



IDEAS
ACTION
RESULTS

Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid

WHITE PAPER

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STAFF

Katherine Hayes

Director, Health Policy

G. William Hoagland

Senior Vice President

Lisa Harootunian

Senior Policy Analyst, Health Project

Eleni Salyers

Project Associate, Health Project

Kevin Wu

Policy Analyst, Health Project

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ADVISORS

The Bipartisan Policy Center staff produced this white paper in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank Henry Claypool and Tim Westmoreland for their contributions to this white paper.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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Glossary of Terms

Affordable Care Act (ACA)

Assistant Secretary for Planning and Evaluation (ASPE)

Center for Medicare and Medicaid Innovation (CMMI)

Centers for Medicare and Medicaid Services (CMS)

Children's Health Insurance Program (CHIP)

Dual-Eligible Special Needs Plan (D-SNP)

Financial Alignment Initiative (FAI)

Fully-Integrated Dual-Eligible Special Needs Plan (FIDE-SNP)

Highly-Integrated Dual-Eligible Special Needs Plan (HIDE-SNP)

Long-Term Services and Supports (LTSS)

Medicaid and CHIP Payment and Access Commission (MACPAC)

Medicare Advantage (MA)

Medicare Payment Advisory Commission (MedPAC)

Medicare-Medicaid Coordination Office (MMCO)

Medicare-Medicaid Plan (MMP)

Program of All-Inclusive Care for the Elderly (PACE)

State Health Insurance Assistance Program (SHIP)

U.S. Department of Health and Human Services (HHS)

Overview

NOTE REGARDING COVID-19:

The Bipartisan Policy Center began working on this report before the outbreak of COVID-19. BPC leaders believe that better integration of services can improve care regardless of the type of illness. There is no question, however, that this virus poses an immediate threat to dual-eligible individuals, who are older and sicker than the general population. In response to the outbreak, BPC is expanding the scope of this project and hopes to include recommendations that address policy and regulatory barriers that limit the ability of states, health plans, and providers to address the unique needs of dual-eligible individuals in this time of crisis. BPC is seeking feedback on the policy recommendations outlined in this report, as well as the more immediate problems faced by stakeholders, recognizing that state and federal policymakers are on the front lines of the crisis.

The Bipartisan Policy Center is continuing its efforts to improve quality of care through the integration of Medicare and Medicaid services for individuals who are eligible for both programs.ⁱ These Medicare-Medicaid beneficiaries, commonly known as “dual-eligible individuals,” must navigate two separate programs with different benefits and eligibility requirements. For most individuals, this would be daunting, but for dual-eligible individuals and their families, who are often dealing with chronic conditions and functional limitations, these challenges can be overwhelming.

i Previous reports from the Bipartisan Policy Center that address dual-eligible individuals include: *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, September 2016. *A Policy Roadmap for Individuals with Complex Care Needs*, Jan 2018. *Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*, Jul 2019.

In recent years, policymakers have sought to better integrate Medicare and Medicaid services, including clinical health, behavioral health, social services, and LTSS for the estimated 12.2 million people that are eligible for both programs.¹ Federal and state governments have implemented approaches that vary in the degree of integration.ⁱⁱ Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) have sought to integrate care for nearly two decades, and the Program of All-Inclusive Care for the Elderly (PACE) has a long history of integrating care. Other efforts have included Medicaid waivers and demonstrations, some of which have gone on to become permanent programs, while others continue as demonstrations.

More than a decade ago, Congress developed bipartisan ideas to integrate care for dual-eligible individuals. Those ideas, which were included in the Affordable Care Act (ACA), authorized Fully-Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) and directed the Department of Health and Human Services (HHS) to establish a single office dedicated to the coordination of coverage and payment of Medicare and Medicaid services for dual-eligible individuals.² That office, the Medicare-Medicaid Coordination Office (MMCO), led agency efforts to implement the Financial Alignment Initiative (FAI) demonstration, authorized by the ACA for dual-eligible individuals through the Center for Medicare and Medicaid Innovation. Those demonstrations are discussed in detail in part I of this two-part series. More recently, the Bipartisan Budget Act of 2018 directed the secretary to better integrate the two programs.

Integration of care for dual-eligible individuals is especially challenging, given the heterogeneity of the population and the unique and significant needs of the various sub-populations. Many have multiple chronic conditions and may need assistance with activities of daily living (ADLs), such as bathing or dressing.³ They may have a mental illness, cognitive impairment, physical limitations, or a combination of these conditions. They may have safe living arrangements, or they may be homeless. Dual-eligible individuals reside in urban, rural and frontier areas, and while the majority are older Americans, 39% of dual-eligible individuals are under age 65.⁴

ii For the purposes of this paper, when we use the term “integration” we are referring to alignment of Medicare and Medicaid program administrative requirements, financing, benefits, and care delivery. Integration may also mean that Medicare and Medicaid services are coordinated and are provided seamlessly to an eligible individual through a single point of contact.

