

# HEALTH CARE TOOLKIT



FOR STATE  
BUDGET  
OFFICERS

Resources for Implementing the Affordable Care Act & Other Health Reforms | Spring 2014



**THE NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS**, founded in 1945, is the instrument through which the states collectively advance state budget practices. The major functions of the organization consist of research, policy development, education, training, and technical assistance. These are achieved primarily through NASBO's publications, membership meetings, and training sessions. Association membership is composed of the heads of state finance departments, the states' chief budget officers, and their deputies. All other state budget office staff are associate members.

### **2012–2013 Executive Committee**

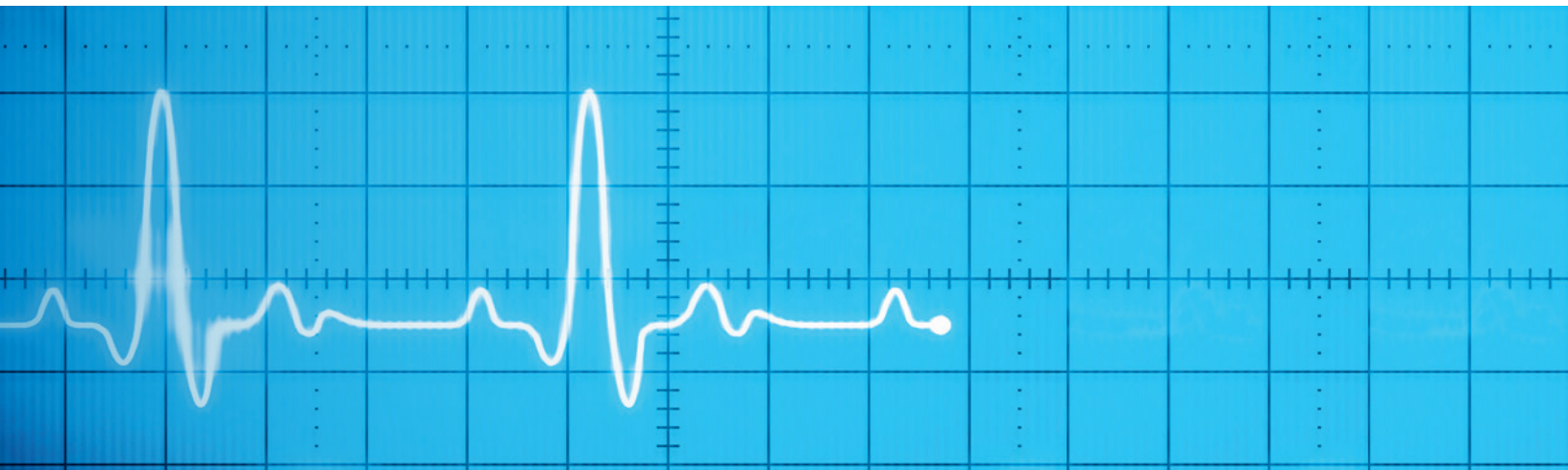
**Jason Dilges**, South Dakota, President  
**George Naughton**, Oregon, President-Elect and Chair, Critical Issue Committee on Lessons Learned from the Downturn  
**John Hicks**, Kentucky, Past President  
**Linda Luebbering**, Missouri, Member-at-Large  
**Gerry OligmueLLer**, Nebraska, Member-at-Large  
**Thomas Mullaney**, Rhode Island, Eastern Regional Director  
**Brian Hayes**, Wisconsin, Midwestern Regional Director  
**Ana Matosantos**, California, Western Regional Director  
**Brandon Sharp**, Arkansas, Southern Regional Director  
**Jerry McDaniel**, Florida, Chair, Health and Human Services Committee  
**Timothy Keen**, Ohio, Chair, Fiscal Management and Reporting Committee  
**Karen Rehfeld**, Alaska, Chair, Education Committee

### **2013–2014 Executive Committee**

**George Naughton**, Oregon, President  
**Mike Morrissey**, Texas, President-Elect  
**Jason Dilges**, South Dakota, Past President  
**Gerry OligmueLLer**, Nebraska, Member-at-Large  
**Thomas Mullaney**, Rhode Island, Member-at-Large  
**Paul Potamianos**, Connecticut, Eastern Regional Director  
**Margaret Kelly**, Minnesota, Midwestern Regional Director  
**Juliette Tennert**, Utah, Western Regional Director  
**Jane Driskell**, Kentucky, Southern Regional Director  
**Michael Cohen**, California, Chair, Health and Human Services Committee  
**Marc Nicole**, Maryland, Chair, Fiscal Management and Reporting Committee  
**Karen Rehfeld**, Alaska, Chair, Annual Critical Issue Committee on Budget Processes in the States  
**Scott D. Pattison**, Executive Director

**This report is based on research funded by the John D. and Catherine T. MacArthur Foundation. The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of the MacArthur Foundation.**

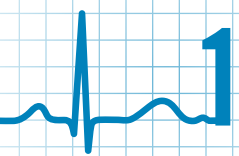
*Copyright © 2014 by the National Association of State Budget Officers. All rights reserved.*



# TABLE OF CONTENTS

<b>1</b>	<b>Acknowledgements .....</b>	<b>4</b>
<b>2</b>	<b>Background.....</b>	<b>5</b>
<b>3</b>	<b>Explaining Health Care Cost Trends.....</b>	<b>6</b>
<b>4</b>	<b>Bracing for State Budget Volatility.....</b>	<b>8</b>
<b>5</b>	<b>Monitoring Health Insurance Marketplaces .....</b>	<b>11</b>
<b>6</b>	<b>Evaluating Medicaid Managed Care Expansions .....</b>	<b>13</b>
<b>7</b>	<b>Assessing the Impacts of Care Delivery and Payment Reforms.....</b>	<b>15</b>
<b>8</b>	<b>Conclusion .....</b>	<b>18</b>
<b>9</b>	<b>Appendix: Summary of Current Resources for Budget Officers .....</b>	<b>19</b>
<b>10</b>	<b>Endnotes.....</b>	<b>21</b>





# ACKNOWLEDGEMENTS



This report was prepared by the National Association of State Budget Officers (NASBO) with funding support from the John D. and Catherine T. MacArthur Foundation. Budget officers were given the opportunity to convene both in the fall of 2012 and in the fall of 2013 to discuss recommendations for addressing current health care issues in the context of state budgets. State budget officers provide a unique perspective on how the crucial delivery of a key service such as health care fits into the framework of state budgets. As part of this work, the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota's School of Public Health assisted NASBO in conducting practical research to inform questions state budget officers have about state health care programs, expenditure trends, and health reform implementation and helped draft the following report.

NASBO thanks Kristin Dybdal, Senior Research Fellow, Minnesota State Health Access Data Assistance Center and former Minnesota state budget officer for drafting the report. NASBO staff members Stacey Mazer, Lauren Cummings, Brukie Gashaw, Michael Streepey, Brian Sigriz, and Kathryn Vesey White also assisted with this report.

Additionally, Andrea Maresca, Director of Federal Policy & Strategy, National Association of Medicaid Directors; Trinity Tomsic, Deputy Director, Federal Funds Information for States; and Angela Vogt, Executive Budget Coordinator, Minnesota Management & Budget reviewed this report and provided valuable feedback and comments.

# BACKGROUND

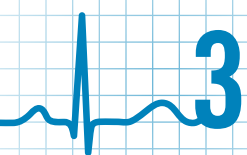
# 2



Health care markets are complex and becoming increasingly so with the implementation of the *Affordable Care Act* (ACA) and multiple layers of related care delivery and payment reforms. Budget officers managing state health care issues find it more important than ever to stay connected to their health and human service counterparts at the state level, federal rule-making and other regulatory developments, state models and best practices, and resources generated by the broader health policy community from both the public and private sectors.

This report examines key health care issues, considerations, and available resources in five core areas pertinent to state budget officers as they analyze the implementation of the ACA and other health reforms: (1) explaining health care cost trends; (2) bracing for budget volatility; (3) monitoring health insurance exchanges or marketplaces; (4) evaluating Medicaid managed care expansions; and (5) assessing the impacts of care delivery and payment reforms. In doing so, the report highlights the many ways in which state budget officers provide a unique perspective to the debate and offer practical recommendations to address overall state health care issues, evaluate new opportunities, and overcome implementation challenges.

While health care spending in general was discussed during the convenings, the Medicaid program, due to its size and complexity, was a focal point of discussion. Medicaid, the largest state health care program, is a means-tested entitlement program financed by the states and the federal government that provides comprehensive and long-term medical care for more than 62 million low-income individuals. Medicaid spending accounted for 24.4 percent of total state spending in fiscal 2013, the single largest component of *total* state expenditures, and 19.0 percent of general fund expenditures, according to NASBO's Fiscal 2011–2013 *State Expenditure Report*. The significant size of the Medicaid program coupled with uncertainty over health care costs makes it one of the most vexing issues in state finance. Although many changes in health care look more broadly across all payers and all services, it is still important to look at the impact on the state budget through the myriad of changes.



# 3 EXPLAINING HEALTH CARE COST TRENDS

**One of the most challenging dilemmas facing states today is how to finance the growing demands for health care services without sacrificing other important investments in K-12 education, higher education, transportation, corrections, the environment, and other government programs. It follows that understanding state health care cost trends, as well as the fiscal impacts of state health care reform initiatives—including those related to the ACA—will be a critical component to informing ongoing policy and budgetary discussions in this area.**

Due to the complexity of health care markets, there is no perfect method for isolating the various factors that contribute to state health care expenditure growth with absolute precision. For example, consider the recent slowdown in health care growth rates overall. Some speculate that there have been fundamental changes in the health care structures driving medical costs down and that these new, lower growth rates represent a “new normal” in health care. Others link this slowdown almost entirely to the recent recession and sluggish economic recovery.

---

**“Despite these national trends, many states continue to experience growth in Medicaid spending that exceeds the rate of growth of the state’s economy.”**

Nationally, recessions have been shown to slow the rate of health care expenditure growth in the private sector, although the impacts are often lagged. In the private sector, individuals newly out of work and uninsured as well as those who continue to be employed and insured hold back on using health care just like they refrain from purchasing other goods and services. Health care utilization rebounds eventually, but it does so slowly over time as the economy improves and returns to full employment. Another related factor that appears to be important in the recent slowdown of health care growth rates in the private sector is the employer trend towards offering insurance products with higher out-of-pocket costs and cost sharing, which provides incentives

that help to contain costs but also reduce individuals’ overall utilization of health care services.<sup>1</sup>

Some of the same trends appear to be at play within the Medicaid program. *The Actuarial Report on the Financial Outlook for Medicaid* by the Centers for Medicare & Medicaid Services (CMS) reported an almost unprecedented decline of 1.9 percent in *estimated spending per beneficiary* (nationally) from 2011 to 2012. This trend reflects a combination of factors including underlying economic trends such as the recession, premium cycles, and other factors depressing prices and utilization in the health care market. Other contributing factors include: state actions to reduce provider payments and optional benefits following the expiration of temporary federal matching rate increases authorized under the *American Recovery and Reinvestment Act of 2009* (ARRA); the changing mix of Medicaid beneficiaries as states expand their programs; and a host of individual programmatic changes at the state level regarding eligibility, managed care delivery systems, and payment rules that influence expenditure trends.<sup>2</sup>

Despite these national trends, many states continue to experience growth in Medicaid spending that exceeds the rate of growth of the state’s economy (even after controlling for the impact of the end of the enhanced federal Medicaid matching rate that was in effect through June 2011). Disentangling the factors influencing state-level Medicaid trends will also be quite difficult moving forward, and as the provisions of the ACA take effect, state budget officers recognize that significant budgetary uncertainties are likely to remain for some time. Chief among these will be related to projecting enrollment growth.

States that have chosen to expand Medicaid eligibility beginning in 2014, as well as those that have not, will be subject to significant uncertainties related to take-up and participation rates both for those newly eligible and those previously eligible but not enrolled; the impacts of eligibility simplifications, health insurance exchanges, and publicity; and changes in the mix of Medicaid enrollees (e.g., children, parents, aged, individuals with disabilities). Other cost impacts related to the ACA’s essential benefit set for all newly eligible adults, pressure to increase provider payments to mitigate access issues, and the potential for decreased use

of other state safety net and mental health programs will also take time to fully understand. To add further complexity, a large program such as Medicaid does not always have a smooth spending pattern and payments for services may not align directly with a given fiscal year.

Layered atop these ACA-related changes are state-driven health care reforms such as Accountable Care Organization (ACO), medical home, and value-based payment initiatives that aim to curb health care cost growth over time while seeking to improve access and quality. Because isolating the individual impacts of these would involve sophisticated economic modeling of counterfactuals over time (i.e., what would have happened in the absence of particular interventions), many states are looking for more practical, albeit imperfect, strategies for monitoring impacts on health care costs.

---

## RESOURCES FOR BUDGET OFFICERS ON HEALTH CARE COST TRENDS

The state health care marketplace is the result of a dynamic interplay between consumers, health care providers, health insurance plans, employers, and government. To help navigate this complex environment, the Minnesota Department of Health (MDH) Health Economics Program's **"Minnesota Health Care Markets Chartbook"** is updated regularly to provide public officials and other stakeholders with access to the most up-to-date Minnesota statistics on a comprehensive range of topics that influence health care cost growth, including:

- Minnesota health care spending and cost drivers,
- Trends and variation in health insurance coverage,
- Employment-based health insurance,
- Small group and individual health insurance markets,
- Public health insurance programs,
- Uninsurance and the safety net,
- Health plans, and
- Health care providers and service availability.<sup>3</sup>

Since a 2008 state health reform law, MDH has also contracted with Mathematica Policy Research to calculate a **baseline for projected health care spending in Minnesota** based on macroeconomic variables and methods used by the Centers for Medicare & Medicaid Services (CMS) to estimate national health care expenditures. Each year, the Department compares actual health care spending with the updated macroeconomic projection model to gauge whether or not the reform law is achieving its goal of curbing health care cost growth. The model has been relatively successful in projecting actual health care spending, which suggests that there have been no substantial changes in

the relationship between health care spending and the macroeconomic variables that have affected health care spending thus far. Over time, the Department believes that substantial differences between actual spending and projected spending will help to determine, at least directionally, the impacts of the 2008 health reforms and other more permanent changes in the Minnesota health care market on public programs.<sup>4</sup>

Another state with a rich history of monitoring health care system performance and cost is Massachusetts. Established pursuant to the recent health care law that sets a target for controlling the growth of state health care costs (e.g., to the rate of growth of the state's Gross State Product through 2017), **Massachusetts' Center for Health Information and Analysis (CHIA)** collects health care cost and quality information and provides analysis of these data related to health care cost trends; hospital financial performance; emergency department utilization; health care safety net expenditures; insurance surveys; and key health care access, cost, and quality metrics.<sup>5</sup>

During NASBO's health care convenings, discussion revolved around forecasting populations for Medicaid, the health insurance exchanges or marketplaces, and other health care services. States provided examples of their internal processes and also some experiences and challenges related to budget forecasting for new or expanded programs.

In **Iowa**, a group convenes once a month to project enrollment within a range, and typically an estimate within that range is used for the state's budget. In **New York**, Medicaid forecasting is performed internally by budget examiners who review specific levels of detail of the program. The state has been relying on outside groups to model changes from federal health care reform and has developed its own model to project Medicaid enrollment and costs and savings associated with Medicaid expansion under the ACA. New York is analyzing data about Medicaid beneficiaries to examine the use of services and has received funding to obtain access to all payers' claims. The state reviews Medicaid spending every month to see if spending projections are on target. As part of the redesign and global cap, the state has published its model and posts monthly reports on the Department of Health's redesign team website.<sup>6</sup>

In **Vermont**, representatives from the finance office, the human services agency's health care office, joint fiscal legislative office, and members of health care reform staff meet frequently to review each other's assumptions. This information is presented in January to the state's Emergency Board that is chaired by the governor and includes legislative members. There is a vote to approve caseload numbers, utilization numbers, and per member per month (PMPM) costs.



# 4 BRACING FOR BUDGET VOLATILITY

Since the enactment of the ACA in 2010, the benefits and costs of the ACA from a state budget perspective have been examined to various degrees by executive and legislative branches of state government, academic researchers, and other stakeholders. Given the U.S. Supreme Court's decision to allow states to choose whether to expand Medicaid to 138 percent of the federal poverty level (FPL) or not, for most states much of this work has centered on analyzing the fiscal implications of the "Medicaid expansion" policy choice. However, the state budget implications of the ACA are potentially much more far-reaching and complex.

---

**"Since states are required to balance their budgets, there is a zero sum game in that higher costs in health care often translate into lower services elsewhere or the need to raise additional revenue."**

Careful analysis incorporates not only the effects of the Medicaid expansion but also the impacts of other ACA provisions (with or without expanded eligibility), the potential for offsetting state savings in programs outside of Medicaid, and associated revenue effects. Since states are required to balance their budgets, there is a zero sum game in that higher costs in health care often translate into lower services elsewhere or the need to raise additional revenue.

The most important budget assumptions state budget officers will make or help to make around the impact of the ACA—including but not limited to those related to a state's optional Medicaid expansion decision—are identified below.

**Costs for adults newly eligible for Medicaid.** This involves making assumptions about the number of newly eligible, take-up rates for the newly eligible, and the average cost of newly insured individuals (i.e., will they have health care needs that are similar to or different from current enrollees and why.) Many states will lack historical data for this population with which to inform their assumptions because they have not covered childless adults in the past. States should

carefully consider their assumptions and weigh available data and research.

**Increased participation rates for currently eligible populations even without a Medicaid expansion (sometimes called the "welcome mat" or "woodwork" effect).** States who opt not to expand Medicaid may nonetheless experience a surge in Medicaid participation among individuals who are currently eligible but not enrolled in the program, for whom states will only receive their standard Federal Medical Assistance Percentage (FMAP). These impacts are widely expected due to the ACA's individual mandate to obtain health insurance coverage, the availability of state-based or federally facilitated health insurance exchanges, and streamlined Medicaid enrollment processes. Individual states may also see a surge of enrollment due to expansive and extensive outreach efforts that they or other entities in their state are undertaking.

**Provider rate enhancements.** While the Medicaid provider rate enhancements for primary care services mandated under the ACA (rate increases to at least 100 percent of Medicare for calendar years 2013 and 2014) will be relatively straightforward to estimate, the long-term impacts of this change will be harder to predict. There will undoubtedly be pressure to either maintain these higher rates or increase them further, particularly if greater demand for providers exacerbates access issues for Medicaid beneficiaries.

**MAGI income conversion impacts.** MAGI stands for modified adjusted gross income. MAGI will be used to measure eligibility for premium tax credits for the purchase of health insurance; states will also now use MAGI to determine income eligibility for Medicaid, with certain exceptions. The ACA requires states to convert their current net income standards, which allow for certain disregards of income (e.g., a portion of earned income) or expenses (e.g., child care), to gross income standards. The conversion is needed to account for the fact that states will no longer be allowed to use income or expense disregards for determining eligibility of the populations to whom the MAGI standard applies, with the exception of a disregard that applies to everyone of an amount equal to five percentage points of the Federal poverty level (FPL) for the applicable family size. States will also no longer be able to use asset tests in determining eligibility. All states, re-



ardless of whether or not they expand Medicaid, have to comply with the new eligibility standards.

**State savings for programs outside of Medicaid.** State general fund spending on other health care programs could be reduced with more limited impacts on consumers if Medicaid coverage to the expansion group provides an acceptable substitute. Places to look for savings would include state-only funded programs for the poor and near-poor uninsured such as uncompensated care pools for hospitals and other safety net providers; high-risk pools; mental health and substance abuse programs and grants; inpatient health care for prisoners; and even public employee and retiree coverage.

**Potential revenue impact.** Some states have projected increases in general state revenues due to downstream economic impacts associated with more individuals having health insurance coverage and purchasing health care services. Other more state-specific impacts on Medicaid managed care premium taxes and provider taxes and fees may need to be considered. Other issues for states to consider include the relationship between premium taxes that may be used to support the operation of health insurance exchanges and the potential volatility of these revenues. In addition, if a state is planning to operate a Basic Health Plan, there can be significant revenue volatility as well since federal funding is based upon the cost of premiums in the broader health care market.

**Benchmark benefit set impacts.** Under the ACA, states are required to construct benchmark benefits for the Medicaid expansion population linked to one of three reference plans in the state (e.g., the state's employee health plan). Slightly different rules will apply for plans selling in individual and small group markets both inside and outside health insurance exchanges. States also need to be aware of adding additional benefit mandates and the cost to the state of paying the incremental cost for all individuals in qualified health plans both inside and outside the exchange.

## RESOURCES FOR BUDGET OFFICERS ON BUDGET VOLATILITY

**State Refor(um)** is an online network for health reform implementation, connecting state officials and other health reform leaders and stakeholders with their peers, experts, research, and resources.<sup>7</sup> The National Academy of State Health Policy (NASHP) sponsors the site with funding from the Robert Wood Johnson Foundation. With a searchable health reform implementation library of well over 2500 documents, State Refor(um) allows users to peruse grants and contracts, legislation, presentations, regulations, reports and other working materials from other states or the federal government. Of



particular interest to state budget officers may be state-specific resources from the “health reform coordination—fiscal analysis,” “provider capacity—Medicaid reimbursement,” “benefit design—essential health benefits,” “benefit design—Medicaid benchmark coverage,” and “financing and program integrity” areas of the library.

In September 2012, **Manatt Health Solutions, the Center for Health Care Strategies (CHCS), and the State Health Access Data Assistance Center (SHADAC)** produced a technical assistance tool for states looking to frame and plan their financial impact analysis related to Medicaid expansion. The tool, developed with funding from the Robert Wood Johnson Foundation under the State Health Reform Assistance Network, provides detailed information on critical areas of financial analysis: (1) the cost of newly eligible; the cost of currently eligible but not enrolled; administrative costs; savings from transitioning current Medicaid populations to the newly eligible group; savings from the reduction in state programs for the uninsured; and other revenue gains/savings. It also provides a decision-framing and planning worksheet to jumpstart the process, and detailed guidance on key assumptions based on available data and research.<sup>8</sup>

A new, in-depth tracking tool published by **State Refor(um)** called “**Tracking Medicaid Expansion Decisions: A Closer Look at Legislative Activity**” may be of particular interest to states

that are still contemplating Medicaid expansion or those that continue to evaluate potential impacts of the expansion.<sup>9</sup> The tool provides timely updates on state-by-state decisions to expand Medicaid such as executive and legislative branch activity around expansion. The tool summarizes these issues in matrix form by state, but also provides direct links to executive branch documents, legislative bills, fiscal analyses, and other key documents.<sup>10</sup>

A recent Robert Wood Johnson-funded study by researchers at SHADAC predicts that the ACA is likely to lead to a *substantial* increase in Medicaid participation among people who are currently eligible for the program but not enrolled.<sup>11</sup> One impact of this “welcome-mat” or “woodwork” effect will be higher Medicaid caseloads and spending, even in states that do not expand Medicaid under the ACA. Massachusetts was used as a case study for this analysis because it is the only state that has implemented reforms of a scale and scope similar to those of the *Affordable Care Act*.

Looking at the health reforms that took place in Massachusetts in 2006 and controlling for other factors that influence Medicaid participation rates, the investigators found that Medicaid participation among eligible low-income parents increased by 19.4 additional percentage points in Massachusetts compared to a group of control states. The authors note that because in many states the Medicaid participation rate has more “room to improve”

than it had in Massachusetts, there is potential that the welcome mat effect could be even larger in some states than that seen in Massachusetts. On the other hand, limited outreach and enrollment efforts in states that choose not to implement the Medicaid expansion or administer their own health insurance exchange could result in lower impacts in those states.

