, 2008).

Alker and Hoadley determined that the majority of credits had been earned as the result of adults and children maintaining primary care appointments. An additional 20% were earned as a result of preventative care, including screenings and immunizations. Disease management programs were responsible for just .1% of all credits, and no credits were earned for participation in exercise, weight loss, and smoking cessation programs (Alker and Hoadley, 2008). This is consistent with previous research indicating that it may be more difficult to use financial incentives to induce long-term behavior changes.

It is likely that insufficient education for participants is the primary cause of poor redemption rates. For instance, Alker and Hoadley found that nearly half of all participants were unaware of the credits two years into the program. When the state specifically advertised the products that consumers could purchase with their credits, the number of credits used doubled within a year, suggesting that outreach efforts have a significant impact on participation. However, this

increased usage still accounted for less than a quarter of all credits earned (Alker and Hoadley, 2008). Further, research reveals that minorities and non-English speakers were less likely to be aware of the program, thus negatively impacting their participation (Lemak et al., 2012).

In addition to Florida, Idaho also seeks to change enrollee behaviors through incentives. The Idaho Behavioral Preventive Health Assistance Program (PHA) is available to Medicaid recipients expressing an interest in altering a long-term health behavior, such as smoking or obesity. In exchange for establishing an improvement plan with a doctor, recipients are given \$100 that can be redeemed on services used to treat their condition. Participants are eligible to receive an additional \$100 in credits if an interim goal is achieved (Redmond et al., 2007). As of 2009, the weight management program enrolled 1,061 individuals, and the smoking cessation program enrolled 361 participants (Kenney and Pelletier, 2010).

While initial results have shown some success, the program only covers seven weeks of tobacco cessation treatment, as opposed to the recommended twelve weeks by the U.S. Preventive Health Task Force. The Task Force also recommended that participants receive six additional weeks of maintenance, which the program does not cover. As a result, many participants have reverted back to smoking after the program ends, illustrating that they may not benefit from incentive programs unless healthy behavior continues to be rewarded (Kenney and Pelletier, 2010). Given that 90% of smoking relapses occur within the first 6 months, states have a lot to gain from ensuring that the program duration is adequate (Vlopp et al., 2008).

While these programs seek to directly change behavior through financial incentives, West Virginia incentivizes healthy behavior by limiting benefits. The Mountain Health Choices Initiative, implemented in 2007 through a DRA amendment, fosters personal accountability by providing members with enhanced health benefits, or “healthy rewards.” In exchange, recipients must sign an agreement that they will keep appointments, cancel any appointments they cannot keep, use the emergency room only for true emergencies, and participate in health improvement programs. Recipients must develop a health improvement plan during a visit to the primary care provider, which specifies “office visits, diagnostic services, and education programs they agree to receive in the coming year (IHPR and Mathematica, 2009).”

In the event of noncompliance, individuals will be moved into the basic benefit package, which will also cover those who fail to choose a plan voluntarily within the ninety-day selection period. In order to compensate for the additional benefits offered under the enhanced program, which include weight management services and nutritional education, the basic plan provides fewer services than regular Medicaid, including “a monthly limit of four prescriptions, an annual limit of \$1,000 for durable medical equipment, and a limit of thirty days per year for inpatient psychiatric services (IHPR and Mathematica, 2009).” Once recipients choose a plan, they are obligated to participate until annual redetermination. As of February 2009 the program enrolled approximately 149,000 low-income children and adults (IHPR and Mathematica, 2009).

An analysis of the program found that only 13% of eligible children and 10% of eligible adults were enrolled in the enhanced plan (Gurley-Calvez et al., Mountain Health Choices Beneficiary Report, 2010). Like Florida, most participants in West Virginia did not possess a comprehensive understanding of the program design. As of 2009, the state lacked an ongoing outreach program,

with education limited to sparse mailings. As a result, patient advocates and providers surveyed by IHPR and Mathematica expressed that enrollees were not receiving adequate support in choosing a plan, indicating that enrollment patterns reflected the program's default mechanism, rather than a conscious choice by participants (IHPR and Mathematica, 2009).

In addition to poor participant education, there is evidence that lack of awareness among providers may be negatively impacting enrollees. According to survey results in West Virginia, providers reported confusion with respect to the program design due to poor outreach on the part of the state. For instance, while West Virginia attempted to incentivize enrollment by offering providers a \$20 reimbursement fee for each member agreement completed, most were unaware of this benefit. Additionally, providers reported uncertainty regarding the length of time covered by the member agreement, and found the number of signatures required by beneficiaries unduly burdensome. This not only complicates the administration of the program, but also weakens its design by making providers unable to articulate the benefits of enrolling in the enhanced benefits (IHPR and Mathematica, 2009).

In terms of utilization, regression analysis revealed that these enrollees in the enhanced benefit plan were more likely to have self-reported a poor health status, and had higher consumption of services, measured by office visits and prescription use. Adults in the Enhanced Plan filled 150% more prescriptions in July 2008 than basic plan enrollees, and had twice as many doctors' visits. Similarly, children in the Enhanced Plan filled nearly 60% more prescriptions, and had 60% more doctors' visits than those in the basic plan (Gurley-Calvez et al., Mountain Health Choices Beneficiary Report, 2010). While this suggests that those most in need were receiving adequate care, the vast majority of enrollees experienced a decline in health benefits as a result of the initiative. This was reflected by increased emergency room utilization among basic plan beneficiaries (Gurley-Calvez et al., Medicaid Reform and Emergency Room Visits: Evidence from West Virginia's Medicaid Redesign, 2012).

### **III. Fiscal Impact**

There are several important components of overall program costs, including administrative costs, costs to providers, and costs to the state. State costs include both the costs of providing rewards, as well as the costs resulting from potential unanticipated changes in utilization. Given these expenses, personal accountability programs will have to significantly alter enrollee behaviors to be sustainable. The federal Agency for Healthcare Research and Quality (AHRQ) asserted that, while there is tentative evidence supporting that incentives are effective in encouraging simple, preventative care in the short run, there is insufficient evidence confirming its effectiveness in inducing long term lifestyle changes required for health improvement. In light of these findings, the agency was skeptical about the cost effectiveness of incentive programs given potentially high administrative costs (Alker and Hoadley, 2008).

It is difficult to quantify a single administrative cost associated with implementing rewards programs, which may vary depending on the existing infrastructure. For example, Idaho could not implement an electronic system, instead creating a manual billing process. Under this system, participant vouchers are submitted to Medicaid by the receiving vendor. This has created a

variety of logistical concerns, as many pharmacies were reluctant to participate due to the paperwork (Greene, 2007).

Alternatively, Florida was able to use its existing pharmacy point of sale system, where enrollee accounts could be established with relative ease (Greene, 2007). Despite the minimal administrative costs, program costs totaled over \$1.1 million dollars (Redmond et al., 2007). While the monetary benefits of the program have not yet been determined, data on participation suggests the possibility of recovering this investment is unlikely.

Focusing on rewarding simple behaviors may also decrease administrative costs. As demonstrated in Florida, it is possible for states to use existing systems to administer simple credits, and Medicaid agencies can more easily evaluate the effectiveness of these incentives through claims data analysis. Conversely, altering chronic lifestyle behaviors is more difficult, and requires additional documentation including signatures of the participants, program representatives, and physicians. The evaluation process is also more complex because there is no simple benchmark to serve as a basis for comparison (Greene, 2007). Despite its great potential for long-term savings, promoting lifestyle changes has clear administrative challenges.

In terms of costs to providers, West Virginia illustrates that there may be hidden costs associated with healthy rewards programs. IHPR and Mathematica found that sudden, poorly communicated cuts in mental health services under the basic plan have resulted in significant losses due to unreimbursed services. Specifically, nine behavior clinics lost \$600,000 in unreimbursed services over a fifteen-month period. In addition, several physicians refused to accept those in the basic plan due to the reduced benefits levels. The analysis revealed that one crisis center would not accept beneficiaries in the basic plan, where the services would not be reimbursed (IHPR and Mathematica, 2009).

Finally, with respect to state costs, IHPR and Mathematica estimated that while the enhanced plan was effective in reducing certain types of ER visits for children, it was more than offset by increased ER use among children and adults in the basic plan, who experienced a 7% increase in the probability of an ER visit and about a 10% increase in the probability of both nonemergency and primary-care treatable visits. This spike in emergency room use was likely spurred by the reduction in benefits. Specifically, the authors noted that beneficiaries might have chosen to receive treatment in the ER in order to circumvent the monthly limit on prescriptions (Gurley-Calvez et al., Medicaid Reform and Emergency Room Visits: Evidence from West Virginia's Medicaid Redesign, 2012).

The ACA now prohibits states from cutting benefits in their default plans, inducing West Virginia to terminate the program in 2010 (Gurley-Calvez et al., Medicaid Reform and Emergency Room Visits: Evidence from West Virginia's Medicaid Redesign, 2012). This indicates that the majority of savings were likely associated with limitations in services, rather than improvements in the health status of participants.

#### **IV. Recommendations**

Financial incentives must be implemented carefully in order to be effective. The following case studies give rise to four recommendations state Medicaid agencies should employ in designing incentive programs.

