THE HIDDEN OPIOID CRISIS | WHY MEDICAID STILL MATTERS | THE AI REVOLUTION BEGINS | HOW BEING BLACK IS A HEALTH RISK

In Reach

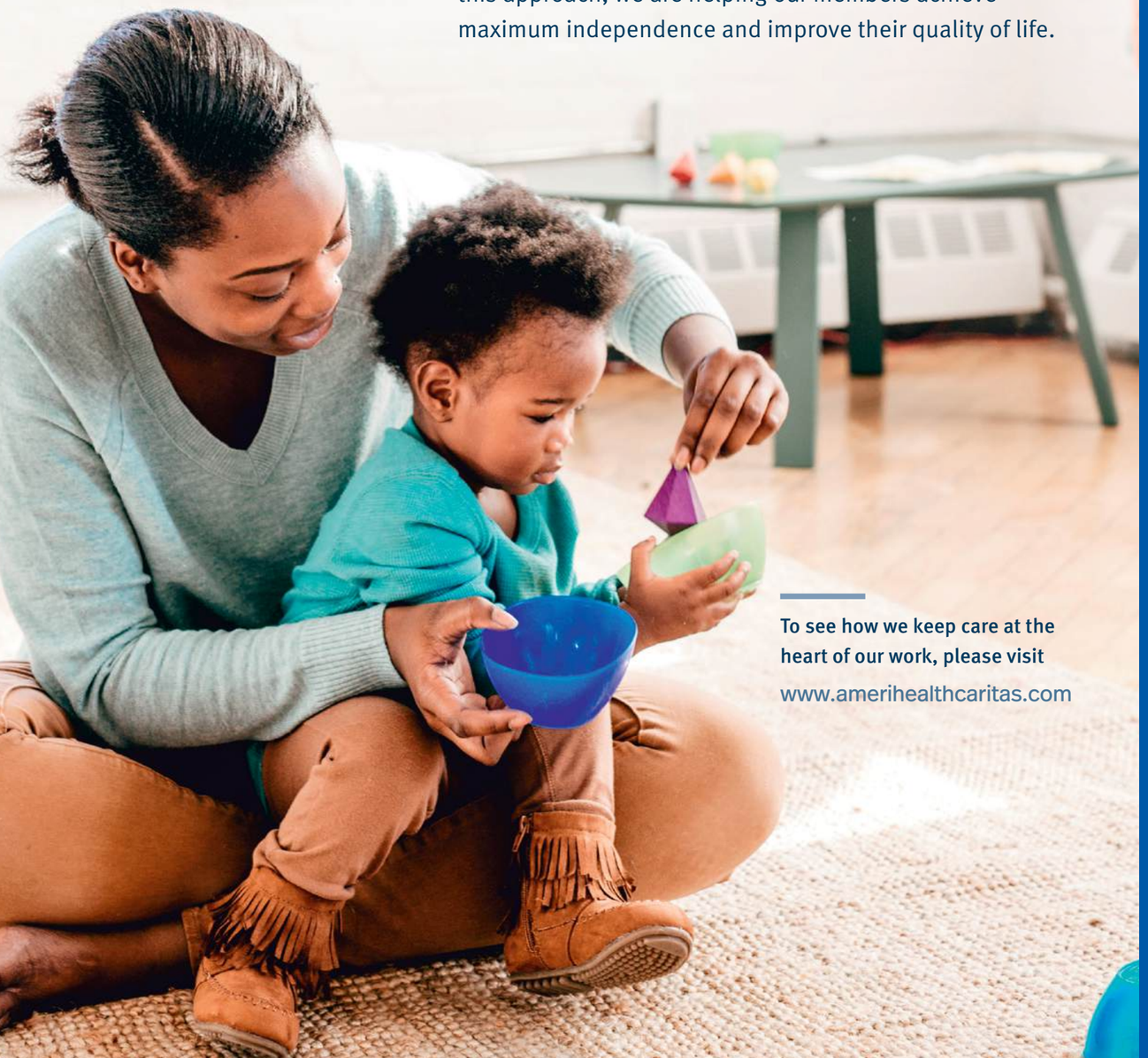
PUBLISHED BY AMERIHEALTH CARITAS INAUGURAL ISSUE

PARADIGM SHIFT

The Promise of Whole-Person Care

Where Care Comes Full Circle

Our whole-person model of care focuses on the full spectrum of physical well-being, mental health, psychosocial needs, and community support. Through this approach, we are helping our members achieve maximum independence and improve their quality of life.



To see how we keep care at the heart of our work, please visit
www.amerihealthcaritas.com

In Reach

FALL 2019 • INAUGURAL ISSUE

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AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need. The company's fully integrated model of care helps improve health outcomes for individuals and families on Medicaid and Medicare, including those with dual eligibility, individuals who are aged, blind, and disabled, and those in need of long-term services and supports. Backed by two of the largest and most well-respected Blue companies, Independence Health Group and Blue Cross Blue Shield of Michigan, AmeriHealth Caritas has worked since 1983 to expand access to care for its members and to maximize value for health care providers, community organizations, and government stakeholders nationwide.

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LEADOFF

Widen the Lens

Health care must be about more than medicine. This idea is at the heart of our company's Next Generation Model of Care. Our approach—which I believe is the future of managed care—is built around a strategy and framework that address the whole person rather than health issues alone.

Our new model of care widens the lens to help our members and their caregivers overcome barriers created by social determinants of health: the conditions where people live, work and play that can create health risks and affect outcomes. As the cover story of this debut issue of *In Reach* makes clear, the increasing focus on social determinants by managed care organizations and providers alike has become a paradigm shift in how we think about and deliver health care.

We need to respond to what we see every day as we walk side by side with our members. They want responsibility for their own lives. They want to work and be fully engaged with their families and communities, and they want opportunities to attain a higher quality of life. Medicaid can be a path for these individuals to achieve the American dream, a dream to which we all aspire. By providing them with a more holistic managed care program, we can help members overcome health inequities to achieve maximum independence and thrive.

But *In Reach* isn't about AmeriHealth Caritas. Its goal is to spotlight important health care trends and emerging topics, including cost-effective and innovative solutions that help break down barriers to quality care. As you read the pages that follow, I hope the stories make clear that when compassion and innovation meet, a healthier future emerges and the American dream is *in reach* for *everyone*.

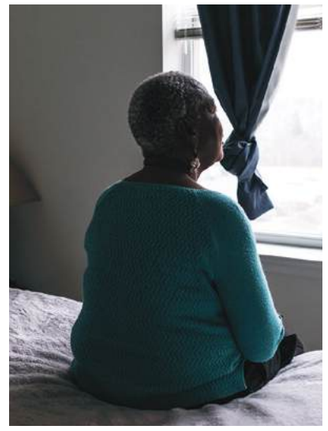
All the best,

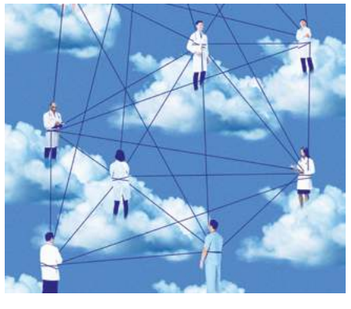
Paul A. Tufano
Chairman and CEO

CONTENTS

Up Front

Features





Next Steps

Help Wanted

Rural America struggles with a shortage of health care workers.

The United States needs more medical professionals—especially in rural areas. A study published in 2019 by the American Hospital Association found that two-thirds of the nation's primary care health professional shortages occur in rural areas. This problem isn't going unnoticed either—1 in 4 rural Americans say they couldn't get the health care they needed recently, according to a 2019 survey from NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health.

Not surprisingly, when a community lacks an adequate number of health care providers, its overall health suffers. People who have more doctors in their area live longer, according to a 2019 study in *JAMA Internal Medicine*. An increase of 10 primary care physicians per 100,000 people is associated with a 41.5-day increase in life expectancy.

It's not just physicians that rural America is missing. It's also home health care professionals, the need for which is only increasing with the nation's growing aging population. Overall demand for in-home aides is expected to rise 41% from 2016 to 2026—far faster than the average 7% for all occupations.

ONLY 1% OF DOCTORS IN THEIR FINAL YEAR OF MEDICAL SCHOOL SAY THEY WANT TO LIVE IN COMMUNITIES WITH FEWER THAN 10,000 PEOPLE.

But the supply of these workers may not keep pace. "We are on the edge of a crisis," William Dombi, president of the National Association for Home Care & Hospice, told CNBC. "We are not prepared for what's coming. Our concern is that the demand is going to outstrip the supply unless we see some dynamic changes occur."

Only 1% of doctors in their final year of medical school say they want to live in communities with fewer than 10,000 people, according to a 2019 Merritt Hawkins survey, spurring some states to incentivize recent medical school graduates to set up practice in rural areas. The state of Michigan, for example, approved funding last year that will cover $75,000 of medical school loans for new doctors if they work in rural or other underserved areas in the state for two years after their residency. But questions remain as to whether the program can fill all of the gaps and whether doctors will stay for the long term.

PREVIOUS SPREAD, CLOCKWISE: STOCKSY; STOCKSY; HANNAH YOON, UNSPLASH; NICOLÁS ORTEGA, GETTY

Autism's Skewed Prevalence

Disparities in autism diagnoses fall along racial and socioeconomic lines—with significant consequences.

Autism is on the rise nationally—but diagnoses appear to mirror socioeconomic divides. Among 4-year-olds, autism's prevalence increased from 13.4 per 1,000 in 2010 to 17.4 per 1,000 in 2014, the Centers for Disease Control and Prevention reported this year. About 1.5 million children in the U.S., or 1 in 40, had been diagnosed with or are living with autism as of 2018, according to the U.S. Department of Health and Human Services.

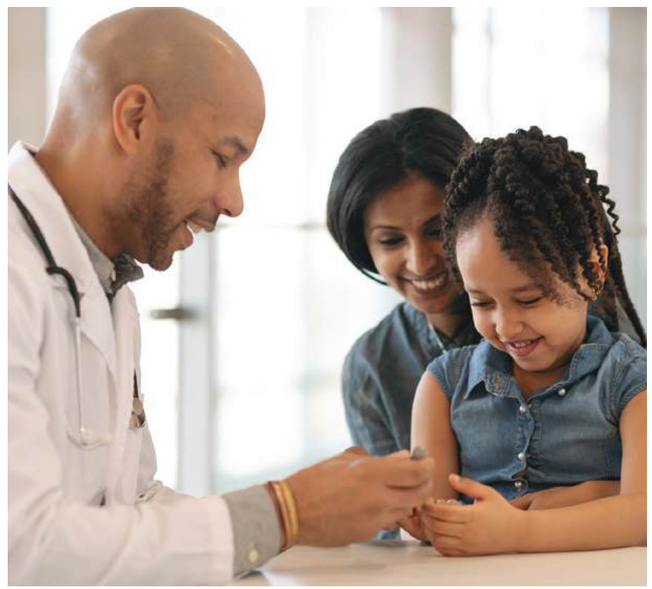
But those numbers tell only part of the story. Disparities in the rates of assessment and diagnosis fall along racial and socioeconomic lines. A 2017 study published by the American Academy of Pediatrics found that groups with higher income and greater access to health care were diagnosed more frequently.

For example, in New Jersey black children are half as likely as white children to receive an autism assessment by age 3. Yet the prevalence of autism is about the same for black and white children in the state. In Colorado and Wisconsin, children without health care records—who are much more likely to be black and Hispanic than white—tend to get categorized as "suspected" of having autism rather than receive a definitive diagnosis. As a result, autism among black and Hispanic children is underdiagnosed.

National statistics tell a similar story. For children in households with incomes 400% or higher above the federal poverty line, autism diagnoses increased by 36% between 2003 and 2012. By contrast, autism diagnoses among children living below the poverty line rose by just 13.3%.

"The way our whole system sees and treats people is based on their ethnic group," Sydney Pettygrove, assistant professor of epidemiology and biostatistics at the University of Arizona in Tucson, told *Spectrum*.

And that has significant consequences. Children evaluated later get treated later—and timely treatment is one of the best indicators of a good outcome for autistic children.



THIS SPREAD, CLOCKWISE: UNSPLASH, ISTOCK, ISTOCK

Troubling Drop in Coverage

Why are children losing Medicaid and CHIP coverage?

Last year, nearly 1 million children lost coverage through Medicaid and the Children's Health Insurance Program (CHIP). The reasons don't look good.

After years of growing or flat enrollment, Medicaid and CHIP enrollment declined by 2.2% across all 50 states, according to researchers at the Georgetown University Health Policy Institute Center for Children and Families. By contrast, between 2000 and 2016, enrollment declined in just one year (2007), and only by 1.1%.

(Continued on following page)

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The recent decline is not a result of a strong economy or a reduction in unemployment levels, the Georgetown researchers say. Case in point: Utah's unemployment went up slightly, while its Medicaid and CHIP enrollment dropped by 7.3%. That makes it unlikely that all the Utah children who lost coverage were gaining it through their families' employers.

"It doesn't really hold up when you look at a very straightforward comparison of economic indicators," Edwin Park, a research professor at Georgetown and a study author, told FierceHealthcare.

The claim is supported by a 2019 study from PolicyLab at the Children's Hospital of Philadelphia. It found that, of the 8.6 million children in working families who are covered by public insurance, more than 70% have a parent who works full-time at a large, private company. In other words, even with the option of private insurance, most of them still need public coverage.

"This may signal dependent coverage is becoming unaffordable for working families across all sectors—even those we think of as having good benefits—creating greater urgency for policymakers to protect Medicaid and CHIP as a safety net," says lead author Doug Strane, a PolicyLab researcher.

Georgetown's Park points to national factors such as the repeal of the individual mandate and immigration status as driving the decline. The Trump administration last year proposed a new rule to change how immigrants are deemed public charges—redefining who can receive government assistance. The new rule, which was finalized in August of this year, would result in more green card or visa applicants being rejected. Though the change targets adults, it also would affect their children, according to a 2019 study published in *JAMA Pediatrics*.

Out of fear and confusion, many immigrants, even those not affected by the rule change, will unenroll their children from Medicaid and CHIP, the study found. Although the federal rule change does not directly affect eligibility for Medicaid, some immigrant families minimize risk by avoiding health care altogether.

"Because there's so much fear and confusion about this particular rule ... many people are disenrolling from these benefits [such as Medicaid and CHIP] even when the rule doesn't apply to them," lead study author Dr. Leah Zallman, assistant professor of medicine at Harvard Medical School and director of research at the Institute for Community Health, told CNN.

State-specific factors also play a role. For instance, state-level changes to Medicaid programs, such as the introduction of work requirements, can drive away people who would be eligible for the program.

But states can also help reverse the negative enrollment trend, the Georgetown study says. How? By investing more resources in outreach and enrollment support, and streamlining enrollment processes through automatic renewal and 12-month continuous eligibility.

The Public's Right to Know

The Supreme Court rejects changes to Medicare reimbursements.

For years, federal Medicare authorities have pursued a policy that aimed to cut billions of dollars in payments to hospitals caring for low-income patients. In June, the U.S. Supreme Court put an end to those efforts.

ISTOCK, STOCKSY

Back in 2014, the government announced a new policy that targeted a program designed to compensate hospitals for the higher costs of treating low-income patients. In April 2018, U.S. Department of Health and Human Services (HHS) Secretary Alex Azar requested the Supreme Court take up the case, arguing that the circuit court's ruling would "significantly impair" the department's ability to administer Medicare reimbursements through third parties, leaving CMS responsible for nearly $4 billion in Medicare Disproportionate Share Hospital payments.

The problem, noted Supreme Court Justice Neil Gorsuch in his majority opinion, was that HHS made this change without abiding by the Medicare Act's requirement to provide public notice and a 60-day comment period.

The opinion began by noting that "one way or another, Medicare touches the lives of nearly all Americans." It went on to say: "Notice and comment gives affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes—and it affords the agency a chance to avoid errors and make a more informed decision."

Telemedicine Tipping Point?

Virtual health care visits are on the rise, but coverage is far from consistent.

