

Reimbursement for Evidence-Based Health Promotion Programs in the Community

Strategies and Approaches to Medicaid and Medicare Advantage Coverage

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ABOUT THE NATIONAL COUNCIL ON AGING

The **National Council on Aging (NCOA)** is a national organization dedicated to improving the lives of older adults, envisioning a caring society in which each person, as they age, lives with dignity, purpose, and security. NCOA reached its goal to improve the health and economic security of 10 million older adults by 2020 one year early and has set a new goal to improve the lives of 40 million aging adults by 2030.

ABOUT THE NATIONAL COUNCIL ON AGING PROJECT DIRECTORS

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Kathleen A. Cameron has over 25 years of experience in the health care field as a pharmacist, researcher and program director focusing on all aspects of healthy aging, including falls prevention, geriatric pharmacotherapy, behavioral health, long-term services and supports, and caregiving. Ms. Cameron is currently Senior Director, at the Center for Healthy Aging at NCOA where she oversees the Administration on Aging-funded National Falls Prevention Resource Center and the National Chronic Disease Self-Management Education (CDSME) Resource Center. The focus of this work is to support the expansion and sustainability of evidence-based health promotion and disease prevention programs in the community and online through collaboration with national, state, and community partners.

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ABOUT THE ADMINISTRATION FOR COMMUNITY LIVING

NCOA and the authors would like to recognize Administration for Community Living (ACL) for their ongoing support of this work.¹ ACL believes all Americans—including people with disabilities and older adults—should be able to live at home with the supports they need, participating in communities that value their contributions. To help meet these needs, HHS created the Administration for Community Living (ACL) in 2012. ACL brings together the efforts and achievements of the Administration on Aging (AoA), the Administration on Intellectual and Developmental Disabilities (AIDD), and the HHS Office on Disability to serve as the federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

ABOUT HEALTH MANAGEMENT ASSOCIATES

Health Management Associates (HMA) is a national consulting firm specializing in publicly funded healthcare, its stakeholders, and its beneficiaries. Dedicated to serving vulnerable populations, HMA assists policymakers, providers, health plans and communities in navigating the ever-changing healthcare environment with a focus on making programs like Medicaid and Medicare operate more effectively. Founded in 1985, HMA has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; Los Angeles, California; New York, New York; Philadelphia, Pennsylvania; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento, California; San Antonio, Texas; San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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¹ This project is supported, in part by grant No. 90CR2001-03-05, from the U.S. Administration for Community Living, Department of Health and Human Services, 2020. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration for Community Living policy. To learn more about ACL visit <https://acl.gov/about-acl>.

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EXECUTIVE SUMMARY

The National Council on Aging (NCOA), with support from the Administration for Community Living (ACL), contracted with Health Management Associates (HMA) to provide research and strategy services to support their joint goal to increase the adoption of evidence-based health promotion and disease prevention programs² (evidence-based programs or EBPs). EBPs include Chronic Disease Self-Management Education (CDSME) programs and falls prevention programs by Medicaid, Medicare and other health insurance markets. This brief seeks to identify:

- Medicaid authorities and financing mechanisms through which states have adopted evidence-based health promotion programs
- Promising practices establishing reimbursable evidence-based health promotion programs and approaches that may be replicated in other states in Medicaid, Medicare Advantage and other emerging markets to support program sustainability beyond grant funding
- Barriers to adoption of evidence-based health promotion programs and actionable steps to avoid or address
- Actionable information to move forward relationships with state Medicaid programs or Medicaid managed care organizations

The most prevalent community-based organization (CBO) EBP funding is through the ACL. ACL offers evidence-based disease prevention and health promotion program support under the authority of the Older Americans Act (OAA) Title III-D, established in 1987 to reduce the need for more costly medical interventions. In addition, the Affordable Care Act (ACA) established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health initiatives designed to improve health outcomes, and enhance health care quality. Through PPHF, ACL provides grants to state and local agencies and organizations that support implementation of EBPs. ACL funding is limited and designed to supplement existing support for dissemination of EBPs through other sustainable funding mechanisms, including the health care sector. **CBOs, with the support of ACL, NCOA and non-profit CBO networks, are engaged in efforts to secure reimbursable relationships with payers such as Medicaid and Medicare to ensure long-term sustainability of their EBPs.**

Some states have incorporated CBO EBPs as a covered benefit under Medicaid Section 1915(c) home and community-based services (HCBS) and 1115 Demonstration waiver

programs. In a few states, health plans have incorporated CBO EBPs into their Medicaid managed long-term services and supports (MLTSS) plan benefits; EBPs are also offered as a benefit covered by a limited number of Medicare Advantage plans.

HMA research identified common themes across five target states and one city – California, Colorado, Maine, Massachusetts, Washington and New York City – selected for their publicly financed programs, i.e. Medicaid and/or Medicare adoption of EBPs as reimbursable services. Research included conducting a comprehensive literature review and interviews with stakeholders from state Medicaid and state and city Aging Agency officials, CBOs offering EBPs and organizations operating as a CBO network.

For purposes of reference in this brief, a CBO network is defined as an entity that organizes, and provides contracting support for, CBOs offering evidence-based health promotion and disease prevention programs. These entities are sometimes referred to as statewide, regional or network “hubs.”

Summary findings and common themes from research are as follows:

- **Building relationships with state Medicaid programs and agencies on aging is important to sharing the value of EBPs for incorporation as a Medicaid reimbursable service.** Ongoing, regular communication with state agencies on aging and state Medicaid officials is integral to share how EBPs improve health outcomes and quality of life for Medicaid enrollees and the importance of Medicaid reimbursement of EBPs.
- **Building partner relationships with health plans at the local level is essential to advancing discussions about contracts to provide EBPs funded by Medicaid and/or Medicare.** Ongoing, regular communication with potential and current contractual partners individually at the local level is important to maintain and underscore the value-add of support from CBO EBPs.
- **CBOs that entered into contractual relationships with health plans often benefited from efforts using grant funding to build out CBO capacity and infrastructure to ready the organization to engage in business relationships with other health care entities.**

² Chronic Disease Self-Management Education (CDSME) programs provide older adults and adults with disabilities with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, and depression. Since 2003, the Administration on Aging (AoA) has supported the dissemination of CDSME programs through competitive grants in the form of cooperative agreements. Grantee organizations include state agencies, area agencies on aging, nonprofits, universities, and tribes. Funds are used to develop capacity for, bring to scale, and sustain evidence-based CDSME programs. <https://acl.gov/programs/health-wellness/chronic-disease-self-management-education-programs>.

- **Establishment of reimbursable EBP programs beyond grant funding is often supported by a CBO network that brings together CBOs under one umbrella and provides business acumen and support.** Business expertise and support can include marketing, contract negotiations, and training around entering business relationships with health care partners. Specific CBO network entities interviewed for this study include Partners in Care Foundation (Partners) Partners at Home (PAH) in California, CommunityCare Link (CCL) in New York City, and Healthy Living Center of Excellence (HLCE) in Massachusetts.
- **Focused efforts that demonstrate, identify and clearly communicate the return on investment (ROI) to health plan partners are key to reimbursement. These efforts may include providing additional services that are not currently part of the CBO's EBP program but a value-add to the health plan.** Outreach services to health plan members can address issues the health plan may grapple with regarding member engagement and retention, and compliance with individual care plans.
- **Health plans are looking for value-based payment (VBP) relationships and CBOs' ability to take on risk.** CBO networks may be able to provide support and training to prepare for VBP relationships.
- **CBOs can benefit from establishing reimbursement relationships with multiple payers to diversify business and funding streams.** Establishing reimbursable relationships with diverse payers helps support CBO long-term business sustainability and viability. CBOs with a single payer source may experience disruption in referrals and business due to discontinuance of health plan and/or program coverage of services.
- **Case managers have limited time to assess individuals and make referrals to CBO EBPs which poses a barrier to enrollment of individuals in CBO EBPs.** CBO networks moved from a single source of referrals from health plan case managers to multiple sources such as receiving lists of individuals that could benefit from EBP services from health plans that they can proactively reach out to and contact.

Although they face challenges, CBOs are well positioned to be valuable partners to Medicaid programs, health plans, including Medicare Advantage plans to promote healthy aging and demonstrate value to decision-makers. They fill gaps by conducting environmental scans, identifying community and healthcare partners, addressing local barriers, applying

approaches needed for successfully serving individuals in a specific community and determining the best types of EBP programs that best meet local needs. For health plans, CBOs have a deep understanding of their communities and can supplement in health plan resources and connect their plan members with other services in the community.

Looking forward, more work is needed for CBOs seeking reimbursable partnerships to identify short-term and long-term ROIs and the impact that their EBPs have on Medicaid and Medicare quality measures of fee-for-service providers, as well as managed care organizations. Tracking successful efforts and replicable approaches for reimbursement outside of grant funding by multiple payors will continue to be important for long-term sustainability of EBPs.

NCOA Call to Action

1. Encourage broader use of state Medicaid authorities/mechanisms that support health promotion and disease prevention evidence-based programs
2. Develop model laws, regulations, and contracts for states to adopt in their Medicaid programs for support of evidence-based programs
3. Demonstrate that evidence-based programs make a difference for the Medicaid population
4. Educate and partner with key decision makers; participate in networking opportunities
5. Advocate for federal incentives to states to implement health promotion and disease prevention programs
6. Create partnerships and develop a framework and infrastructure for CBO networks
7. Adjust quality measures to capture the benefits of evidence-based programs
8. Identify value-based payment models

PROJECT OBJECTIVE

The National Council on Aging (NCOA), through support from the Administration for Community Living (ACL), contracted with Health Management Associates (HMA) to provide research and technical assistance services to support ACL and NCOA's goal to increase the adoption of evidence-based health promotion and disease prevention programs (EBPs). EBPs include Chronic Disease Self-Management Education (CDSME) programs, and falls prevention programs by Medicaid, Medicare and other health insurance markets. This technical assistance brief is the result of HMA's research and aims to summarize:

- Medicaid authorities and financing mechanisms through which states have adopted evidence-based health promotion programs

- Barriers to adoption of evidence-based health promotion programs and actionable steps to avoid or address
- Provide guidance that can support the creation of infrastructure and systems that connect organizations and deliver services that increase consumer or member engagement in preventive care and disease management that may slow increased acuity and improve quality of life
- Promising strategies and practices that establish reimbursable evidence-based health promotion programs that may be replicated in other states in Medicaid, Medicare advantage, and other emerging markets to support program sustainability beyond traditional grant program funding for health promotion programs.

METHODOLOGY

Literature Review

HMA conducted a literature review from January 2019 through February 2019 expanding on information provided by NCOA. Efforts focused on identifying:

- Current Medicaid authorities and funding mechanisms used to pay for evidence-based programs (EBPs) delivered by community-based organizations (CBOs)
- States and health plans participating in Medicaid programs in selected states that have adopted EBPs
- Contracts with health plans or Medicaid waiver documents reflecting reimbursable relationships with CBOs offering EBPs
- Emerging markets or opportunities with Medicare and other payers for payment/reimbursement for EBPs

The following key search phrases were combined with the names of states and cities of interest based upon information provided by NCOA and HMA program knowledge: healthy aging programs, dual eligible demonstration ombudsman programs, national aging and disability networks, state aging and disability networks, aging and disability evidence-based programs, aging and disability evidence-based practices, evidence-based falls prevention programs by state, CDSME, EnhanceFitness, Fit and Strong!, Healthy Steps for Older Adults, HomeMeds, Diabetes Prevention Program, Tai Chi,

Moving for Better Balance, Matter of Balance, Aging CDSME, Chronic Disease Self-Management, Diabetes Self-Management, falls prevention programs, Senior Reach, Powerful Tools for Caregiving. HMA reviewed the Medicaid websites for each state of interest and searched the ACL Older Americans Act Title III-D evidence-based programs by name, as well as the Centers for Medicare & Medicaid Services (CMS) website to identify current Section 1915(c) Home and Community-Based (HCBS) and 1115 Demonstration waivers in states of interest.

State and City Selection for Research

Based upon the literature review results, HMA and NCOA selected California, Colorado, Maine, Massachusetts, New York City, and Washington as target geographies for research to inform successful approaches and lessons learned regarding reimbursement of EBPs outside of traditional grant funding.³ Selection criteria included the existence of one, or a combination of the following: a CBO network, Medicaid Section 1915(c) HCBS or 1115 Demonstration waivers providing authority for Medicaid reimbursement of evidence-based health promotion and disease prevention programs, Medicaid managed care program(s) with participating health plans providing reimbursement for these programs, or Medicare Advantage health plans providing reimbursement for these programs (See Appendix A States – Selection Rationale, Financing Mechanism and Programs).

³ California: <https://www.picf.org/>; <http://www.medi-cal.ca.gov/>
Colorado: <https://www.colorado.gov/pacific/cdhs/state-unit-aging>
Maine: <https://www.maine.gov/dhhs/oads/>
Massachusetts: <https://www.esmv.org/>; <https://www.mass.gov/topics/masshealth>
New York City: <https://www1.nyc.gov/site/dfta/index.page>
Washington: <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage>

Key Informant Interviews

HMA conducted structured interviews and follow-up conversations with available state Medicaid officials and/or city or state aging agency officials, CBOs, and CBO networks (See Appendix B Interview List).

HMA used a template interview tool jointly created with NCOA (See Appendix C External Interview Guide). Information sought through interviews included, but was not limited to:

- Medicaid authority and funding mechanism(s) used by states
- Partners such as state aging agency officials and others engaged by CBOs in EBPs and payment for services (state, or health plan adoption)
- Barriers to pursuit of payment outside of traditional grant funding, how they were addressed, and lessons learned
- Promising practices in developing Medicaid and/or Medicare payment of EBPs

- Strategies for increasing beneficiary and provider engagement in Medicaid and Medicare-reimbursed EBPs through CBOs

CBO Network Definition

The term CBO network is used throughout this brief. For purposes of reference, CBO network is defined as an entity that organizes the dissemination of and provides contracting support for CBOs offering evidence-based health promotion and disease prevention programs. These entities are sometimes referred to as statewide, regional or network “hubs.” Examples referenced in more detail in this brief as to the support they provide include:

- **Partners in Care Foundation (Partners) and their Partners at Home (PAH)** network of community-based organizations in San Fernando, California. [Partners Web Site](#)
- **Healthy Living Center of Excellence (HLCE)** in Lawrence, Massachusetts. [HLCE Web Site](#)
- **NYC Department for the Aging/Aging in New York Fund** in New York, New York. [NYC DFTA Web Site](#)

BACKGROUND – FINANCING AND PROGRAM AUTHORITIES

Current Funding Sources for Evidence-Based Programs

The most prevalent CBO EBP funding is through ACL. ACL offers evidence-based disease prevention and health promotion program support under the Older Americans Act (OAA) Title III-D, which was established in 1987 to reduce the need for more costly medical interventions. OAA Title III-D funds are distributed to states based on a formula related to their share of the population age 60 and over. These funds require disease prevention and health promotion services programs to be “evidence-based.”⁴ Title III-D funds can be spent on an EBP program if:

- It meets the ACL definition of evidence-based, *and*
- The program is effective, appropriate for older adults, and could be considered “evidence-based” by any of the eleven divisions of HHS.

In addition, the Affordable Care Act (ACA) established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health initiatives designed to improve health outcomes, and enhance health care quality. PPHF has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training.⁵ ACL PPHF grants support the implementation and sustainability of a variety of evidence-based programs including:

- **Chronic Disease Self-Management Education programs (CDSME) Programs:** ACL PPHF grants support CDSME programs, which provide older adults and adults with disabilities education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, and depression. ACL supports

⁴ ACL Definition of Evidence-Based Programs

- Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability and/or injury among older adults; and
- Proven effective with older adult population, using Experimental or Quasi-Experimental Design* and
- Research results published in a peer-review journal; and
- Fully translated** in one or more community site(s); and
- Includes developed dissemination products that are available to the public.

* Experimental designs use random assignment and a control group. Quasi-experimental designs do not use random assignment.

** For purposes of the Title III-D definitions, being “fully translated in one or more community sites” means that the evidence-based program in question has been carried out at the community level (with fidelity to the published research) at least once before. Sites should only consider programs that have been shown to be effective within a real-world community setting.

<https://acl.gov/programs/health-wellness/disease-prevention#future>

⁵ <https://www.hhs.gov/open/prevention/fy-2016-allocation-pphf-funds.html>

dissemination of CDSME programs through competitive grants to provide funds to develop capacity for, bring to scale, and sustain evidence-based CDSME programs. Grantee organizations include state agencies, area agencies on aging, nonprofit organizations, universities, and tribal populations.⁶ CDSME programs are offered in

Current Authorities for Reimbursement of Evidence-Based Community Programs: Medicaid Section 1915(c) Waiver

Within Federal guidelines, states can apply for home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to receive long-term services and supports in their home or community, rather than in an institutional setting.

Source: <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html>

HCBS Waiver programs must:

- Demonstrate that providing waiver services will not cost more than providing these services in an institution
- Ensure the protection of people's health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services follow an individualized and person-centered plan of care

Because a separate Section 1915(c) waiver is generally required for each eligible population, states typically operate multiple waivers under this authority. States may offer home and community-based services under their state plan but often choose waiver authority instead due to the greater flexibility.

Source: <https://www.macpac.gov/subtopic/1915-c-waivers/> and <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html>

communities and through the on-line Better Choices Better Health program based at Canary Health.⁷

- **Evidence-Based Falls Prevention Programs:** ACL PPHF grants are designed to significantly increase the number of older adults and adults with disabilities at risk of falls participating in evidence-based community programs designed to reduce falls and falls risks. These grants also build partnerships and/or secure contracts with the health care sector by identifying innovative funding arrangements that can support these evidence-based falls prevention programs, while embedding the programs into an integrated, sustainable, evidence-based prevention program network. Grantee organizations include public and private nonprofit entities, state agencies, community-based organizations, universities and tribal organizations.⁸

ACL funding is limited and designed to supplement existing support for dissemination of EBPs through other sustainable funding mechanisms, including the health care sector. CBOs, with the support of ACL, NCOA and non-profit CBO networks are engaged in efforts to secure reimbursable relationships with payers such as state Medicaid agencies, Medicaid managed care organizations, and Medicare Advantage and their providers to ensure long-term sustainability of EBPs.

CBOs also rely on local funding from counties and/or municipalities, foundations, and in some cases corporate support for EBPs. Program sustainability continues to be a challenge in most communities across the country, which is why support from health care payers – both public and private – is imperative.

Medicaid

Medicaid services vary by state. Each state's Medicaid State Plan identifies the scope and nature of the program, including groups of individuals to be covered, services to be provided (both mandatory and optional) and the administrative activities that are underway in the state including the methodologies for reimbursing providers.⁹ Medicaid State Plan services do not inherently include EBP services provided by CBOs.

States may seek authority to reimburse EBP services as Medicaid services outside of the Medicaid State Plan through submission and approval of waivers to CMS.

States may submit Medicaid waivers to CMS to authorize coverage and reimbursement of certain services that are not traditional Medicaid State Plan services. State Medicaid waivers in place that currently authorize Medicaid service provision and reimbursement of EBPs include:

⁶ <https://acl.gov/programs/health-wellness/chronic-disease-self-management-education-programs>

⁷ <https://www.canaryhealth.com/>

⁸ <https://acl.gov/programs/health-wellness/falls-prevention>

⁹ A Medicaid and Children's Health Insurance Program (CHIP) state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>

■ **Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waivers**

- ◆ Medicaid Section 1915(c) HCBS waivers authorize expenditure of Medicaid funding for HCBS provided to individuals who otherwise would not meet the eligibility requirements for Medicaid-funded institutional care.^{10 11}

■ **Section 1115 Demonstration waivers**

- ◆ Section 1115 Demonstration waivers grant states or regions the flexibility to design or improve programs to pilot and evaluate state-specific policy approaches to better serve Medicaid beneficiaries.¹²

When a state requests a 1915(c) waiver, it sends an application with an official transmittal form (Form CMS-179) to CMS. Once the waiver application is submitted, the Secretary of the Department of Health and Human Services (Secretary) has 90 days to approve the waiver. Without communication from the Secretary after 90 days, the proposed change automatically goes into effect. However, the Secretary can request additional information. Once the state submits the requested information, a new 90-day timeline begins. Section 1915(c) waivers are initially approved for three years and can renew for another three years or up to five years if dually eligible individuals are enrolled in the plan.

When applying for an 1115 Demonstration waiver, a state must utilize the Healthy Adult Opportunity (HAO) Section 1115 Demonstration Template. In accordance with the Affordable Care Act, states will need to include the following components in demonstration applications for CMS to consider the application submission complete for the purpose of initiating federal review:

- A comprehensive program description of the demonstration, including goals and objectives
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals impacted by the demonstration and how the proposal will vary from the state's current program features and the requirements of the Social Security Act
- An estimate of the expected increase or decrease in annual enrollment, and annual aggregate expenditures; this includes historic enrollment or budgetary data, if applicable
- Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration
- Other program features that the demonstration would modify in the state's Medicaid program and/or CHIP
- The specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration

Current Authorities for Reimbursement of Evidence-Based Community Programs: Medicaid Section 1115 Demonstration Waiver

Section 1115 of the Social Security Act gave the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations.

Proposed reforms can:

- Improve access to high-quality, person-centered services that produce positive health outcomes for individuals
- Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term
- Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals
- Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making
- Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition, and
- Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Source: <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

¹⁰ <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html>

¹¹ Before passage of the Affordable Care Act, states typically used Section 1115 waivers to expand coverage to childless adults who, prior to the law, were not eligible for coverage under federal rules. ACA enabled states to cover this population with incomes up to 133 percent of the poverty level without a waiver. https://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf

¹² <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

- The research hypotheses that are related to the demonstration’s proposed changes, goals, and objectives; a plan for testing the hypotheses in the context of an evaluation; and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators; and
- Written documentation of the state’s compliance with the public notice requirements, with a report of the issues raised by the public during the comment period, which shall be no less than 30 days, and how the state considered those comments when developing the demonstration application.

All states operate one or more Medicaid waivers, which are generally referred to by the section of Social Security Act granting the waiver authority and are categorized either as program waivers or research and demonstration projects. States may choose a 1915(c) waiver to explore programmatic changes that will enable long-term services and supports to be provided in the home and community-based settings rather than institutions. States may choose an 1115 waiver if they want to explore the feasibility and measure the impact of a given payment and/or delivery reform. Washington, one of the states of interest, has leveraged both 1115 and 1915(c) waivers to expand and augment services for its elders, as demonstrated in our examples below.