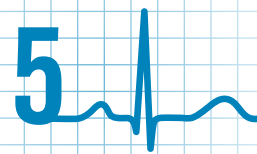
Some type of Medicaid welcome-mat effect has long been anticipated, but there has been limited research evidence to date to help estimate its size. This issue is a particular concern for states, because although the ACA funds 100 percent of the costs associated with newly-eligible Medicaid enrollees from 2014 through 2016 (eventually phasing down to 90 percent), there will be no enhanced federal match rate for Medicaid enrollees who would have qualified under previous Medicaid rules.

Another study published in the *Annals of Family Medicine* addressed the health status of those who are likely to newly enroll by comparing adults potentially eligible for Medicaid under provisions of the *Affordable Care Act* with current adult Medicaid beneficiaries.<sup>12</sup> According to the study, physicians can anticipate a potentially eligible Medicaid population with equal if not better current health status and lower prevalence of obesity and depression than current Medicaid beneficiaries. The research was based on nationally representative data from the National Health and Nutrition Examination Survey, which was conducted between 2007 and 2010 by researchers at the University of Michigan Medical School.

A report by the Medicare & Medicaid Research Institute focused on the experiences and lessons learned by early Medicaid expansion states.<sup>13</sup> Medicaid officials from California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington were interviewed about their experiences with expansion. Interviews explored enrollment outreach, stakeholder involvement, impact on beneficiaries, utilization and costs, implementation challenges, and potential lessons for 2014. The authors identified several themes. First, these expansions built upon pre-existing state-funded insurance programs for the poor. Second, predictions about costs and enrollment were challenging, indicating the uncertainty in projections for 2014. Other themes included greater than anticipated need for behavioral health services in the expansion population, administrative challenges of expansions, and persistent barriers to enrollment and access after expanding eligibility.



# MONITORING HEALTH INSURANCE EXCHANGES OR MARKETPLACES



**The Affordable Care Act will have far-reaching effects on health insurance coverage, health care financing, and health care delivery in the United States. Understanding the state-level impacts of the ACA will be a top priority for state policymakers and will guide ongoing state implementation activities. Work on performance metrics related to the ACA is being done across the country by individual states developing frameworks for evaluating exchanges and health reform more broadly; various federal departments (most notably HHS) charged with developing regulations and monitoring plans; and research and policy think tanks. These efforts range from expansive in scope—for example, comprehensive frameworks for evaluating and monitoring the ACA—to those more narrowly targeted on health insurance exchanges or public program eligibility and enrollment.**

State budget officers, especially those in states running state-based marketplaces, may wish to pay particular attention to performance measures that relate to the long-term financial sustainability of health insurance marketplaces. State-based exchanges are required to be financially self-sustainable beginning in 2015. Generally speaking, exchange start-up costs are being funded by federal grants. Once exchanges are operational, ongoing costs will be covered by assessments that apply to Qualified Health Plans (e.g., a percentage of premiums for enrolled lives) or all health insurance companies in the state, provider taxes and/or other public funding sources (e.g., general state revenues or tobacco taxes). Monitoring key enrollment and financial metrics—such as those described below—will be necessary to ensure that the state exchanges are financially viable and sustainable: that is, that state exchanges generate sufficient revenue to cover costs and build ample reserves.

**Revenues and expenses by category.** It will be important to understand how stable or predictable expected revenue streams and expenditures are. If changes are required, how much lead time will it take and how will that impact overall financial stability?

## **Financial solvency projections and/or break-even analysis.**

These projections should be developed by coverage type and public program or subsidy type. A key input to the projections will be enrollment projections for the various types of enrollees obtaining coverage through the exchange. These projections should be based on historical enrollment trends by subgroup and developed using “low, moderate, and high” uptake or growth assumptions.

**Reserve metrics.** It will also be important to track reserves as a percentage of annual plan reimbursements, other fees (e.g., assister/navigator fees), administrative budgets and other expenditures. Because exchanges will start up with zero enrollees, the establishment of a healthy reserve will take some time. One goal would be to set plan assessment fees and budgets such that after exchange start-up and after an initial period of exchange operations (for example, by the end of 2016), a six-month reserve exists. At this point, reserves as a percentage of annual ongoing expenditures would be roughly 50 percent.

---

**“State budget officers, especially those in states running state-based marketplaces, may wish to pay particular attention to performance measures that relate to the long-term financial sustainability of health insurance marketplaces.”**

Another key input to these forecasts will be exchange full-time equivalent (FTE) staffing and expense projections. Financial modeling to determine exchange solvency should be done on a monthly basis to determine cash flow needs and on an annual basis to identify near- and long-term viability issues for start-up and operations, required plan assessment fee changes, and other needed interventions (outreach and marketing investments, etc.) Break-even analysis can help determine the minimum number of enrollees necessary to cover the costs of operating the ex-



change given certain plan assessment fee assumptions, or the minimum plan assessment fee necessary to cover the costs of operating the exchange (and establish a certain reserve level) given certain enrollment assumptions.

Exchange metrics that go well beyond those related to financial management may also be of great interest to state budget officers in states with state-based exchanges as well as in states evaluating whether to pursue state-based exchanges in the future. States are currently in different stages of designing more broad-based evaluation and monitoring strategies for their exchanges ultimately to answer questions such as:

- Have exchanges facilitated consumer education and choice in health insurance purchasing among individual and small employers?
- Have exchanges improved access to health insurance coverage in the State?
- Have exchanges contributed to improved access to health care?
- Have exchanges promoted health care quality?
- Have exchanges contributed to reduced health care costs?
- Have exchanges contributed to improved health status?



## RESOURCES FOR BUDGET OFFICERS ON HEALTH INSURANCE EXCHANGES

A recent operating budget analysis for **Vermont Health Connect** conducted by Health Management Associates (HMA) and presented in Vermont Legislative Committees provides an excellent overview of one state's exchange operating budget, an analysis of federal requirements for state-based exchanges, a comparison of operating costs estimates across states, and operating areas for focused review and evaluation in the future.<sup>14</sup>

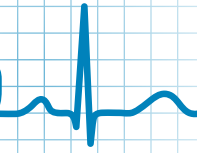
**Colorado, Maryland, and Rhode Island**, in particular, are three states that have planned broad-based evaluation and monitoring strategies for their state-based exchanges to date in areas such as access and enrollment, affordability, consumer choice, consumer satisfaction, health insurance market stability, and operations. Each state has laid out a detailed plan for how they will evaluate their state-based exchanges, a framework or rationale for their plan, specific measures/metrics, and data sources. See Colorado's "Report on Metrics for Evaluation of the Colorado Health Benefit Exchange and Data Source Summary" (March 2012); Maryland's "Framework for Monitoring the Maryland Health Connection and Measures Summary Table" (December 2012); and Rhode Island's "Lessons from Rhode Island Presentation and Performance Measurement Plan" (May 2013).<sup>15</sup>

In addition, SHADAC is preparing a comprehensive exchange evaluation framework for **Minnesota**, which will be forthcoming, that will include the identification of evaluation domains, measure selection criteria, data sources, data gaps, communication strategies, and resource requirements.

In November 2013, the United States Department of Health and Human Services (HHS) began releasing the results from open enrollment for state-based and federally run health insurance exchanges. The figures from HHS also include those determined or assessed eligible for Medicaid or the Children's Health Insurance Program (CHIP). In January 2014, HHS released the third in a series of issue briefs on enrollment in the health insurance exchanges which for the first time included demographic information such as the age and gender of enrollees.<sup>16</sup> Additionally, the Kaiser Commission's state health facts has information on the state-based insurance exchanges that includes unique website visitors, applications, and enrollment by state. The Advisory Board Company is also monitoring the number of individuals who have applied and those who have selected a health insurance plan for the states operating state-based exchanges.



