SECOND REPORT OF THE ADVISORY GROUP ON PREVENTION, HEALTH PROMOTION, AND INTEGRATIVE AND PUBLIC HEALTH

June 25, 2012

Advisory Group:

The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health

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Introduction

The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health was created under the Affordable Care Act to "develop policy and program recommendations and advise the National Prevention Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion" (Section 4001). In fulfilling this mission, the Advisory Group has met two times in person or by phone since our last report. This is our second report, which offers updates on prior recommendations as well as new recommendations for consideration by the National Prevention and Health Promotion Council and the Obama Administration as we assess the Nation's progress in improving the health of Americans through health promotion activities. Many of the recommendations below

are based on presentations from witnesses from across the country who met with us during our April 11-12, 2012 meeting. The agenda for that meeting is attached.

As we work with the Council to enhance the health of all Americans, we have found it helpful to be guided by the Vision of the National Prevention Strategy: **Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.** It is from that perspective, that we offer this report.

Since our April 2012 meeting, the National Prevention Council has released its Action Plan: Implementing the National Prevention Strategy. **We are pleased to see that the NPC members have made a commitment to pursue policy and program changes in three specific areas that have cross-cutting effects on health.** These are:

- Identify opportunities to consider prevention and health within National Prevention Council departments and encourage partners to do so voluntarily as appropriate.
- Increase tobacco free environments within National Prevention Council departments and encourage partners to do so voluntarily as appropriate.
- Increase access to healthy, affordable food within National Prevention Council departments and encourage partners to do so voluntarily as appropriate.

We look forward to working with the NPC members as they develop more specific action steps and timelines for implementing these commitments. At our next meeting in November, we hope to receive updates from the members of the Council on the progress being made in their department-level assessments and to discuss their agency-specific goals.

1. **Protection of the Prevention and Public Health Fund is critical to furthering our Nation's ability to promote health and prevent disease. We commend the Administration for its defense against any further cuts to the Fund during recent congressional deliberations.**

During our April 11-12 meeting, the Advisory Group was impressed by presentations made highlighting efforts supported by the Prevention and Public Health Fund dollars. In particular, we were impressed by the anti-smoking advertisements developed by the Centers for Disease Control and Prevention, the cross-sector collaboration activities in North Carolina that are reflective of the principles of the National Prevention Strategy, and the education campaign regarding the new availability of preventive services under the Affordable Care Act. These are just a handful of examples of the critical investments that the Prevention Fund is making to improve the Nation's health. Indeed, through the first three funding cycles, $2.25 billion has been invested in communities (through the Community Transformation Grants), in direct preventive services (such as support for immunization services and cancer screenings), and in strengthening our state and local health departments (such as strengthening health information technology capacities and efforts to prevent health-care associated infections). A sustained investment in prevention is the only way to assure that our Nation benefits from lower disease prevalence and lower health care costs. The Fund provides that opportunity.

We are concerned, however, about the sustainability of some of the community prevention efforts. The Advisory Group was impressed by a presentation on a Communities Putting Prevention to Work program in Chicago that focused on smoke-free housing. The CPPW grant was a one-time investment and this funding is currently expiring, despite the fact that to effect long-term change, many prevention activities require a sustained effort over time. While policy change does have a long-term impact, the support to create and sustain policy change requires a long-term investment. Similarly, the CDC's anti-smoking campaign, a one-time purchase of advertising time, resulted in a major increase in the number of Americans seeking tobacco cessation support through calls to quitlines. A more sustained investment is needed to make a major, sustainable difference in these health challenges.

We are also concerned that as individual communities demonstrate success in programs such as CPPW and CTG, there are not resources available to bring these programs to scale across the nation. CTGs only reach about one-third of the American people. As we learn from the successes of the CTGs, more resources from the Fund should be made available to ensure that all Americans benefit from the improved health achieved in these demonstration programs.