Through these two waiver authorities, Medicaid EBP reimbursement may be fee-for-service through provider submission of claims to the state Medicaid program or payment to the provider via a health plan with which the state has a contract to provide Medicaid services. For an example of a Section 1915 (c) waiver description of covered EBP services see Appendix D, Massachusetts Section 1915 (c) Frail Elder Waiver EBP Service Description. If the state Medicaid agency contracts with health plans for services covered by these waivers, then providers must enter into contracts with health plans and submit claims for reimbursement for services from the health plan. Medicaid often requires health plans to pay at least the Medicaid fee-for-service rates for HCBS services.

CMS requires states to seek public input when submitting a waiver application for a renewal or an amended waiver. This public comment period provides an opportunity for CBOs to provide information on the value of EBPs and petition their state to include EBPs in the waivers. Being proactive in the new or amended waiver process is key to engaging state Medicaid agencies.

Below are examples of Section 1915(c) HCBS waivers that cover EBPs:

- **Washington state leveraged their Medicaid Community Options Program Entry System (COPES) and New Freedom waivers** to provide HCBS services to disabled persons beyond the age of 64 and to receive services in their home and community while managing their own service plan and budget, respectively.

- **Massachusetts’ Medicaid Frail Elderly Waiver (FEW).** (See Appendix D 1915(c) FEW Waiver EBP Service Description)

Examples of Medicaid Section 1115 Demonstration Waivers supporting EBP services include:

- **New York’s Section 1115 Demonstration Waiver authorized the implementation of their Delivery System Reform Incentive Payment (DSRIP) program.** The DSRIP requires community level collaboration between safety net providers to foster system transformation by implementing innovative projects. The innovations range from delivery reform to population health improvement for which CBO EBPs are reimbursed. (Note: New York’s DSRIP program ended March 31, 2020)
- **Washington state’s Medicaid Section 1115 Demonstration waiver, Healthier Washington is partnering with CBOs to offer EBPs in their supporting Accountable Communities of Health (ACH) pilot.** The state leveraged the 1115 waiver to create a new optional Medicaid alternative care benefit package for individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term services and supports.

Of note, Medicaid health plans have flexibility to reimburse for services not directly covered by Medicaid funding. These services are sometimes called “enhanced benefits” or “value-added benefits” and are offered by health plans to improve the quality and cost-effectiveness of their programs usually based upon an identified return on investment (ROI) for providing additional services not covered by Medicaid funding.

Emerging Markets

Emerging markets for CBO EBPs include Medicare Advantage Plans, Medicaid programs serving individuals not using long-term services and supports, and commercial health plans.

Examples include:

- A large managed care plan in California, with both commercial and Medicare Advantage (MA) enrollees, contracts with Partners to offer CBO EBPs to their members.
- New York City Department for the Aging’s (DFTA) had a contract with DSRIP Performing Provider Systems (hospital systems) to provide care transitions similar to EBPs. DFTA plans to enter into discussions with Medicare Advantage health plans to obtain funding for their EBP falls prevention programs through an ACL falls prevention grant.
- Washington state is in the process of adding access to EBP services to Medicaid enrollees that are not accessing long-term services and supports through its ACH program to expand access to EBPs and provide a broader base of potential consumers to EBP providers. ACHs bring together a multidisciplinary group of local community leaders across the state to align resources and activities to support whole-

person wellness and care. Each identified state region, through its ACH, will pursue projects aimed at transforming the Medicaid delivery system focusing on health systems capacity building, care delivery redesign, prevention and health promotion, and increased use of value-based payment (VBP) models.¹³

- Washington is negotiating with its state employee health insurance plans to cover CBO EBPs, including those offered in the community and digitally, such as, Better Choices, Better Health.
- **Recent Flexibility and Expansions in Supplemental Benefits Provided by Medicare Advantage (MA) Plans.** In recent years, Congress and CMS granted new flexibilities for MA plans to offer tailored and more innovative supplemental benefits. Notably, plans may now offer supplemental benefits, such as in-home services and supports, and support for caregivers, that are not primarily

health related and may tailor these benefits to enrollees with specific chronic diseases and/or conditions. MA plans may offer these benefits in a non-uniform approach to a subset of enrollees and tailor offerings to address gaps in care and improve overall healthcare outcomes in a target geography. CBOs may explore the provision of EBPs as a supplemental benefit offering through MA plans.

Potential Markets

Potential markets for consideration in the future for EBP coverage are Medicare Advantage Special Needs Plans that serve individuals with more complex needs, including people dually eligible for Medicare and Medicaid, referred to as dual eligible special needs plans (D-SNPs). For more information, see CMS Special Needs Plan (SNP) Frequently Asked Questions (FAQs) at: [CMS SNP FAQs](#).¹⁴

FINDINGS

H MA research identified common themes across the five target states and city – California, Colorado, Maine, Massachusetts, Washington and New York City – for publicly financed programs, Medicaid and/or Medicare adoption of CBO EBPs as reimbursable services. Findings are grouped as: 1) successful and replicable approaches; and 2) barriers to adoption of and consumer access to EBPs.

Successful and Replicable Approaches

Build Relationships and Communication Channels with State Medicaid Programs and Agencies on Aging

Ongoing, regular communication with state agencies on aging and state Medicaid agency officials is integral to sharing how EBPs improve health outcomes and quality of life for Medicaid enrollees and the importance of Medicaid reimbursement of EBPs. CBOs and CBO networks can benefit from establishing strong relationships with state agencies on aging to work with state Medicaid officials to establish EBPs as a Medicaid reimbursable service. State agencies on aging work closely with their sister Medicaid agencies and many oversee Section 1915(c) HCBS waiver programs for Medicaid. The state of Washington's Aging and Long-Term Support Administration collaborated with state Medicaid officials to include EBP services in the state's Section 1915(c) Community Options Program Entry System (COPES) and New Freedom HCBS waivers.

CBOs can also build relationships with state Medicaid agencies by attending Medicaid publicly convened meetings for program input. Additionally, each Medicaid agency is required to

convene a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services.¹⁵ Although CBO membership is not required, CBOs should request representation on the state's MCAC.

Build Relationships and Partnerships Through a CBO Network

Statewide CBO networks have supported establishing Medicaid and Medicare Advantage health plan contracting opportunities. These entities provide business function support including marketing, negotiating contracts, executing required paperwork, delivery system development and management, and complying with health care privacy laws.

Examples include:

- **The Partners in Care Foundation (Partners) Partners at Home (PAH)** program in San Fernando, California, is a specialty network of CBOs that supports hospitals, physician groups and health plans by piloting models to provide patient-centered social services in the home and at community sites. PAH offers health self-management education to individuals in the plan's disease management program with five chronic conditions who PAH maps to specific regions in order to identify sufficient numbers of individuals to recruit for workshops. PAH has been supported by several foundations. [Partners Web Site](#)
- **The Healthy Living Center of Excellence (HLCE)** in Lawrence, Massachusetts performs the functions of a CBO network under Elder Services of Merrimack Valley. HLCE is the statewide hub for dissemination of and contracting

¹³ <https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach#what-is-an-ach>

¹⁴ <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Special-Need-Plans-SNP-Frequently-Asked-Questions-FAQ.pdf>

¹⁵ 42 CFR § 431.12 - Medical Care Advisory Committee

for evidence-based self-management programs in Massachusetts. HLCE provides training to local program leaders. HLCE also partners with local health care systems and providers including nutritionists, registered dieticians, and nurse practitioners to connect plan members to care and provide members the support needed to design their own personal action plans for their chronic conditions.