# EVALUATING MEDICAID MANAGED CARE EXPANSIONS

6 

**Many states attempting to control Medicaid spending while increasing access and improving program quality have pursued large-scale expansions to their Medicaid managed care programs or major reforms within these programs. Key changes include expanding Medicaid managed care to new geographic areas; covering or integrating an expanded set of services through Medicaid managed care; modifying enrollment policies so more Medicaid beneficiaries are required or likely to enroll in managed care; and altering managed care payment methods or approaches.**

But one of the most significant changes in state Medicaid managed care over the last several years has been requiring new Medicaid populations—especially high-cost, high-need populations such as seniors and persons with disabilities—to enroll in some form of managed care. With the exception of efforts targeting beneficiaries who are dually eligible for Medicaid and Medicare through ACA-related “State Demonstrations to Integrate Care for Dual Eligibles”, states have generally been planning and implementing these changes independent of the federal health reform law itself.

It is true that the percent of Medicaid beneficiaries enrolled in managed care has grown progressively over the last two decades, with almost three-quarters in some form of managed care program as of July 2011.<sup>17</sup> Still, because most seniors and persons with disabilities enrolled in Medicaid receive their care through the fee-for-service system, and spending on high-cost services like nursing home care largely remains outside of managed care contracts, managed care expenditures continue to account for a disproportionately low percentage of total Medicaid costs (roughly 29 percent).<sup>18</sup> This percentage is likely to grow over time.

Increasingly, states are moving to expand Medicaid managed care to populations beyond traditional ones (children, pregnant women, and parents) in hopes of lowering cost growth and increasing the predictability of Medicaid expenditures; reducing the service “fragmentation” that often accompanies a fee-for-service model, especially for beneficiaries with multiple conditions visiting multiple health care provider settings;

and promoting innovation and greater use of measurement through increased accountability for access and quality.

Many states are adopting and expanding managed care to both improve quality and control costs. Based on previous experiences, states note the need for in-depth knowledge of how managed care operates and an ability to determine if a state is using a managed care system in a fee-for-service environment. States also are reviewing experiences with managed care for long-term care services that have traditionally been fee for service and if states are realizing savings in long-term care from moving to managed care. Some states note that although their costs per unit were low, there was an increased demand for the services and therefore little savings.

Although many studies and evaluations commissioned by federal and state governments, private foundations, and other researchers appear to substantiate claims that enrolling higher-need, higher-cost populations into Medicaid managed care may produce significant cost savings for states, the duration of these savings may be difficult to predict.<sup>19</sup>



---

**“From a state budget perspective, a thorough evaluation of where to expand managed care should include answering questions about implementation, impact on enrollees as well as fiscal outcomes.”**

Beyond costs, state budget officers may also be interested in how access and overall quality of care are likely to be impacted by a shift to Medicaid managed care, and on these topics, the empirical evidence is fairly slim. From a state budget perspective, a thorough evaluation of whether to expand managed care should include answering questions about implementation issues, impacts on program enrollees, as well as fiscal outcomes.

Key questions for state budget officers evaluating the expansion of Medicaid managed care to new populations such as seniors and persons with disabilities include:<sup>20</sup>

- To what extent have Managed Care Organizations (MCOs) developed provider networks and programs to meet the unique care delivery and care coordination needs of the populations in question?
- Given that a breadth of services are often at play for these populations (e.g., mental/behavioral health services, community-based services, supportive housing), how can separate funding streams be consolidated such that care coordination/integration is not compromised?
- How will the state’s risk adjustment system—likely based on diagnostic factors—change to accommodate groups with disabilities, functional impairments, and long term

care needs? What non-medical factors are important in determining risk?

- Are managed care contract requirements focused on the right things from a state purchasing point of view? Are they specific enough? Are they oriented towards outcomes?
- What are the goals for implementing managed care for these groups? Implementing Medicaid managed care and improving care delivery for high-need populations requires a long-term commitment. Short-term goals such as one-time budget savings are not necessarily compatible with this type of policy change.

---

## RESOURCES FOR BUDGET OFFICERS ON MEDICAID MANAGED CARE

In 2012, the **Kaiser Commission on Medicaid and the Uninsured** produced an issue paper on key issues to consider in implementing Medicaid managed care for people with disabilities.<sup>21</sup> The paper outlines key considerations concerning payment, provider networks, delivery systems, beneficiary protections, and oversight of managed care. Included in this piece is also a matrix summarizing key research on risk-based Medicaid managed care for people with disabilities and main findings.

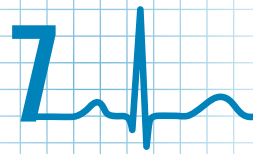
For states looking to transition from fee-for-service systems to risk-based systems for Medicaid beneficiaries receiving long-term services and supports (LTSS), Kaiser also published a useful compendium of state activity related to capitated Medicaid managed LTSS, key considerations, implementation recommendations, and a set of performance measures and monitoring activities.<sup>22</sup>

The Kaiser Commission on Medicaid and the Uninsured tracks changes in Medicaid through its annual budget report and includes the number of states expanding managed care arrangements as well as the nature of these arrangements.<sup>23</sup> Within the report are examples of state approaches and the types of benefits offered within these arrangements.

An important perspective when evaluating managed care expansion initiatives for beneficiaries dually eligible for Medicare and Medicaid is understanding efforts at the federal and state levels to integrate payment systems and coordinate care across Medicare and Medicaid programs. A June 2013 analysis by the **Congressional Budget Office** provides a comprehensive view of dual eligible beneficiaries, examining the characteristics that affect health care utilization and spending, current payment systems, and care coordination and financing reforms at the federal and state level.<sup>24</sup>



# ASSESSING THE IMPACTS OF CARE DELIVERY AND PAYMENT REFORMS



**With the passage of the ACA, states and private payers have accelerated efforts to reorganize health care delivery systems to foster greater provider-level innovation and accountability to achieve better outcomes and lower costs. These new models vary in scope and in strategy—some are provider driven, some are health plan-based, and still others are employer-driven.**

Care coordination across all providers and care settings—including the integration of physical health care with behavioral health services, long-term services and supports, and even social services—are also common themes. Finally, states are bolstering technology and data infrastructure investments so patient health care information is available at the site of service and aligning reporting requirements across health care payers so that participation is seamless from a provider perspective.

Many states are aligning their strategies to improve care delivery and access with payment reform. State payment reforms include moves to reduce the use of fee-for-service payment methods that can create perverse incentives and lead to uncoordinated, duplicative care. States are looking at payment mechanisms that reward providers for coordinating across a wide range of services to achieve better outcomes and reduce costs.

States can use many policy, regulatory, and contractual levers to encourage payment reform and care delivery improvements. Accountable Care Organizations and medical, health or patient-centered medical homes represent structural changes at the provider level, by introducing financial incentives that support targeted transformation of care delivery. Budgeted managed care payment amounts and full- or partial-capitation arrangements within Medicaid and other state programs are also widely used. Global payments, shared savings and gain sharing programs, pay-for-performance initiatives, and bundled payments are additional tools that can be coupled with other changes to the system.

Undoubtedly, the payment model and delivery system changes designed and implemented by states will vary along

a continuum of reform. Regardless of the new initiative forged, states will need to ensure that: (1) robust forecasts of health care utilization and cost impacts under various program design scenarios are available; (2) reimbursement models account for the risk of populations served; and (3) overall financial resources and budgets are adequate to support the changes desired.

Health care modeling and financial analysis—performed by state agency staff or by health care consultants—will be core to informing and supporting these key objectives. However, modeling and financial analysis can only be as good as the research evidence that informs the assumptions and structure of the model. It is important to ensure that the projections rely on objective and rigorous research evidence wherever possible. In addition, projections should be transparent with regard to the modeling of impacts, including assumptions about the effectiveness of interventions for various segments of the population. Transparency is especially important given the multi-stakeholder environment surrounding most state-level reform initiatives.

When it comes to the research evidence available to inform states' assumptions about the impacts of care delivery and payment reform, there are two key challenges. First is scope. While many payers are attempting to reduce unnecessary utilization and costs through payment and delivery system reform, the impact of these innovations has most often been estimated through investigations of standalone pilot programs or narrowly implemented demonstration projects. There are few examples of research studies that can be directly applied to the larger scale, multi-payer implementation efforts that will affect larger and more diverse populations than those participating in demonstrations and pilot programs.

