Medicaid Funding of Community-Based Prevention

Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models

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About Nemours

Nemours is an internationally recognized children's health system that owns and operates the Alfred I. duPont Hospital for Children in Wilmington, Delaware, along with major pediatric specialty clinics in Delaware, Florida, Pennsylvania and New Jersey. In October 2012, we opened the full-service Nemours Children's Hospital in Orlando, Florida. The Nemours promise is to do whatever it takes to treat every child as we would our own. We are committed to making family-centered care the cornerstone of our health system.

Established as The Nemours Foundation through the legacy and philanthropy of Alfred I. duPont, Nemours offers pediatric clinical care, research, education, advocacy and prevention programs to families in the communities we serve. We leverage our entire system to improve the health of our communities by creating unique models, creating new points of access and delivering superlative outcomes. Our investment in children is a response to community health needs as Nemours aims to fulfill our mission to provide leadership, institutions and services to restore and improve the health of children through care and programs not readily available.

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Executive Summary

Chronic disease is a significant driver of health care costs in our nation. Federal and state policymakers, health system leaders and others have embraced the goals of improving health, reducing costs and improving the patient experience of care – the Three Part Aim.[i] Prevention strategies can play an important role in achieving these goals.

The Medicaid program stands to benefit from successful prevention strategies because of its disproportionate spending on chronic conditions. The complexity of Medicaid program rules can make financing of some prevention initiatives through Medicaid seem difficult or impossible, leading to myths about what Medicaid can cover. Some states have overcome these challenges to secure Medicaid financing. Other states are making bold new changes to their Medicaid programs that adopt integrated payment reforms which potentially create an environment that encourages a broad range of prevention strategies.

Myths about Medicaid Financing of Prevention

The complexity of Medicaid program rules and some features of prevention initiatives lead to myths about what federal rules will allow Medicaid to cover. Some of the features of prevention initiatives that make it difficult to fund through Medicaid include the use of non-traditional providers or care settings, non-statewide programs or population-based approaches.

Some states have demonstrated success in navigating Medicaid rules to finance prevention initiatives and have been very adept at using Medicaid as part of a braided funding stream to support broad health goals.

Presented below are key myths about Medicaid financing of community-based prevention and state examples that debunk these myths.

1. **Myth:** ***Medicaid Can't Pay for Nontraditional Providers***
   Example*: Medicaid Coverage of Community Health Workers*

   Some prevention initiatives rely on new types of providers (such as Community Health Workers (CHWs)) who have not typically been recognized for purposes of reimbursement by Medicaid, Medicare or commercial insurers. Federal Medicaid statute requires that preventive services be recommended by a physician or other licensed practitioner. Current regulations require that services be provided by or under the direction of a physician or other licensed practitioner; however, CMS recently proposed revised regulations that would give states the ability to recognize unlicensed practitioners in the delivery of preventive services. The reality is that while some states have been able to navigate existing Medicaid rules to cover nontraditional providers, it is challenging. Minnesota allows CHWs to reimburse for services through its State Plan, and New Mexico is requiring managed care plans to provide CHW services.

2. **Myth:** ***Medicaid Can't Pay for Services Provided in Nontraditional Settings***
   Example*: Medicaid Coverage of Home Visiting*

   Some prevention initiatives are provided in community settings and are outside traditional health care settings. Current Medicaid authority allows states to support prevention, health education and counseling regardless of whether these services are delivered in a medical office or clinic, the patient's home, or a community-based setting, such as a child care center. The reality is that several states have been successful in providing comprehensive home visiting programs under their Medicaid program. Michigan's Maternal and Infant Health Program (MIHP) is one of the largest programs financed through direct reimbursement under the traditional Medicaid plan. Other states, such as Kentucky, have used Targeted Care Management to secure Medicaid financing for home visiting. In Minnesota, home visiting is provided as an additional benefit by all 12 managed care organizations. The challenge is that the location of service is often a focal point in the development of these models of care, which can create confusion about what Medicaid will cover. The focal points for the purposes of Medicaid reimbursement must be the specific definition of the services, the qualifications of the providers and who is eligible to receive the service and under what circumstances.

3. **Myth:** ***Medicaid Can't Pay for Non-Medical Services***
   Example*: Medicaid Coverage for Remediation of Environmental Factors*

   The Medicaid statute defines a list of required health care services that states must offer and optional health care services that they may choose to offer. For children, the Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) is a required benefit, requiring coverage for screening and diagnostic services and "health care, treatment, and other measures to correct or ameliorate any defects or chronic conditions."[ii] Effective health care delivery often requires addressing environmental factors that are not traditionally seen as health care delivery. Some states have adopted Bright Futures as the standard for child health or used it as a framework to improve Medicaid and EPSDT services for children. The Bright Futures Guidelines are based on a model of health promotion and disease prevention and address a comprehensive range of services. The reality is that some states have been able to use Medicaid to cover non-medical services that have a health care benefit. Rhode Island's coverage of lead abatement and Massachusetts' Pediatric Asthma Pilot Program demonstrate how the definition of Medicaid benefits can be used to provide Medicaid coverage for remediation of environmental threats for Medicaid eligible children. The challenge is defining which non-medical services may be covered and how, as well as making the case for coverage.

4. **Myth:** ***Medicaid Only Pays for Services to Medicaid Enrolled Individuals***
   Examples***: Medicaid Coverage of Services to Parents and Outreach to Eligible Populations***

   Medicaid services may only be provided to individuals enrolled in Medicaid. The reality is that in some instances, states have defined who benefits from the service more broadly. For example, Illinois has provided mental health screening to parents of children enrolled in Medicaid even though the parents are not enrolled because there is evidence that parental mental wellness is associated with a child's health and development.[iii] In addition, some states like Virginia have used Medicaid and CHIP to fund outreach to eligible populations. The challenge is navigating Medicaid rules to define who benefits from services.

5. **Myth:** ***Medicaid Can't Pay for Benefits that are Offered on a Non-Statewide Basis***
   Examples***: Medicaid Coverage of Local Initiatives***

   Community-based prevention strategies often develop out of local community initiatives and are funded at the local level. When policymakers look to Medicaid financing, they can be challenged by trying to make a local model apply across a statewide program. Medicaid is a statewide program, and traditionally Medicaid is required to offer the same services throughout the state. The reality is that there are several federal options for states to use to provide services in limited geographic regions. Orange and Alameda Counties in California are examples of where Medicaid has supported locally based service delivery. Both County initiatives stem from California Proposition 10, which encouraged local decision making and flexibility in the delivery system. The challenge is working with state Medicaid leaders on the complexity of starting up a local program.

Funding Prevention through Managed Care and Integrated Payment Models

Almost three out of four Medicaid beneficiaries are enrolled in managed care models, and virtually all states have some type of managed care model in their Medicaid program. The Medicaid expansion under the ACA is likely to increase the number of members who receive care through a managed care organization because coverage is expanding to the types of populations who are already enrolled in managed care in many states. Further, the ACA has opened the door to demonstrations that embrace newer integrated payment models that in many cases share savings with plans and/or providers.

Medicaid managed care has a long history, and some state managed care programs are quite mature. Risk based managed care payments can create a powerful incentive for plans to offer outreach, prevention or management programs that can avoid high cost chronic care. States' long history with Medicaid managed care may provide some lessons for how new integrated payment models may overcome barriers to financing community-based prevention.

In addition to Medicaid managed care models, there is focused attention on payment reforms to lower costs, improve outcomes and improve the patient experience of care under health reform. The Center for Medicare and Medicaid Innovation (CMMI) has offered a number of opportunities to states and others to reform the delivery system. These strategies use payment reforms to integrate payment between payers and providers to align incentives to improve health and reduce costs. These payment models include shared savings models and bundled payments. If these reforms successfully align payment incentives with improved health outcomes, they will create the opportunity for prevention programs that can demonstrate improved care and savings.

Some states are encouraging the development of care coordination strategies in their Medicaid program. CMMI encouraged states to pursue bold new payment models and population health improvements through the State Innovation Models initiative (SIM).

The opportunity to support a broad spectrum of prevention services through managed care and newer integrated payment models is significant. The larger number of Medicaid enrollees served by Managed Care Organizations (MCOs) coupled with financial incentives that would benefit payers and providers for investing in prevention make it highly relevant to consider how prevention services can be financed this way. One of the critical determinants of whether these new payment reforms can be successful in achieving their population health goals is how they are evaluated and encouraged going forward.

Integrator Role in Prevention Initiatives

Dispelling myths about Medicaid financing and fully leveraging it as part of efforts to achieve the Three Part Aim requires an understanding of the complexity of Medicaid and new payment reforms to finance community-based prevention strategies. However, there is an equally important policy development process that is essential to bridging the different environments of Medicaid policymakers and public health leaders to achieve health system transformation.

While the research for this paper focused on the policy levers states used to secure Medicaid financing of community-based prevention, it became clear that the successful efforts to bridge Medicaid and broad health system goals did not happen in a vacuum. There is a unique role for "integrators" - individuals or organizations that can bridge Medicaid, public health and child welfare to provide sustained leadership and champion progress.[iv] Nemours built upon the integrator concept in the paper "Integrator Role and Functions in Population Health Improvement Initiatives."[v] Leveraging Medicaid to fund community-based prevention requires developing significant programmatic details and requires leaders who can drive a sustained partnership between Medicaid and public health. Integrators can navigate the different programmatic requirements, understand data and still see the big picture in order to move positive systems change forward in implementing prevention initiatives. The myths identified in this paper all present potential areas where integrators can navigate challenges in leveraging Medicaid funds for prevention.

Whether it be the example of the long-term effort and process in Minnesota to build the CHW workforce by standardizing training curriculums or the capacity building of organizations like First 5 Alameda to help community based organizations successfully bill Medicaid, the ability to understand how Medicaid can be used and sustained leadership were vitally important to implementing and sustaining progress.

Conclusions and Policy Recommendations

Medicaid funding for community-based prevention services has an important role to play in achieving the transformation of our health care financing and delivery system necessary to achieve the Three Part Aim. The findings in this paper reveal that federal and state policymakers can benefit from dispelling long-held myths, learning how states have been successful in supporting community-based prevention through Medicaid, and recognizing their challenges. States have used different Medicaid financing authorities to successfully secure Medicaid funding for community-based prevention. Integrated payment mechanisms, such as managed care or global payments, hold promise for recognizing the potential of prevention to improve the health of Medicaid enrollees and bend the cost curve, but only if they evaluated in a timeframe that allows the benefits of prevention to be realized. The goals of Medicaid and public health are increasingly aligned. However, leveraging Medicaid to fund community-based prevention requires regulatory flexibility and policy guidance from CMS in addition to partnership with states to develop significant programmatic detail to overcome current myths. It also requires integrators, who can drive a sustained partnership between Medicaid and organizations focused on public health. Implementing the recommendations below will help health care transformation efforts take shape and spread so that the entire population benefits.

Policy Recommendations

The following are strategies policymakers should consider in order to increase opportunities to expand community-based prevention with Medicaid funding to Medicaid beneficiaries. These strategies would help reduce barriers, dispel the myths identified earlier in this paper, and maximize the promise of integrated payment systems to improve health and lower costs.

1. **CMS should adopt as final the proposed revisions to current regulations to provide for Medicaid coverage of preventive services "recommended by a physician or other licensed practitioner."** This regulatory change would permit states to recognize unlicensed providers for reimbursement purposes in the delivery of preventive services as long as a service was recommended by a physician or other licensed provider. This change would make it easier for states to expand access to preventive services provided by nontraditional providers such as CHWs. It also is important to note that this proposed revision would help to

make this regulatory provision better reflect the language of the Social Security Act. [vi]

2. **CMS should provide policy guidance to states to dispel all of the myths identified in this paper.** As part of the state-federal partnership in administering the Medicaid and CHIP programs, CMS policy guidance is crucial to ensuring clarity, fostering innovation, sharing evidence-based best practices, and encouraging coverage of community-based prevention services. For example, guidance on the types of non-medical services that may be covered is particularly important because of the significant influence of environmental factors on health. CMS guidance in this area should build upon Bright Futures and the Guide to Community Preventive Services, recommending its adoption by states as a standard of care for children enrolled in Medicaid and CHIP. Given the complexity of Medicaid, states look to CMS for guidance on what is permissible under federal law. When CMS provides guidance, it focuses the attention of states and others on the possible use of Medicaid financing. Guidance can serve as an invitation for states to pursue initiatives, giving them permission and direction to test new approaches.

3. **CMS should translate the lessons from the innovation of CMMI awardees into new policy and practice by adopting new policy that reflects the lessons and disseminating both the lessons learned and updated guidance to states about what is working well and what federal authority allows.** The ACA has created many opportunities for innovation, especially through CMMI. These new initiatives are designed to test new approaches to payment and health care delivery that can inform future policy and practice. As we learn more about successful models from the many new initiatives under health reform, CMS and CMMI should harness the lessons learned and encourage their take up by working to adopt new policy and providing clear guidance and encouragement to states. The new payment reforms and innovations hold great promise, but that promise can only be recognized if the lessons are quickly turned into policy for the Medicaid program.

4. **State and federal policymakers should foster partnerships between public health and Medicaid leaders to encourage collaboration to increase investments in community-based prevention services**. While the goals of public health and Medicaid are increasingly aligned, population-based models and medical models are still two distinct approaches. Public health and Medicaid leaders often have different programmatic experiences and perspectives on budgeting, policy development and implementation. Bridging these worlds to achieve a highly coordinated health care financing and delivery system requires partnership. Bringing these leaders together through collaborative policy

development or shared learning communities could encourage partnership and support to continue to empower these leaders.

5. **CMS should test the concept of financing integrators that lead efforts to integrate Medicaid and public health to achieve common goals**. It takes leadership and sustained effort to think creatively about how Medicaid financing can be leveraged to support common goals of improving health. Medicaid's complexity requires leaders who are capable of identifying systematic issues and opportunities across Medicaid, public health and child welfare. These leaders can be characterized as integrators because of their ability to coordinate across programs. Effective leaders are able to champion initiatives and figure out how to better align Medicaid and public health, as well as leverage funding in a coordinated way from both sources to support prevention initiatives. Recognizing the value and importance of integrators is critical, and allowing this function to be supported with Medicaid funds would be valuable.

6. **CMS should evaluate integrated payment models over a longer period of time to give prevention strategies (such as obesity prevention) time to demonstrate return on investment and support actuarial analyses of prevention.** CMS has provided a number of ways that states and others can test innovative approaches to financing and delivery of care that result in better health, better care and reduced costs. However, these initiatives are evaluated in ways that may encourage more investment in management of chronic care, rather than population-based strategies. The short timeframe for evaluation misses the opportunity to benefit from primary prevention that could have the most significant long-term impact. CMMI should support actuarial analyses of integrated models of prevention over a long timeframe to better understand how to evaluate the costs, benefits, and savings achieved through prevention initiatives.

7. **CMS should provide pathways for incremental reforms that may help states achieve the long-term goals of delivery reform and population-based health**. The ACA has provided many opportunities for states to think boldly about reform of payment and delivery systems. But for states that are not ready to take on significant health system reforms, there may not be a clear path for incremental steps to use Medicaid to fund population-based prevention initiatives. CMS should consider providing opportunities to innovate under current law, waivers or demonstrations in the context of smaller and more incremental reforms, similar to the SIM or the Health Care Innovation Challenge. Such opportunities could include testing innovative ideas in sub-regions of a state to mitigate perceived risks.

Introduction

Chronic disease is a significant driver of health care costs in our nation. Federal and state policymakers, health system leaders and others have embraced the goals of improving health, reducing costs and improving the patient experience of care – the Three Part Aim.[vii] Prevention strategies can play an important role in achieving these goals.

The Medicaid program stands to benefit from successful prevention strategies because of its disproportionate spending on chronic conditions. The complexity of Medicaid program rules can make financing of some prevention initiatives through Medicaid seem difficult or impossible, leading to myths about what Medicaid can cover. Some states have overcome these challenges to secure Medicaid financing. Other states are making bold new changes to their Medicaid programs that adopt integrated payment reforms which potentially create an environment that encourages a broad range of prevention strategies.

This paper describes several key myths about Medicaid financing of prevention and highlights successful efforts by states to fund prevention initiatives through Medicaid, largely focusing on initiatives for children. The paper also discusses the potential for integrated payment reforms to support prevention. Finally, it offers conclusions and recommendations for state and federal policymakers to encourage the use of Medicaid financing of a broad range of prevention initiatives.

Background: Medicaid Coverage of Prevention

Medicaid covers many preventive services and is particularly comprehensive for children under the age of 21 because of the broad protections of the Early and Periodic Screening Diagnosis and Treatment Program (EPSDT). EPSDT requires coverage for screening and diagnostic services and "health care, treatment, and other measures to correct or ameliorate any defects or chronic conditions."[viii] It requires states to provide children with periodic screening, vision, dental, and hearing services. EPSDT also requires states to provide any medically necessary service discovered by the screening services, whether or not such services are covered under the state's Medicaid State Plan.[ix] Services must be available to all Medicaid enrollees under 21 on a statewide basis.

