

HEALTHY OUTLOOK:

*Public health resources
for systems transformation.*



AMERICAN PUBLIC HEALTH ASSOCIATION
For science. For action. For health.

The Affordable Care Act (ACA) can help transform the health system of the United States from one focused on treating illness to one that promotes prevention and healthy living. Public health has the opportunity to play a large role in this process. Its focus on preventing disease and creating the conditions for individuals and communities to live healthy lives makes public health a vital part of systems transformation.

The ACA is necessary because despite high levels of spending, health outcomes in the U.S. are poor. Too many people go without health care, and health disparities are common. The ACA increases access to insurance and makes it easier to access preventive services, such as diabetes and blood pressure screening and tobacco cessation counseling. It also includes payment and delivery reforms that incentivize prevention and improving the health of populations. Public health, with its focus on interventions that stress preventing disease and addressing the health needs of communities, is critical to the success of these reforms.

The ACA also presents challenges to public health. The increase in insurance coverage means that many people will no longer need to turn to health departments for clinical services. However, millions will remain uninsured and still rely on health departments and other safety net providers. Health departments must also adapt and be actively engaged in the implementation of the ACA's new payment and delivery systems reforms. Without health department engagement, these reforms will not be as successful as they could be, and health departments will lose an opportunity to serve the community and define their role in the changing health system.

HEALTHY OUTLOOK: *Public Health Resources for Systems Transformation* is a series of fact sheets, issue briefs and other resources designed to: 1) Highlight policy issues within the ACA and the implications for public health; and 2) Identify opportunities and promote active engagement of public health in health care systems transformation efforts.

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Suggestions on how to use Healthy Outlook

The resources in Healthy Outlook can be used to:

- Explicate relevant public health policy issues within the ACA. Healthy Outlook offers public health practitioners the background knowledge they need to fully take part in the reforms of the ACA. The Glossary and fact sheets offer short descriptions, while the issue briefs offer in-depth explanations of health systems transformation issues affecting public health.
- Support public health and health care integration: Health systems transformation requires collaboration and integration between the public health and health care systems. Public health practitioners can use Healthy Outlook to educate health care administrators, insurers, and providers about the critical services public health offers and the opportunities for strengthening prevention and improving population health through implementation of the ACA.
- Promote public health within ACA implementation: Healthy Outlook is a resource that can be used to promote the importance of public health's involvement in ACA implementation. Its fact sheets, issue briefs, and tables demonstrate the important contributions the field of public health can make to systems transformation. Public health practitioners can use the different components of Healthy Outlook to educate decision makers.
- Complement existing resources on systems transformation. Resources like the Georgia Health Policy Center's *Leading Through Health System Change: A Public Health Opportunity Planning Tool* offer guidance to public health practitioners in meeting the adaptive challenges of the ACA. Healthy Outlook can be used in conjunction with *Leading Through Health System Change* to provide a more in-depth look into the policy issues and challenges of health reform. Each document links readers to additional resources for more information.



[click to view](#)

FACT SHEET:

Why We Need the Affordable Care Act

There are many reasons why health reform is necessary. Why We Need the ACA describes the health law's focus on increasing prevention and health insurance coverage as the first steps in reducing health disparities and unsustainable health care spending.



[click to view](#)

FACT SHEET:

The Health System, the ACA, and How Public Health Fits In

This fact sheet provides an overview of the health system. It explains how public health and the health care system together make up the health system. It also defines the role of "provider" and "payer" and highlights the importance of public health's engagement in ACA implementation.



[click to view](#)

FACT SHEET:

Health Care Payment Reform and How Public Health Fits In

Health Care Payment Reform details the different health care payment systems and how they are changing in response to the ACA. It also explains how the public health system and Medicare are taking part in payment reform.



[click to view](#)

ISSUE BRIEF:

Public Health and ACA Payment and Delivery System Reforms

The ACA is changing the way health care is delivered and paid for. This issue brief describes the ACA programs designed to base care delivery and payment on quality rather than quantity. Opportunities for the public health system are highlighted throughout.

Affordable Care Act Delivery and Payment Reforms Summary

APHA

TABLE:

Affordable Care Act Delivery and Payment Reforms Summary

The Summary Table includes short descriptions of the operation, participants, funding, and duration of the ACA's delivery and payment reforms.

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The Organization, Services, and Funding of Health Departments, and Implications of the Affordable Care Act

APHA

ISSUE BRIEF:

The Organization, Services, and Funding of Health Departments, and Implications of the Affordable Care Act

This issue brief describes the organization and funding of health departments and how these two factors affect the services health departments offer. The issue brief also examines ways the ACA is changing the way health departments receive funding and offer services.

[click to view](#)

The Role of Prevention and Public Health in the Affordable Care Act

APHA

ISSUE BRIEF:

The Role of Prevention and Public Health in the Affordable Care Act

The ACA makes many investments in public health and preventive services. This issue brief demonstrates the central role of prevention in ACA implementation. It also shows the important role public health departments play in implementing the ACA's prevention initiatives.

[click to view](#)

How the Affordable Care Act Supports Public Health Solutions to Prevention Challenges

APHA

TABLE:

How the Affordable Care Act Supports Public Health Solutions to Prevention Challenges

The ACA emphasizes the need to prevent health conditions before they become serious. This table describes ACA programs devoted to solving prevention challenges like tobacco use and low levels of physical activity.

[click to view](#)

Summary of Selected Prevention Provisions in the Affordable Care Act

This table provides a comprehensive overview of the prevention provisions included in the Affordable Care Act (ACA). It is organized into two main columns: 'Provision' and 'Description'. The 'Provision' column lists specific sections of the ACA, while the 'Description' column explains the details of each provision, including its purpose, scope, and implementation requirements. The table covers a wide range of topics, from community preventive services to tobacco use prevention, and includes references to relevant federal agencies and state-level implementation efforts.

[click to view](#)

TABLE:

Summary of Selected Prevention Provisions in the Affordable Care Act

The ACA bolsters prevention by supporting public health programs and research, establishing public education campaigns, and increasing the number of preventive services offered without cost-sharing. This table describes these prevention efforts and how they have been implemented.

Understanding and Implementing Community Preventive Services

This issue brief provides a detailed overview of the community preventive services included in the ACA. It explains the role of these services in improving public health and reducing the burden of disease. The brief also discusses the challenges associated with implementing these services and provides guidance on how to overcome these challenges. It includes information on the types of services that are covered, the criteria for selecting services, and the role of various stakeholders in the implementation process.

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ISSUE BRIEF:

Understanding and Implementing Community Preventive Services

This issue brief explains what community preventive services are, identifies tools and resources that can be used to support community prevention at the state and local levels, and explains the important role of health departments in providing these services.

Expansion of Medicaid Reimbursement for Preventive Services: Opportunities for Public Health

This issue brief provides a detailed overview of the expansion of Medicaid reimbursement for preventive services. It explains the importance of this expansion in improving access to preventive care and reducing health disparities. The brief also discusses the challenges associated with implementing this expansion and provides guidance on how to overcome these challenges. It includes information on the types of services that are covered, the criteria for selecting services, and the role of various stakeholders in the implementation process.

