

An Opportunity for States to Fund Community-Based Prevention Programs

Introduction

Community-based prevention programs (CBPPs) can serve as an important tool for states to improve health outcomes and reduce costs. New federal authority for states to reimburse for preventive services for physical and mental health provided by unlicensed providers may greatly expand the use of CBPPs.

The Role of Community-Based Prevention Programs

As states consider how to improve health outcomes and reduce costs, many are examining the critical role that changing individuals' health choices can play in those efforts.¹ Health behaviors such as diet, exercise, and substance use can have a large effect on an individual's overall health and wellness.²

Changing health behaviors, however, can be difficult. Evidence-based CBPPs have proven successful at fostering such change.³ Those programs focus on providing participants with support for behavioral changes and fostering accountability for results.⁴ They differ from general health-education campaigns by first teaching participants how to identify the triggers of poor health behaviors, and then to develop a constructive response to those triggers. CBPPs also provide an analysis of the larger context of health behaviors—for example, sources of pollutants in the home for asthmatics and the availability of healthy food options near one's workplace. Finally, they also use friends and family to support healthy behaviors. Examples of evidence-based CBPPs include the Diabetes Prevention Program, the Chronic Disease Self-Management Program, and fall prevention programs such as "A Matter of Balance."⁵

What are community-based prevention programs?

Community-based prevention programs (CBPPs) vary in scope but typically consist of an intervention in a nonclinical setting. CBPPs aim to prevent costly and adverse health outcomes by promoting a healthier lifestyle. They also can provide support to individuals in adhering to medical treatments that will prevent a chronic condition from worsening and requiring more extensive treatment.

How do CBPPs differ from traditional health education programs?

CBPPs go beyond providing information by customizing support for each individual's program of behavioral changes. A CBPP can offer behavioral support and foster accountability for healthier diets and tobacco cessation through small group classes and individual counseling. Other interventions include assessments of participants' homes to prevent falls or asthma triggers.

Who typically provides CBPPs?

Under current regulation, CBPPs can be provided by licensed clinicians. A health educator, community health worker, or other unlicensed professional also can provide the service. The revised Medicaid regulation discussed in this brief allows states to reimburse unlicensed providers offering CBPPs.

Financing of CBPPs

States have expressed interest in exploring financing opportunities for these services, because of their potential wellness benefits, cost savings, and the broad base of evidence that supports their efficacy.⁶

In particular, the National Governors Association Center for Best Practices (NGA Center) recently worked with a cohort of states to identify and develop specific financing options for CBPP services.⁷ Those options included encouraging reimbursement by commercial insurers and managed care organizations and coverage through state employee health programs.⁸

Additionally, some states fund CBPPs through grants and medical home initiatives. Until recently, traditional fee-for-service Medicaid had not been an option to fund CBPPs because of the long-standing Medicaid reimbursement requirement that services be provided in a clinical setting by a licensed provider such as a physician or a nurse practitioner.

Medicaid Rule Change and Next Steps

In July 2013, the Centers for Medicare and Medicaid Services (CMS) announced new federal authority for states to reimburse for physical and mental health preventive services provided by unlicensed providers so long as the services are recommended by a physician or other licensed practitioner.⁹ CMS expects the revised regulation (42 C.F.R. 440.130) to broaden the pool of practitioners available to provide preventive services and to increase beneficiary access to those services.¹⁰

States should be aware that although the rule expands the range of provider types that Medicaid will reimburse for preventive services, it does not expand the *definition* of preventive services, which are defined at the federal level in CMS' *State Medicaid Manual*.¹¹ The manual specifies that preventive services must involve direct patient care and diagnose, treat, or prevent illness, injury, or other impairments to an individual's physical or mental health.¹² Thus, community-wide water fluoridation or a mass media campaign would not be covered under the amended regulation. However, preventive group counseling, a common focus of CBPPs, could qualify as long as it includes direct, one-on-one interaction between the instructor and an individual.

