A Roadmap of Medicaid Prevention Pathways

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INTRODUCTION

The Robert Wood Johnson Foundation awarded Nemours a one-year grant to explore and promote the use of existing Medicaid authority to support prevention. The initiatives described here are intended to sustain approaches that link clinic to community prevention to address chronic disease, including childhood obesity. With 40 examples, this Roadmap is part of a practical resource that includes three case studies and a white paper. Together, these resources bring to light how states have successfully created sustainable financing through Medicaid and the Children's Health Insurance Program (CHIP) for preventing chronic diseases at both the individual and population levels. The toolkit can help states get started or continue their prevention efforts. These documents can be found at: *http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention*.

The Roadmap illustrates how state Medicaid agencies and their partners can maximize the authority that exists under federal Medicaid and CHIP law to deliver a range of preventive services and strategies at both the individual and population levels. The intent is to promote the use of existing federal Medicaid authority so a state may exercise the options that best align with its unique needs and conditions.

The Roadmap is applicable to a broad array of prevention activities that a state may opt to cover under Medicaid. More specifically, the Roadmap focuses a lens on childhood obesity, a challenge for which prevention is particularly relevant. The American Academy of Pediatrics (AAP) states, "because intervention programs are few, and program costs are high, the most successful intervention for promoting a healthy weight is prevention."[1] The AAP's *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* notes that healthy weight has special significance not only because of its importance to childhood and future adult health but also because of "its interrelationships with lifestyle, behavior, the environment, and family life."[2]

Since its passage half a century ago, Medicaid has played an essential role in promoting the health and wellbeing of America's children. Today, 40 percent of children—over 35.5 million—are enrolled in Medicaid or CHIP.[3] Medicaid and CHIP are essential to low income children, and particularly children of color.[4]

The health policy landscape changed dramatically in recent years with the passage and implementation of the Affordable Care Act (ACA). Federal and state level health policy will continue to evolve in the coming years. This Roadmap will continue to be important to promoting the health and wellbeing of children by showing states how they can accelerate the innovative efforts already underway to strengthen prevention.

Health Promotion and Flexibility Under Current Law

Medicaid spends a disproportionate amount on chronic conditions, and therefore can benefit from successful prevention strategies. The Roadmap shows how current law provides flexibility within the core Medicaid triad of paying for covered services provided to individuals enrolled in Medicaid by eligible Medicaid providers. The Medicaid authorities that provide pathways to reimbursement for preventive services are described in Roadmap Appendix A: Medicaid Authorities for Prevention—Reference Document.

Medicaid benefits are more expansive for children than for adults. Under the authority of the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, the Centers for Medicare and Medicaid Services (CMS) emphasize prevention as well as comprehensive care. Unlike other provisions of Medicaid focusing on treatment, EPSDT is the only authority with the ultimate goal of health promotion.

As described by CMS in *EPSDT – A Guide for States*, "[i]t is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development."[5] In addition, according to *EPSDT – A Guide for States*, "[t]he state…should consider the child's long-term needs" and "[t]he state should also consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders."[6]

Health promotion efforts are particularly important to reduce health disparities among children in the U.S. and achieve greater health equity. Social determinants of health are linked to health disparities, and research suggests that many health disparities stem from early childhood.[7]

An AAP Expert Committee recommends approaches to prevention, assessment, and treatment for childhood obesity.[8] These include universal assessment of children for obesity risk to improve early identification of elevated body mass index (BMI), medical risks, and unhealthy eating and physical activity habits. The recommendations recognize the social determinants affecting obesity, while identifying how clinical providers and systems can promote prevention.

Medicaid is essentially a public insurance program that provides medical assistance to eligible individuals, and while there is flexibility under current law, there are clear boundaries limiting Medicaid's reach to social determinants of health and population health. Given this, community prevention initiatives that directly connect to the delivery of medical care will more easily align with Medicaid models. For this paper, we define the linkage of "clinic to community prevention" as strategies that link traditional clinical preventive care with community-based initiatives to address chronic disease.