Less than 10% of dual-eligible individuals are enrolled in programs or care models that integrate Medicare and Medicaid services.⁵ As a result, they or their family members must navigate two separate programs – one administered by the federal government and the other by the state – with different eligibility requirements and different benefits. When beneficiaries have a problem with access to care, such as a coverage denial, they must appeal to the federal government for Medicare-covered benefits and the state for Medicaid-covered benefits. Enrollees in managed care plans that are not integrated must navigate two enrollment periods, two plan points of contact, and may have different in-network providers for each plan.

Because dual-eligible individuals are sicker than the average Medicare beneficiary, Medicare spending for dual-eligible individuals is higher than spending for their non-dual-eligible counterparts. While 20% of Medicare beneficiaries are dual-eligible individuals, 34% of Medicare spending is historically attributed to this population.⁶

The potential for improved outcomes and savings in the short-term is unclear, however many state and federal policymakers believe integration is worthwhile as a means of simplifying and better coordinating care for dual-eligible individuals. Many policymakers believe integration of the Medicare and Medicaid programs has the potential to reduce spending and improve outcomes over the long-term.

Despite the integration efforts listed above, Medicare and Medicaid continue to operate as separate and distinct programs for the majority of dual-eligible individuals across the country. BPC health care leaders agree on the importance of streamlining services for dual-eligible individuals to make the programs more user-friendly and accountable. Leaders also believe integration of care will improve patient outcomes and lower costs over the long-term. In addition, early evaluations suggest positive findings for certain quality and cost measures.⁷ Without changes in federal policy, however, the ability or willingness of more states to move forward is limited.

BPC is working to finalize short-term recommendations designed to remove federal barriers. At the same time, stakeholders have expressed a need for longer-term solutions to incentivize states to integrate services. This white paper identifies policy barriers, and outlines policy options as a starting point for discussion and will inform our final report. In the coming months, BPC health care leaders and staff will seek feedback from stakeholders and will issue final recommendations in the summer of 2020.

These policy options were prepared based on research and discussions with stakeholders, including organizations representing consumers, providers, health plans, as well as state and federal policymakers. The list includes both short-term and long-term recommendations that build on our previous work and recommendations.ⁱⁱⁱ These recommendations fall into four categories:

1. Eliminate regulatory barriers to alignment.
2. Provide incentives and assistance to states.
3. Improve the enrollee experience.
4. Require full integration of Medicare and Medicaid.

iii Some of the short-term recommendations were first discussed in BPC's July 2019 report, *Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*.

Policy Options and Rationale

Eliminate Regulatory Barriers to Alignment

1. *Congress should further align operations and oversight of programs serving dual-eligible individuals by consolidating regulatory authority for all programs serving dual-eligible individuals into the MMCO.*

Regulatory authority over Medicare is the responsibility of the Center for Medicare, while Medicaid's regulatory authority falls within the Center for Medicaid and CHIP Services. Congress recognized this division of authority does not serve the interests of dual-eligible individuals. Through the Bipartisan Budget Act of 2018, Congress granted authority to MMCO to develop regulations and guidance related to: (1) implementation of a unified grievance and appeals process for D-SNPs, and (2) integration or alignment of policy and oversight under the Medicare and Medicaid programs regarding D-SNPs.⁸ While this is a valuable step toward integration and better serving dual-eligible individuals, regulatory authority for all programs serving dual-eligible individuals should be consolidated under MMCO.

2. *Congress should direct the secretary of HHS to adopt best practices from the Financial Alignment Initiative demonstration and apply them to Fully-Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs). The secretary should convene a working group and implement standards agreed upon by the working group where best practices have yet to be identified. The group should be composed of state agency officials, representatives of consumer organizations, private health insurance plans, consumer advocacy and other experts to develop uniform standards in the following areas:*

- *Care management standards for integrated clinical health services, behavioral health, and LTSS*
- *Network adequacy standards appropriate for dual-eligible individuals*
- *Standard materials for marketing, plan notices, and other member materials*
- *A single open enrollment period process*
- *A process for joint oversight of plans by CMS and states*

- ***Alignment of Medicare and Medicaid measures, including measures of access to care, beneficiary experience, and appropriateness of financial incentives among plans, providers, states, and the federal government***
- ***A model outreach and engagement plan to help inform and educate enrollees and providers on the requirements and benefits of fully integrated care models (see enrollee improvement recommendations below)***

The secretary of HHS used demonstration authority to test integration models through the FAI. Under the demonstration, the secretary worked with states, plans, and providers to develop unified standard materials and uniform enrollment periods and processes to establish joint oversight of participating health plans by CMS and states, and to align other administrative requirements. Although evaluations of the broader FAI are inconclusive, stakeholders agree that efforts to align these administrative functions have improved beneficiary experience. The secretary should be given limited authority to extend this alignment to FIDE-SNPs.

