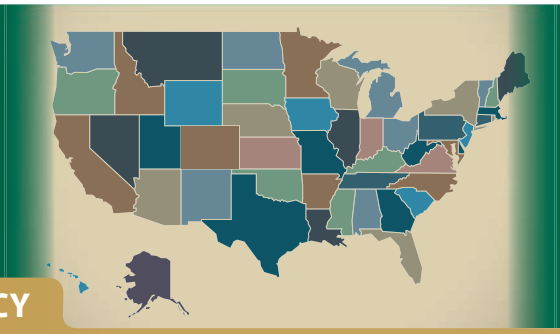


HEALTH POLICY

NATIONAL ACADEMY OF SOCIAL INSURANCE

June 2017 • No. 14

MEDICAID'S ROLE IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH:

OPPORTUNITIES FOR STATES

By **Debra J. Lipson***

Since 1965, Medicaid has provided access to essential health care to millions of American children, adults, people with disabilities, and seniors living in poverty. The number of Americans covered by Medicaid has grown from about 46 million in 2005 to almost 69 million in 2015, making Medicaid the nation's single largest source of health insurance.[1] Another 5 million children are covered by the Children's Health Insurance Program (CHIP). In 2016, more than one in every four people in the U.S. was enrolled in Medicaid or CHIP at some point during the year. As Medicaid enrollment has grown, so has its cost. Federal and state spending on Medicaid reached $556 billion in 2015, compared to approximately $310 billion in 2005.[2] Because state governments pay for nearly half of total program costs, Medicaid's share of state budgets (excluding federal revenue) has also grown from 11 percent in 2000 to 15 percent in 2014.[3] Consequently, Medicaid cost control has been a perennial theme in state budget deliberations.

Recent initiatives by state Medicaid leaders to collaborate with schools, housing and social service agencies, nutrition programs, and others to improve the health status of Medicaid beneficiaries could be dismissed as an unaffordable luxury.

Rising costs have recently led to a focus on reducing federal Medicaid spending, as well. The American Health Care Act of 2017, passed by the U.S. House of Representatives in May 2017, proposes to reduce federal outlays on Medicaid by $834 billion over the next 10 years, a 25 percent decline compared to projected spending under current law.[4] When this brief was written, the Senate had not yet decided whether, or how much, to cut federal Medicaid spending.

In the context of the current policy environment, which raises fundamental questions about the role of Medicaid as a health care safety net for poor and vulnerable Americans, state policymakers will be challenged just to maintain access to essential medical care. If federal Medicaid spending is reduced significantly, state governments will face difficult choices: Raise revenue to compensate for the loss of federal funds? Reduce Medicaid coverage of medical care and long-term services and supports? Restrict eligibility in order to reduce Medicaid rolls? Or perhaps all three? Recent initiatives by state Medicaid leaders to collaborate with schools, housing and social service agencies, nutrition programs, and others to improve the health status of Medicaid beneficiaries could be dismissed as an unaffordable luxury.

***Debra J. Lipson** is a Senior Fellow at Mathematica Policy Research and a member of the National Academy of Social Insurance.
Alexandra L. Bradley provided research support to this project.

But there is a strong business case for state Medicaid programs to address the social determinants of health as a key strategy for providing cost-effective, efficient medical care. Social determinants of health are the economic, educational, housing, environmental, and social conditions that affect health outcomes, both directly and indirectly (Figure 1). When combined with timely access to primary and preventive care, behavioral health and substance abuse treatment, and long-term services and supports in the home and community, efforts to address the social determinants of health for Medicaid beneficiaries can help to reduce the unnecessary use of the most expensive medical services. Both strategies—providing access to essential health care and addressing the social determinants of health—are important to the long-term financial sustainability of Medicaid.

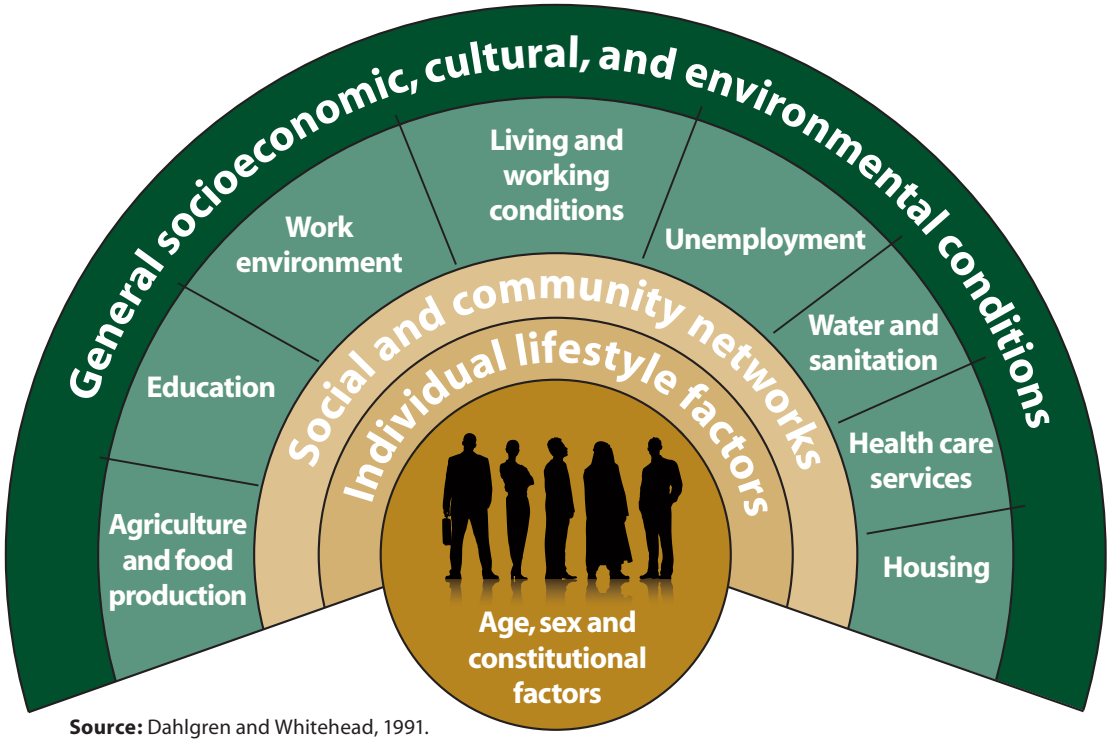
Both strategies—providing access to essential health care and addressing the social determinants of health—are important to the long-term financial sustainability of Medicaid.