Delivery System Flexibility

A state's coverage of preventive services is affected by the extent to which its Medicaid delivery system is characterized by fee-for-service (FFS) versus managed care payment models. Where helpful, the Roadmap makes a distinction between FFS and managed care delivery systems. In FFS and primary care case management (PCCM), which builds on the FFS structure, the state Medicaid agency determines the preventive services that will be covered.[9] Twenty-two states use at least some FFS to pay for services. The majority of Medicaid enrollees, however, are covered by comprehensive risk-based managed care organizations (MCOs).

MCOs can cover preventive services delivered by non-licensed but otherwise qualified providers in many different settings and can opt to cover extra preventive services beyond what is required by FFS Medicaid. If these "value added" services are activities that improve health care quality under 45 CFR Section 158.150, the cost of these services may be counted toward the medical cost portion of the MCO's medical loss ratio (MLR).[10] This rule specifically calls out the provision of "health improvements to the population beyond those enrolled in coverage." MCOs can also substitute services or settings "in lieu of" services or settings that are covered in the State Plan. Under 45 CFR Section 438.3 the alternative services must be deemed by the state to be medically appropriate, cost-effective substitutes that are included in MCO contracts, and are voluntary for members. "In lieu of" services are counted as medical costs in MCO capitation rates.

At a meeting in August 2016 of state and national experts convened by Nemours, a consensus emerged that it would be much easier to design prevention initiatives in a managed care environment as opposed to a FFS environment. This is due to the degree of flexibility MCOs have to cover additional services or credential non-traditional providers. It is also due to the established relationships between MCOs and providers. Many programmatic changes to a FFS model must receive federal approval through the State Plan Amendment (SPA) process. Depending on the state, MCOs face a lower threshold of regulatory approval when adding services or providers to their benefit packages. Yet, while managed care is more flexible and nimble than FFS, it may be harder for states to track utilization of certain upstream services in the managed care environment.

Identification of State Goals

State goals must drive strategies for prevention. Before states use the Roadmap to identify pathways for implementation, the goals must be clear. Roadmap Appendix B: State Planning Document is included as a tool for states to identify and prioritize goals for prevention and engage their partners and local communities. Output from the Planning Document will help states use the Roadmap to identify the optimal Medicaid authority for implementation.

Roadmap Framework

The Roadmap provides examples of state prevention activities across FFS and managed care, for childhood obesity and other conditions. The need to address obesity, and the challenges of doing so, are nationally recognized. The obesity prevention examples presented in the Roadmap may help states to consider new prevention approaches. Other examples show how the Roadmap is more generally applicable to prevention for a variety of conditions. The Roadmap is not comprehensive, but provides a sample of strategies to help identify pathways that a given state may adopt in order to best align with its unique needs and conditions. A matrix summarizing the Roadmap is shown in Roadmap Appendix C.

