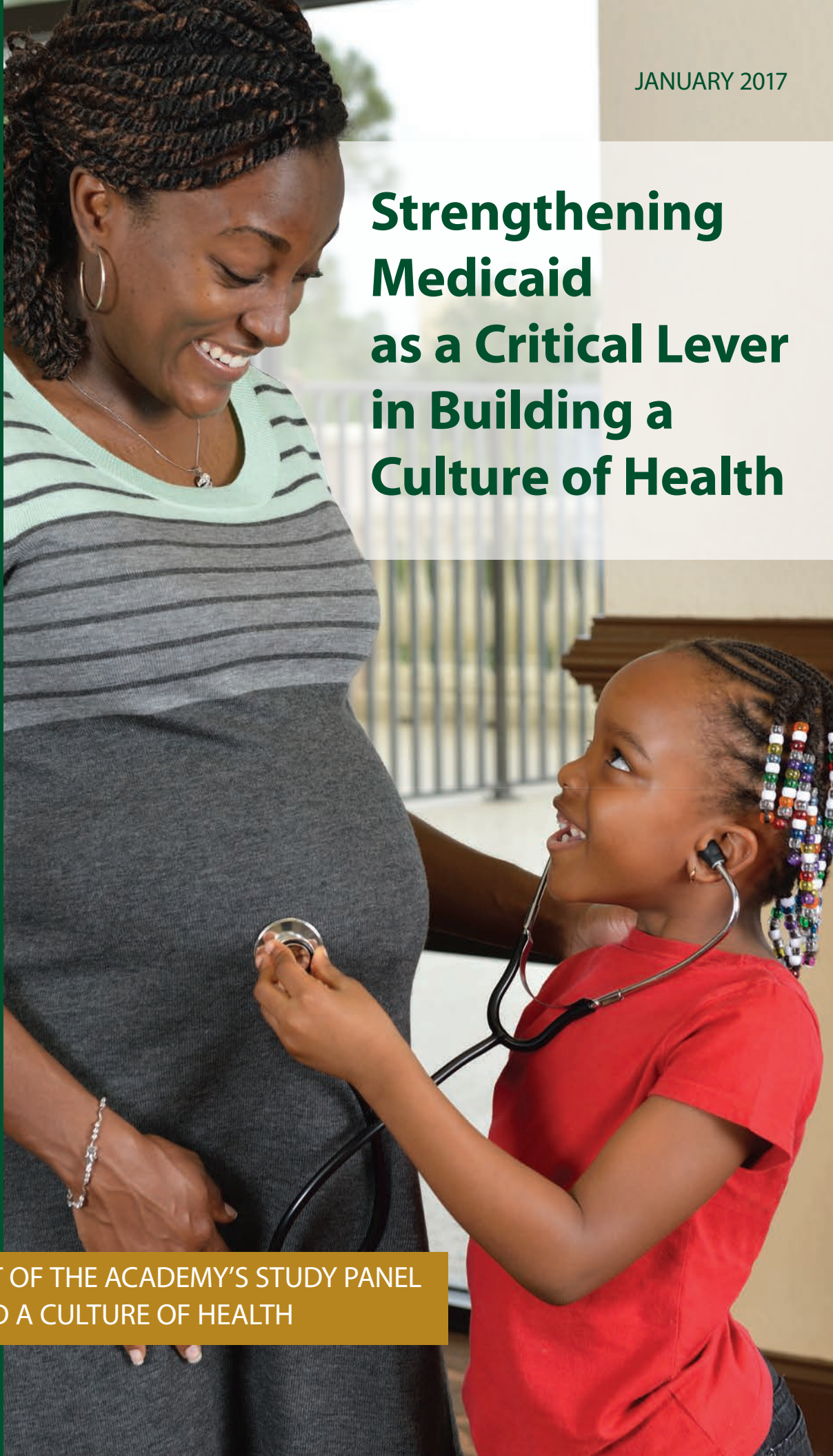


# Strengthening Medicaid as a Critical Lever in Building a Culture of Health

THE FINAL REPORT OF THE ACADEMY'S STUDY PANEL  
ON MEDICAID AND A CULTURE OF HEALTH



# NATIONAL ACADEMY OF • SOCIAL INSURANCE

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JANUARY 2017

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# STUDY PANEL ON MEDICAID AND A CULTURE OF HEALTH

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*The views expressed in this report are those of the study panel members and do not necessarily reflect those of the organizations with which they are affiliated.*





# FOREWORD

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This report was developed through a study panel convened by the National Academy of Social Insurance as part of a project to assess the current and potential future role of Medicaid in building a Culture of Health. The project was funded by the Robert Wood Johnson Foundation (RWJF) as part of its mission to build a Culture of Health in the United States.

The panel met throughout 2016 and produced its draft report prior to the November election. While the election signals new policy discussions about the future of the program and its funding, the analysis and options included here recognize that health care coverage is a critical underpinning for improving health. Whether and how Medicaid might be changed, its role as an insurer is foundational; this report assumes that Medicaid will continue to be central to the health care safety net as an insurer of low-income, vulnerable populations.

Over the past few decades, efforts to improve health in the United States have been focused primarily on the health care system. More recently, leaders from multiple sectors have started to recognize that health can be greatly influenced by complex social factors. But those working to improve health, well-being, and equity still too often find themselves traveling on paths that rarely intersect.

Building a Culture of Health is a national movement, driven by the belief that the nation will make true progress when everyone works together toward a shared goal. RWJF's vision is to see health become a national priority, valued and advanced by collaborators from all sectors. While there is no single definition of a Culture of Health, there are ten principles that help identify progress towards this vision:

1. Good health flourishes across geographic, demographic, and social sectors.
2. Attaining the best health possible is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices.
4. Business, government, individuals, and organizations work together to build healthy communities.
5. No one is excluded.
6. Everyone has access to affordable, quality health care.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. Keeping everyone as healthy as possible guides public and private decision-making.
10. Americans understand that we are all in this together.

The study panel was united in the view that Medicaid has a strong role to play in building in a Culture of Health. Because panel members represented a diverse range of views and professional backgrounds, they sought not to develop a consensus report, but to identify a range of promising strategies and options. Through the opportunities identified in this report, the panel aimed to move Medicaid closer to fulfilling the ten underlying principles of a Culture of Health. The findings and opportunities expressed in this report remain those of the study panel and do not represent an official position of the Academy or its funders.

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# EXECUTIVE SUMMARY

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In February 2016, the National Academy of Social Insurance convened a diverse study panel of experts in health care, health insurance, public health, nutrition, housing, disability policy, child development, and health disparities to examine opportunities to better leverage Medicaid to foster a Culture of Health. The panel explored challenges and opportunities within the context of Medicaid's roles, missions, structure, and impact on the health system.

This report explores the ways in which Medicaid policy might evolve to more actively foster a Culture of Health through both its direct role as a funder of health care and its broader role in helping support services and programs aimed at promoting prevention and population health. It examines how Medicaid can gain traction as a policy lever for aligning clinical care with the types of interventions essential to addressing the social determinants of health. The report discusses both the opportunities for growth and the challenges that may hinder Medicaid's ability to move forward more effectively and efficiently. The panel's report concludes by identifying strategies for strengthening Medicaid as a critical lever in creating a healthy society, providing evidence-based preventive clinical care, facilitating the integration of clinical care and community-based services, and supporting health care providers and institutions that are themselves part of community-wide health improvement efforts.

## The Study Panel's Aims

Five basic aims guided the work of the Study Panel:

1. To strengthen Medicaid as a funder of the type of health care that can begin to move the dial on individual and population health. Good health care is anchored with preventive services that can avert illness and disability, as well as care that can effectively manage physical and mental health conditions to reduce their impact on quality of life.
2. To improve the quality and efficiency of care while improving health outcomes at both the individual and population level, emphasizing high-value care that can promote health.
3. To make Medicaid's value clear – not only to beneficiaries and health care providers, but also to the economy as a whole. Medicaid's value can be measured in the health of both today's workforce and the children who represent the workforce of the future; spending on these populations represents an investment, not simply a cost.
4. To bring value to the Medicaid program itself by helping people get and keep their coverage in order to improve access to continuous health care and using

financial leverage over the health care system to invest in and improve the quality and efficiency of care.

5. To strengthen Medicaid's contribution to a Culture of Health by responding to health conditions created by social circumstances.

### **Medicaid's Roles and Missions**

Medicaid reaches deep into American society. Since its enactment, Medicaid has served as a front-line responder for the country's most vulnerable populations and health problems, from working to reduce infant mortality by transforming care for pregnant mothers and their children, to financing long-term services and supports for individuals with disabilities and the frail elderly. Furthermore, Medicaid's role in the health care system goes beyond whom and what it covers. As the dominant insurer in urban and rural communities experiencing elevated poverty and the associated health risks, Medicaid functions as a key economic engine, anchoring health care services in communities. Medicaid has also been a central player in the public response to community-wide health threats, such as the HIV/AIDS epidemic, the aftermath of the September 11<sup>th</sup> terrorist attacks, Hurricane Katrina, the Zika virus, and the water crisis in Flint, Michigan.

The resilience and flexibility of the Medicaid program have enabled it to take on many roles: promoting healthy births and robust child development that can help children enter school ready to learn and perform to their level of ability; improving the odds that teenagers will emerge from school as healthy young adults ready for higher education and workforce entry; expanding opportunities for people with disabilities to reach their full potential; enabling the elderly to maximize their independence and health; promoting compassionate end-of-life care; and improving prospects for social and community reintegration by ensuring that people who are incarcerated are insured when they are released.

### **Medicaid's Role in Building a Culture of Health**

Medicaid has proven its resilience and utility time and again over the years as a significant tool for improving health by paying for necessary and appropriate clinical treatment and care, from pregnancy and birth through the course of life. For two principal reasons, this is an especially important time to focus on ways to further strengthen Medicaid's role in promoting a Culture of Health.

First, Medicaid's importance as a source of health insurance has grown significantly, not only as a result of the expansions made possible under the Affordable Care Act, but also as a result of recent economic, social, and demographic trends that collectively have contributed to a large and growing population of children and adults who are low-income, medically vulnerable, or both. With Medicaid's expanding size comes a growing potential to influence the future direction of health care, particularly for certain

types of care – such as maternity and pediatric care, services for people with serious behavioral health conditions, and long-term services and supports – in which Medicaid is a dominant player. As Medicaid grows, a critical health policy priority becomes how to efficiently meet the vast array of health needs that the program is designed to address using strategies that complement other efforts to improve population health.

Second, policymakers, program administrators, and health care providers themselves have begun to place an increasing emphasis on using health care as a critical entry point for addressing underlying social determinants of health. These efforts reflect the growing recognition of the extent to which social determinants – the conditions in which people are born, grow, work, live, and age – contribute to population health and well-being. Those most vulnerable to health risks, illness, and injury are also those most likely to depend on Medicaid. One key idea to emerge as part of this increased focus in health on the role played by social and economic factors is the value of better integrating health care and social services.

In its efforts to leverage community assets, Medicaid can use its dominant role as a health funder to move the health care system in two basic directions. First, Medicaid can place greater emphasis on preventive services – both those that can avert threats to health, and those that can alleviate the severity of existing physical and behavioral health conditions. Second, Medicaid can use its power as a health care funder to encourage the development of health care entities that both deliver and coordinate a fuller spectrum of health, educational, nutritional, and social services, as well as to embed clinical care access into community settings such as schools, homeless shelters, and public housing programs.

In several respects, the ACA further enhances Medicaid's potential as a policy lever toward a Culture of Health. First, by offering highly enhanced federal funding to states that expand eligibility to include all non-elderly, low-income adults who are citizens or long-term legal residents, the ACA makes it possible to connect some of the poorest and most medically underserved Americans to health care. Because coverage of the poor is associated with the reduction of preventable mortality, this reform alone can be expected to result in long-term health improvements. Furthermore, considerable research has associated expanded Medicaid coverage with a greater likelihood of having a regular source of health care, decreased likelihood of having unmet medical care and prescription drug needs, reduction in personal bankruptcies and household debt, improved financial well-being, and potentially other positive effects on well-being. As eligibility increases, Medicaid's ability to influence the quality, effectiveness, and efficiency of health care also grows, especially for underserved populations.

### **Key Challenges Facing Medicaid**

In positioning Medicaid to more decisively reshape the ways in which health insurance coverage and health care delivery can advance a Culture of Health, several major

challenges emerge. Some of these challenges confront health insurance and health care generally. Some are unique to Medicaid; these unique challenges arise from the range and scope of the coverage and payment responsibilities that Medicaid has assumed over time as a result of its flexible structure and financing.

- **Poverty and an aging population:** Medicaid is the nation's leading health coverage for low-income individuals and families, and poverty is associated with a cascade of health risks that present significant challenges to securing adequate health care and maintaining optimal health.
- **The cost of transformation:** With federal support, states can introduce reforms to support system transformation initiatives; yet, even with relatively generous levels of funding, states bear a heavy burden under Medicaid with respect to the up-front capital investment necessary to develop, implement, and evaluate transformation programs.
- **The complexity of the transformation and modernization process:** Challenges for states attempting to make transformations to their Medicaid program remain, including the arduous and lengthy task of obtaining waiver or demonstration approval to support change, the high turnover in leadership and short budget windows for proving the effectiveness of a transformation effort, and the difficulty of modernizing Medicaid policy and management practices.
- **Securing the social services that promote health:** Inadequate funding for the types of social service interventions that can help lift the health of the population poses a substantial problem. Medicaid is health insurance, and despite the program's broad reach, there are limits to which health-promoting interventions can be characterized as a covered service. Medicaid cannot go it alone, but rather must be an active partner in breaking down silos and supporting clinical-community linkages.
- **Achieving equity in eligibility and promoting continuity of coverage:** To date, 19 states have not expanded Medicaid eligibility to low-income adults, leaving these individuals without affordable access to any kind of coverage. Even in states that adopt Medicaid expansion, challenges remain with enrollment and renewal practices, outreach efforts to promote continuous enrollment, and coverage for most people who are not long-term U.S. residents or who are not lawfully present in the U.S.
- **A fragmented health care infrastructure:** Although reforms have been made, the currently fragmented data infrastructure and care delivery systems often force health care providers to operate in silos, particularly where integration of physical and behavioral health care is concerned.
- **Misallocation of risks and rewards:** State Medicaid investments in improving health may require capital and entail risk. The absence of a means for generating

shared savings that could flow from broader social and health gains in turn limits the incentive to provide Medicaid programs with the financial flexibility to invest in improvements.

## **Opportunities for Better Leveraging Medicaid to Foster a Culture of Health**

In order to sustain and expand the progress made to date while overcoming the challenges outlined above, a number of options emerge. Some of these options would allow states to make more effective use of program flexibility already built into federal law. Some entail augmenting the flexibility already built into federal law. Other options may entail further legislative reforms that build on fundamental directional shifts already evident in the Medicaid statute in regards to eligibility, benefits and coverage, health care delivery, and program administration.

### **Administrative options**

#### **System transformation, quality improvement, and payment reform**

- A1. Develop health improvement demonstrations that employ a longer-term savings time frame, focus on the social determinants of health, recognize health related expenditures as qualified for federal funding, and count a broader range of estimated cost offsets when calculating budget neutrality.
- A2. Develop a fast-track approval process, a clear implementation roadmap, and a series of definable outcome measures for promising service delivery transformation models.
- A3. Better align federal health, nutrition, housing, and social support eligibility, benefit, and expenditure policies to enable coordination with Medicaid coverage and system transformation efforts in order to extend the reach of programs and ensure that people are connected to the full range of assistance needed to improve health.
- A4. Restructure Medicaid payment policies to improve access to behavioral health services.
- A5. Improve data sharing between physical health, mental health, and substance use disorder services and providers to enhance care coordination.
- A6. Modernize and update Medicaid's role in improving the health of children.
- A7. Strengthen access standards for individuals whose primary language is not English who require language services and people with disabilities who experience challenges in communication.
- A8. Develop and disseminate information on best practices in coverage of comprehensive preventive and primary care for adults.



- A9. Disseminate social determinants screening tools for utilization in managed care and integrated delivery systems and adopt payment methods that foster comprehensive care and the integration of health and social services.
- A10. Develop safety net health care payment reform models that promote access, quality, efficiency, and a Culture of Health.
- A11. Include consultation with state Medicaid and public health agencies as an express requirement for tax-exempt hospitals in developing community health needs assessments under the Internal Revenue Code.
- A12. Make Medicaid an equal priority to Medicare for the Center for Medicare and Medicaid Innovation (CMMI), with special emphasis on pilots aimed at health improvement and prevention.

## **Legislative options**

### **Eligibility and enrollment**

- L1. Create a state option to enable stabilization of Medicaid enrollment over time for adults.
- L2. Permit states to eliminate waiting periods for all legal residents.
- L3. Make three years of 100 percent federal financing available to all states that expand Medicaid, regardless of when they begin.

### **Benefits and coverage**

- L4. Increase the federal financial incentive to expand preventive services to the traditional adult population.
- L5. Expand the definition of preventive services to incorporate interventions aimed at patient groups that include Medicaid beneficiaries.