This issue brief explains how Medicaid agencies can address the social determinants of health (SDH). First, it reviews the evidence demonstrating a link between health status and poverty, inadequate housing, poor nutrition, or other social deficits. Second, it summarizes the business case for Medicaid to support interventions to reduce the economic, educational, housing, and nutritional risks to health, in order to control Medicaid spending on the most expensive care. Third, it describes current opportunities—and limitations—for using Medicaid as a lever to address SDH, and various roles that state Medicaid agencies can play when partnering with other sectors. Last, the brief discusses new avenues and prospects for state policymakers to tackle SDH through Medicaid Section 1115 demonstration waivers and, potentially, through block grants.

The Links between Health Status and the Social Determinants of Health

The association between income and health is well-established. Americans with lower incomes live shorter lives than those with higher incomes; a man in the poorest income group dies nearly 15 years younger than a man in the highest income group, and among women the gap is 10 years.[6] That gap is also growing. Between 2001 and 2014, differences in life expectancy increased across income groups in the U.S. Among those in the top 5 percent of

Figure 1. Social Determinants of Health Framework[5]



Source: Dahlgren and Whitehead, 1991.

Medicaid—People and Benefits Covered

Low-income children receive immunizations, primary care, behavioral health care, and a wide range of other services that allow them to go to school healthy and ready to learn.

Pregnant women receive prenatal care and delivery services, which increases the likelihood that they will give birth to healthy babies. Medicaid also pays for intensive care for infants born prematurely or with serious health problems.

People with disabilities and the frail elderly receive hands-on care with bathing, eating, and other activities of daily living, allowing them to live independently at home and in community settings, or in institutions if they need extensive care.

Low-income working-age adults receive acute, primary, and specialty care, as well as behavioral health and substance use treatment, helping them to work or participate in job training programs.

the income distribution, life expectancy increased by 2.34 years for men and 2.91 years for women, compared to just 0.32 years for men and 0.04 years for women in the bottom 5 percent of the income distribution.[7] The association between socioeconomic status and longevity also applies to many other health indicators, including infant mortality, activity limitations, heart disease, diabetes, and obesity. The relationship holds across the full gradient of income levels; people with the lowest income and lowest education levels are the least healthy, and those with middle income and education levels are less healthy than the wealthiest and most educated.[8]

Americans with lower incomes live shorter lives than those with higher incomes; a man in the poorest income group dies nearly 15 years younger than a man in the highest income group, and among women the gap is 10 years.

There is also strong evidence demonstrating causal links between poverty and health, with cause-and-effect going in both directions. Those in poor health are more likely to have low income because their health status prevents them from working or lowers their earning ability.[9] Conversely, those living in low-income households are more likely to be in poor health because they have less access to medical care, have less education, are more likely to live in unsafe housing conditions, and are more likely to be exposed to pollution and environmental hazards.[10]

Similarly, housing status and health status are closely related. Serious health problems can cause homelessness, while being homeless can cause or exacerbate health conditions.[11] People who are homeless have higher rates of mental illness and substance use disorders, and are more likely to have chronic conditions like diabetes, hypertension, and HIV/AIDS.[12] Substandard housing conditions also are associated with adverse health outcomes, such as lead poisoning, which contributes to cognitive deficits and stunted development in children.[13] Housing stability is also an important factor in promoting health. People who have difficulty paying rent (defined as spending more than 50 percent of household income on housing) or make frequent moves are less likely

to have a usual source of health care, and have more hospital admissions and emergency room visits, than people who have stable housing.[14] The shortage of affordable and accessible housing for people with disabilities has been cited as the most significant barrier to helping people move out of costly nursing homes or other institutions into less expensive residences in the community.[15]

High-quality nutrition is important throughout life, but particularly during pregnancy and early childhood, when good nutrition is essential for growth and healthy development. Diets that are high in fat and refined carbohydrates, along with increasingly sedentary lifestyles, have contributed to rising rates of obesity, diabetes, cardiovascular disease, hypertension, and stroke, and are major causes of disability, premature death, and rising health care costs.[16] Hunger and food insecurity—that is, worrying about or not having enough money to buy more food, or cutting the size of meals or skipping meals due to lack of enough money—contribute to health problems such as increased hypoglycemia among adult diabetics, and are associated with increased use of emergency department visits.[17]

Preventive services such as immunization and cancer screening, as well as access to medical care to treat health conditions, remain important determinants of health status. Yet, strong evidence shows that one's socioeconomic circumstances and health-related behaviors such as smoking, diet, and exercise are key factors that influence life expectancy, mortality, and health status.

The Business Case for Medicaid Investment in Addressing the Social Determinants of Health

In addition to improving health outcomes, there is a strong business case for Medicaid programs and Medicaid managed care plans to invest resources into addressing the social determinants of health for beneficiaries. A growing body of evidence—based on independent, reliable research—indicates that certain interventions targeted at those who can benefit most can produce significant savings to the health care sector.