Another difficulty in forecasting the impact of system change is duration—accounting for long-term versus short-term outcomes. Reducing potentially avoidable admissions and emergency room visits for certain conditions are examples of outcomes that can often be directly associated with specific interventions. Other interventions, such as hypertension



control over many years, are more difficult to directly associate with health care impacts and the performance of the system. Much of the available research evidence focuses on shorter-term, easier to quantify outcomes.

Care delivery transformation initiatives, and medical home initiatives in particular, have proliferated in recent years and the evidence base on the impacts of medical home initiatives is expected to expand rapidly in the next few years. Furthermore, there are many other potential sources of information in addition to the peer-reviewed research literature, and it can be difficult to sort out which information is rigorous and reliable enough to inform states' projections of impact.

When considering any type of evidence, states should keep the following questions in mind:

- Does this study come from a neutral, reputable source?
- How applicable are the study results to the state's proposed initiatives? For example, is the study population similar to the proposed population for the state initiative? Is the intervention similar?
- Does the study clearly describe the intervention, the study population, and the analysis methods? Is enough infor-

mation included to back up the study conclusions about impacts of care interventions?

- What efforts do the study authors make to disentangle their observed results for the study population from other possible factors? For example, do they use a control group?
- How clearly do the study authors describe the impacts of the intervention? For example, do they include cost and utilization impacts? Over what period of time do they observe the impacts?
- What are the study limitations? How likely is it that the study findings are applicable to the type of intervention that the state is considering? For example, states might want to be cautious about applying results from a study of a commercially insured population to an intervention that they are planning in their Medicaid program.<sup>25</sup>

---

## RESOURCES FOR BUDGET OFFICERS ON DELIVERY AND PAYMENT REFORM

Under a contract to provide technical assistance to states awarded State Innovation Model (SIM) cooperative agreements through the Center for Medicare & Medicaid Innovation, **SHADAC** recently produced a comprehensive review of existing evidence about the impacts of delivery system interventions, primarily based in ambulatory care. The types of impacts examined include resource use and utilization, cost effectiveness or cost savings, and health care quality and outcomes. This review of research evidence includes four main categories of interventions:

- **Care Continuity:** describes models designed to ensure that patients establish relationships with specific clinicians over time;
- **Care Management Interventions:** include features such as care coordination, managing transitions across care settings and between providers, and patient self-management interventions;
- **Medical Home Models:** include the care management and care continuity features described above but also includes functions such as IT systems to collect and use data for population management, use of evidence-based guidelines for care management, tracking and coordinating of tests, referrals, and care transitions, and use of performance measures for quality improvement, and
- **Traditional Disease Management Interventions:** often payer-based or sponsored (e.g. nurse care line) and may have limited involvement by a patient's own health care providers.





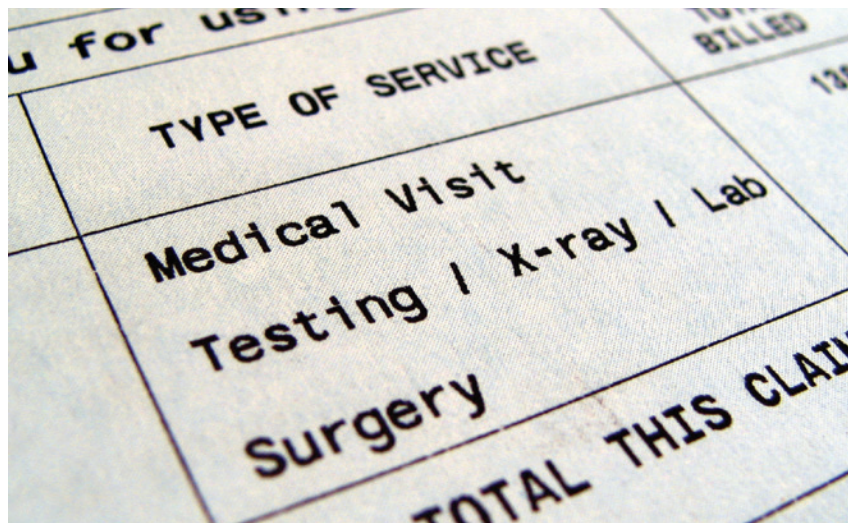
The review primarily relies on evidence from peer-reviewed research studies, although other sources of information were included when they were deemed to be sufficiently well-documented and reliable.<sup>26</sup> Patient-Centered Medical Home (PCMH) programs, initiatives that attempt to enhance health outcomes through team-based, ongoing access to comprehensive primary care services, are gaining momentum and broad support across the country from private payers, the federal government, as well as state and local governments. With funding from the Millbank Memorial Fund, the **Patient-Centered Primary Care Collaborative** recently released a 2012 review of health care cost, acute care service, and quality of care results from evaluations of over 30 public and private-sector PCMH programs across the country. This meta-analysis includes results from peer-reviewed research as well as self-reported data provided by payers, providers, and government agencies that have implemented PCMH programs.<sup>27</sup>

In contrast to care delivery reforms, most of the Medicaid payment reform models that states are pursuing are in their infancy and as such, have not yet generated analyses or research literature demonstrating results. One released by the **Congressional Budget Office** in 2012 summarizes evaluation results for four Medicare demonstration projects that incorporate: (1) pay-for-performance components in which payments to providers are partially based on providers meeting quality and efficiency targets; or (2) bundled payment mechanisms, in which a single, comprehensive payment is defined covering multiple services for a distinct episode of care.<sup>28</sup>

The **National Association of Medicaid Directors (NAMD)** is continually engaging states in shared learning on how Medicaid directors can drive payment and delivery system innovations. NAMD has produced numerous resources that highlight key issues, state activities, and challenges moving forward.<sup>29</sup>

### Selected State Examples

Virtually all states are pursuing some form of change to their payment and delivery systems. Through different delivery and payment approaches, states are also embarking on ways to limit cost increases over a multiyear period through different means. **Arkansas**, for example, is pursuing its Health Care Payment Initiative to improve health outcomes, improve the patient experience, and reduce or control the cost of care.<sup>30</sup> The goal is to adopt a model that integrates two complementary strategies for promoting clinical innovation on a multi-payer basis across the entire state: population-based care and episode-based care. With the state option to expand Medicaid eligibility to 138 percent of poverty under the ACA, Arkansas is also using a private insurance



option whereby federal Medicaid dollars will be used to finance private insurance coverage for the expansion population via state health insurance exchanges.

To address underlying health care cost and quality issues, **New York** is pursuing a Medicaid Redesign Effort to change course and rein in Medicaid spending, while at the same time improve quality.<sup>31</sup> This effort includes the enactment of a global Medicaid spending cap. This cap, which applies to the state share of Medicaid spending and is under the control of the Commissioner of Health, has fundamentally changed how state officials and stakeholders view the program. Every policy change must now be viewed in terms of what, if any, impact it will have on the allocation of finite Medicaid resources. Expenditures are tracked monthly and the figures are posted to the Department of Health web site so the public can observe how the program is performing relative to the spending cap. If spending appears on path to exceed the cap, the Commissioner of Health now has “super powers” to change reimbursement rates and implement utilization controls to rein in spending.

**Oregon** is embarking on a program that aims to change the delivery of health care and control costs.<sup>32</sup> The governor initiated a major overhaul of Medicaid through a Section 1115 waiver that is effective from July 2012 through June 2017. The state will be held accountable for reducing the Medicaid expenditure growth trend while improving quality and access. There are different financing models among provider groups to create coordinated-care organizations (CCOs). The federal government agreed that nontraditional services could be paid for out of that cap, and also attached quality metrics, including hospital readmission rates, avoidable emergency visits, and obesity/diabetes treatment.

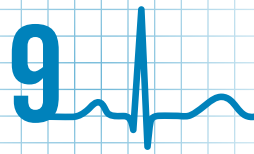
## 8 CONCLUSION



State budget officers recognize that a wave of state health reform initiatives—some required by or authorized under the ACA and others motivated by the need to control costs while improving health care outcomes—is upon us. In most cases, it will take several budget cycles to resolve implementation hurdles and ambiguities, evaluate program performance, and develop findings to inform future reform efforts. One thing is certain: while the roles state budget officers play may continually evolve during this time, their unique contributions to the health care arena will be invaluable. This short paper summarizes the current landscape of state health care reform issue areas, key considerations, and resources that may be of particular interest to state budget officers at this point in time. Over the next several years, staying connected to health and human service policymakers at the state level, federal regulatory developments, state models and best practices, and other resources generated by the broader health policy community will be more important than ever.