Telemedicine and Medicaid are increasingly in sync. Every state in the country now offers reimbursement for some real-time virtual visits to health care providers, according to a 2019 report by the Center for Connected Health Policy (CCHP). But exactly which telehealth services are covered varies greatly from state to state.

"No two states are alike in how telehealth is defined and regulated," the report notes. That creates a confusing environment for telehealth participants, especially when a health system or practitioner provides services in more than one state.

The CCHP report identified three major trends:

- 11 states now offer reimbursement for "store-and-forward"—that is, previously recorded—telehealth services, which allow patients and providers to communicate on their own schedules.
- 21 states reimburse for remote patient monitoring (RPM) programs. Four other states and the District of Columbia require Medicaid to reimburse both store-and-forward and RPM but do not yet have official policies for them.
- Just six states reimburse Medicaid for all three services: live video, store-and-forward and RPM.

"NO TWO STATES ARE ALIKE IN HOW TELEHEALTH IS DEFINED AND REGULATED."

Yet the question remains whether patients and their providers will take to telehealth. Just 7 in 1,000 people nationwide used telemedicine in 2017, according to OptumLabs Data Warehouse.

"Once they use us once, they are going to continue to use us on a repeat basis," Dr. Lyle Berkowitz, MDLive's chief medical officer and executive vice president for product strategy, told the *South Florida Sun Sentinel*. "It's convenient, easy and as wonderful to use as Netflix is compared to going to Blockbuster."

What to Do About Childhood Asthma

At Healthy Hoops® events, children learn how to manage asthma while playing basketball.

The chronic disease continues to disrupt the lives of too many children. But research shows that proactive engagement and education can improve outcomes.

By Ambreen Ali

The leading chronic disease among children in the United States is not diabetes or obesity. It is asthma. The Centers for Disease Control and Prevention (CDC) estimates that 8.4% of children—more than 6 million people under the age of 18—suffer from the respiratory condition, which is also called reactive airway disease. Black and Latino children have asthma at disproportionately high rates and are more likely to die from it than are white children.

The good news is that environmental triggers—like pet dander and cockroaches or tobacco smoke—can be controlled to reduce the instance of asthma attacks. The same is true for exercise-induced asthma. "When well-controlled, patients with asthma need not be limited in their daily activities. In fact, many Olympic athletes have asthma," says Dr. Sakina Bajowala, medical director of Kaneland Allergy and Asthma Center in North Aurora, Illinois, and a fellow of the American Academy of Allergy, Asthma and Immunology.

The bad news is that many children are not receiving the medical care they need to prevent asthma attacks. More than half of children with asthma suffered at least one attack in 2016, the CDC reports. Each year, 1 in 6 visit an emergency room and 1 in 20 are hospitalized. Left unaddressed, the collective impacts of this crisis add up. The cost of uncontrolled asthma among children and adults over the next 20 years (2019-2038) will exceed $963 billion, according to a 2019 study published in the *American Journal of Respiratory and Critical Care Medicine*.

There's no secret to managing asthma successfully: Environmental changes work, and proven medications do exist. So what can providers do to better control asthma among children?

ENGAGE AND EDUCATE

One simple strategy to reduce the rate of attacks in asthmatic children is to ensure that they take their prescribed medication. Most patients are prescribed two kinds of medication: one to address an attack and another to prevent it. But rates of usage for the preventive medication are alarmingly low: A 2013 study by the National Health Interview Survey found that only 55% of children with asthma use the medication. And for those who do, about 25% do not use it regularly as prescribed.

To investigate how providers can improve outcomes for children with asthma, AmeriHealth Caritas conducted a study, first published in the *Journal of Asthma* in 2018. Participants were divided into two pools: The low-risk group received general interventions such as printed education materials and automated messaging, while the high-risk group received both educational materials and personalized care management. Both groups saw significant improvements in adherence to medication as well as a significant reduction in emergency room visits and inpatient admissions.

Educating families about asthma means healthier, happier kids—and reduced costs.

THE COST OF UNCONTROLLED ASTHMA AMONG CHILDREN AND ADULTS OVER THE NEXT 20 YEARS WILL EXCEED $963 BILLION.

The study shows that increasing communication with families whose children have asthma can improve outcomes, says its lead author, Dr. Andrea Gelzer, senior vice president of medical affairs at AmeriHealth Caritas. "You have to really get out into the communities," she said in an interview with Pennsylvania public radio station WITF. "You will get the optimal outcome when you expend a lot more resources and engage with the individual."

AmeriHealth Caritas' Healthy Hoops® program is one such effort. The basketball event for children ages 3 to 18 is also an opportunity for families to learn how to manage asthma and develop an action plan for preventing attacks. Since its inception in Philadelphia in 2002, the program has expanded to locations across South Carolina, Indiana, Kentucky, Florida and Georgia, reaching more than 10,000 children and families.

Educating families about treatment and increasing the use of preventive asthma-controlling medication mean fewer missed days of school and trips to the hospital. It means healthier, happier children—and less money spent on managing the chronic disease.

"It's hugely important from a quality of life perspective and also from a cost perspective," Dr. Gelzer said. "We're talking about millions of dollars in our plan, and that's significant." ■

Out of the Shadows

Stigmas surrounding mental illnesses such as depression prevent countless Americans from seeking the treatment they need. But public discourse is changing.

By Jim Laughman

In recent years, countless celebrities have come forward to discuss their personal struggles with mental illness: Jim Carrey, Ariana Grande, Ellen DeGeneres, Selena Gomez, Jon Hamm —the list goes on. These courageous individuals have stepped out of the shadows to help reduce the stigma associated with depression. They have acknowledged that despite their fame, fortune and success, they, like nearly 20% of Americans, have struggled with a mental health challenge.

While attitudes have gradually evolved over time, both the social stigma and self-stigma surrounding mental illness still prevent many from seeking treatment. Less than half of the adults struggling with mental illness in the U.S. get the treatment they need, and the average delay between onset and intervention is 8 to 10 years. This stigma remains particularly strong among African Americans and Latinos, who are 50% less likely to seek treatment for depression, anxiety or post-traumatic stress disorder (PTSD). Ultimately, lack of treatment can have far-reaching effects on the overall health of those suffering in silence. A groundbreaking study published in 2006 by the National Association of State Mental Health Program Directors found that people living with severe mental illness die on average 25 years earlier than the general population. Other research has shown they have an increased risk of having chronic medical conditions. The World Health Organization even calls depression the leading cause of disability worldwide.

STOCKSY

Warning Signs

Major depression is one of the most common forms of mental illness in the United States. Symptoms vary, and it can often be difficult to realize the cause. Without proper treatment, symptoms can get worse.

Common warning signs of depression include:

- Sadness, anxiety or feeling "empty"
- Feelings of hopelessness, pessimism, guilt, worthlessness or helplessness
- Fatigue or decreased energy level
- Change in appetite
- At the extreme, thoughts of death or suicide, or suicide attempts

If anyone you know exhibits these symptoms, encourage them to speak to their primary care provider or a behavior health specialist. The sooner depression is treated, the more successful the outcome.

17.3 MILLION U.S. ADULTS
had at least one major depressive episode in 2017*—that's 7.1% of all U.S. adults.

8.7% VS. 5.3%
A higher percentage of U.S. women than men had a major depressive episode in 2017.

35%
Approximate percentage of U.S. adults with major depressive episode who did not receive treatment in 2017

44%
Percentage who received combined care (treatment by a health professional and medication) in 2017

15%
Percentage who received treatment from only a health professional in 2017

6%
Percentage who received only medication in 2017

*The most recent year for which data is available
Sources: The National Institute of Mental Health Information Resource Center and The Substance Abuse and Mental Health Services Administration

LOOK AROUND

As you reflect on these facts, take a look around the office, airport, restaurant or street corner and realize the impact of these numbers. Perhaps you have a friend or family member who struggles with a mental health issue—or maybe you yourself have experienced this struggle firsthand. Regardless of how, or if, you've been personally affected by mental illness, it's important to recognize that no one chooses to have depression, anxiety or any other mental illness. When we understand that these are medical conditions, we are better able to find a path to treatment and recovery, and also help shatter the stigmas and myths surrounding these diseases.

The number of people who experience mental illness is perhaps shocking, but here's the good news: People can and do recover. Treatment and recovery can require many steps and can take many forms, including counseling, support groups or medication, which is a critical component for some people to achieve recovery and live a healthy life, just as insulin is for those with diabetes. What's important is that people get help without judgment and that the treatment is customized to treat the whole person—physically, emotionally and socially. Because while depression can trigger job loss and diminish one's ability to access basic needs such as food and housing, the reverse is also true: A lack of access to essential resources can cause depression, especially among those who have other health issues or lack a support network.

With high-profile people leading the way, we have made some tremendous strides in talking about the existence of mental illness and acknowledging that recovery is possible. However, in order to completely eradicate the stigma surrounding mental health challenges, we all must be undaunted when talking about the subject with ordinary people, especially as it affects those who struggle with other stigmatized challenges such as poverty. When it comes to helping those struggling with mental illness move out of the shadows and into the light of acceptance, hope and recovery, we all must do our part. Celebrities grab the headlines, but deep change happens on the ground through the rest of us, each and every day. ■

Jim Laughman is president of PerformCare®, a behavioral health organization within the AmeriHealth Caritas Family of Companies.

From Swamp to Spokes

A lack of accessible fresh food options contributes to many health inequities. But opening a grocery store is just the first step in creating a solution.

By Atif Bostic

We've all heard the term food desert, but a more accurate metaphor is a food swamp. These areas not only suffer from a lack of fresh food but are also bogged down by an overabundance of bad choices. With so few good options available, residents often buy meals at convenience stores or fast-food restaurants. In this environment, the arrival of a new grocery store won't automatically lead most people to change their habits. A more holistic approach that addresses social determinants of health is necessary.

The nonprofit I lead, Uplift Solutions, was founded 10 years ago by a fourth-generation grocer to help eradicate food deserts. But it didn't take long to realize that building a supermarket doesn't remove barriers like affordability or help to change individual behaviors. So we developed a hub-and-spoke approach. The grocery store acts as the hub for healthy food and health-service interventions. These interventions include a health clinic with a benefits manager to help people enroll in Medicare or Medicaid; a dietitian who gives grocery tours and cooking classes, and tailors shopping lists to address health conditions such as hypertension or diabetes; and benefits counselors who help residents enroll in public programs like the Supplemental Nutrition Assistance Program and Women, Infants and Children program, enabling them to afford the fresh food in the supermarket. The spokes are community-based social service agencies that provide additional—and in some cases specialized—support.

MORE THAN JUST FOOD

To drive healthier outcomes, it is imperative to think beyond the grocery aisles. If people can't afford anything in the store or don't feel confident shopping those aisles, what's the point?

What we've found is that when you address these issues, outcomes are exponentially greater. During a two-year, three-store pilot in Philadelphia, for instance, we tracked the shopping habits of individuals who were consulting with our dietitians and visiting our health clinics. Across the board, we saw an uptick in purchases of perishable, healthy foods, an improvement in medication adherence and a reduction in diabetes risk. In some cases, people didn't understand which foods interacted negatively with their prescriptions; one-on-one meetings with a dietitian made a difference.

During the pilot, we saw that the majority of participants who took multiple prescriptions were able to drop at least one of their medications, on average. And more than 95% of all participants made progress toward a healthier weight, either losing pounds if they were overweight or—for those who were food insecure—gaining weight.

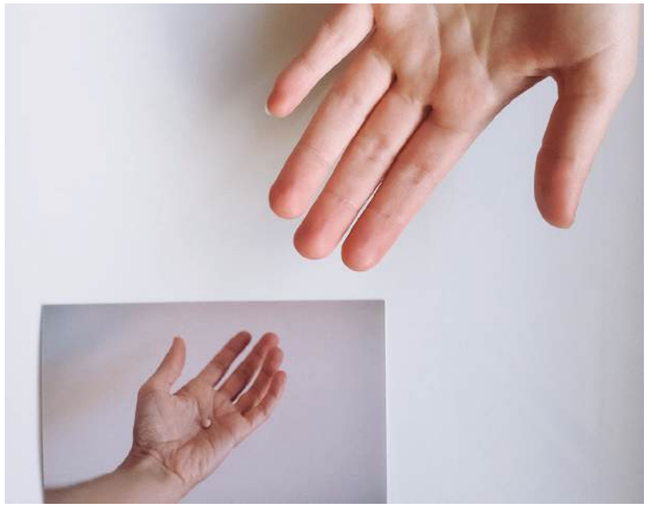
And there was this benefit, as well: People tended to bring family members to cooking classes or grocery tours, and those individuals would become interested in eating healthier as well. Food options don't exist in a vacuum, and neither do individuals. Healthy behavior changes start with the sense that we're all in this together. ■

Atif Bostic is the executive director of Uplift Solutions, a New Jersey–based nonprofit dedicated to giving underserved communities access to fresh and healthy food, nutrition education and health care.

STOCKSY

The Big Barriers to Addiction Treatment

Why the vast majority of people who abuse substances don't receive treatment.



By Michele Pole, Ph.D.

Addiction is a treatable disease that affects 1 in 3 households in the U.S. Yet fewer than 11% of the nearly 22 million Americans who meet the criteria for substance use disorder (or SUD, as addiction is clinically known) receive the specialized treatment they need to live in recovery. Why are so many people unable to access quality addiction treatment? I see three main barriers.

LACK OF UNDERSTANDING

Those suffering from SUD often see their inability to address their addiction as a personal failing. In reality, addiction is a disease. It hijacks the brain's reward system, making us believe the substance is more important than food, sleep, love, friendship and even life itself. It takes more than just willpower to fight it.

Addiction is also a chronic disease, like heart disease or diabetes, and it must be treated as such. "Detox" alone is not treatment. Quality treatment entails getting the proper diagnosis and developing an individualized disease management plan with a licensed and certified professional. A long-term continuing care plan may include an inpatient stay at a residential facility, ongoing outpatient therapy sessions and/or medication-assisted treatment.

DENIAL

This is a hallmark of addiction. There's a misconception among many who suffer that only people who have hit bottom and lost everything have a substance use disorder. Just because you may have learned how to manage or hide your disease does not mean that you are well.

Those suffering from SUD often are afraid to ask for help, because doing so is to admit you have a problem. But the truth is that SUD is a progressive disease: Things will continue to get worse.

SHAME AND STIGMA

The stigma attached to SUD can be so strong that those who suffer often risk death rather than face the shame of their addiction. A cancer patient would not be judged for needing chemotherapy, nor a diabetic for insulin. Yet individuals with SUD are often judged as though they caused their disease—preventing many from seeking treatment.

Shame is the enemy of recovery. It makes us quiet and isolates us from those who can help us most. But no one can do this alone. We will never solve the addiction epidemic if we place blame on the individual.

BREAKING DOWN BARRIERS

Every day, medical science advances our understanding of addiction and how it can be treated most effectively. Today, there are millions of people who live and thrive in recovery. We must do a better job of reaching the 89% of people with an active addiction who are not receiving help. Breaking down barriers starts with casting aside antiquated ideas about addiction. ■

Michele Pole, Ph.D., is the director of psychology at Caron Treatment Centers, an internationally recognized not-for-profit dedicated to addiction and behavioral health care treatment and prevention.

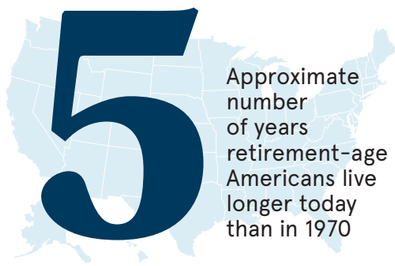
The Other Side of the Baby Boom

The post-World War II baby boom ushered in the country's largest generation. Now that many of the more than 70 million Americans born between 1946 and 1964 are in their 60s and 70s, they're placing unprecedented demands on Medicare.