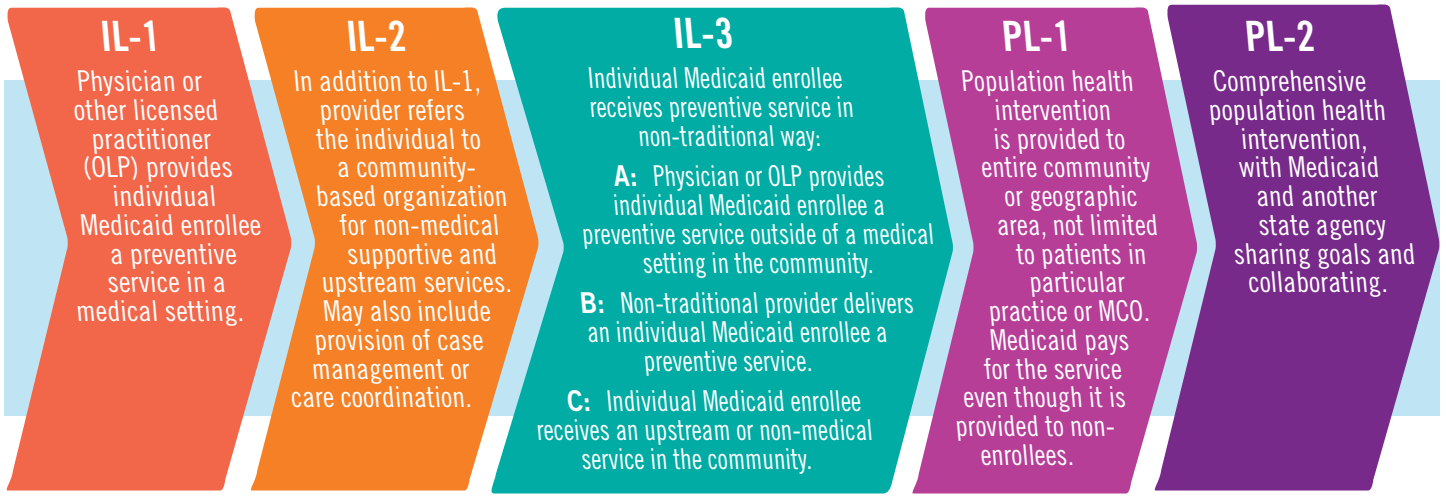
The Roadmap categorizes states' prevention activities along a continuum of five main categories, shown in Figure 1 below. This categorization is based on the basic tenet that Medicaid provides medical assistance to eligible individuals, not to populations defined geographically or otherwise. The continuum moves from individual level (IL) engagement, with services targeting individual Medicaid enrollees, to population level (PL) engagement, with services and strategies targeting an entire geographic area including non-Medicaid enrollees. The five categories are not mutually exclusive; a single state could implement multiple interventions along the continuum.

ROADMAP EXAMPLES

Following are examples of state prevention activities addressing childhood obesity and other areas of health promotion and disease prevention. To be included, initiatives had to (1) be Medicaid funded, (2) have a prevention component, and (3) link clinic to community prevention—that is, strategies that link traditional clinical preventive care with community-based initiatives to address chronic disease. Many of the examples leverage more than one strategy or category—such as reimbursing a non-traditional provider for a service delivered in a non-medical setting. We also describe some hypothetical examples of possible innovative pathways to prevention where real life examples were lacking. Where available, examples include links to federal approval documents, such as the State Plan Amendment (SPA) or the Section 1115 waiver document.

The Roadmap includes 40 examples from 23 states. Slightly fewer than half of the examples are specific to childhood obesity prevention and approximately one-third of all examples focus on children. The other examples describe initiatives that involve broader support for health system navigation and linkage to social services, housing stability and accessibility, asthma management, tobacco use, and lead exposure among others. Fewer examples were available within the Population Level (or PL) categories of initiatives compared to Individual (or IL) categories earlier on the continuum of prevention.

Figure 1: Roadmap of Medicaid Prevention Pathways



Individual Level-1: A physician or other licensed practitioner provides an individual Medicaid enrollee a clinical preventive service (e.g., nutritional counseling) in a medical setting.

Individual Level-1 examples include the following:

- The Colorado Medicaid program lists "healthy diet counseling" as part of preventive wellness services and chronic disease management in the Health First Colorado benefits and services overview.[11]
- Montana Medicaid reimburses specified providers for group nutrition counseling and physical activity coaching by some types of practitioners to prevent diabetes and cardiovascular disease. CMS approved this SPA under preventive services authority 42 CFR 440.130 (c).[12]
- The Oklahoma Medicaid program reimburses for health and behavior CPT codes delivered by mental health providers for a primarily medical weight-related diagnosis. The codes they use have a particularly useful application in the prevention of mental health conditions associated with adolescent overweight/obesity.[13]
- Pennsylvania uses Medicaid funding to pay for tobacco cessation counseling for pregnant women under Section 4107 of the ACA.[14]
- In 2016, Wyoming FFS Medicaid added licensed dieticians enrolled with Medicaid to the list of other licensed practitioners (OLPs) allowed to receive Medicaid payment under CFR 440.130 and CFR 440.60.[15]

Individual Level-2: As in IL-1, a physician or other licensed practitioner provides an individual Medicaid enrollee a preventive service in a medical setting. The provider takes an added step of referring the enrollee to a community-based organization for additional non-medical supportive and upstream services. Ideally, a health professional would contact the community organization to apprise them of the referral, follow-up with the family to ensure additional services are used, and coordinate care of community services where appropriate. At a minimum, the provider makes the referral to the community-based organization. Case management and care coordination of community services and clinical services also may be provided.

Several states provide examples of Individual Level-2 activities:

- **Colorado**'s Regional Care Collaborative Organizations (RCCOs) are paid a per member per month fee to help beneficiaries navigate medical care, and to connect beneficiaries to local social services, among other responsibilities.[16]
- **Missouri** PHIT Kids (Promoting Health in Teens and Kids) has a multi-disciplinary weight management program and refers to community-based organizations such as Big Brothers, Big Sisters for the child or to a parenting program for the parent. The family receives follow-up at subsequent clinic visits to find out if they obtained the support services. The program—18 weekly group meetings for parents and children followed by 20 monthly maintenance meetings—first focuses on families' basic needs (e.g., housing, transportation, safety) before weight loss becomes a goal. PHIT Kids staff anticipate that the Missouri Medicaid program will partially cover clinic- and hospital-based registered dietician services and group health education sessions starting in 2017.[17]
- **Oregon**'s Coordinated Care Organizations (CCOs) tap into the local knowledge of community health workers (CHWs) to connect enrollees to social support services. The CCOs were created under Oregon's Section 1115 waiver.[18] One element of Oregon's approach is a regional social determinants of health network, an approach to providing navigation and coordination, and measuring and evaluating multiple strategies serving the same population. Key components include a registry to avoid duplication and basic client record functions. The approach leverages the expertise of community-based organizations to ensure that the overall needs of enrollees are addressed.[19] Oregon is profiled in a companion case study available at: ***http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention***.

Individual Level-3: An individual Medicaid enrollee receives a preventive service in one or more non-traditional ways:

Individual Level-3A: A physician or other licensed practitioner provides an individual enrollee a Medicaid covered preventive service in a non-traditional setting (outside of a medical office/clinic) in the community (e.g., home, school, child care, community program).

Examples of state FFS or primary care case management (PCCM) models covering non-traditional settings described in Individual Level-3A are as follows:

- In Alabama, the Children's Center for Weight Management receives Medicaid reimbursement for sending nurses and social workers to assess home environments of children with obesity, and for providing education, counseling and medication adherence assistance as part of a Health Homes SPA.[20]
- Maine Medicaid reimburses for asthma home visits through the establishment of a Health Homes SPA for children and adults with chronic health conditions.[21]

Following are state examples of managed care models that cover preventive services in non-traditional settings:

- In **Georgia**, one statewide Medicaid MCO covers in-home visits by a licensed respiratory care practitioner for teen asthma patients. These visits include disease education, medication counseling, and environmental assessment.[22]
- Massachusetts dental hygienists receive Medicaid reimbursement for applying dental sealants for children in schools.[23]
- Case managers and social workers in the Asthma Network of West **Michigan**'s home-based asthma case management model receive reimbursement from four Medicaid MCOs, using skilled nursing visit code 551.[24]
- In **Ohio**, the accountable care organization (ACO) Partners For Kids, which is affiliated with Nationwide Children's Hospital, provides mobile care centers that travel to schools and communities to ensure health care access for children across central Ohio. Nationwide also partners with Columbus City Schools to provide on-site nurse practitioners and behavioral health providers in select locations. Behavioral health specialists also provide assistance to teachers and school administration.[25] The Nationwide ACO is profiled in a companion case study available at: ***http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention***.