2. **The Advisory Group urges the National Prevention Council, in particular the Department of Health and Human Services and the Office of Management and Budget, to continue to fully support discretionary public health and prevention programs during the implementation of the Affordable Care Act. As more Americans gain insurance coverage that may pay for some services currently supported with discretionary funds, these resources should be redirected to support implementation of the National Prevention Strategy and ensure that a strong public health system surrounds and is integrated with the health care delivery system.**

As the number of Americans with health insurance coverage increases as a result of implementation of the Affordable Care Act, it is clear that some discretionary public health programs that provide direct clinical services will need to change. Support for population based public health activities will remain critical, especially to assure that the most vulnerable in our society -- those likely to be gaining coverage under Medicaid expansion – have maximum access to preventive programs and services so their health care services demands can be reduced. Recent reports of declining immunization rates are but one example of the need for continued support of public health programs to assure life and cost-saving clinical preventive services are provided. Other services, such as cancer screening, must continue to reach those who may remain uninsured or who do not have regular sources of care. Public health programs can also play a vital role in assisting people as they transition into regular sources of care.

We commend the ongoing efforts at the Center for Medicare and Medicaid Services and elsewhere to assure accountability for population health throughout the health care system. Strong public health agencies will be essential to ensuring a community's health is advanced. This can be achieved through participation in the new Accountable Care Organizations and by providing technical support in assessing the health impact of policies and approaches across government agencies. Health departments also have the capacity to map on a very targeted basis the health and social needs of their populations to ensure that disparities are addressed. And yet, public health and prevention programs have been chronically underfunded – and have faced

some serious cutbacks in the appropriations process at the federal and state/local levels during the recession. Continued investment in public health is essential to assure that a foundational level of community prevention and health safety is ensured to all Americans, regardless of where they live.

3. **The Advisory Group recommends closer integration of community prevention and lifestyle changes into the Medicare and Medicaid programs, as an important opportunity to both effectively (and often less expensively) treat *and* prevent chronic diseases, such as heart disease and diabetes. We ask that the Center for Medicare and Medicaid Services report back to the Advisory Group at our November 2012 meeting as to what steps have been taken to promote and facilitate state coverage of these interventions in their Medicaid (including their prospective Medicaid expansion) programs and in the Medicare program.**

There is a growing and impressive body of evidence supporting lifestyle changes – from increased physical activity and improved nutrition to relaxation techniques – that successfully reverse and/or prevent some of the key chronic diseases that are driving up health care costs and negatively affecting the quality of life of tens of millions of Americans. Indeed, the inclusion of specific lifestyle changes in the treatment of chronic conditions can be both medically effective and cost effective in very short time horizons. Yet, as the Advisory Group learned during our April meeting, there is considerable uncertainty on the part of states as to whether CMS will permit coverage of specific evidence-based lifestyle programs under Medicaid because they are seen as non-clinical services, often provided in non-traditional settings, even though they are sometimes offered by medical professionals and/or received based on clinical referral. At a time when CMS is holding Accountable Care Organizations responsible for community health and giving them greater flexibility to determine the scope of services available to beneficiaries, it is also critical that the Medicaid program provide states a similar flexibility in assuring that evidence-based activities, such as those endorsed by the Task Force on Community Preventive Services, can be reimbursed under Medicaid. These issues have been outlined in greater detail in the attached memorandum. Similar flexibility is needed in the Medicare program. We believe support for these services is consistent with many aspects of the Affordable Care Act, including the expanded definition of the National Health Care Work Force (Section 5101) and the encouragement to include complementary and alternative medicine providers in the community health teams within Patient-Centered Medical Homes (Section 3505).

4. **As we did in our first report, the Advisory Group continues to urge the Department of the Treasury/Internal Revenue Service to incorporate the principles of the National Prevention Strategy into new regulations associated with the revised approach to Community Benefit for non-profit hospitals. We urge the National Prevention Council to engage with the IRS to assure that the IRS's definition of community benefit accounts for community building activities, the kind of activities that typically reflect the investments that address the underlying determinants of health (e.g., environmental and social) and have long been associated with community health improvement and are at the heart of our National Prevention Strategy. It is also important that these investments are based on effective community consultations and transparently developed, implemented and evaluated**

– through a multi-sector collaborative needs assessment and prioritization process that includes the public health system.

