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ROADMAP APPENDIX C: ROADMAP OF MEDICAID PREVENTION PATHWAYS— SUMMARY MATRIX OF STATE ACTIVITIES

This Appendix provides a high level summary of prevention activities along the continuum of the Roadmap of Medicaid Prevention Pathways' five main categories. The table below describes the categories of prevention initiatives, their associated authorities under current law, examples of implementation in different states, and hypothetical examples of potential pathways to prevention. The body of the Roadmap provides additional information on state examples, available at: *http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention.*

Category	Description	Authority	States†	Potential Pathway to Prevention
IL-1	A physician or other licensed practitioner (OLP) provides an individual Medicaid enrollee a preventive service in a medical setting.	• Medicaid Covered Services: Section 1905(a) • EPSDT: Section 1905(r) • Case Management: Section 1905(a)(19) • Targeted Case Management: Section 1915(g)(1) • Medicaid Health Homes: Section 1945	• *CO* • *MT* • *OK* • PA* • *WY*	
IL-2	A physician or OLP takes the added step of referring the enrollee to a community-based organization (CBO) for additional non-medical supportive services.	Same as IL-1	• *CO** • MO • OR*	A child's pediatrician refers the family to CBOs to help the child and family engage in physical activity, and to ensure that the family is receiving other needed services such as SNAP.
IL-3A	A physician or OLP provides an individual Medicaid enrollee a covered preventive service in non-traditional settings such as schools.	• EPSDT: Section 1905(r) School settings and "right settings" encouraged[1] • Preventive services: Section 1905(a)(13) • 2014 Free Care Guidance[2] • Medicaid Health Homes: Section 1945 • 2016 Home Visiting Guidance[3]	• *AL* • GA* • *ME** • MA* • MI* • OH*	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. The CHW works with the family to make recommended changes. Coverage of CHW home services is authorized through an approved Health Homes 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.
IL-3B	A non-traditional provider (e.g., community health worker) provides an individual Medicaid enrollee a preventive service.	• Preventive Services Rule Change: 42 CFR 440.130(c) • Managed care via 1932(a) State Plan authority and 1915(a), 1915(b) and 1115 waiver authority	• MN* • NM* • OR • WA*	Same as IL-3A.

Category	Description	Authority	States†	Potential Pathway to Prevention
IL-3C	An individual Medicaid enrollee receives an upstream service in the community. Upstream services include those non-medical services that address the systemic conditions that contribute to poor health.	• Managed care via 1932(a) State Plan authority and 1915(a), 1915(b) and 1115 waiver authority • Coverage of Housing-Related Activities and Services for Individuals with Disabilities	• CA • GA • MN* • OH* • OR • PA* • RI* • TX • WA* • VT*	When referred by a Medicaid provider, case managers help beneficiaries access healthier foods, for example by connecting them to SNAP and WIC and helping them to identify local farmers markets and transportation to get there.
PL-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.	• Health Services Initiatives under CHIP: Section 2105(a)(1)(D)(ii) • 1115 waivers • DSRIP initiatives • CMMI models: Accountable Health Communities; Health Care Innovation Awards Rounds 1& 2; State Innovation models (SIM)	• DC • *ME* • MA* • *OK* • OR*	A 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 resources for parents. 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. Services are aimed at the entire community, not only Medicaid or CHIP enrollees. The state supports this through a CHIP SPA HSI. Alternatively, under a managed care model, MCOs could choose to support existing public health programs such as this.
PL-2	Medicaid and another state agency or department share goals and collaborate as partners on a population health/prevention intervention. The funding of the initiative is often a blend of financing mechanisms including Medicaid.	Same as PL-1	• IA • MO* • NY • OR* • WA* • *WY**	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/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 and other supports. Information about home visiting services and infant feeding programs is available at employment centers. Under a managed care model, MCOs could partner with regional CBOs and agencies to address social determinants of health, for example by supporting the above initiatives.

† Note: *Italicized font* indicates the activity was implemented in a fee-for-service setting. Non-italicized font indicates the activity was implemented in a managed care environment.

* Activity is not specific to obesity prevention, but instead involves prevention for other conditions or diseases. State examples are described in the body of the Roadmap of Medicaid Prevention Pathways.

1 Described in EPSDT—A Guide for States. https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. "The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

2 December 2014 State Medicaid Director letter updated CMS guidance on the "Free Care Rule." https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

3 March 2016 HRSA and CMCS Joint Informational Bulletin. Coverage of Maternal, Infant, and Early Childhood Home Visiting Services. http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf