MILKEN INSTITUTE

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Improving and Sustaining Health Through Prevention Across Medicare and Medicaid

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Executive Summary

Medicare and Medicaid broadly cover preventive services, yet utilization remains below goals, with the widest gaps in rural communities and among beneficiaries managing multiple chronic conditions. Excessive emergency department (ED) use and readmissions persist when care coordination and self-management support fall short. These patterns underscore an opportunity for federal agencies to align existing authorities, so prevention becomes the default experience, not the exception.

The Centers for Medicare & Medicaid Services (CMS) already holds the essential levers to improve prevention through benefit design, payment, quality management programs, managed-care contracting, and demonstration authority. Applied together across the care continuum, these tools can transform today's patchwork into an integrated prevention pathway. They can expand access and outreach, reward vigilance in screening and chronic disease management, strengthen accountability through transparent metrics, and embed targeted social supports where evidence shows impact.

Maintaining comprehensive telehealth options (including audio-only where appropriate) keeps routine preventive visits within reach, especially for rural residents. Community health workers (CHWs) and navigators, supported through appropriate reimbursement, can help close navigation and trust gaps and convert screening orders into completed care. Streamlined Annual Wellness Visit (AWV) requirements, modest incentive payments for closing screening gaps, and broader use of programs such as Chronic Care Management (CCM), Principal Care Management (PCM), and Remote Patient Monitoring (RPM) codes enable proactive management of high-risk patients. Expanded shared-savings opportunities and preventive metrics—publicly stratified by geography—reinforce progress. And through Medicaid waivers, Medicare Advantage (MA) supplemental benefits, and cross-agency partnerships, nutrition, transportation, and housing supports can be aligned to sustain clinical gains.

HIGH-LEVEL RECOMMENDATIONS

- **Sustain access and trusted outreach.** Maintain comprehensive telehealth coverage for preventive and follow-up visits; enable CHW- and navigator-supported outreach through clear, credential-based reimbursement pathways in alignment with Community Health Integration (CHI) policy.
- **Reward prevention and proactive chronic disease management.** Streamline the AWV and pair it with modest bonuses for closing screening gaps; embed per-screen incentives in Merit-based Incentive Payment System (MIPS), Accountable Care Organization (ACO) benchmarks, and MA quality programs; and expand use of CCM/PCM/RPM for high-risk beneficiaries.
- **Strengthen accountability with rural visibility.** Reinforce shared-savings arrangements that reinvest avoided admissions; stratify key measures by geography; and add priority preventive indicators (e.g., obesity assessment, kidney surveillance, cognitive screening) where appropriate.
- **Integrate social supports where evidence is strongest.** Fast-track waivers for medically tailored meals, housing supports, and nonemergency transport; encourage MA supplemental benefits; and seed rural consortia that link clinical care with community services, drawing on Accountable Health Communities (AHC) lessons.

With these actions, grounded in existing authority and respectful of state and plan implementation, federal, state, and private partners can reduce preventable high-cost health-care utilization, improve outcomes, and enhance program sustainability while maintaining a clear focus on equity for rural and underserved beneficiaries.

Categories	Proposed Actions for CMS	Impact
Access and Outreach	Permanent telehealth coverage for applicable preventive service deliveries	Keep routine HRA, counseling, and follow-up within reach, especially in rural areas
	Direct reimbursement mechanism for auxiliary personnel under CHI	Reimburse personnel who are a trusted source of outreach and care navigation in communities
Payment and Incentives	Streamlined AWS with modest bonuses for closing screening gaps	Make prevention a default clinical focus and raise the completion of priority screenings
	Provider rewards in MIPS, ACO benchmarks, MA quality bonus pools, and for identified HRA linked to necessary service delivery	Reward practices exceeding risk-adjusted screening targets
	Member incentives for achieving preventive milestones	Encourage beneficiaries to complete screenings and adhere to medications
	Expansion of CCM, PCM, and RPM for high-impact chronic diseases to reduce severely adverse health outcomes	Catch decompensation early and reduce ED/hospital use
Quality and Accountability	Broader shared-savings arrangements	Finance preventive infrastructure by reinvesting realized savings
	Align the Medicaid Adult Core Set with the Medicare ACO benchmark and the MA Star Rating measures	Improve accountability for prevention in both Medicaid and Medicare
	Allow Medicare ACO benchmark and MA Star Rating measures to include metrics related to high-impact chronic diseases	Ensure incentives reflect the current disease burden in seniors