[click to view](#)

ISSUE BRIEF:

Expansion of Medicaid Reimbursement for Preventive Services: Opportunities for Public Health

The ACA enabled Medicaid to reimburse more providers for a greater number of preventive services. Expansion of Medicaid Reimbursement explains the policy change and how health departments can use it as an opportunity to improve the health of the populations they serve.



[click to view](#)

Glossary

Health systems transformation and the ACA encompass a wide variety of topics and terms. Turn to the Glossary for a quick reference.



[click to view](#)

Resource Guide

Useful Resources provides links and short descriptions of resources about public health's role in systems transformation. It also includes resources on prevention strategies and general health department information.

Why Do We Need the Affordable Care Act?

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



There are numerous reasons health reform is critically needed in the United States, including:

Too many people lack health coverage.

- In July 2012, before the ACA took effect, the [Congressional Budget Office estimated](#) that 20% of the population under age 65 was uninsured. Although the ACA has decreased the uninsured rate, according to a recent [Gallup poll](#), more than 13% of people—nearly 1 in 8—still lack health insurance.
- The uninsured are less likely to receive preventive care and less likely to seek care as quickly when they are sick or injured. According to the National Prevention Strategy, this can result in [higher costs](#) when they do seek treatment. In addition, nearly 40% of the health care costs incurred by the uninsured are passed on to consumers who do have coverage, in the form of higher premiums. [According to Families USA](#), this costs each family with health coverage more than \$1,000 a year.

U.S. health care spending is unsustainable.

- Health care spending represented [17.1%](#) of our gross domestic product (GDP) in 2010 and is [expected](#) to reach 18.4% by 2020. [Medicare](#) alone accounted for 14% of our federal budget in 2013, and, absent reform, this share is expected to grow as the baby boom generation continues to retire.
- Rising health care costs both contribute to our federal deficit and reduce our ability to spend in other important areas, including education, housing, and economic development. And the high costs of health care directly impact consumers: family premiums in employer-sponsored coverage rose [70%](#) from 2003 to 2013.

Despite high spending, our health outcomes are poor.

- The U.S. spends far more on medical care than any other industrialized nation but [ranks 26th among 36 OECD countries](#) in terms of life expectancy. The Institute of Medicine [reported in 2012](#) that “the current generation of children and young adults in the United States could become the first generation to experience shorter life spans and fewer healthy years of life than those of their parents.”

Our system emphasizes treatment instead of prevention.

- Today, [7 in 10](#) deaths in the U.S. are related to preventable diseases such as obesity, diabetes, high blood pressure, heart disease, and cancer, and [three quarters](#) of our health care dollars are spent treating such diseases. However, only [3 cents of each dollar spent on health care in the U.S.](#) (total public and private) go toward prevention.

Health disparities exist among numerous populations.

- Health inequities related to income and access to coverage exist across demographic lines, but population-based disparities are impossible to deny as well. For example, as reported by Families USA, African American women are more than [twice as likely to die during pregnancy](#) compared to non-Hispanic White women and Hispanics are [65% more likely to have diabetes](#).
- The Affordable Care Act won't solve all of these problems overnight, but it's an important step forward. By making health coverage more affordable and accessible and thus increasing the number of Americans with coverage, by funding community-based public health and prevention programs, and by supporting research and tracking on key health measures, the ACA will begin to reduce disparities, enhance access to preventive care, improve health outcomes, and lower the nation's health spending. Learn more [here](#).



The American Public Health Association champions the health of all people and all communities. We strengthen the profession of public health, promote best practices and share the latest public health research and information. We are the only organization that influences federal policy, has a 140-plus year perspective and brings together members from all fields of public health. Learn more at www.apha.org.

The Health System, the ACA, and How Public Health Fits In

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THE U.S. HEALTH SYSTEM is composed of both the health care system and the public health system. The public health system focuses on improving the health and living conditions of entire populations and communities. The health care system provides clinical treatment to individuals. In 2010, health system costs totaled 17.1% of GDP, and the total amount increases each year. The Affordable Care Act (ACA) is designed to reduce health system spending and increase the number of people covered by health insurance. One way it is attempting to reduce costs is by incorporating public health's focus on population health and prevention into the health care system.

THE U.S. HEALTH SYSTEM

THE **PUBLIC HEALTH** SYSTEM

- Protects the health and wellness of entire populations
- Tracks and analyzes health trends
- Ensures the safety and cleanliness of air, water, and food
- Educates the public about health
- Designs and implements health policies and programs
- Convenes stakeholders to address factors that affect health

THE **HEALTH CARE** SYSTEM

- Provides services to individuals
- Assesses, diagnoses, and treats symptoms, conditions, and diseases
- Is organized into specialties including primary care, physical therapy, behavioral health services, and surgical procedures
- Involves health care workers, insurers, and government all working together to provide and pay for an individual's health care

Who Is a Provider?

- Individual health workers: physicians, nurses, therapists, health educators, and other health workers
- Institutional providers: hospitals, health departments, long-term care facilities, and outpatient clinics

NOTE: Although Medicare and Medicaid are payers, the providers that accept reimbursement from Medicare and Medicaid are sometimes called Medicare and Medicaid providers.

Who Pays?

- Some patients pay their health care providers directly.
- Third-party payers are much more common and include Medicare, Medicaid, other public programs, and private insurance plans:

Medicare covers about 50 million people and pays more health care costs than any other payer (\$551 billion in 2012).

Medicaid, the largest health insurance program in the United States, covers 62 million people.

Other programs, including the Children's Health Insurance Program (CHIP), make up 4% of health spending.

Private insurance plans, such as those offered by Blue Cross Blue Shield and Aetna, cover most U.S. residents. In 2012, about 165 million people were covered by private insurance.

Health Departments as Providers and Payers

State and local health departments may be both providers and payers. Many provide a range of clinical services such as vaccinations, testing for sexually transmitted diseases, and family planning. Some health departments also act as providers of safety net primary care.

Health departments are payers as well because, at the state level, they make Medicaid and CHIP payments to private providers who see beneficiaries of those programs. State and local health departments also act as payers when they contract with health care providers to offer screenings for conditions and diseases such as HIV/AIDS, cancer, and tuberculosis.

How the ACA and Public Health Can Work Together

Why Do We Need the ACA?

- Too many people lack health coverage.
- U.S. health care spending is unsustainable.
- Despite high spending, our health outcomes are relatively poor.
- Our system emphasizes treatment instead of prevention.
- Health disparities exist among numerous populations.

What Does the ACA Do?

- Increases insurance coverage and helps people access preventative health care.
- Focuses on prevention.
- Reforms payment systems to incentivize a focus on the health of entire populations.

What Is Public Health's Role?

Public health departments can get involved in this process.

- Partnering with the health care system to improve the health of communities (e.g., public health screeners referring patients to providers of clinical services).
- Offering population-based and public health support to groups of health care providers.
- Convening stakeholders to facilitate cooperation across different health care settings.
- Collecting and analyzing health data at the population level and sharing this information with the health care system.

Applying a Public Health Lens to the Health Care System

The public health system has the potential to play an important role in collecting, monitoring, and analyzing relevant health information that other providers might miss. It can then work with the health care system to improve health outcomes for the entire area served.

For example, consider a situation in which several schoolchildren present to different health care providers with uncontrolled asthma. Unaware of the exact cause, the clinician treats the symptoms according to protocol. The local health department conducts a study using electronic health record data and using that as a starting point for more investigation finds that the children ride the same school bus and that the bus has a corroded exhaust pipe. The health department, clinicians, and schools then have the information necessary to address the root cause of the health problem.

As the ACA continues to take effect, public health practitioners can build on their strengths in data collection and surveillance and collaborate with the health care system to improve community health.



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Health Care Payment Reform and How Public Health Fits In

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MOST PEOPLE DO NOT PAY THE FULL PRICE of their health care; instead, insurance companies pay most costs. Rather than paying for health outcomes, insurers often pay for each service. Fee-for-service payments give providers an incentive to provide more treatments, and this is one reason for the rapid growth in health care costs. The payment reforms of the ACA are designed to link payments to health outcomes and reduce the cost of care. The payment systems described below, other than Medicare Prospective Payments, are used by both private insurers and government insurers such as Medicare.

Fee-for-service (FFS) reimbursement: 1960s to today

- Payers reimburse providers for each service rendered.
- Payers and providers agree how much will be paid for each service.
- Providers are incentivized to treat patients with more care than may be necessary.

Public Health's Role in Payment Reform

In order to operate under global payments, the health care system needs the help of the public health system. The goal of ACA payment reforms is to incentivize the maintenance of good health rather than the treatment of illness. The public health system, with its focus on addressing problems before they arise, can help achieve this goal.

Health departments and the public health system play an important role in payment reform, which requires the health system to prioritize population health. The three core functions of public health—assessment, policy development, and assurance—all help create the conditions for entire communities to live in good health. For example, public health departments carry out health education activities that can help people make healthy lifestyle choices. They also develop and implement policies that allow people to live in environments that encourage physical activity and good health.

Medicare Prospective Payment System (PPS)ⁱ : 1980s to today

- Providers' rates are fixed and predetermined for each diagnosis.
- Medicare determines average costs to hospitals for treating each diagnosis, including the costs of nursing, food, and other hospital services.
- PPS applies to inpatient and outpatient hospitals, skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities.

Episode-of-care reimbursement (bundled payments): 1980s to today

- Payers reimburse providers based on diagnosis or length of treatment episode.
- As with Medicare's PPS, payers set prices based on the expected costs of treatment.
 - Advanced episode-of-care reimbursement systems, such as the ACA's Bundled Payments for Care Improvement Initiative, render a single payment to all providers involved in the treatment of a condition.
 - *For example, paramedics, nurses, surgeons, and home health aides would all share one payment for treating a patient.*
 - *The ACA will make such episode-of-care payments more common and reduce the use of FFS.*

Global Payments and Shared Savings: ACA is striving for this payment system

- **GLOBAL PAYMENTS:** Payers reimburse providers an amount based on the number of people served, regardless of the health care services each person receives.
- **SHARED SAVINGS:** Payers reimburse providers based on standards of quality of care. If providers are able to care for patients below a set cost level while also meeting quality standards, they can receive bonuses from Medicare.

Medicare's Role

The federal government's insurance program for older adults, Medicare, pays for more health care than any other insurance company in the U.S. As the largest payer, it has an influential role in determining how providers are paid. The federal government also uses Medicare as an industry leader to test new approaches to paying for and delivering health care, such as those initiated by the ACA. For example, the Department of Health and Human Services announced a goal of transitioning 30% of Medicare payments to quality-based payment methods by 2016.ⁱⁱ

i Although this payment system is different from pure FFS, it is termed Medicare FFS when compared to Medicare Advantage's managed care insurance plans.

ii Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value.
<http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

Public Health and ACA Payment and Delivery System Reform

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THE AFFORDABLE CARE ACT (ACA) HELPS transition our health care system from one that pays providers based on quantity to one that pays based upon the quality of care. This transition requires financial incentives and requires that health care providers cooperate with one another and with patients. The new reforms for delivering health care combine the efforts of multiple health care providers to help patients receive the appropriate care at the appropriate time. Rather than sustaining a health care system focused on episodic care, the delivery reforms are designed to help providers work together for prevention and successful transition from one care setting to another.

The ACA provides financial incentives to health care providers for adopting the new delivery systems. First, providers must meet a set of quality standards to ensure that they supply good care. Then, rather than simply receiving payments for each health care service, providers receive bonuses for treating patients at a lower cost and incur penalties for exceeding costs. The providers most successful in implementing these reforms will be able to help their patients prevent serious health conditions.

PUBLIC HEALTH'S OPPORTUNITY

Public health has the opportunity to play a large role in these payment and delivery reforms. With its focus on the health of entire populations, public health has developed methods to improve the health of large groups of people. Public health's focus on prevention and the social determinants of health also means that it can make valuable contributions to the changing health care system.

Accountable Care Organizations (ACOs)

- **What they are:** Accountable care organizations, or ACOs, are networks of primarily Medicare providers (such as hospitals, primary care physicians, and specialty practitioners) that are responsible “for the quality, cost, and overall care” of a set patient population.¹ However, beneficiaries are not limited to providers in the ACO network, and they can still choose to see any Medicare provider. The goal of the ACO model is to better coordinate care among providers, which should increase quality, reduce inefficiencies and errors, and decrease costs. ACOs receive bonuses for progress toward quality and cost-control goals (and, in some cases, incur penalties for not meeting goals), providing an incentive to emphasize prevention and coordinated care for all patients.
- **What the ACA does:** The ACA uses Medicare, the government-operated insurance program for older adults, to provide these financial incentives to ACOs. Private insurers are also increasingly contracting with ACOs and offering

them quality and cost incentives. The Medicare Pioneer ACO program encourages participating networks to establish ACO contracts with Medicaid and private insurance payers in addition to Medicare. The most advanced ACOs are also beginning to adopt global payments.

- **Progress to date:** In their first year of operation, ACOs saved Medicare \$275 million.² A recent Centers for Medicare & Medicaid Services (CMS) press release indicates that there are currently more than 360 ACOs serving approximately 5.3 million Medicare beneficiaries.³ CMS estimated the start-up and first-year costs for each ACO to be slightly more than \$1.75 million.⁴ According to one survey of ACOs, the average start-up cost is \$2 million.⁵

Patient Centered Medical Homes (PCMHs)

- **What they are:** Patient centered medical homes (PCMHs), also called advanced primary care practices, are individual primary care practices committed to providing comprehensive primary care for their patients. In addition, they coordinate the care a patient may need from other providers and involve the patient in the management of his or her health. PCMHs adhere to certain principles of care and focus on quality measurement and improvement, accessibility, and coordination of care between different providers and settings.⁶ Accordingly, PCMHs may offer features such as evening and weekend hours and staff to help patients access in-home care.
- **What the ACA does:** The ACA's PCMH initiatives help states, providers, and payers strengthen their PCMH infrastructure. The initiatives provide funds to PCMHs to gain accreditation, coordinate the care of patients, help increase patient access and health education, and focus on managing chronic conditions.
- **Progress to date:** The various PCMH initiatives cover more than 1 million Medicare beneficiaries and are being implemented by providers in every state.

