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HEALTH MANAGEMENT ASSOCIATES

Estimated Federal Costs of Recommendations to Strengthen Primary Care in Medicaid

PREPARED FOR
BIPARTISAN POLICY CENTER

BY
ERIC HAMMELMAN
MINDY COHEN

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Executive Summary

In July 2020, the Bipartisan Policy Center (BPC) published a report entitled *Advancing Comprehensive Primary Care in Medicaid* which sets forth 17 distinct policy recommendations to help ensure accessible and patient-centered models of primary care for Medicaid enrollees.

HMA was engaged to conduct an analysis of the policy recommendations to determine the federal budget impact for each over the next 10 years. We accounted for current expected enrollment and federal costs of the Medicaid program, including our assumed impact of the COVID-19 economic downturn. Our analysis of the proposed policy recommendations measured the broad impact that each would likely have on the federal budget, based on the best available information.

Using the details provided in the BPC report we estimate that some of the policy recommendations could significantly increase the federal budget while reducing the number of individuals without health insurance, while others would have a more modest impact on total costs but could improve overall access to primary care for Medicaid enrollees. The outcome of our analysis is summarized in Table 1.

Table 1: Estimated Change in Federal Budget for BPC Primary Care Policy Recommendations

BPC Policy Recommendation	Description	Estimated Increase in Federal Budget ($B) FY21-FY25	FY21-FY30
A1	Create Medicaid Primary Care Learning Collaborative	No impact	
A2	Report primary care spend as percentage of total healthcare spend	No impact	
A3	Appropriate $120m per year for the Primary Care Extension Program	$0.5	$1.1
B1a	Allow states to expand Medicaid to 138% of FPL, with a 100% FMAP phased down to 90% over 5 years	$95.0	$178.4
B1b	Allow states to expand Medicaid to 100% FPL, with an 88% FMAP if they expand within 2 years	$68.5	$115.1
B2	Auto-enroll individuals in Medicaid/CHIP/Marketplace	$90.0	$231.5
B3	State option: 12-month continuous eligibility for adults	$10.2	$24.5
B4	Require no cost-sharing for preventive care for adults	$0.1	$0.3
C1	FMAP at 100% for primary care services set at 100% of Medicare	$27.0	$27.0
C2	Delay new network adequacy requirements, CMS develop data-driven standards	No impact	
C3	Direct Secretary to establish plan to ensure oversight & coordination of federal programs that address healthcare workforce needs	No impact	
C4	Reauthorize Conrad 30 J-1 Visa Program	No impact	
C5	Permit international medical graduate to provide care at another site during a pandemic health emergency	No impact	
C6	Reauthorize the CHCF at $5.6B annually	$17.9	$39.2
D1	Block implementation of 7/20 final rule eliminating nondiscrimination, direct GAO to determine impact	No impact	
D2	Permit states to reimburse community health workers	No impact	
D3	Establish monitoring & enforcement mechanisms to ensure Medicaid providers comply with non-discrimination laws	No impact	
D4	Allow Medicaid coverage of non-medical services that address social needs	No impact	

Note: Proposals were evaluated separately; there may be higher or lower costs if multiple proposals are enacted

Background and Introduction

In July 2020, the Bipartisan Policy Center (BPC) published a report entitled *Advancing Comprehensive Primary Care in Medicaid*[1] which set forth 17 distinct policy recommendations to help ensure accessible and patient-centered models of primary care for Medicaid enrollees. The recommendations center around four broad policy domains:

(A) Support for a comprehensive framework for improving primary care;
(B) Improve access to insurance coverage;
(C) Strengthen the Medicaid primary care workforce; and
(D) Address racial, ethnic, and economic disparities in Medicaid.

HMA was engaged to conduct an analysis of the policy recommendations to determine the federal budget impact for each recommendation over the next 10 years. Our analysis measured the broad impact that each recommendation would likely have on the federal budget, based on the best available information.

Many of the proposed recommendations build on existing regulatory and policy frameworks, with modifications that would increase insurance coverage, access to primary care, and health care quality. Some would also increase state spending, due to the shared financing structure of the Medicaid program, although those estimates are not included in this report. Other recommendations could affect private coverage or reduce the number of people without insurance.