# APPENDIX 9

## SUMMARY OF CURRENT RESOURCES FOR BUDGET OFFICERS



### Explaining Health Care Cost Trends

1. Minnesota Health Care Markets Chartbook. MDH Health Economics Program. Available at: <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html>
2. Minnesota Health Care Spending and Projections, 2011. Minnesota Department of Health, Health Economics Program. December 2013. Available at: <http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2013.pdf>
3. Recent reports from Massachusetts' Center for Health Information and Analysis (CHIA) available at: <http://www.mass.gov/chia/>
4. New York State Department of Health, Monthly Global Cap Updates: Available at: [http://www.health.ny.gov/health\\_care/medicaid/regulations/global\\_cap/monthly/index.htm](http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/index.htm)

### Bracing for State Budget Volatility

1. State Refor(u)m is an online network for health reform implementation, connecting state officials and other health reform leaders and stakeholders with their peers, experts, research, and resources. The National Academy of State Health Policy (NASHP) sponsors the site with funding from the Robert Wood Johnson Foundation. <https://www.statereform.org/>
2. Medicaid Expansion: Framing and Planning A Financial Impact Analysis. State Health Reform Assistance Network, a program of The Robert Wood Johnson Foundation. Prepared by: Manatt Health Solutions; Center for Health Care Strategies; State Health Access Data Assistance Center. September 2012. Available at: <http://www.statenetwork.org/resource/medicaid-expansion-framing-and-planning-a-financial-impact-analysis/>
3. Tracking Medicaid Expansion Decisions: A Closer Look at Legislative Activity. State Refor(u)m . Available at: <https://www.statereform.org/node/11675>

4. Medicaid 'Welcome-Mat' Effect Of Affordable Care Act Implementation Could Be Substantial. Sonier, Julie et al. Health Affairs Web First article, June 26, 2013. Available at: <http://content.healthaffairs.org/content/early/2013/06/20/hlthaff.2013.0360>
5. Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared With Current Adult Medicaid Beneficiaries. Chang, Tammy and Davis, Matthew. Annals of Family Medicine, September/October 2013. Available at: <http://www.annfammed.org/content/11/5/406.full>
6. Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials, Benjamin D. Sommers et al. Institute Medicare & Medicaid Research Review 2013: Volume 3, Number 4. Available at: [http://www.cms.gov/mmrr/Downloads/MMRR2013\\_003\\_04\\_a02.pdf](http://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf)

### Monitoring Health Insurance Marketplaces

1. Vermont Health Connect Operating Budget Analysis. Health Management Associations. May 1, 2013. Available at: [https://www.statereform.org/sites/default/files/vt\\_jfo\\_exchange\\_cost\\_assessment\\_5-1-13.pdf](https://www.statereform.org/sites/default/files/vt_jfo_exchange_cost_assessment_5-1-13.pdf)
2. Colorado's draft report and data source summary are available at: [http://www.shadac.org/files/DAWG%20report%20DRAFT\\_Final.pdf](http://www.shadac.org/files/DAWG%20report%20DRAFT_Final.pdf) and [http://www.shadac.org/files/DAWG%20Evaluation%20Metrics%20Report\\_Final%203-7-12.xls](http://www.shadac.org/files/DAWG%20Evaluation%20Metrics%20Report_Final%203-7-12.xls)
3. Maryland's framework and measures are available at: [http://www.shadac.org/files/MD%20Health%20Connection\\_Monitoring%20Measures\\_Dec2012.pdf](http://www.shadac.org/files/MD%20Health%20Connection_Monitoring%20Measures_Dec2012.pdf) and [http://www.shadac.org/files/MD\\_Performance%20Management%20Initial%20Measures%2003.12.13%20for%20Board%20Presentation.pdf](http://www.shadac.org/files/MD_Performance%20Management%20Initial%20Measures%2003.12.13%20for%20Board%20Presentation.pdf)
4. Rhode Island's presentation and plan are available at: [http://www.shadac.org/files/SGC\\_SBM\\_Faulkner.pdf](http://www.shadac.org/files/SGC_SBM_Faulkner.pdf) and [http://www.shadac.org/files/RI\\_Draft\\_Performance%20Measurement%20Plan%20V2.0.pdf](http://www.shadac.org/files/RI_Draft_Performance%20Measurement%20Plan%20V2.0.pdf)

5. Monthly reports available from the U.S. Department of Health and Human Services. Health Insurance Marketplace: January Enrollment Report For the period: October 1, 2013–December 28, 2013. Available at: [http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib\\_2014jan\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf)
2. Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results. Patient-Centered Primary Care Collaborative. 2012. Available at: [http://www.pcpcc.net/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.net/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

### Evaluating Medicaid Managed Care Expansions

1. People with Disabilities and Medicaid Managed Care: Key Issues to Consider. Kaiser Commission on Medicaid and the Uninsured. February 2012. Available at: <http://kff.org/medicaid/issue-brief/people-with-disabilities-and-medicaid-managed-care/>
2. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Kaiser Commission on Medicaid and the Uninsured. April 2013. Available at: <http://kff.org/medicaid/issue-brief/medicaid-long-term-services-and-supports-key-considerations-for-successful-transitions-from-fee-for-service-to-capitated-managed-care-programs/>
3. Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. Congressional Budget Office. June 2013. Available at: [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308\\_DualEligibles.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf)
4. Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. Kaiser Commission on Medicaid and the Uninsured. October 2013. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf>
3. Congressional Budget Office. Lessons from Medicare's Demonstration Projects on Value-Based Payment: Working Paper 2012–02. Available at: <http://www.cbo.gov/publication/42925>
4. Payment and Delivery System Reform in Medicaid: Progress, Challenges, and Opportunities to Move Forward. National Association of Medicaid Directors. February 5, 2013 Available at: [http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/payment\\_and\\_delivery\\_system\\_reform\\_in\\_medicaid\\_-\\_progress\\_challenges\\_and\\_opportunities\\_to\\_move\\_forward.pdf](http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/payment_and_delivery_system_reform_in_medicaid_-_progress_challenges_and_opportunities_to_move_forward.pdf)
5. Arkansas Health System Transformation State Innovation For submission to CMS and CMMI. September 21, 2012. Available at: <http://www.paymentinitiative.org/referenceMaterials/Documents/SIM%20III.%20%20State%20Innovation%20Plan%202012%2009%2021%20%20FINAL%20-%20TO%20SUBMIT.pdf>
6. New York State Department of Health. A Plan to Transform the Empire State's Medicaid Program Better Care, Better Health, Lower Costs. Available at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrtfinalreport.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf)
7. Oregon Health Policy Board. Oregon's Medicaid Demonstration. Available at: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>

### Assessing the Impacts of Care Delivery and Payment Reforms

1. Health Care Utilization and Cost Impacts of Delivery System Innovations: A Review of Evidence. State Health Access Data Assistance Center. October 2013. Please contact Kristin Dybdal at SHADAC (dybda003@umn.edu) for a copy of this report.