The Nation Is Aging

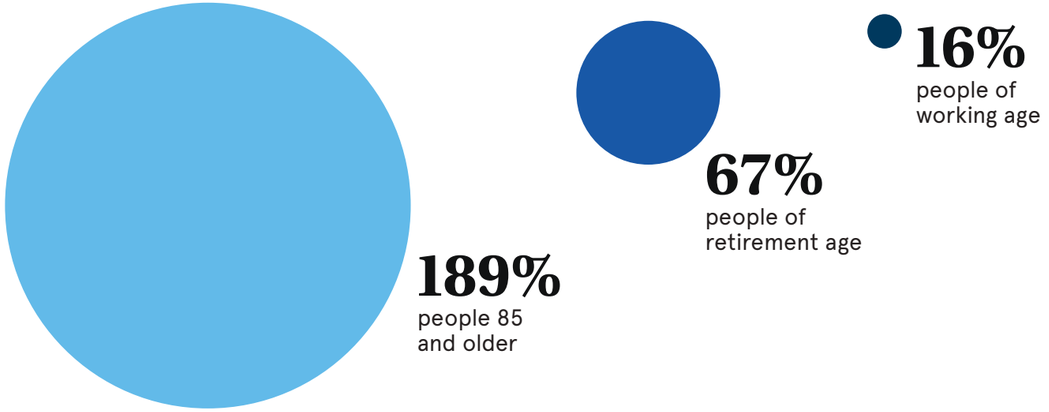
Americans 65 and older (as percentage of population):

- **9.5%** in 1966—the year Medicare launched
- **16.9%** by 2020
- **20.6%** by 2030
- **21.7%** by 2040
- **22.1%** by 2050
- **23.5%** by 2060



5 Approximate number of years retirement-age Americans live longer today than in 1970

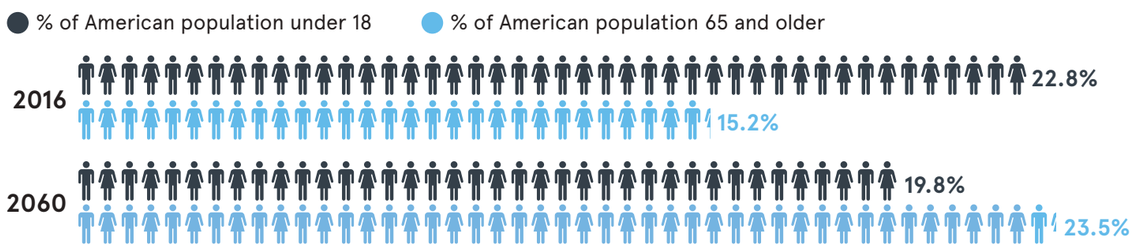
Population growth rates between 2018 and 2050



> **"A growing aging population—especially among those older than 85, who are most likely to require expensive long-term care, suffer disability or require assistance with daily activities—comes with serious financial consequences."**
>
> —*The Growing Cost of Aging in America* series, Milken Institute of Public Health, The George Washington University

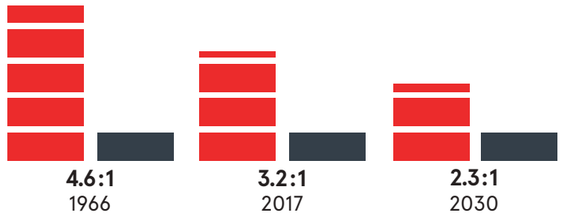
Turning Point

Older adults will outnumber children for the first time in U.S. history in the coming decades.



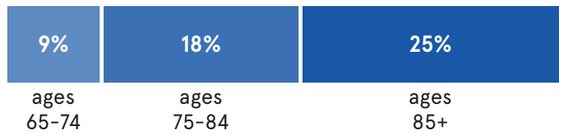
Fewer Workers, More Retirees

Ratio of working Americans to Medicare enrollees:



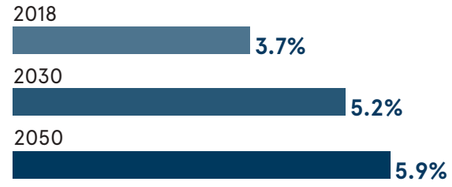
Getting Sicker

Medicare enrollees with more than five chronic conditions:

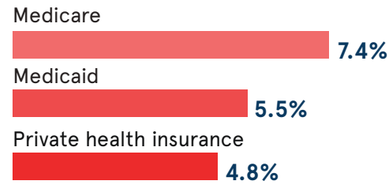


Costs Keep Rising

Medicare spending as the percentage of national gross domestic product:



Medicare spending will grow fastest as more baby boomers reach 65:



Average annual spending growth (2018-2027 projections)

Can Americans Afford Old Age?

American workers over 50 expect to never stop working **1 in 5** Americans 65 and older are working or looking for work as of June 2019

Sources: Associated Press-Norc Center for Public Affairs Research, 2019; Centers for Medicare & Medicaid Services, National Health Expenditures Projections 2018-2027, 2019; Pew Research Center, Millennials Projected to Overtake Baby Boomers as America's Largest Generation, 2018; Politico, Medicare's Time Bomb, in 7 Charts, 2018; Scripps, Baby Boom Generation Is Defining Importance of Healthy Aging, 2018; U.S. Census Bureau, An Aging Nation: Projected Number of Children and Older Adults, 2018; U.S. Census Bureau, Population Estimates Show Aging Across Race Groups Differs, 2019

PARADIGM

By Ned Shaikh

Social determinants of health hugely influence patient outcomes. So providers and payers alike have taken broader approaches to the delivery of care—with promising results.

SHIFT

Health is about much more than health care.

That simple but profound idea is gaining steam among providers and managed care organizations alike, as they rethink how our health care system treats and interacts with patients. A growing body of research shines a light on all the factors beyond the confines of clinical delivery systems that impact a person's well-being—the conditions where people are born, live, learn, work, play and age. These are the social determinants of health (SDOH): things like financial security, addiction, air and water quality, and access to healthy food.

Increasingly, social determinants are moving toward the center of our understanding of what drives health outcomes and overall well-being. Medical care accounts for only 10-20% of health outcomes, while the remaining 80-90% are rooted in SDOH. Those are sobering statistics to anyone familiar with the U.S. health care system, which is mostly focused on treating illness. Given how many medical ailments begin as nonmedical concerns, this reactive approach—called a "sick care" system by some—can only do so much.

"Think of diabetes, hypertension, obesity and depression. These conditions can be affected by limited access to healthy foods, inconsistent meals and exposure to community violence impacting the ability to feel safe," says Dr. Fred Hill, senior vice president of population health at AmeriHealth Caritas. "Your mental state impacts your physical health. If you're constantly worried about financial security or physical safety, it impacts your health status."

The reality is that SDOH-related challenges are widespread. Nearly 70% of patients have at least one SDOH issue, according to a 2018 survey by the health care technology firm Waystar. Fifty-two percent have a moderate-to-high risk in at least one of the following categories: financial insecurity, social isolation, housing insecurity, addiction, transportation access, food insecurity and health literacy.

Medicaid and Medicare beneficiaries had the largest high-stress share of all patient groups, with one-third of these patients having high stress in three or more social determinants, Waystar found. Patients in this category are 50% more likely to need treatment for chronic conditions. The most commonly reported SDOH issues across all income classes were financial insecurity and social isolation, though prevalence and severity differed.

PREVIOUS SPREAD: UNSPLASH; THIS SPREAD: STOCKSY; UNSPLASH

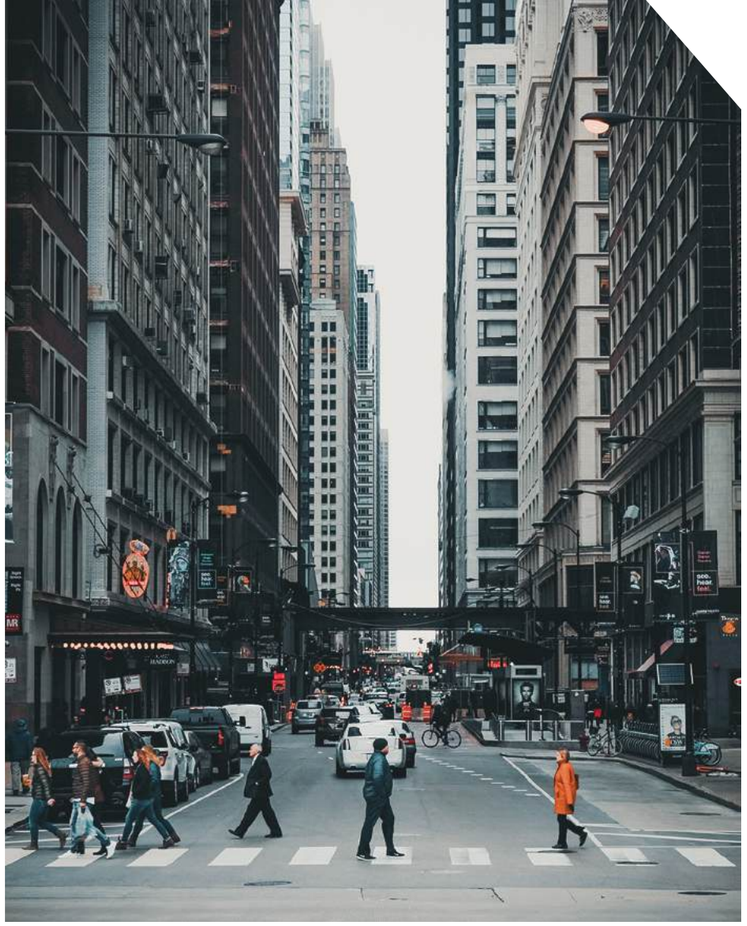
"It's not just those impacted by lower socioeconomic status that have these issues," Dr. Hill says. "Even at the higher socioeconomic levels, there is significant stress and significant obesity; however, members of the former group are more likely to be negatively impacted by social determinants of health."

With all this as background, more than 90% of Medicaid managed care organizations report activities to address SDOH, according to the Kaiser Family Foundation. And a growing number of state governments now require Medicaid managed care organizations to screen beneficiaries for unmet social needs and help them address those needs. (Twenty-four did so as of early this year.) Momentum around SDOH extends beyond insurers and governments, though. In July, pharmacy giant CVS announced it would launch a new platform to connect people with social services that can improve overall health. It will be offered in some states to Medicaid beneficiaries and people qualifying for both Medicaid and Medicare.

What's emerging is a vision of health care that extends far beyond a patient's relationship to doctors and clinical facilities. It's a vision that shifts the health care paradigm away from simply treating illnesses as they arise, toward a community-based patient engagement approach that coordinates care between doctors who can address specific medical problems and social service providers who can address broader challenges like food and housing insecurity.

It all raises the question of whether the more than $3.5 trillion ($11,212 per person in 2018) spent on health care in the U.S. could be used more effectively. Indeed, the shift toward addressing SDOH is happening in concert with the health care sector's shift away from the traditional fee-for-service model and toward value-based care models, which reward health care providers with incentive payments for the quality, rather than the quantity, of care they provide to patients.

But addressing SDOH and achieving related savings can only happen if patients and providers are able to focus on these issues. That can prove challenging, for a few different reasons.



THE FIVE KEY SOCIAL DETERMINANTS OF HEALTH

- **Economic stability:** employment, food insecurity, housing instability, poverty, etc.
- **Education:** early childhood development, higher education level, language skill, literacy, etc.
- **Social and community environment:** civic participation, discrimination, isolation, etc.
- **Health care:** access to health care and health insurance, health literacy, etc.
- **Neighborhood environment:** living conditions, access to transportation, crime rate, access to healthy food/clean air/clean water, etc.

Source: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

REMOVING BARRIERS

For starters, screening for SDOH-related issues can be difficult. "Patients are often embarrassed to talk about some of the areas that they're struggling with," Dr. Hill says. "Lack of food, lack of finances, domestic violence—it's very difficult to get people to share that information."

Waystar found that only 22% of patients with SDOH stress have discussed the topic with their physician. Remarkably, of the patients in the "high risk" category, 60% have never discussed it with their health care provider or health insurer.

Patients can also be reluctant about participating in SDOH-screening programs. For a study published in the September/October 2018 issue of *Annals of Family Medicine*, researchers analyzed screening programs at three separate clinics and found that the majority of patients were not interested in receiving help from clinicians. Only about 20% of patients indicated they would like a clinician's help in addressing their SDOH condition. This finding echoes the Waystar survey, which found that nearly half (46%) of patients declined to participate in programs and services to help address their SDOH stresses when offered.

There are good reasons for nonparticipation. For example, undocumented people may be hesitant to ask for help, particularly in light of the new rules from the Trump administration that could jeopardize access to green cards for immigrants who use public assistance programs such as food stamps and nutritional assistance programs for Women, Infants and Children (WIC). "Even if they're eligible for services, they may be fearful of involvement with local, state or federal governments," says Dr. Laura Gottlieb, associate professor of family and community medicine at the University of California, San Francisco, who was a co-author of the screening program study. Other reasons that many people may choose not to participate in SDOH linkage programs include stigma around receiving public benefits, challenges related to literacy and filling out paperwork, and job obligations that make additional office visits difficult. "Many people are just getting by. They can't miss a day of work in order to go to the doctor's office," Dr. Gottlieb says.

UNSPLASH

Improving the patient participation process requires a two-fold strategy, Dr. Hill says. "Providers need to actively survey their patients through routine screenings, and then also be able to provide the agency referral resources within the office."

Dr. Gottlieb says that ensuring providers are comfortable with having conversations about SDOH-related challenges will require a "massive cultural shift. Providers often don't want to ask about an issue unless they can do something about it," she says.

AmeriHealth Caritas' new health care delivery model, the Next Generation Model of Care, aims to provide whole-person health care in part by helping providers connect patients with resources beyond traditional medical services. Building on a long-standing approach to members' health that addresses physical health, behavioral health and pharmacy needs, the Next Generation Model of Care integrates programs that address the root causes of poverty.

Part of the approach is a program called Let Us Know. "Providers are encouraged to contact us if they identify issues with their patients so we can assist them in providing resources," Dr. Hill says. "We have our member services staff trained in social determinants. They have access to our database of resources, so if a provider calls in, whether they call our clinical area or the customer service area, we're prepared to respond to their needs."

AmeriHealth Caritas' focus on addressing SDOH aligns with the federal government's. The Centers for Medicare & Medicaid Services' Accountable Health Communities Model, launched in 2017, provides support to community organizations to test delivery approaches aimed at linking beneficiaries with community services that address SDOH.

"We are deeply interested in this question (of SDOH impacts), and thinking about how to improve health and human services through greater integration has been a priority throughout all of our work," U.S. Secretary of Health and Human Services Alex Azar said late last year. He suggested the administration may take a holistic approach to SDOH care in the future. That could involve increasing flexibility in how a health care organization uses federal funds—for instance, paying rent for a Medicaid or Medicare beneficiary in unstable housing or ensuring a diabetic has access to affordable, nutritious food.

Such moves at the federal level could accelerate movement toward a health care system that takes a broader, SDOH-informed approach to patient engagement.

BENDING THE COST CURVE

The move toward SDOH dovetails with efforts by the federal government and the health care sector to control costs. A growing body of research shows that hospitals and other provider organizations can cut costs substantially and improve clinical outcomes by connecting people to services that address SDOH, such as secure housing, financial assistance and healthy food.

"By addressing those needs, you can definitely decrease inappropriate inpatient utilization, inappropriate emergency room utilization and better manage the disease states that directly impact cost," Dr. Hill says.

One study of Medicaid and Medicare members published in 2018 found a 10%

Ensuring providers are comfortable with having conversations about SDOH-related challenges will require a massive cultural shift.

STATES OF COVERAGE

A growing number of Medicaid programs require managed care organizations to address social determinants of health (SDOH). But how they do so varies.

More and more states are integrating the social determinants of health (SDOH) into their respective Medicaid programs. About 40 states now incorporate SDOH-related activities into managed care contracts (or Section 1115 demonstration waivers). These encompass a wide range of services, touching on areas like housing, food access and quality, employment, education, transportation and violence/abuse support services.

Exactly how states are attempting to address SDOH via Medicaid varies. But broadly speaking, there is movement toward connecting enrollees to social supports, expanding interventions to address social issues and building networks of community-based organizations—all while evaluating the effectiveness of SDOH-related approaches.