We are grateful that the IRS has welcomed our input with regard to the new community benefit requirements. We have prepared more detailed comments that are appended to this report. We hope that all agencies represented on the National Prevention Council will join in support of the incorporation of the principles of the National Prevention Strategy into community benefit activities.

Conclusion

Finally, we are grateful to the National Prevention and Health Promotion Council for the work they have done to date. We are looking forward to discussing with the Council the specific steps individual agencies are taking to ensure that the National Prevention Strategy is integrated into their work. We also look forward to working with the Surgeon General as she convenes regional equivalents of the National Prevention and Health Promotion Council in the federal regions, to ensure that the Strategy reaches into the implementation of federal programs across the country.

Attachment 1

AGENDA

Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
April 11, 2012 – April 12, 2012

U.S. Department of Health and Human Services
Room 800
200 Independence Ave, SW
Washington, DC 20201.

Wednesday, April 11th

1:00pm – 2:15pm	Roll Call and Introduction of new Advisory Group Members ▪ Corinne Graffunder, Alternate Designated Federal Officer (DFO) ▪ Jeff Levi, Advisory Group Chair Welcoming Remarks ▪ Vice Admiral Regina M. Benjamin, Surgeon General, National Prevention Council Chair Update on the National Prevention Council Action Plan and other implementation efforts ▪ Corinne Graffunder, Alternate Designated Federal Officer (DFO) Update on the First Report of the Advisory Group ▪ Jeff Levi, Advisory Group Chair
2:15pm – 2:45pm	Presentation on Section 4004 Implementation ▪ White House Domestic Policy Council (DPC) (invited)
2:45pm – 3:00pm	Report from the Regional Meetings ▪ Lesley Russell, Senior Public Health Advisor for Outreach and Policy, Office of the U.S. Surgeon General
3:00pm – 3:15pm	Break
3:15pm – 3:45pm	Presentation from the North Carolina Regional Meeting ▪ Ruth Petersen, Chief, Chronic Disease and Injury Section, North Carolina Division of Public Health
3:45pm – 4:45pm	Engagement Working Group ▪ Barbara Otto, Advisory Group Member
4:45pm – 5:00pm	Wrap-up and Overview of Next Day's Agenda

Thursday, April 12th

9:00am – 9:15am	Welcome and Overview of the Agenda ▪ Vice Admiral Regina M. Benjamin, Surgeon General, National Prevention Council Chair ▪ Jeff Levi, Advisory Group Chair
9:15am – 9:45am	Presentation on Smoke-Free Housing and Regional Meetings ▪ Joel Africk, President and Chief Executive Officer, Respiratory Health Association of Metropolitan Chicago ▪ U.S. Housing of Urban and Development (invited)
9:45am – 11:00am	Health Promotion Working Group: Non-Clinical Prevention Issues ▪ Dean Ornish, Advisory Group member ▪ Krista Drobac, Director, Health Division, National Governors Association ▪ Stephen Cha, Chief Medical Officer, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services
11:00am – 11:15am	Break
11:15am – 12:00pm	Resilience Working Group: Part 1 ▪ Nicole Lurie, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services ▪ Melinda Morton, Emergency Medicine Senior Resident, John Hopkins University ▪ Gail Christopher, Vice President, WK Kellogg Foundation
12:00pm – 12:15pm	Break (to gather lunch)
12:15pm – 1:00pm	Resilience Working Group: Part 2 ▪ Nicole Lurie, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services ▪ Melinda Morton, Emergency Medicine Senior Resident, John Hopkins University ▪ Gail Christopher, Vice President, WK Kellogg Foundation
1:00pm – 2:30pm	Health Promotion Working Group: Community Benefit ▪ Maureen Byrnes, Lead Scientist, Department of Health George Washington University ▪ Paul Stange, Policy Advisor, Office of Prevention through Healthcare, Centers for Disease Control and Prevention ▪ Julie Trocchio, Senior Director, Community Benefit and Continuing Care, Catholic Health Association

- Christopher P. Giosa, Economist, Tax Exempt and Government Entities Division, Internal Revenue Service

2:30pm – 3:00pm	Public Comment
3:00pm – 4:00pm	Observations on the meeting and discussion on upcoming activities – Advisory Group Members

Attachment 2

Community-based Prevention, Health Education and Counseling in Medicaid

This paper was prepared by Karen Davenport, from the George Washington University Department of Health Policy, in consultation with Trust for America's Health and Nemours.