More than a dozen state Medicaid agencies, for example, are now supporting intensive case management programs to address the factors that lead to frequent emergency department (ED) use and numerous hospitalizations by beneficiaries with high costs and complex care needs, including access to medical care as well as social determinants of health. Sometimes called "super-utilizers," these beneficiaries have nearly twice as many hospital admissions and higher hospital costs per stay (approximately $12,000 versus $9,000) than other Medicaid patients.[18] Among those with extremely high numbers of emergency room visits—15 or more per year—over 60 percent had a history of both serious mental illness and substance use, compared to 10 percent of those with just one annual ED visit.[19] Although super-utilizers make up only 5 percent of the overall Medicaid population, they are responsible for over 50 percent of total Medicaid expenditures.[20]

Programs to reduce the number of hospital admissions and ED visits for this group are multi-faceted, but nearly all utilize intensive case management to coordinate care across multiple providers, help people better manage chronic illnesses, and address the root causes of their health problems—the social determinants of health. The cost of these programs ranges from $1,850 to $4,165 per person per year, and they have yielded 30-40 percent decreases in inpatient admissions.[21] The Chronic Care Management program in the state of Washington, for example, reduced hospital use by nearly 10 admissions per 1,000 member months, saving approximately $318 per person monthly.[22] An intensive care coordination project at Bellevue Hospital Center in New York City decreased inpatient admissions by 37 percent among Medicaid beneficiaries at high risk, decreasing annual costs to Medicaid by an average of nearly $16,400 per patient.[23] One of the best-known programs,

sponsored by the Camden Coalition of Healthcare Providers, has successfully reduced total monthly visits to both hospitals and EDs by about 40 percent per month, decreasing the overall cost of care for their patients by 56 percent.[24]

Key to producing a positive return-on-investment in programs aimed at super-utilizers are several elements: (a) targeting patients with the highest utilization—at least three inpatient admissions in the past year—who are most likely to benefit from the intervention; (b) comprehensive assessment and care planning to address the wide range of physical health, behavioral health, and social needs; (c) engaging the individual and his or her family in self-care for chronic conditions; and (d) connecting individuals to community resources, ranging from arranging transportation to medical appointments to housing supports.[25]

Programs to reduce the number of hospital admissions and ED visits for this group are multi-faceted, but nearly all utilize intensive case management to coordinate care across multiple providers, help people better manage chronic illnesses, and address the root causes of their health problems—the social determinants of health.

Indeed, safe, accessible, and affordable housing is among the most critical of the social determinants of health. The supportive housing model helps people who are homeless, or at risk of losing their home, locate permanent affordable housing. These programs also provide case management to coordinate and link patients to primary and specialty health care, behavioral health services, substance use disorder treatment, and other community services. When targeted to those at greatest risk, this model has been shown to improve health and lower health care costs. For instance, an evaluation of Massachusetts' Home and Healthy for Good Program, which housed hundreds of chronically homeless individuals in supportive housing, found that the program reduced Medicaid costs by 67 percent after one year of program enrollment; taking into account the cost of housing and program services, the estimated return on investment to the state was $9,118 per person.[26] A program run by the Chicago Housing for Health Partnership provided transitional housing after discharge from the hospital, secured long-term housing, and provided case management services in housing sites. Compared to usual care—regular discharge planning from hospital social workers—the program reduced both the number of hospital admissions and time spent in a hospital, each by 29 percent, and reduced emergency room visits by 24 percent.[27] States participating in the Money Follows the Person demonstration program, which helps people living in institutions return to the community, have found that providing housing-related services—such as assistance with housing searches or one-time moving expenses—is a key ingredient of success for transitioning people with disabilities out of costly nursing homes.[28] One study of Medicaid investment in supportive housing concluded:

> *If the supportive-housing-based care management services generated a 15-20 percent reduction in total Medicaid costs—a seemingly reasonable estimate based on published studies—these savings would equal between $300-$400 PMPM [per member per month]. Since these estimates exclude the cost of care management services, Medicaid should be willing to support up to $300-400 in PMPM care management fees, as such an investment would be cost-neutral from a state budget perspective and would likely generate better health outcomes and reduced rates of expenditures over time. To the extent that care management fees were lower than this threshold, the investment would result in net savings to the state.*[29]

The business case for investing in programs to address SDH applies to Medicaid managed care plans as well as state Medicaid agencies. More than two-thirds of all states contract with private managed care plans to provide Medicaid benefits to enrolled populations. The plans hold financial risk for providing all services within a fixed monthly payment per person (called capitation rates). Consequently, Medicaid managed care plans have a financial stake in tackling the social determinants of health to the extent that they affect their bottom lines.[30] In addition, Medicaid managed care plans are increasingly seeking contracts with provider organizations that hold the providers financially accountable for patient quality and cost outcomes.[31] Known as value-based payment (VBP) models—which include capitation rates, bundled payment rates for treating an episode of illness, shared savings arrangements, and penalties for hospital readmissions—VBP has thus far focused on physical and behavioral health care services, but is expected to evolve to give providers strong economic incentives to address the social factors that contribute to high rates of hospital and emergency room use as well.

Leveraging Medicaid to Address the Social Determinants of Health under Existing Policy

Medicaid agencies, managed care plans, and provider organizations can use a wide range of strategies and policy levers to put cost-effective programs into practice that address the social determinants of health for Medicaid beneficiaries. The strategies discussed in this section are available through current Medicaid authorities (as of May 2017).[32] While some of these strategies require states to submit Medicaid State Plan Amendments or waiver applications to secure federal authority for implementation, in most cases, the process is straightforward and takes three to six months. By contrast, Section 1115 demonstrations permit even greater flexibility to experiment with new financing and delivery approaches, but often take a year or longer to secure and must be negotiated with the Centers for Medicare & Medicaid Services (CMS), as discussed in the next section. Existing options to address SDH include:

Medicaid agencies, managed care plans, and provider organizations can use a wide range of strategies and policy levers to put cost-effective programs into practice that address the social determinants of health for Medicaid beneficiaries.