Medicaid coverage for preventive services for adults is generally considered optional, but most states provide coverage. The federal law defines preventive services as "including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[x]

States have the flexibility to define the provider qualifications, settings, payment systems and performance criteria for these services in their State Plan. The Kaiser Commission on Medicaid

and the Uninsured and Health Management Associates recently conducted a study that found 44 states reported covering at least 30 of the 42 prevention services asked about in their survey.[xi] The Affordable Care Act (ACA) further encourages states to offer preventive services to adults. It requires coverage for tobacco cessation programs for pregnant women. It provides for enhanced federal matching funds in 2013 if states provide the preventive services recommended by the US Preventive Services Task Force and vaccines recommended by the Advisory Committee on Immunization Practices without imposing cost-sharing requirements.

However, within the broad range of preventive services, in practice, Medicaid funding is generally limited to coverage of health care services provided to Medicaid enrolled individuals, by providers enrolled in Medicaid, and defined in section 1905(a) of the Social Security Act as "medical assistance." Some community-based prevention initiatives fall outside of this fundamental Medicaid framework because they target a broad population or address environmental factors or other social determinants[1] important to health.[xiixiii] Securing Medicaid financing for a broader continuum of prevention services may require re-defining prevention initiatives in the context of Medicaid – this may mean pushing the boundaries of definitions of services, enrolled individuals or qualifications of providers necessary for Medicaid enrollment, as well as where beneficiaries receive such services. It also requires an understanding of the basic framework of Medicaid, what it allows and the challenges of providing community-based prevention.

1. **Medicaid is a federal-state partnership, and there is a single state agency responsible for Medicaid operations in each state**. This means that all Medicaid policy must be developed in partnership with state Medicaid leaders. State Medicaid agencies partner with sister agencies and local officials to provide some Medicaid functions. These collaborations can be challenging because some prevention programs are community-based and unique to a local area. Medicaid financing for initiatives developed by local public health agencies requires a high degree of collaboration and partnership between state and local leaders.

2. **Medicaid is a program that pays for covered services to eligible populations, generally on an individual-basis**. Medicaid will only pay for discrete services offered to individuals enrolled in Medicaid. There is some funding for administrative activities, but for the most part, leveraging Medicaid financing requires defining new prevention initiatives as covered services to enrolled individuals or to groups of individuals. Community-based prevention initiatives are often population-based strategies, rather than individual health services, making it challenging to establish eligibility necessary for Medicaid reimbursement.

[1] Health is heavily influenced by factors outside the traditional health care realm, including education, employment, income, poverty, housing, and social networks.

3. **Medicaid services must be defined in the context of federally-defined required and optional benefits**. Federal rules define categories of required and optional benefits. Covering new prevention initiatives as a Medicaid State Plan service requires specifically defining them as one of these categories of benefits.

4. **Medicaid operates under complex federal and state rules, and Medicaid reimbursement can be administratively burdensome**. Numerous federal and state rules govern exactly what can be billed and how. The documentation requirements can be administratively burdensome and potentially outweigh the advantages of leveraging Medicaid financing.

5. **Medicaid has waiver authorities and different options that allow for exceptions to the basic framework of Medicaid**. These authorities allow for Medicaid to continue to evolve and innovate, especially under growing pressures to reduce costs and improve health outcomes. There are a number of ways that states can seek exceptions to Medicaid rules that create potential opportunities to fund prevention.

Myths About Medicaid Financing of Prevention

The complexity of Medicaid program rules and some features of prevention initiatives lead to a few key myths about what federal rules will allow Medicaid to cover. Some of the features of prevention initiatives that make it difficult to fund through Medicaid include the use of non-traditional providers or care settings, non-statewide programs or population-based approaches. These myths about Medicaid coverage of prevention are discussed below:

1. **Myth: *Medicaid Can't Pay for Nontraditional Providers***
   Some prevention initiatives rely on new types of providers (such as Community Health Workers (CHWs)) who have not typically provided services reimbursed by Medicaid, Medicare or commercial insurers. These evolving professional fields can lack formal accreditation or training programs. Federal Medicaid statute requires that preventive services be recommended by a physician or other licensed practitioner. [xiv] The current enabling regulations go further, requiring preventive services be provided by or under the direction of a physician or other licensed practitioner.[xv] However, CMS recently proposed revisions to 42 CFR 440.130(c), which if finalized, would give states the ability to recognize unlicensed practitioners in the delivery of preventive services. These proposed revisions will require that preventive services be *recommended* by a physician or other licensed practitioner, rather than *provided* by them.[xvi] This regulatory change is important as it allows Medicaid financing for the services provided by these new types of professionals rather than requiring states to establish licensure standards. The latter can be a complex task, potentially raising politically contentious scope of practice issues.

Further, states' regulatory oversight of health professional is outside the purview of the Medicaid programs and often housed in separate agencies, necessitating parallel and coordinated efforts to define standards for evolving professions.

2. **Myth:** ***Medicaid Can't Pay for Services Provided in Nontraditional Settings***
   Some prevention initiatives are provided in community settings and are outside traditional health care settings. For example, health screenings provided in senior centers, nutrition counseling in a grocery store or school-based counseling services, can be important prevention services provided outside of health care facilities. Current Medicaid authority allows states to support prevention, health education and counseling regardless of whether these services are delivered in a medical office or clinic, the patient's home, or a community-based setting, such as a child care center. The challenge is that the location of service is often a focal point in the development of these models of care. The focal points for the purposes of Medicaid reimbursement must be the specific definition of the services, the qualifications of the providers and who is eligible to receive the service and under what circumstances.

3. **Myth:** ***Medicaid Can't Pay for Non-Medical Services***
   The Medicaid statute defines a list of required health care services that states must offer and optional health care services that they may choose to offer. Care coordination services are allowed under Medicaid. For children, EPSDT is a required benefit, and it requires coverage for screening and diagnostic services and "health care, treatment, and other measures to correct or ameliorate any defects or chronic conditions."[xvii] States have covered non-medical services under Medicaid for children under EPSDT when recommended by a physician. Some states have adopted Bright Futures as the standard for child health or used it as a framework to improve Medicaid and EPSDT services for children. Bright Futures, widely recognized as an evidence-driven resource for pediatricians, families and child advocates, uses a developmentally based approach to address children's health needs in the context of family and community.[xviii] The Bright Futures Guidelines are based on a model of health promotion and disease prevention and address a comprehensive range of services. States have also covered non-medical services under Home and Community Based options that are designed to support individuals in the community rather than requiring institutional care or under waivers. The challenge is defining which non-medical services may be covered and how, as well as making the case for coverage.

4. **Myth:** ***Medicaid Only Pays for Services to Medicaid Enrolled Individuals***
   Medicaid services may only be provided to individuals enrolled in Medicaid. However, in some instances, states have defined who benefits from the service more broadly. For example, some states have provided mental health screening to parents of children

enrolled in Medicaid even though the parents are not enrolled because there is evidence that parental mental wellness is associated with a child's health and development. [xix] Most states cover children at a higher income level than parents, and while pregnant women get Medicaid at a higher income level, they lose Medicaid post partum. When the ACA is fully implemented in 2014 and many states expand Medicaid coverage for adults, there will be less of a gap in coverage between children and their parents. The challenge is navigating Medicaid rules to define who benefits from services.

5. **Myth:** ***Medicaid Can't Pay for Benefits that are Offered on a Non-Statewide Basis***
   Community-based prevention strategies often develop out of local community initiatives and are funded at the local level. When policymakers look to Medicaid financing, they can be challenged by trying to make a local model apply across a statewide program. Medicaid is a statewide program, and traditionally Medicaid is required to offer the same services throughout the state. However, there are several federal options for states to use to provide services in limited geographic regions. States may offer Medicaid services on a non-statewide basis through their managed care programs, provide Targeted Case Management services in limited geographic regions, or use waiver authority to waive statewide requirements. The ACA's new Health Home option may be provided in limited geographic areas. However, Medicaid is still administered as a statewide program, sometimes making it difficult for local initiatives to be championed through Medicaid.

Debunking the Myths – State Examples of Medicaid Financing

States have demonstrated success in navigating Medicaid rules to finance prevention initiatives. Some states have been very adept at using Medicaid as part of a braided funding stream to support broad health goals. There are a few ways states have historically secured Medicaid financing for prevention. These federal authorities as well as new options available under the ACA are summarized in Table 1.