Here is how some state Medicaid programs are evolving:

Quality care coordination starts with risk assessment of members to better allocate resources according to needs.

- **Ohio** requires managed care organizations (MCOs) to include social determinants and safety risk factors in risk stratification frameworks.
- Similarly, **Michigan** requires MCOs to incorporate social determinants into database processes to improve health management.
- **Wisconsin** requires programs to use a health needs assessment that evaluates socioeconomic barriers facing members—things like housing instability and transportation.

Some MCOs offer a value-added service as a cost-effective substitute for the covered service.

- In **Texas**, "value-added services" can be health care services, benefits or incentives that the state determines will promote healthy lifestyles and improve health outcomes; for example, transportation benefits, cellphones and home health services. Value-added services can be added or removed only by written amendment of the contract.

New technology infrastructure is in the mix in some states to support integration with community-based organizations.

- **Louisiana**, **Minnesota** and **Arizona** have developed policies to require implementation of health information exchange technologies allowing standardized information to be shared among community-based organizations.
- **Washington** is developing a "clinical data repository" to allow authorized HIPAA entities, including community-based organizations such as housing providers, to share information on common members.

MCO contracts vary in the amount of specificity used to describe SDOH activities. Some are quite specific about services they want addressed.

- **New Mexico**'s MCO contracts contain extensive terms. For example, MCOs are required to maintain a "full-time supportive housing specialist" who provides training to care coordination teams.
- **North Carolina**'s contracts specify social determinant activities in a broad array of categories including: care coordination and management requirements, quality and performance improvement, value-based payment and medical loss ratio calculations. The state also has three specific tools for MCOs to use:
  - the North Carolina Resource Platform, a comprehensive database and referral platform
  - the North Carolina "Hot Spot" Map, which uses geographic technology to map resource needs in the state
  - standardized screening questions about health-related resource needs, such as food, housing/utilities, transportation and interpersonal safety

NEW APPROACH, SAME VALUES

With the goal of reversing the cycle of poverty while improving health outcomes, some organizations are rethinking their model of care, opting instead for a more holistic approach.

As the impact of social determinants of health becomes clear to both health care providers and payers alike, some organizations are rethinking their approach. AmeriHealth Caritas' new health care delivery model, the Next Generation Model of Care, is one such example. Addressing the social determinants of health is fundamental to the model, which focuses on physical health, behavioral health and social well-being.

"As health care becomes more complex and as those most in need face increasing social barriers to achieving health and wellness, managed care organizations need to be more agile and nimble in addressing members' specific challenges," said AmeriHealth Caritas Chairman and CEO Paul Tufano.

As part of the new model of care, the managed care organization collaborates with its community partners on a number of programs that focus on the social determinants of health. In the District of Columbia, the organization partners with Mom's Meals™ to provide in-home delivery of meals to members with various health challenges. The meal plans are designed to address the specific dietary needs and preferences of the culturally diverse members within the District's six most prevalent ethnic groups.

In Southeastern Pennsylvania, the group works closely with MANNA, a nonprofit organization that supports the nutrition needs of people with life-threatening illnesses. MANNA provides home-delivery meal service and medical nutrition therapy to members identified by its Care Management team. The program especially benefits members returning home from a hospital stay or coping with multiple health conditions. These people may be unable to shop or prepare meals independently, or may simply need guidance on the best food choices for managing their health.

"By developing strategic partnerships with social service organizations within communities we serve, we can help members and their caregivers address the nonmedical factors that can affect their lives," explains Dr. Fred Hill, AmeriHealth Caritas' senior vice president of population health. "We know it's a nontraditional approach to health care, but it is one that clearly works."

reduction in costs for those connected by their managed care organization to social services versus a control group. At the provider level, Chicago-based Advocate Health Care saved $4.8 million within six months of launching a program to address malnutrition among its patients.

Research shows that SDOH programs are most effectively executed in tandem with community partners such as local government agencies, social workers, community centers and religious organizations. For example, Maryland's Health Enterprise Zone Initiative created incentives for providers to take a proactive community-based approach in addressing SDOH. The initiative was implemented by the state of Maryland in 2013 with the goal of improving access and outcomes in underserved communities while reducing costs, ER admissions and hospital readmissions. Primary care physicians and community health workers were deployed to five geographic areas and coordinated care among hospitals, health departments and community-based organizations.

Each area was provided with resources to incentivize health care providers to engage in these underserved communities. The physicians and health workers provided an array of services to residents, paying special attention to diabetes, cardiovascular illnesses, asthma, obesity and behavioral health problems. Health education services, screenings, behavioral health services, dental care and access to relevant social services were also made available.

A Johns Hopkins University study published in the October 2018 issue of *Health Affairs* found that from 2013 to 2016, the Health Enterprise Zone Initiative was associated with a reduction of 18,562 inpatient stays. This led to a net cost savings from reduced inpatient stays. The study concluded that the savings "far outweighed the initiative's cost to the state."

Indianapolis-based Eskenazi Health offers wraparound services designed to address social determinant-related hospitalizations and ER visits. The organization partnered with Indiana University-Purdue University Indianapolis to conduct a study to determine which wraparound services were utilized most often and how effective they were in reducing costs and hospitalizations. For wraparound service patients, dietitian services were the most highly used offering, with 49% receiving counseling from a dietitian.

"There's room for improvement in basically every link in the chain between the person and the delivery of care."

UNSPLASH

This was followed by consultation with a social worker at 29% and behavioral health services at 10%.

According to the study, published last year, from 2006 to 2016 the association between wraparound services and patient outcomes resulted in an estimated cost savings of $1.4 million annually from potentially avoided hospitalizations. The study also found a 7% reduction in the expected number of hospitalizations in the year following the receipt of a wraparound service.

TEAM EFFORT

Governments, providers and managed care organizations are ramping up efforts to address SDOH in ways that improve health outcomes. But there is much change to come—the sector has just begun to grapple with a seismic shift in how health care is delivered to support overall well-being.

"There's room to improve in how we identify or screen patients and design interventions," says Melinda Abrams, senior vice president and director of the Commonwealth Fund's Health Care Delivery Reform Program. "There's room for improvement in how we structure our payments to encourage and incentivize greater integration of health and social needs. There's room for improvement in basically every link in the chain between the person and the delivery of care."

For a paradigm shift to occur around health care and SDOH, fundamental cultural change is necessary, Abrams further explains. Health care clinicians need to view the understanding of health-related social needs as essential to achieving better patient outcomes. Likewise, social service providers need to recognize how things like social isolation or housing insecurity lead to health problems. Ideally, "together in collaboration with the patient, they all need to come up with a comprehensive care plan," she says.

In the future, a patient's health care may not be defined and executed solely by one medical provider. "A single clinician cannot do everything," Dr. Gottlieb says. "Increasingly, I think some payers are trying to provide more case management support, particularly for high-cost, high-complexity cases. We need to shift toward providing patients a health care team, a group of people with complementary skills." ■

Health Beyond Health Care

The conditions in which a person is born, grows, lives, works and ages account for most health outcomes. These are the social determinants of health, which can influence and compound one another in complex ways.

Spheres of Influence

20% How much medical care—including both access to and quality of care—is estimated to contribute to modifiable contributors to health outcomes in a population

80% How much social determinants of health are estimated to contribute to modifiable contributors to health outcomes in a population

That 80% can be broken into three social determinants of health categories:

40% **Social and economic factors:** education, employment, income, family and social support, community safety

30% **Health behaviors:** tobacco use, diet and exercise, sexual activity

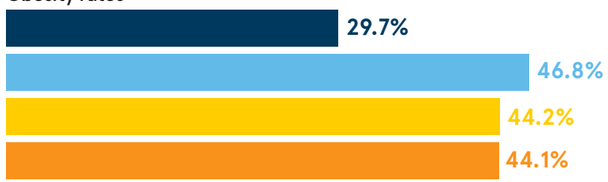
10% **Physical environment:** air and water quality, housing and transit

24 states require Medicaid managed care organizations to screen beneficiaries for unmet social needs and help them address those needs.

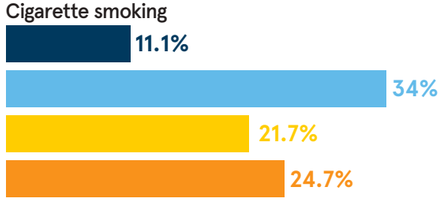
Social Determinants of Health Spotlight: **Educational Attainment**

college graduate or above | some college or associate degree | high school diploma (or GED or equivalent) | less than high school

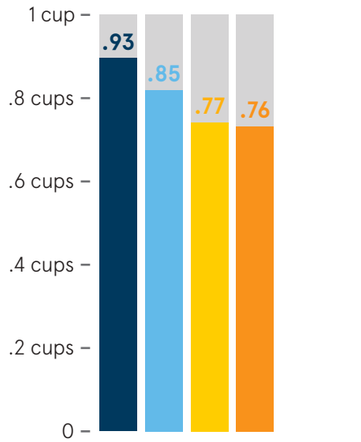
Obesity rates



Cigarette smoking



Vegetable consumption
average cups per 1,000 calories per day



Social Determinants of Health Spotlight: **Where a Patient Lives**

Life expectancy in the U.S. is 78.6 years. But that figure can differ by as much as 20 years in neighborhoods separated by a scant 5 miles.

Chicago, IL

The Loop
85 years

Washington Park
69 years

Richmond, VA

Westover Hills
83 years

Gilpin
63 years

Violence Impacts Education

5% Drop in the standard deviation of math and language test scores for every homicide that occurs within 80 feet of a school each year

1-2% Drop in student attendance for every homicide that occurs within 80 feet of a school each year

Industry Action

91% of Medicaid managed care plans report activities to address social determinants of health

93% work with community-based organizations to link members to social services

91% assess members' social needs

81% maintain community or social service resource databases

67% use community health workers

66% use interdisciplinary community care teams

52% offer application assistance and counseling referrals for social services

Sources: Centers for Disease Control and Prevention; Henry J. Kaiser Family Foundation; "Violence and Human Capital Investments," Institute of Labor Economics; Healthy People 2020, Office of Disease Prevention and Health Promotion; 2018 Survey of America's Physicians, Merritt Hawkins; Robert Wood Johnson Foundation; Center on Society and Health, Virginia Commonwealth University

Population Health Hangs on More Than Clinical Care

Discussions about health care in the United States today, as in most of the world, are inundated with the term social determinants of health (SDOH). There appears to be general consensus that equity, quality of care and outcomes in health care are intrinsically linked with things that go far beyond the walls of our medical and clinical delivery systems.

By Glenn Ellis

STOCKSY, UNSPLASH

With clear, compelling evidence from the National Academy of Medicine confirming that clinical care accounts for only 10% to 20% of health outcomes for a given population, we can no longer ignore that the other 80% to 90% is attributable to SDOH.

The World Health Organization's Commission on the Social Determinants of Health has defined SDOH as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions." As reported by Kaiser Family Foundation, for people living in low-income communities, average life expectancy is reduced by 15 to 20 years due to increased risk for stroke, chronic disease and other health concerns.

Despite being ranked as one of the richest countries in the world, the United States experiences sizable health disparities among its citizens in terms of social, economic and environmental factors. Sadly, here in the United States, where you are born is more strongly associated with your life expectancy and health status than race or genetics.

Although it may appear that SDOH is a recent revelation with its genesis in today's landscape of the Affordable Care Act (Obamacare), the first obstacle to addressing SDOH in our society is to recognize that this has been a subject of discussion for quite some time. As far back as the mid-1800s, Friedrich Engels and Rudolf Virchow, two German philosopher/scientists, established the clear and indisputable connection between health outcomes and political, economic and social conditions. Since that time, we have seen a continued gap in health outcomes for populations in this country that are disproportionately impacted by SDOH. The data is alarming when examining the human toll of SDOH.

A 2011 research study at Columbia University's School of Public Health measured the adult deaths attributable to social factors and found that, in 2000, approximately 245,000 deaths were attributable to low education, 176,000 were due to racial segregation, 162,000 were due to low social support, 133,000 were due to individual-level poverty, and 119,000 were due to income inequality. Despite improved access to clinical care, the absence of appropriate interventions in the areas of housing, education, poverty and environment will continue to yield such poor and unacceptable outcomes. Physicians and the entire public health community are clear that the solutions to this dilemma are beyond the scope of their practice, but we seem to be locked into a pattern that clearly is not working for our annual $3.5 trillion industry.

We, as a society, must begin to think differently about how we approach health care. No longer can we continue to think about health simply as "disease management"; we must adopt a systemic, paradigm shift in our efforts by viewing successful health care as the result of a collaborative effort by all stakeholders.

We, as a society, must begin to think differently about how we approach health care. No longer can we continue to think about health simply as "disease management."

It is time, as a society, that we develop the political will to seriously explore and develop multisectorial public-private partnerships that include alternative payment models, city and state innovation models, improved monitoring for unintended consequences and community-based partnerships.

Every major health and medical professional organization of clinicians, practitioners and providers has made clear that it is aware, engaged and committed. The rest of us, as stakeholders, must become advocates. "Safety net" health care is not equitable health care. We have to collectively decide what we want to be as a society. We have to muster up the political will to acknowledge, and act upon, the reality that addressing the social determinants of health is not the sole responsibility of our health care system. To create the kind of health care we want, there needs to be a systemic focus on the entire patient and the world in which they live. ■

Glenn Ellis is a research bioethics fellow at Harvard Medical School and author of *Which Doctor?* and *Information Is the Best Medicine*. Ellis is also an active media contributor and a consultant on health equity and medical ethics.

TO EXPAND OR NOT TO EXPAND

By Ambreen Ali

It's been nearly 10 years since the Affordable Care Act enabled states to expand Medicaid programs.

The debate over whether and how to do so is going strong.

THE DEBATE OVER THE AFFORDABLE CARE ACT IS NOT OVER.

One provision of the federal health care legislation in particular continues to spark arguments, at least in some states: expansion of Medicaid coverage. The ACA mandated Medicaid eligibility to all individuals with incomes up to 138% of the federal poverty level. But a 2012 Supreme Court ruling essentially made expansion optional.

Fast-forward to today, and 36 states (along with Washington, D.C.) have embraced expansion. In the 14 other states, more than 2 million uninsured adults fall into the health care coverage gap—meaning they make too little money to qualify for federal subsidies in the private marketplace but too much to qualify for Medicaid, according to the Kaiser Family Foundation. The effects of this coverage gap are widely felt across the health care system: Uninsured individuals tax hospital systems and state budgets, which must cover the cost of care for those unable to pay. Rural hospitals at risk of closure are heavily concentrated in the states that have not expanded Medicaid, according to Stateline, a news service of the Pew Charitable Trusts.

"One thing we know for sure is that Medicaid expansion does reduce uncompensated care in hospitals, especially in hospitals that heavily rely on government subsidies and see a lot of uninsured people," says Donna Friedsam, health policy programs director at the University of Wisconsin's Institute for Research on Poverty.

The idea of enrolling more low-income Americans in the government-provided health care system remains politically charged in many state legislatures. But what has steadily shifted over time is public support for Medicaid. In 2013, 67% of Republicans opposed expanding Medicaid, according to the Kaiser Family Foundation. Five years later, the group found that 65% of Republicans—along with 82% of Democrats and 74% of independents—held a favorable view of Medicaid. Some states have seen ballot measures passed to expand Medicaid after years of political stalemate. Voters in Utah, Idaho and Nebraska did exactly that in November 2018.

Larry Berg and his wife, Carol, at their home in White Sulfur Springs, Montana. A dip in their income qualified them for Montana's Medicaid expansion program. The insurance came in handy when Berg was diagnosed and treated for a rare medical condition affecting blood flow in his neck.

ABOVE: GETTY; LEFT: SHUTTERSTOCK

SHIFTING SENTIMENT

In Utah, 54% of voters backed a ballot measure to expand Medicaid. A poll five months prior to the election found support for the proposition among 63% of moderates, 52% of "somewhat conservative" Utahans and 34% of "very conservative" Utahans.