Medicaid benefit coverage: Currently, all states must provide certain mandatory benefits—such as hospital, physician, nursing home, laboratory, and x-ray services—but have flexibility to define the amount, scope, and duration of such services. In addition, states have the option to cover a range of other services, such as targeted case management, which can help individuals gain access to needed medical, social, educational, housing, and other services. Medicaid agencies can also provide housing-related services for people with disabilities, including those who are chronically homeless, either through Section 1915(c) home and community-based services (HCBS) waiver programs, or through other state plan options covering HCBS such as 1915(i) and 1915(k) Community First Choice.[33] These housing-related services include: (a) transition services to help these individuals find permanent housing; and (b) housing and tenancy sustaining services. For beneficiaries with disabilities, HCBS waiver authority also allows states to provide employment-related services, such as training in workplace safety and mobility, as well as peer-support, which matches people with serious mental illness and pays the peer workers to help their peer obtain employment. An evaluation of a peer-support program

in Georgia found that it saved nearly $6,000 annually per person in its first three years by substituting for more expensive day treatment programs.[34]

Medicaid managed care "value-added services": About two-thirds of Medicaid beneficiaries are enrolled in risk-based managed care programs, in which states contract with private managed care plans to provide all covered benefits for a fixed monthly amount per person. Current federal rules allow Medicaid managed care plans to substitute state-plan-covered benefits with more cost-effective services,[35] and to provide services not otherwise covered in the state plan if they choose to do so. This represents an important opportunity. Managed care plans can provide a host of housing and other social supports that substitute for, or offset the cost of, expensive medical care. For example, managed care plan representatives reported providing food vouchers to patients at risk of developing diabetes, paying for pest control in the homes of children with severe asthma, and covering post-discharge care in special recovery units for patients who are homeless.[36]

Managed care plans can provide a host of housing and other social supports that substitute for, or offset the cost of, expensive medical care.

Patient-centered medical homes: This model represents a comprehensive form of primary care that aims to enhance access to timely care, provide risk-stratified care management, engage patients and their caregivers in self-care, and coordinate care with other providers. About half of state Medicaid agencies operate some type of patient-centered medical home (PCMH) model.[37] While PCMH programs tend to focus on improving access to primary care and rationalizing the use of specialty referrals, it can serve as a platform for linking patients with non-medical services and supports to affect the social determinants of health. For example, Oregon's Coordinated Care Organizations are integrating SDH data into electronic health records to coordinate referrals to community services.[38]

Medicaid Health Homes: As of November 2016, 20 states and the District of Columbia have approved Medicaid

Health Home programs.[39] Available as a new Medicaid state plan option since 2011, the program provides intensive care coordination and management for beneficiaries with chronic physical and behavioral health conditions. Designated Health Home providers coordinate physical and behavioral health care across settings and connect patients to community-based social services and supports. While similar to patient centered medical homes, Medicaid Health Homes include a broader set of providers, rather than just primary care physicians as in PCMHs, and are required to link patients with community services and supports, such as employment and community integration support. Savings can be sizable; for example, an evaluation of Iowa's Health Home program found that it saved $132 per beneficiary in the first month of enrollment, increasing by $10.70 per beneficiary in each additional month, with total savings for the state estimated at over $9 million after the first year.[40]

Partnerships: Besides covering and paying for specific services, Medicaid has a critical role to play in collaborating with housing agencies, schools, social service organizations, and other groups at the state and local level. For example, CMS describes Medicaid agency options for promoting stable, affordable housing for Medicaid beneficiaries to include "formal and informal agreements with state and local housing and community development agencies to facilitate access to existing and new housing resources."[41] One state Medicaid director describes the various roles Medicaid can play as ranging from "seat of strategy to

convener among sister departments to partner with state entities and community partners."[42] As a result of such partnerships, Medicaid agency staff have helped to create online housing locator resources that not only list available units and rental costs, but accessibility features as well, such as elevators, grab bars, and modified kitchens and bathrooms for wheelchair users. In the past, these efforts were supported by Money Follows the Person demonstration grants to states; more recently, Medicaid agencies have obtained technical assistance support for partnerships with housing authorities though the Medicaid Innovation Accelerator Program.[43] Medicaid partnerships with state agencies responsible for delivering mental health and substance use services, like Texas' Wellness Incentives and Navigation program, are also important to connect individuals with behavioral health conditions with community services and social supports to prevent relapse.[44]

Besides covering and paying for specific services, Medicaid has a critical role to play in collaborating with housing agencies, schools, social service organizations, and other groups at the state and local level.

Limitations of Medicaid benefit coverage

Although federal law and rules broadly define the range of services that state Medicaid programs can cover and pay for, there are important limits to what can be covered under current law. For example, federal law prohibits Medicaid funds from being used to pay for rent (with narrow exceptions), or for a Medicaid beneficiary's room and board in community residences. In addition, Medicaid rules generally discourage or may even prohibit payment for services that duplicate those covered by other federal and state programs. For example, Medicaid is required to be the "payer of last resort" for services that are covered by Medicare for Medicare-Medicaid dual eligibles. In addition, it makes little sense for Medicaid to provide nutritional supplements for those covered by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP), which provide important nutritional benefits and alleviate hunger and food insecurity for people who are poor. To the extent that these programs do not serve vulnerable

Medicaid beneficiaries, there may be a role for Medicaid to play, if doing so saves overall Medicaid costs. For example, a Medicaid provider organization in Colorado has worked with local businesses and social service agencies to address the shortage of grocery stores in low-income neighborhoods. If grants and funding provided by federal and state housing agencies are insufficient to remove mold or pests from housing units, Medicaid managed care plans may choose to pay for such services if it prevents hospitalizations among people with asthma.[45]

New Strategies and Prospects for Medicaid to Address the Social Determinants of Health

No matter how much state Medicaid agencies may want to address the social determinants of health, barriers and challenges remain. As discussed, there are statutory limitations on the types of services Medicaid can cover. In addition, states often need up-front capital to develop, implement, and evaluate new initiatives, and it can be difficult to secure the funds for these down payments. There are limits on the capacity of housing, social services, and nutrition support programs to serve Medicaid beneficiaries at risk due to budget constraints. Policymakers at both the federal and state level are incentivized to spend Medicaid resources on programs and services that produce short-term savings to the Medicaid program over those that would yield savings for other human service sectors in the long term.