# END NOTES 10

1. Kaiser Family Foundation Issue Brief. *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending*. April 22, 2013. See also: Martin, A. et al. "Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged From 2009." *Health Affairs*, 31:1 (2012): 208-219. And Haviland, A. M. et al. "Growth of Consumer-Directed Health Plans To One-Half Of All Employer-Sponsored Insurance Could Save \$57 Billion Annually." *Health Affairs*, 31:5 (2012): 1009-1015.
2. Office of the Actuary, Centers for Medicare & Medicaid Services, US Department of Health & Human Services. *2012 Actuarial Report on the Financial Outlook for Medicaid*. March 2013.
3. MDH Health Economics Program. *Minnesota Health Care Markets Chartbook*. January 2014. Available at: <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html>.
4. Minnesota Department of Health, Health Economics Program. *Minnesota Health Care Spending and Projections, 2011*. December 2013.
5. A link to recent reports from CHIA can be found at: <http://www.mass.gov/chia/>.
6. New York State Department of Health. *Medicaid Monthly Global Cap Updates*. January 2014. Available at: [http://www.health.ny.gov/health\\_care/medicaid/regulations/global\\_cap/monthly/index.htm](http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/index.htm).
7. See <https://www.statereform.org/>.
8. The Robert Wood Johnson Foundation. *Medicaid Expansion: Framing and Planning A Financial Impact Analysis*. State Health Reform Assistance Network. A program prepared by: Manatt Health Solutions; Center for Health Care Strategies; State Health Access Data Assistance Center. September 2012. Available at: <http://www.statenetwork.org/resource/medicaid-expansion-framing-and-planning-a-financial-impact-analysis/>.
9. State Refor(u)m is an online network for health reform implementation, connecting state officials and other health reform leaders and stakeholders with their peers, experts, research, and resources. The National Academy of State Health Policy (NASHP) sponsors the site with funding from the Robert Wood Johnson Foundation.
10. See State Refor(u)m, *Tracking Medicaid Expansion Decisions: A Closer Look at Legislative Activity*. Available at: <https://www.statereform.org/node/11675>.
11. Sonier, Julie et al. "Medicaid 'Welcome-Mat' Effect Of Affordable Care Act Implementation Could Be Substantial." *Health Affairs* Web First article (June 2013). Available at: <http://content.healthaffairs.org/content/early/2013/06/20/hlthaff.2013.0360>.
12. Tammy Chang, MD, MPH, MS and Matthew Davis, MD, MAPP. "Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared With Current Adult Medicaid Beneficiaries." *Annals of Family Medicine*, 11:5 (September/October 2013): 406-41. Available at: <http://www.annfam.org/content/11/5/406.full>.
13. Benjamin D. Sommers, Emily Arntson, Genevieve M. Kenney, Arnold M. Epstein. "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials." *Medicare & Medicaid Research Review*. 3:4 (2013). Available at: [http://www.cms.gov/mmrr/Downloads/MMRR2013\\_003\\_04\\_a02.pdf](http://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf).
14. See Vermont Health Connect Operating Budget Analysis. Health Management Associations (May 1, 2013). Available at: [https://www.statereform.org/sites/default/files/vt\\_jfo\\_exchange\\_cost\\_assessment\\_5-1-13.pdf](https://www.statereform.org/sites/default/files/vt_jfo_exchange_cost_assessment_5-1-13.pdf).
15. Colorado's draft report and data source summary are available at: [http://www.shadac.org/files/DAWG%20report%20DRAFT\\_Final.pdf](http://www.shadac.org/files/DAWG%20report%20DRAFT_Final.pdf) and [http://www.shadac.org/files/DAWG%20Evaluation%20Metrics%20Report\\_Final%203-7-12.xls](http://www.shadac.org/files/DAWG%20Evaluation%20Metrics%20Report_Final%203-7-12.xls).  
  
Maryland's framework and measures are available at: [http://www.shadac.org/files/MD%20Health%20ConnectionMonitoring%20Measures\\_Dec2012.pdf](http://www.shadac.org/files/MD%20Health%20ConnectionMonitoring%20Measures_Dec2012.pdf) and [http://www.shadac.org/files/MD\\_Performance%20Management%20Initial%20Measures%2003.12.13%20for%20Board%20Presentation.pdf](http://www.shadac.org/files/MD_Performance%20Management%20Initial%20Measures%2003.12.13%20for%20Board%20Presentation.pdf).  
  
Rhode Island's presentation and plan are available at: [http://www.shadac.org/files/SGC\\_SBM\\_Faulkner.pdf](http://www.shadac.org/files/SGC_SBM_Faulkner.pdf) and [http://www.shadac.org/files/RI\\_Draft\\_Performance%20Measurement%20Plan%20V2.0.pdf](http://www.shadac.org/files/RI_Draft_Performance%20Measurement%20Plan%20V2.0.pdf).
16. Department of Health & Human Services. *Health Insurance Marketplace: January Enrollment Report*. January 13, 2014. Available at: [http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib\\_2014jan\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf).

17. *Kaiser State Health Facts for 2011—Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees (United States)*. Original data source: Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2012.
18. *MACPAC Report to Congress on Medicaid and CHIP, March 2013*. MACStats on “Total Medicaid Benefit Spending by State and Category, FY 2012.” Here, the Medicaid managed care category is broad, including comprehensive and limited-benefit managed care plans, primary care case management, employer-sponsored premium assistance programs, Programs of All-inclusive Care for the Elderly (PACE), and rebates for drugs provided by managed care plans. Comprehensive plans account for about 90 percent of spending in the managed care category.
19. See, for example, *Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies*. Prepared for America’s Health Insurance Plans. Falls Church (VA): The Lewin Group (2009).
20. Partially adapted from: Kaiser Commission on Medicaid and the Uninsured. *Current and Emerging Issues in Medicaid Risk-Based Managed Care: Insights from an Expert Roundtable*. September 2012. Available at: <http://kff.org/health-reform/issue-brief/current-and-emerging-issues-in-medicaid-risk/>.
21. Kaiser Commission on Medicaid and the Uninsured. *People with Disabilities and Medicaid Managed Care: Key Issues to Consider*. February 2012. Available at: <http://kff.org/medicaid/issue-brief/people-with-disabilities-and-medicaid-managed-care/>.
22. Kaiser Commission on Medicaid and the Uninsured. *Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs*. April 2013. Available at: <http://kff.org/medicaid/issue-brief/medicaid-long-term-services-and-supports-key-considerations-for-successful-transitions-from-fee-for-service-to-capitated-managed-care-programs/>.
23. Kaiser Commission on Medicaid and the Uninsured. *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*. October 2013. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf>.
24. Congressional Budget Office. *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*. June 2013. Available at: [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308\\_DualEligibles.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf).
25. State Health Access Data Assistance Center. *Health Care Utilization and Cost Impacts of Delivery System Innovations: A Review of Evidence*. October 2013.
26. State Health Access Data Assistance Center. *Health Care Utilization and Cost Impacts of Delivery System Innovations: A Review of Evidence*. October 2013.
27. Patient-Centered Primary Care Collaborative. *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results*. 2012. Available at: [http://www.pcpcc.net/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.net/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf).
28. Congressional Budget Office. *Lessons from Medicare’s Demonstration Projects on Value-Based Payment: Working Paper 2012–02*. Available at: <http://www.cbo.gov/publication/42925>.
29. National Association of Medicaid Directors. *Payment and Delivery System Reform in Medicaid: Progress, Challenges, and Opportunities to Move Forward*. February 5, 2013. Available at: [http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/payment\\_and\\_delivery\\_system\\_reform\\_in\\_medicaid\\_-\\_progress\\_challenges\\_and\\_opportunities\\_to\\_move\\_forward.pdf](http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/payment_and_delivery_system_reform_in_medicaid_-_progress_challenges_and_opportunities_to_move_forward.pdf).
30. Arkansas Department of Human Services. *Arkansas Health System Transformation: State Innovation Plan*. September 21, 2012. Available at: <http://www.paymentinitiative.org/referenceMaterials/Documents/SIM%20III.%20%20State%20Innovation%20Plan%202012%2009%2021%20%20FINAL%20-%20TO%20SUBMIT.pdf>.
31. New York State Department of Health. *A Plan to Transform the Empire State’s Medicaid Program: Better Care, Better Health, Lower Costs*. December 13, 2011. Available at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrtfinalreport.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf).
32. Oregon Health Policy Board. *Oregon’s Medicaid Demonstration*. December 2012. Available at: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>.





## **The National Association of State Budget Officers**

**444 N. Capitol Street NW, Suite 642, Washington DC 20001**

**P: 202.624.5382 F: 202.624.7745 E: [nasbo-direct@nasbo.org](mailto:nasbo-direct@nasbo.org) [www.nasbo.org](http://www.nasbo.org)**