Possible Pathway to Prevention

A child's pediatrician recommends in-home visiting by a CHW to address obesity- and asthma-related health issues, as well as pre-diabetes concerns. The CHW assesses the home environment and educates the child and family about nutrition and weight-related chronic conditions such as asthma and diabetes. The CHW works with the family to make recommended changes, such as providing allergen covers for the bed and an air purifier for the home. The goals of the intervention include informing the child and family about health conditions, better controlling the child's asthma to achieve better overall health and fewer asthma-related complications such as emergency department visits, and helping the family make healthier food choices to result in better overall health of the family. Coverage of CHW home services (non-traditional provider in a non-traditional setting) is authorized through an approved Health Homes State Plan Amendment (SPA). Alternatively, in a managed care model, the MCO could pay for these "in lieu of services" without a Health Homes SPA, with the service costs counted as medical costs in MCO capitation rates.

Individual Level-3B: A non-traditional provider (e.g., CHW, personal health navigator, healthy homes specialist, certified asthma educator) provides an individual Medicaid enrollee a preventive service.

A number of states cover non-traditional providers under managed care models:

- The **Minnesota** Medicaid program reimburses CHWs for education services for individual and group self-management and health promotion education and training. Registered CHWs can provide services in an outpatient, home, clinic, or other community setting. CHWs bill enrollees' MCOs. In 2015 CMS approved the SPA to amend supplemental payment for medical education for various provider types.[26]
- Also in **Minnesota**, the Medicaid MCO Hennepin Health offers health education and coaching provided by CHW-delivered at sites such as the county's mental health center and correctional facility. This is also relevant to IL-3A. Hennepin Health is authorized under the state's Section 1115 waiver.[27]
- The **New Mexico** Medicaid agency leverages contracts with MCOs to encourage the use of CHWs for care coordination.[28] Contracts require MCOs to describe the role of CHWs in providing patient education and specifically include CHW-delivered services in the list of covered services. According to the **Managed Care Policy Manual**, costs associated with CHWs, including salaried employees and contracted groups, are characterized as MCO administrative costs. Costs associated with care coordination functions, including CHWs, are counted toward the MCO's medical loss ratio as medical expenditures.[29]
- The **Oregon** Medicaid program created Patient-Centered Primary Care Homes via a Health Homes SPA for individuals who have one chronic condition and are at risk for another, including overweight. Certified CHWs can be reimbursed for delivering four health home services: health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services.[30] Under **Oregon's State Innovation Model (SIM) grant**, CCOs (a type of accountable care organization) are required to include non-traditional health care workers such as CHWs on their care teams.[31] The CCO model contract requires CCOs to "develop formal relationships with [p]roviders, community health partners, including culturally and socially diverse community based organizations and service providers…"[32]
- Under **Washington's Health Homes SPA**, CHWs participate in Health Homes to provide administrative support for the Health Home Coordinator. This can include mailing promotional material, arranging for beneficiary transportation, and facilitating face-to-face visits with the care coordinator. CHWs receive funding from Medicaid for serving individual patients.[33]

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

The following are examples of states that provide upstream services under managed care models:

- Inland Empire Health Plan, a **California** MCO, offers a community resource center that is open to all community members, not just MCO members. The center offers education and fitness classes to the broader community and provides incentives (e.g., asthma kits, hypoallergenic mattress covers, car seats) for plan enrollees to take the classes.[34]
- Some **Georgia** MCOs cover extra services to help members manage their weight and stay active, including Weight Watchers meetings and Boys & Girls Club memberships.[35]
- **Minnesota**'s Hennepin Health, described previously, covers interim housing for patients being discharged from the hospital who need housing. Help is also provided for permanent housing and job placement. These efforts are funded through savings from reductions in emergency department visits. Hennepin Health is authorized under the state's Section 1115 waiver.[36]
- In **Ohio**, the ACO affiliated with Nationwide Children's Hospital works with a network of partners and activities in Columbus' south side. Network members have committed funding and support for a suite of initiatives to develop the neighborhood by providing housing support, community development resources, workforce development, early care and education, wellness resources, and many other services. Nationwide developed housing competency internally and lends FTEs (a cost burden) to the community housing initiative, Healthy Homes.[37] The Nationwide ACO is profiled in a companion case study available at: ***http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention***.
- **Oregon**'s Section 1115 waiver requires CCOs to consider flexible non-State Plan services that result in better health and lower costs. The flexible services fall into three categories: wellness (e.g., exercise shoes, gym memberships); housing supports and services (e.g., home improvement such as ramps or air conditioners, rental assistance, or temporary housing after hospital discharge); and mental health and counseling (e.g., counseling in every school in a rural county). The Section 1115 waiver authority allows the state to include non-State Plan services in the administrative portion of CCO capitation payments to fund health-related social services.[38]
- One Medicaid MCO in **Pennsylvania** associated with the University of Pittsburgh Medical Center (UPMC) participates in a Shelter Plus Care pilot that is a collaboration among the U.S. Department of Housing and Urban Development (HUD), UPMC Health Plan, Metro Family Practice, and Community Human Services. UPMC pays the housing agency a per member per month amount to provide case management/care coordination which includes helping the member establish housing.[39]
- **Rhode Island** Medicaid covers window replacement for children with lead poisoning under its Section 1115 waiver.[40]
- **Texas** established a Delivery System Reform Incentive Payment (DSRIP) pool under its Section 1115 waiver, which funds prevention and improvement projects. For example, the San Antonio Metropolitan Health District is investing in ways to address obesity through nutrition, physical activity, and environmental improvements like new sidewalks.[41]
- **Vermont**'s Section 1115 waiver allows the state to operate as its own MCO. The state invests excess funding beyond per member per month limits in innovative programs such as tuition support for health professionals.[42] Vermont has pursued a coordinated statewide approach to health, wellness, and disease prevention through a broad set of delivery system reforms.[43]
- In **Washington**, Medicaid will reimburse for certain housing-related activities with the goal of promoting community integration for certain population groups including those experiencing chronic homelessness.[44] Washington is profiled in a companion case study available at: ***http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention***.

Population Level–1: A population health prevention intervention is provided to an entire community or geographic area. The service is aimed at improving the health of the population rather than improving the health of a specific individual. The intervention is not limited to patients in a particular medical practice or enrollees in an MCO. Medicaid pays for the service even though it is provided to non-enrollees.

The following are examples from FFS environments:

- **Maine** uses CHIP funding—approved as a health services initiative (HSI) under Maine's 10 percent administrative cap—to promote a variety of activities, including health education in schools regarding tobacco use, physical activity and healthy eating, outreach campaigns for community-based pregnancy prevention and family planning, and media campaigns to discourage use of tobacco products.[45]
- **Oklahoma** Medicaid uses funds from the Tobacco Settlement Endowment Trust for provider training on best practices for tobacco cessation, including referring patients to a help line. This state match draws down federal Medicaid administrative funds. Providers apply the training to all children in their practices, regardless of whether they are on Medicaid. Thus, the impact of the training is spread to a broader group of people than Medicaid enrollees. Oklahoma is planning to expand to obesity prevention in the next fiscal year.[46]

Managed care models provide examples of population level prevention interventions:

- Health Services for Children with Special Needs (HSCSN), a specialty Medicaid health plan in **Washington, D.C.**, offers a Healthy Living Program at a local community center. The program includes: obesity awareness and prevention, weight management counseling, cooking demonstrations, food shopping field trips, and exercise and dance classes. The Healthy Living Program is funded in part by D.C. Medicaid and is open to HSCSN members as well as the broader community.[47]
- Under an HSI, **Massachusetts** uses CHIP funds to cover nine public health programs related to improving the health of all children (e.g., youth violence prevention, young parent support).[48]
- A **Oregon** CCO funds a CHW to support pregnant teens at a local high school, whether or not they are on Medicaid, linking these teens to health services, and providing support to address social determinants of health (housing, food security, and income stability).[49,50]