To overcome these challenges, a group of experts on Medicaid and the social determinants of health convened

by the National Academy of Social Insurance identified several administrative options that would allow states to make more effective use of flexibility already built into federal law to shape Medicaid programs, as well as legislative reforms that would give states new tools to address the social determinants of health more directly.[46]

For example, the Academy panel identified changes to Section 1115 demonstration authority that would enable states to implement innovations designed to improve the social determinants of health more easily. Since the start of the Medicaid program in 1965, states have had the ability to request waivers from the Secretary of the Department of Health and Human Services (HHS) to test new approaches to delivering and paying for Medicaid services. Section 1115 demonstrations allow states to depart from existing federal rules as long as they further the overall goals of the program and are budget neutral to the federal government. More than 30 states currently operate Section 1115 demonstrations. Because Section 1115 authority is so broad, the range of innovations tested by states is just as wide-ranging. For example, Section 1115 demonstrations have expanded eligibility to new categories of beneficiaries, provided new services, and experimented with delivery system and payment reforms. The Academy panel suggested that HHS explicitly recognize improving the health of Medicaid beneficiaries as a specific objective of 1115 waivers. This might allow states' estimated cost savings to the federal government to include reduced spending in non-Medicaid budgets, for example.

Other ideas and innovations using Section 1115 demonstration authority are also expected to become available under the new Administration. HHS Secretary Tom Price and CMS Administrator Seema Verma issued a joint letter[47] to the nation's governors in March 2017 encouraging the use of Section 1115 demonstrations to:

- **"Support Innovative Approaches to Increase Employment and Community Engagement. . .** *by assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment.*

- **Provide States with More Tools to Address the Opioid Epidemic. . .** *by explor[ing] additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities."*

The invitation to state Medicaid agencies to innovate in these areas may offer new avenues to experiment with programs and partnerships that address the social determinants of health. While the March 2017 letter pledged to "improve the process and speed to facilitate expedited—or 'fast-track'—approval of waiver and demonstration project extensions," securing a new Section 1115 demonstration may take longer. Historically, it has taken at least a year, and often longer, for a state to negotiate the special terms and conditions, assure the project will be budget-neutral to the federal government, and provide a reasonable amount of time for public review and input, as required by current rules. In addition, proving that such programs will not cost the federal government more than it would under current policy may be difficult if it takes longer than five years to produce significant savings—the typical period for a Section 1115 demonstration.

New opportunities—and risks—to address the social determinants of health may also lie in one of the Congressional proposals to reform Medicaid by allowing states the option to turn federal program funding into a block grant. Under this approach, states would receive a fixed amount of federal Medicaid funding to use mostly

as they wish to provide health coverage to low-income residents. On the one hand, states may lose the opportunity to combat social determinants of health because the amount of federal funding is expected to be significantly less than under existing policy, which could lead to major reductions in Medicaid benefits, eligibility, and provider payment rates. Due to this risk, prior proposals to turn Medicaid into a block grant have not been successful, and several governors have expressed serious concerns about such a change.[48] On the other hand, if passed by Congress, and depending on how block grants are structured, such an approach could offer an avenue for state Medicaid programs to spend their dollars on services that are outside the health system, particularly if they have a large effect on health care costs. States that choose to receive a block grant might, for example, be able to use Medicaid funds to provide job training and placement services to non-disabled people who may otherwise lose Medicaid eligibility if they did not work or could not find a job.

Finally, ideas and lessons on how to best address the social determinants of health for Medicaid beneficiaries may be found in new initiatives by other health care payers. For example, the Center for Medicare & Medicaid Innovation within CMS just launched a new demonstration called Accountable Health Communities (AHC) for Medicare beneficiaries, some of whom will also be eligible for Medicaid. Designed to address health-related social needs, such as food insecurity and inadequate or unstable housing, the program will screen and assess beneficiary needs for such services and forge linkages between medical providers and community-based social service providers to address their needs. Over the next five years, the AHC model "will test whether systematically identifying and addressing beneficiaries' health-related social needs impacts total health care costs and reduces inpatient and outpatient utilization."[49] In addition, several studies are currently underway that will evaluate the effectiveness of current Section 1115 demonstrations that are transforming the health care delivery system by giving providers financial incentives to provide more efficient and effective care, including those operating in New York, Texas, California, New Hampshire, and other states.[50] These demonstrations, known as Delivery System Reform Incentive Payment (DSRIP) programs, are promoting care integration across settings, providing greater access to primary care, and collaborating with community organizations to address the social factors that lead to avoidable hospitalization.

CONCLUSION

Over its 52-year history, Medicaid has continually evolved to meet the changing needs of beneficiaries by testing innovations in coverage, delivery systems, and payment. State policymakers retain significant flexibility under current law to shape the program in ways that respond to the priorities and needs of each state. Opportunities for states to experiment further may emerge as Congress and the new Administration consider Medicaid reform options to control federal spending. States that want to use Medicaid as a lever to break down traditional silos between the health system and social, nutritional, housing, employment, and other sectors may find opportunities to reduce Medicaid costs and improve the health of Medicaid beneficiaries. By partnering with state and local agencies to address the social determinants of health, state Medicaid leaders may enhance their ability to control medical care costs and strengthen the program's financial sustainability in the long term.

Over its 52-year history, Medicaid has continually evolved to meet the changing needs of beneficiaries by testing innovations in coverage, delivery systems, and payment.

ENDNOTES

1 MACPAC, 2016.

2 Ibid. Exhibit 8, Medicaid Enrollment and Spending, FYs 1966–2015.

3 Ibid. Exhibit 13, Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014. Counting all federal revenues in state budgets, Medicaid's share of state budgets from all sources rose from 19.1 percent in 2000 to 25.6 percent in 2014.