Categories	Proposed Actions for CMS	Impact
Integrated Care	Integrate admission, discharge, transfer alerts, and health information exchange across diverse health-care settings	Improve care transitions and follow-up to prevent readmissions
	Facilitate C-SNP implementation in Medicaid	Tailor benefits to high-need conditions for better outcomes
Health-Related Social Needs (HRSN)	Fast-track Medicaid waivers for evidence-based HRSN and encourage MA plans to tailor SSBCI benefits for high-need areas	Address practical barriers that block prevention and self-management and sustain health outcomes
	Pilot CMMI AHC model-like demonstrations and include measures relevant to prevention	Link clinical care to community services and track preventive metrics as outcomes
	Encourage cross-agency coordination in addressing HRSN and upfront investment for rural ACO to collaborate with social service providers	Leverage federal programs and ACO funds for HRSN

Note: HRA = health risk assessment; C-SNP = Chronic Special Needs Plan; SSBCI = Supplemental Special Benefits for Chronically Ill; CMMI = Center for Medicare and Medicaid Innovation

Expanding Early Screening, Timely Treatment, and Effective Management of Chronic Diseases

Despite a decade of no-cost coverage for many screening and counseling services, the use of preventive care remains below clinical goals. In 2022, an estimated 61.4 percent of US adults aged 45–75 were up to date with colorectal cancer screening,[1] and rural residents were significantly less likely to be screened than urban residents.[2] At the same time, about two-thirds of Medicare beneficiaries have two or more chronic conditions,[3] and beneficiaries with multiple chronic conditions account for roughly 93–94 percent of Medicare spending.[4] Preventable ED visits and hospital readmissions persist when care coordination and self-management support are inadequate, underscoring the importance of follow-up and seamless transitions in care.[5]

CMS already wields a comprehensive array of policy tools—spanning benefit definitions, payment schedules, quality reporting programs, managed-care contract requirements, and nationwide demonstration authority. By strategically aligning these authorities along the entire care continuum, CMS can transform isolated efforts into an integrated framework for preventive care.

First, CMS could be given authority to improve access and outreach by embedding telehealth, reliable transportation options, CHWs, and culturally tailored education into every point of care. Second, it can realign payments and incentives so that clinicians, health plans, and even beneficiaries themselves are rewarded for timely screenings and rigorous chronic disease management. Third, by strengthening quality metrics and public accountability, CMS can ensure that progress toward preventive goals is both transparent and financially meaningful. Finally, by broadening coverage to include supplemental social risk supports, advancing coordinated care models, and refining plan design, the agency can eliminate the nonmedical barriers that too often undermine clinical advances.

ACCESS AND OUTREACH

Recommendation 1.1: Make Telehealth Flexibilities Permanent

Accelerate routine health and risk assessment, counseling, and follow-up within reach for beneficiaries.

Patients, on average, spend two hours in transit or waiting for a 20-minute in-person visit, a burden that rises sharply for Americans who live in remote areas. Emergency flexibilities issued during the pandemic, extended through fiscal year 2025, allow video and audio-only visits from home for behavioral health, Federally Qualified Health Center, and Rural Health Clinic services, the AWV, and certain preventive screenings.[6]

Recommendation 1.2: Establish Direct Reimbursement for Nonphysician Providers

Address the gap in which Medicare reimburses billing providers for CHI to directly reimburse auxiliary personnel.

CMS could be authorized to amplify outreach to people about the availability and importance of preventive screenings. For example, collaboration with trusted local community-based organizations (CBOs) to disseminate information on preventive services could increase utilization. Patient navigators or CHWs are extremely valuable nonphysician providers who have built trust in the communities they serve. These providers can help reduce community distrust in medical practices and conduct outreach to schedule screening appointments for hard-to-reach populations. Evidence shows that CHWs can serve as effective liaisons, improving the uptake of preventive care by providing education and coordinating services within the patient's community.