First, it is imperative that incentive programs are accompanied by extensive outreach. The experiences of Florida and West Virginia reveal that lack of awareness has deleterious impacts on program effectiveness. A program analysis of the Enhanced Benefit Rewards Program illustrates that merely increasing the frequency of mailings has the potential to double credit redemption. Additional outreach efforts should target non-English speakers and minorities, which may require special attention.

Second, states should focus on better educating providers in order to ensure proper administration and accurate communication to participants.

Third, the West Virginia experience illustrates that states should be cautious of the unintended consequences of limiting benefits to incentivize healthy behavior. While the ACA now prohibits the use of a more limited plan as the default, instituting other penalties for non-compliance may have a similar effect.

Finally, due to the newness of these programs, it is recommended that additional research be conducted on the ability of incentives to induce long-term behavioral changes in the Medicaid population. At minimum, Idaho's program suggests that efforts to reduce smoking must be supported for an adequate length of time, and continue to be monitored and rewarded to prevent relapse. Until more conclusive research is established, states may be best served targeting simple, short-term behaviors.

## Health Savings Accounts

### I. Overview

Health Savings Accounts (HSAs) are market-based instruments designed to reduce costs by holding individuals accountable for their health care expenditures. Initially authorized in the private insurance market by the Medicare Modernization Act of 2003, the system has two components: a savings account to which contributions are made to fund medical care, and an accompanying high deductible health plan (HDHP) used to fund catastrophic healthcare expenses (Texas HHS, 2008).

HSAs were first introduced to the Medicaid population in 2005 through the Deficit Reduction Act (DRA), however there are several key distinctions between Medicaid HSAs and those offered in the private market. Unlike private HSAs, Medicaid HSAs are jointly financed by individuals and the state, and offer services through a plan authorized by the state. While private HSAs encourage individuals to “shop around” for care, Medicaid accounts can only be used for services explicitly provided by the plan’s in-network providers. As a result, Medicaid enrollees have significantly less control over their accounts, potentially reducing the incentive to assume full accountability of expenditures. Additionally, individuals do not receive tax incentives under a Medicaid HSA (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

### II. Case Study: Healthy Indiana Plan (HIP)

This section will evaluate the efficacy of HSAs based on data from the Healthy Indiana Plan (HIP), which provides Medicaid coverage modeled after a health savings account. Implemented in 2008, the plan covers both low-income parents who have been uninsured for at least six months and other adults lacking access to health insurance. HIP insures parents age 19-64, with incomes between 22%-200% of the federal poverty line (FPL). Indiana estimates that it will enroll approximately 120,000 individuals by the end of the five- year period for which the program was approved (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

In order to obtain coverage, enrollees must make monthly contributions to their account, called a POWER account, ranging from 2-5% of income. Indiana pays the balance in order to ensure that the deductible is fully funded, although it is possible for employers to make up to half of employee contributions. In families with two enrolled adults, the total of both enrollees’ payments cannot exceed the limit for the family. For families with adults enrolled in HIP and children enrolled in Medicaid or SCHIP, the total amount of premiums and HIP contributions is limited to 5% of income. Individuals with no income are not required to make monthly contributions (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

If enrollees fail to make a payment within the first two months, or miss a monthly payment, they lose coverage, along with 25% of account contributions. In order to ensure that individuals have an incentive to contribute monthly, they are prevented from re-enrolling for twelve months following a missed payment, and must repay any outstanding funds (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

The plan includes three major components, each provided through managed care plans. The features of HIP are summarized below (see figure 10). Services provided by managed care plans under HIP include inpatient and outpatient care, physician care, prescription drugs, home health care, and mental health care. HIP does not include copayments for services except for emergency room use, for which parents are charged between \$3 and \$25 per visit, based on income. Non-caretakers pay \$25 per visit, regardless of income. While parents can receive a refund in the event that the visit was an emergency, plans are not required to reimburse non-caretakers (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

**Figure 10. Components of Healthy Indiana Plan**

<b>High Deductible Coverage</b>	Individuals receive state-specified benefits up to a \$300,000 annually (\$1 million lifetime), after meeting a \$1,100 deductible.
<b>POWER Account</b>	Account used to cover the deductible, administered by enrollee’s managed care plan and jointly funded by the enrollee and state.
<b>Preventative Care</b>	Individuals receive up to \$500 in preventative care, not subject to a deductible

Source: Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008

*Access to Care*

Enrollment in HIP has been relatively strong, serving 61,797 people during the first two years. By the end of 2009, the program covered 16% of eligible participants, insuring 35% of eligible caretakers, and 11% of eligible non-caretakers (Irvin, 2009).

HIP ensures that the most vulnerable populations receive coverage by targeting low-income individuals and adults that do not have access to coverage through their employers- 69% have incomes below 100% of the poverty level. While affordability has emerged as an important concern with respect to HSAs for the Medicaid population, 74% of participants enrolled in HIP remained in the plan. Between January 2008 and December 2009, 90% of the 61,797 enrollees made their first monthly contribution, with nearly all continuing to make payments. Of the 6,581 members who did not contribute, half had incomes above the poverty level, suggesting that financial constraints may not be the primary deterrent to cost-sharing (Irvin, 2009).

While HIP provides access to poor caretakers and adults lacking employer-based insurance, the eligibility parameters remain relatively narrow. Unlike Medicaid, which has no waiting period, individuals must be uninsured for at least six months in order to qualify for benefits under HIP. Given the propensity for recipient incomes to fluctuate, this waiting period may be unduly restrictive. A Kaiser study reveals that 40% of applications during the first year were denied due to eligibility restrictions of the program (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

*Health Outcomes*

Health coverage under HIP is inferior to traditional Medicaid in several capacities (see figure 11). Although the design will vary by state, high administrative costs coupled with the requirement for budget neutrality, explained further below, could potentially increase the likelihood that HSAs will provide benefit packages that are more limited in scope than regular Medicaid plans.

**Figure 11. Comparison of Coverage Under HIP and Medicaid**

	HIP	Medicaid
Benefits	Does not cover dental, vision, non-emergency transportation, and pregnancy care.  Capped at \$300,000/ year and \$1 million/lifetime.  Skilled nursing care, physical, speech, and occupational therapy provided on limited basis.	Covers dental, vision, non-emergency transportation, and pregnancy care.  No cap.  No caps on skilled nursing care, and physical, speech, and occupational therapy covered more extensively.
Eligibility	6 month waiting period after becoming uninsured.	No waiting period.
Retroactive Coverage	Coverage only effective one month after payment to POWER account.	Provides retroactive coverage for services three months prior to application.

Source: Center on Budget and Policy Priorities, Paying More for Less “Healthy Indiana Plan” Would Cost More Than Medicaid While Providing Inferior Coverage, 2008

Another important consideration in terms of health outcomes is the potential impact that HIP will have on regular Medicaid coverage over time. In order to ensure that HIP is budget neutral, states must achieve enough cost savings to offset program expenditures. One method that Indiana proposes to meet this goal cutting costs in its regular Medicaid program (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008). A Mathematica report states that, in 2009, regular Medicaid in Indiana was not as costly as anticipated (Irvin, 2009). This may imply that in order to continue using the program as a mechanism for overall cost savings, limitations in services and access may be required in the future.

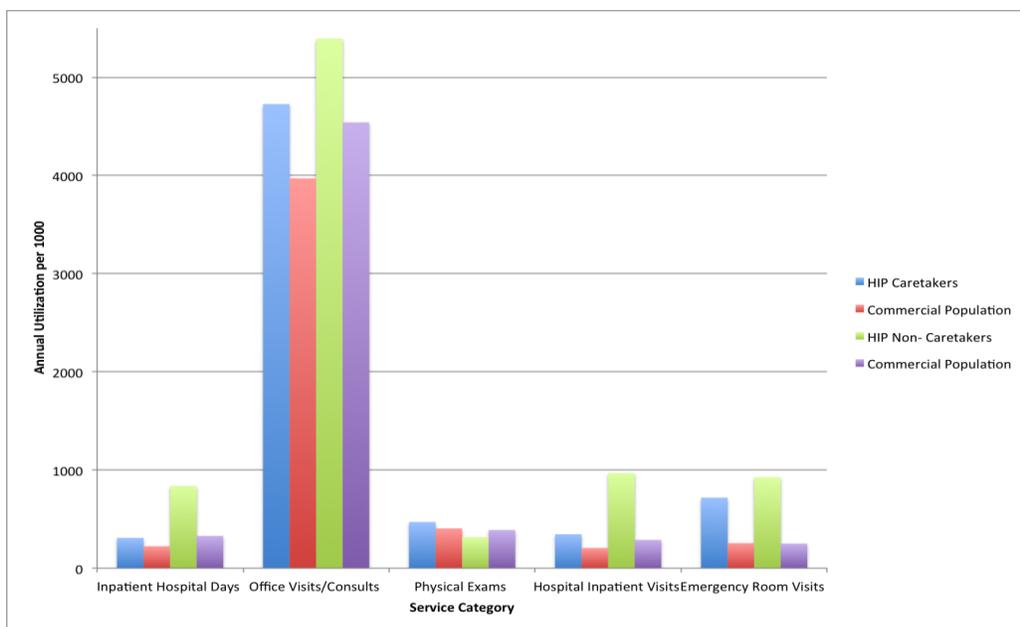
*Fiscal Impact*

There are two major costs associated with implementing the Healthy Indiana Plan: the medical cost of providing health care to those previously uninsured, and the administrative costs of operating the program. In order for HIP to ultimately achieve cost savings, individuals must reduce consumption of healthcare services over time. When individuals use services efficiently enough to roll over funds, this will create further savings by reducing Indiana’s contribution the

following year. These potential reductions in per person costs must be enough to offset the fixed costs of administering the program.