[HLCE Web Site](#)

- **The CommunityCare Link (CCL)** program is a management services program for a network of participating CBOs housed under the Aging in New York Fund with initial funding from the NYC Department for the Aging. CCL connects health plans' (and other payers') older adult members with high quality, evidence-based health promotion services to remain healthy and active in their communities. CCL began with a focus on evidence-based falls prevention programs and expects to expand services to include social adult day care and chronic care management. [CCL Web Site](#); [NYC DFTA Web Site](#)

Position CBOs as Key Community Resources

CBOs are community partners that are uniquely positioned to identify the most suitable EBPs based on community needs. It is important for CBOs to demonstrate their essential knowledge of local geographies, communities, and residents to health plan and system partners. As community partners, they add an array of programs and services that attract membership and compete with other local activities. Partners established a "Wellness Club" packaging a number of their EBPs with other wellness activities, such as healthy cooking demonstrations.

Action to Deepen Health Plan Partner's Understanding and Appreciation of EBPs

Partners walked the case managers of a large health plan in California it contracts with through sample CDSMP exercises to experience and deepen understanding of the programs they may refer members to. This activity generated buy-in among plan staff related to the value of EBPs.

Establish Listening Sessions with Prospective Health Care Partners to Tailor Services

Interviewees highlighted the critical value of listening to the needs of prospective health plan partners. Conducting listening sessions supports offering EBP programs that fit their needs and adding on services that support what health plans and systems are struggling with – whether it be enrollee engagement and retention, compliance with care plans and showing up for primary care provider visits.

A large managed care plan in California with both commercial and Medicare Advantage (MA) enrollees approached Partners based upon its research of case management programs which continually identified the strength of the Partners case management network. When the plan approached Partners the conversation extended to not just case management services but to the work of Partners' community network of CBO EBPs. Partners listened upfront to the health plan's needs, concerns, priorities and business interests. Partners highlighted the ROI of not only more appropriate service utilization by members, but also putting incentives in place to retain members. Based upon the health plan's needs, reimbursement was stratified using a three-pronged approach: 1) reaching out to members; 2) individuals enrolling in the EBP; and 3) individuals attending programs.

Build Business Infrastructure and Understanding of the Health Care System

Interviewees shared it is important for CBOs to ready themselves for contracting with health plans and systems prior to entering contractual relationships. They will need to have information technology and infrastructure, understand and comply with health care information privacy and compliance rules and laws, process and submit paperwork, maintain training curriculums and market their services. CBOs need to invest in staff with knowledge of the broader health care sector to gain a full understanding of their immediate health care system environment. They may do this as a solo CBO or join a CBO network, if available.

In preparation to develop a partnership with a local health care system, NYC DFTA increased in-house expertise by hiring a key staff person who brought a health care administration background and knowledge of the health care delivery system to the team. Partners also added staff with knowledge of the health care system and health plans to support and cultivate relationships with health plans.

Leverage Grant Funding and State Interests and Resources

States and CBOs can leverage existing Medicaid programs and grant funding to broaden and enhance their CBO provider network readiness for expanding their CBO EBP business. NYC Department of Health obtained grant funding from the state of New York for *A Blueprint for Contracting with a Community Based Organization (CBO) Network* to develop a model contract for health plans and CBOs. The base contract is intended to support contracting with multiple health care payers including Medicaid, Medicare Advantage and commercial health plans.

Washington state seeks to support the sustainability of Medicaid participating CBO EBP providers by increasing the number of members eligible to receive their services. It is embarking on broadening access to CBO EBPs to more of its Medicaid enrollees by making these services available in Medicaid programming for different populations. In addition

to including services in its Medicaid long-term services and supports fee-for-service delivery system, Washington is in the process of making EBP services a covered benefit in its Accountable Communities of Health program, extending these services to Medicaid enrollees not using long-term services and supports.

Use a Multi-Pronged Referral Structure

HLCE started by receiving EBP referrals from Medicaid care managers; however, care managers have limited time when conducting assessments to discuss EBPs available through CBOs. After six months, HLCE transitioned to a three-pronged referral system. They now receive referrals through: 1) case managers; 2) member self-identification; and, 3) an internal health plan registry provided every two months identifying members to target for outreach for EBP participation. HLCE conducts proactive outreach by sending letters from their case managers and HLCE providers, as well as phone calls from a live person. Fourteen to seventeen percent of individuals contacted through the registry complete EBPs.

After Securing Contractual Relationship Establish Channels for Ongoing Communication and Training

Partners shared that after securing its contractual relationship with the large health plan, they held quarterly joint operating committee meetings, which have been critical to staying engaged and maintaining a strong relationship. The meetings provide a venue to address issues or concerns and promote continuing a strong relationship. Partners additionally conduct annual trainings with the health plan.

Barriers to Adoption of and Consumer Access to EBPs

Demonstrating Return on Investment (ROI)

Inability to concretely demonstrate the ROI of EBPs has posed one of the greatest challenges to CBOs for successfully entering into contractual relationships with health plans. Interviewees expressed health plans want EBP ROI identified for the *specific* populations they serve. CBOs are often unable to communicate the cost-benefit of EBPs due to lack of access to claims data to show program benefits, such as reduction in preventable hospitalizations and emergency department diversion. Patient-specific data and information demonstrates the value of prevention and self-management. Health Insurance Portability and Accountability Act (HIPAA) provisions related to health care privacy are cited as reasons for lack of access to this data. To ameliorate this, CBOs are encouraged to identify pain points of health plans or other potential partner organizations and build measures of success addressing health plan challenges. In lieu of data, CBOs can offer services that are not part of their EBPs, such as screening and outreach services to pilot ideas and initiate relationships for their EBPs. One interviewee noted CBO assistance with increasing health plan member engagement can lead to member retention and compliance with person-centered care plans. Another interviewee cautioned that it is important not to overpromise

outcomes and results to the health plans that cannot be proven due to lack of access to claims and outcome data and may be beyond CBO capabilities due to technology, health privacy or other limitations.

CBOs may be hesitant to share ROI with health plans due to concerns that the plan may choose to build its own internal EBPs. This concern may be addressed by underscoring the CBO's value as a local presence in the community rich with essential knowledge of community needs and resources. The CBO can be partners in conducting essential local community needs assessments for health plans among other tasks.

There is national data cited by peer-reviewed journal articles studying the impacts of EBPs on health outcomes which examined measures like depression symptoms, hypoglycemia, medication nonadherence, and exercise at six and 12 months post EBP engagement.

At six months, diabetes EBPs were proven to reduce the number of study participants expressing depression symptoms from 22% to 16.3%. EBPs reduced the number of study participants experiencing symptoms of hypoglycemia from 38.4% to 32.4%, and reduced medication nonadherence in study participants from 35% to 29.4%. Twelve months after study participants engaged in the diabetes EBP, the number of individuals expressing depression symptoms was further reduced to 15.6%. The number of individuals expressing symptoms of hypoglycemia was further reduced to 30% and the number of participants demonstrating medication nonadherence was further reduced to 30.5%. In six months, non-exercisers increased aerobic exercise by 43 minutes per

Providing CBO EBPs to Individuals in Rural Areas

Participant take-up rates of EBP programs are often higher in urban and suburban areas. It takes longer to obtain member take-up rates of a critical mass to run an EBP program in rural geographies. An approach employed by Senior Whole Health, Cambridge, Massachusetts, with Elder Services of Merrimack Valley in Lawrence, Massachusetts, is to filter a central registry of pre-screened members for EBPs by address enabling identification of individuals in independent living or public housing. By specifically promoting programs to individuals living in the same geographical area or living situation, take-up rates of EBP programs in rural locations can reach numbers as high as those in large urban and suburban areas.

week and averaged 46 minutes of aerobic exercise per week at 12 months.^{16 17 18}

Exclusion from Covered Plan Benefits and Reimbursement

Despite community need and potential partner interest, EBP lack of inclusion as a Medicaid-covered benefit and lack of funding were shared as significant barriers to entering reimbursable relationships with Medicaid health plans. EBPs are not a covered Medicaid State Plan benefit. They may be covered under Medicaid if a state chooses to include EBP services in a Medicaid waiver request to CMS for federal approval. One interviewee relayed the state in which they operate experienced Medicaid managed long-term services