The 2024 Medicare Physician Fee Schedule included Medicare Part B coding and payment changes to allow Medicare-billing providers to be reimbursed for CHI with trained auxiliary personnel, such as CHWs.[7] Although this is an important step forward, this reimbursement pathway does not directly reimburse the auxiliary personnel. Many CBOs, CHWs, and other nonphysician providers still rely on contracts with billing providers, which limits the utility of these valuable community assets.

PAYMENT AND INCENTIVES FOR PROVIDERS AND BENEFICIARIES

Recommendation 2.1: Align Clinician and Patient Incentives for Screening

Address barriers that dampen AWV; embed per-screen bonuses in MIPS, ACO benchmarks, and MA quality bonus pools; and ensure MA reward and AWV HRA tie to the actual delivery of preventive services.

The AWV has been available with no cost-sharing since 2011;[8] however, rigid coding, frequency limits, and exhaustive documentation have dampened clinician enthusiasm, resulting in uptake for only about half of all Medicare beneficiaries.[9]

Beyond the AWV, CMS could be given authority to embed per-screen bonuses in the MIPS,[10] ACO benchmarks, and MA quality bonus pools, rewarding practices whose breast or colon cancer screening rates exceed risk-adjusted targets.[11]

MA organizations are increasingly linking reward balances to patients to encourage the completion of screenings, medication adherence, and disease management milestones. In traditional Medicare, HRAs are part of AWV, collecting beneficiaries' characteristics and health status.[12] The use of such

incentives and rewards will be beneficial for preventive screening uptake when CMS ensures that the assessment results in actual delivery of preventive services.[13]

Recommendation 2.2: Scale Care Management Services

Expand CCM and deploy PCM and RPM in a single, complex, chronic condition to detect decompensation early.

Introduced in 2015, CCM reimburses clinicians for non-face-to-face coordination among beneficiaries with multiple chronic conditions. After CMS introduced new Current Procedural Terminology codes for additional service time and raised reimbursement rates by increasing the underlying Work Relative Value Units in 2022, code utilization climbed 7.4 percent annually from 2019 to 2023.[14] Evaluation shows that CCM lowered expenditures by $28 per beneficiary per month at 12 months and by $74 at 18 months, primarily through fewer emergency visits and hospitalizations.[15]

For beneficiaries whose primary risk stems from a single, complex, chronic condition, such as heart failure, hypertension, or diabetes, PCM codes fund intensive management by the most relevant clinician. In contrast, RPM codes reimburse the review of blood pressure, glucose meter, or continuous glucose monitor data. Ensuring that hypertension clinics and diabetes educators utilize these services systematically would enable the detection of decompensation early and prevent costly, severe health outcomes.

QUALITY AND ACCOUNTABILITY

Recommendation 3.1: Promote Outcome-Based Savings

Authorize wider shared-savings arrangements across Medicare by aligning with the Medicaid Core Set outcomes, such as avoidable hospitalization.

In 2023, Shared Savings ACOs reported a record $2.1 billion in net savings, following statistically significant improvements in diabetes and blood pressure control, breast cancer and colorectal cancer screening, screening for future fall risk, statin therapy for prevention and treatment of cardiovascular disease, and depression screening and follow-up.[16] Oregon's Coordinated Care Organizations demonstrate similar potential on the Medicaid side, achieving $2.2 billion in savings over seven years of implementation. CMS can authorize wider shared-savings arrangements, allowing plans or ACO-like entities to retain a portion of avoided admissions and reinvest those funds in further preventive infrastructure.

Low volumes make statistical reliability challenging for rural clinics. CMS has acknowledged unique issues with quality measurement in rural settings and is funding efforts to identify scientifically valid measures tailored for rural providers.[17] The agency could be authorized to require that all MA Star Rating and ACO Shared Savings data be publicly stratified by geography, so that underperformance remains visible, allowing states to target technical assistance.

Recommendation 3.2: Integrate Broader Preventive Metrics Across Programs

Continuously enforce 2024 state reporting of the Adult Core Set and align ACO benchmarks and MA Star Ratings on similar measures that spur case management, home visits, and predictive analytics.