Partnership for Patients

- **What it is:** The goals of the Partnership for Patients initiative are to reduce hospital acquired infections (HAIs) by 40 percent and unnecessary readmissions by 20 percent by the end of 2013, as compared to 2010.
- **What the ACA does:** The Community-based Care Transitions Program (CCTP) tests models designed to reduce

Public Health's Benefit to ACOs

The use of global payments—paying health care providers a set amount per person—gives public health an opportunity to take part in the transformation of the health system. With its focus on measures designed to improve the health of entire communities, public health has a wealth of knowledge to use in collaboration with ACOs. Health departments are payers as well because, at the state level, they make Medicaid and CHIP payments to private providers who see beneficiaries of those programs. State and local health departments also act as payers when they contract with health care providers to offer screenings for conditions and diseases such as HIV/AIDS, cancer, and tuberculosis.

The Convening Power of Public Health

Health departments work with a variety of stakeholders to address community health needs. Some also provide safety net clinical care to patients who are unable to access other health care providers. Public health's expertise in performing these essential services is valuable to PCMHs interested in learning how to effectively serve new patient populations. Public health departments can also play a key role in the Partnership for Patients and the Pay-for-Performance initiative by convening stakeholders to support reductions in hospital readmission rates.

- **What the ACA does:** The Community-based Care Transitions Program (CCTP) tests models designed to reduce hospital readmissions by helping high-risk Medicare beneficiaries transition from a hospital to another health care setting.⁷ CCTP participants are community-based organizations that provide transition services from one care setting to another. For example, CCTP partners provide information to patients and their families after discharge to help them understand subsequent steps to follow.⁸ There are currently 102 organizations in the CCTP.⁹

In addition, the Center for Medicare & Medicaid Innovation has awarded \$218 million to 26 state, regional, and national Hospital Engagement Networks that help to identify and disseminate known solutions for reducing HAIs.¹⁰ These networks are also responsible for establishing and implementing systems to track hospitals' progress in meeting quality goals.

Pay-for-Performance (P4P) Programs

The P4P measures below affect all Medicare hospitals other than those that meet certain exemptions. These programs went into effect on October 1, 2012.

- **Hospital Value-based Purchasing:** Under value-based purchasing, Medicare payments to most hospitals depend partly on the quality of care received by their patients. The program operates by withholding a small percentage of each Medicare payment to create a funding pool and then redistributing payments based on performance. Some hospitals receive a small increase in payments, while others see a small decrease.¹¹
- **Progress to date:** Kaiser Health News reports that this program will affect 20 times more hospitals than will ACOs.¹² In 2013, 1,231 hospitals received increased payments from Medicare, while 1,451 saw decreased payments.¹³
- **Hospital Readmissions Reduction Program:** This program compares a hospital's readmission rates with national averages and penalizes excessive preventable readmissions. The program focuses on readmissions for three conditions: acute myocardial infarction, heart failure, and pneumonia. The penalty is up to 1 percent of a hospital's potential payment.
- **Progress to date:** Early results of the program suggest that hospital readmission rates are declining. According to CMS, the readmission rate for 2012 decreased to 18.5 percent after being above 19 percent in the preceding five years.¹⁴

Bundled Payments for Care Improvement Initiative

- **What it is:** The Bundled Payments for Care Improvement Initiative allows Medicare to pay one specified amount per episode for all of the health care a patient receives. For example, rather than paying an individual patient's surgeon, nurses, primary care physician, and physical therapist separately for treating one health condition, Medicare renders a single payment that the providers divide among themselves. Providers must coordinate their care to maximize quality and efficiency.
- **Progress to date:** Four different models, involving different combinations of providers and payment methods, are being tested. Overall, 465 providers are participating.¹⁵

Challenges and Opportunities

- The ACA's payment and delivery system reforms are an opportunity to reduce health care costs and improve the health of the entire country. Aligning incentives for providers to offer the appropriate treatments at the appropriate time and in the appropriate care setting is a challenge, however. For example, while large providers might be able to easily absorb fee reductions from pay-for-performance programs, some safety net providers may not. In addition, strong oversight will be required to ensure that ACOs and PCMHs compete fairly in terms of price with other providers.

- 1 Health Reform GPS. Accountable care organizations—Medicare pilot program. <http://www.healthreformgps.org/resources/accountable-care-organizations-%E2%80%93-medicare-pilot-program/>
- 2 Centers for Medicare & Medicaid Services. Medicare's delivery system reform initiatives achieve significant savings and quality improvements—off to a strong start. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30.html>
- 3 Centers for Medicare & Medicaid Services. More partnerships between doctors and hospitals strengthen coordinated care for Medicare beneficiaries. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-12-23.html>
- 4 Rosenbaum S. Medicare Accountable Care Organizations. <http://www.healthreformgps.org/resources/medicare-accountable-care-organizations/>
- 5 National Association of ACOs. National ACO Survey, November 2013. <https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf>
- 6 Agency for Healthcare Research and Quality. Defining the PCMH. <http://pcmh.ahrq.gov/page/defining-pcmh>
- 7 Centers for Medicare & Medicaid Services. Community-based Care Transitions Program. <http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html>
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Affordable Care Act Delivery and Payment Reforms Summary

This document is part of **Healthy Outlook**, which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



REFORM MODEL	SUMMARY	AUTHORITY/ ADMINISTRATION	PARTICIPANTS/SCOPE	FUNDING/DURATION
Accountable Care Organizations (ACOs)^a	Networks of providers that coordinate care for patient populations. ACOs receive bonuses (and incur penalties in some cases) for meeting quality and cost targets.			
Medicare Shared Savings Program (MSSP) ^b - One-sided risk - Two-sided risk - Advance Payment Model^c	Different options for new and intermediate ACOs (one- and two-sided risk models), as well as rural and other practices that are interested in starting an ACO but need help in initiating the process (Advance Payment Model).	ACA § 3022. Administered by the Center for Medicare & Medicaid Innovation (CMMI).	Payer: Medicare fee-for-service (FFS). Providers: Physicians, hospitals, others; 338 ACOs, including 36 operating under the Advance Payment Model. Population: 4.9 million Medicare FFS patients, including at least 650,000 in the Advance Payment Model program.	\$175 million. First ACOs announced in 2012, more in 2013. Funded at least through 2015.
Pioneer ACO Model ^c	Greater rewards and risks for more advanced ACOs; ACOs must also contract with private insurers and Medicaid.	ACA § 3021. Administered by CMMI.	Payer: Medicare FFS. Providers: Physicians, hospitals, others; 32 ACOs originally, 19 continuing. Providers: More than 650,000 Medicare patients.	\$77 million. Three to five years: 2012–2015, optional to 2017.
Patient Centered Medical Homes (PCMHs)^{b,d}	Primary care practices (PCPs) that receive monthly fees to provide “whole person” enhanced care for patients (primarily those with chronic illnesses).			
Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration ^c	Connects Medicare with existing state efforts to coordinate Medicaid and private insurers in supporting PCMH care for chronically ill patients. States are linking PCMHs to health promotion and disease prevention initiatives.	Social Security Amendments of 1967, § 402 (as amended). CMMI linking with state-led efforts.	Payer: Medicare FFS, Medicaid, private insurers. Providers: 1,200 PCPs expected in 8 states. Population: More than 900,000 chronically ill Medicare patients.	\$283 million. Three years: phased in starting July 2011, through 2016.
Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) Demonstration ^c	Medicare payments to support FQHCs in adopting medical home practices for most patients and in gaining accreditation from the National Committee for Quality Assurance (NCQA) as medical homes.	ACA § 3021. Administered by CMMI with the Health Resources and Services Administration (HRSA).	Payer: Medicare FFS. Providers: 434 FQHCs in 46 states. Population: 195,000 Medicare patients.	\$42–\$50 million. Three years: November 1, 2011–October 31, 2014.

REFORM MODEL	SUMMARY	AUTHORITY/ ADMINISTRATION	PARTICIPANTS/SCOPE	FUNDING/DURATION
Medicaid Health Home State Plan Option ^{b,e}	New option for state Medicaid programs to support medical home care for chronically ill patients. Includes enhanced federal payments to states. States must coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA).	ACA § 2703. Administered by the Centers for Medicare & Medicaid Services (CMS).	Payer: Medicaid. Providers: PCPs in 16 states currently (20+ more expected). Population: Chronically ill Medicaid patients.	Ongoing since January 2011. Only 2 years of enhanced federal payments to each state.
Comprehensive Primary Care Initiative (CPCI) ^c	Similar to MAPCP except that CMMI, rather than the states, coordinates multi-payer efforts.	ACA § 3021. Administered by CMMI.	Payer: Medicare FFS, Medicaid, private insurers. Providers: 4 states (Arizona, Colorado, New Jersey, Oregon) and 3 metropolitan regions. 2,725 providers in total. Population: 408,599 Medicare and Medicaid patients.	\$322 million. Four years: 2012–2016.
Partnership for Patients^c	Initiative aimed at reducing hospital acquired infections (HAIs) by 40 percent and inappropriate readmissions by 20 percent by the end of 2013.			
Community-based Care Transitions Program (CCTP) ^c	Per-discharge payments to community-based organizations that partner with hospitals and other providers to offer a continuum of care transition services as a means of reducing inappropriate readmissions.	ACA § 3026. Administered by CMMI.	Payer: Medicare FFS. Providers: Eligible community-based organizations that apply (currently 72 organizations). Population: “High-risk” Medicare patients.	Up to \$300 million. Five years: 2011–2015. Two-year agreements that can be extended.
Hospital Engagement Networks ^c	Funding for state, regional, and national hospital networks. Additional funding is provided for expert organizations to identify and disseminate HAI-reduction best practices and resources and to track hospitals’ progress toward meeting quality measures.	ACA § 3021. Administered by CMMI.	Payer: CMMI. Providers: 26 networks supporting more than 3,700 hospitals in the 50 states. Population: n/a.	\$218 million to date, up to \$500 million in total. Ongoing since April 2011.
Pay-for-Performance (P4P) Programs^f	Various efforts to incentivize quality and efficiency in patient care and move the health care system away from volume-based payments. P4P does not refer to a specific program but, rather, is a categorization of certain types of programs.			
Hospital Value-based Purchasing (VBP) ^{b,g}	Medicare FFS payments to hospitals will depend in part on their performance on a range of quality and patient-experience measures. The ACA also requires CMS to implement this program for Medicare payments to skilled nursing facilities (SNFs; via SNF fees) and physicians (via the physician fee schedule, or PFS) in the future.	ACA § 3001 (for FFS payments to hospitals). Administered by CMS. (SNFs: § 3006; PFS: § 3007).	Payer: Medicare FFS. Providers: Nearly all Medicare hospitals and, eventually, SNFs and physicians. Population: Medicare patients of affected providers.	Ongoing since October 2012. New hospital measures to be introduced over time, along with new providers.
Hospital Readmissions Reduction Program ^b	Medicare payments to hospitals will be reduced for “excessive readmissions,” determined through a comparison of hospitals’ performances with national averages.	ACA § 3025. Administered by CMS.	Payer: Medicare FFS. Providers: Nearly all Medicare hospitals. Population: Medicare patients of affected providers.	Ongoing since October 2012. New measures to be introduced over time.

REFORM MODEL	SUMMARY	AUTHORITY/ ADMINISTRATION	PARTICIPANTS/SCOPE	FUNDING/DURATION
Bundled Payments for Care Improvement Initiative^{c,h}	Medicare is testing four new payment approaches; all involve providing one bundled payment per episode of care to multiple providers to encourage greater coordination and efficiency of care.	ACA § 3023. Administered by CMS.	Payer: Medicare FFS. Providers: More than 6,000 hospitals, physicians, and community providers. Population: Medicare patients of affected providers.	\$118 million. Three years: 2013–2015.

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- b For more information, see the CMS Web site at <http://www.cms.gov/>.
- c For more information, see the CMMI Web site at <http://innovation.cms.gov/>.
- d See Agency for Healthcare Research and Quality. Patient Centered Medical Home resource center. http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
- e See Kaiser Family Foundation. Medicaid's new "health home" option. <http://www.kff.org/medicaid/upload/8136.pdf>
- f See Health Resources and Services Administration. What is pay-for-performance? http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78
- g See Werner RM, Dudley RA. Medicare's new Hospital Value-based Purchasing program is likely to have only a small impact on hospital payments. <http://content.healthaffairs.org/content/31/9/1932.abstract>
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The Organization, Services, and Funding of Health Departments, and Implications of the Affordable Care Act

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



HEALTH DEPARTMENTS ORGANIZE THEMSELVES, offer services, and receive funding in different ways, and these three factors are important to consider as the Affordable Care Act (ACA) is implemented. Health departments are part of our nation's health safety net—the system of providers, payers, and programs that offer clinical care to people without insurance coverage, Medicaid beneficiaries, and other vulnerable populations.¹ The ACA will ease the burden on the safety net by expanding health insurance coverage to 30 million additional people by 2022.² However, about 30 million people will also remain uninsured³ and will rely on safety net providers. Even after full ACA implementation, there will be a substantial need for the clinical services health departments provide.