There are numerous examples of states financing prevention initiatives by leveraging Medicaid funds. Presented below are just a few examples of where states have secured Medicaid financing to debunk the myths described above. This is not meant to be a comprehensive discussion of these state efforts or a complete inventory of all state efforts. Examples that address the first three myths (coverage for nontraditional workers, coverage in nontraditional settings, and coverage for nonmedical services) are described in greater detail. Examples that address the remaining two myths are more generally discussed.

Table 1: Federal Medicaid Financing Authorities		
	Authority	Description
Pre-ACA	Medicaid Covered Service (Section 1905(a))	Medicaid allows direct reimbursement for services covered under the Medicaid State Plan. Medicaid statute defines required and optional services. Service must be offered to all recipients statewide.
	Enhanced Prenatal Benefit (42 CFR §440.250)	Allows states to provide additional services to pregnant women compared to what the state provides to other Medicaid-eligible individuals as long as the services are related to pregnancy or conditions that may complicate pregnancy.
	Research and Demonstration Waivers (Section 1115)	Broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations to further the objectives of the Medicaid program. Waivers are required to be budget neutral over 5 years.
	Managed Care Waivers (Section 1915(b))	Provides flexibility to: 1. Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits; 2. Allow a county or local government to act as a choice counselor or enrollment broker in order to help people pick a managed care plan; 3. Use the savings that the state gets from a managed care delivery system to provide additional services; or 4. Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).
	Home- and Community-Based Services Waivers (Section1915(c))	Permits states to offer a variety of long-term care services (including habilitation) in home- and community-based settings to individuals (including children) who meet an institutional level of care.
	Targeted Case Management (42 CFR §440.169 and 42 CFR §441.18)	Helps beneficiaries gain access to medical, social, educational and other services; waives rules that comparable services be offered to all enrollees statewide; allows states to specify provider qualifications.
	Administrative Case Management	Helps beneficiaries gain access to Medicaid services; may include eligibility, outreach and prior authorization.
	Managed Care	States that contract with Managed Care Organizations (MCOs) pay a capitated amount to an MCO that in turn can pay for services that are not otherwise required by Medicaid.
ACA	Section 1945 Health Home State Plan Option	Provides 90% federal matching funds for states to provide Health Home Option to coordinate care for people with Medicaid who have chronic conditions. Health Home Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support and referrals to community and social support services, and use of health information technology.
	Demonstration Opportunities under the Center for Medicare and Medicaid Innovation (CMMI)	CMMI has created new payment reform demonstrations including: Innovation Challenge Awards, State Innovation Models, Shared Savings and Bundled Payments, Pioneering ACOs. Some of these models have encouraged the use of Community Health Workers.
Table adapted from "Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges," Pew/NASHP, June 2012 and "At-a-Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid health Care Delivery or Payment," Integrated Care Resource Center, April 2012.		

Myth 1: ***Medicaid Can't Pay for Nontraditional Providers***
Example*: Medicaid Coverage of Community Health Workers*

Some community-based prevention initiatives employ new types of health professionals to provide services. Community Health Workers (CHWs) are an example of a new provider that some Medicaid programs are covering. Two examples are presented below that demonstrate CHWs can be covered under Medicaid through a State Plan Amendment or through managed care contracting.

The role of the CHW has evolved over time as the health system tries to find ways to improve outcomes and stem the growth in health care costs associated with chronic disease. CHWs have demonstrated promise in improving outcomes and reducing health care costs and are being looked to as a part of the solution to rising health care costs. CHWs are lay members of communities who are trained to provide a range of health-related services and help medically underserved individuals navigate the health system. CHWs can be paid or work as volunteers. They usually share ethnicity, language, socioeconomic status and/or life experiences with the community members they serve. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give information counseling and guidance on health behaviors, advocate for individuals and community health needs, and provide some direct services such as first aid and blood pressure screening.[xx]

The ACA recognized the value of CHWs and created new opportunities to support the development of the field. The ACA created a new grant program within the Centers for Disease Control and Prevention (CDC) to support the development of the Community Health Workforce.[xxi] Additionally, the Center for Medicare and Medicaid Innovation (CMMI) has encouraged the use of CHWs in its Healthcare Innovation Challenge Awards. The CMMI Innovation Challenge provides $1 billion for innovative initiatives including workforce development and specifically the training and use of CHWs. Several of the CMMI funded projects include support for CHWs, including the Nemours project, Optimizing Health Outcomes for Children with Asthma in Delaware. This project integrates a medical home primary care model with community-based population health to reduce asthma-related emergency room and inpatient admissions for children covered under Medicaid. The project seeks to improve population health outcomes; reduce costs that will include strategies such as deploying CHWs to serve as patient navigators and provide case management services to families with high needs; and deploy integrators who work at community level to advance promising practices and promote system-wide change to impact population health outcomes (see page 21 for a discussion of the role of integrators).

One of the fundamental challenges to increased use of CHWs for Medicaid enrollees is creating a pathway to sustainable funding. Historically, many CHWs operate as unpaid volunteers or through grant funded initiatives. CHWs focus on serving hard-to-reach populations and communities that face cultural and ethnic disparities. These same populations are often covered by Medicaid or will be covered when the ACA is fully implemented in 2014. Therefore, Medicaid reimbursement is a potential source of stable funding and critical to sustaining the work of CHWs with Medicaid enrollees.

In some ways, payment for CHWs seems incompatible with Medicaid both in what the service is and who provides it. CHWs provide services that help facilitate access to care. It can be difficult to clearly define the services provided by CHWs. Because CHWs are "lay members of communities they serve," it is difficult to meet the current federal requirements that only allow for payment for services provided by a physician or other licensed providers. CMS has recently proposed a regulation[xxii] that gives states the ability to recognize unlicensed practitioners in the delivery of preventive services as long as they are recommended by a physician or other licensed practitioner; however, states must still define what CHW services are and who may provide them.

Some states have been able to cover CHW services under current Medicaid rules. In 2007, Minnesota successfully passed enabling legislation as a part of a larger health reform plan aimed at improving health and controlling cost. In 2008, Minnesota secured a State Plan Amendment to directly reimburse CHWs under their Medicaid program. Minnesota's coverage of CHWs under Medicaid builds on long-term efforts to support the development of this new field. As early as 2000, the Blue Cross and Blue Shield of Minnesota Foundation was funding initiatives to better define the role of the emerging CHW field and build partnerships with communities, CHWs and their employers and educators. In 2004, the Minnesota State Colleges and Universities received funding to develop and implement a standardized training curriculum for CHWs through the State's community college systems.[xxiii] This long term and sustained effort to support the development of the field of CHWs and define educational requirements was important groundwork for securing Medicaid financing.

The 2007 Minnesota legislation was estimated to save state funds based on prior research measuring the return on investment of CHWs.[xxiv] The research cited was a study of Denver Health's use of CHWs. In this study, researchers found for every $1.00 investment in CHWs, there were $2.28 savings because care shifted from higher cost inpatient and urgent care settings to less expensive primary care services.[xxv] Because CHW services were found to result in savings, the State did not need to identify state matching funds to support Medicaid coverage.

The Minnesota program navigates complex Medicaid rules to cover CHW services for all Medicaid and Minnesota Care enrollees by specifically defining requirements for CHW

providers and the services they may provide. The enabling legislation provides for Medicaid coverage of care coordination and patient education services provided by a certified CHW.[xxvi] The Medicaid program description further defines CHW services as a diagnosis related, medical intervention, not a social service.[xxvii] The enabling legislation narrowly defines the CHW services that are allowed to be billed to Medicaid.

Minnesota requires eligible CHW providers to "have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the applicant has completed approved community health worker curriculum," building on the progress that had been made in Minnesota to develop standardized training curriculums.[xxviii] CHW services are only covered by Medicaid when they are provided and billed under the supervision of physician, registered nurse, advanced practice registered nurse, mental health professional or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government. These requirements were critical at the time to meeting current Medicaid requirements that services be provided by a physician and or other licensed provider. However, there may be more flexibility for states in how they reimburse CHWs should the proposed rule on 42 CFR 440.130(c) become effective.

The Minnesota CHW Alliance estimates that over 500 CHWs have graduated from the certification program. However, only about 30 CHWs are enrolled and active in the Medicaid program. The CHWs who are enrolled in Medicaid are employees of health clinics. There are a number of CHWs who work outside of traditional health care settings and provide a broader range of service. The Medicaid coverage of CHWs was narrowly defined to fit into Medicaid's medical model of financing. It suggests that Medicaid reimbursement does not necessarily mean opening the door to financing an entire existing workforce or that it may take time for new providers to prepare to bill Medicaid.