### **System transformation, quality improvement, and payment reform**

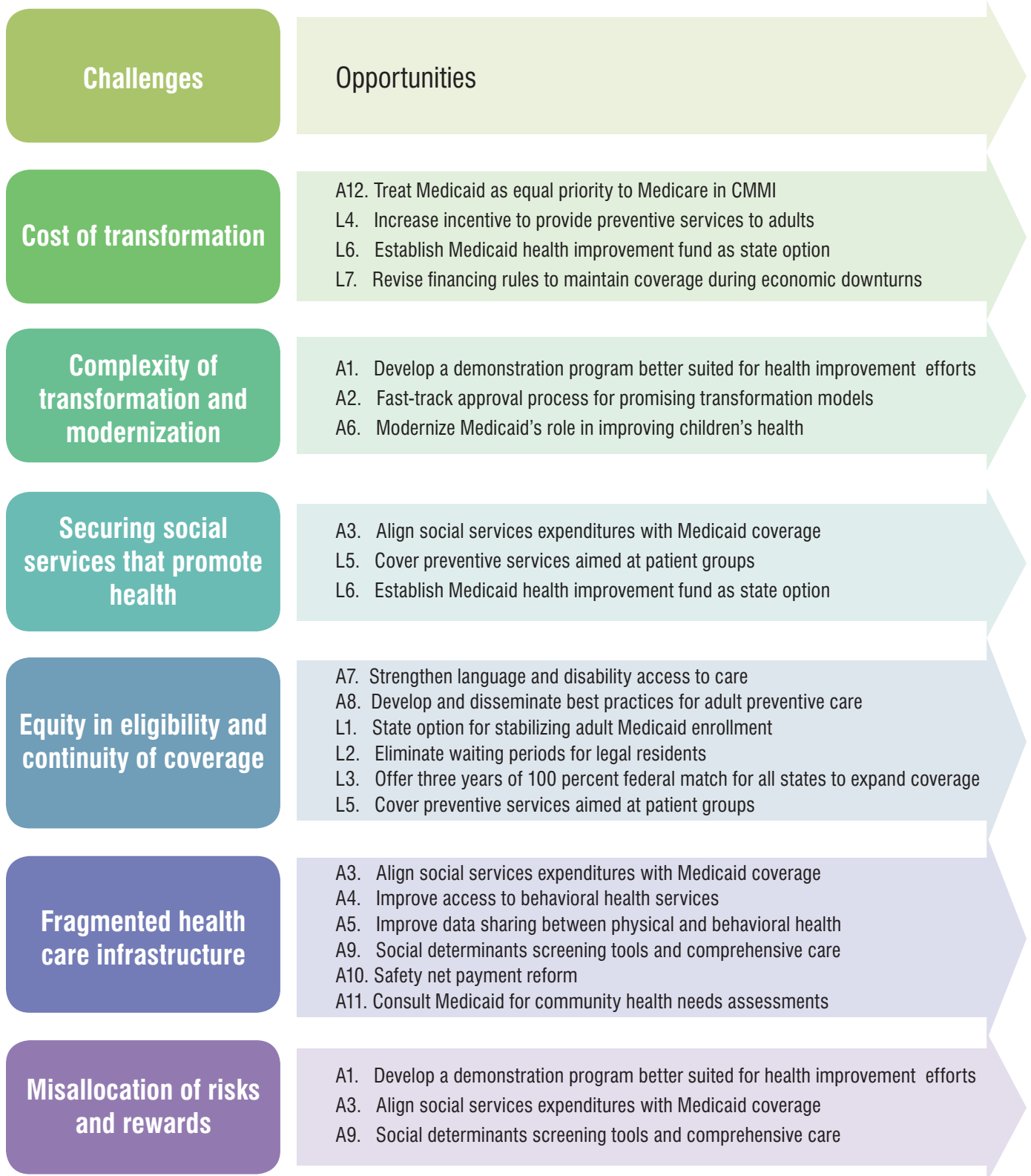
- L6. Establish a Medicaid health improvement fund as a state option.

### **Strengthening Medicaid performance during economic downturns, when community health needs are greatest**

- L7. Support Medicaid's capacity to maintain coverage during economic downturns by revising federal Medicaid financing rules

Study panel members note that along with continued exploration of ways Medicaid can be further strengthened as a tool for improving health, attention must focus on ways to ensure the preservation of Medicaid's core mission as the largest source of public health insurance, in a manner that respects the need for budgetary limits and efficient program management.

**Figure 1.**  
**Better Leveraging Medicaid to Foster a Culture of Health: Challenges and Opportunities**





# INTRODUCTION

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A core element of building healthy communities is ensuring access to affordable, high-quality health care. To that end, no form of health insurance merits greater policy focus than Medicaid, America's largest public health insurance program. Medicaid's role is essential to the proper functioning of the American health care system. Like private insurance, Medicaid guarantees coverage for the people who meet its eligibility criteria. But unlike private insurance, Medicaid is structured to address the health needs of especially vulnerable populations, while also allowing states to tailor the program to respond to underlying economic, demographic, and population health trends.

Medicaid is known for its size and scope. However, the program also has a flexible structure that makes it unique compared to other sources of coverage. Medicaid operates as health insurance, entitling those who meet its conditions of eligibility to a range of covered benefits and services. But within this insurance framework, Medicaid is also built to act as a more nimble player than traditional health insurance, and as a partner in broader efforts to address population health. This special structure is central to the multiple, special missions Medicaid is designed to fulfill: insurance for the poorest populations, coverage for the range of long-term services and supports essential to the ability of aging seniors and individuals with disabilities to live in the community, and a "first responder" that can rapidly accommodate itself to major health threats – whether naturally-occurring or man-made. Furthermore, given the populations whose health needs Medicaid is designed to address, state Medicaid agencies are accustomed to working in partnership with other agencies and programs whose focus is also on vulnerable populations and who furnish educational, nutrition, housing, and social services.

Medicaid's role in the health care system goes beyond whom and what it covers. As the dominant insurer in urban and rural communities experiencing elevated poverty and the health risks with which poverty is associated, Medicaid functions as a key economic engine, providing access to health care services in communities that would otherwise struggle with pervasively high rates of uninsurance among community members.<sup>1,2</sup> Medicaid's unique ability to support health care institutions operating in underserved communities, coupled with its broad population health mission, underscore its ability to exert a powerful influence on health that reaches well beyond its immediate role as an insurer.

This report focuses on how Medicaid's effectiveness as an insurer and partner in broader health efforts could be strengthened through a series of policy reforms. The

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1 Institute of Medicine: Committee on the Consequences of Uninsurance (2003). *A Shared Destiny: Community Effects of Uninsurance*. Washington, DC: National Academies Press. <http://nationalacademies.org/hmd/reports/2003/a-shared-destiny-community-effects-of-uninsurance.aspx>.

2 Benjamin D. Sommers, Katherine Baicker, & Arnold M. Epstein (2012). Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 367,1025-1034. <http://www.nejm.org/doi/pdf/10.1056/NEJMs1202099>.

issues addressed in this report go beyond simply expanding eligibility, although access to coverage is a vital first step. Using the Robert Wood Johnson Foundation's Culture of Health as the touchstone, this report focuses on steps that policymakers might take – in terms of both administrative and legislative reforms – to build on Medicaid's foundational structure and increase its ability to operate more effectively alongside and in greater harmony with education, employment, and social services programs that can enhance health.

The Robert Wood Johnson Foundation's Culture of Health framework offers an important lens through which to consider Medicaid reforms. This framework lays out the core elements of a Culture of Health, identifying ten factors that characterize a society committed to the health of all members:

1. Good health flourishes across geographic, demographic, and social sectors.
2. Attaining the best health possible is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices.
4. Business, government, individuals, and organizations work together to build healthy communities.
5. No one is excluded.
6. Everyone has access to affordable, quality health care.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. Keeping everyone as healthy as possible guides public and private decision-making.
10. Americans understand that we are all in this together.

Taken together, these elements provide a conceptual strategy for efforts to reshape current social welfare programs. A Medicaid reform strategy guided by Culture of Health principles would emphasize structural and operational changes that promote health, rather than simply treating illness and disability; build community engagement across social and economic sectors, underscoring the social value of Medicaid reform; create a pathway to affordable and equitable care for all who could qualify for Medicaid's assistance; and emphasize investments that reduce the social and economic burdens of unnecessary health care spending.

A Medicaid reform strategy that is guided by these principles may require greater outlays, at least in the short term. But the long-term yield of taking fuller advantage of

Medicaid's capacity to improve health is great; these gains ultimately can and should be measured not only in terms of reduced health care spending on intensive health care needs, but also on a lessening need for a vast array of educational, social, justice-involved, and community interventions that are too often the consequence of health conditions that could be prevented or whose impact could be lessened.

The options identified in this report reflect a series of discussions with experts in health care, health insurance, public health, nutrition, housing, disability and aging, child development, and health disparities. For readers who may not be fully familiar with the program's intricacies, an extensive description of Medicaid's structure can be found in Appendix A. The report examines Medicaid's role in building a Culture of Health, placing particular attention on how Medicaid can gain traction as a policy lever for aligning clinical care with the types of interventions essential to addressing the social determinants of health. The report discusses both the opportunities for growth and the challenges that may hinder Medicaid's ability to move forward more effectively and efficiently. It concludes by identifying strategies for strengthening Medicaid as a critical lever in creating a healthy society, providing evidence-based preventive clinical care, facilitating integration of clinical care and community-based services, and supporting health care providers and institutions that are themselves part of community-wide health improvement efforts.



## THE STUDY PANEL'S AIMS

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In producing this report, the Study Panel has been guided by five aims:

1. To strengthen Medicaid as a funder of the type of health care that can begin to move the dial on individual and population health. Beginning during the pre-natal period, to birth and childhood, and continuing onward throughout the life course, access to good health care is an intrinsic element of overall health. Good health care is anchored with preventive services that can avert illness and disability, as well as care that can effectively manage physical and mental health conditions to reduce their impact on quality of life.
2. To improve the quality and efficiency of care while improving health outcomes at both the individual and population level. This means emphasizing high-value care that can promote health and keep people healthy, such as providing comprehensive care for pregnant women and infants and services that optimize health during childhood, fostering a generation of healthy young adults ready to begin higher education or enter the workforce, enabling the elderly to maximize their independence and health, and facilitating community engagement and integration for people with significant disabilities.
3. To make Medicaid's value clear – not only to the tens of millions of beneficiaries it serves and to the health care providers whose community presence is sustained by the program, but also to the economy as a whole. Medicaid's value is reflected in the crucial financial support its funding brings to thousands of hospitals, health centers, medical practices, pharmacies, and other health care providers that anchor poor communities. Its value can also be measured in the health of both today's workforce and the children who represent the workforce of the future; spending on these populations represents an investment, not simply a cost. Similarly, maintaining the health of aging seniors brings value through ongoing engagement and avoidance of higher-cost health care spending. Simply put, Medicaid enables investment in prevention, which can save money in the long term through services such as appropriate care during pregnancy (estimated to save \$3.00 for every dollar spent)<sup>3</sup> and the full immunization of children (estimated to save \$5.30 in direct medical costs and \$16.50 in societal costs for every dollar spent).<sup>4</sup>

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3 E.A. Reece, G. Lequizamon, J. Silva, V. Whiteman, & D. Smith (2002). Intensive interventional maternity care reduces infant morbidity and hospital costs. *The Journal of Maternal-Fetal & Neonatal Medicine*, 11(3), 204-210. <http://www.ncbi.nlm.nih.gov/pubmed/12380679>.

4 Fangjun Zhou, Jeanne Santoli, Mark L. Messonnier, Hussain R. Yusuf, Abigail Shefer, Susan Y. Chu, Lance Rodewald, & Rafael Harpaz (2005). Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. *Arch Pediatr Adolesc Med*, 159(12), 1136-1144. <http://archpedi.jamanetwork.com/article.aspx?articleid=486191>.



4. To bring value to the Medicaid program itself. This means helping people get and keep their coverage in order to improve access to continuous health care, which is associated with better health outcomes. It also means using Medicaid's potential financial leverage over the health care system to invest in and improve the quality and efficiency of care.
5. To strengthen Medicaid's contribution to a Culture of Health by improving its capacity to mitigate the consequences of social conditions that can impair health.



## MEDICAID'S ROLES AND MISSIONS

***In 2016, Medicaid and CHIP insured over 73 million Americans. Together, Medicaid and CHIP finance nearly half (48 percent) of all births and health care for more than 1 in 3 children.***

Medicaid reaches deep into American society. In 2016, Medicaid and its companion Children's Health Insurance Program (CHIP) insured over 73 million Americans.<sup>5</sup> Together, Medicaid and CHIP finance nearly half (48 percent) of all births<sup>6</sup> and health care for more than one in three children.<sup>7</sup> Over 27 million working-age adults depend on Medicaid, as do 6.3 million elderly people and nearly one million children and adults with disabilities.<sup>8</sup> Medicaid accounts for 51 percent of spending on long-term services and supports,<sup>9</sup> 75 percent of public funding for family planning services,<sup>10</sup> and nearly 3 in 10 dollars spent on mental health treatment.<sup>11</sup>

Funded jointly by the state and federal governments and administered by states under broad federal requirements, Medicaid is a highly complex program that has been steadily transformed over the past half century into a major component of U.S. health care policy. This transformation has come in response to a host of shifting social and economic circumstances. One such change has been the steady erosion of employer-sponsored insurance for low-wage workers and their families, which in turn has necessitated an alternative pathway to coverage.<sup>12</sup> The need for health care coverage is also significant for those experiencing unemployment, the struggle of responding to family caregiving needs, and disabilities that prevent work. Since its enactment, Medicaid has served as a front-line responder to the problem of infant mortality, transforming care for pregnancy, delivery, and newborns for millions of families. Through its comprehensive coverage principles and its ability to support services in community settings, such as home visiting programs, Medicaid represents the single most important source of health care financing for the health conditions found among children who experience adverse childhood experiences (ACEs) – potentially traumatic childhood experiences that can have a long-lasting negative impact on health and well-being.<sup>13</sup>

5 Centers for Medicare and Medicaid Services (2016). Medicaid & CHIP: August 2016 Monthly Applications, Eligibility Determinations and Enrollment Report. <https://www.medicaid.gov/medicaid/program-information/downloads/august-2016-enrollment-report.pdf>.

6 Anne R. Markus, Ellie Andres, Kristina D. West, Nicole Garro, & Cynthia Pellegrini (2013). Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform. *Women's Health Issues*, 23(5), e273-e280. [http://www.whijournal.com/article/S1049-3867\(13\)00055-8/pdf](http://www.whijournal.com/article/S1049-3867(13)00055-8/pdf).

7 Secretary Sylvia Mathews Burwell (2014). 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP. The Department of Health and Human Services. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf>.

8 U.S. Department of Health and Human Services (2014). 2014 CMS Statistics. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2014\\_final.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf).

9 Erica L. Reaves & MaryBeth Musumeci (2015). Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

10 Adam Sonfield & Rachel Benson Gold (2012). Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980 – 2010. New York: Guttmacher Institute. [https://www.guttmacher.org/sites/default/files/report\\_pdf/public-funding-fp-2010.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-fp-2010.pdf).

11 Substance Abuse and Mental Health Services Administration (2014). Projections of National Expenditures for Treatment of Mental and Substance Use Disorders: 2010-2020. <http://store.samhsa.gov/shin/content/SMA14-4883/SMA14-4883.pdf>.

12 Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2014 (April to April). <http://kff.org/slideshow/recent-trends-in-employer-sponsored-insurance/>.

13 Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, & James S. Marks (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14, 245–258.

Medicaid was also shaped by the same social welfare concerns and human rights imperatives that led to the enactment and enforcement of the Americans with Disabilities Act, and as a result, has transitioned from serving merely as the principal payer of long-term institutional care to a central player in progressing the right of persons with disabilities to receive care and treatment in the most integrated setting appropriate to their individual needs.<sup>14</sup> In so doing, Medicaid is undergoing a fundamental shift away from prioritizing care in institutions to becoming the mechanism by which home and community-based care is financed.<sup>15</sup>

In taking on all of these missions, Medicaid has remained remarkably agile. Giving Medicaid the ability to carry out all of these missions has involved countless federal amendments over a half century. It has also required an extraordinary effort on the part of states to continually restructure their programs to meet the needs of their populations and test innovations in coverage, payment, and care. Furthermore, Medicaid's evolution rests on enduring federal/state partnerships, vital advocacy work by consumers and health care providers, and guidance from public health and social welfare experts.

### **Box 1. Who Depends on Medicaid? Mandatory and Optional Eligibility Groups for Which Federal Funding is Available**

#### **All States Must Cover:**

- Low-income children and their parents
- Low-income pregnant women
- Children in foster care
- Elderly and disabled SSI beneficiaries
- Qualified Medicare beneficiaries
- Qualified working individuals with disabilities

#### **States Have the Option of Covering:**

- Low-income, non-parent adults under age 65
- Individuals receiving home and community-based supports
- Medically needy children and adults, pregnant women, parents, and individuals with disabilities
- Low-income individuals above federal thresholds but under higher state thresholds

<sup>14</sup> *Olmstead v L.C.*, by Zimring, 527 U.S. 581 (1999).