A Milliman analysis of annual utilization patterns per 1,000 adult caretakers demonstrates that, on average, HIP participants used more services than their non-HIP counterparts. Caretakers used significantly more emergency room services than a commercial population with the same age and gender characteristics, and non-caretakers consumed nearly three times as many inpatient services per capita (see figure 12). Additionally, relative to the commercial population, pharmacy utilization was nearly 50% higher among non-caretakers (Damler, 2009).

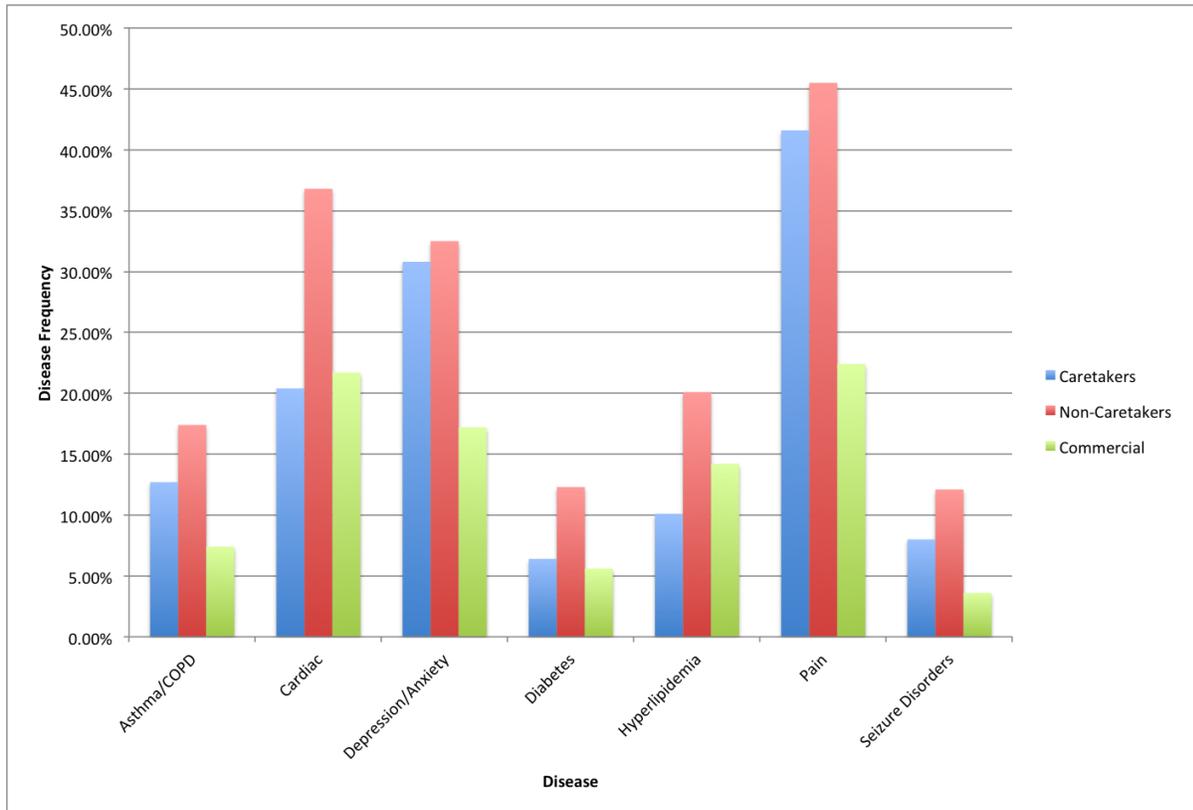
**Figure 12. First-Year Utilization of HIP Caretakers and HIP Non-Caretakers v. Commercial Population**



Source: Damler, Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured, 2009

In addition to using services at a higher rate, HIP members are also more likely to have chronic diseases. According to Milliman, relative to the commercially insured, asthma and depression were twice as prevalent in the HIP populations. Cardiac issues also occurred more frequently among HIP non-caretakers (see figure 13).

**Figure 13. First year Disease Frequency of HIP Caretakers and HIP Non-Caretakers v. Commercial Population**



Source: Source: Damler, Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured, 2009

Additionally, relative morbidity indices, which capture the expected costs of treating these health conditions, were significantly higher among the HIP population during the first year. On average, the risk-adjusted relative morbidity of HIP caretakers was 25% higher overall than that of the commercial population throughout the first year of enrollment. Among non-caretakers, the risk-adjusted relative morbidity exceeded the commercial population by 65% (Damler, 2009). The higher expected costs of treating HIP members, coupled with their higher frequency of disease, suggests that per person costs in the program are likely to exceed those in a comparable population.

Finally, given general utilization patterns and enrollee characteristics, Milliman also studied specific utilization of services within the first year of enrollment. They found that costs spiked during the second and third months of coverage, indicating that enrollees likely had pent-up demand for care due to previous lack of access. This is consistent with the fact that the earliest enrollees also had the highest risk scores (Damler, 2009).

In a voluntary program where those most in need of care have the greatest incentive to enroll, this is not surprising. Although not yet determined, the extent to which this will decline over time will be an important determinant of fiscal sustainability in the long run.

A cost-benefit analysis of implementing an HSA pilot program in Texas estimated fixed administrative costs at over \$6.5 million. While the Texas study determined that the small scope of the program (800 enrollees) was not enough to offset these fixed costs, it is possible that the larger enrollment of HIP (120,000 by 2013) may be sufficient to achieve cost-effectiveness (Texas HHS, 2008). Regardless, Indiana would still have to see significant declines in utilization, which is not promising based on initial evidence.

The costs of the Healthy Indiana Plan are shared between the federal government and the state of Indiana, with the majority of funding being provided by the federal government. For instance, in 2009, the federal government provided 74% of total funding (Irvin, 2009). Although the state contributes a relatively small portion of overall funding, the terms of the Section 1115 waiver dictates that the program must be budget neutral to the federal government. This implies that, throughout the demonstration, the cost of HIP cannot exceed the cost of providing regular Medicaid to the same population. Therefore, any additional expenses of expanded coverage must be offset through cost savings or tax revenue. In the event that this is insufficient, states will have to draw from other sources of funding in order to meet the balance (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008).

Although Healthy Indiana was budget neutral throughout the first two years of the demonstration, budgetary projections raise concern about the long-term sustainability of the program. While Indiana plans to offset the additional costs of the demonstration by achieving savings in existing Medicaid coverage for pregnant women, children, and parents, the means through which this will be accomplished has not been specified (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008). Moreover, health care costs for HIP members have been higher than anticipated, requiring increased payment rates to health plans (Irvin, 2009). These payment rates, comparable to Medicare levels, already exceed typical Medicaid rates (Solomon, 2008). In addition, the cigarette tax revenue used to fund the program has been steadily declining. In 2009, revenue from the cigarette tax failed to offset program costs, requiring Indiana to use reserve funds (Irvin, 2009).

In order to minimize their risk and assure that HIP is budget neutral, the federal government established a per capita cap on funding based on a predetermined per person cost and annual growth rate (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008). The limit on federal funding coupled with the expectation that savings will offset program expenses puts the risk of payment primarily on Indiana. In the event that the program is not budget neutral, the state will have to make up the shortfall from other portions of the budget, as was the case in 2009.

Fundamental in its design, HIP also places a portion of the payment risk on individuals. According to Kaiser, enrollee payments in 2008 ranged from \$0 to \$1,040 annually (Kaiser, Summary of Healthy Indiana Plan: Key Facts and Issues, 2008). However, personal accountability is inherently limited by the fact that, as of December 2009, a quarter of

participants had no cost-sharing requirements (Irvin, 2009). Moreover, regardless of contribution levels specified by the program, Indiana bears the risk that individuals will default on monthly payments and keep three quarters of account funds. This risk may be relatively small; Mathematica determined that 90% of enrollees made their first monthly payment, and nearly all continued to do so through 2009 (Irvin, 2009).

### **III. Recommendation**

Based on evidence from the Healthy Indiana Plan, there are several recommendations that state policymakers can employ in implementing HSAs for the Medicaid population.

First, waiving the requirement that individuals must be previously uninsured may be an effective way to mitigate the accelerated consumption of services due to pent up demand. States may further address adverse selection by making participation in HSAs mandatory in order to prevent those with the highest risk from enrolling exclusively.

Second, in addition to encompassing a population with more balanced health risks, it may be wise for states to expand HSA plans to those with higher incomes. Since the program depends on individuals reducing consumption in response to financial accountability, targeting a population that can assume a greater degree of cost sharing may improve the efficacy of HSAs in achieving savings. For instance, as of 2009, a quarter of HIP enrollees made no monthly contribution due to financial constraints (Irvin, 2009). HSAs are limited in the degree to which it can encourage personal accountability when such large portions of enrollees are not able to contribute financially.