Other states have covered CHWs under their Medicaid Managed Care program. In New Mexico, the Coordinated Systems of Care Community Access Program of New Mexico (CSC-CAPNM) partnered with one of the largest Managed Care Organizations (MCOs), Molina Health Care, to pay for CHWs who work at the CSC-CAPNM provider sites. Molina worked with the State Medicaid office to establish a billing code for the CSC-CAPNM program to provide CHW services. This allowed Molina to have a specifically identified reimbursement code to reimburse CHWs and track utilization. Molina contracts with CHWs in all 33 New Mexico counties. Molina offered these services as a voluntary, value-added benefit, meaning they were not a required service and funding was not built into the capitation rate paid to Molina by the State. New Mexico is currently re-contracting their managed care program and has made CHW services a requirement for all MCOs.[xxix]

Minnesota and New Mexico have covered CHWs within existing Medicaid authority and demonstrated how states can cover nontraditional health care providers under Medicaid.

Myth 2: ***Medicaid Can't Pay for Services Provided in Nontraditional Settings***
Example*: Medicaid Coverage of Home Visiting*

Many community-based prevention initiatives provide services outside of traditional health care settings. Services provided in homes are just one example of services provided in nontraditional settings. Presented below are several examples of state efforts to provide comprehensive home visiting under their Medicaid programs.

Early childhood home visiting initiatives have demonstrated effectiveness in improving child health outcomes.[xxx] The initiatives have shown to improve health and social outcomes, preventing the need for more costly long-term health or social services. Moreover, because these preventive efforts focus on such young children and families, the programmatic savings accrue over a long period of time.

Home visiting programs typically provide voluntary home visits to at-risk expectant and new parents to offer guidance, risk assessment, and referrals to other services offered in the community. The home visit can be provided by a nurse, a social worker, other trained professional, or volunteer.

The ACA authorized and funded $1.5 billion over five years for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The purpose of the new program is to strengthen and improve home visiting programs, improve coordination of services and identify and provide comprehensive services to improve outcomes for at-risk families. [xxxi] The program provided formula-based funding as well as competitive grants to states. Even with significant federal grant funding for state home visiting initiatives, interest in Medicaid funding remains high. Medicaid pays for 41% of all births nationally, and this will likely increase with the Medicaid expansions anticipated in 2014.[xxxii] Medicaid has the potential to provide a long-term source of sustainable financing for these home visiting initiatives.

States can pay for Medicaid-covered services provided in a home, but it can be challenging for Medicaid to pay for the broad range of services associated with an evidence-based home visiting initiative. The Pew Center on the States engaged the National Academy for State Health Policy (NASHP) to study how states could use Medicaid financing to support home visiting. The report, Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges, provides a thorough review of how some states have been successful in securing Medicaid for specific aspects of home visiting programs.

Michigan's Maternal and Infant Health Program (MIHP) is one of the largest state home visiting programs in the nation. MIHP is jointly administered by the Medical Services Administration and the Public Health Administration, both within the Michigan Department of Community Health. MIHP was established by a 2009 Medicaid State Plan Amendment to define MIHP as a state plan service. MIHP is built on two prior home visiting programs – the Maternal Support Services and Infant Support Services Programs. These programs were consolidated and redesigned to become a population management model, add specificity about how services are delivered, and enhance data reporting.

All pregnant women and infants enrolled in Medicaid are eligible for MIHP services. Pregnant women can receive services until 60 days postpartum, and infants are eligible for services following hospital discharge until their first birthday. MIHP services include care coordination and intervention services to supplement routine prenatal and infant care that are provided by an agency certified by the Michigan Department of Community Health. MIHP providers are typically local health departments, federally qualified health centers or other private facilities. In Michigan, pregnant women and infants are enrolled in managed care plans. In addition to receiving referrals from the plans, MIHP providers must have a coordination agreement with each plan in their area. MIHP providers are also required to coordinate with medical providers or help members find a medical provider.

Michigan is one of a few states that has secured Medicaid financing through direct reimbursement under the traditional Medicaid plan. Table 2 shows how a variety of states have leveraged Medicaid financing through different means.

Table 2: Medicaid Financing Mechanisms for Select Home Visiting Programs

State	Home Visiting Program Name	Medicaid Financing Mechanism
Illinois	Family Case Management	Administrative Case Management
Kentucky	HANDS	Targeted Case Management
Michigan	Maternal and Infant Health Program	Traditional Medicaid Service
Minnesota	Family Home Visiting	Managed care
Vermont	CIS Nursing and Family Support	Global 1115 Waiver
Washington	First Steps	Targeted Case Management and Traditional Medicaid Service

Source: Medicaid and Home Visiting State Case Studies, Pew Center on the States and NASHP, June 2012

According to the Pew/NASHP study, Targeted Case Management is the most commonly used approach to secure Medicaid financing for home visiting. Targeted Case Management helps Medicaid beneficiaries gain access to medical, social, educational and other services.[xxxiii] Kentucky is an example of a state that uses Targeted Case Management to fund its home visiting initiatives. Health Access Nurturing Development Services (HANDS) is a home visiting program for first time parents. HANDS was originally developed as a public health program using state funds. The Department of Public Health approached the Kentucky Medicaid program to form a collaborative agreement when it was determined that 90% of mothers participating in HANDS were eligible for Medicaid. The Department of Public Health used tobacco settlement funds to pay for the state share of services provided to Medicaid enrollees and to cover the costs for individuals without Medicaid coverage. HANDS services are billed fee-for-service for the assessment, home visit by a professional nurse, social worker and/or by a paraprofessional. Local health departments are the providers of the service and the State Department of Public Health is the billing provider for all claims.

In Minnesota, home visiting is provided as an additional benefit by all 12 managed care organizations. According to the Pew/NASHP study, most local health departments have contracts with multiple managed care organizations to provide home visiting, building on the local health department's long history of providing direct services.

These examples show how states have used different Medicaid authorities to provide for comprehensive home visiting programs, in a community setting other than a clinical setting, focusing on defining what services may be provided, what types of professionals may provide them and how they will be reimbursed.

Myth 3: ***Medicaid Can't Pay for Non-Medical Services***
Example*: Medicaid Coverage for Remediation of Environmental Factors*

Effective health care delivery often requires addressing environmental factors that are not traditionally seen as health care delivery. Two examples highlighted below show how states used Medicaid waiver authority and the definition of Medicaid benefits to provide Medicaid coverage for nontraditional medical services such as remediation of environmental threats or triggers for Medicaid eligible children.

Rhode Island was an early leader in expanding the definition of covered services. In 1999, Rhode Island received a waiver to use Medicaid funds to cover the cost of replacing windows in the homes of children diagnosed with lead poisoning. At the time, the Health Care Financing Administration (HCFA) sent a letter to Medicaid Directors encouraging states to consider such an approach and noting "while replacing windows is not a covered item under the 'regular' Medicaid program, Rhode Island was able to

obtain HCFA approval for this because it financed the program with Medicaid savings created through other aspects of its 1115 waiver. This innovative program is expected to improve the health of lead poisoned children by removing the major source of contamination from their homes."[xxxiv]

Massachusetts received federal approval of a Pediatric Asthma Pilot Program to provide comprehensive coverage for asthma-related care, including addressing environmental triggers and alternative payment methodology that provides an incentive for providing prevention services in its Mass Health Comprehensive 1115 Demonstration Waiver. Massachusetts' coverage of services to address environmental triggers is an example of state efforts to cover health related non-medical services.

The Massachusetts initiative was based on the experience of the Community Asthma Initiative, which began in 2005 by the Children's Hospital of Boston to provide a continuum of care from individualized treatment, community education and policy/advocacy. The Community Asthma Initiative initially targeted four Boston zip codes with high asthma rates and health disparities, and was later expanded. Through the Initiative, home visits were provided that included environmental assessment and remediation, including HEPA vacuum, bedding encasements and Integrated Pest Management (IPM) supplies.[xxxv] An evaluation of the Initiative found a positive Return on Investment and estimated that the Net Program Value (Cost Savings – Program Cost) was over $500,000 within five years.[xxxvi]

In June 2010, the Massachusetts legislature approved a budget amendment[xxxvii] that directed the Medicaid program to develop a pilot bundled payment to include evidence-based interventions shown to improve care. As a result, the State developed the Pediatric Asthma Pilot Program. The CMS approval requires the Program to use an integrated delivery system for preventive and treatment services through methodologies that may include a per member per month payment to participating providers for asthma-related services, equipment and supports for management of pediatric asthma for high risk patients. CMS's approval requires the State to "evaluate the degree to which such a payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower costs." The Pilot limits provider participation to primary care clinician sites identified through a Request for Proposal. Participating providers are responsible for the supervision and coordination of the medical team; delivery of asthma-related services paid for by the per member per month payment; and per member per month costs for each beneficiary enrolled. Participating providers received up to $10,000 per practice to defray start-up costs associated with the Pilot.