<sup>15</sup> Erica L. Reaves & MaryBeth Musumeci (2015). Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

The goal of further strengthening Medicaid’s role as a critical lever in building a Culture of Health takes many different forms: promoting healthy births and robust child development that can help children enter school ready to learn and perform to their



highest level of ability; improving the odds that teenagers will emerge from school as healthy young adults ready for higher education and workforce entry; expanding opportunities for people with disabilities to reach their full potential; enabling the elderly to maximize their independence and health; promoting compassionate end-of-life care; and improving prospects for social and community reintegration by ensuring that people who are incarcerated are insured when they are released. Medicaid has become foundational to the recovery effort following community-wide threats, whether from natural disasters such as the HIV/AIDS epidemic, Hurricane Katrina, or the Zika virus, or from such man-made disasters as the World Trade Center attacks or the water crisis in Flint, Michigan.<sup>16</sup>

As Medicaid moves forward, two parallel and fundamental policy imperatives emerge. First, how can Medicaid be further strengthened as a tool for improving health? Second, how can this goal be accomplished while simultaneously preserving the program’s core mission as the largest source of public health insurance, in a manner that respects the need for budgetary limits and efficient program management?

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<sup>16</sup> Sara Rosenbaum (2016). Caring for Flint: Medicaid’s Enduring Role in Public Health Crises. The Commonwealth Fund. <http://www.commonwealthfund.org/publications/blog/2016/feb/caring-for-flint>.

# MEDICAID'S ROLE IN BUILDING A CULTURE OF HEALTH

Medicaid has proven its resilience and utility time and again over the years as a significant tool for improving health by paying for necessary and appropriate clinical treatment and care, from pregnancy and birth through the course of life. For two principal reasons, this is an especially important time to focus on ways to further strengthen Medicaid's role in promoting a Culture of Health.

First, Medicaid's importance as a source of health insurance has grown significantly, not only as a result of the expansions made possible under the Affordable Care Act, but also as a result of recent economic, social, and demographic trends that collectively have contributed to a large and growing population of children and adults who are low-income, medically vulnerable, or both.<sup>17</sup> With Medicaid's expanding size comes a growing potential to influence the future direction of health care, particularly for certain types of care – such as maternity and pediatric care, services for people with serious behavioral health conditions, and long-term services and supports – in which Medicaid is a dominant player. As Medicaid grows, a critical health policy priority becomes how to efficiently meet the vast array of health needs that the program is designed to address using strategies that complement other efforts to improve population health.

Second, policymakers, program administrators, and health care providers themselves have begun to place an increasing emphasis on using health care as a critical entry point for addressing underlying social determinants of health (see Box 2). These efforts reflect the growing recognition of the extent to which social determinants – the conditions in which people are born, grow, work, live, and age – contribute to population health and well-being.<sup>18</sup> Social, environmental, and behavioral factors are estimated to account for about 60 percent of all preventable deaths in the U.S.<sup>19</sup> Those most vulnerable to health risks, illness, and injury are also those most likely to depend on Medicaid. One key idea to emerge as part of this increased focus on the role played by social and economic factors – such as income security, education, housing, transportation, food security, a clean environment, and community safety – is the value of better integrating health care and social services.



17 Cindy Mann & Deborah Bachrach (2015). Medicaid as Health Insurer: Evolution and Implications. The Commonwealth Fund. <http://www.commonwealthfund.org/publications/blog/2015/jul/medicaid-as-health-insurer>.

18 Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

19 JM McGinnis & WH Foege (1993). Actual Causes of Death in the United States. *JAMA*, 270, 2207-2212.



## Box 2. What are Social Determinants of Health?

Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. According to the World Health Organization, the main categories of social determinants are: material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself.

Material circumstances include factors such as housing and neighborhood quality, consumption potential (e.g. the financial means to buy healthy food, warm clothing, etc.), and the physical work environment.

Psychosocial circumstances include psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles (or the lack thereof).

Behavioral and biological factors include nutrition, physical activity, tobacco consumption, and alcohol consumption, which are distributed differently among different social groups. Biological factors also include genetic factors.<sup>20</sup>

***How Medicaid as an insurer aligns its coverage and payment policies with these broader efforts to enhance community-wide social interventions – such as covering clinical care offered in supportive housing satellite locations, nursing and health counseling services in high-poverty schools, or connecting patients to federal nutrition programs – thus becomes a key issue.***

In communities with concentrated poverty and food insecurity, and their attendant health risks, there is an even greater justification for community-wide interventions that can change living circumstances to promote health. How Medicaid as an insurer aligns its coverage and payment policies with these broader efforts to enhance community-wide social interventions – such as covering clinical care offered in supportive housing satellite locations, nursing and health counseling services in high-poverty schools, or connecting patients to federal nutrition programs – thus becomes a key issue. Directly paying for services and infrastructure, such as affordable housing, public transportation, and quality child care, is largely beyond the scope of Medicaid. But Medicaid, as an insurer, can support a broad array of clinical and preventive services furnished in embedded community settings.

Enhancing Medicaid's ability to act as a central partner in fostering connections to the wide array of services that communities need will be a critical step forward. Patient-Centered Medical Homes (PCMHs), for instance, are providing additional payments to certified primary care practices to perform functions such as chronic disease management and prevention, care coordination, and health promotion, which are not typically incentivized in a fee for-service payment structure. There are 24 states

<sup>20</sup> World Health Organization (2010). A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion: Paper 2 (Policy and Practice). [http://www.who.int/sdhconference/resources/Conceptualframework-foractiononSDH\\_eng.pdf](http://www.who.int/sdhconference/resources/Conceptualframework-foractiononSDH_eng.pdf).

with active Medicaid payments to medical homes underway.<sup>21</sup> In this strengthened relationship, Medicaid – by virtue of its size, scope, and penetration into communities – effectively becomes a central policy lever for fashioning an approach to health care in which delivery systems marshal a wide range of services and sources of funding to improve patient and population health.

### **Box 3. Fostering a New Generation of Integrated Health and Social Services Delivery**

**Minnesota** is creating locally-based teams that coordinate health and social services for Medicaid beneficiaries. These teams aim to improve the overall health of communities through the delivery of person-centered, coordinated care that addresses clinical and social needs. They foster community-clinical linkages to improve patient care and develop a population-based prevention plan specific to their communities. A key feature of the Minnesota model is its unique alignment with the health care delivery system; the state requires each team to partner with an accountable care organization (ACO).<sup>22</sup>

**Texas'** Wellness Incentives and Navigation (WIN) program fosters partnership between Medicaid and the state's various mental health and substance use disorder agencies to improve health self-management, use of preventive services, and reduce chronic disease.<sup>23</sup>

**New York** is investing state-only Medicaid dollars to promote supportive housing services for beneficiaries with unstable housing situations. The Supportive Housing Initiative is used to provide rental subsidies and service funds to assist high-cost Medicaid members in securing housing.<sup>24</sup>

**Louisiana** is currently implementing a 1915(c) home and community-based services waiver providing housing supports for seniors and individuals with disabilities. Social services covered under the waiver include adult day care, caregiver support, home-delivered meals, housing stabilization, housing transition or crisis intervention, monitored in-home caregiving, non-medical transportation, and transition services.<sup>25</sup>

**Vermont** coordinates the resources of social service agencies, community health providers, and non-profit housing organizations to support aging individuals and those with special needs who choose to live independently at home.<sup>26</sup>

21 National Academy for State Health Policy (2015). State Delivery System and Payment Reform Map. <http://nashp.org/state-delivery-system-payment-reform-map/>.

22 Health Reform Minnesota. Accountable Communities for Health. [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_ACH](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACH).

23 Centers for Medicare and Medicaid Services. MIPCD State Summary: Texas. <https://innovation.cms.gov/files/x/mipcd-tx.pdf>.

24 New York State Department of Health. Supportive Housing Initiatives. [https://www.health.ny.gov/health\\_care/medicaid/redesign/supportive\\_housing\\_initiatives.htm](https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm).

25 Department of Health and Hospitals: Aging and Adult Services (2015). Community Choices Waiver. [http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/CCW\\_Fact\\_Sheet.pdf](http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/CCW_Fact_Sheet.pdf).

26 For more information, see: <http://sashvt.org/learn/>.



In its efforts to leverage community assets, Medicaid can use its dominant role as a health funder to move the health care system in two basic directions. First, Medicaid can place greater emphasis on preventive services – both those that can avert threats to health, as well as those that can alleviate the cost and severity of physical and behavioral health conditions that already exist. Second, Medicaid can use its power as a health care funder in order to encourage the development of health care entities that both deliver and coordinate a fuller spectrum of health, educational, nutritional, and social services, as well as promoting entities that embed clinical care access into community settings such as schools, homeless shelters, and public housing programs.<sup>27</sup> This second goal may be furthered through incentivizing payment models for integrated care entities that are financed through a diverse array of sources. For example, ten states have launched Medicaid Accountable Care Organizations (ACOs), taking initial steps to integrate social services and supports with health care to improve care coordination and delivery, keep patients healthy, and manage costs.<sup>28</sup>

#### Box 4. Improving Primary Health Care

The ACA increases support and incentives for innovative forms of primary care that offer prevention and health promotion services and better integrate and coordinate services.

Health homes are a state plan option that authorize federal financing with time-limited, enhanced federal participation, for the development of “health home” entities that support the creation of more comprehensive, team-based primary care models for patients with chronic disease, including health promotion and referral to community and social support services among other core services.<sup>29</sup> There are 22 states with active Medicaid payments to health homes underway.<sup>30</sup>

In several respects, the ACA further enhances Medicaid’s potential as a policy lever toward a Culture of Health. First, the ACA offers highly enhanced federal funding to states that expand eligibility to include all non-elderly, low-income adults who are citizens or long-term legal residents, making it possible to connect some of the poorest and most medically underserved Americans to health care. Because coverage of the poor is associated with the reduction of preventable mortality,<sup>31</sup> this reform alone can

27 JM McGinnis, P Williams-Russo, & JR Knickman (2002). The Case for More Active Policy Attention to Health Promotion. *Health Affairs*, 21(2), 78-93.

28 Center for Health Care Strategies. Medicaid Accountable Care Organizations: State Update. September 2016. <http://www.chcs.org/media/ACO-Fact-Sheet-9-21-16.pdf>

29 Centers for Medicare and Medicaid Services (2016). Medicaid Health Homes: An Overview. Health Home: Information Resource Center, Fact Sheet. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-overview-fact-sheet-jul-2016.pdf>.

30 National Academy for State Health Policy (2015). State Delivery System and Payment Reform Map. <http://nashp.org/state-delivery-system-payment-reform-map/>.

31 Benjamin D. Sommers, Katherine Baicker, & Arnold M. Epstein (2012). Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 367, 1025-1034. <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099>.

be expected to result in long-term health improvements. Furthermore, considerable research has associated expanded Medicaid coverage with a greater likelihood of having a regular source of health care, decreased likelihood of having unmet medical care and prescription drug needs,<sup>32</sup> reduction in personal bankruptcies and household debt, improved financial well-being, and potential having other positive effects on well-being.<sup>33</sup> As more people become eligible for coverage, Medicaid's ability to influence the quality, effectiveness, and efficiency of health care also grows, especially for underserved populations.

Second, the ACA has further increased the level of policy emphasis given to Medicaid's role in health system transformation and care integration. Many Medicaid delivery and payment initiatives have a goal of using health care to promote access to interventions that can address broader social needs in order to improve health. The ACA adds new options for promoting community-based health services and supports. It also contains modest incentives for states to improve preventive services coverage for the special populations of adult beneficiaries who were eligible for Medicaid prior to the ACA expansion and therefore are not covered under the Essential Health Benefit standard (see Appendix A: Box A1 for more detail).

States have made wide-ranging use of Medicaid's flexibility and options. Today, state initiatives range from enhanced primary care for high-risk populations to services that enable working-age adults with disabilities to live and work in community settings.

### **Box 5. Serving People with Disabilities in Community Settings**

The ACA provided new options and incentives for states to encourage community-based services and supports for Medicaid beneficiaries outside of institutional care. Community-based health care, designed to reach and treat individuals in their own homes and communities, offers opportunities to prevent disease and injury, improve health, reduce costs, and enhance quality of life.

For example, Money Follows the Person, a state demonstration waiver, aims to increase the use of home and community-based services and reduce institutionally based services. Covered services such as job coaching, transportation to and from work, and qualified housing support services can address social determinants of health. Expanded through the ACA, it is now operating in 43 states and the District of Columbia.

32 Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope, & Dean Resnick (2013). What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf>.

33 Luojia Hu, et. al (2016). NBER Working Paper Series, The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being. National Bureau of Economic Research. <http://www.nber.org/papers/w22170.pdf>.



for both Medicare and Medicaid (dual eligibles),<sup>35</sup> as well as Medicaid health homes for beneficiaries with both physical and mental health conditions who experience high-need, high-cost health challenges.<sup>36</sup>

Reflecting the ACA's emphasis on health system transformation and under the authority of Section 1115 of the Social Security Act,<sup>37</sup> the federal government has partnered with the states to develop delivery system reform models known as Delivery System Reform Incentive Payment (DSRIP) initiatives.<sup>38</sup> These initiatives incentivize health care providers with close ties to Medicaid to make long-term investments in service integration, health information improvements, workforce retraining, and other reforms promoting quality and efficiency improvements that, in turn, can help improve outcomes while controlling spending growth.



Another state option for innovation developed by the Centers for Medicare and Medicaid Services (CMS) is the State Innovation Models (SIM). The goal of the SIM program is to help states develop health payment and delivery reform models that can more fully address population health through financially efficient service integration. States currently testing SIM models are approaching integration of primary care services with a variety of different sources of care, including social services and community organizations, public health, long-term services and supports, and behavioral health.<sup>39</sup>

Table 1 lists the state system transformation initiatives that are underway as of 2016. These initiatives include states in the SIM planning or implementation stages, states pursuing DSRIP reforms, states pursuing health home or integrated delivery system initiatives, and state initiatives towards care integration for dual eligibles. As states implement these initiatives, it will be critical for them to simultaneously evaluate their effectiveness in meeting health objectives.

35 The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation (2015). State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries. <http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

36 Centers for Medicare and Medicaid Services (2015). Medicaid Health Homes: An Overview, Fact Sheet. <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Medicaid-Health-Homes-Overview.pdf>.

37 Section 1115 authorizes the Secretary of Health and Human Services to alter federal Medicaid requirements and payment policies in order to conduct demonstrations that s/he believes will further the program's objectives. Social Security Act, Sec. 1115. [42 U.S.C. 1315].

38 Alexandra Gates, Robin Rudowitz, & Jocelyn Guyer (2014). An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation, Issue Brief. <http://files.kff.org/attachment/an-overview-of-dsrp>.

39 Amanda Van Vleet & Julia Paradise (2014). The State Innovation Models (SIM) Program: An Overview. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/>.

**Table 1. Medicaid System Transformation Initiatives as of 2016, by State**

|                      | Delivery System Reform Incentive Payment (DSRIP) <sup>1</sup> | State Innovation Models (SIM) <sup>2</sup> | Health Homes <sup>3</sup> | Dual-Eligible Demos <sup>4</sup> |
|----------------------|---|--|---------------------------|----------------------------------|
| Alabama              | X   |  | X                         |                                  |
| Alaska               |   |  |                           |                                  |
| Arizona              |   | X  |                           |                                  |
| Arkansas             |   | X  |                           |                                  |
| California           | X   | X  |                           | X                                |
| Colorado             |   | X  |                           | X                                |
| Connecticut          |   | X  |                           |                                  |
| Delaware             |   | X  |                           |                                  |
| District of Columbia |   | X  | X                         |                                  |
| Florida              |   |  |                           |                                  |
| Georgia              |   |  |                           |                                  |
| Hawaii               |   | X  |                           |                                  |
| Idaho                |   | X  |                           |                                  |
| Illinois             |   | X  |                           | X                                |
| Indiana              |   |  |                           |                                  |
| Iowa                 |   | X  | X                         |                                  |
| Kansas               | X   |  |                           |                                  |
| Kentucky             |   | X  |                           |                                  |
| Louisiana            |   |  |                           |                                  |
| Maine                |   | X  | X                         |                                  |
| Maryland             |   | X  | X                         |                                  |
| Massachusetts        | X   | X  |                           | X                                |
| Michigan             |   | X  | X                         | X                                |
| Minnesota            |   | X  | X                         | X                                |
| Mississippi          |   |  |                           |                                  |
| Missouri             |   |  | X                         |                                  |
| Montana              |   | X  |                           |                                  |
| Nebraska             |   |  |                           |                                  |

|                | Delivery System Reform Incentive Payment (DSRIP) <sup>1</sup> | State Innovation Models (SIM) <sup>2</sup> | Health Homes <sup>3</sup> | Dual-Eligible Demos <sup>4</sup> |
|----------------|---|--|---------------------------|----------------------------------|
| Nevada         |   | X  |                           |                                  |
| New Hampshire  | X   | X  |                           |                                  |
| New Jersey     | X   | X  | X                         |                                  |
| New Mexico     | X   | X  | X                         |                                  |
| New York       | X   | X  | X                         | X                                |
| North Carolina |   |  | X                         |                                  |
| North Dakota   |   |  |                           |                                  |
| Ohio           |   | X  | X                         | X                                |
| Oklahoma       |   | X  | X                         |                                  |
| Oregon         | X   | X  |                           |                                  |
| Pennsylvania   |   | X  |                           |                                  |
| Rhode Island   |   | X  | X                         | X                                |
| South Carolina |   |  |                           | X                                |
| South Dakota   |   |  | X                         |                                  |
| Tennessee      |   | X  |                           |                                  |
| Texas          | X   | X  |                           | X                                |
| Utah           |   | X  |                           |                                  |
| Vermont        |   | X  | X                         |                                  |
| Virginia       |   | X  |                           | X                                |
| Washington     | X <sup>5</sup>  | X  | X                         | X                                |
| West Virginia  |   | X  | X                         |                                  |
| Wisconsin      |   | X  | X                         |                                  |
| Wyoming        |   |  |                           |                                  |

1 National Academy for State Health Policy (2016). Selected Reform Activities, by State. <http://nashp.org/wp-content/uploads/2016/09/Discourse-Initiative-Chart.pdf>.