Health Department Organization

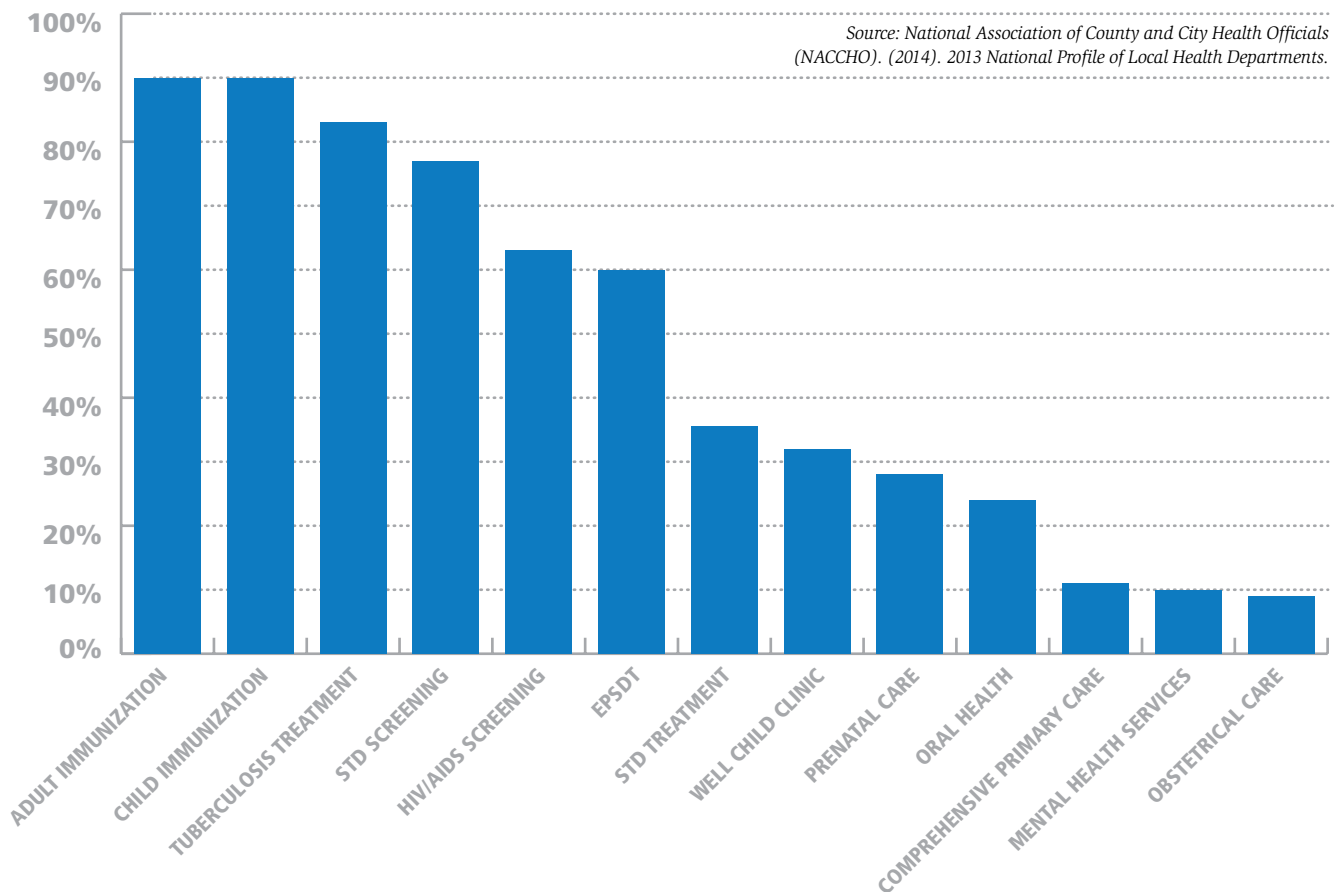
Health departments serve a wide variety of jurisdictions, from small towns to the largest cities, and these jurisdictions vary by state. In approximately 68% of states, the local public health system is organized around county health departments. Health department governance can be centralized, decentralized, or mixed.⁴ In the 4 U.S. states with centralized jurisdictions, the state health department has extensive legal and operational control over local departments. In the 27 states with decentralized health departments, local departments operate autonomously. Seventeen states incorporate a mixed model, with some public health services provided by the state and others by localities (state health departments in Hawaii and Rhode Island operate at the local level and do not have substate units). The size, jurisdiction, and governance of a health department can all affect the services it offers and the funding it receives.

Clinical Services Offered by Health Departments

Clinical services are generally delivered to an individual patient by a health care provider in an office or some other part of the health care system. Although most do not offer primary care, health departments provide a wide variety of clinical services, including immunizations and tuberculosis screening.

:: The Clinical Services of Local Health Departments Vary by Community

Local health departments are more likely to provide clinical services than state health departments, but the types of services offered by each vary (see Figure 1). In addition, health departments often work closely with other safety net providers, including public hospitals and federally qualified health centers. The likelihood of local health departments providing services generally increases with the size of the population they serve.⁵ Although rare, health departments sometimes contract with other organizations to provide clinical services (the service most frequently contracted out is treatment for HIV/AIDS and other sexually transmitted diseases [STDs]).⁶

FIGURE 1: Percentages of Local Health Departments That Provide Selected Clinical Services

:: Clinical Services from State Health Departments

Overall, the clinical services most often provided by state health departments are screening for HIV/AIDS and other STDs and oral health services.⁷ Many also offer clinical services related to treating infectious diseases such as HIV/AIDS, STDs, and tuberculosis, although provision of these services is becoming less common.⁸ State health departments decreased the treatment services offered for these conditions from 2010 to 2012.⁹

Clinical Services and Health Systems Transformation

The ACA Challenges Health Departments to Refocus Delivery of Clinical Services

In the past, increasing insurance coverage decreased the demand for health departments to serve as safety net providers.¹⁰ Through its health insurance exchanges, subsidies, and Medicaid expansion, the ACA could have a similar effect.

Overall, the provision of clinical services by health departments has been in decline for many years, particularly among local health departments.^{11,12} For example, in 2014, 20% of local health departments reduced the immunization services they provided.¹³ Some health departments are increasing the amount of services they provide, however; for example, 26% report increasing their provision of population-based primary preventive services.¹⁴ As the ACA reduces the number of people without insurance, health departments will have to adapt and continue to serve the more than 15%¹⁵ of adults who remain uninsured and in need of safety net care. According to an Urban Institute study, increases in insurance coverage will give health departments an opportunity to refocus their services.¹⁶ At the same time, health departments will have to highlight their value to the public and policymakers and quickly adapt to the changing health system.

Health Department Funding

State and local health departments receive much of their support from federal funds, primarily from the Health Resources and Services Administration and the Centers for Disease Control and Prevention (CDC). These two agencies provide about \$13.4 billion annually to state and local public health departments. However, funding for health departments has declined in many states.¹⁷ Although the ACA has increased investments in public health, these funds have not been enough to boost the overall budgets of health departments.