Other issues could be resolved by directing the secretary to convene stakeholders and giving the secretary the authority to implement regulations where there is consensus. For example, in most states, the FAI was implemented without adequate beneficiary and provider engagement, which resulted in confusion and led beneficiaries to disenroll from care models. Other outstanding issues, such as care management standards and network adequacy requirements, should also be considered and resolved through this consensus-based process.

3. Limit enrollment in integrated models to full-benefit dual-eligible individuals.

The Medicare Payment Advisory Commission (MedPAC) has proposed limiting enrollment in integrated products to only full-benefit dual-eligible individuals to facilitate the development of uniform materials. Full-benefit dual-eligible individuals are eligible for the full-range of Medicare- and Medicaid-covered services, while partial-benefit dual-eligible individuals are eligible for Medicare-covered services as well as assistance with premiums, copays, and deductibles, based on income. This bifurcation of benefits has prevented the development of uniform materials. Limiting enrollment to full-benefit dual-eligible individuals should have little impact on enrollees. MedPAC found relatively few partial-benefit dual-eligible individuals later qualify for full Medicaid, and those with partial Medicaid benefits fare equally well in MA plans.⁹ States that have implemented FIDE-SNPs have recognized this, and every state with a FIDE-SNP limits enrollment in those plans to full-benefit dual-eligible individuals.¹⁰

Provide Incentives and Assistance to States

To encourage states to fully-integrate care for dual-eligible individuals, Congress should:

1. Provide the secretary of HHS with authority to develop a shared savings program in existing payment and delivery models for dual-eligible individuals.

One issue frequently mentioned by states is the lack of financial incentives to integrate care. In many cases, integration requires increased state spending under Medicaid and to the extent that savings are achieved, they arise from reduced utilization of emergency departments or inpatient hospitalization. These savings accrue to the Medicare program and go to the federal government. For example, research has demonstrated that investments in Medicaid home and community-based services can reduce hospital readmissions and emergency department visits.¹¹ Absent a mechanism for sharing the Medicare savings and program investments, such as those built into the FAI demonstrations, states are reluctant to move forward.

2. Direct the secretary of HHS to provide resources and in-person technical assistance to states that would like to integrate Medicare and Medicaid services, building on the existing Integrated Care Resource Center.

Another common challenge identified by states is the lack of Medicaid program state-level staff who have an expertise in the Medicare program. Critical to integration at the state level is understanding how the Medicare program works, including eligibility requirements, covered benefits, grievance and appeals processes, and federal rules governing Medicare managed care plans. While states have significant expertise in Medicaid, few have staff within their Medicaid agencies that have expertise in Medicare.

States may also need additional resources to invest in infrastructure prior to implementation of Medicare and Medicaid integration. For example, when the State of Massachusetts implemented integrated care for their under-65 dual-eligible population, the mental health needs of the newly-enrolled populations exceeded the state's capacity to provide services. As a result, the state had to invest to bring more outpatient mental health centers online. Integration also requires resources to hire staff and absorb additional legal costs associated with aligning the programs, revising contracts and plan materials, and other costs associated with rolling out a new program. Policy options that create a pathway to full integration could support states in these efforts by providing technical assistance with additional funding to support states in achieving full integration.

Improve the Enrollee Experience

To help beneficiaries make informed choices, promote continuity of care, and assure beneficiary access to both Medicare and Medicaid services, Congress should:

- 1. Direct the secretary of HHS to require collaboration between CMS, ACL, and states to implement model standards for outreach and education and increase funding to the State Health Insurance Assistance Program to help dual-eligible individuals better understand the options available to them in order to make informed choices.***

The federal government, through the State Health Insurance Assistance Program, (SHIP) assists Medicare-eligible individuals in better understanding coverage options and Medicare premiums and cost-sharing, and assists beneficiaries in applying for Medicaid.¹² The Administration for Community Living, within HHS, administers SHIP program grants to provide funding for free local health coverage counseling and assistance for Medicare-eligible individuals and their families. While the complexity of coverage options for dual-eligible individuals has grown through new coverage options, budget proposals for FY 2021 propose reducing funding for SHIP by \$16 million.¹³ Funding for this program should be increased, not reduced, to better assist dual-eligible individuals.