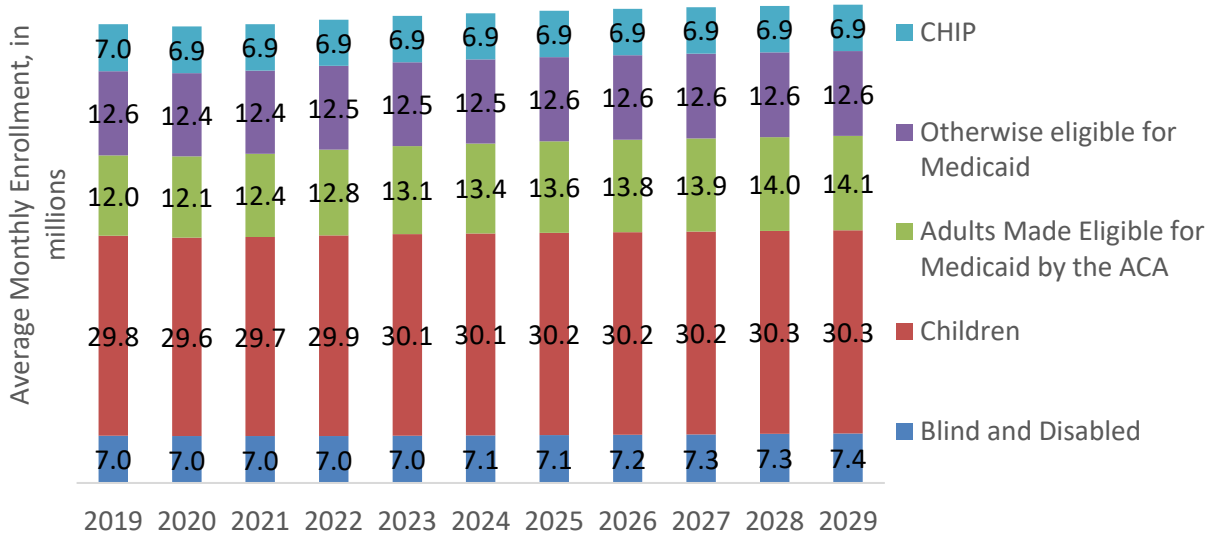
There are two limitations to our analysis. First, many of BPC's proposed policy recommendations would require additional implementation details for legislative or regulatory action which could lead to costs or savings that we have been unable to estimate in our analysis. Second, we evaluated each recommendation independently, and did not consider any interaction effects between the various recommendations that could result in higher or lower costs compared to our estimates.

Baseline Medicaid Enrollment and Costs

Our cost estimates are driven by data from the Congressional Budget Office (CBO). These data include the expected enrollment and federal spending on Medicaid and the Marketplace over the next 10 years. With regards to Medicaid, the CBO baseline appears to indicate an expectation for additional states to expand their Medicaid programs. Given the pattern over the last several years of states opting to expand, along with recent action by voters in Oklahoma, we believe that the CBO is assuming approximately 25% of remaining non-expansion states will expand within the next 5-7 years. Refer to Figure 1 for CBO's estimates of Medicaid enrollment changes through 2029.

[1] Available at bipartisanpolicy.org.