4 Congressional Budget Office, 2017.

5 Dahlgren & Whitehead, 2007.

6 Chetty, Stepner, Abraham, et al., 2016.

7 Ibid.

8 Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010.

9 See for example: Braveman, Egerter, & Williams, 2011; Grundy & Sloggett, 2003.

10 Haas, 2006; Mulatu & Schooler, 2002.

11 Institute of Medicine, 1988.

12 Wright, 1990.

13 Afeiche, Peterson, Sánchez, Schnaas, Cantonwine, Ettinger, et al., 2012; Lanphear, Kahn, Berger, Auinger, Bortnick, & Nahhas, 2001.

14 Kushel, Gupta, Gee, & Haas, 2006.

15 Lipson, Stone Valenzano, & Williams, 2011.

16 World Health Organization, 2003.

17 Nelson, Brown, & Lurie, 1998; Kersey, Beran, McGovern, Biros, & Lurie, 1999; Cook, Frank, & Berkowitz, 2004.

18 Jiang, Barrett, & Sheng, 2014.

19 Billings & Raven, 2013.

20 CMCS, n.d.b.

21 Billings & Mijanovich, 2007; California Medicaid Research Institute, 2003; Smulowitz, Honigman, & Landon, 2013.

22 Xing, Goehring, & Mancuso, 2015.

23 Raven, Doran, Kostrowski, Gillespie, & Elbel, 2011.

24 Green, Singh, & O'Byrne, 2010; Hong, Siegel, & Ferris, 2014.

25 McCarthy, Ryan, & Klein, 2015.

26 Massachusetts Housing and Shelter Alliance, 2014.

27 Sadowski, Kee, VanderWeele, & Buchanan, 2009.

28 Lipson et al., 2011.

29 Nardone, Cho, & Moses, 2012.

30 Gottlieb, Ackerman, Wing, & Manchanda, 2017.

31 Bachrach, Pfister, Wallis, & Lipson, 2014.

32 For a list of Medicaid authorities that can be used to cover or facilitate access to social services, see Table 1. Summary of Coverage Opportunities in Bachrach, Guyer, & Levin, 2016.

33 CMCS, 2015.

34 Purington, 2016.

35 42 Code of Federal Regulations §438.3(e). "In lieu of" services can also be provided under 1915(b) waiver authority.

36 Gottlieb et al., 2017.

37 National Academy of State Health Policy, n.d.

38 DeVoe, Bazemore, Cottrell, Likumahuwa-Ackman, Grandmont, Spach, & Gold, 2016.

39 CMCS, 2016.

40 Momany, Nguyen-Hoang, Damiano, Bentler, & Shane, 2014.

41 CMCS, 2015.

42 Medicaid Innovation Accelerator Program (IAP) Webinar, 2017.

43 CMCS, n.d.a.

44 CMS, n.d.

45 Gottlieb et al., 2017.

46 Rosenbaum, Riley, Bradley, Veghte, & Rosenthal, 2017.

47 Price & Verma, 2017.

48 Goodnough & Pear, 2017.

49 CMS, 2017.

50 Irvin, Lipson, Appold, Colby, Bradley, Heeringa, Libersky, Byrd, & Baller, 2015.

REFERENCES

Afeiche, M., K.E. Peterson, B.N. Sánchez, L. Schnaas, D. Cantonwine, A.S. Ettinger, et al. (2012). "Windows of Lead Exposure Sensitivity, Attained Height, and Body Mass Index at 48 months." *Journal of Pediatrics*, 160:1044-9.

Bachrach, D., J. Guyer, and A. Levin (2016). "Medicaid Coverage of Social Interventions: A Road Map for States." New York, NY: Milbank Memorial Fund. Available at: http://www.milbank.org/wp-content/files/documents/medicaid_coverage_of_social_interventions_a_road_map_for_states.pdf

Bachrach, D., H. Pfister, K. Wallis, and M. Lipson (2014). "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." The Commonwealth Fund, Skoll Foundation and Pershing Square Foundation. May.

Billings, J., and M.C. Raven (2013). Dispelling an Urban Legend: Frequent Emergency Department Users Have Substantial Burden of Disease. *Health Affairs*, 32(12): 2099–2108.

Billings, J., and T. Mijanovich (2007). "Improving the Management of Care for High-Cost Medicaid Patients." *Health Affairs*, 26(6):1643–1654.

Braveman, P.A., C. Cubbin, S. Egerter, D. R. Williams, and E. Pamuk (2010). "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." *American Journal of Public Health*, 100(S1): S186-S196.

Braveman, P., S. Egerter, and D. Williams (2011). "The Social Determinants of Health: Coming of Age." *Annual Review of Public Health*, 32:381-398 https://doi.org/10.1146/annurev-publhealth-031210-101218

California Medicaid Research Institute (2003). "Emergency Department Visit Reduction Programs: Executive Summary." Prepared for the Medicaid and CHIP Payment and Access Commission. San Francisco: University of California, San Francisco

Center for Medicaid and CHIP Services (CMCS), Center for Medicare & Medicaid Services (n.d.a). Medicaid Innovation Accelerator Program (IAP). https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html

CMCS (n.d.b). Promoting Community Integration through Long-Term Services and Supports. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/community-integration-ltss/ci-ltss.html

CMCS (2015). "Coverage of Housing-Related Activities and Services for Individuals with Disabilities." CMCS Information Bulletin. June.

CMCS (2016). Map of State Health Home Activity. November. Available at: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-map.pdf

Centers for Medicare & Medicaid Services (CMS; n.d.). Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) State Summary: Texas. Available at: https://innovation.cms.gov/files/x/mipcd-tx.pdf

CMS (2017). "Accountable Health Communities (AHC) Model Assistance and Alignment Tracks Participant Selection." Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-06.html

Chetty, R., M. Stepner, S. Abraham, et al. (2016). "The Association Between Income and Life Expectancy in the United States, 2001-2014." *Journal of the American Medical Association*, 315(16):1750-1766.