Possible Pathway to Prevention

Through a CHIP SPA HSI, the state participates in a pilot project that establishes a regular farmers market in a low-income community. The state has a booth that offers children's health screenings and referrals as well as employment information for their parents. Local community leaders share employment opportunities and assist parents with resume and cover letter writing. CHWs provide developmental and mental health screenings to children and basic nutrition counseling to their parents, and also refer children to other services in the community. These population-level prevention activities are aimed at the entire community, not only Medicaid or CHIP enrollees. Alternatively, under a managed care model, MCOs could choose to support existing public health programs such as this.

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

The following example demonstrates how data sharing among agencies can be a powerful tool for prevention under a PL-2 approach, even in a FFS environment:

- **Wyoming** Medicaid has a shared electronic health record (EHR) that promotes cross-referral and data sharing between Medicaid and Public Health. The EHR system—Total Health Record—pools patient data from multiple sources to flag problems and promote population health. The Wyoming integrated data program allows all providers in the state to access, at no cost, an EHR system. It links Department of Health databases such as Medicaid claims and immunization data.[51]

Managed Care examples of PL-2 include:

- Iowa's SIM grant is intended to integrate Medicaid and Public Health to address referral systems, care coordination, and social determinants of health. Community intervention topics include obesity, patient engagement, tobacco use, and diabetes.[52]
- According to a recent Center for Medicaid and CHIP Services (CMCS) informational bulletin, **Missouri** has an HSI for lead screening. Through a Memorandum of Agreement with the Missouri Department of Health & Senior Services and Medicaid, the state funds local public health departments to provide blood lead screening and conduct outreach and education to children in high risk areas.[53]
- In 2014, New York obtained a Section 1115 waiver to reinvest federal Medicaid savings into redesigning New York's health care delivery system known as DSRIP. DSRIP promotes value-based payment reform, and works to break down silos between health care and other systems that serve communities, including social services, employment, housing, education, and criminal justice. New York Medicaid has committed to meet a metric of increased kindergarten readiness.[54]
- **Oregon** CCOs work with community partners and public agencies, for example through the Regional Social Determinants of Health Network. This is a multi-sector approach linking clinical needs related to social determinants of health to the various community resources to address these determinants with a goal of providing navigation, coordination, measurement, and evaluation of multiple strategies serving the same population.[55] Oregon is profiled in a companion case study available at: *http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention*.
- In January 2017 CMS approved Washington's request for a new Section 1115 waiver to implement Accountable Communities of Health (ACHs). The ACHs will convene providers to coordinate health transformation activities, implement interventions for high utilizers and the social determinants of health, connect clinical and community-based organizations, and track regional health performance.[56] Washington is profiled in a companion case study available at: *http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention*.

Possible Pathway to Prevention

Three state cabinet-level agencies establish a workgroup to reduce obesity/overweight prevalence in children birth to age 5 and pregnant women, using funding blended from the agencies. Obesity-related health education on healthy eating and physical activity are embedded in childcare curricula used by childcare centers, and Medicaid pays for developmental screenings in childcare settings, as well as dietician services for the family. CHWs conduct screening follow-up and arrange to address social determinants such as food security, and help to coordinate the array of community and clinical services. State agencies adopt programs to increase breastfeeding rates, funded by public health and Medicaid. State agencies coordinate so that home visitors and others interacting with parents reinforce healthy eating and physical activity, and provide information and connections to employment programs as well as other supports for parents. Information about home visiting services and infant feeding programs is available at employment centers. Under a managed care model, MCOs could partner with regional community-based organizations and agencies to address social determinants of health, for example by supporting the above initiatives.

CONCLUSION

The examples included above are not exhaustive. The Roadmap is intended to provide an overview of potential prevention strategies that could be supported by Medicaid, and to connect state policy makers and those working to transform state health systems to additional information on other states' prevention interventions.

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