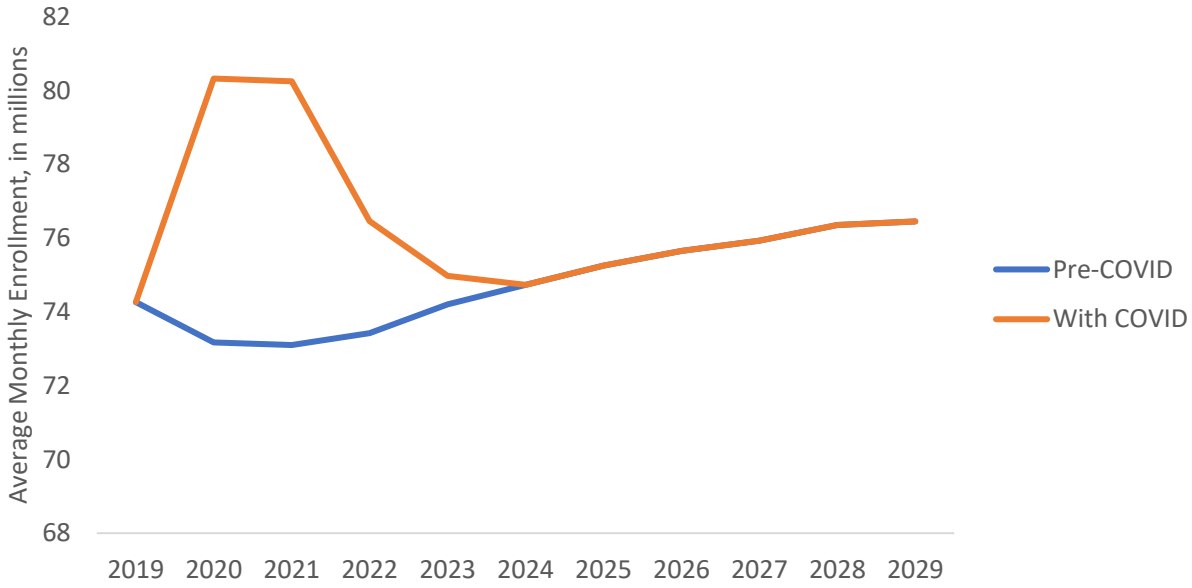
Figure 1: Estimated Medicaid Enrollment, 2020-2029, CBO Baseline Pre-COVID



Source: Congressional Budget Office

The COVID-19 pandemic has significantly impacted employment in the United States, which is expected to increase the number of people who will enroll in Medicaid in the coming years. HMA has separately assessed how Medicaid enrollment and costs could change, and we incorporated those estimates into this analysis. In general, we expect enrollment could increase by 8-10 million between 2020 and 2022, gradually returning to pre-COVID levels around 2024 as depicted in Figure 2.We expect the vast majority of these additional enrollees will be children and non-disabled adults, and have adjusted our estimated Medicaid spending accordingly.

Figure 2: HMA Estimated Impact of COVID-19 on Medicaid Enrollment



Source: Health Management Associates

Estimated Federal Budget Implications for BPC Policy Recommendations

Policy Recommendation Domain A: Support for a Comprehensive Framework for Improving Primary Care

Recommendation A1: Work with existing learning collaboratives and researchers to elevate primary care as a priority for Medicaid and share best practices on primary care among states.

We believe this proposal would have an insignificant impact on the federal budget. The Centers for Medicare & Medicaid Services (CMS) currently operates many different learning collaboratives, and while participants express appreciation for the opportunity to learn and share best practices, it is unclear if the efforts have had any significant impact on total healthcare costs. We believe the BPC recommendation could be incorporated into existing collaboratives and thus require little-to-no new funding.

Recommendation A2: Direct the secretary of HHS to work with states and other stakeholders to promote measurement and report of spending on primary care as a percentage of total health care spending.

We believe this proposal would have an insignificant impact on the federal budget. There are several different organizations that publicly report estimates of primary care spending, although these estimates vary widely as there is not a consistent and standard definition of 'primary care'. If the Secretary of HHS standardizes the definition, it could lead to increased focus on this measure. However, there is little evidence to support that this increased focus would lead to either costs or savings.

Recommendation A3: Appropriate funding for the Primary Care Extension Program.

Table 2: Estimated Impact of Policy Recommendation A3, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	**$0.5**	**$1.1**

The Affordable Care Act created the Primary Care Extension Program (PCEP), authorizing $120 million in FY11-FY14. However, Congress did not appropriate this funding, which limited the ability of the Agency for Healthcare Research and Quality (AHRQ) to fully implement the program. Our cost estimate assumes Congress will fully fund the program starting in FY21. Given the lack of current evidence for cost savings, we have not included any potential offsets from this proposal.

Policy Recommendation Domain B: Improve Access to Insurance Coverage

Recommendation B1a: Permit non-expansion states to expand Medicaid coverage to adults with incomes up to 138% of the federal poverty level with 100% Federal Medical Assistance Percentages phased down over five years to 90%.

Table 3: Estimated Impact of Policy Recommendation B1a, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$14.1	$18.5	$22.5	$20.9	$19.0	$17.2	$15.1	$16.1	$17.0	$18.0	**$95.0**	**$178.4**

The Urban Institute recently estimated there are 7.2 million individuals residing in non-expansion states who would be eligible to enroll if the state expanded to allow income up to 138% of the Federal Poverty Level (FPL). The same study estimated there would be 1.7 million fewer individuals enrolled in subsidized Marketplace plans, as they would instead be eligible for Medicaid. This estimate from Urban Institute included Nebraska and Oklahoma as non-expansion states, which we have adjusted in our analyses given impending expansions in both locations.