2 *Ibid.*

3 Centers for Medicare and Medicaid Services (2016). Approved Medicaid Health Home State Plan Amendments (effective September 2016). [https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-map\\_v55.pdf](https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-map_v55.pdf).

4 MaryBeth Musumeci (2015). Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.

5 On October 3, 2016, Washington State and the federal Centers for Medicare & Medicaid Services (CMS) reached an agreement in-principle on a five-year Medicaid demonstration waiver with a DSRIP component. For more information, see: <http://www.governor.wa.gov/news-media/washington-secures-federal-support-transform-health-system-improve-behavioral-health-care>.



## Key Challenges Facing Medicaid

Poverty and an aging population

Cost of transformation

Complexity of transformation and modernization

Securing social services that promote health

Equity in eligibility and continuity of coverage

Fragmented health care infrastructure

Misallocation of risks and rewards

## KEY CHALLENGES FACING MEDICAID

In positioning Medicaid to more decisively shape the ways in which health insurance coverage and health care delivery can advance a Culture of Health, several major challenges emerge. Some of these challenges are ones that confront health insurance and health care generally. Others are unique to Medicaid. These unique challenges arise from the range and scope of the coverage and payment responsibilities that Medicaid has assumed over five decades as a result of its flexible structure and financing.

### Poverty and an aging population

Medicaid is the nation's primary health coverage for low-income individuals and families, and the influence of poverty on health is profound. Poverty in the U.S. is often a geographically concentrated phenomenon; 14.4 percent of all Americans living in poverty reside in communities of concentrated poverty, defined as census tracts with poverty rates higher than 40 percent.<sup>40</sup> By their very nature, communities with concentrated poverty, which lack a stable economic base, struggle to access adequate services, including medical care.<sup>41</sup> Furthermore, poverty is associated with a cascade of barriers that present significant challenges to securing adequate health care and maintaining optimal health. Among these are language and cultural differences, substandard housing,<sup>42</sup> a higher prevalence of chronic illness and mental health conditions,<sup>43</sup> and neighborhoods that carry public health threats such as environmental hazards, increased exposure to violence, and a lack of options (e.g. grocery stores, sidewalks) to support healthy behaviors.<sup>44</sup> All of these risks intensify the problem of finding adequate health care providers and increase the need for more supportive care management that can connect them to social services such as nutritional supports (e.g., the Supplemental Nutrition Assistance Program), education, job training, and housing supports.

Medicaid has achieved its current size – as well as its central importance to improving the health of the poor – because its flexible design and financing structure have enabled the program to grow in response to trends in poverty and demographic changes. As with all insurers, Medicaid is affected by the increasing price of medical care. But Medicaid is especially sensitive to broader population trends, such as the aging of the Baby Boom generation. Since 2000, the single most important factor in explaining

40 Paul Jargowsky (2015). Architecture of Segregation: Civil Unrest, the Concentration of Poverty, and Public Policy. The Century Foundation. <https://tcf.org/content/commentary/new-data-reveals-huge-increases-in-concentrated-poverty-since-2000/>.

41 Jennifer E. DeVoe, Alia Baez, Heather Angier, Lisa Krois, Christine Edlund, & Patricia A. Carney (2007). Insurance plus Access Does Not Equal Health Care: Typology of Barriers to Health Care Access for Low-Income Families. *Annals of Family Medicine*, 5(6), 511-518. <http://www.medscape.com/viewarticle/567154>.

42 Mary Shaw (2004). Housing and Public Health. *Annual Review of Public Health*, 25, 397-418. <http://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.25.101802.123036>.

43 Alyssa Brown (2012). With Poverty Comes Depression, More than Other Illnesses. Washington, DC: Gallup. [http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm\\_source=genericbutton&utm\\_medium=organic&utm\\_campaign=sharing](http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm_source=genericbutton&utm_medium=organic&utm_campaign=sharing).

44 University of Wisconsin Population Health Institute (2015). County Health Rankings Key Findings Report 2015. <http://www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418649>.

Medicaid's growth has been a steady rise in poverty, coupled with changes in Medicaid's eligibility rules such as the ACA Medicaid expansion. In 2000, 9.6 percent of working-age adults, 16.2 percent of children under 18, and 9.9 percent of seniors were poor. By 2014, 13.5 percent of working-age adults, 21.1 percent of children under 18, and 10.0 percent of seniors lived in poverty.<sup>45</sup> The causes of poverty are numerous and reflect long-term economic, social, and labor-related factors, such as a growing low-wage sector, wage stagnation, and the large number of families headed by single parents. High poverty, along with its associated health and social risks, in turn have affected Medicaid, which by its very nature is designed to enable a dynamic response to poverty and the health challenges it generates. Factors such as high poverty, the needs that emerge in an aging population, and remarkable health care advances enabling people with severe disabilities to live full and productive lives with proper assistance and supports have increased the need for Medicaid.

### **The cost of transformation**

Through its flexible structure where coverage, service delivery, and payment are concerned, Medicaid can support innovative system transformation initiatives. With federal support, states can: introduce reforms that use program flexibility to alter eligibility rules; add or modify benefits, services, and covered health care settings; and alter payment arrangements. Indeed, Medicaid today is dramatically different from Medicaid 20 years ago.

But even with relatively generous levels of funding, states bear a heavy burden under Medicaid, particularly with respect to the staff capacity, expertise, resources, and political will necessary to develop transformation program designs, implement the initiatives once designed, and evaluate their impact while administering the complex program. Agencies also need funds to help their delivery reform partners, including managed care organizations (especially those that are community-based and therefore lack investor capital), provider networks, and partnering health and social service agencies in acquiring the staff, information systems, and care management tools necessary for effective implementation.

Medicaid represents a large financial responsibility for states. Medicaid spending accounts for over 15 percent of all state-funded state budgets.<sup>46</sup> This means that, in the absence of new investment financing, states must prioritize their transformation investments. The question becomes how to prioritize these efforts. On the one hand, it is possible to argue for giving highest priority to programs, services, and initiatives that hold the promise of near-term Medicaid savings. For example, state Medicaid programs could focus on initiatives that target very-high-cost, high-need patients for intensive health care interventions coupled with social supports and active care management. Such

*Medicaid is the nation's primary health coverage for low-income individuals and families, and the influence of poverty on health is profound.*

<sup>45</sup> Carmen DeNavas-Walt & Bernadette D. Proctor (2015). U.S. Census Bureau, Current Population Reports, P60-252, Income and Poverty in the United States: 2014. Washington, DC: U.S. Government Printing Office. <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

<sup>46</sup> MACPAC (n.d.). Medicaid's Share of State Budgets. <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>.



an initiative would be better equipped to address the needs of patients with multiple physical and mental health burdens who are at heightened risk not only for frequent and costly medical interventions, but also for other adverse events such as homelessness or incarceration, and therefore could yield rapid and significant cost savings.

On the other hand, equally high priority might be given to initiatives that yield long-term benefits. Of particular importance in this regard are initiatives focusing on pregnant women and infants, early childhood development, and those designed to promote the health of children and adolescents in order to keep them in school and positioned to achieve. Such investments might include: enriched prenatal care; home visiting for new parents and infants; a strong investment in early childhood development services aimed at integrating social services, nutrition, health, and early childhood education; programs for children at risk for experiencing adverse childhood experiences (ACEs); and early intervention for children exhibiting signs of developmental delay. Parallel programs of strong importance for adolescents include those that work to better ensure educational achievement, graduation in the best possible health, and a strong start in college or work. It is possible to find examples of each of these types of initiatives at the state level. (For an example of a state tool for improving long-term health outcomes, see Box 6.)

### Box 6: Social Impact Bonds

One tool aimed at fostering long-term benefits is social impact bonds – also known as pay-for-success initiatives – which generate added capital investment revenues to supplement states’ shares of a program’s costs. In pay-for-success initiatives, the government typically contracts with a private sector or non-profit intermediary to obtain evidence-based social services. The intermediary raises funds from private commercial or philanthropic investors who provide upfront capital in exchange for a share of the government payments that become available if the performance targets are met. Such initiatives hold the potential to not only achieve positive social impact, but also to generate a return on investment, such as by reducing chronic homelessness, preventing the need for high-cost treatment for childhood asthma, or reducing infant mortality.<sup>47</sup> Social spending of this nature is designed to create pilots which, if proven effective, government can later grow. Although they play a critical role in advancing social policy, pilots alone cannot bring promising interventions to scale. Achieving the critical mass, sufficient scope, and intensity to produce real transformation at a population level requires more systematic and sustained investment.

47 For examples, see: Jeffrey Liebman & Alina Sellman (2013). Social Impact Bonds: A Guide for State and Local Governments. Harvard Kennedy School Social Impact Bond Technical Assistance Lab. <http://govlab.hks.harvard.edu/files/siblab/files/social-impact-bonds-a-guide-for-state-and-local-governments.pdf>; Urban Institute (n.d.). Chronic Homelessness Pay for Success Initiative. Accessed September 24, 2016. <http://pfs.urban.org/pfs-project-fact-sheets/content/chronic-homelessness-pay-success-initiative>; Mary Garvey (2015). Massachusetts Chronic Individual Homelessness Pay for Success Initiative. Institute for Child Success. <http://www.instituteforchildsuccess.org/pay-for-success.php>. South Carolina’s pay-for-success model for improving birth outcomes was developed through a 1915(b) waiver. [https://www.scdhhs.gov/sites/default/files/2016\\_0321\\_AMENDED%20NFP%20PFS%20Contract\\_vFinal%20Executed.pdf](https://www.scdhhs.gov/sites/default/files/2016_0321_AMENDED%20NFP%20PFS%20Contract_vFinal%20Executed.pdf); The Urban Institute. South Carolina Nurse-Family Partnership Project. <http://pfs.urban.org/pfs-project-fact-sheets/content/south-carolina-nurse-family-partnership-project>.

## The complexity of the transformation and modernization process

Aside from the cost of transformation, the very process of achieving transformation presents significant challenges. Health system transformation requires not only ideas but also the logistical planning and execution needed to put change in motion, as well as a willingness on the part of many stakeholders with very different needs and perspectives to agree to invest in making those changes. The federal government has recognized the challenges that come with system transformation, and through its demonstration authority, the Centers for Medicare and Medicaid Services (CMS) has made both additional financial resources and technical supports available to states through demonstrations – such as Section 1115 delivery system reform initiatives and State Innovation Models (SIM) – that support state efforts to create all-payer solutions to complex health care delivery problems.

At the same time, challenges remain. One challenge lies within the process used to approve and conduct Medicaid demonstrations. Section 1115 demonstrations can enable states to pursue options not otherwise permitted under federal law and secure federal funding for services and activities not normally recognized as qualified. But the process of designing a demonstration, getting federal approval (which is subject to elaborate additional terms and conditions), and conducting and evaluating the demonstration is an arduous one. It is also a lengthy one, due to the special rules that necessarily apply to demonstrations. Lengthy delays diminish the potential for the type of rapid-cycle learning often associated with system change. Additionally, since the average tenure for a state Medicaid director is two years and three months,<sup>48</sup> it is not uncommon for the cycle of application, approval, implementation, and evaluation to span multiple directors. This raises the risk of a lack of institutional memory. Finally, the short budget windows used in federal demonstrations, coupled with a narrow definition of budget neutrality that considers only Medicaid spending, hamper more wide-ranging efforts to provide health care that can make a true social difference.

A related challenge is the difficulty of modernizing Medicaid policy and management practices. For example, the past generation has witnessed a revolution in our understanding of the lifelong consequences of health threats to children, measured not only in terms of a greater level of disability and developmental delay throughout childhood, but also in the onset of adult health conditions that are linked to social stress. As the single largest source of health care financing for pediatric and adolescent health care, Medicaid should be rapidly incorporating screening and intervention practices into its coverage and payment rules that in turn can promote the earliest possible identification and amelioration of health risks.<sup>49</sup> To ensure that coverage reforms actually reach the children and families who need them, Medicaid payment reforms should be linking updated coverage standards to performance incentives. But absorbing the

***Health system transformation requires not only ideas but also the logistical planning and execution needed to put change in motion, as well as a willingness on the part of many stakeholders with very different needs and perspectives to agree to invest in making those changes.***

48 National Association of Medicaid Directors (2014). State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors. [http://medicaiddirectors.org/wp-content/uploads/2015/07/14-297\\_namd\\_survey\\_final.pdf](http://medicaiddirectors.org/wp-content/uploads/2015/07/14-297_namd_survey_final.pdf).

49 Bright Futures/American Academy of Pediatrics (2016). Recommendations for Preventive Pediatric Health Care. [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf).

evidence regarding the health needs of children and translating that evidence into coverage and practice improvement requires multiple skills: the ability to identify interventions that work, the ability to rapidly identify pilots that show promise in the creation of effective screening and treatment interventions, the ability to translate these interventions into coverage and payment principles, and the ability to train health care providers and work with them to evaluate and modify their practice and performance as needed.

### Securing the social services that promote health

Perhaps the most overlooked challenge is inadequate funding for the social, educational, nutrition, economic, transportation, housing, and other interventions and services that can help lift the health of the population. While Medicaid participates in cross-program, community-based improvement initiatives that enable local coordination of activities and programs to occur,<sup>50</sup> Medicaid cannot go it alone. Researchers have identified many reasons for the problem of health and social service underfunding,<sup>51</sup> including

the limited prioritization given to improving population health, the misalignment of financial and political incentives, and a lack of consensus regarding who, exactly, is responsible for improving health.

Whatever the underlying reasons, the shortage of social services and material supports poses a major problem – one that Medicaid has an enormous stake in addressing. State Medicaid programs can use payment reform to reward providers and organizations that develop effective working relationships with social service programs, either by incorporating such services into their own delivery systems or by establishing formal affiliation agreements that ensure a smoother referral process. But Medicaid providers and managed care organizations

that expand their services in this fashion may also encounter real barriers. For example, a community health center that provides case management assistance to help young parents locate high-quality child care for their toddlers and preschool children may find that its patients face a lengthy waiting list for help. An ACO that has designed its services to reach the highest-need community residents requiring intensive community-based primary and specialty health care in addition to supportive housing and employment programs may run into a dearth of program availability. Inadequately funded senior nutrition programs under the Older Americans Act may in turn diminish the willingness



50 The Camden Coalition Accountable Care Organization (ACO) is a community-based ACO that brings together Camden-area providers, community organizations, and city residents to provide better health care at lower costs through coordinated, efficient care for local residents enrolled in Medicaid. <https://www.camdenhealth.org/the-camden-coalition-aco-saving-money-improving-lives/>

51 Erika Rogan & Elizabeth Bradley (2016). Investing in Social Services for States' Health: Identifying and Overcoming the Barriers. Milbank Memorial Fund. <http://www.milbank.org/publications/milbank-reports/515-investing-in-social-services-for-states-health-identifying-and-overcoming-the-barriers>.

on the part of Medicaid agencies and health care providers serving seniors to build nutrition insecurity screening tools into their preventive services programs, simply out of concern over their inability to refer seniors for the level of assistance needed. Adult education and training programs may be filled to overflowing. A \$200 home lead testing inspection could yield immense savings to Medicaid over time, yet the up-front funds for home inspection may be lacking, as may be the funds to abate any discovered lead threats. To be effective itself, Medicaid must be able to partner with other effective health and social sectors.

From a federal policy perspective, Medicaid's financial structure is unique among social programs and is essential to carrying out the responsibilities that, over many decades, have been assigned to the program. But Medicaid is health insurance. Although federal policy broadly defines the concept of what is covered, there are important limits – under traditional rules as well as potentially under demonstration authorities – to the extent to which health-promoting interventions can be characterized as a covered service. For this reason, Medicaid has a vested interest in ensuring that complementary programs fund education, housing, nutrition, transportation, community development, and other social services and activities. For example, because certain food programs, such as SNAP, entitle entire eligible families to help regardless of whether all individual members are also entitled to Medicaid, using Medicaid-financed health care to link patients to food can improve health for entire families.

New strategies are needed to end the silos of financing and eligibility requirements that challenge Medicaid coordination with those social supports. Given the financial and structural constraints on the Medicaid program, partnerships are essential to the clinical-community linkages for better health outcomes. As the Medicaid program considers social determinants and new ways of promoting health, one challenge will be how the program can support clinical-community linkages and help stimulate other sources of funding for related health support systems, which may themselves be underfunded or, in some cases, non-existent. As insurance, Medicaid's primary emphasis is on paying for covered services for eligible individuals. But to be effective at what it does, Medicaid needs partners with a mission to address upstream social determinants of health and to improve health at a community level.