Showing Short-Term CBO EBP Return on Investment to Health Plans and Sharing Risk

CBOs can identify how they may be accountable for shorter term ROI through efforts to assist with enrollee engagement, retention, and the use of individual care plans. Elder Services of Merrimack Valley, an Area Agency on Aging (AAA) located in Lawrence, Massachusetts, took on shorter term, shared risk approach with Massachusetts Medicaid Senior Care Options health plan, Senior Whole Health, in Cambridge, Massachusetts, through its reimbursement structure. They did not offer a six-week exclusive EBP but rather a package of services and activities around the six-week program. The CBO receives fifty percent payment upon its first meaningful contact that results in the member signing up for the EBP. The remaining fifty percent is paid to the CBO upon the member's completion of the six-week program. The resulting arrangement is one of joint risk:

- The health plan makes a fifty percent payment for individuals who may not fully engage and complete the full program.
- The CBO is at risk of providing services to individuals who may not complete the program resulting in loss of the final fifty percent payment.

and supports (MLTSS) program funding shortfalls. The articulation of EBP ROI was not enough to overcome the case for funding EBP. The MLTSS plans relayed that the services are not a covered benefit and could impact payment of Medicaid covered services they are required to provide.

Clinical Perspective on ROI

Interviewees noted the clinical community is interested in near-term ROI, treatment versus prevention, and may not experience the benefits achieved from longer-term ROI of EBPs. Health plans and network clinicians have immediate accountability and risk for quality measures they must meet nearer term. In a case management program, interviewees relayed that clinicians are looking for shorter term ROI realized in a year or less rather than change in behavior and outcomes that are realized over a longer period of time. *EBPs offer long term ROI on slowing the progression of chronic conditions and preventing new conditions and other common issues related to aging like falls and chronic pain.*

Case Managers have Limited Time to Assess Individuals and Make Referrals

Case managers find themselves short on time with all that needs to be addressed while conducting individual assessments for risks, need for services and making referrals to appropriate providers and community-based resources, resulting in a barrier to enrollment of individuals in CBO EBPs. As some CBO networks gained experience working with health plans, they transitioned referrals from a single source of referrals from case managers to multiple sources, like receiving lists of individuals who may benefit from EBP services from health plans that CBOs can proactively reach out to.

Consumer Attendance and Adherence to EBPs

It is difficult for frail individuals or those with more advanced chronic conditions to attend EBPs outside of their homes. Most EBP interventions are workshops that run between six and eight weeks with two in-person hours per session to provide education related to chronic condition management, falls prevention and healthy living. Individuals who are less frail and earlier in chronic disease progression are more likely to be able to get to, attend and gain greater benefit from the EBP. *An interviewee suggested CBOs work with health plans to refer individuals earlier in the stage of progression of disease and frailty. These individuals are more likely to be able to complete and follow through on what they gain from the EBP.*

Cost of Running a Program, Staffing and Maintaining a Training Network

EBPs need ongoing funding outside of service provision reimbursement to support program infrastructure. Maintaining

¹⁶ Lorig, K., Ritter, PL., Turner, RM., et. Al. (2016). Benefits of Diabetes Self-Management for Health Plan Members: A 6-month Translation Study. Journal of Medical Internet Research, 18(6).

¹⁷ Lorig, K., Ritter, PL., Turner, RM., et. Al. (2016). A Diabetes Self-Management Program: 12-Month Outcome Sustainability From a Nonreinforced Pragmatic Trial. Journal of Medical Internet Research, 18(12).

¹⁸ Turner, R.M., Ma, Q., Lorig, K., et. Al. (2018). Evaluation of a Diabetes Self-Management Program: Claims Analysis on Comorbid Illnesses, Healthcare Utilization, and Cost. Journal of Medical Internet Research, 20(6).

training networks and curricula is challenging due to staff turnover and ongoing changes to a given EBP curriculum, where even small changes to a curriculum can be a challenge. Creation of a CBO network may provide shared support needed to address training needs and updates to curricula.

Geographic location is another challenge connected to a network's ability to improve the health of Medicaid beneficiaries. Building infrastructure in rural areas is often difficult and expensive. Funding for digital programming may help maintain programs in rural areas.

Beyond cost, staff changes, mergers and acquisitions, closures by and of other entities can lead to loss of CBO EBP program champions leading efforts to establishing business relationships with Medicaid managed care and Medicare Advantage health plans. A few years ago, in Colorado, CBO EBPs' primary community partner supporting processes for state Medicaid reimbursement was the Consortium for Older Adult Wellness (COAW). COAW held the licenses for

many EBPs and coordinated the training for program leaders throughout the state. COAW ended operations resulting in loss of coordination at the state level supporting relationships with the state Medicaid program at the time. There is no longer a centralized agency that oversees these programs, but the Colorado Department of Human Services still provides a large number of EBPs throughout the State. However, funding to support decentralized licensure could prevent such an adverse impact in the event of a lost partnership for other states.

CBOs Risk Program Disruption and Loss of Business if Contracting is Limited to One Payer

CBOs would benefit from establishing reimbursement relationships with multiple payers to diversify business and funding streams. Establishing reimbursable relationships with diverse payers and entities supporting relationships with those payers can enhance CBO long-term business sustainability and viability. CBOs with a single payer source may experience disruption in referrals and business due to discontinuance of health plan and/or program coverage of services.

CONCLUSION

CBOs and CBO networks offering EBPs have diverse experiences in different states for pursuing Medicaid and Medicare reimbursement of EBPs. Myriad factors must be considered when CBOs seek Medicaid, Medicare and other payor relationships. Strategic partnering and marketing services can be adversely affected by state administration leadership changes and shifting state priorities.

Although they have faced challenges, CBOs are well positioned to be valuable partners to Medicaid programs and health plans, including Medicare Advantage plans, to promote healthy aging and demonstrate their value to the decision makers. They can fill gaps by conducting environmental scans, including identifying community and healthcare partners, local

barriers and factors for success and determining what types of EBP programs are going to be the best fit to meet needs. CBOs know local communities' needs and the cultural, health, and disability status of their populations, available resources and gaps in resources.

Looking forward, more work is needed for CBOs seeking reimbursable partnerships to identify short-term and long-term ROIs and the impact that their EBPs have on Medicaid and Medicare quality measures for fee-for-service providers, as well as managed care organizations. Tracking successful efforts and replicable approaches for reimbursement outside of traditional grant funding by multiple payors will continue to be critical for long-term sustainability of EBPs.

NCOA's CALL TO ACTION

1. **Encourage broader use of state Medicaid authorities and other mechanisms that support health promotion and disease prevention evidence-based programs.**

States are excellent laboratories for experimentation. This report provides examples of states that have used Medicaid as an avenue to support evidence-based programs delivered by CBOs. The high need Medicaid population can benefit significantly from these programs with the appropriate structures in place for outreach, referral, and follow-up. NCOA will continue to educate CBOs about steps needed to advance coverage and reimbursement of EBPs in Medicaid programs through webinars, conference sessions, Medicaid and network development learning collaboratives, among other opportunities.

2. **Develop model laws, regulations and contracts for states to adopt in their Medicaid programs for support of evidence-based programs.**

There is precedent for the development of model laws to positively impact policy change at the state level. NCOA will partner with other organizations to examine strategies used by others to develop and encourage states to adopt model laws or regulations and use these or similar strategies to advance the use of evidence-based programs. In addition, states need model contracts for contracting with CBOs. An environmental scan is needed to identify where these contracts exist to develop a model Medicaid contract template.