State and local health departments receive funding from different sources. The largest single source of funding for state health departments is the federal government,¹⁸ whereas the largest source for local health departments is local funding.¹⁹

Health Department Funding and Health Systems Transformation

To Increasing Funding, Health Departments Are Billing for Clinical Services

Public health departments face more difficulty than health care system providers in billing third-party payers, and thus they receive fewer funds from this billing practice. Health departments in some states lack the tax status to bill third parties, for example, and some payers require a full-time doctor on staff. One way health departments are adapting to health reform is by enhancing their capacity to claim reimbursements from third-party payers. In 2014, 86% of local health departments billed third-party payers for at least one clinical service, and 60% were able to bill both public (Medicare and Medicaid) and private insurers.²⁰ Only 7% of local health departments are not currently billing third-party payers or working to develop this capability.²¹ Recognizing the importance of billing as a source of revenue for health departments, CDC has a grant program in place to help build this capacity.²²

Conclusion

The ACA strengthens investments in health departments, though it also presents challenges. The various organizational structures of health departments mean that health system transformation will happen in different ways in each state. In addition, health departments must take part in health systems transformation while also advocating for the funding they need to continue offering their traditional services. Millions of people will continue to rely on health departments for safety net care, and they need to support this population, as well. The organization, traditional services, and levels of funding all affect how an individual health department can take part in systems transformation.

Additional Resources

- National Association of County and City Health Officials (NACCHO): [National Profile of Local Health Departments](#)
- Trust for America's Health: [Investing in America's Health](#)
- Association of State and Territorial Health Officials: [Profile of State Public Health](#)
- Georgia Health Policy Center: [Leading Through Health System Change: A Public Health Opportunity Planning Tool](#)
- deBeaumont Foundation: [A Practical Playbook](#)
- NACCHO: [2014 Forces of Change Survey](#)

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- 19 NACCHO. 2010 national profile of local health departments. http://www.naccho.org/topics/infrastructure/profile/resources/2010report/upload/2010_Profile_main_report-web.pdf
- 20 NACCHO. Billing for clinical services: findings from the 2014 Forces of Change Survey. <http://www.naccho.org/topics/research/forcesofchange/upload/Billing.pdf>
- 21 Ibid.
- 22 CDC. Immunization Billables Project. <http://www.cdc.gov/vaccines/programs/billables-project/index.html>



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The Role of Prevention and Public Health in the Affordable Care Act

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PREVENTABLE ILLNESS IS AN ONGOING THREAT TO OUR NATION'S HEALTH AND EXACTS A STEEP COST:

- Chronic diseases such as high blood pressure, heart disease, obesity, diabetes, and cancer cause 7 of every 10 deaths in the U.S.¹
- Nearly one of two adults in the U.S. lives with at least one chronic disease.²
- The U.S. spends the most on health care among industrialized nations but ranks near the bottom of the group in terms of life expectancy.^{3,4}
- The U.S. expends 75% of its health care dollars on treating preventable illnesses, yet spends only 3 cents of every health care dollar on prevention.^{5,6,7}

The Affordable Care Act (ACA) was enacted by Congress to address these challenges by reducing health care costs, expanding access to care, and ultimately improving health outcomes.⁸ The ACA includes several provisions designed to shift the focus of health spending to increase support for disease prevention and health promotion (see the Why We Need the ACA fact sheet). The public health system plays a central role in the success of the ACA and in achieving overall improvements in the health of the U.S. population.

This issue brief discusses the ACA's initiatives to invest in public health and expand coverage of preventive services and shows how public health departments and other community health-oriented organizations play a pivotal role in implementing the ACA's prevention focus and ensuring the health of the entire population.

ACA Investments in Public Health

The ACA includes two important provisions to coordinate and support the nation's prevention and public health activities at the local, state, and federal levels: the National Prevention Strategy (NPS) and the Prevention and Public Health Fund (Prevention Fund). These initiatives demonstrate a national commitment to prevention and the importance of public health in prevention.

:: National Prevention Strategy

The Affordable Care Act created the National Prevention, Health Promotion and Public Health Council (the National Prevention Council) to lead federal efforts on prevention, wellness, and health promotion and advance

a national prevention agenda.⁹ The National Prevention Council issued the National Prevention Strategy in June 2011 and has issued annual status reports from 2010 to 2014 on progress in implementing the NPS.¹⁰

The NPS includes a series of strategic directions and topic-based priorities (e.g., eating healthy, active living, tobacco-free living) with specific recommendations and suggested actions that various sectors such as governments and health care systems can take to promote health.¹¹ The NPS can be used as a tool by public health departments and other community-oriented organizations to guide their own targeted prevention activities and to reach out to other partners to educate them about the steps they can take to incorporate prevention concepts and actions into their policies and daily activities. (See the Resources section below for more information about how health departments are implementing the NPS and other ACA initiatives.)

:: Prevention and Public Health Fund

The Affordable Care Act created the Prevention and Public Health Fund to invest in public health and preventing chronic diseases and serious health conditions and, in turn, decrease health care costs.¹² The fund represents the U.S.'s first mandatory funding for public health and is a much-needed investment in prevention.¹³ The fund is meant to supplement rather than supplant existing funding.¹⁴

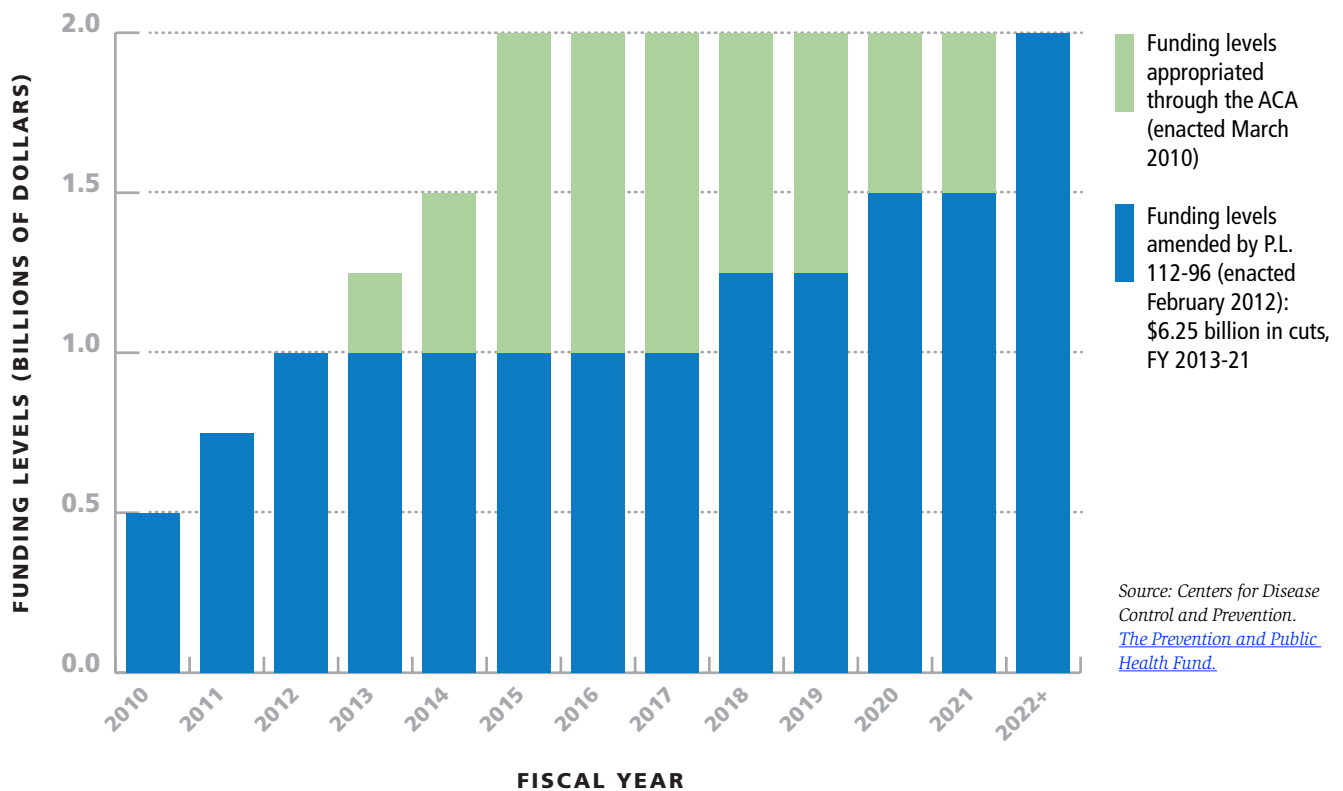
The Prevention Fund is being used in a variety of ways, including supporting the work of state and local health departments, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA).