Beginning in 2024, every state must report the Adult Core Set, which tracks HbA1c control, blood-pressure control, asthma medication adherence, and hospitalizations and admission rates for ambulatory care-sensitive conditions as part of the quality measure.[18] Many states already impose pay-for-performance or withhold arrangements tied to these metrics. Both the ACO benchmark and the MA Star Rating also track similar metrics, which could potentially prompt MA plans to fund case managers, home visits, and predictive analytics that avert deterioration.[19]

In addition to the current preventive metrics indicated, MA Star Ratings and ACO benchmarks can also include obesity assessment, kidney function surveillance, and cognitive screening—conditions that often overwhelm senior health yet remain undermeasured[20]—to both programs, aligning quality-related incentives with the current disease burden.

INTEGRATED CARE

Recommendation 4.1: Integrate Care Across Diverse Settings

Require MA and Medicaid plans to participate in health information exchanges.

Fragmentation among specialists, hospitals, and post-acute care providers undermines the stability of chronic disease management. CMS can require MA and Medicaid plans to share real-time admission and discharge alerts with primary care teams, as some states mandate that plans contribute data to health information exchanges or embed care managers within high-volume hospitals to orchestrate early follow-up.[21] Behavioral health screening and treatment should become standard components of chronic disease workflows because untreated depression or anxiety accelerates physical decline. Expectations can be enforced through quality measures.

Recommendation 4.2: Scale Specialized Plan Options for High-Need Conditions

Facilitate growth of C-SNPs when they confirm improvements and refine Dual-Eligible SNP rules to increase accountability through the full continuum of care.

Medicare's C-SNPs already tailor benefits and networks to diagnoses such as heart failure, chronic obstructive pulmonary disease (COPD), diabetes, renal failure, and dementia. Condition lists are reviewed periodically; when evaluations confirm improvements—better glycemic control

among diabetic C-SNP members, for instance—CMS can facilitate C-SNP growth, allow Medicaid managed-care organizations to create analogues, and align quality measures across platforms.

Capitated Medicare-Medicaid Plans in the Financial Alignment Initiative coordinate benefits for dual-eligible beneficiaries, many with multiple chronic diseases. Early evidence suggests a better patient experience and lower hospital utilization in several states. CMS can translate those lessons into enduring national policy by refining Dual-Eligible SNP rules or launching new, unified programs, so that one entity becomes accountable for the entire continuum of care, support, and outcomes.

Addressing Health-Related Social Needs to Enhance Prevention Health Outcomes

The clinical strategies outlined in the preceding section cannot succeed at scale unless those clinical strategies are paired with efforts to address the HRSN that shape people's ability to sustain healthy lives. In addition, when HRSN are not secured, when communities are experiencing poor transportation, food insecurity, and housing instability, it derails chronic disease early screening and long-term self-management and contributes to more adverse health outcomes.

The stakes are highest in rural America, where poverty rates are higher, access to grocery stores is limited, public transit is scarce, and communities experiencing food insecurity are at a higher rate (more than 90 percent of counties in the US with the highest food insecurity rates are rural). CMS can leverage existing authorities—without expanding bureaucracy—to clear these roadblocks, so that the early screening and chronic disease management agenda flows seamlessly into daily life.

LEVERAGING EXISTING CMS TOOLS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Recommendation 5.1: Fast-Track Targeted Medicaid Waivers to Remove Barriers in Rural America

Approve waivers for health-related social needs and consider permanent coverage of high-value services or requiring managed-care plans to provide nutrition and transport for documented needs.

Even the best clinical care fails if people cannot reach the clinic, access healthy food, or find a safe place to live. Nonmedical barriers—such as poor transportation, housing instability, and

food insecurity—are leading drivers of costly hospitalizations and emergency rooms.[22] For rural Americans, these challenges are magnified by geography and limited infrastructure.[23]

Nearly 90 percent of counties experiencing the highest food insecurity are rural.[24] Rural communities face higher poverty rates, more limited grocery store access, and a lack of public transportation. These are proud, self-reliant communities, but the deck is stacked against them when basic logistical hurdles block access to preventive care.

Rather than creating new pathways, CMS can deploy existing tools—such as waivers, pilot programs, and public–private partnerships—to efficiently remove these barriers. In North Carolina, a Medicaid 1115 waiver was approved in 2018 and has been utilized to test a targeted approach, providing time-limited, evidence-based services, such as meal delivery or transportation, to individuals with chronic conditions.[25] Early results show fewer ED visits and lower hospital costs, proving that a smarter safety net can reduce long-term government spending while promoting individual responsibility.[26]

Medicaid often serves a high-need population that includes low-income families, seniors, and individuals with disabilities. For many, it is the only coverage option that provides supplemental services such as long-term care or help navigating chronic conditions. Medicaid has an incentive to invest in long-term prevention strategies, which can be a practical platform for targeted interventions that reduce downstream costs by addressing social barriers to health.

