
Discussion Paper:

Opportunities for Medi-Cal to Support Community Health Initiatives

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**CALIFORNIA
ACCOUNTABLE
COMMUNITIES
FOR HEALTH
INITIATIVE**



INTRODUCTION

There is growing recognition that social and environmental factors such as exposure to toxins, access to healthy food, community violence, economic insecurity, and inadequate housing have a substantial influence shaping health outcomes and spending patterns (including total cost of care and high utilization among certain populations).^{i,ii} These factors are often termed social determinants of health (SDOH). As California’s largest payer for health care and behavioral health services for low-income individuals, who are disproportionately affected by SDOH, Medi-Cal has an unmistakable interest in these factors. In fact, as Medi-Cal has expanded to cover the formerly uninsured, in response to the additional resources provided by the Affordable Care Act, the social needs and complexity of the enrolled population has increased. Growing research and understanding along with changes to health care coverage and incentives have led to a proliferation of projects and analysis lead by both the health care system and other

Note: This paper was produced as background and framing for a roundtable discussion convened in April 2018 by the California Accountable Communities for Health Initiative (<http://cachi.org>). The information, and structure for organizing it, may be useful to others in the field, so the content has been slightly modified for wider distribution.

governmental, philanthropic, or community-based entities focused on health improvement for populations that experience adverse SDOH.^{iii, iv}

Historically, there has been a divide between population health improvement efforts that are implemented by clinical institutions and those that are led by public health or community-based organizations. Clinically-driven efforts have generally focused specifically on defined patient

populations and strategies that are implemented within clinical settings, though there has been recent movement to expand focus on social factors. These strategies are sometimes referred to as population health management or population medicine. There is growing evidence for the effectiveness of strategies within clinical settings that move beyond medical concerns to focus on addressing social needs.^v Initiatives led by public health or community-based organizations often focus on target geographies and/or environmental, social, and policy factors that are shaping patterns of illness and injury. For the purposes of this discussion, we’ll use the term “community health initiatives” to describe this type of effort. There is growing evidence in this area as well of impact and comparative effectiveness.^{vi,vii}

Increasingly, health thought leaders assert that in order to substantially move the needle on health and safety outcomes that are fundamentally shaped by SDOH, it will be necessary to bridge the divide and align resources and strategies across multiple sectors.^{viii,ix} This is in part the result of experiences such as California’s successful tobacco control efforts, which required a range of strategies including clinical spokespeople, taxation, improved assessment of tobacco use, cessation programs, and changes to local policies. In the case of tobacco, those efforts have been shown to have saved significant health care resources.^x

California leaders who are working on housing as a health issue (motivated in part by the high cost of high- utilizing chronically homeless individuals) have similarly recognized that no sector alone has the expertise and assets necessary to facilitate stably housed individuals; the imperative is to coordinate services and align resources.^{xi} There are numerous initiatives across the country focused on the alignment of clinical and community resources and strategies to achieve health outcomes by addressing a range of SDOH issues. These include federal,^{xii} statewide,^{xiii} and philanthropic projects.

The California Accountable Communities for Health Initiative (CACHI) is an example of a community health initiative that is pursuing cross-sector strategy and resource alignment. CACHI is funding sites across the state that intend to build the collaborative capacity (relationships, data sharing, financing, etc.) necessary to implement strategies across a portfolio of interventions and address community-health priorities.

The purpose of this paper is not to identify ways in which specific Medi-Cal managed care plans (MCPs) can support specific CACHI sites. It is rather to consider ways that MCPs and community health initiatives such as CACHI can align resources and partner more effectively, and to explore opportunities and barriers to doing so. For example, it is critical to recognize that MCPs operate in a highly regulated environment. MCPs in California are currently supporting activities focused on meeting social needs and improving community health—and there are additional opportunities to do so given current rules, guidelines, and incentives. There are also significant limitations and challenges to MCP participation in community-health initiatives and there may be statewide policy changes that could facilitate such participation.