Congressional Budget Office (2017). "Cost Estimate May 24, 2017. H.R. 1628, American Health Care Act of 2017, As passed by the House of Representatives on May 4, 2017." https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

Cook, J.T., D.A. Frank, and C. Berkowitz (2004). "Food Insecurity is Associated with Adverse Health Outcomes among Human Infants and Toddlers." *Journal of Nutrition*, 134:1432–8.

Dahlgren, G., and M. Whitehead (2007). "European Strategies for Tackling Social Inequities in Health: Leveling Up, Part 2." Copenhagen: World Health Organization Regional Office for Europe.

DeVoe, J.E., A.W. Bazemore, E.K. Cottrell, S. Likumahuwa-Ackman, J. Grandmont, N. Spach, and R. Gold (2016). "Perspectives in Primary Care: A Conceptual Framework and Path to Integrating Social Determinants of Health into Primary Care Practice." *Annals of Family Medicine*, 14(2):104-108.

Goodnough, A., and R. Pear (2017). "G.O.P. Governors Seek Flexibility on Medicaid and Health Markets." *New York Times*, January 20, 2017. https://www.nytimes.com/2017/01/20/health/medicaid-republican-governors.html?ref=politics&_r=2

Gottlieb, L., S. Ackerman, H. Wing, and R. Manchanda (2017). "Understanding Medicaid Managed Care Investments in Members' Social Determinants of Health." *Population Health Management* (e-publication ahead of print). January. http://online.liebertpub.com/doi/abs/10.1089/pop.2016.0092

Green, S.R., V. Singh, and W. O'Byrne (2010). "Hope for New Jersey's City Hospitals: The Camden Initiative." *Perspectives in Health Information Management*, vol. 7.

Grundy, E., and A. Sloggett (2003). "Health Inequalities in the Older Population: The Role of Personal Capital, Social Resources and Socioeconomic Circumstances." *Social Science & Medicine*, 56(5):935–947.

Haas, S.A. (2006). "Health Selection and the Process of Social Stratification: The Effect of Childhood Health on Socioeconomic Attainment. *Journal of Health and Social Behavior,* 47:339–54.

Hong, C.S., A. Siegel, and T. Ferris (August 2014). "Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?" Issue Brief, vol. 19, no. 1764. New York, NY: The Commonwealth Fund.

Institute of Medicine (1988). "Homelessness, Health and Human Needs." Committee on Health Care for Homeless People. Washington DC: National Academy Press.

Irvin, C., D. Lipson, C. Appold, M. Colby, K. Bradley, J. Heeringa, J. Libersky, V. Byrd, and J. Baller (2015). "Medicaid 1115 Demonstration Evaluation Design Plan." Cambridge MA: Mathematica Policy Research. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf

Jiang, H.J., M.L. Barrett, and M. Sheng (2014). "Characteristics of Hospital Stays for Nonelderly Medicaid Super-Utilizers." Healthcare Cost and Utilization Project Statistical Brief, no. 184. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ). November. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb184-Hospital-Stays-Medicaid-Super-Utilizers-2012.pdf

Kersey, M.A., M.S. Beran, P.G. McGovern, M.H. Biros, and N. Lurie (1999). "The Prevalence and Effects of Hunger in an Emergency Department Patient Population. *Academy of Emergency Medicine*, 6:1109–14.

Kushel, M., R. Gupta, L. Gee, and J.S. Haas (2006). "Housing Instability and Food Insecurity as Barriers to Health Care among Low-Income Americans." *Journal of General Internal Medicine*, 21(1):71–77.

Lanphear, B.P., R.S. Kahn, O. Berger, P. Auinger, S.M. Bortnick, and R.W. Nahhas (2001). "Contribution of Residential Exposures to Asthma in U.S. Children and Adolescents." *Pediatrics*, 107:E98.

Lipson, D. J., C. Stone Valenzano, and S. R. Williams (2011). "What Determines Progress in State MFP Transition Programs?" National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program, Report from the Field, No. 8. Washington, DC: Mathematica Policy Research. http://www.disabilitypolicyresearch.org/~/media/publications/pdfs/health/mfpfieldrpt8.pdf

Massachusetts Housing and Shelter Alliance (2014). *Home and Healthy for Good June 2014 Progress Report*. Available at: http://www.mhsa.net/matriarch/documents/June%202014%20HHG%20Report.pdf

McCarthy, D., J. Ryan, and S. Klein (2015). "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis." New York, NY: The Commonwealth Fund. October.

Medicaid and CHIP Payment and Access Commission (MACPAC; 2016). *MACStats: Medicaid and CHIP Data*. Exhibit 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1966–2015. https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf

Medicaid Innovation Accelerator Program (IAP) Webinar (2017). "Factoring Social Determinants of Health into Strategies That Impact Medicaid Beneficiaries with Complex Care Needs." Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/bcn-factoring-social-determinants.pdf

Momany, E.T., P. Nguyen-Hoang, P. Damiano, S.E. Bentler, and D.M. Shane (2014). "Cost Analyses of the Iowa Medicaid Health Home Program." Iowa City, IA: University of Iowa Public Policy Center. Available at: http://ppc.uiowa.edu/publications/all?f[author]=437

Mulatu, M.S., and C. Schooler (2002). "Causal Connections between Socioeconomic Status and Health: Reciprocal Effects and Mediating Mechanisms." *Journal of Health and Social Behavior*, 43(1):22–41.

