

Expanding Access for Preventive Services: Key Issues for State Public Health Agencies

Background

As the healthcare landscape continues to shift, state public health agencies are playing an increasingly important role in promoting a more efficient, less costly, and more equitable system. In fact, few groups are as well positioned as state health agencies to help achieve the population health goals of the Institute for Healthcare Improvement's [Triple Aim](#). Along with extending access to health insurance through the Affordable Care Act (ACA), and expanding Medicaid, a number of states are increasing their prevention activities in the community, targeting vulnerable populations to promote health and prevent avoidable illnesses and hospitalizations.

Since its creation in 2006, the Triple Aim has evolved from a clinical model to a population health framework that focuses much more on public health activities.¹ Community prevention services are being provided in nearly every state, but the mechanism for providing those services may vary. This issue brief gives a broad overview of the strategies being used to expand preventive services and the opportunities for state public health departments to influence and lead such efforts.

How Preventive Services are Currently Provided in the Community

Public health has long funded prevention and health promotion activities through a combination of block grants and state funding, and many states also provide a variety of prevention activities through their Medicaid programs. Activities such as smoking cessation services, asthma prevention and education, and diabetes management and education are often funded through both grant programs and included in Medicaid benefits provided by Medicaid managed care organizations (MCOs), or through a fee-for-service schedule. As part of the ACA implementation, most states have expanded Medicaid and have used the Medicaid state waiver and state plan amendment process to promote preventive care. (See more information about waivers and state plan amendments below).

The ACA itself expanded access to preventive services by mandating coverage for a number of services for adults and children. In its 2014 report "[Financing Prevention](#)," the National Academy for State Health Policy documents the broad strategies that states are implementing to provide community prevention services, including:²

- Leveraging state Medicaid programs.
- Evaluating opportunities for increased funding through grant programs such as the [State Innovations Model Initiative](#) or the [Community Transformation Grant Program](#).
- Supporting healthcare delivery system transformation.
- Implementing workforce initiatives to develop care models that include non-traditional providers.
- Promoting collaboration with stakeholders through the IRS's nonprofit hospital community benefit requirement.³

Understanding the Medicaid Landscape in Your State

Any effort to expand community prevention should begin with a solid understanding of Medicaid. First, review which benefits are provided under Medicaid in your state. You can learn about how your state organizes its Medicaid program and provides services by following the links in the Helpful Resources section below. Consider the following key questions:

- How is my state's Medicaid program structured?
- Which model does my state utilize to pay for services: fee-for-service, managed care, bundled payment, or global payment, or a combination of these models?
- How can I find out what is in my state plan?
- Which benefits are mandatory, and which are optional?
- Which types of providers can deliver the benefits that are offered?
- Which benefits are provided for prevention activities, and who can provide those services?

Medicaid Resources

State Plan Amendments

Because Medicaid is a state-federal partnership, each state is required to detail the administration of its program in a state plan. The state plan operates as an agreement between a state and the federal government about how a state's Medicaid program will operate. When a state makes changes to its policy or operations, it must send a [state plan amendment](#) describing the changes to the Centers for Medicare and Medicaid (CMS) for approval. State plan amendments are used during changes to covered benefits, changes to reimbursement rates for providers, and other administrative changes.

Waivers

Waivers are more significant and comprehensive tools for states to exercise flexibility when testing or implementing changes in how they organize their Medicaid programs. Waivers are designed for states to experiment and evaluate new approaches that go beyond the federal requirements for Medicaid programs.

There are four main categories of Medicaid waivers:

- [Section 1115 Research and Demonstration Projects](#): These waivers are usually used for large system transformation efforts: for example, states have used Section 1115 waivers to expand Medicaid eligibility and to design new payment models. Several states also use Section 1115 waivers to promote community prevention efforts. Oregon used the waivers to create a [Transformation Fund](#) that is available to coordinated care organizations to help support community need assessments, the use of community health workers and the use of peer wellness counselors.
- [Section 1915\(b\) Managed Care Waivers](#): These waivers allow states to use managed care organizations to provide services and manage costs.
- [Section 1915\(c\) Home and Community-Based Service Waivers](#): These waivers are designed to cover long-term care in community settings rather than in institutions.
- [Concurrent 1915\(b\) and 1915\(c\) Waivers](#): These waivers allow states to provide a "continuum of services" to elderly and disabled individuals as long as federal rules for both programs are met.

You can find out more about Medicaid waivers and view a list of pending and approved state waivers on [CMS' website](#).

Increasing Access to Preventive Services through Emerging Professions

In addition to the traditional means of providing preventive services in the community, states are working to expand access by supporting workforce initiatives that broaden the delivery system for preventive services. The most prominent example of such efforts is establishing formalized training, rules, and certifications for community health workers.

A number of states are expanding their healthcare provider workforces using various public policy strategies. [Minnesota](#), which pioneered providing official recognition for community health workers, used a legislative and regulatory framework to integrate the workers into the state's healthcare ecosystem. States like [Massachusetts](#) have undertaken a wide-ranging collaborative effort with relevant stakeholders to establish training and certification requirements for community health workers. Massachusetts also supported expanding health services for vulnerable populations in non-traditional settings by providing dental hygienist services for children in schools and social service settings.⁴ [South Carolina](#) leveraged existing public health demonstration programs to expand community health workers' roles more widely into the state's healthcare system.

Preventive Services Rule Change

On Jan. 1, 2014, CMS changed Medicaid regulations regarding which providers can be reimbursed for preventive services to Medicaid and Children's Health Insurance Program recipients. This regulatory change can be activated "at state option," which simply means that a state's Medicaid program must file a state plan amendment describing its plan to use this new reimbursement option.

What the Rule Changes

According to CMS, the Medicaid Preventive Services rule change affects who can deliver the services, but not which services can be delivered. Prior to the change, the rule stated that preventive services must be *delivered* by a physician or other licensed practitioner in the healing arts. Now, these preventive services can be *recommended* by a physician or licensed practitioner in the healing arts.⁵

Medicaid funding supports preventive services in a number of settings. However, because Medicaid is a medical assistance program, preventive services have always been clinically oriented toward improving the health of individuals. In fact, according to the [CMS State Medicaid Manual](#), preventive services have always been interpreted to include services that involve direct patient care and are for the express purpose of diagnosing, treating, or preventing illness, injury, or other impairments to an individual's physical or mental health.

Many states deliver services through Medicaid managed care organizations. These organizations already have the flexibility to deliver preventive services through non-licensed providers, but they may not use these care models, either because they are not required to do so or because these services are not included in their capitated payments.

How this Regulatory Change Can Improve Community Prevention Efforts

This rule change provides states with another option for delivering preventive services in the community. Several states are currently developing programs to leverage community health workers' skills. These workers can provide a strong network of culturally competent care-extenders for populations who use Medicaid.

In order to take advantage of this regulatory change, state Medicaid agencies must file a state plan amendment with CMS that details the following:

- Which services will be covered.
- Who will provide the services.
- What kinds of education, training, experience, credentialing, or registration providers will need.
- The state's process for qualifying providers.
- The state's reimbursement methodology.

Opportunities to Expand Preventive Services through Community Benefit Programs

The ACA changed how nonprofit hospitals maintain their tax-exempt status by changing the "community benefits" standard and requiring nonprofit hospitals to conduct a community health needs assessment every three years, publish the results of that assessment, and develop an implementation strategy.⁶

This new requirement offers significant opportunities for collaboration between hospitals and state health departments. Traditionally, community benefit programs were primarily focused on providing uncompensated care, or "charity care." However, the new rules require hospitals to support community-based interventions based on the specific needs of the community. State public health agencies are well positioned to help hospitals meet this new requirement by offering expertise in community assessments, data collection and analysis, and providing visibility for existing assessments and population health initiatives.