THE COMMON AGENDA

MCPs and community-health initiatives such as CACHI sites have closely aligned perspectives and share a number of priorities including:

- *A commitment to improving health across designated geographies:* As figure 1 illustrates, there is significant overlap between the populations that a community-health initiative and MCP focus on but not precise alignment. A community-health initiative that focuses on an issue such as violence that has broad community impact or includes strategies such as increasing physical activity through improved physical environments is likely to have some effect on all MCP enrollees.
- *A focus on populations and neighborhoods with the greatest needs:* MCPs by definition serve a low-income population with a high-degree of physical, behavioral, and social needs. Community-health initiatives typically focus on health equity and geographies where there are the greatest inequities. MCP enrollees are likely disproportionately represented in the

communities where community- health initiatives focus.

- *Implementation of a range of strategies to address priority complex health conditions:* Although it may not be described as a “Portfolio”, MCPs are supporting a range of strategies including expanding timely access to services and supports, effective care coordination, improved data sharing and analysis, and partnership and support for community-based organizations. To varying degrees, MCPs and community-health initiatives focus on mitigating the effects of illness and injury and preventing future incidence.

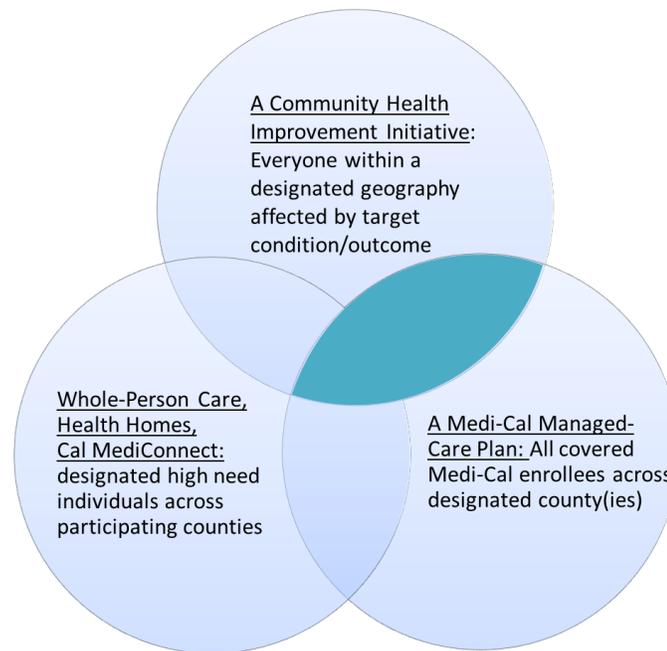


Figure 1. Overlapping population focus. *Notes: a) Whole Person Care, et al are implemented entirely with Medi-Cal populations, but a given MCP will only cover a portion of the participants in a given county; b) community-health improvement initiatives frequently focus on geographic areas smaller than a county.

CHALLENGES AND CONSIDERATIONS

A number of issues come up repeatedly in discussions of MCP engagement in community-health improvement including:

1. *Reduced rates or “premium slide”:*

Expenditures to address community health priorities could result in lowering other medical costs (e.g., investments in healthy eating active living programming could lead to less need for outpatient services for diabetes). If the community health expenditures are not considered when the state sets future rates, because it is not classifiable on the service and quality Improvement (QI) side of the medical-loss ratio (see “glossary” below), the result could be reduced rates.

2. *Wrong pockets problem:*

investments in initiatives that address community health priorities will likely result in benefits for entities that do not contribute to the initiative. For example, if an MCP pays for a home-remediation program focused on reducing asthma triggers, employers may benefit when their employees don’t have to stay home with a sick child and schools don’t lose revenue associated with an absence. Similarly, community-health strategies that focus on community-wide change, such as improved park infrastructure and safety to promote physical activity, are

likely to benefit all community residents not only enrollees in a given health plan. It is important to note that this issue exists in all directions as, for example, health plans also benefit from local government expenditures that improve health outcomes and save costs.

