

ROADMAP APPENDIX A: MEDICAID AUTHORITIES FOR PREVENTION – REFERENCE DOCUMENT

Medicaid may be a source of sustainable funding for childhood obesity prevention and other prevention services. This document provides background on a variety of pathways to authorization of Medicaid reimbursement for preventive services. The statutory citations are from the Social Security Act unless otherwise noted. Some of the challenges of implementing specific pathways are discussed in the three case studies and white paper available at: <http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>.

The reimbursement pathways described below are organized by individual or population level. The pathways are further broken down by service, setting, and provider type. This organization corresponds with the *Roadmap of Medicaid Prevention Pathways*, which can also be found using the link above.

Individual Level Prevention

A physician or other licensed practitioner (OLP) provides an individual Medicaid enrollee a preventive service in a medical setting (IL-1) and may take an added step of referring the enrollee to a community-based organization for additional non-medical supportive services (IL-2).

- **Medicaid Covered Services: Section 1905(a).** Medicaid allows direct reimbursement for services covered under each state's Medicaid State Plan. Medicaid statute defines required and optional services. Services must be offered to all recipients statewide. States have the option to include preventive services in their benefit package. Preventive services include immunizations, screenings for common chronic and infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic diseases like obesity.¹ States may need to amend their State Plans to describe services, providers, and reimbursement methodologies.
- **Early Periodic Screening Diagnosis and Treatment (EPSDT): Section 1905(r).** The EPSDT benefit entitles Medicaid-enrolled children (under age 21) to any medical service, treatment, supply or device determined to be medically necessary and coverable under Section 1905(a). The goal of this benefit is to ensure that children who are enrolled in Medicaid receive age-appropriate screenings, preventive services, and treatments that are medically necessary to correct or ameliorate any identified conditions²—the right care to the right child at the right time in the right setting.³ With respect to childhood obesity, for example, the measurement of height and weight, calculation of body mass index, and assessment for risk for obesity and related health problems may be covered under the screening component of EPSDT. In addition, the health education component provides an opportunity for the provider to discuss health concerns such as weight and nutrition.
- **Case Management: Section 1905(a)(19) and Targeted Case Management: Section 1915(g)(1).** Both services are optional benefits under Medicaid. They allow states to use Medicaid to pay for the costs associated with helping beneficiaries gain access to needed medical, social, and educational services as well as to other services such as housing and transportation. Case managers can conduct a needs assessment, develop a care plan, refer the individual enrollee to services and assist in scheduling appointments, and provide monitoring and follow-up support.⁴
- **Health Homes: Section 1945/Section 2703 of ACA.** The Health Homes State Plan benefit option allows states to design Health Homes to provide coordinated care for Medicaid beneficiaries with chronic conditions (including overweight). With an approved State Plan Amendment, Medicaid will reimburse for critical services: comprehensive care management, care coordination and health promotion, transitional care, individual and family support, and referral to community and social support services.⁵ Enhanced Medicaid match is provided for two years. States have flexibility in determining providers and payment methodologies.

A physician or OLP provides an individual Medicaid enrollee a covered preventive service in non-traditional settings such as schools (IL-3A).

- EPSDT: Section 1905(r). As described previously, the EPSDT program recognizes the importance of delivering care in different settings, including practitioners' offices, maternal and child health facilities, community health centers, and schools.⁶ The Centers for Medicare and Medicaid Services (CMS) has long encouraged states to provide services in home and community settings, particularly for children, because community-based care is considered a best practice for supporting children with disabilities and chronic conditions. In addition, it is generally more cost-effective.⁷
- Preventive Services: Section 1905(a)(13). This section allows states to provide preventive and other services in an array of settings, including in a person's home or work environment rather than only in a hospital, primary care practice, or other clinical setting.⁸
- Free Care Guidance: December 2014 State Medicaid Director Letter.⁹ Historically, Medicaid payment was generally not allowable for services that were available without charge to the beneficiary. The 2014 guidance changed this, stating that Medicaid reimbursement "is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met." With regard to third party liability, the guidance "allows states to determine that public agencies with general responsibilities to ensure health and welfare are not considered legally liable third parties."
- Health Homes: Section 1945/Section 2703 of ACA. Health Homes, described previously, include teams of professionals that may be based in primary care or behavioral health care settings, coordinated virtually, or located in other settings that suit beneficiaries' needs.¹⁰
- Home Visiting Guidance: HRSA and CMCS Joint 2016 Informational Bulletin.¹¹ The 2016 guidance noted that "Medicaid coverage authorities offer states the flexibility to provide services in the home...However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options." The guidance provides examples of Medicaid benefits that could be provided in home visiting. It also describes that "...state agencies should work together to develop an appropriate package of services" which "may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs."

A non-traditional provider (e.g., community health worker) provides an individual Medicaid enrollee a preventive service (IL-3B).

- Preventive Services Rule Change: 42 CFR 440.130(c). A January 2014 rule change allows Medicaid to reimburse for preventive services administered by a health professional when these services have been initially *recommended* by a physician or other licensed practitioner. This makes the regulatory definition of preventive services consistent with the statute at section 1905(a)(13). Previously, Medicaid covered only preventive services *provided* by a physician or other licensed practitioner. This means that state Medicaid agencies now have the option to pay for preventive services provided by professionals that fall outside the state's clinical licensure system such as community health workers (CHWs). A State Plan Amendment must be submitted and approved by CMS. It is important to note that services eligible for reimbursement must be covered in the State Plan, involve direct patient care, and primarily address an individual's health. It excludes care coordination and activities intended to address the broader social determinants of health (e.g., smoke detectors, dust-mite proof bedding, lead abatement activities, community water fluoridation, and access to healthy food).
- Managed Care. MCOs can cover preventive services delivered by non-licensed but otherwise qualified providers in many different settings and can opt to cover extra preventive services beyond what is required by fee-for-service Medicaid. Individual MCOs may opt to do this, or states, through their contracts with MCOs, can set requirements, for example that MCOs make CHWs available to enrollees or establish a minimum list of services that CHWs must provide. States can implement managed care through the following basic types of authorities:¹²
 - o Section 1932(a) State Plan Authority. This authority does not have a periodic renewal requirement as waiver authority does. Under this authority, a state cannot require certain populations to enroll in managed care.
 - o Section 1915(a) Waiver Authority. This authorizes voluntary managed care through execution of a contract with companies a state procures through a competitive process.