As noted earlier, it appears the CBO currently assumes approximately 25% of states will expand Medicaid coverage over the next several years. We estimate this recommendation could increase that rate to 65%, given the higher FMAP incentive, pressure from residents, and the effects that the COVID-19 economic crisis is having on state budgets. We estimate that the expansion would happen between FY21 and FY23, leading to nearly 3.4 million fewer uninsured.

We anticipate the Medicaid costs for individuals in these states would be approximately $7,800 per person per year and increase 5-6% per year in-line with current forecasts from the CBO. The Marketplace, meanwhile, would likely see lower costs, as a study from the Assistant Secretary for Planning and Evolution (ASPE) found that Marketplace premiums in expansion states are approximately 6% lower than premiums in non-expansion states.

Recommendation B1b: Permit non-expansion states to expand Medicaid coverage to adults with incomes up to 100% federal poverty level with 88% Federal Medical Assistance Percentages, provided they expand coverage within two years of enactment.

Table 4: Estimated Impact of Policy Recommendation B1b, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$9.3	$16.7	$15.3	$14.2	$13.0	$11.4	$8.3	$8.5	$9.0	$9.4	**$68.5**	**$115.1**

The Urban Institute estimated there are 3.5 million individuals who would be eligible to enroll in non-expansion states if Medicaid included adults with incomes up to 100% of the FPL. However, there would be no change to Marketplace enrollment, as subsidies are not available to people with income below 100% of the FPL.

We again assumed that 65% of states would expand their coverage if this proposal were enacted, offset by the 25% expansion assumed in the baseline estimates. We believe the lower FMAP along with the limited window of opportunity for expansion would result in approximately the same number of states expanding their Medicaid programs as recommendation B1a.

Recommendation B2: Permit states to auto-enroll individuals eligible for coverage under Medicaid, Children's Health Insurance Program (CHIP), or Marketplace subsidies in the appropriate programs. Marketplace auto-enrollment should only apply if the individual's subsidy meets or exceeds Marketplace premium costs.

Table 5: Estimated Impact of Policy Recommendation B2, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$9.2	$14.5	$20.7	$22.1	$23.5	$25.0	$26.6	$28.1	$29.8	$31.9	**$90.0**	**$231.5**

Of the estimated 30 million individuals without insurance in the US, approximately 8.1 million are currently eligible for Medicaid, and another 8.5 million are currently eligible for subsidized Marketplace coverage. There is a myriad of reasons that eligible individuals do not enroll in coverage, including lack of awareness and uncertainty regarding process and opportunity.

Some states have previously used an auto-enrollment process for Medicaid, shifting people into coverage based on information from individual tax filings. One state found that nearly 40-60% of individuals who were auto-enrolled in Medicaid decided to drop the coverage, often due to other sources of coverage.

Maryland has recently implemented a modified auto-enrollment process for the Marketplace by sending letters to subsidy-eligible individuals who indicate on their tax returns that they do not have health insurance. Prior research has found this approach leads to a 1-3% increase in Marketplace enrollment.

Based on conversations with BPC, we have assumed individuals would be automatically enrolled in either Medicaid or subsidized Marketplace coverage based on tax returns or other financial documents. Based on a variety of studies, we estimate 30% of the individuals auto-enrolled in Medicaid and 60% of the individuals auto-enrolled in a Marketplace plan will choose to drop the coverage. We also estimate that only half of all states would implement the auto-enrollment processes. All told, we estimate 4.5 million additional Medicaid enrollees and 1.4 million additional Marketplace enrollees.

In addition, research has shown that the uninsured are generally less-costly than the currently insured. As such, we assume the new enrollment will lower Medicaid costs by approximately 5% on a per-person basis, as well as lower Marketplace premiums by approximately 3%. Finally, we assume that states would gradually adopt these processes over the next 3-4 years.

Recommendation B3: Create a new state option for 12-month continuous Medicaid eligibility for adults.