3. *Mismatched timeframes:* In many cases, the community-health improvement investments that are likely to have the greatest impact will not realize outcomes or significant reduction in costs for many years. For example, childhood exposure to lead is associated with a host of negative health, behavioral health, educational, and economic outcomes.^{xiv} However, most of those outcomes occur years or decades after exposure. Many other prevention investments follow a similar course. Turnover within enrolled populations and annual budget cycles may make long-term investments challenging for a given MCP. However, if all of the plans that anticipate remaining in operation within a geography, or at least the plans with the majority of covered lives, invested together, this challenge would be minimized.

4. *Evaluation/valuation:* With many SDOH interventions, it can be hard to model impacts and ascertain causality. There is a growing body of literature focused on the effectiveness of SDOH interventions, but there are numerous contextual factors that can make results unpredictable, particularly when multiple interventions are

implemented simultaneously.^{xv} For example, California has had remarkable success reducing rates of tobacco use. However, it would be very difficult to determine that an individual or group of individuals covered by a particular MCP changed their behavior as a result of changes in tax policy vs. limitations on smoking in public venues vs. public service campaigns vs. MCP-sponsored cessation programs, etc.

5. *Impact on providers:* Investments in community health improvement could have a number of consequences for providers that should be considered. For instance, resultant reductions in medical utilization can have adverse effects on health care organizations, including many hospitals, that are paid on a fee-for-service basis. Providers, such as community health centers, are largely paid for services provided and, as a result, may not have a mechanism to be reimbursed for activities related to community health improvement and may also need to develop new technical and staff capacities.

6. *Medi-Cal rates and budget:* California has among the lowest Medicaid rates in the country, which makes any

strategy that asks MCPs to take downside risk a difficult sell.^{xvi} State leaders have been very reluctant to increase the budgetary allocation for the Medi-Cal program, which makes it difficult to develop incentives that would pay plans on top of capitation rates (upside risk). However, a new Governor will be elected in late 2018, so this is an opportune time to consider new strategies.

7. *Bandwidth/Prioritization:* MCP leaders are faced with a wide array of financial, political, and programmatic challenges to consider and prioritize from potential changes in federal Medicaid policy to implementing new initiatives such as Health Homes and Whole Person Care to requests from local partners and government officials. Focusing on alignment with community-health improvement has opportunity costs in terms of other issues or opportunities that are de-prioritized, stakeholders whose interests may not receive attention, the staff capacities that need to be developed, etc.

Medi-Cal Funding Glossary

Managed Care Capitation Rate: The capitation rate is the amount the state contracts to pay a MCP per enrolled Medi-Cal member per month (PMPM). Roughly 80% of California’s Medi-Cal members are enrolled in managed care. The capitation rate is set based on services designated in California’s state plan; spending on quality initiatives intended to improve access and quality of care; and non-benefit costs such as administration and operations, taxes and regulatory fees, contributions to reserves, cost of capital, etc. Actuaries will calculate rates using past utilization of services, the prices paid for past utilization, and trend factors that account for projected program changes and/or changes in prices in the future. Capitation rates are reset by the state every 2 years dependent on approval from CMS.

Value-Based Payments: Value-based payments (VBPs) are payments that a payer makes to a provider that incent delivery of “value,” or quality for a given unit of cost, rather than simply paying for a service regardless of the outcomes produced. Value-based payments to providers come in two major categories: risk-based payments with quality reporting and outcome-based payments. Risk-based payments are usually a fixed amount of money paid to a provider for a member (a capitation rate) in exchange for the provider assuming responsibility for the care and quality outcomes for that member. Outcomes-based payments are contingent upon achieving a certain outcome as opposed to providing a certain service. The term Pay for Performance is one outcomes-based payment model. Shared savings are another type of outcomes-based payment where a provider only receives savings if certain total-cost-of-care and quality goals are met. MCPs can build VBPs into their agreements with providers to incentivize certain activity (e.g., inputting additional data into EHRs) or outcomes (e.g., reducing health-care setting acquired infections). The state also has leeway to require MCPs to implement VBPs and also to set incentive payments for plans to achieve themselves.