### **Achieving equity in eligibility and promoting continuity of coverage**

A principle of achieving a Culture of Health is that everyone has access to affordable, high-quality health care. For low-income individuals, Medicaid is the vehicle to achieve that end, but states, with differing priorities and budgetary realities, have not all chosen to adopt the ACA provisions to expand coverage to all adults. To date, 31 states and





*Medicaid needs partners with a mission to address upstream social determinants of health and to improve health at a community level.*

the District of Columbia have expanded Medicaid; six of these have done so on an experimental basis. Whether by adopting the Medicaid expansion as enacted or by using the added flexibility permitted, states play the central role in deciding whether their poorest residents will be able to secure health insurance coverage and maintain it over time. Given the essential link between health insurance coverage on the one hand and health care access, utilization, and health outcomes on the other, Medicaid expansion emerges as a foundational step in a Culture of Health.

However, even in states that do adopt the expansion, challenges remain. Also key are enrollment and renewal practices, as well as outreach efforts that promote continuous enrollment over time and lessen the risk of coverage interruption. Furthermore, expansion does not cover all populations who need insurance. Federal Medicaid funding limits exclude most people who are not long-term U.S. residents (currently defined as residing in the U.S. for at least five years). Moreover, no federal funding is available for people who are not legally present in the U.S.

### **A fragmented health care infrastructure**

Limitations in data infrastructure and capacity also pose a barrier to Medicaid programs as they seek to advance a Culture of Health. Although reforms have been made, health care providers still often operate in silos in the current fragmented delivery system, especially where integration of physical and behavioral health care is concerned. Privacy and security regulations and concerns complicate the task of data sharing, particularly with respect to health conditions arising from mental illness or substance use. Data sharing between the health care system and other entities such as schools and social services agencies can be even more daunting, further complicating efforts to integrate health and social services. Electronic health records typically do not have the capacity to capture and maintain data on social determinants. Billing codes do not focus on social determinants, and when they do – as in the case of the new billing codes under ICD-10<sup>52</sup> that focus on poverty or lack of food and safe drinking water as health factors – the payment system is not currently structured to augment financing for patients whose social risks demand a more expansive response.

Developing interoperable data systems that can facilitate information sharing, with informed beneficiary consent, across all members of patient health teams, all while protecting privacy and security, is critical to the operation of a health system that can best deploy resources where they are most needed.

### **Misallocation of risks and rewards**

A final consideration in making strategic Medicaid investments to promote a Culture of Health is the allocation of risks and rewards across stakeholders. State Medicaid

<sup>52</sup> The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), which is a medical classification list used by the World Health Organization (WHO).

investments in improving health often require capital and entail risk. These investments will not be sustainable if they cannot achieve a return on investment that enables them to continue to invest in health-promoting services and foster ongoing system transformation incentives. The investments can be particularly challenging when addressing the needs of dually eligible beneficiaries, where better management of patients' long-term services and support needs can reduce the need for Medicare spending on acute and high-cost health care events. Yet, Medicaid programs have limited opportunities to share in the savings that accrue to Medicare through better long-term care. The same challenges arise in the case of health care for infants, children, and adolescents who face elevated health risks, where maintaining good health and addressing developmental delays can reduce such long-term consequences as educational and social services costs.<sup>53</sup>



Demonstrations are underway in several states experimenting with shared savings approaches for those dually eligible for Medicaid and Medicare, and their evaluation will inform the policy discussion. But the absence of a means for generating shared savings that could flow from broader social and health gains in turn limits the incentive to provide Medicaid programs with the financial flexibility to invest in improvements such as service integration, better information sharing, and the development of well-trained health teams that could make a difference in overall performance. Federal demonstrations and initiatives aimed at promoting delivery system reform hold promise to help states achieve the types of transformations needed to enable health care to perform more efficiently and effectively. But a central challenge of federal Medicaid policy remains in how to systematically identify these opportunities and give states the flexibility to make strategic investments in more effective health care delivery.

***...the absence of a means for generating shared savings that could flow from broader social and health gains in turn limits the incentive to provide Medicaid programs with the financial flexibility to invest in improvements...***

<sup>53</sup> David C Grabowski (2007). Medicare and Medicaid: Conflicting Incentives for Long-Term Care. *Milbank Q*, 85(4), 579–610. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690349/>.

# OPPORTUNITIES FOR BETTER LEVERAGING MEDICAID TO FOSTER A CULTURE OF HEALTH

In order to sustain and expand the progress made to date while overcoming the challenges outlined above, a number of options emerge. Some of these options would allow states to make more effective use of program flexibility already built into federal law. Some entail augmenting the flexibility already built into federal law. Other options may entail further legislative reforms that build on fundamental directional shifts already evident in the Medicaid statute in regards to eligibility, benefits and coverage, health care delivery, and program administration.

## Opportunities for Better Leveraging Medicaid to Foster a Culture of Health

### System transformation, quality improvement, and payment reform

- A1. Develop a demonstration program better suited for health improvement efforts
- A2. Fast-track approval process for promising transformation models
- A3. Align social services expenditures with Medicaid coverage
- A4. Improve access to behavioral health services
- A5. Improve data sharing between physical and behavioral health
- A6. Modernize Medicaid's role in improving children's health
- A7. Strengthen language and disability access to care
- A8. Develop and disseminate best practices for adult preventive care
- A9. Social determinants screening tools and comprehensive care
- A10. Safety net payment reform
- A11. Consult Medicaid for community health needs assessments
- A12. Treat Medicaid as equal priority to Medicare in CMMI
- L6. Establish Medicaid health improvement fund as state option

### Eligibility and enrollment

- L1. State option for stabilizing adult Medicaid enrollment
- L2. Eliminate waiting periods for legal residents
- L3. Offer three years of 100 percent federal match for all states to expand coverage

### Benefits and coverage

- L4. Increase incentive to provide preventive services to adults
- L5. Cover preventive services aimed at patient groups

### Strengthening Medicaid performance during economic downturns

- L7. Revise financing rules to maintain coverage during economic downturns



## ADMINISTRATIVE OPTIONS (REQUIRING NO ADDITIONAL LEGISLATIVE ACTION)

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### **System transformation, quality improvement, and payment reform**

**A1. Develop health improvement demonstrations that employ a longer-term savings time frame, focus on the social determinants of health, recognize health-related expenditures as qualified for federal funding, and count a broader range of estimated cost offsets when calculating budget neutrality.**

Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to alter federal Medicaid requirements and payment policies in order to conduct demonstrations that s/he believes will further the program’s objectives.<sup>54</sup> It has been used extensively to promote demonstrations that are budget neutral, further Medicaid program objectives, and are consistent with the ten Culture of Health principles. The HHS Secretary has broad discretion to determine program objectives and typically focuses on demonstrations that take new approaches to eligibility, benefits and coverage, delivery system reform, and provider payment. Through its demonstration authority, HHS has done much to enable states to elevate the importance of patient health improvement as a measurable outcome of Medicaid payment and delivery reform. At the same time, HHS has not used its authority to make federal funding available to states for interventions that go more directly to the underlying social conditions of health and that recognize longer time frames for accruing savings.

One approach that could encourage states to implement innovations designed to improve the social determinants of health and long-term health outcomes would be to recognize improving the health of Medicaid beneficiaries as a specific objective of 1115. Such recognition would authorize the Secretary to make more comprehensive use of his/her 1115 powers in order to test interventions that have the potential to advance the health of specific at-risk populations, such as children and adults who have experienced or are at risk for adverse childhood experiences (ACEs), incarceration, homelessness, domestic violence, and serious mental and substance use disorders. For these specific classes of demonstrations, the Secretary could act under existing authority to:

- (i) recognize state and local expenditures on housing, environmental, nutritional, educational, employment-related, and other social services for which there is an evidence base of effectiveness at improving health as expenditures that can qualify for federal financing;
- (ii) allow states’ estimated cost savings to include reduced spending on services such as incarceration, special education, and long-term services for children and adults with serious disabilities – while ensuring that Medicaid coverage standards and beneficiary protections remain in place – in order to begin to address the problem of misaligned incentives; and

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<sup>54</sup> Social Security Act, Sec. 1115. [42 U.S.C. 1315].

***One of the great challenges in Medicaid is the length of time it can take for proposed state Medicaid innovation plans to be approved by the federal government.***

- (iii) utilize a longer time frame (e.g., a 10-year budgeting period) than is customary with 1115 demonstrations focused on more traditional undertakings. This approach could be employed to support Medicaid demonstrations with a longer-term payoff across multiple economic sectors, not simply short-term health care spending reductions.

**A2. Develop a fast-track approval process, a clear implementation roadmap, and a series of definable outcome measures for promising service delivery transformation models.**

One of the great challenges in Medicaid is the length of time it can take for proposed state Medicaid innovation plans to be approved by the federal government. Even for relatively straightforward changes – such as instituting a home visiting program for new mothers that targets high-risk communities and uses an established protocol to furnish services already covered by Medicaid – the approval process can be lengthy. One option for alleviating these types of delays would be the development of a series of evidence-based, specified health innovation models that would be subject to a fast-track

approval process for states to integrate into their Medicaid programs. Candidates for such a fast-track approval process might include home visiting for new mothers and infants, efforts to connect patients to federal nutrition programs like SNAP and WIC, supportive housing assistance, supported employment initiatives, medically-tailored meals, and certain home and community-based services for long-term care. CMS could bring together beneficiary representatives, experts in public health, state Medicaid officials, and other stakeholders to identify candidates for health innovation models that will merit fast-track approval while retaining important beneficiary safeguards, as well as to develop a proposal template to expedite and encourage fast-track approval.



**A3. Better align federal health, nutrition, housing, and social support eligibility, benefit, and expenditure policies to enable coordination with Medicaid coverage and system transformation efforts.**

The National Prevention Council, developed as part of the ACA, convenes senior leadership from 20 federal departments, agencies, and offices around a shared health agenda. Under the leadership of the Surgeon General, the council developed the National Prevention Strategy, identifying collaborative opportunities through a public health lens to advance health and wellness across all federal agencies. While it serves as a critical first step, that effort may not be enough to break down the silos of programming and financing that limit the capacity of state Medicaid programs to coordinate effectively with other programs to address the social determinants that drive poor health.

Increasingly, Medicaid agencies are seeking to address the social factors that negatively affect health through targeted case management and medical homes, contracts with managed care organizations, and the establishment of new entities such as community care organizations that use global payments to foster flexibility. But those efforts can be confounded by Medicaid's own rules and by the complexity of coordinating across multiple federal agencies, each with varied and sometimes conflicting rules, some of which prohibit the payment of needed services to help improve the overall health of Medicaid beneficiaries and their families.

In 2015, CMS took a step to address a key social determinant – housing – when it issued a bulletin explaining that Medicaid can reimburse for certain housing-related activities, even through Medicaid funds cannot be used to pay for room and board.<sup>55</sup> Medicaid can fund housing-related activities such as referral, support services, and case management services that help individuals connect to and remain in stable housing. This marked a step forward in policy, but did not address the broader housing needs, nor other significant cross-agency concerns. For example, weatherization assistance through the Department of Housing and Urban Development cannot be used to address health and safety issues like mold, failing roofs, or poor ventilation. Community Development Block Grant funds generally can't be used to build new housing, even if that is the greatest need in a community. Low Income Home Energy Assistance cannot pay for lighting or water. The Supplemental Nutrition Assistance Program (SNAP) is time-limited (as short as three months), limiting its ability to alleviate long-term food insecurity. The Social Services Block Grant cannot generally pay for room and board or wages. Help is needed in understanding and aligning programs that support child care, transportation, nutrition, income, and job training and placement with health care transformation goals. This would allow Medicaid programs to more effectively access needed supportive services and ensure that the total health of members is addressed, rather than just the medical care and other services that Medicaid can fund itself.

Governors can act as conveners to coordinate these programs on a state level and identify federal barriers where that coordination is impeded. The HHS Secretary, working with the states, could systematically document the cross-agency barriers that limit the capacity of Medicaid programs to coordinate with other federal programs in order to target interventions that address the social determinants of health for Medicaid beneficiaries. With this tool in hand, the Secretary could convene leaders of federal agencies to identify and address specific regulatory and statutory options to better coordinate Medicaid with other federal programs to improve the health of Medicaid beneficiaries.

***Increasingly, Medicaid agencies are seeking to address the social factors that negatively affect health ... But those efforts can be confounded by Medicaid's own rules and by the complexity of coordinating across multiple federal agencies.***

<sup>55</sup> Vikki Wachino (2015). CMCS Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

**Barriers to the integration of physical health, mental health, and substance use disorder services... not only inhibit access to care, but also jeopardize quality of care, putting patients' safety at risk.**

#### **A4. Restructure Medicaid payment policies to improve access to behavioral health services.**

Various barriers prevent better integration of physical and behavioral health services under current policy. The lack of parity for behavioral health care coverage has long been a barrier. The Mental Health Parity and Addiction Equity Act (MHPAEA) has had a significant impact on coverage parity, but the next challenge is utilizing payment principles to advance the goal of equal treatment. Payment reforms will be critical to promoting health care practices that reward access improvements – such as payment strategies that make full use of the diverse range of available coverage options, including peer counseling, trauma services, and community health workers – and that recognize the value of integrated treatment teams capable of more fully meeting the needs of beneficiaries with both physical and mental health conditions. Another option is to permit providers or care teams furnishing both physical and behavioral health services on the same day to bill for the multiple distinct encounters provided, since currently there are many restrictions on same-day billing for physical and behavioral health services.

#### **A5. Improve data sharing between physical health, mental health, and substance use disorder services and providers to enhance care coordination.**

Barriers to the integration of physical health, mental health, and substance use disorder services under current federal and state laws not only inhibit access to care, but also jeopardize quality of care, putting patients' safety at risk. Individuals with physical and behavioral health conditions often receive fragmented care, resulting in higher costs and poorer outcomes.<sup>56</sup> One limitation on better integration of care lies in the challenges faced by health care entities in sharing data. HIPAA plays an essential role in protecting patient privacy while still enabling health care professionals to share personal health information for the purposes of health care treatment, payment, and operational purposes. But other state and federal laws may place greater restrictions on information sharing than those applicable under HIPAA, particularly for highly sensitive information related to conditions such as substance use disorders and mental illness. These laws are extremely important, yet they may affect the ability of physical health care providers to gain access to ongoing treatment information related to behavioral health needs. In addition, HIPAA and other laws may prevent health care providers from sharing information across the range of programs and services involved in treatment. Public health crises such as the opioid epidemic, for example, have brought into sharp focus the importance of understanding a patient's past history of treatment and addiction in prescribing pain medication for a physical health condition.

As team approaches and health and social services integration increasingly are recognized as essential strategies for supporting people with complex health conditions, models of information sharing are needed to improve cross-sector collaboration, while

<sup>56</sup> Benjamin G. Druss & Elizabeth Reisinger Walker (2011). Mental Disorders and Medical Comorbidity. Robert Wood Johnson Foundation. Research Synthesis Report No. 21. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf69438/subassets/rwjf69438\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1).

still safeguarding sensitive personal information to ensure patient privacy and confidentiality. Because some of the most important information sharing policies can be found in state rather than federal law, this is an area in which federal/state cooperation in the development of information sharing models will be especially important.

Much work has been done in recent years, but much work remains. For example, the Obama Administration has issued regulations revising the longstanding rules governing information related to substance abuse.<sup>57</sup> These revised rules will improve information transparency between providers, but more needs to be done to help patients understand the importance of, and make decisions about, information sharing. Substance use treatment providers still remain excluded from health information exchanges and other electronic health record systems under the terms of the rules, isolating them from information that would improve the quality of care and coordination with other providers. Greater efforts to align these special federal protections related to substance abuse with HIPAA privacy protections would help improve the coordination of physical and behavioral treatments for patients with substance use disorders.<sup>58</sup>

While there are no directly comparable federal prohibitions on sharing mental health information as with substance use records, many state laws and regulations contain similar prohibitions. To extend the protections of HIPAA to patients treated in mental health or substance use programs, and to improve safe and efficient communication between health care providers, federal and state governments should consider developing model laws or pilot programs aimed at eliminating unneeded barriers while strengthening the protections against the unauthorized, discriminatory use of mental health, substance use, and other sensitive medical information. Efficient and secure exchange of health information is essential to integrated physical and behavioral health care. Updating and harmonizing behavioral health privacy regulations to be consistent with the protections of other medical privacy regulations, while ensuring the protection of sensitive information, will go a long way toward treatment of the whole person.

#### **A6. Modernize and update Medicaid's role in improving the health of children.**

In the effort to translate research and evidence into practice, no population stands to benefit more than the tens of millions of children who depend on Medicaid and its



<sup>57</sup> Association for Community Affiliated Plans (2016). The Impact of 42 CFR Part 2 on Care Coordination by Health Plans for Members with Substance Use Disorders. <http://communityplans.net/Portals/0/Fact%20Sheets/The%20Impact%20of%2042%20CFR%20Part%202%20on%20Care%20Coordination.pdf>.