Table 6: Estimated Impact of Policy Recommendation B3, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$1.1	$2.1	$2.2	$2.3	$2.4	$2.6	$2.7	$2.9	$3.0	$3.2	**$10.2**	**$24.5**

States are currently permitted to provide 12 months of continuous coverage for children. As of 2020, 75% of children resided in states utilizing this option. Research has demonstrated that continuous coverage for children leads to an approximate 2% increase in average monthly Medicaid enrollment.

We assume only 50% of states will adopt the 12-month continuous eligibility for adults, given the higher costs associated with this population compared to children. In total, we estimate this recommendation will increase Medicaid enrollment by approximately 0.6 million individuals.

Based on the most recent Financial Management Report (FMR) data, Medicaid spends approximately $74 per enrollment on administrative costs tied to their eligibility and enrollment systems, of which 73% is paid by the federal government. As states adopt continuous enrollment for adults, we estimate roughly 50% of this per-enrollment cost will not be required, with the other 50% associated with fixed costs and therefore redistributed to the remaining enrollees.

Recommendation B4: Require coverage of preventive care services for adults in traditional Medicaid without cost-sharing.

Table 7: Estimated Impact of Policy Recommendation B4, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	**$0.1**	**$0.3**

The ACA mandated zero cost sharing for preventive services for adults covered in an expanded Medicaid program, as well as adults covered via Marketplace plans, most employer-sponsored plans, and Medicare. However, adults covered under the traditional Medicaid program may be subject to out-of-pocket costs for these services. The ACA offered a 1% FMAP increase incentive to states to cover these services without cost sharing.

A recent Kaiser Family Foundation survey suggests that 2.4 million adults with Medicaid coverage are required to pay an average $3 out-of-pocket for preventive services, and another 0.5 million adult enrollees do not have coverage for most preventive care services.

The BPC proposal would require all states to offer preventive services without cost sharing, although it would also leave the 1% enhanced FMAP in place. Therefore, we estimate all 2.9 million adults enrolled in traditional Medicaid programs would have access to this care without restrictions.

Policy Recommendation Domain C: Strengthen the Medicaid Primary Care Workforce

Recommendation C1: Increase state Federal Medical Assistance Percentages to 100% for primary care services for states that reimburse at Medicare rates for five years.

Table 8: Estimated Impact of Policy Recommendation C1, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$5.1	$5.1	$5.3	$5.6	$5.9	$0.0	$0.0	$0.0	$0.0	$0.0	**$27.0**	**$27.0**

The ACA offered states a 100% FMAP for primary care services paid at parity to Medicare rates for 2 years. While the provision expired at the end for 2014, recent data suggests 9 states have continued to set Medicaid payment for primary care near or above Medicare rates.

Based on data from the Robert Graham Center, we estimate approximately 6% of all Medicaid spending on medical care was for primary care services, or roughly $16 billion per year. The Kaiser Family

Foundation recently estimated that Medicaid payment for primary care was 34% lower than Medicare payment for similar services.

A wide range of research has been undertaken on the impact of the ACA payment parity provision. Some studies found it had little effect on access, which was attributed to the short timeframe of the proposal. Other studies suggest it increased overall utilization of primary care, emergency departments, and pharmaceuticals, although it is unclear how much this increase was due to primary care payment parity. Given the uncertainty regarding the impact on utilization, we have not included any costs other than the amounts required by payment parity.

Finally, we estimate that only 50% of states will adopt this policy, given the limited timeframe and a general reluctance by state policymakers to reduce payment for primary care in the future.

Recommendation C2: Direct the HHS secretary to delay proposed changes to managed care organization network adequacy requirements and direct the Centers for Medicare & Medicaid Services to develop data-driven access standards, taking into account the impact on medically underserved populations, including rural residents. Congress should direct the secretary to promulgate regulations based on the new data-driven standard.

We estimate this proposal will have a negligible effect on the federal budget. CMS did not include an estimated cost or savings associated with their proposed network adequacy requirement, suggesting there is limited evidence as to the impact a change in network adequacy could have on costs.

Recommendation C3: Direct the HHS secretary to establish a comprehensive plan to ensure oversight and coordination of all federal programs that address healthcare workforce needs.