Expanding the program to the newly eligible may be a way to achieve both of these objectives by attracting a higher income population with more balanced health risks. Indiana recently submitted a waiver to HHS requesting that HIP be used as the mechanism for implementing the Medicaid expansion. While CMS approved a one-year extension of the program in 2012, the state is awaiting a decision regarding the Medicaid expansion in 2014 (Reichard, 2012).

An initial analysis by Milliman finds that using HIP to expand Medicaid would increase costs to the state 13.5% by 2020, amounting to an additional \$516 million annually. However, this analysis did not take into account potential reductions in per person costs as a result of the expansion. Moreover, by 2020 Indiana would receive \$3.4 billion in federal matching grants by proceeding with the expansion (Wall, 2012). While additional research must be conducted on the effectiveness of using HIP as the vehicle for Medicaid expansion, using HSAs to serve the newly eligible may maximize cost savings by best utilizing the program's design.

## Statutory and Waiver Authority

### I. Overview

States may look to the statutory waiver authority for new cost-saving options for their Medicaid programs. Waivers can be useful for discovering new ways to provide coverage and deliver services by affording states greater flexibility to reduce costs.

Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid (Medicaid.gov, Medicaid Managed Care Enrollment Report, 2011). There are four primary types of waivers and demonstration projects:

1. Section 1115 Research & Demonstration Projects
2. Section 1915(b) Managed Care Waivers
3. Section 1915(c) Home and Community-Based Services Waivers
4. Concurrent Section 1915(b) and 1915(c) Waivers

Section 1115 Research and Demonstration Projects provide a mechanism for states to achieve greater program flexibility to test new or existing financing and delivery models. By utilizing Section 1915(b) Managed Care Waivers, states can provide services through managed care delivery systems or institute other means to limit the choice of providers that beneficiaries have. States can apply for Section 1915(c) waivers to provide long-term care services in home and community settings as opposed to institutional settings. Additionally, states can apply to simultaneously implement both 1915(b) and 1915(c) waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met. Finally, under the Affordable Care Act, there are two new sources of waiver authority, Section 1115A and Section 1332. “Section 1115A authorizes the Secretary to waive provisions of Medicare, Medicaid, and CHIP law, establishes the Center for Medicare and Medicaid Innovation (CMMI), and provides \$10 billion per year through FY2019 to test, evaluate and expand different service delivery and payment models to slow cost growth while preserving or enhancing quality of care. In addition, beginning in 2017, Section 1332 of the ACA provides authority for State Innovation Waivers of non-Medicaid provisions of the new law related to Exchanges, benefits, and cost-sharing protections and includes provisions to coordinate the Section 1115 and Section 1332 waiver processes.” (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). Thus, states have multiple opportunities to innovate beyond existing statutory authority through waivers.

Each of the policy proposals discussed in this paper has been implemented in various states through waiver authority, and all of the proposals, including managed care changes could be implemented through Section 1115 waiver authority. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to allow individual states to waive provisions of major health and welfare programs authorized under the Act (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). This authority is provided at the Secretary’s discretion for demonstration projects that promote Medicaid program objectives (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). Under Section 1115 waiver authority, states may use federal Medicaid matching funds to pay for expenditures that would not typically qualify for

federal matching funds. This includes expenditures used to expand coverage to new populations provide services not normally covered, provide services through some means not otherwise authorized, or a combination of these options. While some Section 1115 waivers are comprehensive, such as the Rhode Island Global Waiver, and provide for multiple programmatic changes and financing changes, others cover changes in eligibility, benefits, cost sharing, or provider payments alone or are narrowly tailored to address specific populations or types of services (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011).

## **II. Advantages of Pursuing a Section 1115 Waiver**

### *Flexibility*

Section 1115 waivers provide states with flexibility to develop Medicaid plans that suit their particular needs. Most rules governing Medicaid programs can be waived under Section 1115 including: statewide uniformity; comparability requirements; eligibility; provider choice; managed care organizations; reimbursement; and freedom of choice of family planning services providers. Programs or policies that reduce access to care cannot be approved and states are expected to maintain quality assurance programs.

### *Opportunity for semi-permanent changes*

Under Section 1115, the Secretary of Health and Human Services can allow states to “experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid statute.” The language of the statute (“experimental” and “pilot”) would suggest that Congress did not intend for Section 1115 to permanently waive or exempt states from statutory requirements, but many states have had waivers for years that are *virtually* permanent. Section 1115 waivers are generally approved for a five-year period and then the state can obtain a waiver renewal, which can be renewed in three-year increments (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). Some waivers have been continually renewed over many periods, allowing the waiver programs to remain in operation for many years. It is important to note that the Affordable Care Act now gives the Secretary discretion to extend waivers that have a focus on Medicare and Medicaid dual eligible beneficiaries for five years at a time, as opposed to three. (Section 1915(b)(2) of the Social Security Act, as added by Section 2601(a) of the Affordable Care Act, P.L. 111-148).

### *Budget neutrality to the federal government*

States seeking a Section 1115 waiver must demonstrate that the policy will be budget neutral to the federal government, meaning that the federal government must not spend more than it would in the absence of a waiver (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). This increases budget predictability for the federal government, and helps to ensure that any deviations from the federal law through the use of waivers are limited to cost-efficient changes. “The federal government enforces budget neutrality by establishing a cap on federal funds over the life of the waiver, placing a state at risk

for all waiver costs above the cap. Most comprehensive Section 1115 waivers have relied on per capita caps; two states (Rhode Island and Vermont) have waivers with aggregate or global caps” (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). These budget neutrality caps are established based on estimates of what the state’s spending would be in the absence of the waiver and can be allocated on a per capita basis or a global basis.

### *Increased transparency*

Considering the broad changes that can be instituted under waivers, transparency is very important. The Affordable Care Act requires Health and Human Services to issue new regulations to increase the transparency of the waiver approval process in addition to the creation of new waiver authorities (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). “Because waivers are intended to be research and demonstration projects, federal law requires that they be formally evaluated. However, for many years, there has been a limited focus on waiver evaluations” (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011). Over the years, the focus has shifted towards more specific, state-funded evaluations. Accordingly, the Affordable Care Act also directs the Secretary of Health and Human Services to allow for public input at both the state and federal level in the approval and renewal process (Kaiser, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011).

### **III. Recommendation**

Rather than pursue revisions to federal law, states interested in implementing these proposals should use statutory waivers. Waiver authority is widely utilized today and is much easier to leverage by negotiating with the Center for Medicaid Studies and the Department of Health and Human Services, than to amend federal law to permanently allow these deviations from the norm. Moreover, if successfully implemented under waiver authority, Congress may find the state’s success persuasive when considering future amendments to the Social Security Act.

## Final Recommendations

The six Medicaid financial reform policies described in this paper offer a diverse set of options for states considering reform. Block grants and shared savings both combat the perverse incentive caused by federal matching funds that reduces state motivation to cut costs, but do so in different ways. Block grants' fixed funding forces states to consider which Medicaid expenditures are necessary and which can be eliminated, and means that states take on the burden of unforeseen costs. Shared savings does not provide quite as strong an incentive as block grants to cut costs because the risks to the state are not as high. However, the quality indicators tied with shared savings means that quality is less likely to decrease under this approach.

Similarly, Managed Care and alternatives to supplemental payments tackle the issue of provider incentives in very different ways. Managed care severs the link between services and payment, with the goal of decreasing providers' incentive to provide unnecessary services and increase cost efficiency. Supplemental payments, on the other hand, have become so removed from specific services that there is no way to guarantee that the money is producing value.

Health Savings Accounts and other personal accountability options confront the problem of recipient incentives. Since recipients are responsible for very minimal charges for health care, at most, they do not have a motive to closely examine which medical services are necessary and how to get the best prices. HSAs and other accountability options attempt to increase recipients' investment in their own care without decreasing their use of necessary medical procedures.

The six policies presented above offer a variety of means for reducing the cost of Medicaid. This diversity is significant because states face an assortment of fiscal challenges, political conditions, and recipient needs. While both the federal government and the states want to reduce Medicaid costs there are a number of ways to work towards this goal that are appropriate under different circumstances. The concluding recommendations below describe the conditions under which the reforms assessed in this paper would be appropriate.

- 1) Shifting Medicaid from a categorical to a block grant has been politically unsuccessful and is unlikely to become much easier. However, individual states may want to pursue global waivers that allow them to act as if Medicaid is a block grant, either through a broad fixed federal contribution or fixed per-capita federal contribution. This is most appropriate when states have large-scale reforms that would be difficult to implement under a more limited waiver. States would need to be confident of their ability to manage unexpected increases in Medicaid costs and have sufficient funds reserved for economic downturns, as demand for Medicaid will increase while tax revenue drops. Per-capita federal contributions decrease states' risk during economic downturns as the population eligible for Medicaid expands.
- 2) Shared savings is appropriate to implement in states that are concerned with both cost-savings and quality improvement. Shared savings does not appear likely to achieve a dramatic reduction in cost, but does achieve some savings. It also seems to have a positive impact on quality indicators when they are tied to the performance payment.

States interested in shared savings should plan on using the performance payment to reinvest in their health care infrastructure, to further shift the cost curve in and increase future savings. States might also explore enrolling in demonstrations that include a shared savings element.