The CMS approval required the State to come back with a description and listing of the asthma-related benefit package that will be provided to children enrolled in the pilot. The approval generally describes the services in their approval letter as:

> "For example, pending CMS approval, services may include for Phase 1: non-traditional services and supplies to mitigate environmental triggers of asthma and home visitation and care coordination services conducted by qualified Community Health Workers. In Phase II, the payment structure such as a PMPM, bundled, global, or episodic payment may be expanded to also include certain Medicaid State plan services with utilization that is particularly sensitive to uncontrolled asthma (i.e. treatment provided by physicians, nurse practitioners and hospitals, medical equipment such as a nebulizer, spacer, peak flow meter, etc.)."[xxxviii]

The benefit package for the Medicaid pilot has not yet been finalized. It is hoped that when finalized, it could cover services currently provided through the Boston Community Asthma Initiative at Boston Children's Hospital, including environmental assessments and remediation such as HEPA vacuum and bedding and encasements for each child, IPM (Integrated Pest Management) materials, and professional pest control services. Providing these non medical services through a bundled payment strategy would give participating practices the flexibility they need to address environmental triggers and improve health outcomes and lower costs.

Myth 4: ***Medicaid Will Only Pay for Services to Medicaid Enrolled Individuals***
Example*: Medicaid Coverage of Services to Parents and Outreach to Eligible Populations*

Medicaid provides services that benefit eligible individuals. For children, so much of their health and well-being is dependent upon a positive and productive family structure. Because children are eligible for Medicaid at higher income levels than parents, there are many families where the children are enrolled in Medicaid but the parents are not. Effectively providing services to the child may require expanding the concept of who benefits from the service. As noted earlier, screening for maternal depression and treatment is an important part of care for young children because there is evidence that parental mental wellness is associated with a child's health and development. In 2004, Illinois implemented a policy that allows Medicaid reimbursement for screening of maternal depression. If the service is provided during a well-child or acute care visit for a child enrolled in Medicaid, the service may be billed under the child's Medicaid eligibility. [xxxix] In other states, where services may only be billed when the mother is enrolled in Medicaid, some children may not benefit from having their primary caretaker screened for depression.

Some states have used Medicaid and CHIP to fund outreach to eligible populations. For example, the Virginia program has a Teen Campaign designed to market the message "teenagers need to take care of their health." The social media campaign, funded by CHIP Administrative Funding, designed a teen page on the CHIP website, created promotional materials and used social media to promote the campaign and reach the teenage population more broadly.[xl] This is an example of how a state has used Medicaid and CHIP funding to support population-based outreach strategies.

Myth 5: ***Medicaid Can't Pay for Benefits Offered on a Non-Statewide Basis***
Example***: Medicaid Coverage of Local Initiatives***

States have used Medicaid to fund prevention services that are only provided in limited geographic regions of a state. Orange and Alameda Counties in California are examples of where Medicaid has supported locally based service delivery. Both County initiatives stem from California Proposition 10. Proposition 10 emphasized local decision making and flexibility in designing the delivery system, funding local Children's and Families Trust Funds in each county.[xli] According to a forthcoming financing strategy case study on First 5 Alameda County, the organization has been a leader in leveraging Medicaid funds for community-based prevention services in California.[xlii] Using their local Proposition 10 funding and other grant sources, First 5 Alameda has leveraged Medicaid funds by providing non-federal match to community-based organizations and county agencies. Further, First 5 Alameda supports capacity building efforts so that community-based organizations can successfully bill for Medicaid services under a variety of Medicaid financing authorities.

Many states have used Targeted Case Management to provide locally based services. In Orange County, California used Targeted Case Management to secure Medicaid funds for local programs such as MOMS Orange County. The MOMS program provides home visits to pregnant women and early parenting to low income mothers. In addition, MOMS provides prenatal and post partum support and wrap-around services. About one third of the MOMS home visits were supported by Medicaid through Targeted Case Management, according to the Children and Families Commission of Orange County. Other states have provided services in limited geographic regions through managed care or waivers. These examples demonstrate that states have used Medicaid to pay for benefits offered on a non-statewide basis in local areas.

Funding Prevention through Managed Care and Integrated Payment Models

Almost three out of four Medicaid beneficiaries are enrolled in managed care programs, and virtually all states have some type of managed care model in their Medicaid program. The Medicaid expansion under the ACA is likely to increase the number of members who receive care through a managed care organization because coverage is expanding to the types of

populations who are already enrolled in managed care in many states. Further, the ACA has opened the door to demonstrations that embrace newer integrated payment models that in many cases share savings with plans and/or providers.

Medicaid managed care has a long history, and some state managed care programs are quite mature. Risk-based managed care payments can create a powerful incentive for plans to offer outreach, prevention or management programs, which can avoid high cost chronic care. Yet, even with these payment incentives, there are a number of reasons that Medicaid Managed Care Organizations (MCOs) may not fund community-based prevention services. States with a long history of Medicaid managed care may provide some lessons for how new integrated payment models may overcome barriers to financing community-based prevention.

Challenges of Funding Community-Based Prevention through Managed Care

1. **The cost of new prevention services may not be included in the capitation payment they receive from the state**. Medicaid programs traditionally pay MCOs a prospective per member per month payment (capitation payment) that is based on historical Medicaid spending for Medicaid covered services. The capitation payment pays for Medicaid covered services. MCOs are expected to provide the services that are required by Medicaid, and funding is included in their capitation payments. Most managed care programs give MCOs the option of providing additional benefits at their cost, and many offer services that they believe are cost-effective or may help them attract membership. However, it can be politically difficult for states to require MCOs to provide a service that is not funded through their capitation payments. Although the costs of some of these prevention initiatives are small, it could be argued that a requirement to cover them may violate federal requirements that capitation payments be actuarially sound.

2. **The length of time necessary to benefit from the cost saving potential of prevention services may be longer than necessary for managed care organizations to get a return on their investment**. The return on investment of preventive services takes time and may be difficult for MCOs or integrated payment models to realize savings. Most managed care programs set capitation rates annually or competitively award MCO contracts every few years. This short time, coupled with the fact that individuals on Medicaid have frequent gaps in eligibility make it difficult for MCOs to benefit from long-term investments in prevention. Achieving savings in the time horizon necessary to support an investment in prevention may require taking a long term-view of return on investment.

3. **Some managed care organizations have proprietary approaches to care management that make it difficult to collaborate with competitors on community-based initiatives.** MCOs or health care providers have a competitive interest in developing their own models of care delivery. Their proprietary models of care management may make it difficult for them to buy into community-based approaches that require payers or providers to work in partnership to share community investments. For example, MCOs may have their own disease management models that make it difficult for local initiatives to change the approach of competing MCOs to buy into one community-based model.

4. **There may be barriers for managed care organizations to contract with public providers**. Some community-based prevention initiatives are delivered by public providers. Leveraging Medicaid financing through MCOs or other integrated payment models requires the private organizations to either buy into funding the public infrastructure or be compelled to do so through regulations or other strategies. Additionally, contracting with public providers may be complicated because these providers may not have traditionally contracted with private health plans. They may lack the experience necessary to work through private plan contracting requirements such as credentialing or rate negotiations.

5. **National plans may have less flexibility to develop local partnerships with community-based prevention initiatives**. Many Medicaid managed care organizations are nationally run. It can be difficult for national plans to adapt to the unique needs of a local environment and have the flexibility to work with local partners to leverage community-based public health initiatives.

6. **There may be administrative barriers for MCOs to reimburse for new types of services or providers**. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required CMS to adopt standards for coding systems that are used for reporting health care transactions. These standards apply to Medicaid MCOs as well as others. The increased standardization required in heath care transactions and coding practices makes it difficult to recognize new and different types of services and/or providers for reimbursement.