Chronic disease – long-term conditions such as diabetes, hypertension, depression and asthma that require on-going care and often limit what an individual can do – drives public and private health care spending in the United States. Individuals with chronic illnesses are the largest consumers of health care services and health care resources. Within the Medicaid program, 78 percent of program spending on non-institutionalized beneficiaries is dedicated to the 40 percent of individuals who have chronic health conditions.[i]

Many of these conditions can be ameliorated or avoided altogether through prevention – in particular, a combination of clinical services, health education, counseling, and community-based interventions. With a focus on diabetes and asthma, this memo looks at recent initiatives to prevent or delay the onset of chronic conditions, and to reduce their impact on patients' health and health spending, through community-based programs, health education, and counseling targeted to at-risk individuals as well as diagnosed patients. It then considers existing options for providing these services within state Medicaid programs, and how CMS could encourage greater use of these approaches.

Background – Proven and Promising Chronic Disease Interventions

Preventing and managing chronic disease is challenging. Patients must often change their lifestyle and behavior – for example, by changing their diet, increasing their physical activity or changing their physical environment – and maintain and manage daily self-care routines, such as medication, blood-glucose monitoring or inhalation devices. While a supportive and responsive health care system is an important element of chronic disease prevention and management, patients also need appropriate health education and social supports together with changes in the physical and social environment in the places where children, families and adults live, learn, play and work. Many health plans, public and private initiatives, and vendors working with state Medicaid programs have developed effective, evidence-based strategies for providing these supports and other interventions to improve care and reduce costs associated with chronic illness, and to prevent the onset of chronic disease. Some of these initiatives provide services in community-based settings, such as community centers, often working with non-traditional providers, such as community health workers, service navigators, life coaches, or health educators, and encompassing strategies well beyond clinical services, such as group education, social supports and improvements in physical environment. Examples addressing diabetes and asthma include:

- The YMCA's Diabetes Prevention Program, which targets individuals at high-risk for diabetes through a 16-week lifestyle improvement program. This program engages individuals in group education with a trained lifestyle coach, focusing on improved eating habits, increased physical activity, and other behavior modifications. UnitedHealth Group began partnering with the YMCA in 2010 to replicate this program in additional settings, in combination with pharmacist-led education and behavioral intervention within the pharmacy setting at Walgreens.
- Optima Health Plan's "Life Coaches" Disease Management Programs. In Optima's Diabetes Disease Management Program, Life Coaches educate patients about blood-glucose self-monitoring, medication, self-management skills, meal planning and physical activity. Life Coaches periodically lead supermarket tours and cooking classes for program participants. In the Asthma Management Program, Life Coaches visit severely asthmatic members in their home to review known triggers, conduct environmental assessments, identify home modifications to reduce exposure to triggers, and educate members on effective asthma management. Diabetes participants were 50 percent more likely to control their diabetes than individuals who did not work with a Life Coach, while Optima estimates a return-on-investment of $4.40 to $1 for the Asthma Management program.[ii]
- The Asthma Network of West Michigan provides intensive home-based case management to low-income children and adults with moderate to severe asthma. This program encompasses twelve months of home visits by trained professionals, which cover environmental assessments, patient and caregiver education on asthma management and trigger avoidance. The Network estimates that the case management program generates net per child savings of $800 per year.[iii] The Network also sponsors a week-long Asthma Camp that educates children in asthma management techniques in addition to engaging them in regular summer camp activities.
- The McKesson Group Education Intervention, a component of the Medicaid Value Program demonstration, provided group health education to patients with diabetes or congestive heart failure and a diabetes comorbidity program in New Hampshire and Oregon. An early assessment estimated that this program returns savings of $4.34 on a $1 investment in group educational sessions.[iv]
- The Community Asthma Initiative of Boston, which provides a comprehensive program for high-risk pediatric asthma patients – including asthma education, environmental assessments and remediation, and care coordination with primary care and asthma specialists – in combination with community-based education efforts, such as educational workshops and health promotion activities. Results include a 62 percent decrease in emergency department visits and an 81 percent decrease in inpatient admissions, as well as a 74 percent reduction in annual per patient health care spending.[v]