We estimate this proposal will have a negligible effect on the federal budget. The recommendation does propose to adjust how Medicaid Graduate Medical Expense (GME) payments are distributed, but it does not propose to increase or decrease these amounts. As such, while there could be an impact on the availability of certain physician types that in turn could impact costs and outcomes, there is not enough evidence to estimate the impact this could have on the federal budget.

Recommendation C4: Reauthorize the Conrad 30 program and expand the number of J-1 Visa Waivers each state receives through the program from 30 to 50, with priority given to those in rural areas.

We estimate this proposal will have a negligible effect on the federal budget. Not all states currently use their full allotment of Conrad 30 waivers, and there is little evidence to suggest that additional physicians receiving J-1 visa waivers would lead to overall higher utilization in the Medicaid population.

Recommendation C5: During a public health emergency, revise restrictions on international medical graduates on H-1B visas to permit an employer to deploy an international medical graduate from an assigned site of service to another within the health system and permit an international medical graduate to provide telehealth services outside that location.

We estimate this proposal will have a negligible effect on the federal budget. While the US is currently responding to the COVID-19 pandemic, it is not feasible to estimate the frequency of future public health emergencies. This unknown element limits our ability to estimate the budgetary impact of this recommendation.

Recommendation C6: Reauthorize federal funding for the Community Health Care Center Fund at the current level of $5.6 billion annually, including both mandatory and appropriated.

Table 9: Estimated Impact of Policy Recommendation C6, in billions

	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	**FY21 - FY26**	**FY21 - FY30**
Est. change in federal spending	$1.7	$3.4	$4.2	$4.3	$4.3	$4.3	$4.3	$4.3	$4.3	$4.3	**$17.9**	**$39.2**

Over the past several years, funding for community health centers (CHC) has been split between $1.8 billion per year in mandatory funding and $4.0 billion in discretionary funding. The mandatory funding is nearly always included in the annual budget appropriations, and we assume will continue to be included and therefore is already reflected in baseline federal cost estimates.

The $4.0 billion discretionary funding is currently set to expire November 2020. The BPC recommendation would provide for a full 10 years of discretionary funding resulting in a stable outlook for CHCs for the next decade. Per standard scoring convention, we estimate the funding would not be fully used in the initial 1-2 years and would likely lead to slightly higher costs over the subsequent years as more Medicaid enrollees are able to receive care at CHCs.

Policy Recommendation Domain D: Address Racial, Ethnic, and Economic Disparities in Medicaid

Recommendation D1: Block implementation of the June 2020 final rule eliminating non-discrimination provisions, and direct GAO to determine the impact of the rule.

We estimate this proposal will have a negligible effect on the federal budget. HHS did not include an estimated cost or savings associated with the non-discrimination provision, although it did note that it was possible the elimination of this provision could reduce access for certain individuals.

Recommendation D2: Permit states to define and reimburse community health workers, where evidence has demonstrated improved outcomes for those with chronic conditions.

We estimate this proposal will have a negligible effect on the federal budget. States currently have multiple options to reimburse community health workers (CHW), including filing state plan amendments (SPA), utilizing Section 1115 waivers, reimbursing through managed care contracts, or using other health system transformation efforts. The BPC recommendation would call attention to these avenues, but we assume that states interested in funding CHW services would likely take advantage of these existing opportunities regardless.

Recommendation D3: Direct the HHS secretary to require states to establish monitoring and enforcement mechanisms that ensure providers who receive Medicaid and CHIP funding comply with laws prohibiting discrimination against individuals with disabilities.

We estimate this proposal will have a negligible effect on the federal budget. Any amounts associated with penalties or fees for noncompliance would likely be nominal.

Recommendation D4: Provide the HHS Secretary with the authority to approve Medicaid coverage of non-medical services that address social needs.

We estimate this proposal will have a negligible effect on the federal budget. There is a growing body of evidence related to the costs and benefits that coverage of services related to social needs can have on

traditional medical costs. Some studies have found immediate savings, others have found that savings can take multiple years to accrue, and some studies have found that the costs of providing these services to a broad segment of the population is likely not recovered by cost savings from a subset of those individuals.

One element of the BPC recommendation is a requirement that the CMS Office of the Actuary certifies that coverage of any non-medical service would result in no net increase in Medicaid spending. Given the current state of the research, it is unclear what non-medical services could meet this definition in the near-term that is not already allowed in Medicaid. As such, we have assumed no impact on the federal budget.

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