<sup>58</sup> For more information on the topic of revising 42 CFR Part 2, please see: Eric Goplerud & Renée Popovits (2015). Now is the Time to Strengthen Protection of Substance Use Records by Revisiting the Substance Use Privacy Law. Association for Behavioral Health and Wellness. [http://www.abhw.org/publications/pdf/42%20CFR%20paper%20Final%20Dec%202015%20\(2\).pdf](http://www.abhw.org/publications/pdf/42%20CFR%20paper%20Final%20Dec%202015%20(2).pdf).



companion CHIP. Medicaid in particular offers a crucial means for financing delivery reform because of its early and periodic screening, diagnostic, and treatment (EPSDT) benefit.<sup>59</sup> EPSDT establishes a broad framework for covering and financing pediatric health care, not only because of the broad range of services it covers, but also because of its emphasis on early access to treatments that can ameliorate both physical and mental health conditions in children as they develop. Medicaid's unique pediatric coverage structure thus enables states to create care systems that can address children's physical, mental, developmental, and oral health needs, and to effectively anchor and integrate broadly-defined pediatric services into community-based settings such as schools, youth employment programs, child care and Head Start settings, and early childhood development programs for children with special needs.

Developing Medicaid policy to reflect what we know today about the impact of child health on long-term health thus emerges as a major priority. Isolated Medicaid policies – currently scattered over thousands of pages of (significantly outdated) regulations, transmittals, state Medicaid directors' letters, and other forms of guidance – need to be brought together into a more comprehensive and holistic explanation of Medicaid's role in child health. Medicaid's flexibility can be used to support broader aims such as promoting health beginning in early childhood and continuing through adolescence in order to promote development, school readiness, and the ability to learn, and to mitigate the effects of adverse childhood experiences and childhood trauma. Over a generation, the evidence base for child and adolescent health investment has been completely transformed. So, too, should Medicaid coverage and payment policies.

A clear, comprehensive articulation of Medicaid's potential to enable states to build on this evidence base through coverage and payment reform could help show the way toward better performance. A more complete policy review of Medicaid's role in child and adolescent health would illustrate how Medicaid financing might be used to further an evidence-based approach to pediatric care. This would include the use of research-based standards for preventive health care such as Bright Futures – a national health promotion and prevention initiative that began as a partnership convened by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), and the Centers for Medicare & Medicaid Services (CMS), which is now maintained by the American Academy of Pediatrics (AAP). Most state Medicaid programs use Bright Futures in some capacity as the standard for health supervision, or at least have incorporated it into state Medicaid handbooks.<sup>60</sup> Federal policy could incentivize Medicaid programs to use the Bright Futures protocol, which officially governs the preventive health benefit standard applicable to all insurance coverage sold in the individual and small group markets.<sup>61</sup> By explicitly promoting Bright Futures as the official standard for health supervision, state performance on key child health indicators could be better gauged.

***Developing Medicaid policy to reflect what we know today about the impact of child health on long-term health thus emerges as a major priority.***

59 Changed to "diagnostic" in 2006 by the deficit reduction act.

60 Association of State and Territorial Health Officials (2014). Bright Futures and State Implementation. Issue Brief. <http://www.astho.org/Maternal-and-Child-Health/bright-futures/>.

61 42 U.S.C. § 300gg-13.

Along with promoting Bright Futures, a federal Medicaid child health policy modernization effort could elucidate policies that are achievable under federal law without additional amendments, such as states' ability to pay for evidence-based services furnished in home and community settings (with waivers needed only if services are limited geographically), states' ability to develop onsite service programs located in a range of settings, and states' flexibility to adopt "two-generation" approaches that can extend treatment to parents in situations where treatment is integral to children's health, such as anticipatory guidance, efforts to identify maternal depression, or family smoking cessation support to improve the health of children with asthma.<sup>62</sup> Home visits to new parents and young families exist as coverage options today without changes in law, and these services have been shown to be effective in ensuring that both mothers and children receive the services they need to thrive. This makes Medicaid a critical source of funding for home visiting initiatives. The federal government could incentivize such interventions through comprehensive policy guidance that illustrates Medicaid's potential to work alongside other programs to promote access to health, nutritional, social, and educational services, as well as services aimed at reducing threats to child health.



**A7. Strengthen access standards for individuals whose primary language is not English who require language services and people with disabilities who experience challenges in communication.**

In order to support a Culture of Health where no one is excluded from care, Medicaid can help support reforms that make access to coverage and care more accessible to communities that face language or functional communication barriers, which can contribute to disparities in health and health care. In helping to finance language access improvements, Medicaid can help reduce communication barriers, in turn promoting stronger capacity for self-management, use of health supports, and effectiveness of care and health coordination.

The policy context for Medicaid's involvement in language access is found in U.S. civil rights laws – Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, and Section 508 of the Rehabilitation Act – which are extended to federally assisted activities under the Affordable Care Act by Section 1557 of the ACA, which requires programs and services receiving federal financial assistance to be language-accessible. As such, language access becomes a basic element of system redesign and payment reform, from simplified enrollment systems to improvements in the provision of health

<sup>62</sup> Alan Weil, Shayla Regmi, & Carrie Hanlon (2014). The Affordable Care Act: Affording Two-Generation Approaches to Health. The Aspen Institute & The National Academy of State Health Policy. <http://www.nashp.org/sites/default/files/ACA.8Sept2014.pdf>.



care itself. Examples of language access strategies include bi/multi-lingual and bi/multi-cultural providers able to communicate with patients effectively, interpretation and translation assistance and materials, communication methods such as taglines, sign language interpreters, large print and Braille materials, and other effective auxiliary aids and supports.

**A8. Develop and disseminate information on best practices in coverage of comprehensive preventive and primary care for adults.**

Advancing best practices in child health and Medicaid is vital, and so is advancing the adoption of health-promoting policies for adults. At various points, this report describes Medicaid's potential to cover preventive and primary care services for beneficiaries that align Medicaid policies more closely with other efforts to improve health, such as supportive housing services, oral health care, routine health screenings, and supports that can assist beneficiaries in learning how to better manage the environmental and social stressors that cause health harms. Under current law, these services can be furnished in clinical and community settings. They also can, in many instances, be furnished by health workers other than licensed medical and nursing professionals.

A federal Guide to Medicaid and Community Prevention could help stimulate state uptake of options that are recognized to be associated with better health outcomes and are part of an overall health improvement approach to the design of health and social services supports. Such a compendium could not only identify "health smart" services, but also provide states with detailed guidance on how such modifications can be readily adopted into state plans, with guidance for operationalizing coverage changes using accepted payment and quality measurement tools.

**A9. Disseminate social determinants screening tools for utilization in managed care and integrated delivery systems, and adopt payment methods that foster comprehensive care and the integration of health and social services.**

There is growing interest in screening for the social determinants of health within primary care settings in an effort to identify patients' needs and connect them to appropriate services. To be sure, screening for the sake of screening does not represent sufficient progress. Rather, the purpose of expanding screening activities should be to identify resource needs and to provide evidence regarding the types of resources and interventions necessary to improve and maintain health. That said, while the advent of better screening tools should not be separated from simultaneous efforts to create a higher degree of responsiveness to identified needs, screening does represent a critical step in recognizing the broader range of factors that influence health and that can (and should) be put to work to improve health.

The Accountable Health Communities model promoted by the Center for Medicare and Medicaid Innovation is intended to test models for identifying and addressing the gap between clinical care and social services to improve health outcomes and reduce

*Advancing best practices in child health and Medicaid is vital, and so is advancing the adoption of health-promoting policies for adults.*

costs.<sup>63</sup> As part of this initiative, a team of experts in housing, food security, interpersonal violence, transportation, education, employment, and other social determinants of health is providing recommendations on how to best implement such a screening tool that can not only identify problems, but also establish teams capable of putting resources to work to address those problems. Based on the results of this demonstration and other evidence that screening is a critical first step in identifying concerns for follow-up services, CMS could institutionalize and incentivize screening for the social determinants as an integral part of health care – when paired with service integration that connects patients to community resources – either as part of health care visits or through co-located services furnished by non-medical professionals (e.g., social workers, community health workers, student volunteers).

For reforms to be effective at reducing the silo effect in health care, changes in practice must be supported by payment reforms that recognize the reality that individual patients often present multiple conditions, all of which require care and management. Payment reform should be designed to truly capture the cost of efficiently managing patients with multiple physical, behavioral, and oral health needs, whether paid on a per capita basis, a case basis, or through multiple encounters on a single day. Regardless of the payment model used, payment systems should be tied to health care quality and outcome measures that allow both agencies and providers to measure improvement. Whether these reforms can be accomplished on a demonstration basis or through comprehensive guidance showing states how existing coverage and payment flexibility options can be applied, CMS should place emphasis on clarifying exactly what states can do within the parameters of existing Medicaid policy to enhance both screening for and the integration of care to address social needs.

#### **A10. Develop safety net health care payment reform models that promote access, quality, efficiency, and a Culture of Health.**

The delivery system reform initiatives launched by CMS and various states under the auspices of Section 1115 are designed to test models for reforming Medicaid payment structures that are grounded in large-scale, integrated health care delivery systems. However, as with Medicare and physician payment, there is merit also in developing payment reforms that explicitly focus on community-based primary care providers such as community health centers, clinics furnishing health care for women funded through Title X of the Public Health Service Act, rural and community behavioral health centers, clinics operated by state and local health agencies, and other community-based providers who deliver a large amount of primary and preventive health services to Medicaid beneficiaries. Typically, these community providers also have a legal obligation to furnish care to the uninsured, whether their uninsured status is long-term in nature or shorter-term due to breaks in coverage.

***For reforms to be effective at reducing the silo effect in health care, changes in practice must be supported by payment reforms that recognize the reality that individual patients often present multiple conditions, all of which require care and management.***

63 Centers for Medicare and Medicaid Services (2016). Accountable Health Communities Model. <https://innovation.cms.gov/initiatives/AHCM>.

In some places, these community-based primary care providers may be a formal part of larger integrated delivery models. But in thousands of communities, they operate independently, participating in multiple managed care systems or, in some cases, operating as freestanding primary care case management systems and health homes.

Much less formal attention has been paid to payment reform efforts aimed specifically at value-based primary care involving safety net ambulatory care providers. But federal law fully supports the development of alternative payment models by Medicaid agencies in collaboration with primary care safety net providers. The potential to develop alternative approaches to payment that build in principles of value-based purchasing – such as bundled and per capita payment structures that encourage efficiencies and reduce volume incentives, coupled with performance metrics tied to financial rewards – is equally great in an ambulatory care context. Indeed, in several states, health centers are involved in precisely this type of undertaking in conjunction with their state Medicaid programs.<sup>64</sup>

To promote the development of alternative payment models applicable to primary care that can either stand alone or be aligned with hospital-based delivery reform, the federal government could fund pilots involving state agencies and primary care safety net providers. These pilots would test the feasibility of payment reform approaches that move toward value-based purchasing while simultaneously ensuring that other safety net funding sources targeted to uninsured populations and services remain available.

**A11. Include consultation with state Medicaid and public health agencies as a requirement for tax-exempt hospitals in developing community health needs assessments under the Internal Revenue Code.**

In order to further amplify the resources available for health and social services integration, the Internal Revenue Service – which oversees policy related to tax-exempt organizations, including hospitals – could consider revisions to existing community health needs assessment requirements – with which all hospitals must comply as a condition of their tax exempt status<sup>65</sup> – to specify a planning process that requires state Medicaid and public health agency input in order to ensure that hospital assessments align with state and local health improvement plans. In addition, the IRS could work with public health experts and Medicaid financing experts to identify examples of collaborations between hospitals, health departments, and Medicaid programs that target hospital community benefit expenditures on improving underlying health conditions of low-income communities with high concentrations of Medicaid beneficiaries. Examples of such community health improvement activities might include home visiting and social services programs for new parents and the frail elderly, supportive housing, farmers’ markets, and efforts to abate environmental threats such as lead.

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64 Peter Shin, Jessica Sharac, Zoe Barber, & Sara Rosenbaum (2016). Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States. Geiger Gibson RCHN Community Health Foundation, Issue Brief #45. <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Community-Health-Centers-and-Medicaid-Payment-Reform-45.pdf>.

65 26 U.S.C. § 501(r).

**A12. Make Medicaid an equal priority to Medicare for the Center for Medicare and Medicaid Innovation (CMMI), with special emphasis on pilots aimed at health improvement and prevention.**

The ACA expanded the demonstration powers of the federal government through establishment of the Center for Medicare and Medicaid Innovation. CMMI operates under a special long-term budget that has enabled the agency to undertake demonstrations designed to test the efficiency and cost-effectiveness of modifications in health care organization and practice. However, CMMI's principal focus is on improving the delivery of covered Medicare and Medicaid services in a more efficient manner, not on altering the definition of medical assistance itself. CMMI has focused largely on Medicare innovation because the federal government has authority to control re-design of payments under this federal program. Re-design of Medicaid, a federal-state partnership, is more complex. Yet, state demonstrations can serve as laboratories of innovation. In order to become more relevant to the Medicaid program, CMMI should consider a shift towards financing state demonstration programs that promote state health improvement efforts and/or prevention agendas. CMMI could test community and payment infrastructure reforms around states' broader population health campaigns. Using Medicaid's payment structure increasingly for prevention has the potential to improve cost-effectiveness in the long term.



# LEGISLATIVE OPTIONS

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## Eligibility and enrollment

### L1. Create a state option to enable stabilization of Medicaid enrollment over time for adults.

Stable coverage over time is associated with continuity of care and greater use of preventive services.<sup>66</sup> As a result, when programs are able to cover individuals for a longer period of time, they reap a greater return on investment from those individuals, as they typically become healthier due to the prevention of poor outcomes. Coverage stability is particularly critical for individuals with disabilities and those receiving long-term services and supports.

Twelve-month continuous Medicaid enrollment, regardless of any change in status, is currently an option in the case of children, but not adults. Congress could consider adding a state option that would allow for – or even incentivize – twelve-month continuous Medicaid enrollment for all beneficiary populations, regardless of age, in order to achieve greater coverage stability and reduce the gaps between systems where individuals tend to lose access to care.

### L2. Permit states to eliminate waiting periods for all legal residents.

Medicaid eligibility for legal residents currently requires a five-year waiting period. States have the option to eliminate the waiting period for children and pregnant women; thus far, 28 states have done so for children, and 23 have done so for pregnant women.<sup>67</sup> Extending this option to non-elderly adults would permit states to more readily assist those who remain uninsured simply by virtue of the length of time they have resided in the U.S.

Individuals who are granted Deferred Action for Childhood Arrivals (DACA) – a limited immigration benefit created by the Obama administration for undocumented youth – are not eligible for affordable health insurance options such as full Medicaid and CHIP. The policy created a distinction between individuals granted deferred action and those granted immigration relief through other mechanisms. The eligible population in 2016 is estimated at just under 2 million people.<sup>68</sup> Eliminating the distinction between these individuals and other lawfully present immigrants would open pathways to health insurance options that are already available to other populations.<sup>69</sup>

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66 Institute of Medicine (US) Committee on the Consequences of Uninsurance (2002). *Care Without Coverage: Too Little, Too Late*. Washington (DC): National Academies Press (US). <https://www.ncbi.nlm.nih.gov/books/NBK220639/>.

67 Tricia Brooks, Joe Tuschner, Samantha Artiga, Jessica Stephens, & Alexandra Gates (2015). Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <http://kff.org/report-section/modern-era-medicare-medicare-and-chip-eligibility/>.

68 Migration Policy Institute. Deferred Action for Childhood Arrivals (DACA) Data Tools. <http://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles>.

69 National Immigration Law Center (2012). Frequently Asked Questions, Exclusion of Youth Granted “Deferred Action for Childhood Arrivals” from Affordable Health Care. <https://www.nilc.org/issues/health-care/acadafaq/>.

### **L3. Make three years of 100 percent federal financing available to all states that expand Medicaid, regardless of when they begin expansion.**

Under the ACA, states were entitled to 100 percent federal funding between 2014 and 2016 to cover the cost of medical assistance for the adult expansion population. Following this initial time period, federal financing would slowly decline until stabilizing at 90 percent as of 2020. This time frame was adopted on the assumption that all states would begin their expansion coverage in 2014. However, because of the Supreme Court's 2012 decision in *National Federation of Independent Businesses v Sebelius*, expansion effectively became a state option.

As of 2016, 19 states have not yet implemented the expansion. For these states, the three-year 100 percent financing period is no longer available. Nearly three million of the nation's poorest adults remain in the coverage gap created by lack of Medicaid expansion.<sup>70</sup> Those who remain uninsured disproportionately reside in states with some of the lowest traditional Medicaid eligibility levels for adults in the nation. As a result, the coverage gap – and the costs to close it – is even wider than it might be in states with somewhat more generous traditional program eligibility standards. For this population, Medicaid is foreclosed from strategic deployment to advance health, since these individuals are not entitled to coverage. Since the Medicaid expansion has been shown to have a positive impact not only on insurance coverage itself but also on access to the types of services considered effective for improving or maintaining health, creating a pathway to coverage for the population left out to date remains a critical step.

In order to ensure that the incentive to expand Medicaid remains available to all states, Congress might modify the expansion's federal funding formula to provide a three-year 100 percent financing window for all states, no matter the year in which they begin the expansion.

## **Benefits and coverage**

### **L4. Increase the federal financial incentive to expand preventive services to the traditional adult population.**

Preventive services are required for children and adolescents up to age 21 as part of Medicaid's EPSDT benefit, but they are an option for adults under traditional Medicaid coverage rules. With the exception of family planning services and supplies – which are funded at a 90 percent matching rate – federal funding for optional adult preventive services is provided at the same federal medical assistance rate used to pay for other types of medical assistance. The ACA provided a modest one-percentage-point financial incentive for these optional services to encourage states to cover the same range of preventive services for traditional adults as those newly covered under essential health benefits. This would include coverage for all preventive screening and intervention

***Nearly three million of the nation's poorest adults remain in the coverage gap created by lack of Medicaid expansion.***

70 Rachel Garfield & Anthony Damico (2016). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation, Issue Brief. <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update-2>.





services recommended by the United States Preventive Services Task Force (USPSTF).<sup>71</sup> As of 2014, only eight states had submitted proposals to take advantage of this incentive.<sup>72</sup> Low participation rates may have occurred at least in part because such a modest incentive on this small subset of services does not justify the work required to report on them.