Under recent 1115 waivers in states like North Carolina and Oregon, states cover nontraditional services—such as housing supports, medically tailored meals, and home modifications—that have been rigorously evaluated to demonstrate a reduction in hospitalizations and improve care continuity.[27] CMS can quickly green-light additional waivers focusing on rural populations, such as nonemergency transportation in remote counties and healthy food boxes for people with diabetes.[28] Based on the presented positive outcomes from evaluation, CMS and Congress could allow states to permanently cover high-value services, such as medically tailored meals, or require managed-care plans to provide nutrition and transportation for members with documented needs.

Recommendation 5.2: Leverage Medicare Pathways to Address Social Needs

Encourage MA supplemental benefits by adjusting benchmarks or risk adjustment for social risk and establishing CMMI pilots with flexible capitated payments for low-cost, high-impact items, such as air conditioners for COPD and CHW visits.

In Medicare fee-for-service, addressing HRSN is more challenging because the program generally cannot pay for nonmedical services without legislative change. However, MA plans have new flexibility under the CHRONIC Care Act of 2018 to offer SSBCI that address HRSN and improve outcomes for chronically ill members.[29] Many MA plans now provide meal delivery, healthy food allowances, transportation to medical appointments, and home support services for eligible beneficiaries.

CMS can further encourage MA plans to tailor these benefits by adjusting payment benchmarks or risk adjustment to account for social risk factors so that plans serving high-need rural areas are adequately funded. For beneficiaries in traditional Medicare, the CMMI could test a pilot program, such as models through hospitals or ACOs, that receive a flexible capitated payment, which they may spend on low-cost, high-impact items such as air conditioners for COPD patients or CHW visits for isolated seniors.

Recommendation 5.3: Scale Linkage to Community Service

Build on the AHC model by seeding hospital–public health–nonprofit partnerships that both identify and fund necessary services, with tracking outcomes and evidence of reduced inpatient admissions.

A notable CMMI pilot, the AHC model,[30] recently tested screening Medicare and Medicaid patients for social needs and referring them to community resources. While the AHC model focused on referral rather than direct funding of services, it underscored the importance of linking clinical care with community services. Building on its lessons, CMS could seed rural consortia of hospitals, health departments, and nonprofits that not only identify needs but also fund the services themselves, such as transit vouchers when transportation is lacking or Meals on Wheels when food insecurity is detected.

The demonstration could measure outcomes such as screening adherence, HbA1c, blood pressure trends, and acute care utilization, which would parallel the chronic disease outcomes measures mentioned in the earlier section. Evidence from medically tailored meal studies—up to 50 percent fewer inpatient admissions—suggests such consortia could quickly pay for themselves.[31]

CROSS-SECTOR PARTNERSHIPS

Recommendation 6.1: Coordinate Cross-Agency Supports and Financing

Convene and align the US Department of Agriculture (USDA) food assistance, the US Department of Transportation (DOT) transit, and the US Department of Housing and Urban Development (HUD) housing programs with CMS to create pilots for long-term sustainable financing and a framework toward the most cost-effective mix of medical and social services.

CMS does not need to resolve such social drivers of health alone; instead, it should convene and align existing programs across the federal government to drive maximum impact. Currently, states administer multiple federally funded programs that originate from different federal agencies, with varying measured objectives and distinct administrative requirements, yet the programs share similar goals. CMS could better coordinate across agencies and programs, such as food assistance programs at USDA, road and public transit investments at DOT, and housing assistance at HUD.

Better coordination of Medicaid benefits with USDA food programs, such as Supplemental Nutrition Assistance Program (SNAP) and SNAP for Women, Infants, and Children, can create efficiencies—ensuring individuals have access to food through programs with lower marginal costs to operate. Likewise, CMS could encourage that some of the upfront investment given to rural ACOs be used to collaborate with local social service providers, as explicitly allowed in the new ACO investment model, where funds can be allocated toward patients' food, housing, or transportation needs.