Rigorous evaluations of community prevention programs for diabetes and asthma have demonstrated the value of these approaches. For example, a review of home asthma interventions on environmental triggers for the Community Guide found a return of $5.30 to $14 for a $1 investment in initiatives focused on children and adolescents.[vi] Similarly, the Community Guide's Community Preventive Services Task Force has recommended diabetes self-management education in community gathering places – such as community centers,

libraries and faith-based organizations – for adults with Type 2 diabetes, and self-management education in the home for children and adolescents with Type 1 diabetes based on these initiatives' ability to improve glycemic control.[vii]

The Role of Medicaid

Medicaid covers a significant proportion of Americans with chronic illnesses, including asthma and diabetes. For example, in 2003, Medicaid financed care for 1.9 million individuals with diagnosed diabetes – a prevalence rate of 6 percent, which exceeded the national prevalence rate of 4.9 percent in the overall U.S. population – and, on average spent nearly $17,000 per person on their health care.[viii] Given the burden that chronic conditions, including asthma and diabetes, place on individuals with Medicaid coverage and the state Medicaid programs that finance their care, CMS should take a number of steps to support community prevention within the Medicaid program. These steps range from important clarifications about existing authority, to encouraging innovation under current law, to an aggressive demonstration or pilot strategy.

Current authority enables states to support prevention, health education and counseling when these services are delivered by Medicaid-participating providers directly to Medicaid beneficiaries in the traditional Medicaid program, 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. States are more constrained, however, in their ability to offer uncovered services, such as group health education, or to use non-traditional providers, such as community health workers, lifestyle coaches or community-based organizations. For example, a public health department that is not a Medicaid-participating provider cannot receive Medicaid payment for one-on-one health education provided to Medicaid beneficiaries, nor can a YMCA receive Medicaid payment for one-on-one health education or group exercise classes. A further complication arises when a community-focused prevention effort engages individuals who are not eligible for Medicaid coverage as well as Medicaid beneficiaries. For example, a FQHC cannot receive Medicaid reimbursement for a nutritionist-led class on healthy eating for all of its diabetic patients because some of the participants are not Medicaid beneficiaries, even though the FQHC participates in Medicaid.

Existing Authority

Under existing program authority, states have supported community-based prevention initiatives through several avenues, including managed care arrangements and disease management approaches that offer individual and group-based health education. Existing authority also enables states to cover individual environmental assessments, targeted health education and anticipatory guidance, and other prevention activities. To help states expand their use of community-based prevention, health education and counseling, CMS should reinforce through various communications with state Medicaid leadership that existing authority enables states to use non-traditional providers and group education strategies within state Medicaid programs. It would also be helpful for CMS to identify and disseminate existing state initiatives to share successful approaches and encourage innovation.

Optional Preventive Benefits

States may provide preventive services to their Medicaid enrollees under their Medicaid state plan. Section 1905(a)(13) of the Social Security Act allows states to offer preventive services as an optional benefit under Medicaid; the statute and federal regulations define these services as services provided by a physician or other licensed practitioner, within their scope of practice, designed to prevent or slow the progression of disease, disability and other health conditions, prolong life and promote physical and mental health and efficiency.[ix] States can define the provider qualifications, settings, payment systems and performance criteria for these services in their state plan.

States can currently use this authority to cover certain types of preventive services, including:

- Home visits by asthma experts, such as licensed respiratory therapists or registered nurses, which could encompass environmental assessments and patient and caregiver education about asthma management.
- One-on-one patient education by a life coach, such as a nurse trained in diabetes management.
- One-on-one health education visits with a physician.
- One-on-one patient education and health promotion with a pharmacist.