Value-based Purchasing: This is a term used to describe a state Medicaid agency’s practice of trying to incentivize value when contracting with MCPs. States can provide incentive dollars or withhold a portion of the MCP rate contingent on MCPs achieving certain outcomes. In California, Medi-Cal uses performance on the External Accountability Set (EAS), a set of population health measures, to do auto-assignment of Medi-Cal members who do not select a provider. This is a form of value-based purchasing at the state level in managed care in California.

Medical-Loss Ratio: The ACA established an 85% benchmark for the Medical-Loss Ratio (MLR) for health plan spending, and California has been enforcing MLR requirements since 2011. The MLR is calculated by adding spending on services, quality improvement expenses, and fraud prevention expenses (often referred to collectively as the “numerator”) and dividing by capitation revenue minus any taxes and fees (often referred to as the “denominator”). If community health improvement spending can be counted in the numerator, then it contributes to keeping the MLR at or above 85% (a plan with an MLR below 85% might be compelled to spend on services or quality improvement activities that support community health); if not, plans will see such spending as being taken from a limited amount of administrative, discretionary resources and plan profits..

Reserves and Profits: Managed care plans are required to carry reserves in order to maintain fiscal solvency. The expenditure of reserve funds is largely at the discretion of the MCP governing board. In recent years, some California plans have amassed reserves that are in excess of their minimum requirement.¹ Some MCPs, especially public Medi-Cal plans, have decided to reinvest these excess reserve funds in the communities they serve. Other MCPs systematically allocate funds to a community investment office or philanthropy. Reserve funds have been used to support community-health initiatives focused on improvements that impact all community members.

POTENTIAL MCP-COMMUNITY HEALTH INITIATIVE PARTNERSHIP STRATEGIES

What follows are strategies that MCPs either are currently implementing in specific California communities or could potentially pursue to support community health improvement initiatives. The strategies are divided into a set that appear feasible given the current regulatory landscape in California and a set that are feasible given federal regulations but would require action at the state level. The strategies are organized beginning with those that could be supported within current capitation to those that depend on additional funding or flexibility from new programs to those that would require spending reserves or other discretionary funds.

These strategies are not mutually exclusive or exhaustive. In fact, two of the crucial questions for those interested in partnership between MCPs and community-health initiatives are:

- 1) Given the challenges discussed above, which strategy(ies) would lead to the greatest mutual benefit; and,
- 2) Are there priority policy changes at the state level that could significantly advance such strategic partnership?

A. Currently feasible

Capitation payments

1. *Emphasize strategies that that are already covered and can be included in the MLR numerator and MCP capitation rate setting.* A few examples include the Diabetes Prevention Program (which California made a required Medi-Cal benefit through state legislation and Merced’s CACHI site is implementing), community care coordination with other service and social support providers, and Inland Empire Health Plan’s use of Health Navigators (community health workers) to support disease prevention and management. These strategies are likely to fall at the services, community programs, and clinical-community linkage end of the CACHI Portfolio of Interventions.
2. *Increase support for “value-added” services.* Plans have some flexibility to provide “services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes.” These services can be considered in the numerator of the MLR but cannot be considered for the purposes of future capitation rate setting.^{xvii} Examples include community-based medication compliance initiatives and home-based asthma assessment and remediation.^{xviii}

Incentives

3. *Create community-health aligned P4P incentives to providers (e.g., screening for SDOH, achieving improvements in BMI, etc.).* An MCP could offer their network providers an incentive that is aligned with community-health priority outcomes such as achieving a high-level of screening for exposure to trauma or achieving BMI improvements among pre-diabetic patients. Such incentives don't prescribe provider activity but could be implemented in coordination with providers and local community-health stakeholders as part of a comprehensive set of community health improvement strategies.