State policymakers may be able to encourage Medicaid financing of prevention initiatives by MCOs. States have tremendous and sometimes untapped power in their role of providing information about plan and provider performance. By highlighting successful efforts by MCOs and others to cover prevention, states can provide a seal of approval that has competitive value to MCOs. Many states have well developed, value-based purchasing initiatives that incentivize MCOs or others to achieve goals. Funding and inclusion of community-based prevention services can be a part of these strategies.

States that competitively procure their managed care programs could use support for community-based prevention as a requirement or a selection criteria (see page 9 for discussion of New Mexico's coverage of CHWs under their managed care program). States could also provide clear guidance to MCOs on how new types of services or providers should be reported in standardized transactions.

New Integrated Payment Reforms

In addition to Medicaid managed care models, there is focused attention on payment reforms to lower costs, improve outcomes and improve the patient experience of care under health reform. CMMI has offered a number of opportunities to states, providers, and other organization to reform the delivery system. These strategies use payment reforms to integrate payment between payers and providers as a means to align incentives in order to improve health and reduce costs. These payment models include shared savings models and bundled payments. If these reforms successfully align payment incentives with improved health outcomes, they will create the opportunity for prevention programs that can demonstrate improved care and savings.

Some states are encouraging the development of care coordination strategies in their Medicaid program. For example, Connecticut has adopted a Person-Centered Medical Home (PCMH) Model for Medicaid and now has a new Administrative Service Organization (ASO) to support this initiative. PCMH provides enhanced reimbursement for providers recognized by NCQA as a medical home at level 2 or 3 and provides bonus payments for practices that meet certain performance benchmarks, including important prevention services such as developmental screening for children.[xliii] The ASO has invested significant resources in care coordination and care management. These resources have been leveraged to expand care coordination to families identified through a variety of community-based initiatives, including Help Me Grow, which works with child health providers; early care and education programs and other community providers to identify children at risk and link them to community-based services; and ChildFirst, which works with families and children with mental health concerns. The ASO provides care coordination services supported by its contract with the Medicaid program, with high risk patients identified and contacted through direct outreach.

CMMI encouraged states to pursue bold new payment models through the State Innovation Models initiative (SIM). The SIM is testing innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. CMMI's goal is to create multi-payer models with a broad mission to improve community health status and reduce long-term health risks for beneficiaries of Medicare, Medicaid, and CHIP. In February 2013, CMMI awarded

nearly $300 million to 25 states to support the development and testing of state-based models. Six states were awarded over $250 million over 42 months in Model Testing awards to implement and test their State Health Care Innovation Plans, a proposal that describes the state's strategy to use all the levers available to it to transform its health care delivery system through multi-payer payment reforms and other state-led initiatives. Additionally, 3 states received Model Pre-Testing awards to continue their work on their State Health Care Innovation Challenge; and 16 states received Model Design Funding to produce a State Health Care Innovation Plan. States with Model Pre-Testing and Design awards will have 6 months to submit their State Health Care Innovation Plan to CMS.

Some states have used their recent SIM projects as part of larger reform strategies. These states have led the way in the development of new payment reforms that have the potential to create a funding path for prevention services.

1. Vermont - Vermont's SIM proposes to develop a high performance health system that achieves full coordination and integration of care throughout a person's lifespan, ensuring better health care, better health, and lower costs. Vermont proposes to achieve these goals through three models: a shared-savings ACO model that involves integration of payment and services across an entire delivery system, a bundled payment model that involve integration of payment and services across multiple independent providers, and a pay-for-performance model aimed at improving quality, performance, and efficiency of individual providers. This effort builds on Vermont's recently renewed Global Commitment to Health Waiver. The Global Commitment Waiver gives the State flexibility to manage its Medicaid program. It allows the State to operate a single state-run managed care organization. The State receives a fixed per member per month payment and has latitude to use any program savings to fund additional services or coverage to non-Medicaid enrolled individuals. Expenditures within the per member per month limit can be used to invest in public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid eligible individuals. [xliv]

2. Minnesota - Minnesota has a number of initiatives underway and is pursuing broader reforms under the SIM. The Minnesota SIM implements the Minnesota Accountable Health Model. The Model will ensure that every citizen has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services. The SIM builds on Minnesota's prior initiatives for payment and system transformation, including the Minnesota Health Care Delivery Systems Demonstration, which is a Medicaid demonstration project to test innovative and

alternative delivery systems. The demonstration will hold delivery systems accountable for the total cost of care delivered to the population they serve relative to a pre-established spending target. In addition, in January 2012, the State entered into a contract with Hennepin County to establish Hennepin Health, an integrated health delivery network. By integrating medical, behavioral health and human services in a patient-centered model of care within a local area, the project seeks to improve health outcomes dramatically and lower the total cost of care. The contributions of community-based public health initiatives are more likely to be recognized when care is integrated at the local level.

3. Oregon - Oregon is transforming its Medicaid program through the use of Community Care Organizations (CCOs). Oregon received approval for its 1115 Waiver to implement the changes to its Medicaid program. It will use the SIM funding to foster the the spread of this new model of care to additional populations and payers, including Medicare and private plans such as those covering state employees. A CCO is a local network of all types of health care providers working together to deliver care for Medicaid members. CCOs are organized around natural health care communities, such as counties or hospital referral areas. The business model calls for these local health care delivery entities to comply with four central elements. The first one is service integration, care coordination, and a focus on wellness, prevention, and the community-based management of chronic conditions. Second, these provider entities must connect with community-based programs that try to improve public health, and the governance structure of the CCOs must reflect this emphasis on the health of the local population. Third, they must manage the utilization of health care resources using a global budget that grows at a fixed rate, with adjustments made to compensate in areas that have a sicker population. Fourth, they must meet standards for access to health care and for clinical outcomes.

   The CCO model is a significant departure from current Medicaid practice because it provides for local differences, shared accountability and shared savings. The federal waiver provides for flexibility for Medicaid services, allowing coverage for nontraditional health care workers or services. All services will have to be used for health-related care; however, the CCO will have broad flexibility in creating the array of services.

The opportunity to support a broad spectrum of prevention services through managed care and newer integrated payment models is significant. The large number of Medicaid enrollees served by MCOs, coupled with financial incentives that would benefit payers and providers for investing in prevention, make it highly relevant to consider how prevention services can be financed this way. One of the critical determinants of whether these new payment reforms can be

successful in achieving their population health goals is how they are evaluated and encouraged going forward. The fact that most initiatives are evaluated on a three-five year time period and must achieve savings for specific populations makes true system transformation difficult to achieve. This approach to evaluation may further focus policymakers on managing high cost users where the immediate pay-off can be quantified. True system transformation would encourage payment for services to prevent a high cost user from developing chronic illness in the first place, which would only be able to demonstrate savings if evaluated over a long timeframe.

Integrator Role in Prevention Initiatives

Dispelling myths about Medicaid financing and fully leveraging it as part of efforts to achieve the Three Part Aim requires an understanding of the complexity of Medicaid and new payment reforms to finance community-based prevention strategies. However, there is an equally important policy development process that is essential to bridging the different environments of Medicaid policymakers and public health leaders to achieve health system transformation.

While the research for this paper focused on the policy levers states used to secure Medicaid financing of community-based prevention, it became clear that the successful efforts to bridge Medicaid and broad health system goals did not happen in a vacuum. There is a unique role for "integrators" - individuals or organizations that can bridge Medicaid, public health and child welfare to provide sustained leadership and champion progress. Nemours built upon the integrator concept in their paper "Integrator Role and Functions in Population Health Improvement Initiatives."

An integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvements in health and well-being. The integrator role is not one-size-fits-all, but rather must be flexible to adapt in response to the needs of the community or population it serves.

Integrators work at a population-level, with health care, public health and other community partners, to promote prevention, improve health and well-being, improve quality and reduce health care costs, in a sustainable fashion. A wide array of entities could assume the integrator role, depending upon the goals of the initiative, the context of the community and its leadership, and the capabilities and resources of various stakeholders. Examples of an integrator might include: group or staff model HMOs, integrated health systems, community clinics, Accountable Care Organizations, public health departments or public trusts.

Ultimately, a successful integrator or system of integrators benefits the community or population by making the whole macro-system transparent to those who pay for it and those who use it, and by catalyzing and facilitating the integrated systems-work necessary to address the upstream social determinants of health.

Integrators will pursue financial sustainability via various methods, including leveraging existing and new sources of funding (e.g., Medicaid, public health and population health promotion programs, such as Community Transformation Grants, and others) to test payment reforms that promote value and incentivize disease prevention and healthy development and demonstrate how strategies such as connecting and utilizing different funding streams targeted to one purpose, program or initiative, reallocating, or pooling funding streams can advance the Three Part Aim and assist in spreading what works.