"Utah is very compassionate," says Stacy Stanford, health policy analyst for the Utah Health Policy Project, which supported the proposition. "We have talked to so many Republicans who need the support or care."

What happened after the proposition passed underscores how politically fraught expansion remains. In February, Utah's governor signed a replacement bill that narrowed expansion of Medicaid coverage, limiting eligibility to 100% of the federal poverty level—$12,140 for an individual—instead of the 138% upper limit approved by voters. The governor argued that individuals whose income falls in between those levels can seek out subsidized care in the private marketplace, although such plans frequently carry high deductibles and copays.

The Utah Legislature also stipulated that unemployed individuals must supply proof that they are actively seeking work in order to gain coverage through the expansion. Such requirements have popped up in states across the country, with supporters seeing them as a fiscally responsible way to promote self-sufficiency and employment.

"What you've seen is a string of efforts among some states to say that there can't just be a straight health care coverage expansion. There have to be some strings attached," says Elaine Ryan, the AARP's vice president of state advocacy and strategy integration.

SEEKING WAIVERS

Like many states pursuing a partial expansion, Utah is seeking a waiver from the federal government to proceed with its reduced Medicaid expansion while retaining federal funding. Such waivers are a key tool some state governments are using to stop short of the full expansion enabled by the ACA. Georgia Gov. Brian Kemp signed legislation in March that enables his administration to seek federal support for a limited expansion that would cap eligibility at or below the federal poverty level.

Chris Bemis helps his girlfriend's son Shane Edwards, 12, with his homework at their apartment. Bemis was cut off from MaineCare in 2016, and he didn't make enough money to get insurance through the Affordable Care Act. With Medicaid expansion, Bemis is now eligible for coverage.

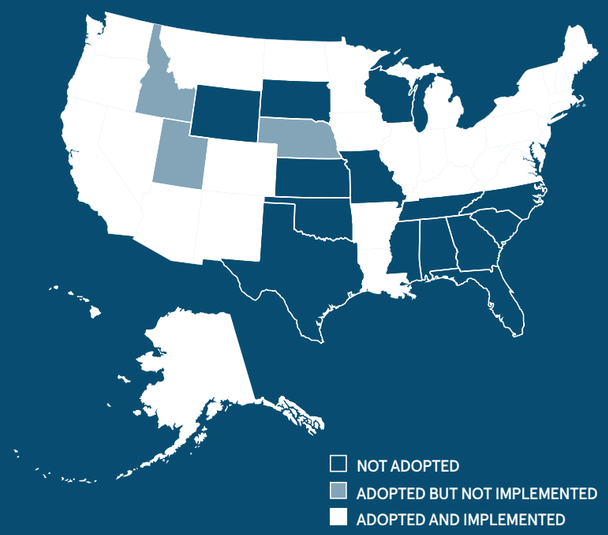
"Really, all the ACA did was give the state a lot of federal funding to cover more people. It wasn't a philosophical shift."

"By passing this legislation, we have decided to abandon the status quo," Kemp said at the signing of the bill, adding, "Our Medicaid program costs too much and fails to deliver like it should.... Our state will reform a broken system with conservative solutions." In May, the state announced plans to hire a consulting firm that will help formulate these solutions.

In Idaho, where 60.6% of voters backed a proposition to expand Medicaid last November, the state Legislature passed work and volunteer requirements similar to Utah's. Earlier this year Montana's Legislature also passed such requirements. The state expanded Medicaid back in 2015—but only for four years. Less than two months before the sunset date of June 30, 2019, the Legislature passed a bill to extend expansion for six years, adding some limitations including work and community engagement requirements. The Trump administration has approved waiver requests relative to Medicaid work require-

STATE BY STATE

A large majority of states, along with the District of Columbia, have expanded their Medicaid programs through the Affordable Care Act.



Not Adopted

Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Wyoming

Adopted but Not Implemented

Idaho, Nebraska, Utah

Adopted and Implemented

Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, West Virginia

Jerald Brooks, left, one of the original participants in a Seattle program called Law Enforcement Assisted Diversion, or LEAD, goes shopping for groceries with Chris Cates, right, his caseworker, in Seattle. Funding from the expansion of Medicaid in some states has made repeat drug offenders such as Brooks eligible for coverage, which could be a new tool for shifting addicts out of the criminal-justice system as an alternative to the drug war.

ments; the big question is whether these policies will survive legal challenges.

In Nebraska, where an expansion approved by voters will take effect next year, the governor has proposed a tiered system that would restrict full Medicaid benefits to individuals who work, apply to jobs, volunteer, attend postsecondary school or care for a family member. Tiffany Friesen Milone, policy director of the Nebraska-based think tank OpenSky Policy Institute, says the policy is about encouraging people to earn more income so they can get out of the Medicaid system.

"Especially in Nebraska, there is a big push for smaller government," she says. The think tank did not take a position on the expansion measure approved by voters but is opposed to coverage requirements being sought. Milone says they could be costly for the state to administer if those enrolled must register their compliance with work requirements every six months, as proposed. "It could end up creating a bigger state government because you have to hire people to process applications," she says.

THE VALUE OF EXPANSION

The states that expanded their Medicaid programs early this decade can offer insights into whether the benefits touted by proponents or the fears of those opposed have been realized.

New Jersey, which provides Medicaid coverage to over 1.8 million residents at a cost of nearly 20% of its state budget, expanded the program in 2014 with widespread support from across the political spectrum. Even before the ACA, the state government had sought to expand Medicaid but could not find a way to fund it.

"Really, all the ACA did was give the state a lot of federal funding to cover more people. It wasn't a philosophical shift; it was a way to better cover the program," says Matt D'Oria, who leads the Medicaid Policy Center at the New Jersey Health Care Quality Institute.

After the expansion, New Jersey added 552,000 people to Medicaid. As a result, the level of uninsured individuals fell from 13% to 9%, the lowest it has ever been. The money the state spent on charity care to subsidize hospital visits by uninsured individuals has fallen by half. "Overall, it's been financially better for the state, better for the hospitals, better for people," D'Oria says.

Other states that have expanded Medicaid have seen similar benefits. For example, Virginia captured $421 million in state budget savings after its expansion in 2018.

APPEALING BENEFITS

Will such savings last forever? A shared concern on both sides of the debate is whether the federal funding meant to incentivize expansion will last. As of 2020, the ACA will require the federal government to foot 90% of the cost of Medicaid expansion. Some worry state governments will ultimately be on the hook to cover costs—costs projected to keep rising beyond inflation.

Yet as the health care industry strains to rein in costs, the overall benefits of insuring more people—supported with federal funding incentives—are clearly becoming more appealing. That's true even in traditionally red parts of the country.

"You're seeing the economic value of this is really making a difference," the AARP's Ryan says. "Public sentiment is changing." ■

SHUTTERSTOCK

AN OPIOID CRISIS

OVERLOOKED

SENIORS ARE MISUSING OR ABUSING THE DRUGS, TOO. SOLUTIONS TAILORED TO THEM ARE EMERGING, ALBEIT NOT FAST ENOUGH.

BY KATE ROCKWOOD

By now every corner of the country is aware of the severity and stakes of the opioid crisis. The last few decades have seen more than 400,000 Americans die of opioid overdose, according to the Centers for Disease Control and Prevention. The epidemic is now undoubtedly part of the country's public consciousness and political discourse.

Less widely noted, though, is how seniors have been caught in the crosshairs of this crisis.

Opioid-related emergency room visits more than doubled among seniors between 2010 and 2015, according to federal government data. And opioid-related deaths among those 65 and older more than doubled from 2.7 deaths per 100,000 to 6.9 deaths between 1999 and 2017. There was also an alarming rise in the number of adults over 60 who reported misuse of opioids in the most recent National Survey on Drug Use and Health, published in 2018. Nearly all other age groups in the survey saw a dip in misuse.

Yet relatively few inpatient and outpatient treatment services focus on older adults, "whose unique characteristics may demand different or more nuanced solutions," says Olivia Dean, a policy research senior analyst at AARP's Public Policy Institute. "On the diagnosis side, it's difficult to quantify the number of older Americans with prescription drug use disorders who go undiagnosed or misdiagnosed. And on the treatment side, standard treatments may not always be appropriate for older adults."

The issue is especially pressing in rural areas where more older Americans tend to live. Fewer than 1 in 10 opioid treatment centers are located rurally, according to the American Society on Aging. "You tend to have fewer providers and fewer resources," says Dr. William Burnham, vice president of Population Health Medical Services at AmeriHealth Caritas. He helped start the geriatrics program at the University of South Carolina before spending a decade as ER medical director of a small hospital in a county with 22,000 residents.

Tackling this issue requires a clear understanding of why seniors are more vulnerable to opioid abuse disorder and its misdiagnosis. To reverse the troubling trend, health care providers, pharmacists and managed care organizations will have to work together.

MULTIDIMENSIONAL CHALLENGE

The vulnerability of older, rural Americans to opioid misuse has several dimensions. To start with, older adults use more prescription drugs than do any other age group. As Dr. Burnham says: "Getting older is an exercise in collecting comorbidities"—and the medications to manage them.

Eighty percent of people 65 and older live with multiple chronic conditions, such as diabetes and high cholesterol, according to the Agency for Healthcare Research and Quality. They also report high rates of conditions like chronic pain, anxiety and sleep disorders—and are thus more likely to be prescribed medications with potential for misuse and abuse. Sixty-five percent of seniors reported using three or more prescription drugs in the past 30 days, according to the National Center for Health Statistics. That means juggling medications and specialists who might not realize a prescription conflicts or overlaps with a prescription from a different provider, Dr. Burnham points out.

"There's a lot of fragmented care of all Americans, but especially seniors, who are more likely to see more specialists," he says.

Yet medication volume isn't the only factor making rural seniors vulnerable. A 2018 study in the *Journals of Gerontology* found that, among older Americans, the poorest were roughly twice as likely to have used prescription opioids.

"This might be explained by provider treatment decisions, in part, but also possibly patient preferences," says Hanna Grol-Prokopczyk, Ph.D., lead researcher on the study and a professor of sociology at the University at Buffalo. Alternatives to pharmacological therapy for pain—like physical therapy, acupuncture and cognitive behavior therapy—often require weekly or more frequent visits to a clinic, as well as copays, she notes. When weighing the choice between a prescription or a multipronged treatment plan, a health care provider may see the prescription pad as a faster, more convenient option. "But it may also be the

"WE NEED TO DO EVERYTHING WE CAN TO MINIMIZE OPIOID EXPOSURE FOR THOSE PEOPLE WHO HAVE NEVER BEEN ON OPIOIDS."

PREVIOUS SPREAD: GETTY; THIS PAGE: STOCKSY

BLUEPRINT FOR CHANGE

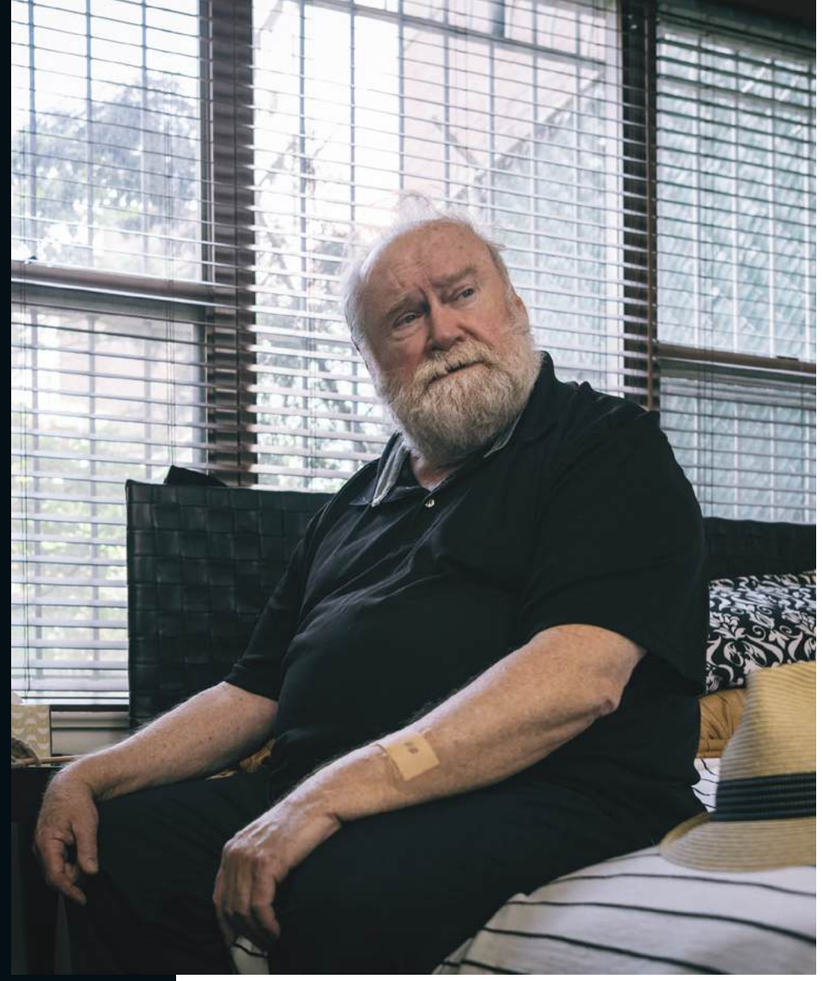
Through a comprehensive and collaborative approach, AmeriHealth Caritas is working to reduce opioid use and abuse.

The opioid epidemic is both dangerous and expensive. Health and social costs related to prescription opioid misuse top $55 billion each year. Twenty billion of that is spent on emergency room and inpatient care for opioid poisonings.

Improving health outcomes can't happen with a myopic view of the problem. In 2017, AmeriHealth Caritas launched its Opioid Blueprint to comprehensively and collaboratively drive progress. "We are driving improved health outcomes to some of the most challenged communities in the country," explains Dr. Andrea Gelzer, senior vice president of medical affairs for AmeriHealth Caritas. "This frontline approach and personalized interface have given us a deeper understanding of the opioid crisis and helped to fully inform the best practices in our blueprint that are leading to our successes."

Since implementing the Opioid Blueprint, the organization has seen a decline in opioid prescription claims and an increase in the medication-assisted treatment (MAT) claims. In 2019 alone, AmeriHealth Caritas saw a 24.8% decline in opioid use and a 39.3% increase in the use of MAT among its members compared with the previous year. These successes are built on a multipronged approach:

- **Pharmacy interventions:** Pharmacies are often on the front lines of providing appropriate care. AmeriHealth Caritas helps set them up for success through data analytics to identify inappropriate prescribing and utilization patterns, lock-in programs to align members receiving opioid prescriptions from multiple providers with a single pharmacy for better monitoring, and the implementation of daily and dosing prescribing limits for patients who are new to opioids.
- **Provider support:** Many physicians receive a scant nine hours of training on medications during med school. To right the scales—and also reach those who graduated before the opioid epidemic took root—AmeriHealth Caritas has launched comprehensive training programs centered around evidence-based prescribing and alternatives for opioids. The organization also deploys data analytics to proactively identify overprescribing risk factors and make provider networks aware of more care management resources, such as in-network multidisciplinary pain centers and cognitive therapy support.
- **Member engagement:** Through direct engagement efforts, AmeriHealth Caritas has been able to identify at-risk members and generate buy-in for both intervention and follow-up services available through its care management program. One example: Pregnant women and very high utilizers of medical services can be paired with peer support specialists who provide face-to-face engagement and ongoing support. Through its Bright Start® maternity care management program, the organization reduced the use of maternal opioid pain medication over the course of pregnancy by 25% between 2017 and 2018.



STOCKSY

patient who prefers the pills, rather than having to find transportation and spend money on frequent medical appointments," Grol-Prokopczyk says.

There's no question that health care can sometimes feel out of reach in rural areas. A 2019 poll by the Robert Wood Johnson Foundation found that 1 out of every 4 people living in a rural setting said they recently couldn't get the health care they needed. And about one-quarter of those people said that health care facilities were too far away or difficult to get to.