By explicitly incorporating social supports into preventive health policy, CMS would enable a more holistic approach, which is especially needed in rural communities. These interventions have immediate effects and create long-term improvements. The short-term strategy involves testing and refining these approaches through waivers and pilot programs in interested states and plans. The long-term goal is to establish a sustainable framework that allocates health-care dollars to the most cost-effective mix of medical and social services, promoting overall health.

Conclusion

The path to prioritizing prevention does not hinge on new authorities. It depends on the disciplined execution of those already available. CMS can move to consistent, measurable progress by sequencing near-term actions and partnering closely with states, plans, providers, and community organizations.

In the next phase, sustaining comprehensive telehealth options—including audio-only where appropriate—will keep routine preventive visits within reach for beneficiaries who face distance, broadband, or mobility barriers. Strengthening trusted, local outreach through CHWs—building on the CHI policy—will help translate coverage into completed care. Payment should reinforce this emphasis on vigilance. Streamlining the AWV and aligning modest incentives with closed screening gaps can focus clinical attention where it matters, while the broader use of CCM, PCM, and RPM enables earlier intervention for high-risk patients. Evaluations already show reductions in emergency visits and hospitalizations, as well as associated savings.

Accountability can be strengthened without adding a burden by expanding shared-savings arrangements that reinvest in avoided admissions and by publicly stratifying key measures—especially for rural settings—so that performance is visible, and assistance can be targeted. Finally, clinical gains will endure only if practical barriers are addressed. Existing Medicaid waivers and MA supplemental-benefit flexibilities allow targeted support for housing, nutrition, and transportation, and the AHC model offers operational lessons for linking care with community services and tracking outcomes. Cross-agency coordination can help states braid resources where evidence is strongest.

By phasing these steps, publishing clear metrics, and maintaining close federal–state alignment, CMS can make prevention the default experience, advancing health outcomes, strengthening equity in rural and underserved communities, and supporting program sustainability.

The Milken Institute is uniquely positioned to transform these recommendations from paper to practice. By convening federal and state officials, health plan leaders, provider systems, and community organizations, the Institute can facilitate cross-sector dialogue that moves pilot successes to a national scale. We look forward to expanding this work by lifting state success stories and showcasing the return on investment from these innovative models.

