



Community-based Prevention, Health Education and Counseling in Medicaid

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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.¹

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.²
- 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.³ 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.⁴
- 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.⁵

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.⁶ 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.⁷

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.⁸ 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.⁹ 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"¹⁰ 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.¹¹ 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.¹²

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.

¹ 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>.

² 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.

³ 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.

⁴ Berg GD & Wadhwa S. Diabetes disease management in a community-based setting. *Managed Care*. 2002;11(6):42, 45-50.

⁵ Julianne R. Howell, “Transforming Population Health: Case Studies of Place-Based Approaches. Children’s Hospital Boston Community Asthma Initiative.”

⁶ Nurmagametov, 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.

⁷ The Community Guide to Preventive Services. Diabetes Prevention and Control: Self-Management Education. 2002. Available at: <http://www.thecommunityguide.org/diabetes/selfmgmteducation.html>

⁸ 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>.

⁹ §1905(a)(13) of the Social Security Act; 42 CFR 440.130.

¹⁰ §1902(a)(30) of the Social Security Act.

¹¹ 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.

¹² 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; Nurmagametov, 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.