Programs

4. *Leverage initiatives such as Health Homes and Whole Person Care.* Both Health Homes and Whole Person Care have an explicit focus on social factors (in particular homelessness) and multi-sector coordination. Though both initiatives focus primarily on high-utilizing populations, there are significant resources designated for services that address social factors, linkage between clinical and community partners, and building the infrastructure for cross-sector collaboration.^{xix} For example, Health Homes reimbursable services include "family support" and "referral to social and community

services";^{xx} and WPC includes an emphasis on communications, data sharing, adaptive leadership, and workforce development.

Reserves and profits

5. *Fund community health work out of reserve funds.* MCPs have discretion over the allocation of reserve resources and could choose to invest in community-health-improvement programs if they are deemed priorities. Some MCPs have established an official mechanism for grantmaking such as LA Care's Community Health Investment Fund and Partnership Health Plan of California's SDOH Innovation Grants. Community investments can also be made at the discretion of boards of directors. In order to be successful, particularly in the start-up and proof of concept phases, community health initiatives require flexible funding to support backbone functions such as partnership development, evaluation and data system development, and sustainability planning and fundraising. Support for these activities from MCPs is most likely to come from reserves and profits.
6. *Establish data-sharing agreements to monitor indicators related to priority health conditions.* MCPs hold data that could potentially be of significant value for demonstrating the impact of

CACHI activities. As CACHI sites develop their evaluation and data approaches, MCPs could play an important role by agreeing to make data available both on intermediate measures (e.g., BMI, PHQ 9 scores, etc.) and utilization patterns.

7. *Lend support to local policy change efforts that CACHI sites are prioritizing.* The type of support may range from signing on to endorse a policy, communicating support to local decision makers, supporting staff to be spokespeople for the policy, or allocating resources to support advocacy efforts (this would obviously not be counted as service or quality improvement). For example, MCPs have joined collaborative policy-focused efforts to address healthy housing, violence prevention, and numerous other issues.^{xxi, xxii}

**Examples & Considerations:
Feasible Approaches under Existing Federal/State Regulations and Programs**

Financing sources	Description	National examples	California examples	Considerations
MCP capitation payments	<ul style="list-style-type: none"> MCPs may use capitation payments to pay for community care coordination and linkages and “value added services” 	<ul style="list-style-type: none"> MCP payment for Pathways HUB programs in Michigan, Ohio, and Oregon MCP payment for Community Servings, Massachusetts: prepared meals 	<ul style="list-style-type: none"> Coverage for Diabetes Prevention Program implemented by Merced CACHI site 	<ul style="list-style-type: none"> Services can be included under MLR requirements Capitation rates must be adequate to meet community care coordination requirements Only coordination services can be included in rate setting
Incentives: VBP arrangement between MCPs and Providers	<ul style="list-style-type: none"> Providers are incentivized to cover services via VBP payments that align with community-health initiative priorities 	<ul style="list-style-type: none"> Johns Hopkins uses its global PMPM budget to fund the Men and Families Center to run a Neighborhood Navigators program 	<ul style="list-style-type: none"> HbA1c Control (measure of diabetes management) is one of the Medi-Cal P4P Core Measures 	<ul style="list-style-type: none"> MCPs can leverage existing VBP program or contract requirements to encourage provider investments VBP payments are included in MLR and rate setting Providers have flexibility in how to use VBP funding
Programs: Whole Person Care and Health Homes	<ul style="list-style-type: none"> Health Home providers use PMPM reimbursement to pay for referrals to community services. WPC programs coordinate interventions, data sharing and policy agenda with ACHs 	<ul style="list-style-type: none"> Vermont’s Hub and Spoke Programs makes payments to multi-disciplinary Community Health Teams that coordinate activity across a designated region. 	<ul style="list-style-type: none"> The WPC pilot includes provisions for new services and infrastructure related to housing. 	<ul style="list-style-type: none"> May only cover a subset of ACH populations, but complementary objectives
MCP reserves and profits	<ul style="list-style-type: none"> MCPs may use reserve resources to invest in a community health programs 	<ul style="list-style-type: none"> Caresource (Ohio) funds permanent housing for nursing home residents 	<ul style="list-style-type: none"> LA Care’s Community Health Investment Fund and Partnership Health Plan of California’s SDOH Innovation Grants 	<ul style="list-style-type: none"> Can be established via grant making or formal contracts