- 3) Increasing enrollment in managed care may prove to be successful at reducing Medicaid costs under some circumstances. Increasing the population in MCOs can be expected to reduce costs for states with high fee-for-service payments. Additionally, MCOs must have the capacity to care for new recipients, particularly since the population not enrolled in MCOs tends to have more complex needs. To ensure that these populations receive necessary services states should have strong contracts with MCOs that include careful monitoring.
- 4) Alternatives to supplemental payments will be important to consider in light of the Medicaid expansion to help providers expand their capacity, invest in infrastructure like IT, and improve delivery as they prepare for the increase in patients with health care coverage by tying payments to measureable objectives. Alternatives are also important when states transition recipients from fee-for-service to managed care, because allowable UPL payments decrease with increased managed care. Since removing UPL payments all at once can financially threaten safety net providers, a transition period allows time for providers to adapt.
- 5) HSAs will work best if the risk pool is balanced, otherwise, adverse selection may inflate per person costs. Coupled with high administrative costs, this has the potential to make the program more expensive than regular Medicaid. HSAs may be an especially good option for the Medicaid expansion population since they have higher incomes and potentially fewer health problems.
- 6) States that wish to implement personal accountability options should do so carefully, taking into consideration possible unintended consequences of this strategy. States must also have a clear outreach plan so that recipients are aware of the new program. Finally, personal accountability options are in need of further study, as the long-term effectiveness of modifying behavior through financial incentives is unclear. States creating such programs should monitor new research in this area and evaluate program data to the extent possible and adapt accordingly.

**Figure 14. When to Implement Specific Medicaid Reform Policies**

<b>Policy</b>	<b>When to Use</b>
<b>Block Grants</b>	<p>Preferable for large-scale reform not possible under more limited waivers.</p> <p>State is fiscally sound and able to cope with unanticipated Medicaid costs.</p>
<b>Shared Savings</b>	<p>Willing to use performance payments to reinvest in health infrastructure.</p> <p>Equally invested in reducing costs and increasing quality.</p>
<b>Managed Care</b>	<p>MCOs must have the capacity to serve the new population.</p> <p>State contracts must be strong and monitored.</p> <p>States with high fee-for-service reimbursement will see the most benefit.</p>
<b>Alternatives to Supplemental Payments</b>	<p>With expected increase in coverage (ACA).</p> <p>While transitioning Recipients from fee-for-service to managed care.</p>
<b>Health Savings Accounts</b>	<p>When target population is less prone to adverse selection.</p> <p>Potentially for Medicaid expansion population.</p>
<b>Personal Accountability Options</b>	<p>When resources are available to combine incentives with education and outreach.</p>

## Bibliography

### General Medicaid Overview

- Deloitte (2011). The Fiscal Impact to States of the Affordable Care Act (ACA): Comprehensive Analysis. *Deloitte*. Retrieved from <http://www.deloitte.com/us/acafiscalimpactstates>
- Kaiser Commission on Medicaid and the Uninsured (2012, May). 5 Key Questions about Medicaid and its role in State/Federal Budgets & Health Reform. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8139-02.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2012, July). How will the Medicaid Expansion for Adults Impact Eligibility and Coverage? *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8338.pdf>
- Kaiser Commission on Medicaid and the uninsured (n.d.). The Medicaid Program at a Glance. *The Henry J. Kaiser Family Foundation*. Retrieved September 2012, from <http://www.kff.org/medicaid/upload/7235-05.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2011, June). Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8196.pdf>
- Weil, A. R., & Rossiter, L. F. (n.d.). The Role of Medicaid. In *Budgeting for National Priorities project* (pp. 105- 131). Retrieved from <http://www.brookings.edu/es/research/projects/budget/fiscalsanity/2007chapter4.pdf>

### Block Grants

- Angeles, J. (2011, May 3). Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children. *Center on Budget and Policy Priorities*, 1-10. Retrieved from <http://www.cbpp.org/cms/?fa=view&id=3483>.
- Bragdon, T. (2011, November 9). Backgrounder: Florida's Medicaid Reform Shows the Way to Improve Health, Increase Satisfaction, and Control Costs. *The Heritage Foundation*. Retrieved from [https://thf\\_media.s3.amazonaws.com/2011/pdf/bg2620.pdf](https://thf_media.s3.amazonaws.com/2011/pdf/bg2620.pdf)
- Collins, B. K., & Gerber, B. J. (2006). Redistributive Policy and Devolution: Is State Administration a Road Block (Grant) to Equitable Access to Federal Funds? *Journal of Public Administration Research and Theory*, 16(4), 613-632. Retrieved from DOI: 10.1093/jopart/muj010.
- Congressional Budget Office (2011, April 5). Long-Term Analysis of a Budget Proposal by Chairman Ryan. *Congressional Budget Office (CBO)*. Retrieved from <http://www.cbo.gov/publication/22085>
- Cross-Call, J. (2012, March 16). Claimed State Savings From Rhode Island's Medicaid Cap Heavily Overblown, Report Shows. *Center on Budget and Policy Priorities*. Retrieved from <http://www.cbpp.org/files/3-16-12health.pdf>
- Eldridge, G. N. (2007, May). The Medicaid Evolution: The Political Economy of Medicaid Federalism. *The University of Texas at Austin LBJ School of Public Affairs*. Retrieved from <http://proquest.umi.com/pqdlink?did=1402174601&Fmt=7&clientI d=79356&RQT=309&VName=PQD>

- Finegold, K., Wherry, L., & Schardin, S. (2004, April 21). Block Grants Historical Overview and Lessons Learned. *New Federalism: Issues and Options for States*, (63), 1-7. Retrieved from <http://www.urban.org/url.cfm?ID=310991>.
- Gorin, S. H. (2012). The Ryan Plan Redux. *Health & Social Work Advance Access*, 1-2. Retrieved from DOI: 10.1093/hsw/hls008.
- Guyer, J. (2006, April). Vermont's Global Commitment Waiver: Implications for The Medicaid Program. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/7493.pdf>
- Guyer, J., Heberlein, M., & Alker, J. (2011, June 2). CHIP: Not a Model for a Medicaid Block Grant. *Georgetown University Health Policy Institute Center for Children and Families*. Retrieved from <http://ccf.georgetown.edu/>.
- Holahan, J., Buettgens, M., Chen, V., Carroll, C., & Lawton, E. (2011, May 10). House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing. *The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from <http://www.kff.org/medicaid/upload/8185.pdf>
- Holahan, J., Buettgens, M., Carroll, C., Chen, V., & The Urban Institute (2012, October). National and State-by-State Impact of the 2012 House of Republican Budget Plan for Medicaid. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from <http://www.kff.org/medicaid/upload/8185-02.pdf>
- Health Affairs Health Policy Brief (2012, January 12). Medicaid Reform. Many states want greater flexibility, and there is pressure to limit federal spending. Critics fear serious damage to the social safety net. *Robert Wood Johnson Foundation*. Retrieved from DOI: 10.1377/hbp2012.1
- House of Representatives Committee on the Budget (2012). The Path to Prosperity: A blueprint for American Renewal. *Committee On The Budget*. Retrieved from <http://budget.house.gov/fy2013prosperity/>
- Howard, P. (2012, September). How Block Grants Can Make Medicaid Work: Improving Health, Decreasing Costs. *Manhattan Institute for Policy Research*. Retrieved from [http://www.manhattan-institute.org/pdf/ir\\_24.pdf](http://www.manhattan-institute.org/pdf/ir_24.pdf)
- Lambrew, J. M. (2005). Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals. *The Milbank Quarterly*, 83(1), 41-64. Retrieved from <http://www.jstor.org/stable/30045602>.
- Manchester, J. (2011, April 5). Long-Term Analysis of a Budget Proposal by Chairman Ryan. *Congressional Budget Office (CBO)*. Retrieved from [http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan\\_letter.pdf](http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf)
- Medicaid and CHIP Payment and Access Commission (2012, March). Report to the Congress on Medicaid and CHIP. *Medicaid and Chip Payment and Access Commission*. Retrieved from <https://docs.google.com/a/email.wm.edu/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6MzM2ZWZWM3ZjlhMDI1ZGFhNw>
- Merriman, D. (2006). A Theoretical Analysis of Medicaid Supplantation. *Public Finance Review*, 34(1), 33-59. Retrieved from DOI: 10.1177/1091142105282555.
- Park, E., & Broaddus, M. (2012, March 27). Ryan Medicaid Block Grant Would Cut Medicaid by One-Third by 2022 and More After That. *Center on Budget and Policy Priorities*. Retrieved from <http://www.cbpp.org/cms/index.cfm?fa=view&id=3727>

- Pryor, A. (2012, April 13). Using Medicaid Block Grants to Eliminate Moral Hazard. *Georgetown University School of Public Policy & Management*. Retrieved from <http://search.proquest.com/docview/1010410673?accountid=15053>
- The Kaiser Commission on Medicaid and the Uninsured (2011, April). Implications of a Federal Block Grant for Medicaid. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8173.pdf>
- Thompson, F. J., & Burke, C. (2007). Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process. *Journal of Health Politics, Policy and Law*, 32(6), 1-34. Retrieved from DOI 10.1215/03616878- 2007-039.
- The Lewin Group (2011, December 6). An Independent Evaluation of Rhode Island's Global Waiver. *The Lewin Group*. Retrieved from [www.ohhs.ri.gov/documents/.../Lewin\\_report\\_12\\_6\\_11.pdf](http://www.ohhs.ri.gov/documents/.../Lewin_report_12_6_11.pdf)
- Volden, C. (2006). States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program. *American Journal of Political Science*, 50(2), 294-312.