Nardone, M., R, Cho, and K. Moses (2012). "Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case." Center for Health Care Strategies. June. Available at: http://www.chcs.org/resource/medicaid-financed-services-in-supportive-housing-for-high-need-homeless-beneficiaries-the-business-case/

National Academy of State Health Policy (n.d.). State Delivery System and Payment Reform Map. Available at: http://www.nashp.org/state-delivery-system-payment-reform-map/

Nelson, K., M.E. Brown, and N. Lurie (1998). "Hunger in an Adult Patient Population." *Journal of the American Medical Association*, 279:1211–4

Price, Secretary T.E., and Administrator S. Verma (2017). Letter to the Nation's Governors. Centers for Medicare and Medicaid Services, Department of Health and Human Services. Available at: https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf

Purington, K. (2016). "Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness." National Academy for State Health Policy. January. Available at: http://www.nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf

Raven, M.C., K.M. Doran, S. Kostrowski, C.C. Gillespie, and B.D. Elbel (2011). "An Intervention to Improve Care and Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: A Pilot Study." *BMC Health Services Research*, 11(270).

Rosenbaum, S., T. Riley, A.L. Bradley, B.W. Veghte, and J. Rosenthal (2017). "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." Washington, DC: National Academy of Social Insurance. January. Available at: https://www.nasi.org/research/2017/strengthening-medicaid-critical-lever-building-culture

Sadowski, L.S., R.A. Kee, T.J. VanderWeele, and D. Buchanan (2009). "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial." *Journal of the American Medical Association*, 301(17): 1771-1778.

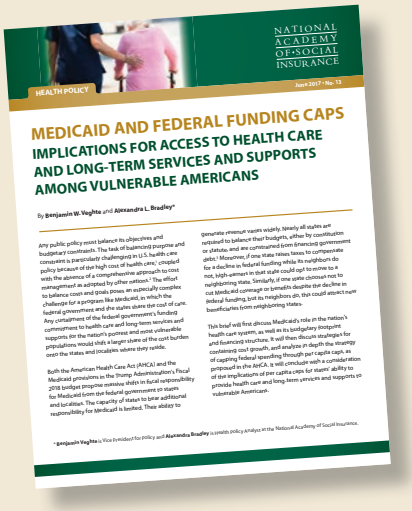
Smulowitz, P.B., L. Honigman, and B.E. Landon (2013). "A Novel Approach to Identifying Targets for C*ost Reduction in the Emergency Department." Annals of Emergency Medicine*, 61(3): 293–300.

World Health Organization (2003). "Diet, Nutrition and the Prevention of Chronic Diseases." Report of a Joint WHO/Food and Agriculture Organization Expert Consultation. Technical Report No. 916.

Wright, J. D. (1990). "Poor People, Poor Health: The Health Status of the Homeless." *Journal of Social Issues*, 46(4): 1540-4560. doi:10.1111/j.1540-4560.1990.tb01798

Xing, J., C. Goehring, and D. Mancuso (2015). "Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs." *Health Affairs*, 34(4): 653–661.

ALSO AVAILABLE from the National Academy of Social Insurance at www.nasi.org

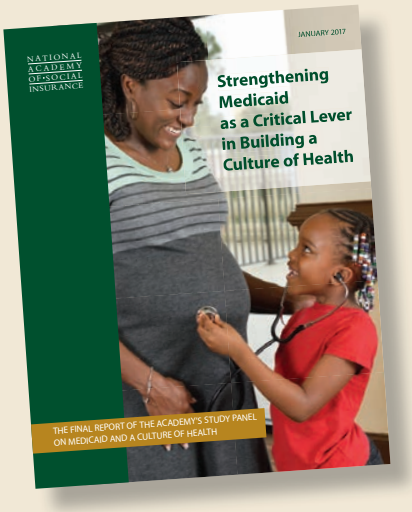


MEDICAID AND FEDERAL FUNDING CAPS: Implications for Access to Health Care and Long-Term Services and Supports among Vulnerable Americans

By: **Benjamin W. Veghte** and **Alexandra L. Bradley**, June 2017

Health care costs in the United States are by far the highest in the world, and hence controlling them is a perennial challenge of public policy. Any effort to balance the costs and fundamental goals of a program as complex and sizable as Medicaid poses challenges for both states and the federal government. However, controlling overall Medicaid costs and capping federal Medicaid spending are fundamentally different approaches. Recent proposals to curtail the federal government's funding commitment to health care and long-term services and supports for the nation's poorest and most vulnerable populations would shift a substantial share of the program's cost burden onto states. Yet, the capacity of states to bear additional responsibility for Medicaid is limited. There are strategies for controlling costs in the health care system, such as addressing the social determinants of health, that would not fundamentally alter the structure of the program and would maintain Medicaid's great strength to grow in response to a range of often unpredictable factors.

This brief discusses Medicaid's role in the nation's health care system, as well as its budgetary footprint and financing structure. It discusses strategies for containing cost growth and analyzes in depth the policy of capping federal spending through per capita caps, and its implications for states' ability to provide health care and long-term services and supports to vulnerable Americans.



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

By: **Sara Rosenbaum**, **Trish Riley**, **Alexandra L. Bradley**, **Benjamin W. Veghte**, and **Jill Rosenthal**, January 2017

Strengthening Medicaid as a Critical Lever in Building a Culture of Health is a nonpartisan study panel report which offers a series of steps that would enable Medicaid to leverage its unique role as an insurer to increase its capacity for addressing the underlying social determinants of health. The study panel was convened to assess the current and possible future role of Medicaid in building a Culture of Health. The panel included state Medicaid program directors, public health and health policy experts, health researchers, medical and health professionals, and health plan representatives.

While the current political landscape signals new policy discussions about the future of the program and its funding, the analysis and options included in this report 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.

This brief was supported by the Robert Wood Johnson Foundation in conjunction with the project Strengthening Medicaid as a Critical Lever in Building a Culture of Health.

The National Academy of Social Insurance is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to advance solutions to challenges facing the nation by increasing public understanding of how social insurance contributes to economic security.

Visit www.nasi.org for more resources.

1200 New Hampshire Avenue, NW • Suite 830 • Washington, DC 20036
Phone: 202-452-8097 • Fax: 202-452-8111 • nasi@nasi.org

NATIONAL ACADEMY OF SOCIAL INSURANCE