"There aren't enough providers willing to practice in a rural setting," says Dr. Burnham. "In a rural area, you do a lot of primary care in the ER and see many patients who don't have a primary care provider." That's especially troubling when one considers that ER doctors tend to underestimate how often they prescribe opioid painkillers, according to a 2018 study in the journal *Academic Emergency Medicine*. Researchers found that, over a 12-month period, 109 ER doctors at four different hospitals wrote 15,124 prescriptions for opioids—about 20% of all their prescribing. Nearly two-thirds of the ER providers estimated their prescriptions at far lower amounts.

Rural seniors, then, may be managing chronic conditions while having less access to integrated and continuing care, and seeing providers who underestimate their own prescribing habits.

PREVENT AND PROTECT

In many ways, preventing opioid abuse disorder among seniors is no different than for younger adults. "We need to do everything we can to minimize opioid exposure for those people who have never been on opioids," Dr. Burnham says. As with younger adults, once addiction develops, managing it is a lifelong condition plagued by high recidivism rates.

Yet there are particular frustrations when tailoring these tactics to seniors. For instance, many research studies on opioid use and misuse exclude people over 65 from data sets, Grol-Prokopczyk says. And studies that focus on seniors specifically tend to be few and far between. "That's a big frustration, because while we know the treatment isn't really fundamentally different, the approach to the patient does have to be modified," Dr. Burnham says.

There are also challenges with identifying abuse in the first place, Dean says. Providers, who aren't typically trained on how to diagnose opioid abuse disorder in seniors, may attribute certain symptoms of opioid abuse disorder to depression or dementia. That's a challenge made greater by the fact that 14% of adults ages 50 and older do have a mental illness, such as depression or anxiety, according to the National Institute of Mental Health. Complicating things still further is the reality that substance abuse and mental illness often occur together, requiring a comprehensive approach to evaluation and treatment. Teasing out the root issue requires both adequate provider training and sustained, consistent care.

THE WAY FORWARD

Against this tapestry of challenges, solutions are beginning to emerge. Project Lazarus, for instance, has partnered with providers in rural North Carolina to increase prescription opioid users' access to naloxone, an overdose prevention medication. The approach has since spread to more than two dozen rural communities nationwide. There are also senior-specific treatment programs gaining attention, such as Recovery@50Plus at the Betty Ford Foundation and Senior Hope Counseling, an outpatient substance use program in New York state.

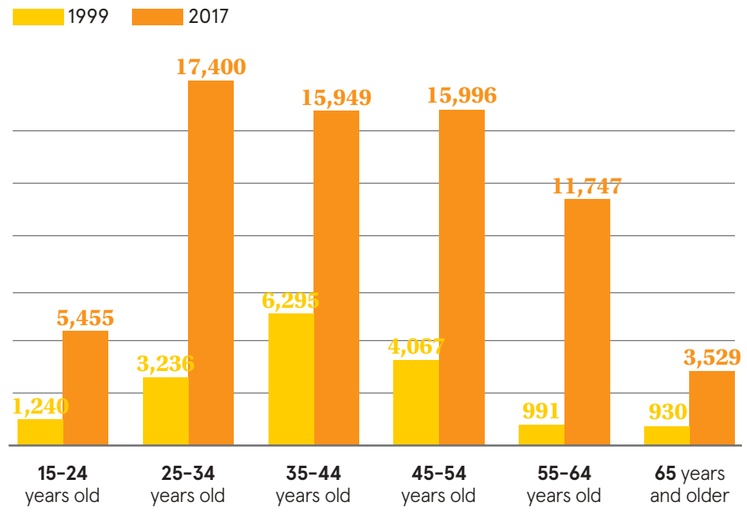
Still, it's important to remember that in resource-strapped rural areas, not all recovery needs to involve a treatment facility, Dr. Burnham says. Medication-assisted treatment (MAT)—which combines the use of medications like buprenorphine and methadone with counseling and behavioral therapies—has been shown to have higher efficacy and lower rates of relapse than treatment programs that stress abstinence alone. "The problem is that there aren't enough MAT providers anywhere," he says. Getting more frontline rural providers qualified to offer medication-assisted treatment could prove a lifeline for rural seniors, he explains.

For the best long-term success, treatment must be tailored to the older patient. That means being both mindful of a senior's higher propensity for the side effects of MAT, such as constipation and sleep disturbances, and also greater time and attention spent on making sure the treatment plan is fully understood so that patients are more likely to comply.

"Patients are supposed to be counseled around new medications—by a doctor, by the pharmacist—but everyone who touches the patient needs to work together to make sure that's truly happening," Dr. Burnham says. "A pamphlet provided with a prescription bottle is never enough." ■

AGE OF IMPACT

Across the last 20 years, opioid abuse has risen across every age group. In absolute numbers, younger adults have borne the brunt of the crisis. But seniors have experienced a spike in overdoses as well.



Source: Centers for Disease Control and Prevention

Health Records for the Smartphone Era

The federal government's MyHealthEData initiative aims to improve interoperability while giving patients unprecedented control over their personal health data.

By Jen Thomas
Illustrations by Nicolás Ortega

Health informatics and interoperability is nothing new in Washington, D.C.—policymakers and politicians have lamented the persistence of the fax machine in the health care sector for years. But there's been a ramp-up in focus of late. Much of that push stems from today's on-demand world, explains Jeffery Smith, vice president of public policy for the American Medical Informatics Association. "If we lived in a world without smartphones and apps, you wouldn't have members of Congress waving their phones in the air and saying, 'Why can't I get my health records on my phone?'" he says.

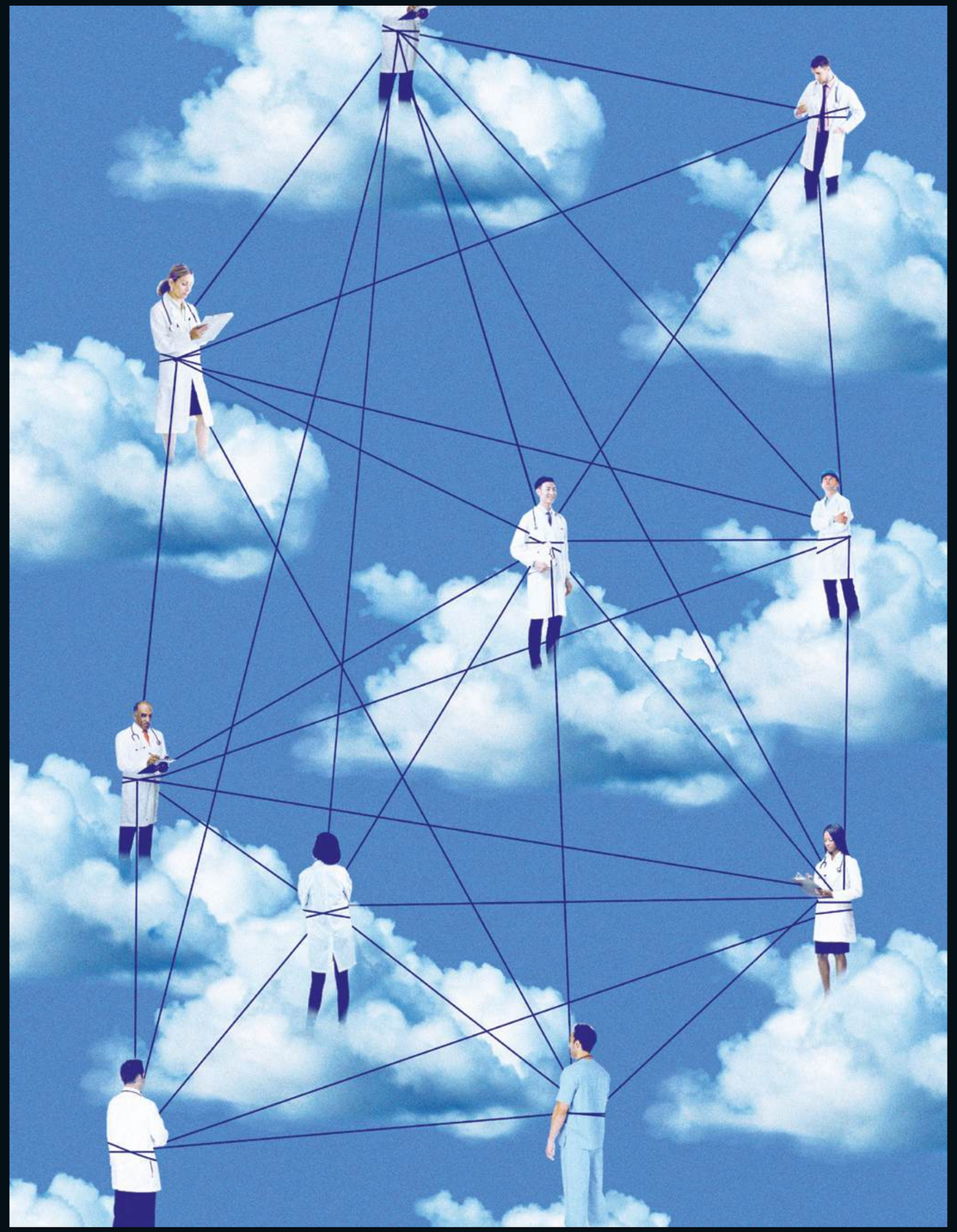
While consumers can access their health records or insurance information through online portals and apps, that information isn't easily shared from provider to provider. And there's no such thing as a "print all" button for medical records. Such barriers to access can make it difficult for patients to seek out new providers based on their unique needs.

In 2018, the White House Office of American Innovation and U.S. Department of Health and Human Services (HHS) announced a new initiative designed to change the way health care payers and providers share information, including standards for application program interfaces. Smith likens the changes to taking the health care industry out of the BlackBerry era and into the modern smartphone era.

Increasing Interoperability

At the heart of the program is the MyHealthEData initiative, which aims to give patients easy, safe and secure access to an electronic version of their personal health record, enabling them to quickly share their records with their health care providers and payers. The proposal includes plans to improve interoperability by requiring providers to update their systems to facilitate data sharing. It also aims to streamline billing and documentation requirements and reduce unnecessary or duplicative testing. The goal? To save doctors time and to save consumers money.

The standardization of data has been an issue in health care for a long time, says Robert Tennant, health information technology policy director for the Medical Group Management Association. "We've struggled to move data in a structured format that makes it



NICOLÁS ORTEGA

The Speed of Innovation

Third-party apps and new sharing rules could boost patient care.

These days, 81% of us walk around with high-powered computers small enough to fit in our pockets that enable us do everything from order dinner to watch movies. Proposed changes by the Centers for Medicare & Medicaid Services could push health care into the world of on-demand, at-your-fingertips data. Here are a few glimpses of what the future might hold.

Cost-comparison shopping. Consumers are already comparison shopping online for everything from mortgages to mattresses. Soon, they could also use their smartphones to compare the prices of medical procedures. This could potentially help consumers make more informed decisions and even drive down costs, says Robert Tennant, health information technology policy director for the Medical Group Management Association. "They could see, 'Oh, an MRI across the street is $500, but it's $480 down the block,'" he says.

Immediate ADT. In a separate rule, CMS has proposed that hospitals be required to send an Admission, Discharge or Transfer alert to a patient's primary care physician. That could lead to better and quicker treatment, Tennant says. "If someone with diabetes goes to the ER on a weekend, his or her physician will get that information right away. They can call them and say, 'Why don't you come in this week, and we'll talk about changing your medication or your treatment options?'" he explains.

Amped-up apps. Health care providers are often limited to certain tools to collect and track information. But opening up information to third-party applications could expand the offerings. For example, most doctors have no choice but to use the "notoriously bad" native charts built into their electronic health record systems, says Jeffery Smith, vice president of public policy for the American Medical Informatics Association. Instead, the use of standard APIs could enable providers to use an app to collect chart information.

digestible on the back end with an [electronic health record] so a physician can more effectively parse the data," he says.

The proposal includes a requirement for providers to adopt an application programming interface (API) to make their data available to third-party apps and developers.

"If you're downloading your mental health information, your HIV status, your pregnancy information, you want to be absolutely aware of what this app will do with your data and what rights you have once it's downloaded."

In support of the plan, the Centers for Medicaid & Medicare Services (CMS) proposed requirements designed to prevent health care providers participating in Medicare or Medicaid from engaging in data blocking. "By outlining specific requirements about electronic health information, we will be able to help patients, their caregivers and providers securely access and share health information," Health and Human Services Secretary Alex Azar said in a statement.

There's an App for That

Under the proposed plan, CMS would open up health data to outside apps and developers to innovate, Smith says. For patients, the benefit is clear: Such updates would enable patients to walk into their doctor's office with information they can use during their conversation about their care. They also would have access to insurance information, enabling them to compare plan coverage. To facilitate this, payers would need to adopt the standard API that would allow patients to access the information in their electronic health record through their preferred app.

This would make it easier for consumers to access their own data, as well as for health care providers and payers to share records. For example, managed care providers would be able to send a member's information to a doctor before an appointment, says Vrajesh Shah, vice president of information services strategy and shared services for AmeriHealth Caritas.

"It changes how they will determine treatment for the member and how they will spend their time," Shah explains.

Of course, making personal health care data available to third-party apps and developers doesn't come without concerns. Currently, app developers typically aren't required to adhere to HIPAA rules or even be certified, Tennant says. The Medical Group Management Association would like the Office of the National Coordinator for Health Information Technology to educate consumers on the potential privacy risks. In addition, the organization would like to establish guidelines requiring developers to clearly spell out their privacy policy and terms for consumers, and agree to maintain certain security standards. It would also like the government to create a certification process for these developers so both patients and health care providers can easily identify trustworthy platforms.

"If you're downloading your mental health information, your HIV status, your pregnancy information, you want to be absolutely aware of what this app will do with your data and what rights you have once it's downloaded," Tennant says. "If Facebook and Google and Amazon are any indication, the monetization of this data is highly probable."

For now, the government's position is not that it will be responsible for vetting these applications. Instead, it may potentially foster a marketplace to vet the apps, Smith says. He anticipates that eventually, someone will create a consumer review platform designed to evaluate these apps. A few organizations like the CARIN Alliance and Xcertia have already started to create clinical guidelines for apps.

The Path Forward

The final CMS requirements may take some time to go into effect. Smith expects it could take up to two years before hospitals and physicians are required to implement a standard patient-facing API. In the meantime, many health organizations are asking for deadlines to be pushed back and for CMS to use a phased approach to any changes. The Medical Group Management Association is hoping larger organizations with more resources can pilot test some of the proposed changes before the program is implemented nationwide.

Still, it's a time of serious momentum in the health informatics world, Smith says. "We're moving toward a much more granular, data-centric world where you can literally say, 'I want John Doe's blood pressure from three days ago,' and that's all you get. You don't have to send a 300-page document anymore if all you need is a sentence." ■

Breaking Down Silos

Q&A with Vrajesh Shah

Like many managed care organizations, AmeriHealth Caritas, which serves more than 5 million Medicaid, Medicare and Children's Health Insurance Program members, knows a lot about its members. The ability to more easily access its members' data and use it to help people manage their health is a top goal for the company, says Vrajesh Shah, the company's vice president of information services strategy and shared services.

AmeriHealth Caritas plans to harness the power of informatics by breaking down data-sharing barriers and focusing on whole-person care, Shah says.

AmeriHealth Caritas is building a large data platform. What impact will that have on your access and use of medical information?
In the past we had a lot of data silos. The new platform will allow us to collect all the information about members in one place and generate insights immediately.

How will the platform change how you interact with health care providers?
One example: We would have the ability to receive an Admissions, Discharge and Transfers message when a member is admitted to a hospital within a fraction of a second and evaluate using our analytics capabilities exactly how urgent a response is and how best to engage the care team and the member. We could then potentially make an intervention based on critical information about that member, such as they're pregnant. The traditional claims process can delay awareness of member admissions, often well beyond the time frame for an intervention.