## Shared Savings

- Bailit, M., & Hughes, C. (2011, August). Key Design Elements of Shared-Savings Payment Arrangements. *The Commonwealth Fund*. Retrieved from [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539\\_Bailit\\_key\\_design\\_elements\\_sharesavings\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharesavings_ib_v2.pdf)
- Ballard, D. J. (2012). The Potential of Medicare Accountable Care Organizations to Transform the American Health Care Marketplace: Rhetoric and Reality. *Mayo Clinic Proceedings*, 87(8), 707-709. Retrieved from DOI: 10.1016/j.mayocp.2012.06.005.
- Centers for Medicare & Medicaid Services (2011, July). Medicare Physician Group Practice Demonstration . *Centers for Medicare & Medicaid Services*. Retrieved from [https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP\\_Fact\\_Sheet.pdf](https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf)
- Centers for Medicare & Medicaid Services (2011, August 8). Physician Group Practice Demonstration succeeds in improving quality and reducing costs all participating practices to continue in 2-year PGP Transition Demonstration. *Centers for Medicare & Medicaid Services*. Retrieved from [https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP\\_PR.pdf](https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_PR.pdf)
- Centers for Medicare & Medicaid Services (n.d.). Physician Group Practice Demonstration: Performance Year 1 - Preliminary Performance. *Centers for Medicare & Medicaid Services*. Retrieved from [http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP\\_Summary\\_Results.pdf](http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP_Summary_Results.pdf)
- Department of Health and Human Services (2011, October). Accountable Care Organizations: What Providers Need to Know. *Centers for Medicare & Medicaid Services*. Retrieved from [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Providers\\_Factsheet\\_ICN907406.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf)
- Department of Health and Human Services (2011, October). Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program . *Centers for Medicare & Medicaid Services*. Retrieved from [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Summary\\_Factsheet\\_ICN907404.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf)

- Eddy, D. M., & Shah, R. (2012). A Simulation Shows Limited Savings From Meeting Quality Targets Under The Medicare Shared Savings Program. *Health Affairs*, 31(11), 2554-2562. Retrieved from DOI:10.1377/hlthaff.2012.0385.
- Medicaid and CHIP Payment and Access Commission (2012, March). Report to the Congress on Medicaid and CHIP. *Medicaid and Chip Payment and Access Commission* . Retrieved from <https://docs.google.com/a/email.wm.edu/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6MzM2ZWZWM3ZjlhMDI1ZGFhNw>
- Meyer, H. (2011). Accountable Care Organization Prototypes: Winners And Losers? *Health Affairs*, 30(7), 1227-1231. Retrieved from DOI: 10.1377/hlthaff.2011.0699.
- Sebelius, K. (2009). Physician Group Practice Demonstration Evaluation Report. *Centers for Medicare & Medicaid Services*. Retrieved from [https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP\\_RTC\\_Sept.pdf](https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_RTC_Sept.pdf)
- Staff Report U.S House of Representatives (2012, April 25). Uncovering Waste, Fraud, and Abuse in the Medicaid Program. *Committee On Oversight & Government Reform*. Retrieved from <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>
- Trisolini, M., Aggarwal, J., & Leung, M. (2008, February). The Medicare Physician Group Practice Demonstration: Lessons Learned on Improving Quality and Efficiency in Health Care. *The Commonwealth Fund*. Retrieved from [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2008/Feb/The%20Medicare%20Physician%20Group%20Practice%20Demonstration%20Lessons%20Learned%20on%20Improving%20Quality%20and%20Effici/1094\\_Trisolini\\_Medicare\\_phys\\_group\\_practice\\_demo\\_lessons\\_learned%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2008/Feb/The%20Medicare%20Physician%20Group%20Practice%20Demonstration%20Lessons%20Learned%20on%20Improving%20Quality%20and%20Effici/1094_Trisolini_Medicare_phys_group_practice_demo_lessons_learned%20pdf.pdf)
- Weissman, J. S., Bailit, M., D'Andrea, G., & Rosenthal, M. B. (2012). The Design And Application of Shared Savings Programs: Lessons From Early Adopters. *Health Affairs*, 31(9), 1959-1968. Retrieved from DOI: 10.1377/hlthaff.2012.0383.
- Wilensky, G. R. (2011). Lessons from the Physician Group Practice Demonstration - A Sobering Reflection. *The New England Journal of Medicine*, 365, 1659-1661. Retrieved from DOI: 10.1056/NEJMp1110185.

## Managed Care

- Austin, B. J. (2005). Managed Care Mandates Fall Short of Curbing California Medicaid Costs. *Changes in Health Care Financing & Organization: Findings Brief*, 8(2), 1-3. Retrieved from <http://www.hcfo.org/pdf/findings0305.pdf>.
- Blumstein, J. F., & Sloan, F. A. (2000, January). Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and Paradigm. *Social Science Research Network*. Retrieved from [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=208731](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=208731)
- Burns, M. (2009). Medicaid Managed Care and Cost Containment in the Adult Disabled Population. *Medical Care*, 47(10), 1069-1076. Retrieved from DOI:10.1097/MLR.0b013e3181a80fef.
- California Department of Health Care Services (2010, November). California Bridge To Reform A Section 1115 Waiver Fact Sheet. *DHCS CA.gov*. Retrieved from <http://www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf>

- California Department of Health Care Services (2010, May). California Section 1115 Comprehensive Demonstration Project Waiver. *DHCS CA.gov*. Retrieved from [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Waiver\\_ImpPlan\\_5-2010.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Waiver_ImpPlan_5-2010.pdf)
- Center for Health Care Strategies (2010, May). Payment Reform: Creating a Sustainable Future for Medicaid. *Center for Health Care Strategies (CHCS)*. Retrieved from [http://www.chcs.org/usr\\_doc/Medicaid\\_Payment\\_Reform\\_Brief.pdf](http://www.chcs.org/usr_doc/Medicaid_Payment_Reform_Brief.pdf)
- CMS (2011, July 1). Medicaid Managed Care Enrollment Report. *Medicaid.gov*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>
- Cutler, D. M., McClellan, M., & Newhouse, J. P. (2000). How Does Managed Care Do It? *The Rand Journal of Economics*, 31(3), 526-548. Retrieved from <http://www.jstor.org/stable/2600999>.
- Duggan, M. (2004). Does contracting out increase the efficiency of government programs? Evidence from Medicaid HMOs. *Journal of Public Economics*, 88, 2549-2572. Retrieved from DOI: 10.1016/j.jpubeco.2003.08.003.
- Gifford, K., Smith, V., Snipes, D., & Paradise, J. (2011, September). A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8220.pdf>
- Harman, J. S., Lemak, C. H., Al-Amin, M., Hall, A. G., & Duncan, R. P. (2011). Changes in Per Member Per Month Expenditures after Implementation of Florida's Medicaid Reform Demonstration. *Health Services Research*, 46(3), 787-804. Retrieved from DOI: 10.1111/j.1475-6773.2010.01226x.
- Herring, B., & Adams, E. K. (2011). Using MHOs to Serve the Medicaid Population: What are the effects on Utilization and Does the Type of HMO Matter? *Health Economics*, 20, 446-460. Retrieved from DOI: 10.1002/hec.1602.
- Howell, E. M., Palmer, A., & Adams, F. (2012, July). Medicaid and CHIP Risk-Based Managed Care in 20 States. *The Urban Institute*. Retrieved from <http://www.urban.org/UploadedPDF/412617-Medicaid-and-CHIP-Risk-Based-Managed-Care-in-20-States.pdf>
- Hurley, R. E., & McCue, M. J. (2000, May). Partnership pays: Making Medicaid Managed Care Work in a Turbulent Environment. *Center for Health Care Strategies (CHCS)*. Retrieved from [http://www.chcs.org/usr\\_doc/Hurley.pdf](http://www.chcs.org/usr_doc/Hurley.pdf)
- Hurley, R. E., & Somers, S. A. (2003). Medicaid and Managed Care: A Lasting Relationship? *Health Affairs*, 22(1), 77-88. DOI:10.1377/hlthaff.22.1.77.
- Iglehart, J. K. (2011). Desperately Seeking Savings: States Shift More Medicaid Enrollees To Managed Care. *Health Affairs*, 30(9), 1627-1629. Retrieved from DOI:10.1377/hlthaff.2011.0836.
- Kaiser Commission on Medicaid and the uninsured (2011, October). California's "Bridge to Reform" Medicaid Demonstration Waiver. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8197-R.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2012, February). People with Disabilities and Medicaid Managed Care: Key Issues to Consider. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8278.pdf>