Integrators can play a critical role in working with the Medicaid program to implement community-based programs that meet the rules despite the complexities and challenges presented in this paper. Leveraging Medicaid to fund community-based prevention requires developing significant programmatic details and requires leaders who can drive a sustained partnership between Medicaid and public health. Integrators can navigate the different programmatic requirements, understand data and still see the big picture and move positive systems change forward in implementing prevention initiatives despite the challenges. The myths identified in this paper all present potential areas where integrators can navigate challenges in leveraging Medicaid funds for prevention. Whether it be the example of the long-term effort and process in Minnesota to build the CHW workforce by standardizing training curriculums or the capacity building of organizations like First 5 Alameda to help community-based organizations successfully bill Medicaid, sustained leadership with the knowledge and ability to understand how Medicaid can be used were vitally important to implementing and sustaining progress.

Conclusions and Policy Recommendations

Medicaid funding for community-based prevention services has an important role to play in achieving the transformation of our health care financing and delivery system necessary to achieve the Three Part Aim. The findings in this paper reveal that federal and state policymakers can benefit from dispelling long-held myths, learning how states have been successful in supporting community-based prevention through Medicaid, and recognizing their challenges.

1. **States have used different Medicaid financing authorities to successfully secure Medicaid funding for community-based prevention**. There is an increasing recognition that services can and should be delivered outside the traditional medical setting and new types of providers, and different types of services can play an effective role in prevention.

2. **The goals of Medicaid and public health are increasingly aligned**. Medicaid is an evolving program. The coverage expansions anticipated under health care reform will provide Medicaid coverage to larger portions of the population. Nationally, four out of ten children have Medicaid or CHIP coverage, but in communities where there are more lower-income populations, the percentage is much higher. Depending on how

the population is defined, Medicaid or CHIP-covered individuals are becoming the majority of individuals targeted for public health initiatives. This, coupled with an increased recognition that so many determinants of health are social and environmental, blurs the boundaries of what the responsibility of Medicaid is versus public health.

3. **Integrated payment mechanisms, such as managed care or global payments, hold promise for recognizing the potential of prevention to improve the health of Medicaid enrollees and bend the cost curve, but only if evaluated in a way that allows the benefits of prevention to be realized**. Many Medicaid enrollees are covered by MCOs or newer state payment reforms. These per person payment models that allow shared savings are designed to benefit from investments in prevention. However, the potential for these reforms to focus on community-based prevention may rest in how they are evaluated and whether such prevention programs can perform effectively under these metrics. The evaluation of savings that result from community-based prevention initiatives may require a longer timeframe for study and a broader study population than evaluations of direct medical services.

4. **Leveraging Medicaid to fund community-based prevention requires developing significant programmatic details and requires integrators who can drive a sustained partnership between Medicaid and public health**. Medicaid is indeed a complex program with many requirements. It has to be given its size and fundamental nature as an entitlement program. This means that leveraging Medicaid funding for prevention requires developing programmatic details that specifically define what a service is and how it will be billed, the qualifications for providers that may provide the service and who can receive services as well as in what setting. It takes creative leadership and sustained effort to navigate the different programmatic objectives and requirements of public health and Medicaid to fully support prevention initiatives. Integrators, that is, organizations or individuals who work intentionally and systematically across Medicaid, public health and child welfare and who provide vision and a convening role, are important leaders. Integrators can navigate the different programmatic requirements, understand data and still see the big picture and move positive systems change forward necessary to implement and sustain prevention initiatives.

Policy Recommendations

The following are strategies policymakers should consider in order to increase opportunities to expand community-based prevention with Medicaid funding to Medicaid beneficiaries. These strategies would help reduce barriers, dispel the myths identified earlier in this paper, and maximize the promise of integrated payment systems to improve health and lower costs.

1. **CMS should adopt as final the proposed revisions to current regulations to provide for Medicaid coverage of preventive services "recommended by a physician or other licensed practitioner."** This regulatory change would permit states to recognize unlicensed providers for reimbursement purposes in the delivery of preventive services as long as a service was recommended by a physician or other licensed provider. This change would make it easier for states to expand access to preventive services provided by nontraditional providers such as CHWs. It also is important to note that this proposed revision would help to make this regulatory provision better reflect the language of the Social Security Act. [xlv]

2. **CMS should provide policy guidance to states to dispel all of the myths identified in this paper.** As part of the state-federal partnership in administering the Medicaid and CHIP programs, CMS policy guidance is crucial to ensuring clarity, fostering innovation, sharing evidence-based best practices, and encouraging coverage of community-based prevention services. For example, guidance on the types of non-medical services that may be covered is particularly important because of the significant influence of environmental factors on health. CMS guidance in this area should build upon Bright Futures and the Guide to Community Preventive Services, recommending its adoption by states as a standard of care for children enrolled in Medicaid and CHIP. Given the complexity of Medicaid, states look to CMS for guidance on what is permissible under federal law. When CMS provides guidance, it focuses the attention of states and others on the possible use of Medicaid financing. Guidance can serve as an invitation for states to pursue initiatives, giving them permission and direction to test new approaches.

3. **CMS should translate the lessons from the innovation of CMMI awardees into new policy and practice by adopting new policy that reflects the lessons and disseminating both the lessons learned and updated guidance to states about what is working well and what federal authority allows.** The ACA has created many opportunities for innovation, especially through CMMI. These new initiatives are designed to test new approaches to payment and health care delivery that can inform future policy and practice. As we learn more about

successful models from the many new initiatives under health reform, CMS and CMMI should harness the lessons learned and encourage their take up by working to adopt new policy and providing clear guidance and encouragement to states. The new payment reforms and innovations hold great promise, but that promise can only be recognized if the lessons are quickly turned into policy for the Medicaid program.

4. **State and federal policymakers should foster partnerships between public health and Medicaid leaders to encourage collaboration to increase investments in community-based prevention services**. While the goals of public health and Medicaid are increasingly aligned, population-based models and medical models are still two distinct approaches. Public health and Medicaid leaders often have different programmatic experiences and perspectives on budgeting, policy development and implementation. Bridging these worlds to achieve a highly coordinated health care financing and delivery system requires partnership. Bringing these leaders together through collaborative policy development or shared learning communities could encourage partnership and support to continue to empower these leaders.

5. **CMS should test the concept of financing integrators that lead efforts to integrate Medicaid and public health to achieve common goals**. It takes leadership and sustained effort to think creatively about how Medicaid financing can be leveraged to support common goals of improving health. Medicaid's complexity requires leaders who are capable of identifying systematic issues and opportunities across Medicaid, public health and child welfare. These leaders can be characterized as integrators because of their ability to coordinate across programs. Effective leaders are able to champion initiatives and figure out how to better align Medicaid and public health as well as leverage funding in a coordinated way from both sources to support prevention initiatives. Recognizing the value and importance of integrators is critical, and allowing this function to be supported with Medicaid funds would be valuable.

6. **CMS should evaluate integrated payment models over a longer period of time to give prevention strategies (such as obesity prevention) time to demonstrate return on investment and support actuarial analyses of prevention.** CMS has provided a number of ways that states and others can test innovative approaches to financing and delivery of care that result in better health, better care and reduced costs. However, these initiatives are evaluated in ways that may encourage more investment in management of chronic care, rather than population-based strategies. The short timeframe for evaluation misses the opportunity to benefit from primary prevention that could have the most significant long term impact. CMMI should support actuarial analyses of

integrated models of prevention over a long timeframe to better understand how to evaluate the costs, benefits, and savings achieved through prevention initiatives.

7. **CMS should provide pathways for incremental reforms that may help states achieve the long term goals of delivery reform and population-based health**. The ACA has provided many opportunities for states to think boldly about reform of payment and delivery systems. But for states that are not ready to take on significant health system reforms, there may not be a clear path for incremental steps to use Medicaid to fund population-based prevention initiatives. CMS should consider providing opportunities to innovate under current law, waivers or demonstrations in the context of smaller and more incremental reforms, similar to the SIM or the Health Care Innovation Challenge. Such opportunities could include testing innovative ideas in sub-regions of a state to mitigate perceived risks.

Leveraging Medicaid to fund community-based prevention requires regulatory flexibility and policy guidance from CMS, plus partnership with states to develop significant programmatic detail to overcome current myths. It also requires integrators, who can drive a sustained partnership between Medicaid and organizations focused on public health. By implementing these recommendations, health care transformation and effective systems change will take shape, accelerate and spread so that the entire population benefits.

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