However, CMS could issue two clarifications that would significantly improve states' ability to offer optional preventive services within Medicaid. First, CMS should clarify that under the implementing regulations for optional preventive services, the phrase "physician or other licensed practitioner" includes any practitioner who has gone through a state certification program, thus allowing for different practitioners to receive Medicaid reimbursement for these services. States may not necessarily license many providers, such as nutritionists, health educators or lay health workers, but these providers can obtain professional certification.

Second, CMS should clarify that 1902(a)(30), which requires that the state plan assure that payments are "consistent with efficiency, economy and quality of care"[x] enables states to pay for group health education classes, such as a nutrition class, an exercise program or a perinatal education program. While the implementing regulations focus on states' payment methodologies, the language generally requires that states consider program efficiency as they develop their payment systems – which may include considering how services are delivered. Certain types of health education, such as a healthy cooking class or an exercise program, would clearly be delivered more efficiently in a group setting than through a one-on-one interaction.

These two clarifications – plus a reminder that Medicaid can reimburse services provided in any setting recognized by state law – would enable states to establish new community-based prevention programs for Medicaid beneficiaries, such as:

- A prenatal education class for pregnant women with Medicaid coverage, led by a certified health educator;

- A wellness intervention program for dual eligibles, which would combine clinical preventive services with an exercise and fitness class led by a certified group fitness instructor at an adult day care facility; and
- Child nutrition classes for families of Medicaid-eligible infants and toddlers, run by the public health department and led by a certified nutritionist in child care centers.

Outreach Activities

CMS could clarify that states may reimburse community-based organizations, public health departments, and other entities that perform "in-reach" to their client populations, with the goal of enrolling Medicaid beneficiaries in community-based prevention, health education and counseling activities. Under current law, States may reimburse Medicaid outreach and enrollment activities by other entities, such as schools, under administrative claiming authority. For example, school nurses and other health professionals, school staff and other district employees regularly inform students and families about the availability of Medicaid and CHIP coverage and help with the application process. School districts then use a time study to determine the proportion of time these employees allocate to allowable Medicaid administrative activities (including case management and other activities beyond outreach and enrollment) and submit a reimbursement claim to the Medicaid program.

Early, Periodic, Screening, Diagnosis and Treatment

The EPSDT benefit, the pediatric component of Medicaid, ensures that Medicaid-enrolled children receive a broad range of preventive, acute care, and diagnostic and treatment services. Most notably in this context, EPSDT covers periodic assessments – "screening" – of growth and development. These assessments include anticipatory guidance to families on child health and development. States have traditionally paid for anticipatory guidance within a pediatric visit – that is, health education delivered by the pediatrician or other health professional in a one-on-one setting. However, anticipatory guidance could also take the form of health education and counseling classes for Medicaid-covered families – which would enable pediatric practices, FQHCs, and other community-based organizations to develop group classes on relevant topics, such as child nutrition, physical activity, injury (including violence) prevention, dental health, and discipline strategies.

Managed Care Arrangements

Managed care arrangements – including commercial managed care plans that serve Medicaid beneficiaries and other enrollees, Medicaid-only managed care organizations, primary care case management programs, PACE programs and other arrangements – provide health care services to more than 70 percent of Medicaid enrollees. Managed care will continue to play a very significant role in the Medicaid program, with states likely to turn to managed care organizations to serve the 17 million individuals projected to become newly eligible for Medicaid coverage under the Affordable Care Act.

While states contract with managed care plans to deliver a comprehensive set of services within the Medicaid benefit package, plans also have the flexibility to manage their members' health

using cost-effective techniques that go beyond the traditional definition of medical care. Plans often use disease management and care coordination strategies to manage high-cost conditions and control spending, financing these services through their regular capitation payment. In some instances, this flexibility has enabled plans to partner with community-based organizations to deliver group education, engage non-traditional providers such as life coaches or community health workers, create home-based interventions, and otherwise develop creative approaches to prevent and manage chronic diseases for their Medicaid enrollees, in addition to implementing more traditional care management approaches. These strategies can make non-traditional services or non-traditional providers and non-traditional settings available to Medicaid beneficiaries.