With unequal requirements and incentives for access to preventive care between children and adults, Medicaid is falling short of providing efficient and equitable care for many beneficiaries. Preventive services can provide strong returns on investment, and the high-quality prevention and early detection services recommended by the USPSTF have the potential to curb some excessive health care spending on preventable illness. In order to increase the number of states that expand Medicaid benefits to include all USPSTF-recommended preventive services for both traditional and

newly eligible populations, Congress might consider revising the incentive upward from one percentage point to the same 90 percent federal matching rate used for family planning. This 90 percent federal matching rate also applies to all medical assistance services furnished to newly eligible Medicaid beneficiaries beginning in 2020 and thereafter. By aligning the preventive services coverage incentive for traditional adults with the 90 percent federal matching rate used for family planning services, federal Medicaid policy could increase the emphasis on preventive services that have been proven effective, and may even save money in the long term by avoiding much more costly illnesses and other negative health outcomes.

#### **L5. Expand the definition of preventive services to incorporate interventions aimed at patient groups that include Medicaid beneficiaries**

Under federal Medicaid law, preventive services can qualify for federal funding. However, under existing standards, federal financial assistance is available only for preventive services furnished to individual Medicaid beneficiaries. These standards could be revised to cover evidence-based preventive services – when furnished by certified or licensed health professionals and connected to improving physical, behavioral, and/or social determinants of health – for patient groups that include Medicaid beneficiaries, regardless of whether every individual in the group is a Medicaid beneficiary. In so doing, Medicaid would provide health-promoting services not only for specific beneficiaries, but also for group health efforts that improve broader population health. Considering the importance of community and social supports to many health outcomes, services

71 For the full list of USPSTF recommended services, see: U.S. Preventive Services Task Force (2016). *USPSTF A and B Recommendations*. <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

72 Alexandra Gates, Usha Ranji, & Laura Snyder (2014). Coverage of Preventive Services for Adults in Medicaid. The Henry J. Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/>.



that reach a broader population context could have an amplified effect on improving the health of Medicaid beneficiaries. Additionally, such a change would promote health education group services that would improve efficiency.

Some state Medicaid programs already recognize the benefits of group classes for Medicaid beneficiaries.<sup>73</sup> Extending the concept further, such interventions could also be aimed at improving community health by reducing the impact of violence and trauma. Low-income communities often lack access to the kinds of services that would mitigate the negative health outcomes – particularly in terms of mental health – that can result from exposure to violence and trauma in childhood and continue across the lifespan. Medicaid coverage for such services has the potential to incentivize providing these needed and often under-funded services.

## **System transformation, quality improvement, and payment reform**

### **L6. Establish a Medicaid health improvement fund as a state option**

As an insurer, Medicaid has a scope and reach that extends beyond private insurance norms. At the same time, Medicaid is designed to function as health insurance in that coverage is limited to medical and remedial care, devices, and equipment furnished by licensed or certified health professionals and health care institutions. As a result, many of the types of services that could reduce long-term health costs and improve health simply may be unavailable because of significant funding limits for social services programs (e.g., education, housing assistance) in the U.S. For example, home visits by health professionals to assess children’s living environments for risks such as lead or asthma triggers could qualify for federal Medicaid funding as covered EPSDT benefits. However, services that actually remove asthma triggers or lead poisoning threats in the home do not qualify for federal financing. Intensive physical, speech, and other therapies for a child with developmental disabilities would qualify for funding as an EPSDT benefit when furnished by a licensed or certified health professional, but enriched child care programs overseen by trained and certified child care instructors would not.

Research suggests that investments in social, nutrition, educational, housing, and other services designed to address the social determinants may yield improved health while controlling costs by reducing repeated use of emergency departments, frequent inpatient hospitalization, or the higher costs associated with increased severity of existing disabilities or health conditions. The federal government does permit states to use Medicaid as a tool to cover services related to the social determinants of health through several waiver demonstration options. Section 1115 demonstrations, for example, have been used by states on occasion to enable Medicaid coverage for services that would typically not be eligible for federal funding because they are not medical

*Low-income communities often lack access to the kinds of services that would mitigate the negative health outcomes...that can result from exposure to violence and trauma in childhood and continue across the lifespan.*

<sup>73</sup> The Colorado Medicaid program, for example, added diabetes-related training for group or individual assessment and group-only diabetes education as covered benefits. For more information, see: <https://www.colorado.gov/pacific/sites/default/files/DSME%20Fact%20Sheet.pdf>.

in nature. Unfortunately, successive Administrations have declined to make full use of this authority to expand Medicaid to interventions that might enhance health while holding down costs. These demonstrations are also paired with an additional hurdle in that authorized demonstrations must be carried out under special federal requirements, rather than implemented as a state option.

With states actively engaged in health system transformation efforts through the use of integrated service delivery, accountable health organizations, and managed care arrangements, and with promising efforts underway to better integrate health and social services, Congress might consider the creation of a ten-year state Medicaid option enabling states to test alternative financing and delivery reform innovations in health care and social service alignment. A state option approach, with capped allotment to each participating state modeled on Medicaid's disproportionate share hospital payments, could enable partnerships with managed care entities and integrated delivery systems. Together, these stakeholders could introduce reforms to speed the integration of health and social services by assessing how health care services are organized and structured, payment is structured and aligned with performance measures, health care

and social services are aligned, and information is exchanged. In this way, federal financing could be made available to states in accordance with the existing federal funding formula specifically to test new approaches to health and social services integration, without the administrative overlay of the waiver or demonstration process.

### **Strengthening Medicaid performance during economic downturns, when community health needs are greatest**

#### **L7) Support Medicaid's capacity to maintain coverage during economic downturns by revising federal Medicaid financing rules.**

Assuring that low-income families can rely on Medicaid coverage supports a Culture of Health. But economic downturns challenge states' capacity to finance coverage for all who become eligible. Economic downturns increase poverty and joblessness – factors that contribute to Medicaid enrollment growth, and therefore higher costs, at times when states are least likely to be able to afford those increases in spending. Faced with balanced budget requirements, states may cut costs by reducing eligibility levels or benefits – actions that impede stable coverage and belie support for a Culture of Health. The statutory formula that allocates federal financing to states is based on a retrospective three-year rolling average of per capita income that does not keep up with changes in the economy. Congress enacted temporary increases in 2003, 2009, and again in 2010, tying increased federal funding to a requirement that states maintain current enrollment levels, but these emergency measures are neither predictable nor guaranteed. The Government Accountability Office



(GAO) proposed revisions to the dated funding formula that would increase federal funding at the start of downturns by automatically triggering funding based on increases in state unemployment and reductions in total wages and salaries.<sup>74</sup> Such a mechanism represents an option for Medicaid to better promote a Culture of Health by assuring that states receive increased federal funding quickly and can maintain access to coverage when it is most needed.



<sup>74</sup> United States Government Accountability Office (2016). Medicaid: Changes to Funding Formula Could Improve Allocation of Funds to States. Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives; Statement of Carolyn L. Yocom, Director, Health Care. <http://www.gao.gov/assets/680/675072.pdf>.

## CONCLUSION

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Medicaid – a remarkably agile and resilient program and America’s largest public health insurer – has continually evolved to meet the needs of beneficiaries and to test innovations in coverage, payment, and care. Medicaid’s role as a critical lever in building a Culture of Health takes many different forms: promoting healthy births and robust child development that can help children enter school ready to learn and perform to their level of ability, improving the odds that teenagers will emerge from school as healthy young adults ready for higher education and workforce entry, expanding opportunities for people with disabilities to reach their full potential, enabling the elderly to maximize their independence and health, promoting compassionate end-of-life care, and improving prospects for social and community reintegration by ensuring that people who are incarcerated are insured when they are released.

With a large and growing population of individuals who are eligible for Medicaid, as well as an increasing recognition of and emphasis on using health care as a critical entry point for addressing underlying social determinants of health, this is an especially important time to focus on ways to further strengthen Medicaid’s role in promoting a Culture of Health. Medicaid policy can continue to evolve to achieve greater health through both its direct role as a funder of health care and its broader role in supporting services and programs aimed at promoting prevention and population health.

Medicaid can use its leverage in creating a healthy society by providing evidence-based preventive clinical care, facilitating integration of clinical care and community-based services, and supporting health care providers and institutions that are themselves part of community-wide health improvement efforts. Medicaid can place greater emphasis on preventive services – both those that can avert threats to health and those that can alleviate the cost and severity of existing physical and mental health conditions. Medicaid can use its power as a health care funder in order to encourage the development of health care entities that both deliver and coordinate a fuller spectrum of health, educational, nutrition, and social services, and embed clinical care access into community settings such as schools, shelters, and public housing programs.

In positioning Medicaid to more decisively reshape the ways in which health insurance coverage and health care delivery can advance a Culture of Health, several major challenges emerge, including the influence of poverty and an aging population, the cost and complexity of transformation, the availability of funding for social services that promote health, equity gaps in eligibility and continuity of coverage, fragmentation in the health care infrastructure, and misallocation of risks and rewards that limit investment in health-promoting services and transformation incentives.



In order to sustain and expand the progress made to date while overcoming the challenges outlined above, a number of options emerge. Some of these options are administrative in nature, and entail augmenting and making more effective use of the flexibility already built into federal law in the areas of system transformation, quality improvement, and payment reform. Other options may entail further legislative reforms that build on fundamental directional shifts already evident in the Medicaid statute. In addition to addressing system transformation, quality improvement, and payment reform, these legislative options also address eligibility and enrollment, benefits and coverage, and strengthening Medicaid performance during economic downturns, when community health needs are greatest.

Medicaid is a complex program, and bringing about change presents major challenges for policy, practice, and program administration. At the same time, over the past half century Medicaid has demonstrated resilience and a unique ability to respond to far-reaching changes in underlying economic, social, and health circumstances. As the nation continues to build health improvement strategies into the health care system itself, Medicaid – as the nation’s largest public insurer – will play a crucial role in transforming the delivery system’s contours. Furthermore, more than any other insurer, Medicaid stands to gain real value from improvements to population health and health care integration, given the populations and health needs the program insures. Reforms that spur health improvement through the strategic use of Medicaid’s power as an insurer should be central to the program’s future steps towards building a Culture of Health.

***Medicaid policy can continue to evolve to achieve greater health through both its direct role as a funder of health care and its broader role in supporting services and programs aimed at promoting prevention and population health.***



## APPENDIX A. Medicaid's Structure and Impact

**Medicaid is a vital source of insurance in all states for a diverse range of low- and moderate-income population groups: children and adolescents, pregnant women, parents and other caretakers of minor children, children and adults with long-term disabilities, and the frail elderly, especially those in need of long-term services and supports.**

Enacted in 1965, Medicaid began modestly as a source of insurance for individuals and families receiving welfare assistance. States also had the option to cover certain financially needy groups, such as very poor children, as well as “medically needy” people who required high-cost health care, including nursing home care that far outstripped their available incomes and resources. After more than five decades of change and development, Medicaid has evolved into one of the most complex of all social welfare programs.

Medicaid establishes a legal entitlement to coverage for people who are eligible. All states must follow certain federal requirements.<sup>75</sup> Despite the uniformity of certain federal requirements, there can be significant variation in program eligibility, benefits and coverage rules, payment strategies, and, indeed, Medicaid's fundamental interactions with the underlying health care system, all depending on the unique needs of each individual state in response to their social, economic, and political circumstances. Regardless of these variations, however, Medicaid is a vital source of insurance in all states for a diverse range of low- and moderate-income population groups: children and adolescents, pregnant women, parents and other caretakers of minor children, children and adults with long-term disabilities, and the frail elderly, especially those in need of long-term services and supports. By 2014, Medicaid insured 65.9 million people at a total cost of \$495.8 billion.<sup>76</sup> As expansion is adopted by new states and the continued impacts of the Affordable Care Act (ACA) take effect, Medicaid is expected to grow even further in the coming years.<sup>77</sup>

Unlike private insurance, Medicaid is designed to function not only as an insurer but also as a true safety net program on which the entire U.S. health care system has come to depend. As the single largest component of the health care safety net, Medicaid does not rely on the key financial risk management structures that are the lifeblood of private health insurance. People who are eligible can enroll in coverage whenever they need it. Unlike private insurance, the program does not limit access to either open enrollment or designated special enrollment periods, which are essential to avoiding the type of adverse risk selection that can threaten the viability of private insurance programs and increase premiums. Medicaid imposes no waiting periods before coverage begins, and in some cases coverage can even be established retroactively,<sup>78</sup> thereby removing the disincentive to treat people who may be uninsured at the time they receive care. Enrollment continues until a beneficiary is no longer eligible, although states by law must re-determine eligibility both periodically and when new information

<sup>75</sup> Medicaid programs are also found in U.S. territories, but are subject to separate requirements and funding limits.

<sup>76</sup> Anne B. Martin, Micah Hartman, Joseph Benson, Aaron Catlin, & the National Health Expenditure Accounts Team (2016). National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending. *Health Affairs*, 35(1). <http://content.healthaffairs.org/content/early/2015/11/25/hlthaff.2015.1194>.

<sup>77</sup> Congressional Budget Office (2016). Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026. [https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline\\_OneCol.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf).

<sup>78</sup> Medicaid.gov (n.d.). Eligibility. Centers for Medicare and Medicaid Services. Accessed 7/26/2016. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html>.



arises. Medicaid also uses far broader definitions than those found in private health insurance regarding what is – and can be – covered, as well as the settings in which covered services can be delivered. Increasingly Medicaid recognizes the role played by community health workers – who are not licensed clinical professionals but who play a key role in access and quality as a result of their ability to interact in a highly effective manner with community residents – in making high-quality care accessible to vulnerable populations. Medicaid also makes it possible to target new investment on high-need populations and services, and its provider payment structure enables states, health care providers, and managed care organizations to experiment with new approaches to payment and service delivery.

The federal and state governments partner in financing both medical assistance and program administration costs, including costs associated with enrollment, retention of coverage, and care management services that assist in securing access to necessary health, educational, nutrition, and social services. Each partner has a strong interest in controlling spending – the federal government because of Medicaid’s size as a health care entitlement,<sup>79</sup> and state governments because of the essential nature of balancing budgets and controlling spending. At the same time, the fact that federal Medicaid funding is not subject to arbitrary caps or limits – with the exception of the U.S. territories – means that states can consistently rely on it, which becomes particularly critical during economic downturns and periods of rising poverty and unemployment.<sup>80</sup>

Federal Medicaid policy establishes certain minimum benefit and coverage rules, which vary somewhat between traditional beneficiary groups and those who are newly eligible under the ACA (i.e. adults between the ages of 18 and 64 not previously entitled to coverage under a traditional eligibility category, with incomes up to 138 percent of the federal poverty level). As shown in Box A1, coverage standards for traditional beneficiaries are tied to specific classes of benefits and services. On the other hand, beneficiaries eligible under the ACA expansion are entitled to an augmented version of an “essential health benefit” standard that guides insurance coverage in the individual and small group private health insurance markets.

There are differences between the two standards. Traditional Medicaid coverage typically offers greater coverage for long-term services and supports. By contrast, essential health benefits tend to encompass a greater range of evidence-based clinical



79 Congressional Budget Office (2016). The 2016 Long-Term Budget Outlook. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51580-LTBO-One-Col-2.pdf>.

80 Laura Snyder & Robin Rudowitz (2015). Medicaid Financing: How Does It Work and What are the Implications? Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>.

preventive services for adults, many of which are optional for traditional beneficiaries.<sup>81</sup> Regardless of which standard applies, states can add coverage for a wide range of services at their discretion. Box A2 provides a listing of the optional benefits that states can choose to provide for traditional Medicaid beneficiaries.

### **Box A1. Mandatory Benefits Traditional versus ACA-Eligible Beneficiaries**

**States must cover the following benefits:**

#### ***Mandatory Benefits for Traditional Beneficiaries***

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

#### ***Essential Health Benefits for ACA- Eligible Beneficiaries***

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care (both before and after birth)
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services

<sup>81</sup> Sara Rosenbaum, Devi Mehta, Mark Dorley, Carla Hurt, Sara Rothenberg, Nancy Lopez, & Sara Ely (2015). Medicaid Benefit Designs for Newly Eligible Adults: State Approaches. The Commonwealth Fund, Pub. 1815, Vol. 11. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1815\\_rosenbaum\\_medicaid\\_benefit\\_designs\\_newly\\_eligible\\_adults.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1815_rosenbaum_medicaid_benefit_designs_newly_eligible_adults.pdf).