B. Require State Action

Capitation payments

1. *Specify non-traditional social services as covered benefits or “in-lieu-of” services.* States have significant leeway to approve services that are “medically necessary and cost effective.” Examples include in-home visits and nutritional assessment and meals. There are challenges in ensuring that added services are available across the state, but because these services become part of the benefit package for rate-setting purposes, this is an important strategy for creating sustained funding.
2. *Revise rate-setting process.* California Department of Health Care Services has acknowledged that the current rate setting process is limited in its ability to incentivize innovation that reduces cost and utilization.^{xxiii} The state could develop a proposal for a rate adjustment process that would allow MCPs that make investments in initiatives focused on improving health and reducing costs to keep part of any savings that result. A similar concept has been developed in Oregon and is in the process of pre-implementation refinement.^{xxiv}

Incentives

3. *Designate that a percentage of value-based payments can be*

invested in “community health improvement strategies” aligned with community- health quality metrics. Health plans would still need to identify strategies that are likely to lead to achieving the metrics but establishing the metrics and providing financial flexibility (and premium slide protection) could lead to a significant domain of shared interest with CACHI sites. As discussed above, given California’s Medi-Cal reimbursement rates and budget allocation, this would need to be designed within the parameters of current capitation rates.

Programs

4. *Use waiver authority to pilot broad investments addressing social factors.* As California considers the focus of its next 1115 waiver, a package of strategies aimed at increasing efforts to address SDOH could become a focus. The waiver could become the vehicle for clarifying the state perspective on a number of the strategies above.

Reserves and Profits

5. *Require community investment as part of contracting.* The state could make a certain level of community investment a requirement for operating a health plan in California. Other states have implemented this sort of requirement

(Arizona requires 6% of Regional Behavioral Health Authority profits be reinvested in communities;^{xxv} Massachusetts established a Prevention and Wellness Trust Fund supported by an assessment on health plans and certain hospitals^{xxvi}). In California, health plans have agreed to community investment requirements as part of Medi-Cal rural expansion and recent merger agreements.^{xxvii}

6. *Use portion of reserves for community investment with social return.* MCPs are required to maintain a certain level of equity. Other states have specified that a share of that equity can be held in mission-driven investments. For example, Arizona authorized investments in low-income housing and a portion of the units would be set aside for Medicaid beneficiaries.^{xxviii}

**Examples & Considerations:
Activities Requiring California Department of Health Care Services Action**

Financing Sources	Description	National examples	Considerations
MCP capitation payments: SDOH Risk Adjustment	<ul style="list-style-type: none"> State uses social determinants data to adjust MCP capitation payments, increasing payments based on higher risk patient populations 	<ul style="list-style-type: none"> Massachusetts is using SDOH risk adjustment to set MCP/ACO rates based on stability of housing status and “neighborhood stress” score 	<ul style="list-style-type: none"> Requires state resources and external expertise to undertake Leverages existing state authorities
MCP capitation payments: Coverage of in lieu of services or other non-traditional Medicaid services	<ul style="list-style-type: none"> MCP covers services that are determined by the state to be a medically appropriate and cost effective substitute for the covered services or service-delivery setting in the state plan 	<ul style="list-style-type: none"> Arizona includes respite services in the Medicaid Behavioral Health benefit package to relieve primary care givers 	<ul style="list-style-type: none"> State must approve and include in lieu of services in the MCP contract
MCP capitation payments: MCP Rate-setting	<ul style="list-style-type: none"> State uses rate setting methodology to reward MCPs that invest in upstream interventions 	<ul style="list-style-type: none"> Oregon received 1115 approval to build a higher percentage of profit margin into the capitation rates of efficient and high-quality CCOs/MCPs 	<ul style="list-style-type: none"> Rate-setting adjustments may require federal approval Can be structured to be budget neutral
Incentives: MCP incentives	<ul style="list-style-type: none"> State offers MCPs incentives to invest in upstream interventions that improve quality 	<ul style="list-style-type: none"> In 2019, Ohio will reward MCPs .5% of capitation payments to help achieve improved academic performance 	<ul style="list-style-type: none"> State budget implications Leverages existing state authorities
Programs: MCP program requirements	<ul style="list-style-type: none"> State uses MCP program to require SDOH screening/referral State uses MCP VBP contracting requirements to incentivize investments in upstream interventions 	<ul style="list-style-type: none"> New York uses its MCP VBP requirements to include MCP/Provider/CBO partnerships around SDOH North Carolina will require MCPs to screen for and address SDOH 	<ul style="list-style-type: none"> Leverages existing state authorities
MCP reserves and profits: profit requirements	<ul style="list-style-type: none"> State requires a percent of profits to be re-invested in the community 	<ul style="list-style-type: none"> Arizona requires behavioral health MCPs to re-invest 6% of profits in the community 	<ul style="list-style-type: none"> California could use MCP recouped profits to create a Wellness Fund or SDOH-related incentive pool Leverages existing state authorities
MCP reserves and profits: capital requirements	<ul style="list-style-type: none"> State clarifies MCP capital requirements in support of SDOH investments 	<ul style="list-style-type: none"> Arizona allows MCPs to use a share of their capital as a line of credit for low income housing 	<ul style="list-style-type: none"> Leverages existing state authorities May be under Department of Insurance purview