In addition to the federal requirements, a number of [states](#) have rules governing hospital community benefit programs. Aligning the goals and requirements of state programs with the new federal rules also provides an opportunity for hospitals and health policymakers to partner.

Key Points for State Health Departments on Expanding Community-Based Prevention Services

The following themes and lessons learned emerged during conversations that ASTHO staff had with states who are actively working to expand community preventive services:

- States have several options for expanding community preventive services, and federal guidance tends to be very broad. While some states may see this as an advantage, others may view the lack of specificity as a deterrent to undertaking what for many is a time- and resource-intensive effort.
- Strong relationships with state Medicaid agencies are crucial for success and momentum. To leverage Medicaid resources, state Medicaid agencies must file state plan amendments to cover new services. State health officials should invest the time to build relationships with key Medicaid staff and seek common ground regarding shared policy goals.

- State health departments should ensure that program proposals to work with Medicaid are coordinated and consolidated. Presenting a unified public health strategy is crucial for promoting focus and efficiency and preventing duplicative efforts.
- Champions in both state Medicaid and state health departments are critical for success. States that have made progress in expanding or launching new preventive service initiatives have had leaders in one or both agencies who see the value in undertaking such efforts, and are willing to devote the human and financial capital to create momentum.
- Changes due to electoral transitions can slow momentum, and normal senior official and staff turnover can slow progress on health policy changes.
- To be successful, state health departments must take a collaborative approach to developing a comprehensive community prevention strategy. For example, plans supporting introduction of a new category of healthcare provider should be developed with those providers at the table from the beginning. Likewise, if educational and certification standards require changes in state law or regulations, relevant policymakers must be included as well.

Helpful Resources

- [“Financing Prevention: How States are Balancing Delivery System & Public Health Roles”](#) —National Academy for State Health Policy
- [“Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers, and the Promise of Integrated Payment Models”](#) —Nemours
- [“The ACA and Medicaid Expansion Waivers”](#) —Kaiser Family Foundation
- [“Wiki on State Innovation Models”](#) —ASTHO
- [“The Evolving Community Benefit Standard: Defending Not-For-Profit Tax Exemption Amid Coverage Expansion”](#) —The Advisory Board Company
- [“The Internal Revenue Service’s Final Rule: Charitable Hospitals and Community Health Needs Assessments”](#) —ASTHO
- [“Medicaid Reimbursement and Community-Based Prevention”](#) —Nemours and Trust for America’s Health
- [“Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach”](#) —CDC
- [ASTHO Community Health Worker Website](#)
- [CMS Q&A on Medicaid Preventive Services Rule Change](#)
- [CMS Presentation on Medicaid Preventive Services Rule Change](#)

Acknowledgements

This brief was created in June 2015 thanks to funding from CDC under Cooperative Agreement 5U380T000161-01 year 1. The contents of this document are solely the responsibility of ASTHO and do not necessarily represent the official views of the sponsor.

Issue Brief



References

¹ Institute for Healthcare Improvement, "Triple Aim for Populations." Available at <http://www.ihl.org/Topics/TripleAim/Pages/Overview.aspx>. Accessed 6-15-2015.

² ChangeLab Solutions. "Financing prevention: How States are Balancing Delivery System & Public Health Roles." Available at http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf. Accessed 6-29-2015.

³ Internal Revenue Service. "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act." Available at: [http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act). Accessed 6-15-2015.

⁴ Massachusetts Public Health Dental Hygienist Program. "Public Health Dental Hygienist." Available at <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/healthcare-workforce-center/oral-workforce-dev/dental-hygienist/>. Accessed 6-15-2015.

⁵ Centers for Medicare & Medicaid Services. "Update on Preventive Services Initiatives." Available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>. Accessed 6-29-2015.

⁶ Federal Register. "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirements of a Section 4959 Excise Tax Return and Time for Filing the Return." Available at <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>. Accessed 6-15-2015.