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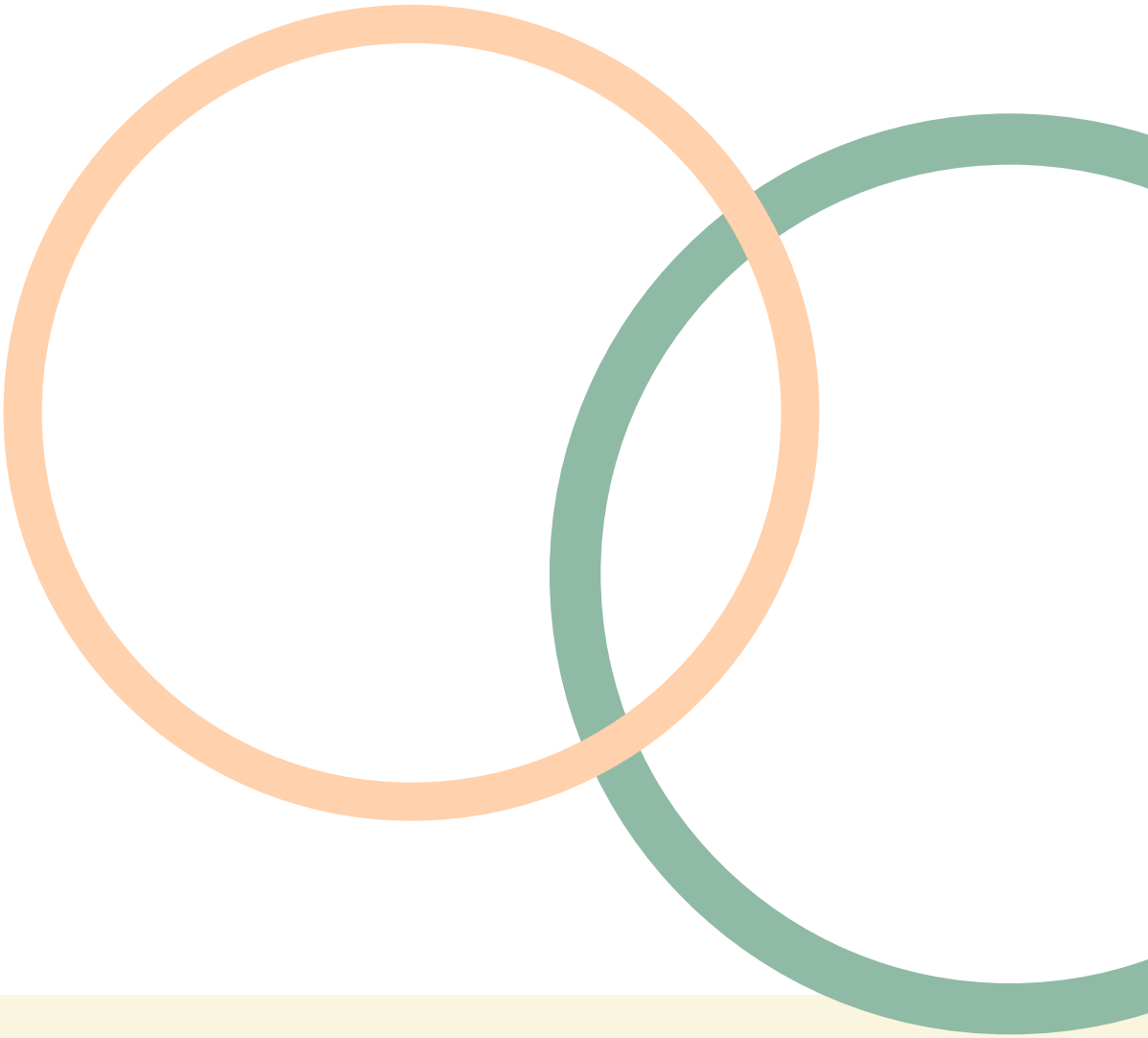

About the Authors

June Cha, PhD, is the policy director at FasterCures, Milken Institute Health. She brings two decades of leadership experience spanning infectious disease research, nonprofit and multilateral organizations, the US government, and the pharmaceutical industry. Her expertise encompasses medical product research and development, as well as pharmaceutical regulatory laws, regulations, and policies. She is leading policy efforts aimed at accelerating biomedical innovation and access, as well as promoting a prevention-first approach to health care.

Cha has advised the Bill & Melinda Gates Foundation and the African Union Development Agency on expanding a continental pharmacovigilance platform, and in the industry, has shaped evidence-based regulatory policy in partnership with academia, trade associations, and federal agencies. Earlier, as a public health advisor at the US Department of Health and Human Services, she directed strategic planning to advance women's health priorities. She began her policy career by championing efficient HIV-prevention policies for mothers, infants, and children in sub-Saharan Africa. Cha holds a PhD in biochemistry (infectious diseases) from the University of Notre Dame and an MPH in global public health leadership from New York University.

Kody Kinsley served as North Carolina's 18th Secretary of Health and Human Services under Governor Roy Cooper, unanimously confirmed by the North Carolina Senate. Throughout his tenure, he focused on making health care more affordable and accessible for all North Carolinians, including those in underserved, overlooked rural areas. Kinsley played a pivotal role in expanding Medicaid through bipartisan collaboration with the General Assembly, resulting in over 600,000 North Carolinians gaining coverage in the first year—twice the expected pace. He secured one of the largest behavioral health investments in state history—$835 million—and major policy reforms to expand access to mental health and substance use services. He implemented North Carolina's groundbreaking Health Opportunities Pilots—the nation's first large-scale experiment proving that paying for nonmedical health needs, like food and housing, improves health and lowers costs. In partnership with all of the state's hospitals, Kinsley provided $4 billion in medical debt relief for 2 million North Carolinians. His career includes roles at the White House, the US Department of Health and Human Services, and the US Department of the Treasury, where he was appointed by President Barack Obama and continued under President Donald Trump as assistant secretary for management. Kinsley currently serves as a senior advisor at the Milken Institute, senior policy advisor at Johns Hopkins University, and is a fellow of the Aspen Institute. He holds a Master of Public Policy from the University of California, Berkeley.

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