- Kaye, N. (2005, June). Medicaid Managed Care Looking Forward Looking Back. *National Academy for State Health Policy*. Retrieved from [http://www.nashp.org/sites/default/files/mmc\\_looking\\_forward.pdf](http://www.nashp.org/sites/default/files/mmc_looking_forward.pdf)
- Ku, L., MacTaggart, P., Pervez, F., & Rosenbaum, S. (2009, July). Improving Medicaid's Continuity of Coverage and Quality of Care. *Association for Community Affiliated Plans ACAP*. Retrieved from <http://communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>
- Lo Sasso, A. T., & Freund, D. A. (2000). A Longitudinal Evaluation of the Effect of Medi-Cal Managed Care on Supplemental Security Income and Aid to Families with Dependent Children Enrollees in Two California Counties. *Medical Care*, 38(9), 937-947. Retrieved from <http://www.jstore.org/stable/3766902>.
- Long, S. K., & Yemane, A. (2005). Commercial Plans in Medicaid Managed Care: Understanding Who Stays with Who. *Health Affairs*, 24(4), 1084-1094. Retrieved from DOI: 10.1377/hlthaff.24.4.1084.
- MACPAC (2012, June). Medicaid and CHIP Program Statistics: June 2012 MACStats. *Medicaid and Chip Payment and Access Commission*. Retrieved from <http://www.macpac.gov/macstats>
- MACPAC (2011, June). The Evolution of Managed Care in Medicaid. *Medicaid and CHIP Payment and Access Commission*. Retrieved from <https://docs.google.com/a/email.wm.edu/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJjNjMkMDZiYw>
- McCue, M. (2012). Financial Performance of Health Plans in Medicaid Managed Care. *Medicare & Medicaid Research Review*, 2(2), E1-E10. Retrieved from DOI: <http://dx.doi.org/10.5600/mmrr.002.02.a07>.
- Medicaid.gov (2011, July 1). Medicaid Managed Care Enrollment Report. *Medicaid.gov*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>
- Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., & Snyder, L. (2012, October). Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8380.pdf>
- The Lewin Group (2009, March). Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies: Final Report. *The Lewin Group*. Retrieved from <http://www.lewin.com/publications/publication/395/>
- The National Bureau of Economic Research (2012, December 2). The Effect of Medicaid HMOs on Spending and Health Outcomes. *The National Bureau of Economic Research*. Retrieved from <http://www.nber.org/bah/winter03/w9091.html>

## Supplemental Payments

- American Hospital Association (2012). Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare and Medicaid, 1990-2010. *Avalere Health analysis of American Hospital Association Annual Survey data*. Retrieved from <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml>
- Bachrach, D., & Dutton, M. (2011, August). Medicaid Supplemental Payments: Where Do They Fit in Payment Reform? *Center for Health Care Strategies, Inc.* Retrieved from [http://www.chcs.org/usr\\_doc/MedicaidSupplementalPaymentBrief.pdf](http://www.chcs.org/usr_doc/MedicaidSupplementalPaymentBrief.pdf)
- CAPH (2011, June). Policy Brief Executive Summary: The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems. *CAPH California Association of Public Hospitals and Health Systems*. Retrieved from [http://www.caph.org/content/delivery\\_system\\_reform.htm](http://www.caph.org/content/delivery_system_reform.htm)
- Coughlin, T. A., Bruen, B. K., & King, J. (2004). States' Use of Medicaid UPL and DSH Financing Mechanisms. *Health Affairs*, 23(2), 245-257. Retrieved from DOI: 10.1377/hlthaff.23.2.245.
- Coughlin, T. A., Zuckerman, S., & McFeeters, J. (2007). Restoring Fiscal Integrity To Medicaid Financing? *Health Affairs*, 26(5), 1469-1480. Retrieved from DOI: 10.1377/hlthaff.26.5.1469.
- Department of Health & Human Services (2011). 2011 Actuarial Report on the Financial Outlook for Medicaid. *Centers for Medicare & Medicaid Services*. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf>
- Department of Health & Human Services (2011, December 12). Letter to State Medicaid Director Texas Health and Human Services. *Department of Health & Human Services*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovalDocuments.pdf>
- Department of Health & Human Services (2010, June). Review of Medicaid Disproportionate Share Hospital Payment Distribution. *Office of Inspector General U.S Department of Health & Human Services*. Retrieved from <http://oig.hhs.gov/oas/reports/region7/70904150.pdf>
- HHSC (2011). Texas Health Care Transformation and Quality Improvement 1115 Waiver. *Texas Health and Human Services Commission*. Retrieved from [www.hhsc.state.tx.us/Program-Brief-080411.pdf](http://www.hhsc.state.tx.us/Program-Brief-080411.pdf)
- Kaiser Commission on Medicaid and the Uninsured (2011, December). California and Texas: Section 1115 Medicaid Demonstration Waivers Compared. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/8266.cfm>
- Kaiser Commission on Medicaid and the Uninsured (2011, December). Medicaid Financing Issues: Provider Taxes. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/8193.cfm>
- MAC Facts (2012, November). Medicaid UPL Supplemental Payments. *Medicaid and CHIP Payment and Access Commission*. Retrieved from [https://a7d050c2-a-10078ef1-sites.googlegroups.com/a/macpac.gov/macpac/publications/MACFacts-UPL-Payments\\_2012-11.pdf?attachauth=ANoY7crLNx8NnDmLhK20tJeMFtINER5biFFcjduziaj0eWVIFTJfEBb\\_kB8W9pBDinqXWLL\\_enYh5ucYx-](https://a7d050c2-a-10078ef1-sites.googlegroups.com/a/macpac.gov/macpac/publications/MACFacts-UPL-Payments_2012-11.pdf?attachauth=ANoY7crLNx8NnDmLhK20tJeMFtINER5biFFcjduziaj0eWVIFTJfEBb_kB8W9pBDinqXWLL_enYh5ucYx-)

[mtEWttoLb\\_zI0cPw5HMm\\_GTbQHnDIccLyPvnxPo1DI9MEaX9HIAa\\_ZRVoiL1Mm\\_A2W\\_QZM2xrsbys6TlpUwXxputJRGHsA8cTsSRLqKBXwOVpIaMRtQEd5pMb2P\\_Velpmqiz-AMXvR8TB39iqUxdtw7O3QRYX8CL-mhWVEZBKHVD9ASPB27rCqmN&attredirects=2](https://docs.google.com/a/email.wm.edu/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6MzM2ZWM3ZjlhMDI1ZGFhNw)

- MACPAC (2012, March). Report to the Congress on Medicaid and CHIP. *Medicaid and Chip Payment and Access Commission*. Retrieved from <https://docs.google.com/a/email.wm.edu/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6MzM2ZWM3ZjlhMDI1ZGFhNw>
- McKay, N. (2010, August). Evaluation of the Low-Income Pool Program Using Milestone Data: 2008-09. *University of Florida*. Retrieved from <http://search.ufl.edu/web?site=mre.phhp.ufl.edu&query=sfy%202008-09>
- McKethan, A., Nguyen, N., Sasse, B. E., & Lawrence Kocot, S. (2009). Reforming The Medicaid Disproportionate-Share Hospital Program. *Health Affairs*, 28(5), w926-w936. Retrieved from <http://content.healthaffairs.org/content/28/5/w926.full.html>
- Mechanic, R. E. (2004, September 14). Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments. *National Health Policy Forum*. Retrieved from [http://www.nhpf.org/library/background-papers/BP\\_MedicaidDSH\\_09-14-04.pdf](http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf)[http://www.nhpf.org/library/background-papers/BP\\_MedicaidDSH\\_09-14-04.pdf](http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf)
- Perryman, S. (2010, November 10). Federal Financing Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for Oct. 1, 2011 through September 30, 2012. *ASPE: Assistant Secretary for Planning and Evaluation*. Retrieved from <http://aspe.hhs.gov/health/fmap12.pdf>
- Texas Hospital Association (2011). Medicaid 1115 Waiver - Texas Healthcare Transformation and Quality Improvement Program. *Texas Hospital Association*. Retrieved from <http://www.tha.org/HealthCareProviders/Issues/FinanceandReimburse098F/MedicaidBBBFWaiver/index.asp>
- The Lewin Group, McKethan, A., & Menges, J. (2006, November 13). Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion. *The Lewin Group*. Retrieved from <http://www.lewin.com/publications/publication/198/>
- Robinson, A., & Laughton, A. H. (2012, June). Replacing Medicaid UPL Programs with 1115 Waivers. *EBSCO Host*. Retrieved from <http://web.ebscohost.com/ehost/detail?sid=dac92e3d-635a-46d4-a5a6-37daaaab7c6a%40sessionmgr110&vid=1&hid=108&bdata=JnNpdGU9ZWhvc3QtG12ZQ%3d%3d#db=bth&AN=75149903>
- U.S. Government Accountability Office (2008, May). CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. *U.S. Government Accountability Office (U.S. GAO)*. Retrieved from <http://www.gao.gov/products/GAO-08-614>
- U.S. Government Accountability Office (2011, February). High-Risk Series: An Update. *U.S. Government Accountability Office (U.S. GAO)*. Retrieved from <http://www.gao.gov/products/GAO-11-278>
- U.S. Government Accountability Office (2007, March). Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency. *U.S. Government Accountability Office (U.S. GAO)*. Retrieved from <http://www.gao.gov/products/GAO-07-214>