CONCLUSION

The two sets of strategies above indicate the need for two parallel but related conversations. One is between community health initiative leadership and leaders from local MCPs to explore both the nuances of their shared perspective and opportunities for collaboration in the short term. The other conversation involves a broader set of stakeholders focused on how to bring California back into the forefront of innovation on health improvement by providing the guidance and incentives necessary to facilitate increased managed-care engagement on SDOH and community health.

ENDNOTES

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- ⁱ University of Wisconsin Population Health Institute. *Explore Health Rankings | What and Why We Rank. County Health Rankings & Roadmaps*. Robert Wood Johnson Foundation. Accessed April 6, 2018 at www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank.
- ⁱⁱ McGovern L, Miller G & Hughes-Cromwick P. *The Relative Contribution of Multiple Determinants to Health Outcomes*. Health Affairs, August 2014. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf415185
- ⁱⁱⁱ McGinnis T, Crumley D & Chang D. *Implementing Social Determinants of Health Interventions in Medicaid Managed Care*. AcademyHealth, February 2018. <https://movinghealthcareupstream.org/media/2056/polimplementingsocialdeterminantsinmedicaidpolicybriefwebfinal.pdf>
- ^{iv} Bachrach D, et al. *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools*. Commonwealth Fund, January 2018. www.commonwealthfund.org/publications/fund-reports/2018/jan/social-interventions-medicare-managed-care-rate-setting.
- ^v UCSF Social Interventions Research & Evaluation Network (SIREN) *Research on Integrating Social & Medical Care | SIREN | Evidence Library*. Accessed April 10, 2018 at sirennetwork.ucsf.edu/tools/evidence-library.
- ^{vi} Mays G, Mamaril C & Timsina L. *Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks*. Health Affairs 2016 35:11, 2005-2013. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0848>
- ^{vii} Chokshi D & Farley T. *The Cost-Effectiveness of Environmental Approaches to Disease Prevention*. N Engl J Med July 26, 2012; 367:295-297. <http://www.nejm.org/doi/full/10.1056/NEJMp1206268>
- ^{viii} Kindig D & Milstein B. *A Balanced Investment Portfolio For Equitable Health And Well-Being Is An Imperative, And Within Reach*. Health Affairs, April 2018; 37:4, 579-584. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1463>
- ^{ix} Georgia Health Policy Center. *Bridging for Health Project*. Georgia State University. Accessed April 6, 2017 at <http://ghpc.gsu.edu/project/bridging-for-health/>
- ^x Lightwood J, Dinno A, & Glantz S. *Effect of the California tobacco control program on personal health care expenditures*. PLoS Medicine, 2008; 5(8), e178.
- ^{xi} Cantor J, Tobey R & Greenberg E. *Integrating Housing Strategies with Health: An Opportunity to Advance Whole Person Care in California*. JSI, June 2015. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15757&lid=3
- ^{xii} Alley D, Asomugha C, Conway P & Sanghavi D. *Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid*. N Engl J Med 2016; 374:8-11. <http://www.nejm.org/doi/full/10.1056/NEJMp1512532>
- ^{xiii} Hester J. *A Balanced Portfolio Model For Improving Health: Concept and Vermont's Experience*. Health Affairs, April 2018. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1237>
- ^{xiv} World Health Organization, *Lead Poisoning and Health Fact Sheet*. Updated August 2017. <http://www.who.int/mediacentre/factsheets/fs379/en/>
- ^{xv} UCSF Social Interventions Research & Evaluation Network (SIREN) *Research on Integrating Social & Medical Care | SIREN | Evidence Library*. Accessed April 10, 2018 at sirennetwork.ucsf.edu/tools/evidence-library.