How is AmeriHealth Caritas' Next Generation Model of Care program using population health data and social determinants of health to improve the care of members?
Informatics can tell us what role a person's environment or community may be playing in their health. For example, we receive a lot of specific information about members from providers that we can begin capturing and analyzing. This information can correlate to social determinants of health—home ZIP code, where someone works, their occupation. When we can input all this information, it will allow our analytics systems and business leaders to see everything all in one place. Then we can take more targeted action to improve a member's care.

HOW BEING BLACK IN AMERICA IS BAD FOR YOUR HEALTH

Poor African Americans have worse health outcomes than whites, but disparities also exist for blacks who earn six figures, research suggests.

By Ruben Castaneda

ON AN OVERCAST, HUMID MORNING,

Antonice C. Woodfork grabs an umbrella, sets out from her home in a far-from-gentrified neighborhood in the District of Columbia and starts marching to the nearest grocery store, seven-tenths of a mile away.

Woodfork, 42, who is African American, could take a bus with one transfer, but the buses don't run as frequently in this part of town, in deep Northeast Washington, as they do downtown. That means it may take her as long as an hour to get there, so she starts moving. It's not the safest neighborhood—her street is a couple of blocks from where, a week earlier, four masked gunmen jumped out of a car and opened fire. A 10-year-old girl, Makiyah Wilson, was fatally shot.

Woodfork is accustomed to living with the specter of violence; she knows which streets to avoid. Besides, walking will do her good. At 5 feet 9 inches tall and just south of 300 pounds, Woodfork is obese, but she's in much better shape than she was two years ago. That's when Woodfork started consistently attending wellness classes offered by AmeriHealth Caritas District of Columbia, a Medicaid managed care organization serving nearly 120,000 members in the District. Medicaid is a nationwide federal and state health insurance program for low-income and poor people. Since she started attending wellness classes routinely, Woodfork has dropped a little more than 100 pounds.

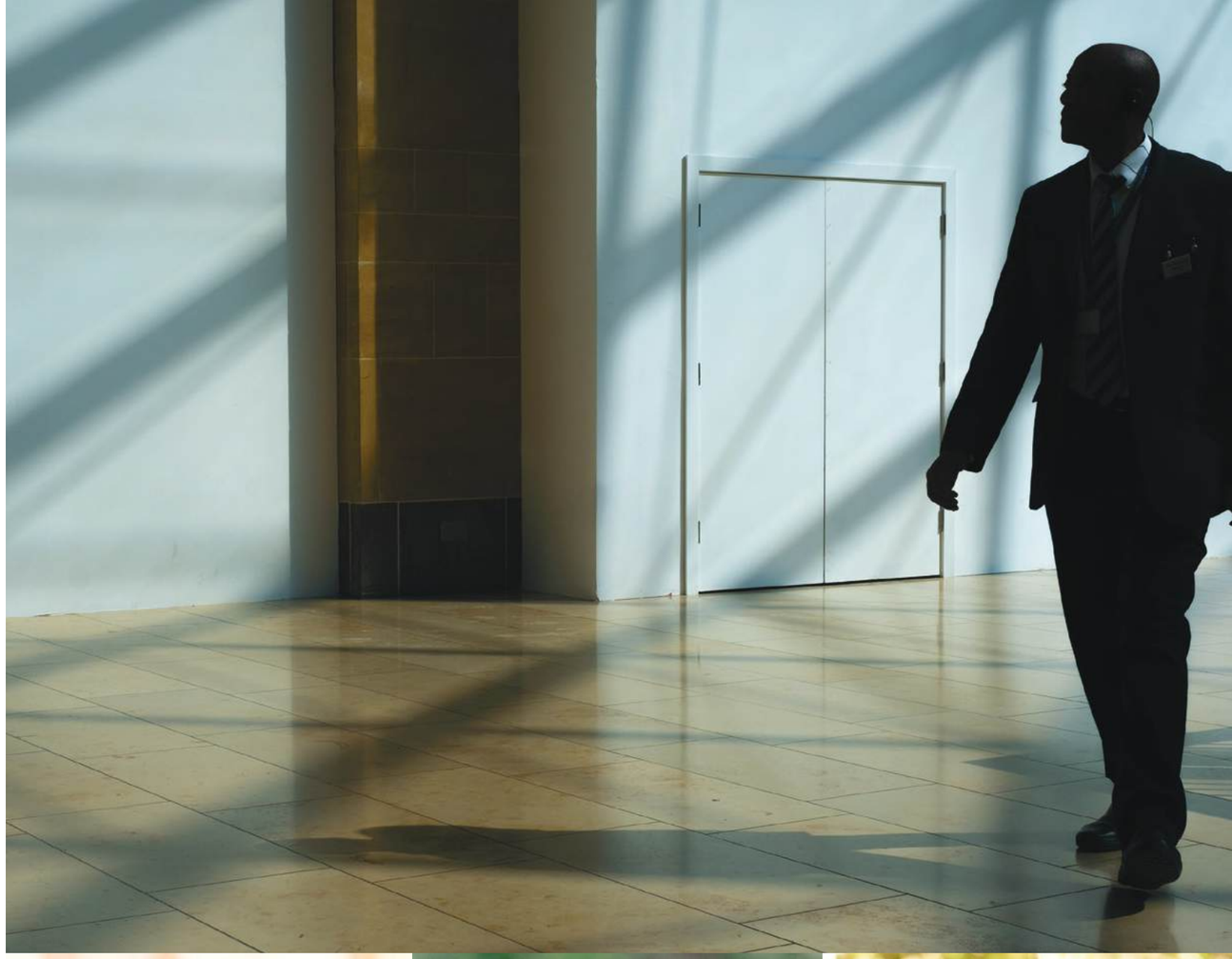
Poor and working-class blacks like Woodfork are particularly at risk for troubling health outcomes, says Karen M. Dale, market president for AmeriHealth Caritas District of Columbia. People who live in distressed neighborhoods are more likely to focus on surviving day to day than on their health, says Dale, who's also a registered nurse. The stress of dealing with racial discrimination can lead to chronic stress, which can put people at risk of numerous health problems, including anxiety, depression, digestive issues, headaches, heart disease, weight gain, and memory and concentration impairment, according to the Mayo Clinic.

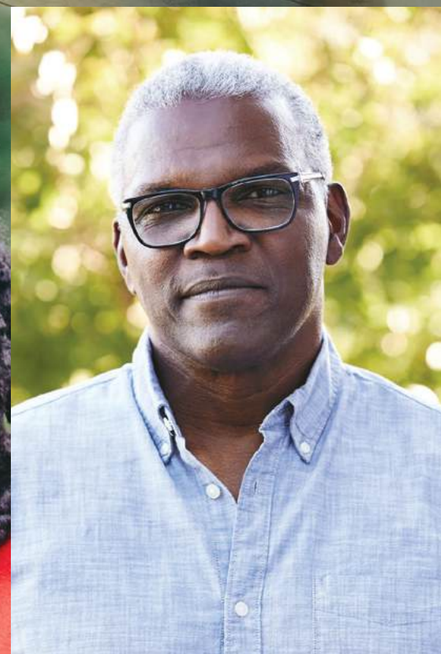
"IT'S A VICIOUS CYCLE," DALE SAYS.

"Let's take a hypothetical Miss Jones. She's a low-income earner who lives in a poor neighborhood and has a chronic disease. Miss Jones needs to strategize how to improve her health and have the energy and focus to concentrate on her disease, but instead she's putting out fires, figuring out how to pay this month's rent or how to buy groceries for the week. Things get worse, and she feels worse, so she's in this cycle of anxiety and depression. She starts to have symptoms of depression—she has difficulty falling asleep, starts waking up very early. Stomach problems set in. This is the body saying, 'I can't cope' with all of this unrelenting stress," Dale says. And, she notes, research has shown that stress can contribute to a multitude of chronic health problems, such as cardiovascular issues, obesity, hypertension, cancer and diabetes. "Our minds are not meant to be on such high alert all the time," she says.

A raft of studies verifies that, even before birth, U.S. blacks face a multitude of serious health problems:

- Non-Hispanic blacks have an infant mortality rate more than double that of non-Hispanic whites, according to the U.S. Department of Health and Human Services Office of Minority Health. In





PREVIOUS SPREAD AND THIS SPREAD: UNSPLASH; BOTTOM RIGHT: STOCKSY

2014, the infant mortality rate for non-Hispanic black infants was 11 per 1,000 births and 5 per 1,000 live births for non-Hispanic whites. The leading causes of infant death for non-Hispanic blacks were low birth weight; congenital malformations; maternal complications and sudden infant death syndrome. African American mothers were more than twice as likely than non-Hispanic white moms to receive late or no prenatal care, according to the HHS.

- Large numbers of non-Hispanic black children have obesity, according to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). For non-Hispanic black kids between the ages of 6 and 11, the rate of obesity is 22% for girls and 21% for boys. Among African Americans between the ages of 12 and 19, the obesity rates are 24% for girls and 21% for boys.
- The percentage of African Americans with obesity doubles in adulthood, according to the NIDDK. Overall, 48% of non-Hispanic blacks are obese, and 12% are morbidly obese, according to the NIDDK.

These and other negative health conditions aren't exclusive to African Americans who struggle to make ends meet. Research published in 2016 in the journal *Preventive Medicine* suggests that racial disparities exist even for blacks who earn a six-figure salary. The study found that for blacks and other racial and ethnic minorities who earned $175,000 annually, there were disparities compared with whites when it came to diabetes, hypertension, high cholesterol and self-reported excellent or very good health. "We do find health disparities even between highly affluent African Americans and other groups such as white Americans," says Thomas LaVeist, dean of the School of Public Health and Tropical Medicine at Tulane University in New Orleans.

ANTONICE WOODFORK HAS LOST MORE THAN 100 POUNDS SINCE SHE STARTED ATTENDING WELLNESS CLASSES.

Now when Woodfork shops she primarily buys healthy foods like fresh fruits and leafy greens.

Before dropping the weight, "I had to get on the big people's scale," she says, explaining that most scales in health care settings she went to topped out at about 350 pounds. "I hated getting on the big people's scale. I was miserable." Woodfork, who has four adult children, wants to lose another 30 or so pounds while managing an array of health challenges. She takes 10 medications daily: for her high blood pressure, for the arthritis in her lower back, for asthma and other chronic conditions. Walking assists her effort to lose weight, and it also helps her manage stress. That she has plenty of: In addition to the anxieties of paying the monthly rent on her three-bedroom home while unemployed, Woodfork is dealing with the recent deaths of her boyfriend and of a newborn grandchild. Her boyfriend died in late May after dealing with a host of chronic health conditions. Woodfork's grandson, the child of her only daughter, died in early July, 10 days after he was born. An autopsy is pending, she says. Staying physically active helps shield her from feeling depressed. "When I get depressed, I just stay to myself and do nothing," Woodfork says.

The multiple health challenges Woodfork faces are emblematic of the hurdles faced by millions of blacks nationwide. Among blacks ages 65 and older, deaths from cancer, heart disease and stroke have declined significantly since 1999, the Centers for Disease Control and Prevention reported in 2017. But among other age groups, health disparities for blacks persist. Even some high-earning blacks are more vulnerable than well-off whites to a host of chronic diseases because of their race, research suggests.

For moderate-to-low-income blacks like Woodfork, the challenges of living a healthy lifestyle are particularly acute, says Kate Griffin, vice president of programs for Prosperity Now, a nonprofit that works through education and advocacy to help low-income people in the U.S., especially people of color, achieve financial security.

As she heads to the grocery store, Woodfork is aware of her stress. She plans on going to therapy—which she says AmeriHealth Caritas will pay for—to help her deal with the trauma of losing her boyfriend and grandchild. At the store, she heads straight for the produce section, where she puts a container of freshly cut mango chunks into her cart. She praises the health benefits of cucumbers, which are low in calories and fat, and plucks two fresh ones. In the frozen foods section, she points to a package of broccoli cauliflower pasta with cheddar cheese. "I used to eat stuff like this all the time," she says. One serving has 400 calories and accounts for 50% of the recommended daily allowance of saturated fat, according to the label.

Woodfork walked to the store in 25 minutes, but it takes an hour to get home. She catches the first bus right away but has to wait about 45 minutes for her transfer. She's been looking for work as a hair stylist and had one lead, but renting space at the salon and paying for transportation would cost $115 a week, which she can't afford. Asked what one change in her life's circumstance would help improve her health, Woodfork doesn't hesitate to name the one thing that would relieve much of her stress. "A good job," she says. ■

The Promise of Medicaid

The war on poverty is not over. More than 50 years after Medicaid's creation, the federal health care program continues to deliver health and hope to millions of Americans, says **Paul Tufano**, chairman and CEO of AmeriHealth Caritas.

When President Lyndon B. Johnson signed the bill turning Medicaid into law in July 1965, the action was part of his administration's "unconditional war on poverty." Fifty-four years later, poverty and the need for Medicaid remain. About 14% of Americans now live below the federal poverty line—a 1% increase since the war on poverty began. During this time, even as public debates have vacillated for and against Medicaid, poll after poll has shown a majority of Americans look favorably on the program to aid the poor.

Paul Tufano, chairman and CEO of AmeriHealth Caritas, has seen how Medicaid serves as a pathway out of poverty. In this interview, he discusses the profound impact of Medicaid and why Americans must recommit to the program's original intent: ending poverty.

WHY IS MEDICAID AN ESSENTIAL GOVERNMENT PROGRAM?

In 1965, President Lyndon B. Johnson reaffirmed our nation's commitment to treat all people equally when he signed Medicaid legislation into law. And with that simple stroke of a pen, he changed our country, if not the world, forever.

Medicaid is a commitment to helping our most vulnerable citizens at a time of need, and that commitment is grounded in the founding principle of our nation—that all people have the right to "life, liberty and the pursuit of happiness." With the enactment of Medicaid—part of President Johnson's war on poverty—our leaders sought to honor this unique American value by seeking to eradicate the scourge and despair of poverty and give every American, regardless of race, income or standing, the same chance to be healthy.

CASS DAVIS/GUERRERO MEDIA

WHY DO WE HEAR ARGUMENTS AGAINST MEDICAID?

Unfortunately, the word "entitlement" has become part of our lexicon to describe programs such as Medicaid, rather than words like "compassion" and "empowerment." We hear debates about its cost and see finger-pointing at recipients who are often stereotyped. These misconceptions, unfortunately, often overshadow the facts.

CAN YOU CLARIFY SOME OF THE MISCONCEPTIONS AROUND MEDICAID?

Medicaid serves low-income families and individuals who have no other means for health care, including the elderly, blind, disabled, chronically ill and children. Today, with Medicaid's expansion in 36 states following an optional provision in the Affordable Care Act, an estimated 1 in 5 Americans are covered by Medicaid. According to the Centers for Medicaid & Medicare Services, that's around 75.1 million people who are enrolled in Medicaid programs nationwide; nearly 40% of them are children and another 22% are elderly or disabled. And the 6 million recipients who are senior citizens use a disproportionate percentage of resources, as compared to the larger population, at nearly 40%. The reality is, the faces of Medicaid are the faces of America. They're our neighbors, co-workers, friends and family members. For many of them, Medicaid serves as an engine for their American dream—a dream to live a healthy life that puts them on the pathway to independence and prosperity.

WHAT ARE THE RESULTS OF MEDICAID?

Since it started over 54 years ago, Medicaid has served and improved the lives of hundreds of millions of Americans by giving them access to health care. People have gone on to become teachers, first responders, athletes and, yes, legislators.

MAYBE WE SHOULD ACTUALLY REFRAME THE MEDICAID DEBATE AND ASK OURSELVES INSTEAD, "WHAT IF WE DIDN'T NEED MEDICAID ANYMORE?"

The idea that healthy people who are capable of self-sufficiency are on Medicaid for life is a fallacy—studies have proven that Medicaid can actually be a pathway out of poverty for many. One of the more recent studies said Medicaid "is among the most effective anti-poverty programs." Researchers found that it reduced child poverty by as much as 5.3%, and in Hispanic and African American households without disabilities, Medicaid reduced poverty by 6.1 and 4.9%, respectively. This is what we should focus on—how to leverage Medicaid even more to help people overcome poverty.