- o Section 1915(b) Waiver Authority. The four types of 1915(b) Waivers are:
 - (1) Freedom of Choice, which restricts Medicaid enrollees to receive services within the managed care network;
 - (2) Enrollment Broker, which utilizes a central broker;
 - (3) Non-Medicaid Services Waiver, which uses cost savings to provide additional services to beneficiaries; and
 - (4) Selective Contracting Waiver, which restricts enrollees' choice of provider.
- o Section 1115 Waiver Authority. The Secretary of Health and Human Services has broad authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Under this authority states can expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible and provide services not typically covered by Medicaid.

An individual Medicaid enrollee receives an upstream service in the community. Upstream services include those non-medical services that address the systemic conditions (e.g., environmental, economic) that contribute to poor health (IL-3C).

- Managed Care. MCOs are generally paid an actuarially sound capitated rate to cover a defined set of benefits that is specified in their contracts with the state Medicaid agency. MCOs have flexibility to cover additional services (e.g., social support services) that are not covered in their state's Medicaid Plan. "Value added" services are services that are not included in the State Plan or MCO contract but the MCO elects to provide these services to improve quality of care and/or reduce costs. In general, MCOs must notify the state of plans to cover a "value added" service according to state timeframes and requirements. MCO marketing materials advertising the service are subject to state approval. The costs of "value added" services are included in the administrative portion of the rate. If the "value added" service is an activity that improves health care quality under 45 CFR Section 158.150, it may be included as a medical cost rather than an administrative cost.¹³ MCOs may report "value added" services separately from other encounters. MCOs can also substitute services or settings "in lieu of" services or settings that are covered in the State Plan. Under 45 CFR Section 438.3 the alternative services must be deemed by the state to be medically appropriate and cost effective substitutes and included in MCO contracts, and must be voluntary for members. "In lieu of" services are counted as medical costs in MCO capitation rates. The authorities under which a state may implement managed care are described under IL-3B.
- Coverage of Housing-Related Activities and Services for Individuals with Disabilities. CMS released an informational bulletin on June 26, 2015 that is intended to assist states in designing Medicaid benefits and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities with the goal of promoting community integration of individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness.¹⁴

Population Level Services and Strategies

A population health prevention intervention is provided to an entire community or geographic area. The service is aimed at improving the health of the population rather than improving the health of a specific individual. The intervention is not limited to patients in a particular medical practice or enrollees in an MCO (PL-1).

Medicaid and another state agency or department (e.g., public health) share goals and collaborate as partners on a population health/prevention intervention. The funding of the initiative is often a blend of financing mechanisms including Medicaid (PL-2).

- Health Services Initiatives under the Children's Health Insurance Program (CHIP): Section 2105(a)(1)(D)(ii). Under CHIP, states have the option to receive reimbursement for a health services initiative (HSI). These are defined as activities that protect the public health and health of individuals and improve or promote a state's capacity to deliver public health services and strengthen the human and material resources necessary to accomplish public health goals. They must be funded within the 10 percent limit after funding CHIP administration costs. CMS allows flexibility under HSI as long as these initiatives are aimed at improving the health of children and target low-income children; however, they may serve children under 19 years of age regardless of income.
- Section 1115 Waiver Authority (Research and Demonstration Waivers). As described under IL-3B Managed Care, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The

purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate approaches such as expanding eligibility, providing services not typically covered, and using innovative service delivery systems. They also allow piloting of initiatives on a less-than-statewide basis. Waivers are required to be budget neutral over five years.

- Delivery System Reform Incentive Payment (DSRIP). DSRIP initiatives are part of broader Section 1115 waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.
- CMS Innovation Center. The CMS Innovation Center provides funding for Medicare and Medicaid Services (CMS) provides funding to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for beneficiaries. Models that may support a population health prevention approach include the following:
 - Accountable Health Communities. This model tests whether systematically identifying and addressing the health-related social needs of beneficiaries impacts total health care costs, improves health, and improves quality of care. (Applications currently under review.)
 - Health Care Innovation Awards Round 2. This funding supported models that improve the health of populations—defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class—through activities focused on engaging beneficiaries, prevention (e.g., a diabetes prevention program or hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery system. CMS awarded three-year cooperative agreements to 39 organizations in 2014.
 - Health Care Innovation Awards Round 1. This funding supported models that deliver better health, improved care, and lower costs to beneficiaries, particularly those with the highest health care needs. CMS awarded three-year cooperative agreements in 2012 to 107 organizations.
 - State Innovation Models (SIM). Under the SIM initiative, CMS gave financial and technical support to a limited number of states to design and test innovative, state-based multi-payer health care delivery and payment systems. The aim of the SIM initiative is to test whether new models with potential to improve care and lower costs in Medicaid will produce better results when implemented in the context of a state-sponsored plan that involves multiple payers, broader state innovation, and larger health system transformation to improve population health. These initiatives may extend beyond the Medicaid population. In round 1, \$300 million was awarded to 25 states. In round 2, over \$660 million was given to 32 awardees (states, territories, and DC) in 2014 for a four-year period.

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