U.S. Government Accountability Office (2012, July). States Reported Billions More in Supplemental Payments in Recent Years. *U.S. Government Accountability Office (U.S. GAO)*. Retrieved from <http://www.gao.gov/products/GAO-12-694>

## Targeted Behavior Interventions

- Alker, J., Hoadley, J. (2008, July). The Enhanced Benefits Rewards Program: Is it Changing the way Medicaid Beneficiaries Approach their Health. *Jessie Ball DuPont Fund*. Retrieved from [http://ccf.georgetown.edu/wp-content/uploads/2012/03/FL\\_healthy-beh7.08.pdf](http://ccf.georgetown.edu/wp-content/uploads/2012/03/FL_healthy-beh7.08.pdf)
- Follick, M. J., Fowler, J. L., & Brown, R. A. (1984). Attrition in Worksite Weight-Loss Interventions: The Effects of an Incentive Procedure. *Journal of Consulting and Clinical Psychology*, 52(1), 139-140.
- Greene, J. (2007, July). Medicaid Efforts to Incentivize Health Behaviors. *Center for Health Care Strategies*. Retrieved from [http://www.chcs.org/usr\\_doc/Medicaid\\_Efforts\\_to\\_Incentivize\\_Healthy\\_Behaviors.pdf](http://www.chcs.org/usr_doc/Medicaid_Efforts_to_Incentivize_Healthy_Behaviors.pdf)
- Gurley-Calvez, T., Kenney, G., Pellillo, A., Kosali, S., & Wissoker, D. (2012, October). Medicaid Reform and Emergency Room Visits: Evidence from West Virginia's Medicaid Redesign. *Mercatus Center, George Mason University*. Retrieved from [http://mercatus.org/sites/default/files/Medicaid-Reform-Emergency-Room-Visits-Working-Paper\\_1.pdf](http://mercatus.org/sites/default/files/Medicaid-Reform-Emergency-Room-Visits-Working-Paper_1.pdf)
- Gurley-Calvez, T., Fitzgerald Bone, P., Pellillo, A., Plein, C., & Walsh, M. (2010, January). Mountain Health Choices Beneficiary Report. *WVU College of Business and Economics*. Retrieved from <http://www.be.wvu.edu/bber/pdfs/BBER-2009-09.pdf>
- Hendryx, M., Irvin, C., Richardson, S., Beane, J., & Rosenbach, M. (2009, August). Evaluation of Mountain Health Choices: Implementation, Challenges, and Recommendations. *Robert Wood Johnson Foundation*. Retrieved from <http://www.rwjf.org/content/dam/farm/reports/evaluations/2009/rwjf45283>
- Jeffery, R. W., Thompson, P. D., & Wing, R. R. (1978). Effects on Weight Reduction of Strong Monetary Contracts For Calorie Restriction or Weight Loss. *Behav. Res. & Therapy*, 16, 369-369.
- Kane, R. L., Johnson, P. E., Town, R. J., & Butler, M. (2004). A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *American Journal of Preventive Medicine*, 27(4), 327-352. Retrieved from DOI:10.1016/j.amepre.2004.07.002.
- Kenney, G. M., & Pelletier, J. E. (2010, September). Medicaid Policy Changes in Idaho under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges. *Robert Wood Johnson Foundation*. Retrieved from <http://www.rwjf.org/content/dam/web-assets/2010/09/medicaid-policy-changes-in-idaho-under-the-deficit-reduction-act>
- Lemak, C. H., Landry, A. Y., & Duncan, R. P. (2012). Incentives for Healthy Behaviors: Experience From Florida Medicaid's Enhanced Benefit Rewards Program. *Journal of Primary Care & Community Health*. Retrieved from DOI:10.1177/2150131912458437.
- Redmond, P., Solomon, J., & Lin, M. (2007, June 1). Can Incentives For Healthy Behavior Improve Health Hold Down Medicaid Costs? . *Center on Budget and Policy Priorities*. Retrieved from <http://www.cbpp.org/files/6-1-07health.pdf>

Volpp, K. G., Troxel, A. B., Pauly, M. V., Glick, H. A., Puig, A., Weiner, J., & Audrain-McGovern, J. (2009). A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation. *The New England Journal of Medicine*, 360, 699-709. Retrieved from DOI: 10.1056/NEJMsa0806819.

## Health Savings Accounts

- Damler, R. (2009, August 26). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured - Milliman Insight. *Milliman Insight*. Retrieved from [http://insight.milliman.com/article.php?cntid=7175&utm\\_source=search&utm\\_medium=web&utm\\_content=7175&utm\\_campaign=Search](http://insight.milliman.com/article.php?cntid=7175&utm_source=search&utm_medium=web&utm_content=7175&utm_campaign=Search)
- Galbraith, A., Ross-Degnan, D., Soumerai, S. B., Rosenthal, M. B., Gray, C., & Lieu, T. A. (2011, February). Nearly Half of Families in High-Deductible Health Plans Whose Members have Chronic Conditions Face Substantial Financial Burden. *Health Affairs*, 30(2), 322-331. Retrieved from DOI: 10.1377/hlthaff.2010.0584.
- Hadley, J., & Holahan, J. (2004). Is Health Care Spending Higher under Medicaid or Private Insurance? *Inquiry*, 40(4), 323-342. Retrieved from <http://www.jstor.org/stable/29773091>.
- Hoffman, C., & Tolbert, J. (2006, October). Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families? *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from <http://www.kff.org/uninsured/upload/7568.pdf>
- Irvin, C. (2010, July 15). Healthy Indiana Plan: The First Two Years. *Mathematica Policy Research*. Retrieved from [http://www.mathematica-mpr.com/publications/PDFs/health/healthyIndiana\\_Irvin.pdf](http://www.mathematica-mpr.com/publications/PDFs/health/healthyIndiana_Irvin.pdf)
- Milliman (2012, September 18). Re: Affordable Care Act (ACA) - Medicaid Financial Impact Analysis Update. *IN.gov*. Retrieved from [http://www.in.gov/aca/files/ACA\\_Fiscal\\_Impact\\_Update\\_9.2012.pdf](http://www.in.gov/aca/files/ACA_Fiscal_Impact_Update_9.2012.pdf)
- Reichard, J. (2012). Washington Health Policy Week in Review Cohen Returning to CMS to Run CCIIO. *The Commonwealth Fund*. Retrieved from <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/Aug/August-20-2012/Cohen-Returning-to-CMS-to-Run-CCIIO.aspx>
- Solomon, J. (2008, January 24). Paying More For Less: "Healthy Indiana Plan" Would Cost More Than Medicaid While Providing Inferior Coverage. *Center on Budget and Policy Priorities*. Retrieved from <http://www.cbpp.org/files/1-24-08health.pdf>
- Texas Health and Human Services Commission (2008, May). Health Savings Account Pilot Report: Cost-Effectiveness and Feasibility Analysis. *Texas Health and Human Services Commission*. Retrieved from <http://drupal.linux.qa.zimmerman.com/hma/assets/Publications/HealthSavings0508.pdf>
- The Kaiser Commission on Medicaid and the Uninsured (2008, June). Summary of Healthy Indiana Plan: Key Facts and Issues. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from [http://www.kff.org/medicaid/upload/7786\\_S.pdf](http://www.kff.org/medicaid/upload/7786_S.pdf)
- Wall, J. K. (2012, September 24). Bill for Medicaid expansion? \$516M a year. *Indianapolis Business Journal*. Retrieved from <http://www.ibj.com/bill-for-medicaid-expansion---516m-a-year/PARAMS/article/36859>

## Statutory and Waiver Authority

- Center for Medicare & Medicaid Services (2012, July 10). RE: Policy Considerations for Integrated Care Models. *Medicaid.gov*. Retrieved from <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>
- Gallant, M. H. (n.d.). Medicaid Managed Care: Statutory Standards, Provider Network Access and Coverage Obligations, and Hot Button Contract Issues. *The American Health Lawyers Association*. Retrieved from <http://www.healthlawyers.org/Events/Programs/Materials/.../gallant.pdf>
- Insure The Uninsured Project (2011). 1115 Waiver. *Insure The Uninsured Project (ITUP)*. Retrieved from [www.itup.org/pdfs/LA1115Waiver01-02.pdf](http://www.itup.org/pdfs/LA1115Waiver01-02.pdf)
- Kaiser Commission on Medicaid and the Uninsured (2011, June). Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicaid/upload/8196.pdf>
- NAMI Policy Research Institute (2003, December). What lies beneath the Medicaid Waivers: A guide for Consumers and Families. *National Alliance on Mental Illness (NAMI)*. Retrieved from [http://www.nami.org/Content/ContentGroups/Policy/Issues\\_Spotlights/HIFA\\_Waiver\\_Policy\\_Raises\\_Concerns.htm](http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/HIFA_Waiver_Policy_Raises_Concerns.htm)
- Rosenbaum, S., Thorpe, J. H., & Schroth, S. (2009, November). Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options. *Center for Health Care Strategies*. Retrieved from [http://www.chcs.org/usr\\_doc/Supporting\\_Alternative\\_Integrated\\_Models\\_for\\_Dual\\_Eligibles.pdf](http://www.chcs.org/usr_doc/Supporting_Alternative_Integrated_Models_for_Dual_Eligibles.pdf)