States do not uniformly take advantage of this flexibility. For example, while some states specify that managed care organizations utilize interventions such as patient education, monitoring and care coordination to improve care for individuals with chronic illness in their managed care contracts, others do not address this issue.[xi] Through the managed care contracting process, including plan performance measures and program requirements, states can take a more proactive role to encourage or ensure that Medicaid-contracting plans provide prevention and health education services in the community. CMS can develop best practice resources for health plan contracting and otherwise encourage states to use plan contracting requirements and other tools to engage plans in community-based prevention and health education for their Medicaid enrollees.

Demonstration Authority

While current authority supports community-based prevention and health education efforts within Medicaid, current law does not enable states to develop certain types of interventions – particularly those that use non-traditional providers, such as community-based organizations – for their Medicaid enrollees. Similarly, current law necessarily stipulates that medical assistance be provided to Medicaid beneficiaries but not to individuals who are not enrolled in the Medicaid program, which inhibits providers' ability to develop group health education classes and other interventions that mix Medicaid beneficiaries with other participants.

However, CMS can use demonstration authority to test interventions with non-traditional providers and interventions that engage Medicaid beneficiaries with other participants. These types of initiatives would be particularly useful demonstration programs leading up to the implementation of the Affordable Care Act, when expanded health insurance coverage will offer Medicaid coverage to many individuals who do not qualify for Medicaid today. For example, demonstrations that provide these individuals with health education and prevention will likely result in new-eligibles entering the program in 2014 with fewer expensive health conditions. In addition, to the degree that coverage expansions test delivery system capacity, non-traditional providers may provide one avenue for providing appropriate services to a larger enrollee population.

CMS should use the broad demonstration authority within the Center for Medicare and Medicaid Innovation (CMMI) to waive statutory restrictions that prevent states from engaging uncovered

providers or uncovered populations in prevention, health education and counseling activities. When appropriate, these efforts could test the use of innovative payment methodologies – for example, the cost-allocation model – to determine Medicaid's responsibility for costs associated with these services. CMS should also use demonstration authority to borrow from consumer-directed efforts in the long-term care arena, thus enabling states to cover traditionally uncovered services, such as environmental modifications for asthma patients.

More specifically, CMMI should develop several demonstration models for community-based prevention, health education and counseling and solicit state participation in each of these models. Potential demonstrations could include:

- Establishing a group wellness program through a community-based organization, such as a YMCA or a community center. This program could include exercise classes, wellness classes and individualized coaching on lifestyle behavior changes. In addition, beneficiaries could be enrolled without a chronic disease diagnosis;
- Developing a workplace wellness initiative targeting small businesses with low-wage workers – some of whom will be Medicaid beneficiaries, while others will not qualify for coverage under current program rules;
- Creating a partnership between a children's hospital and a youth-serving organization to develop an education and coaching program for parents of premature infants, regardless of insurance status;
- Developing a public health department-led community prevention and coaching initiative on healthy eating, exercise, parenting and other aspects of wellness that targets low-income neighborhoods, where many – although not all – residents would be Medicaid beneficiaries; and
- Enabling a community-based asthma management initiative to purchase items and services that are not traditionally covered by Medicaid, but are needed to manage a child's indoor environment, or enabling the family to purchase these items and services themselves. Examples include bedroom furnishings, such as an allergen-proof mattress cover, dehumidifiers, and plumbing repairs.[xii]

Conclusion and Summary of Recommendations

The Centers for Medicare and Medicaid Services can promote increased use of community-based prevention, health education, and counseling for Medicaid beneficiaries with asthma and diabetes, or those who are at-risk of developing these conditions. A range of program approaches and research efforts have demonstrated the value and return on investment offered by these services. CMS should address perceived barriers in current authority, encourage and promote innovative approaches possible under current law, and explore new approaches to community-based prevention by taking the following steps:

- Clarify that states may pay Medicaid-participating providers to conduct group health education classes, thus enabling states to take advantage of the economies of scale and peer-group motivation offered by group classes.