HOW DO WE RECONCILE THE ISSUE OF MEDICAID'S COST VERSUS ITS BENEFITS?

There are no easy answers because approximately 14% of Americans still live in poverty, and we can't stop providing our most vulnerable citizens with health care. So, maybe we should actually reframe the Medicaid debate and ask ourselves instead, "What if we didn't need Medicaid anymore?"

In other words, what if we could finally and truly eliminate poverty? Some may find this an absurd question. But is it really any more absurd than asking 50 years ago, "What if we could send a man to the moon and bring him safely back to Earth?" And when talking about poverty, we already know the answer to this "what if" scenario. We know that eliminating poverty would be one of the most important achievements in our nation's history. The challenging part is figuring out the "how." But I am confident the solution is in our midst.

WITH ALL THE GOOD MEDICAID HAS DONE, WHY DO WE HEAR MORE DEBATE IN CONGRESS ABOUT ITS FUTURE?

That's a great question, because the debate playing out in both Washington, D.C., and in states and courtrooms across the country has pushed many to pick a side: Either shrink Medicaid's burden on the taxpayers who fund it or expand access to health care and improve health outcomes for our neighbors in need. It's a false choice. We are America. We can and must do both. ■

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Work Requirements Hit Snags

State efforts to make Medicaid coverage conditional prove difficult to implement.

A handful of state governments keep hitting snags as they push to tie Medicaid coverage to work requirements. In July, New Hampshire paused its plan after estimating that only about one-third of the 25,000 state residents subject to the new work rules had actually complied—meaning approximately 17,000 people would suddenly lose health care coverage.

The legality of the policy—which required Medicaid expansion beneficiaries between the ages of 19 and 64 to work, volunteer, participate in job training or be in school at least 100 hours per month—is up for debate in federal court. In October, a circuit court of appeals appeared skeptical of the Trump administration's arguments for letting states' Medicaid work requirements stand. The same judge who blocked New Hampshire's law struck down similar work requirements in Arkansas and Kentucky in March. Nonetheless, the federal government has been giving state governments a hand as they push for waivers that would allow Medicaid coverage to be conditional. The Centers for Medicare & Medicaid Services (CMS) approved states' waiver plans 16% faster last year than two years earlier. As of July, CMS had approved nine waivers requiring work, with more applications pending review.

Experts expect the issue to end up in the U.S. Supreme Court. While the legal process plays out, policy experts are trying to understand the consequences of these changes. A 2019 study published in the *New England Journal of Medicine* found that in Arkansas, requirements did not increase employment or enrollment in private insurance.

17K
PEOPLE IN NEW HAMPSHIRE WOULD LOSE HEALTH CARE COVERAGE UNDER WORK REQUIREMENTS.

The policy would require 100 hours of work, volunteering or education per month.

Similar work requirements were struck down in Arkansas and Kentucky.

Are Medicaid Block Grants Viable?

Tennessee may soon become the first state to apply for one.

The Trump administration's efforts to convert Medicaid funding into block grants seem to be heating up. With block grants, states would receive a fixed amount of federal funding for Medicaid, not the open-ended federal funding currently provided. Proponents claim this would help states spend the money better with fewer federal restrictions. This fall, Tennessee will become the first state to submit an application for a block grant from the federal government, Gov. Bill Lee said in July.

"We will pursue a deal that is good for Tennesseans and that improves the quality of life for Tennesseans," he said.

Opponents say block grants could enable states to limit Medicaid coverage. "What I think is most concerning is [block grants] will lead to losses of coverage, and that is not what the Medicaid program is supposed to be doing," Cindy Mann, who oversaw Medicaid under President Barack Obama, told Vox. "It's supposed to be promoting coverage and promoting affordable coverage."

It's unclear if block grants and their spending caps are even legally permissible—or if CMS has the authority to change Medicaid's funding structure without congressional approval.

Some Democrats believe such changes are illegal. "The plain language of the statute prohibits the secretary [of the U.S. Department of Health and Human Services] from approving a waiver that requests a block grant or per capita cap in Medicaid through a cap on federal funds," Rep. Frank Pallone Jr., of New Jersey, said in late June.

If block grants proceed, expect legal battles to ensue.

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A Leg Up for Rural Hospitals

But tweaked Medicare reimbursement index could hurt urban hospitals.

Rural hospitals have been closing at an alarming rate—over 100 since 2010. In light of that, Centers for Medicare & Medicaid Services (CMS) this year proposed a plan to increase Medicare reimbursements to rural hospitals. If that happens, Alabama's mostly rural hospitals, for example, would get an additional $43 million from Medicare in 2020.

Rural hospitals' gain, however, would come at urban hospitals' loss. That's because legally, the overall federal Medicare budget must remain fixed.

At issue is a controversial regulation known as the Medicare Wage Index. Created in the 1980s, the Wage Index was intended to give urban hospitals more funding in order to help offset higher operating costs. But how "more" is calculated has long been a point of contention. U.S. Secretary of Health and Human Services Alex Azar calls the Wage Index "one of the more vexing issues in Medicare."

The American Hospital Association supports increasing the index for low-wage (rural) hospitals. "However, this should not be accomplished by penalizing other hospitals, especially in light of the fact that Medicare currently reimburses all inpatient [Prospective Payment System] hospitals below the cost of care," the organization wrote in a June letter to the CMS, responding to the agency's proposed rule change. "Importantly, CMS is not bound by statute to apply budget neutrality for Wage Index modifications as proposed."

The rule went into effect Oct. 1 of this year.

Arizona was the first state to register ridesharing companies as Medicaid providers.

Florida recently became the second state, and Texas is currently paving the way.

3.6M
AMERICANS MISS APPOINTMENTS OR DELAY DIAGNOSIS AND TREATMENT DUE TO LACK OF TRANSPORTATION.

Medicaid Gets a Lyft

Ride-sharing companies are registering as providers.

Receiving health care services often requires transportation. But each year, 3.6 million Americans miss appointments or delay diagnoses and treatment because they have no way to get to their providers, according to a National Conference of State Legislators report.

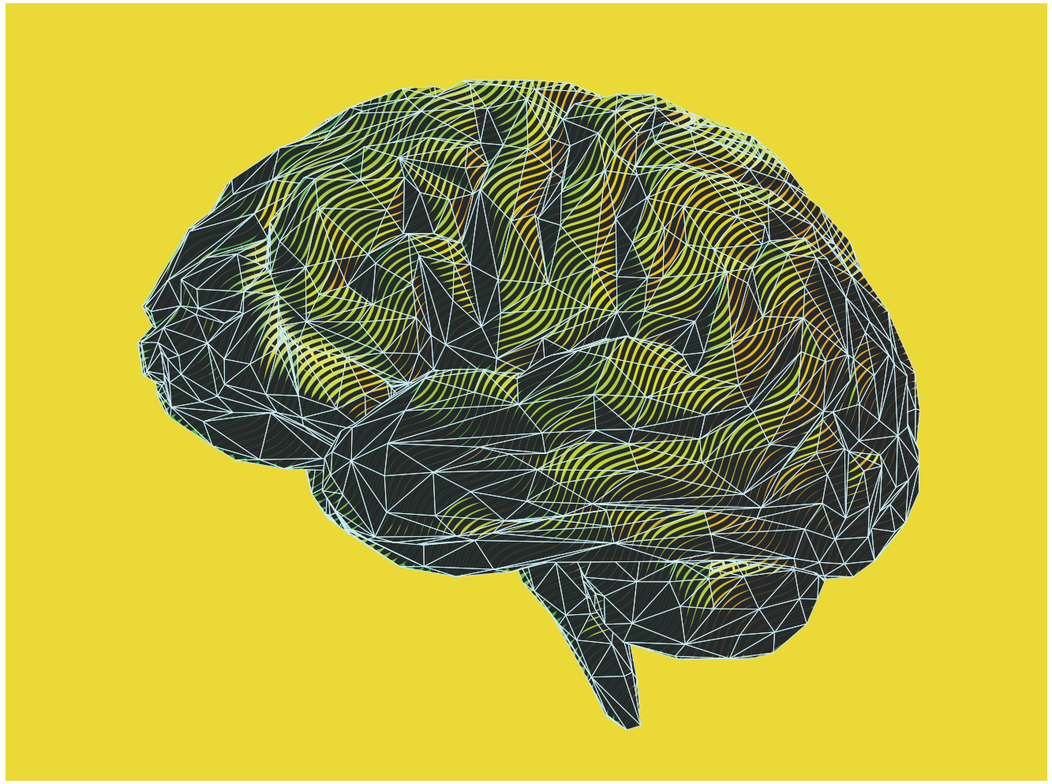
The ride-share company Lyft can now offer a solution to some Medicaid patients in need. In May, Arizona became the first U.S. state to register national ride-sharing companies as Medicaid providers, with Lyft becoming the first to register. The company now offers nonemergency medical transportation to the 23% of Arizonans covered under Medicaid, enabling them to be reimbursed for qualifying Lyft rides. Uber is working to get approved to transport Medicaid members in the state as well.

"This is a significant step forward in medical transportation services, and we look forward to seeing its positive impact," Jami Snyder, director of Arizona's Medicaid agency, said in a statement.

Other states are following Arizona's lead. In July, Florida became the second state to allow Lyft to provide this service to Medicaid recipients. Texas has been paving the way for such a law as well.

Lyft and Uber see opportunities in the Medicare space as well. As momentum to address social determinants of health grows, the competing ride-share giants are trying to persuade Medicare Advantage payers to cover more nonmedical services like transportation. Uber wants to partner with companies in the home-based care industry, for example.

"The old way is caregivers getting into their own cars or a home care agency having to have its own fleet of vehicles.... I think [providers] are starting to see the power of ride-share," Dan Trigub, head of Uber Health, told Home Health Care News earlier this year.



ISTOCK

Artificial Intelligence Gets Personal

The health care industry is starting to get serious about AI. But will patients be willing to share vast amounts of personal data for the promise of improved outcomes?

The central task before the U.S. health care industry is daunting: improve and expand care while simultaneously controlling costs. A business-as-usual approach isn't likely to get the job done. Could artificial intelligence (AI) drive improvements in everything from patient diagnostics to operational efficiency to understanding the myriad factors that influence patient outcomes? Industry leaders and experts alike increasingly believe the answer is yes.

"The industry understanding [of AI's potential] has evolved over a very short period of time," says Greg Tennant, chief strategy and marketing officer at Tampa, Florida-based Inspirata, which develops technology-based solutions to fight cancer.

Accenture projects that the use of AI in health care could yield $150 billion in annual savings to the U.S. economy by 2026. And 94% of respondents to a 2018 OptumIQ survey cited AI as the most reliable path toward making health care more equitable, accessible and affordable. The survey indicates that while just a third of health care organizations are currently using AI, 42% have an AI strategy in development.

"Now it's about how organizations can take that to the next level," Tennant says, "from getting the insights to taking real action."

AI has already been successful at improving health care operations, such as the 2017 partnership between GE Healthcare and Oregon Health & Science University (OHSU). The partners used AI to analyze capacity across OHSU's hospital system, recommending certain patients transfer to partner facilities so that the university's primary research hospital could focus on patients in need of advanced care.

Industry leaders hope the next generation of AI applications will leverage a broad range of data to uncover health risks and opportunities that, up until now, have largely been invisible to most caregivers. The success of those efforts hinges not only on smart engineering but also on the delicate navigation of privacy issues.

POTENTIAL—AND PRIVACY PITFALLS

AI is well-suited to pooling and analyzing massive amounts of disparate data to identify patterns. That's just what is needed to support the health care industry's evolving understanding of the social determinants of health (SDOH). A broad array of circumstances like literacy, employment, cultural background and access to care can have a large impact on health outcomes. Yet providers can struggle to take all of these factors into account when considering an individual patient's health. The newest wave of AI solutions aims to use data to help better inform providers.

Northwell Health, the largest health system in New York state, is working with multiple med tech startups in hopes of building out a suite of AI-powered tools designed to tackle this issue starting with a social vulnerability index—a personalized SDOH score that can identify specific actionable issues for each patient.

Another Northwell collaboration, with Chicago-based software developer NowPow, relies on diagnostic codes in health records to identify patients' most urgent needs and uses matching logic and evidence-based algorithms to recommend community-based organizations that can help. For example, a patient who is experiencing car troubles might be connected with a transportation service, making it easier for them to attend necessary follow-up appointments. The software will then track the patient outcomes resulting from those referrals in order to build a set of best practices for dealing with various SDOH issues in the community.

But Northwell's twin solutions steer clear of one of the key challenges in this arena: privacy concerns. Though information such as credit scores and court-related data could be particularly valuable to an AI-enabled SDOH index, Northwell does not collect such personal information, believing that doing so could also deter patients.

"We're conservative with our approach because we don't want patients looking at us as Big Brother," says Stephanie Kubow, assistant vice president for community health and education at Northwell. "We're going to be very sensitive and make sure this is a positive interaction for our patients and our communities."

Kubow expects that some of Northwell's interventions may be imperceptible to patients and the communities where they live. For example, if a group of patients is identified as living in a food desert, instead of simply providing food at a point of crisis, the health system could work with a farmer's market or a grocery store in that area to address the issue upstream.

Inspirata's tech platform promises to be even more personal but also transparent. This is because participants will opt into the system by signing up for the company's "patient empowerment platform," knowing that Inspirata will make recommendations based on insights provided by the patient or through integrations with popular fitness apps such as MyFitnessPal. The platform includes a social layer that allows patients to communicate and cheer one another on as they share information that is also useful to caregivers.

"You can glean a lot of information just from the comments," Tennant says.

It all adds up to an environment in which AI tech solutions are making steady progress yet remain a long way from reaching their full potential.

"These are still fairly early times," Tennant says. "What's heartening is that there's traction. As more organizations get access to the data and take advantage of it, you'll see it really take off." ■

IT ALL ADDS UP TO AN ENVIRONMENT IN WHICH AI TECH SOLUTIONS ARE MAKING STEADY PROGRESS YET REMAIN A LONG WAY FROM REACHING THEIR FULL POTENTIAL.

Emilia Ford now helps other plan members pass the GED.

From Mentee to Mentor

Emilia Ford earned her GED with support from AmeriHealth Caritas' Mission GED® program. Then she began assisting health plan members herself.

Emilia Ford was determined. After dropping out of high school at age 15 and giving birth to her daughter, she set a goal for herself to open up her career possibilities: She would earn her general equivalency diploma (GED). It wouldn't be easy, but it would be worth it.

"I just knew I had to further my education to pursue jobs that I wanted," Emilia says.

With a young child to care for, it was hard to find time to prepare for the GED exam. Years passed. Then in 2017, she learned from a relative that her Medicaid benefits offered through AmeriHealth Caritas' Southeastern Pennsylvania plan supported GED exam prep. Emilia called her plan and connected with Bonnie, a coach with the plan's Mission GED program.

As she has with many other members, Bonnie helped Emilia sign up for prep classes, connect with nonprofit organizations that offer tutoring support, and register and pay for the tests. (The program, which launched in 2013, also offers child care and transportation.)

But if you ask Emilia, now 26, Bonnie did much more than help with logistics. Every two weeks, they would connect to see how things were going. "When I spoke to her, it was on a personal level," Emilia says. "She let me know I was not alone."

The mentorship inspired Emilia to not only pass the GED exam last year. Soon afterward she began an internship in the AmeriHealth Caritas plan's member services department—and in August 2018 was hired into a full-time role to help members pass the GED.

"I feel attached to this role because I've been the other person on the phone," Emilia says. "I can relate. It makes the members feel comfortable and trusting."

She has helped more than 70 members prepare for the GED—including more than 20 who have passed the exam. She's part of a small group of health insurance plans across the country that offer a GED benefit. The idea is that because low education levels and poor health are correlated, insurers can boost members' health and thereby reduce costs by helping people further their education.

The core of her job, Emilia says, is to motivate people.

"Whatever you do to advance toward your goal, even if it's a small step forward, counts. Keep trying, keep pushing forward." ■

HANNAH YOON

AmeriHealth Caritas