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- ^{xvi} Zuckerman S, Skopec L & Epstein M. *Medicaid Physician Fees after the ACA Primary Care Fee Bump*. Urban Institute, March 5, 2017. https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump/view/full_report
- ^{xvii} McGinnis T, Crumley D & Chang D. *Implementing Social Determinants of Health Interventions in Medicaid Managed Care*. AcademyHealth, February 2018. <https://movinghealthcareupstream.org/media/2056/polimplementingsocialdeterminantsinmedicaidpolicybriefwebfinal.pdf>
- ^{xviii} California Chronic Care Coalition. *Right Care Initiative*. Accessed April 4, 2018 at www.chroniccareca.org/san-diego-programs.
- ^{xix} Community Partners. *Comparison of Key Aspects of California's Health Home and Whole Person Care Pilot Initiatives with the California Accountable Communities for Health Initiative*. Community Partners, March 2016, <http://communitypartners.org/sites/default/files/documents/HH%20WPC%20ACH%20Comparison%20March%202016.pdf>.
- ^{xx} California Department of Health Care Services. *Health Homes for Patients with Complex Needs - California Concept Paper - Final*. California Department of Health Care Services, March 2016, www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf.
- ^{xxi} Community Development Agency (CDA) - Alameda County. *Healthy Homes Alliance - Healthy Homes Department*. Accessed April 4, 2018 at www.achhd.org/hh-alliance.htm.
- ^{xxii} Violence Prevention Coalition of Orange County, *Endorsing Coalition Members*. Accessed April 4, 2018 at <http://www.vpcoc.org/members>.
- ^{xxiii} California DHCS. *Medi-Cal 2020, Key Concepts for Renewal*. Accessed April 9 at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf
- ^{xxiv} Manatt Health & Optumas Healthcare. *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*. California Health Care Foundation. March 2018. <https://www.chcf.org/wp-content/uploads/2018/03/IntendedConsequencesMediCalRateSetting.pdf>
- ^{xxv} Bachrach D, et al. *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools*. Commonwealth Fund, January 2018. www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicare-managed-care-rate-setting.
- ^{xxvi} Institute on Urban Health Research and Practice. *The Massachusetts Prevention and Wellness Trust - An Innovative Approach to Prevention as a Component of Health Care Reform*. Northeastern University. Accessed April 5, 2018 at www.northeastern.edu/iuhrp/wp-content/uploads/2013/12/PreventionTrustFinalReport.pdf.
- ^{xxvii} Roulliard S & Kim C. *Blue Shield/Care1st and Centene/Health Net Undertakings*. Presentation at IHA Stakeholder Meeting, September 19, 2017. http://www.ih.org/sites/default/files/files/page/session_2b-ca_dmhc_undertakings.pdf
- ^{xxviii} Bachrach D, et al. *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools*. Commonwealth Fund, January 2018. www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicare-managed-care-rate-setting.