3. **Demonstrate that evidence-based programs make a difference for the Medicaid population.**

National research conducted on many evidence-based programs has not specifically targeted the impact on the Medicaid population on improving health outcomes, quality measures, or on reducing health care utilization. This research could provide the evidence needed by Medicaid systems to accept payment for these programs as part of a broader package of services for older adults and persons with disabilities. Garnering support from the Centers for Medicare & Medicaid Innovation Center is an important first step. In addition, the ACL Research, Evaluation and Demonstration Innovation Center included in the recent reauthorization of the Older Americans Act is another potential avenue to conduct needed research.

4. **Educate and partner with key decision makers; participate in networking opportunities.**

NCOA will continue to collaborate and network with other national organizations such as ADvancing States (formerly

NASUAD), National Governor's Association, and National Association of Medicaid Directors about evidence-based programs and the benefits they can provide to Medicaid enrollees. A key component of this education is to provide successful examples of what states have implemented in their Medicaid waiver programs, such as those provided in this report. National and state conference presentations, blog posts, newsletter articles, and webinars are some of the ways in which this education and networking will take place.

5. **Provide federal incentives to states to implement health promotion and disease prevention programs.**

These incentives could include grants to states that test out the use of evidence-based programs for individuals enrolled in Medicare and Medicaid demonstration programs. Another incentive could be enhanced Federal Medical Assistance Percentages or FMAP, which is the percentage rates used to determine the matching funds allocated by the federal government for state Medicaid programs.

6. **Create partnerships and develop a framework and infrastructure for CBO networks.**

NCOA will continue to partner with other national organizations and governmental agencies to build a framework for national, state and local CBO networks that have the capacity to deliver health promotion and disease prevention programs and other programs and services that address the social determinants of health for older and persons with disabilities. A key step in building CBO networks is identifying funding sources for sustainability. In addition, data exchange is key to the success of CBO networks, as well as determining value (outcomes and costs), and improving quality.

7. **Adjust quality measures to capture the benefits of evidence-based programs.**

NCOA can also work with others to advocate for states to adjust or tailor quality measures within their managed long-term services and support systems to include the benefits of health promotion and disease prevention programs.

8. **Identify Value-based Payment Models.**

More work is needed to identify examples in which CBOs have entered into value-based payment (VBP) arrangements with health payers in order to understand their successes and challenges and develop models that can be replicated based on current experience and emerging arrangements through Medicaid and other payors.

APPENDICES

APPENDIX A: States – Selection Rationale, Financing Mechanisms, and Programs

Target State	Reason for Selection	Financing Mechanisms	Programs Offered
California	Partners In Care Foundation (Partners) is a national leader in organizing CBOs and EBPs	<p>OAA IIID for the City and County of Los Angeles, ACL Fall Prevention and CDSME grant</p> <p><i>Contracts with:</i></p> <ol style="list-style-type: none"> 1. A health plan for their commercial and Medicare Advantage plans for EBPs 2. A Medicaid health plan for underwriting workshops and health education lectures for individuals in the community regardless of payer of health care 3. A Medicaid plan to provide Tai Chi and exercise classes in family resource centers for individuals in the community regardless of payer of health care 	<ul style="list-style-type: none"> ■ OAA IIID supports: <ul style="list-style-type: none"> ◆ Chronic Disease Self-management Program (CDSMP) (Chronic Disease, Chronic Pain & Diabetes) ◆ A Matter of Balance ◆ Arthritis Exercise ◆ Walk With Ease ◆ Bingocize ◆ HomeMeds ■ ACL Falls supports: <ul style="list-style-type: none"> ◆ Tai Chi Moving for Better Balance ◆ A Matter of Balance ■ ACL CDSME supports: <ul style="list-style-type: none"> ◆ Chronic Pain Self-management ◆ Diabetes Self-management ■ Solera Health Contract supports: <ul style="list-style-type: none"> ◆ National Diabetes Prevention Program ■ Partnerships with health plans support: <ul style="list-style-type: none"> ◆ A Matter of Balance (Falls Prevention) ◆ CDSMP/DSMP/CPSMP
Colorado	The State Unit on Aging established channels for becoming a reimbursable provider of EBP programs	Older Americans Act (OAA) funds. The OAA Network has a variety of programs running and operating	<ul style="list-style-type: none"> ■ Matter of Balance, N’Balance, Stepping On, Tai Chi Quan: Moving for Better Balance, Tai Chi for Arthritis, On the Move (Falls Prevention) ■ Chronic Pain Self-Management, Arthritis Foundation Exercise Program, Arthritis Foundation Aquatic Program, Healthy Moves for Aging Well (Pain Management) Diabetes Prevention Program, Diabetes Self-Management Program (CDSMP and DSMP) ■ Senior Reach, Aging Mastery (Mental Health) ■ Powerful Tools for Caregivers, Stress Busting Program for Family Caregivers, Aging Mastery for Caregivers

Target State	Reason for Selection	Financing Mechanisms	Programs Offered
Maine	Diverse EBP providers and a strong statewide network to easily connect with older adults.	<p>OAA Title III- D funds (allocated to the Area Agencies on Aging) and ACL funding to stand up EBPs</p> <p>Some programs are funded through Section 1915(c) HCBS waivers and lines of billing are in place</p> <p>The Maine Diabetes Prevention and Control Program is funded by the Centers for Disease Control and Prevention</p>	<ul style="list-style-type: none"> ■ Living Well for Better Health (CDSMP) ■ Living Well with Chronic Pain (CPSMP) ■ National Diabetes Prevention Program (NDPP) ■ Living Well with Diabetes (CDSMP) ■ Tai Chi for Health and Balance, A Matter of Balance, Tai Ji Quan ■ Enhance Fitness (Falls Prevention) ■ Savvy Caregiver
Massachusetts	<p>Statewide CBO network has a contract with a Medicaid Senior Care Options (SCO) health plan</p> <p>The State amended their Section 1915(c) HCBS waiver to offer EBPs as a reimbursable service</p>	Elder Services of Merrimack Valley (ESMV) has a Medicaid reimbursable relationship with SCO Senior Whole Health and is a Section 1915(c) waiver provider	<ul style="list-style-type: none"> ■ Chronic Disease Self-management, Diabetes Self-management Program, Pain Management Program (CDSME Programs) ■ A Matter of Balance (Falls prevention)
New York City	New York City Department for the Aging (DFTA) established a Managed Services Organization (MSO) to support CBOs and those operating EBPs in establishing relationships with Medicaid and Medicare Advantage MCOs.	Medicaid reimbursable partnership with One City Health, a Performing Provider/Hospital System	<ul style="list-style-type: none"> ■ Home Meds, PEARLS (Home care) ■ A Matter of Balance (Falls Prevention) ■ Diabetes Self-Management (CDSMP)
Washington	Washington EBPs are reimbursable under Section 1915(c) HCBS waivers	<p>Section 1115 Demonstration waiver – includes the DSRIP Program</p> <p>Washington chronic disease self-management programs (CDSMPs) are Medicaid reimbursable under the State’s Section 1115(c) HCBS waiver</p>	<ul style="list-style-type: none"> ■ Chronic Disease Self-Management

APPENDIX B: Interview List

State	Interviewees
California	<ul style="list-style-type: none"> ■ Dianne Davis, MPH — Vice President, Community Wellness, Partners in Care Foundation
Colorado	<ul style="list-style-type: none"> ■ Jayla Sanchez Warren — Area Agency on Aging Director, Denver Regional Council of Governments ■ Leighanna Konetski, RDN — Colorado State Department of Human Services, State Unit on Aging
Maine	<ul style="list-style-type: none"> ■ Mary Walsh, MEd — Consultant, National CDSME Resource Center, National Council on Aging ■ Michelle Cloutier — Healthy Aging Manager, Department of Health and Human Services, State of Maine ■ James Moorhead, MA — Aging Services Manager, Department of Health and Human Services, State of Maine ■ Paul Saucier, MA — Director, Office of Aging and Disability Services, State of Maine
Massachusetts	<ul style="list-style-type: none"> ■ Jennifer Raymond, MBA, JD — Director, Healthy Living Center of Excellence, and Chief Strategy Officer, Elder Services of Merrimack Valley
New York	<ul style="list-style-type: none"> ■ Meghan Shineman, MPA — Director of Healthcare Integration, The Department For The Aging ■ Carin Tinney, MSW — Chief Program Development Officer, The Department For The Aging ■ Jennie Sutcliffe, MSc — Senior Health Care Policy Analyst, NYC Department of Health and Mental Hygiene
Washington	<ul style="list-style-type: none"> ■ Karen Fitzharris, Duals Director at State of Washington, Aging and Long-Term Support Administration ■ Todd Dubble, Office Chief, Home and Community Services Division, Aging and Long-Term Support Administration ■ Barbara Hanneman, MSW — Quality Assurance Manager, Washington State Department of Social and Health Services ■ Kelli Emans, Programs Management Division, Aging and Long-Term Support Administration

APPENDIX C: External Interview Guide

National Council on Aging
Identifying Medicaid Funding Opportunities for
Evidence-Based Healthy Aging Programs
Interview Guide

Organization Name

Date | Time

Attendees: (Interview Invitees)

Name, Title, Organization

Name, Title, Organization

Welcome and Introductory Points: (3 min)

Housekeeping for Interview: (2 min)

Interview questions: (55 min)

- **Evidence-based programs:** What evidence-based programs (EBPs) are reimbursed by Medicaid? Was the EBP implemented in the state for Medicaid populations, or a broader population, prior to being Medicaid reimbursable? If so, under what program and with what funding? How does the state define or determine what is an evidence-based program? Does the state fund programs delivered digitally? Which beneficiaries are eligible to receive the EBP?
- **Medicaid Authority and Funding Mechanism:** Describe the combination of authority (i.e. state legislation, state plan amendment, waivers, etc.) used to make the evidence-based program Medicaid-reimbursable. If multiple pathways were considered, why was each strategy successful or unsuccessful?
- **Partners in Adoption and Implementation:** Who are/were the partners involved in getting the Medicaid policy changed and implementing the change providing the EBP? Which state agencies, local governments, managed care organizations (MCOs), or community-based organizations (CBOs) have been involved in the process and in what roles? Was there a particular “champion” supporting Medicaid payment for EBP?
- **Medicaid Reimbursement:** How does Medicaid reimburse for the EBP (value-based or FFS)? How was the reimbursement mechanism and level decided? When reimbursed through an MCO, is the program considered medical or administrative? What requirements to entities have to meet to be eligible to deliver and bill for the EBP?
- **Uptake:** Have beneficiaries/providers (clinical and/or non-clinical)/MCOs been receptive to using and promoting the EBP as a covered benefit?
- **Barriers to Adoption:** What barriers stalled or prevented the adoption of an EBP as a Medicaid benefit? How were they overcome? Where did the greatest resistance come from and why?
- **Best Practices Supporting Adoption:** Are there replicable strategies that you would consider leveraging to adopt another EBP?
- **Other:** Is there anything we should know that we have not covered today?

APPENDIX D: Massachusetts Section 1915(c) Frail Elder Waiver EBP Service Description

Frail Elder Waiver EBP and Service Description from Mass.gov Website

“The Frail Elder Waiver (FEW) is an HCBS waiver program that makes community supports available to Massachusetts residents aged 60 and older. FEW supports individuals with a variety of needs that can be met with supports ranging from basic to intensive levels. FEW is a MassHealth program. The Massachusetts Executive Office of Elder Affairs (EOEA) is responsible for the day-to-day operation of this waiver program.”

Source: <https://www.mass.gov/frail-elder-waiver-few>

Frail Elder Waiver EBP and Service Description from Medicaid Website

MA Frail Elder (0059.R07.00) “Provides Alzheimer’s/Dementia coaching, home health aide, homemaker, personal care, respite, chore, companion, complex care training and oversight (formerly skilled nursing), enhanced technology/cellular personal emergency response system (PERS), environmental accessibility adaptation, evidence based education programs, goal engagement program, grocery shopping and delivery, home based wandering response systems, home delivered meals, home delivery of pre-packaged medication, home safety/independent evaluations (formerly occupational therapy), laundry, medication dispensing system, orientation and mobility services, peer support, senior care options (SCO), supportive day program supportive home care aide, transitional assistance, transportation for individuals physically disabled ages 60–64 and aged 65–no max age.”

Source: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/MA-Waiver-Factsheet.html#MA40059>

Excerpt of Massachusetts Section 1915(c) Frail Elder Waiver Application (pages 98 to 101) is on the following pages.

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptation Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptation Agencies

Provider Qualifications

License (specify):

If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc)

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that contracts with the ASAP as such and successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Confidentiality:

Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEPA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Evidence Based Education Programs

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

- **Service is not included in the approved waiver.**

Service Definition (Scope):

Evidence Based Education Programs provide participants with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS and depression, to better manage/prevent falls, or to appropriately manage/assist their caregivers in provision of their care (eg., for individuals with dementia). All Evidence Based Education Programs are provided either as peer-facilitated self-management workshops that meet weekly for six or eight weeks or as 1:1 interventions with a trained coach. They promote participant's active engagement to undertake self-management of chronic conditions by teaching behavior management and personal goal-setting. Topics include diet, exercise, medication management, cognitive and physical symptom management, problem solving, relaxation, communication with healthcare providers and dealing with difficult emotions. Each course requires trained facilitators who adhere to prescribed, evidence-based and validated modules for each workshop. Workshops are broken down to include training in: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) optimal nutrition, 6) decision making, and 7) how to evaluate new treatments. Classes and/or 1:1 trainings are highly interactive, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

Evidence Based programs may include but are not limited to: Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (Spanish CDSMP), Arthritis Self-Management Program (English and Spanish), Chronic Pain Self-Management program, Diabetes Self-Management Program (English and Spanish), Positive Self-Management Program (HIV/AIDS), A Matter of Balance falls prevention, Healthy Ideas (identifying depression empowering activities for seniors), Healthy Eating for Successful Living, Savvy Caregiver, Powerful Tools for Caregivers, Enhanced Wellness, and Fit for Your Life.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Participants may enroll in no more than two courses per calendar year.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Evidence Based Education Program provider agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Evidence Based Education Programs

Provider Category:

Agency

Provider Type:

Evidence Based Education Program provider agencies

Provider Qualifications

License *(specify):*

Must be under license maintained by the Healthy Living Center of Excellence or Self-Management Resource Center (formally known as the Stanford Patient Education Research Center)

Certificate *(specify):*

Certificate of good standing from the Healthy Living Center of Excellence

Other Standard *(specify):*

Agency provider must employ staff who have been trained and certified by the Healthy Living Center of Excellence or by the Self-Management Resource Center, and must demonstrate:

1. Leadership
2. Delivery infrastructure
3. Partnerships
4. Centralized and coordinated logistical processes
5. Business planning and financial sustainability
6. Quality assurance and fidelity to the model of licensure and quality standards set forth by the evidence-based program developer.

Education, Training, Supervision:

Providers must ensure training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Individual staff who implement Evidence Based Education Program workshops and 1:1 trainings must complete 2 hours of continuing education (in person or webinar) annually with the Healthy Living Center for Excellence or the Self-Management Resource Center.

Adherence to continuous QI Practices:

Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:

Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:

Providers must be able to initiate services with little or no delay.

Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L.c.66A. (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years