- 2. Provide resources and technical assistance to states for consumer and provider engagement and education, and encourage states to partner with community organizations and local governments.***

States play a significant role in beneficiary outreach and education. A major challenge to enrollment in fully integrated programs has been the lack of education for consumers and health care providers. In the initial FAI states, dual-eligible individuals were enrolled in integrated health plans with little understanding of the program or the plans in which they were enrolled.¹⁴ At the same time, health care providers who did not want to participate in the plans encouraged their patients to disenroll. Because dual-eligible individuals are permitted to disenroll at any time – an important beneficiary safeguard – the result was a significant drop in enrollment.¹⁵

Since the early days of FAI implementation, states have begun to invest more time in the education of consumers and also providers. However, states with limited resources have been less able to do this. The Assistant Secretary for Planning and Evaluation, (ASPE) has encouraged states to take a more active role in educating dual-eligible individuals on the benefits of enrolling in integrated programs.¹⁶ States need the resources to support these activities, and the results have been positive. Ongoing beneficiary education in Arizona “has made beneficiaries more aware of the advantages of being in aligned plans for their Medicaid and Medicare benefits.”¹⁷

- 3. Allow states to implement 12 months of continuous Medicaid eligibility for dual-eligible individuals.***

States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP;¹⁸ evidence demonstrates that policy has been effective.¹⁹ However, states do not have the option of offering continuous enrollment to adults in Medicaid unless they seek a waiver.²⁰ The Medicaid and CHIP Payment and Access

Commission, or MACPAC, has recommended that Congress extend a statutory option for 12-month continuous eligibility for adults in Medicaid, similar to the state option for children.²¹ Continuous eligibility can promote continuity of coverage and care for dual-eligible individuals.

Because of federal requirements related to eligibility redeterminations, almost one-third of new full-benefit dual-eligible individuals lose their Medicaid coverage for at least one month within 12 months of initial transition to that status.²² Within that population, most lost their coverage for three months or longer. The most common reason is the failure to comply with administrative requirements, such as not completing paperwork on time.²³ Transitioning in and out of Medicaid – often referred to as “churn” – results in disruptions in the continuity of care and causes individuals to forgo primary and preventive care that can curb more costly health care utilization.

²⁴

Require Full Integration of Medicare and Medicaid

To promote full integration of care for dual-eligible individuals over the long term, Congress should:

- 1. Require full integration of Medicare and Medicaid Services within five years. Direct the secretary of HHS to consolidate and designate specific payment and delivery models designed to integrate care for dual-eligible individuals. In designating models of care, Congress should draw from models that have shown promise in integrating care, such as the FAI, or other successful programs implemented by states. These care models could include a managed fee-for-service approach similar to the successful model implemented in Washington State, D-SNPs, HIDE-SNPs, FIDE-SNPs, or PACE. The secretary should consider models designed to address the needs of consumers in urban, rural, and frontier areas.***
- 2. Require all MA carriers to offer one FIDE-SNP in each service area in which they offer coverage to provide choice and continuity of care.***
- 3. Allow states that wish to be responsible for fully integrating care for dual-eligible individuals to notify the secretary of their intent to implement one or more of the payment and delivery models outlined above, and present a plan on how they intend to signal to current and future dual-eligible individuals that they will enter into a coordinated plan.***
- 4. Direct the secretary of HHS to directly contract with plans and provider care models in states that choose not to fully integrate care and require contributions from those states to financially support programs at the end of the five-year period similar to the “claw-back” implemented in Medicare Part D. In developing this federal “fallback” program, the secretary should determine models to be used, establish eligibility standards, benefits, and determine which Medicaid eligibility groups should be included. Eligible individuals should be auto-enrolled using the same requirements established under the FAI, and individuals should be able to opt-out.***

While Congress and CMS have taken steps to advance the integration of Medicare and Medicaid for dual-eligible individuals, stakeholders believe integration of the two programs will improve quality and value in both Medicare and Medicaid. Stakeholders also indicate a federal requirement to integrate care will be necessary to achieve this goal. At the state level, there are many competing interests that preclude integration. Policy options provide financial incentives to states, resources, and technical assistance to encourage states to integrate care. BPC seeks to provide necessary assistance to states that choose to integrate services and provides a federal fallback program for states that choose not to move forward with integration.

Conclusion

BPC's leaders are committed to improving care for dual-eligible individuals. They agree that the current system must be improved. In the coming months, BPC leaders and staff will seek feedback on these policy options with a goal of producing final recommendations in the summer of 2020.

Endnotes

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Bipartisan Policy Center

1225 Eye St NW, Suite 1000
Washington, DC 20005

bipartisanpolicy.org

202 - 204 - 2400

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