Under the new rule, states are not required to broaden the pool of practitioners for preventive services; use of the amended regulation to obtain reimbursement is entirely voluntary. States that wish to use the amended regulation can do so through a state plan amendment (SPA). The SPA must include a summary of the practitioner qualifications the state has established to allow reimbursement of preventive service providers, including levels of training, experience, and credentials.¹³ The state also would be required to document its reimbursement methodology and describe how its amended plan would meet the requirements of Section 1902 of the Social Security Act, which governs Medicaid plans. States should be especially mindful of SPA compliance with Section 1902 provisions that require that benefits be available throughout the entire state, meet standards for comparability with other services, and allow beneficiaries freedom of choice.

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¹ Goodarz Danaei et al., “The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors,” *PLoS Med* 6, no. 4 (April 28, 2009), doi:10.1371/journal.pmed.1000058; and J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, “The Case For More Active Policy Attention To Health Promotion,” *Health Affairs* 21, no. 2 (March 1, 2002): 78–93, doi:10.1377/hlthaff.21.2.78, <http://content.healthaffairs.org/content/21/2/78.full>.

² For example, scholars in 2011 estimated that health behaviors were responsible for 50 percent of health status; environmental factors, 20 percent; genetics, 20 percent; and access to care, 10 percent. For more information please see Figure 12-5 on page 423 in *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*, Institute of Medicine, ed. Pierre L Yong, Robert S. Saunders, and LeighAnne Olsen, (Washington, D.C.: National Academies Press, 2010), <http://iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>.

³ Ralf Schwarzer, “Modeling Health Behavior Change: How to Predict and Modify the Adoption and Maintenance of Health Behaviors,” *Applied Psychology: An International Review* 57, no. 1 (January 2008): 1–29, doi:10.1111/j.1464-0597.2007.00325.x.

⁴ Jeffrey Levi, “Community Prevention and Healthcare Costs,” in *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*, Institute of Medicine, ed. Pierre L Yong, Robert S. Saunders, and LeighAnne Olsen, (Washington, D.C.: National Academies Press, 2010): 420–432, <http://iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>.

⁵ The NIDDK National Diabetes Information Clearinghouse, “Diabetes Prevention Program (DPP),” National Institutes of Health, <http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/> (accessed October 29, 2014); Kate R. Lorig et al., “Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial,” *Medical Care* 37, no. 1 (January 1, 1999): 5–14, <http://www.jstor.org/discover/10.2307/3767202?uid=3739584&uid=2129&uid=2&uid=70&uid=4&uid=3739256&sid=21104425411091>; and National Council on Aging, “A Matter of Balance,” <http://www.ncoa.org/improve-health/center-for-healthy-aging/a-matter-of-balance.html> (accessed October 29, 2014).

⁶ Ibid.

⁷ States participated in the NGA Center’s Learning Collaborative on Integrating Chronic Disease Prevention Services with the Health Care Delivery System from 2011 to 2012.

⁸ Deneen Vojta et al., “Effective Interventions for Stemming the Growing Crisis of Diabetes and Prediabetes: A National Payer’s Perspective,” *Health Affairs* 31, no. 1 (January 1, 2012): 20–26, doi:10.1377/hlthaff.2011.0327.

⁹ Diagnostic, Screening, Preventive, and Rehabilitative Services, 42 C.F.R. § 440.130 as amended at 78 Fed. Reg. 42,306, July 15, 2013, http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=e4d656c05cf1fa8cf700ffd33f912abc&ty=HTML&h=L&r=PART&n=pt42.4.440#se42.4.440_1130 (accessed October 29, 2014).

¹⁰ Division of Benefits and Coverage, “Medicaid Preventive Services: Regulatory Change” (CMS Webinar, April 2014), Center for Medicaid and CHIP Services, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf> (accessed October 29, 2014).

¹¹ CMS State Medicaid Manual, Chapter 4, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html?DLPage=1&DLSort=0&DLSortDir=ascending> (accessed October 24, 2014).

¹² Ibid.

¹³ Cindy Mann, “Update on Preventive Services Initiatives,” *CMCS Informational Bulletin*, November 27, 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf> (accessed October 29, 2014).