- Clarify that "physician or other licensed practitioner" under 42 CFR 440.130 includes any licensed or certified practitioner, thus allowing states to include certified nutritionists, community health educators, fitness instructors and others to provide preventive services. CMS could issue this clarification, reinforce that Medicaid reimbursement to participating providers for preventive services, education and counseling is not restricted to clinical settings, and clarify authority for group health education classes in a State Medicaid Director letter focusing on increased support for community-based prevention.

- Identify, catalogue and disseminate best practices in Medicaid programs' use of community-based prevention, health education and counseling, including – where possible – illustrative state plan amendments, other implementation tools, and information on initiatives' return on investment and health outcomes.

- Encourage states to use managed care plan contracting requirements and plan performance measures to engage health plans in community-based prevention and health education for their Medicaid enrollees. CMS could use an informational bulletin to outline best practices and raise state awareness about these tools.

- Clarify that states may reimburse public health departments and community-based organizations for "in-reach" activities related to community-based prevention, health education and counseling programs.

- Clarify that anticipatory guidance under EPSDT may be delivered through group health education and counseling activities.

- Develop an aggressive demonstration portfolio for community-based prevention and health education under CMMI. These demonstrations could enable states to reimburse non-traditional providers, cover non-traditional services, or develop education approaches that also serve individuals who are not eligible for Medicaid coverage.

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[i] Gerard Anderson, "Chronic Care: Making the Case for Ongoing Care," Robert Wood Johnson Foundation, March 2010, available at http://www rwjf.org/files/research/50968chronic.care.chartbook.pdf.

[ii] K Bray, RS Turpin, K Junkind and G Heuser, "Defining Success in Diabetes Disease Management: Digging Deeper into the Data," *Dis Manag* 2008 April: 11(20):119-29; Environmental Protection Agency, "Optima Health: 2005 Winner of EPA's National Environmental Leadership Award in Asthma Management," available at http://www.epa.gov/asthma/pdfs/optima_health_case_history.pdf.

[iii] Polly Hoppin, Molly Jacobs and Laurie Stillman, "Investing in Best Practices for Asthma: A Business Case for Education and Environmental Interventions," Asthma Regional Council of New England, June 2010.

[iv] Berg GD & Wadhwa S. Diabetes disease management in a community-based setting. *Managed Care*. 2002;11(6):42, 45-50.

[v] Julianne R. Howell, "Transforming Population Health: Case Studies of Place-Based Approaches. Children's Hospital Boston Community Asthma Initiative."

[vi] Nurmagambetov, et al, "The Economic Value of Home-Based, Multi-Trigger, Multi-Component Interventions with an Environmental Focus for Reducing Asthma Morbidity – A Community Guide Systematic Review," *American Journal of Preventive Medicine*, 2011; 41(2S1): S33-S42.

[vii] The Community Guide to Preventive Services. Diabetes Prevention and Control: Self-Management Education. 2002. Available at: http://www.thecommunityguide.org/diabetes/selfmgmteducation html

[viii] Mindy Cohen, "An Overview of Medicaid Enrollees with Diabetes in 2003," Kaiser Commission on Medicaid and the Uninsured, October 2007, available at http://www kff.org/Medicaid/upload/7700.pdf.
[ix] §1905(a)(13) of the Social Security Act; 42 CFR 440.130.
[x] §1902(a)(30) of the Social Security Act.
[xi] Sara Rosenbaum, Anne Markus, Jennifer Sheer and Mary Elizabeth Harty, "Negotiating the New Health System at Ten: Medicaid Managed Care and the Use of Disease Management Purchasing," Center for Health Care Strategies, May 2008.
[xii] Community Guide recommendations related to these potential demonstrations include: Task Force on Community Preventive Services, "Recommendations for Worksite Interventions to Improve Workers Health," *American Journal of Preventive Health*, 2010; 38(2S):S232-S236; Nurmagambetov, Op Cit; and Task Force on Community Preventive Services, "Recommendations from the Task Force on Community Preventive Services to Decrease Asthma Morbidity Through Home-Based, Multi-Trigger, Multi-Component Interventions," *American Journal of Preventive Health*, 2011; 41(2S1):S1-S4.