## **Box A2. Optional Medicaid Benefits for Traditional Beneficiaries**

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive, and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services – 1915(i)
- Self-Directed Personal Assistance Services – 1915(j)
- Community First Choice Option – 1915(k)
- Tuberculosis (TB) Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary
- Health Homes for Enrollees with Chronic Conditions – Section 1945

For both traditional and ACA-eligible populations, federal cost-sharing principles apply in order to keep care affordable for beneficiaries who, by definition, are low-income or medically impoverished and vulnerable (Box A3).<sup>82</sup>

### Box A3. Cost-Sharing Principles

| Exemptions from Premiums and Cost-Sharing           |  |   |   |
|---|--|---|---|
| Exempt populations                                  | Those exempt from most types of cost sharing include most children under age 18, pregnant women, beneficiaries receiving hospice care, certain beneficiaries in institutions such as nursing facilities and intermediate care facilities, American Indians who are furnished a Medicaid item or service through an Indian Health Service provider or through a contract health service referral an individuals eligible for Medicaid under the Breast and Cervical Cancer Act pathway. Except for certain pregnant women about 150% FPL, these populations are also exempt for premiums. |   |   |
| Exempt services                                     | Emergency services, family planning services and supplies, preventive service for children regardless of family income, pregnant related services, and services relate to provider-preventable conditions are exclude from cost-sharing.   |   |   |
| Aggregate Limit Allowable Premiums and Cost-Sharing |  |   |   |
| Aggregate limit for all populations                 | The total amount of premiums and cost-sharing incurred by individuals as in Medicaid households may not exceed 5% of the family's monthly or quarterly income.   |   |   |
|   | At or below 100% FPL   | 100%-150% FPL   | Above 150% FPL  |
| Allowable Premiums                                  |  |   |   |
| Specified populations                               | Up to \$20.00 per month for individuals eligible under a medically needy pathway. Sliding scale based on income for individuals eligible under certain disability pathways for children and working adults.  | Same as rules at or below 150% FPL for medically needy and disability pathways. Up to 10% of amount by which income exceed 150% FPL for certain pregnant women. |   |
| All other populations                               | Not permitted  | No specific limit   |   |
| Allowable Cost-Sharing                              |  |   |   |
| Outpatient services                                 | Up to \$4.00.  | Up to 10% of the amount the Medicaid agency pays.   | Up to 20% of the amount the Medicaid agency pays.   |
| Inpatient stays                                     | Up to \$75.00.   | Up to 10% of the amount the Medicaid agency pays.   | Up to 20% of the amount the Medicaid agency pays.   |
| Non-emergency use of the emergency department       | Up to \$8.00.  |   | No specific limit   |
| Prescribed drugs                                    | Preferred drugs up to \$4.00. Non-preferred up to \$8.00.  |   | Preferred drugs Up to \$4.00. Non-preferred up to 20% of the amount the Medicaid agency pays. |

82 MACPAC (n.d.). Cost sharing and premiums. Accessed October 5, 2016. <https://www.macpac.gov/subtopic/cost-sharing-and-premiums/>.

Federal payment standards apply to select classes of health care providers, such as hospitals that treat a disproportionate share of low-income and Medicaid beneficiaries (known as DSH hospitals), rural health clinics, and community health centers (which are known as federally qualified health centers (FQHCs) for the purposes of Medicaid, Medicare, CHIP, and qualified health plan payments). At the same time, federal payment standards permit states and providers, including community health centers and rural health clinics, to negotiate alternative payment approaches that can better promote efficiency and quality.

Operating under extensive federal standards, states nonetheless play a leading role in shaping the fundamental aspects of the program, from eligibility and coverage to service delivery and provider payment. In doing so, states can adapt their programs to reflect their own priorities and meet population health needs.

Since the conditions of health, as well as the structure of health care service and delivery, can vary from state to state – and indeed, within localities in a single state – states play a key role in the design of program details and the delivery system on which Medicaid financing rests. Within federal limits, states can add benefits and establish the amount, duration, and scope of coverage they will provide. They can determine the settings in which they will authorize payment for covered services, such as care furnished in the home or in community settings. They also determine the basic health care delivery and payment strategies they will utilize, including the use of managed care and integrated delivery systems.

States also make important choices regarding what, and how much, preventive care to cover. This is true with respect to both services aimed at the early identification and removal of health risks, as well as services that can help alleviate or lessen the effects of identified risks. Examples include smoking cessation, adult oral health care, home-based services to reduce health threats (e.g., for childhood asthma), care management for children and adults with potentially serious and long-term physical and mental health conditions (e.g., health conditions complicated by or connected to food insecurity, diabetes, or conditions associated with adverse childhood experiences), and supportive housing and employment. Medicaid's basic program flexibility is enhanced in several ways. Within the Medicaid statute itself, Congress has included a series of waiver authorities that augment regular state plan options by enabling states to expand home and community-based services for people who otherwise might require or be at risk for institutional care.<sup>83</sup> Waiver provisions within the program also permit states to introduce types of managed care arrangements and cost efficiencies related to the purchase of health care.



83 42 USC §1396n; Terence Ng, Charlene Harrington, MaryBeth Musumeci, & Erica L. Reaves (2012). Medicaid Home and Community-Based Services Programs: 2012 Data Update. Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/>.



In addition, Medicaid's statutory limits can be expanded by Section 1115 of the Social Security Act,<sup>84</sup> which predates Medicaid itself. Section 1115 authorizes the Secretary of Health and Human Services to alter federal Medicaid requirements and payment policies in order to conduct demonstrations that s/he believes will further the program's objectives. Since the Carter Administration, 1115 demonstrations have been administered on a budget-neutral basis.<sup>85</sup> Today, these demonstrations – which offer a

range of variations on federal Medicaid program rules – represent many types of innovations in eligibility, coverage, service delivery, and payment reform, all designed to test new ways of operating Medicaid. Many of these demonstrations span decades. As a means of introducing new approaches to federal funding and administration rules, 1115 has become a program staple. For example, 1115 played a critical role in extending Medicaid's transition into the managed care structure on which the program rests heavily today. Experiments in long-term services and supports in community settings predated many of the state flexibilities built into the statute over time. Eligibility expansion through 1115 demonstrations ultimately yielded the ACA's coverage reforms for the non-elderly poor, and demonstrations aimed at improving Medicaid's

performance in the area of family planning have led to permanent changes in state options to strengthen family planning coverage and services.

The diversity of the Medicaid beneficiary population and the complexity of their health needs and challenges give state programs the incentive to act as an innovator in health care delivery and payment reform across the full spectrum of health needs. Although the purchase of private health insurance has been a state option since 1965, amendments enacted in 1981 began Medicaid's lengthy transformation to a program that makes extensive use of what is known today as managed care: coverage furnished through a network of health care providers organized and overseen by a managing organization. Such an organization may specialize in Medicaid managed care or – as is increasingly common – may offer plans across a range of insurance markets, especially the new health insurance marketplaces.<sup>86</sup> Today, states have the option to enroll most beneficiary groups into managed care plans as a condition of coverage. Managed care accounts for

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84 Social Security Act, Sec. 1115. [42 U.S.C. 1315].

85 MACPAC (2015). Chapter 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform. *Report to Congress on Medicaid and CHIP*. <https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf>.

86 Sara Rosenbaum (2014). Addressing Medicaid/Marketplace Churn through Multimarket Plans: Assessing the Current State of Play. *Journal of Health Politics, Policy and Law*, 40(1), 233-242. <http://jhppl.dukejournals.org/content/40/1/233.full>.





55 million beneficiaries – 77 percent of Medicaid enrollees.<sup>87</sup> On numerous occasions, the HHS Secretary has used Section 1115 to allow states to make broader use of Medicaid managed care than is normally permitted under traditional program standards. Program rules also permit states to use targeted case management for beneficiaries with complex health needs,<sup>88</sup> thereby offering more efficient and effective tools where a traditional managed care plan may not provide sufficiently intensive support.

More recently, states have experimented with initiatives to encourage greater patient participation in health improvement. In 2011, ten states were selected to participate in special Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) demonstrations to test the effectiveness of incentives to help beneficiaries change health behaviors.<sup>89</sup> These ten states have implemented evidence-based disease prevention and management programs that encourage program participation and completion and do not include cost sharing increases. These initiatives ended in December 2015, and an evaluation of the outcomes is expected in 2017. Three states – Indiana, Iowa, and Michigan – expanded Medicaid through 1115 waivers that included new, higher cost-sharing requirements for some enrollees. The waivers, which are controversial and whose effects on beneficiary health and wellness activities have not yet been evaluated, seek to incentivize participation by reducing otherwise-applicable cost sharing for those who participate in wellness programs or complete health risk assessments. Several other states have included similar provisions in more recent waiver requests to CMS.

***The diversity of the Medicaid beneficiary population and the complexity of their health needs and challenges give state programs the incentive to act as an innovator in health care delivery and payment reform across the full spectrum of health needs.***

87 Centers for Medicare and Medicaid Services (2016). Medicaid Managed Care Enrollment and Program Characteristics, 2014. U.S. Department of Health and Human Services. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>.

88 Sara Rosenbaum (2008). The CMS Medicaid Targeted Case Management Rule: Implications for Special Needs Service Providers and Programs. Center for Health Care Strategies: Issue Brief. [http://www.chcs.org/media/CMS\\_Medicaid\\_Targeted\\_Case\\_Management\\_Rule.pdf](http://www.chcs.org/media/CMS_Medicaid_Targeted_Case_Management_Rule.pdf).

89 The ten states selected to participate in MIPCD demonstrations are: CA, CT, HI, MN, MT, NH, NV, NY, TX, and WI. For more information, see: <https://innovation.cms.gov/initiatives/mipcd/>.

## Box A4. Payment Reform to Encourage Health

CMS is partnering with states to put demonstration and system reform funds to work to change the way people gain access to health and social services. Future evaluation of these demonstrations may help to identify best practices for improving individual and community health.

**Oregon**, operating under 1115 demonstration authority, has used Medicaid to help create Coordinated Care Organizations (CCOs).<sup>90</sup> These comprehensive managed care arrangements not only insure their members, but also combine delivery capacity for both health care and social services in order to promote access to social, housing, nutrition, and environmental services that can lower costs over time. Examples of ways in which CCOs can improve access to health promoting services using health care as the point of intervention include: air conditioners that can lower the risk of hospitalization for beneficiaries with severe asthma or congestive heart failure, vacuum cleaners to help control allergens and thereby reduce asthma triggers,<sup>91</sup> nutrition assistance as part of a hospital discharge plan, and community health workers who can link pregnant and parenting teens to medical, housing, food, and income services.<sup>92</sup>

**Washington's** 1115 demonstration waiver identifies transforming the Medicaid delivery system through Accountable Communities of Health as one of its three initiatives. ACHs create partnerships among local organizations (e.g., health care providers, health plans, public health agencies, local government, social service agencies) to coordinate activities and investments and improve health. They focus on prevention activities, primary care and behavioral health integration, and workforce development. ACHs will create regional collaboratives to organize local services, select transformation projects based on community needs, manage the financing and implementation of transformation projects, and build and broker clinical-community linkages to establish effective models of coordinated care.<sup>93</sup>

**New York** has aligned its Medicaid 1115 delivery system reform efforts with its state Prevention Agenda, creating synergy among programs and providing financial incentives to improve population health. The state's program provides incentives for providers to collaborate at the community level to improve the care delivered to Medicaid beneficiaries. New community-based organizations conduct community health care needs assessments based on multi-stakeholder input and objective data, implement projects based on the needs assessment, and report on outcomes. Population-wide projects must align with the priorities of the New York State Prevention Agenda, making Medicaid a key instrument in achieving the Prevention Agenda's goal.<sup>94</sup>

90 Oregon Health Policy Board (n.d.). Coordinated Care: The Oregon Difference. <http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx>.

91 Oregon Health Authority (2013). Flexible Services: Frequently Asked Questions. <http://www.oregon.gov/oha/Transformation-Center/Resources/Flexible-services-final.pdf>.

92 Harry J. Heiman & Samantha Artiga (2015). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. The Henry J. Kaiser Family Foundation. <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

93 Healthier Washington (2016). Medicaid Transformation Initiative #1: Transformation through Accountable Communities of Health. <http://www.hca.wa.gov/assets/program/waiverfactsheet-i1.pdf>.

94 New York State Department of Health (2015). DSRIP Domain 4 and the Prevention Agenda. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016/d4guidance\\_2015-06-08\\_final.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/d4guidance_2015-06-08_final.htm).

Medicaid can provide the supportive services to deliver meals to the homes of Medicaid beneficiaries with functional limitations. The HHS Secretary and states have used Section 1115 to recognize costs associated with home-delivered, medically tailored food and nutrition services as part of an integrated program of long-term services and supports to “severe disease populations,” including people living with HIV/AIDS.<sup>95</sup>

Virtually all Medicaid programs rely on safety net health care providers who serve lower-income communities and have adapted their services to meet their more expansive health needs. Leading examples of such providers are community health centers (which in 2015 served 12.3 million Medicaid beneficiaries, one in six beneficiaries nationally)<sup>96</sup>; public and private DSH hospitals; clinics supported through Title X of the Public Health Service Act, which funds comprehensive family planning programs; clinics for patients with HIV/AIDS, funded under the Ryan White Care Act; community mental health centers; and clinics operating under the aegis of state and local public health agencies. Safety net providers are likely to offer both clinical and social services onsite; to offer assistance with scheduling, transportation, and translation; and to have formal working relationships with key social service, educational, nutrition, and employment programs in the community.

Safety net providers form the backbone of health care for low-income and medically vulnerable populations. Just as Medicaid programs rely more extensively on safety net providers, safety net providers rely on Medicaid as an essential resource for sustaining operations. Because of this reciprocal reliance, the close relationship between Medicaid and safety net providers offers the potential to introduce innovations that can simultaneously improve health outcomes and strengthen the quality and capacity of these anchoring institutions and clinics.

Long-term services and supports (LTSS) are a critical focus of all state Medicaid programs, given the importance of these services to the elderly and individuals with disabilities. Together these beneficiaries make up approximately 21 percent of the total beneficiary population.<sup>97</sup> For the low-income elderly and those otherwise qualified through Medicare, Medicaid provides critical assistance paying for Medicare’s cost-sharing requirements and, for the very low-income, wrap-around benefits providing coverage for additional services otherwise only available through supplemental plans. One of the most dramatic evolutions under Medicaid – parallel to the transition to managed care – has been the transformation of Medicaid’s role in financing LTSS. As recently as 20 years ago, the majority of Medicaid LTSS spending was for institutional care; by Fiscal Year 2013, spending on services and supports furnished in home and

***One of the most dramatic evolutions under Medicaid – parallel to the transition to managed care – has been the transformation of Medicaid’s role in financing LTSS.***

95 God’s Love We Deliver and The Center for Health Law and Policy Innovation of Harvard Law School (2015). The Food Is Medicine Advocacy Toolkit. <http://www.chlpi.org/wp-content/uploads/2014/01/Food-is-Medicine-Advocacy-Toolkit-Oct-2015.pdf?pdf=advocacy-toolkit>

96 Bureau of Primary Health Care, HRSA, HHS (2015). Uniform Data System (Health Center Program Grantee and Look-Alike Data). <http://www.bphc.hrsa.gov/datareporting/index.html>.

97 U.S. Department of Health and Human Services (2014). 2014 CMS Statistics. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2014\\_final.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf).

community-based settings had surpassed institutional spending.<sup>98</sup> Because Medicaid is by far the dominant LTSS payer, the program has been a pioneering and innovative force in supporting access to care for the elderly and individuals with disabilities in their own communities. Federal policy has changed dramatically over the years to encourage – and, to some degree, require – these innovations by giving states the flexibility to create service delivery models that emphasize patient-directed care and supports,<sup>99</sup> services furnished in community settings, and integration with social services and activities.

To enable states to design programs that meet the needs of their populations, federal funding is open-ended; that is, for every dollar states spend on covered medical assistance services furnished by qualified health care providers to people who are eligible, the federal government will pay a percentage of the expenditure. The federal medical assistance percentage, as it is known, varies depending on state per capita income.<sup>100</sup> However, the federal funding formula draws on state economic data that may lack currency during periods of economic hardship when per capita income falls. As a result, confronted with balanced budget requirements, states often make program cuts at precisely the time when Medicaid might be needed most – as poverty rates, unemployment, and underemployment rise. These times of economic hardship focus a bright light on the lack of what experts refer to as countercyclical funding – a timely increase in federal Medicaid funding as states' own Medicaid spending capabilities decline.<sup>101</sup> Congress most recently used such an approach to Medicaid financing in its 2009 economic stimulus legislation, which coupled enhanced federal funding with temporary maintenance of effort rules. In combination, both reforms, although temporary, helped states avoid the types of program reductions that could have led to a substantial adverse impact on health care access and health outcomes, such as those experienced in past economic downturns.<sup>102</sup>

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98 Steve Eiken, Kate Sredl, Brian Burwell, & Paul Saucier (2015). Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Truven Health Analytics. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>.

99 Mary Takach (2012). About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations. *Health Affairs*, 31(11), 2432-2440. <http://content.healthaffairs.org/content/31/11/2432.full.pdf>.

100 42 U.S.C. §1396b.

101 Laura Snyder and Robin Rudowitz (2015). Medicaid Financing: How Does It Work and What are the Implications? Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>.

102 Nicole Lurie, Nancy B. Ward, Martin F. Shapiro, & Robert H. Brook (1984). Termination from Medi-Cal — Does It Affect Health? *New England Journal of Medicine*, 311, 480-484. <http://www.nejm.org/doi/pdf/10.1056/NEJM198408163110735>.



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