- **Community prevention:** Funds are being used to enhance community-based preventive health programs including tobacco cessation, obesity prevention, and disease-specific efforts.¹⁵ For example, the Prevention Fund has provided \$21 million to 41 states, the District of Columbia, Guam, and Puerto Rico to enhance the capacity of tobacco cessation quitlines to assist people seeking to end their tobacco use.¹⁶
- **Clinical prevention:** Funds are being used to expand awareness of clinical preventive services and benefits authorized under the ACA, fund immunization programs, and integrate primary and behavioral health care.^{17,18} Regarding immunization, the Act authorized states to purchase adult vaccines with state funds from federally negotiated contracts and reauthorized the Section 317 Immunization Grant Program.¹⁹ The 317 program makes federally purchased vaccines and grants available to the 50 states, the territories, and selected large cities to provide immunizations to priority populations.²⁰
- **Public health infrastructure and training:** Funds are being used to bolster public health infrastructure at the state and local levels, increase the training capacity of the health care workforce, and expand public health officials' ability to prevent and respond to infectious disease outbreaks.²¹ The Prevention Fund is also being used to support epidemiology and laboratory capacity grants that have helped to improve outbreak response times.²² For example, the Prevention Fund supported Colorado's communicable disease surveillance/reporting system and public health laboratory, which were responsible for limiting the spread of a nationwide *Listeria* outbreak to two weeks rather than the typical one month.²³
- **Research and tracking:** Funds are being used to increase and expand data collection on public health services nationwide.²⁴ Funding includes support for the National Prevention Council and National Prevention Strategy, prevention research centers, and environmental public health tracking systems.²⁵

:: Ongoing Challenges to the Prevention Fund

While the Prevention Fund has been a much-needed acknowledgment of and investment in prevention and public health activities, the fund and other sources of public health funding have been threatened by cuts and elimination since its creation.²⁶ The mandatory character of the fund was intended to protect funding from reduction or elimination during the annual appropriations process.²⁷ However, beginning in FY 2013, Congress and the president have repeatedly cut funding due to sequestration and enrollment activities related to the Department of Health and Human Services (HHS) Health Insurance Marketplace, as well as to offset cuts to Medicare (see Figure 1).²⁸

FIGURE 1: Prevention and Public Health Fund Annual Amounts



Expansion of Preventive Services Coverage

The ACA requires that health benefit plans, including Medicare, provide selected preventive services with no cost sharing for individual and group plans.²⁹ The preventive benefit requirement went into effect in 2010 for new private coverage and in 2011 for Medicare beneficiaries. Preventive services covered are those recommended by the [U.S. Preventive Services Task Force](#) and immunizations recommended by the [Advisory Committee on Immunization Practices](#); services vary according to the age of the person and other factors. The services covered include screening for specific types of cancer, depression, high blood pressure, and obesity. The ACA also encouraged—but did not require—states to expand Medicaid coverage for preventive services.³⁰

:: Clinical Preventive Services

By expanding the coverage of preventive services, the ACA provided public health agencies with both a challenge and an opportunity. State and local health departments often offer clinical preventive care and represent part of our nation's health safety net—the system of providers, payers, and programs that provide care to the uninsured, Medicaid beneficiaries, and other vulnerable populations.³¹ Because many previously under- and uninsured people now have access to health insurance under the ACA, there is the perception³² that most clinical preventive care services provided by health departments are no longer needed and that funding should be directed toward other priorities. However, even upon full implementation of the ACA, there will still be a need for safety net providers, including health departments, to serve the remaining uninsured individuals who are not covered under the ACA or who reside in states that did not elect to expand Medicaid.³³

Public health agencies have also recognized the opportunities the ACA has presented to promote prevention and transform their public health systems. For example, state and local health departments are forming new partnerships with health care systems through the creation of accountable care organizations (ACOs) and expanding their capacity to seek reimbursement from private and public payers such as Medicaid for preventive services (see the Public Health and ACA Payment and Delivery Systems Reform issue brief).

Safety Net Still Needed for the Uninsured

While the ACA has increased the number of people with health insurance, there are still an estimated 35 million nonelderly people without health insurance as of 2015. Once the ACA is fully implemented in 2022, an estimated 25 million additional nonelderly people will be insured. However, about 26 million people will remain uninsured and will continue to rely on safety net providers such as public health agencies.³⁴

:: Community Preventive Services

The ACA's focus on prevention also allows the field of public health to demonstrate the importance of community preventive services in supplementing and enhancing the provision of clinical preventive services.³⁵ Community preventive measures reinforce clinical care interventions by supporting health care providers' recommendations to their patients and identifying effective community prevention programs to which providers can refer their patients for further support and education.³⁶ Public health agencies and organizations are uniquely positioned to provide effective, evidenced-based, population-focused messaging to promote prevention and healthy choices.

The ACA included the use of broad-based public health and health education campaigns as a strategy to address the high prevalence of preventable diseases in the U.S., including heart disease, diabetes, and cancer, by altering behaviors.³⁷ The Centers for Medicare & Medicaid Services (CMS) has used public-private partnerships to develop prevention campaigns for the general population as well as specific populations, such as African Americans and Hispanics, to educate the nation's diverse population about disease prevention and health promotion.³⁸ The CDC's Tips from Former Smokers campaign was developed with support from the Prevention Fund. Another campaign (pending Food and Drug Administration guidance) would focus on providing nutritional information on menus at chain restaurants with 20 or more locations and foods sold through vending machines.^{39,40}

A third ACA initiative would establish a national campaign to promote oral health care and prevention of oral diseases among certain populations, including children and the elderly.⁴¹ As of summer 2014, Congress had not authorized funds for the oral health campaign.

:: Effectiveness of Prevention Approaches

The ACA authorized, but did not necessarily fund, a number of research and development programs designed to improve the health system's capacity to promote prevention and public health and to ensure that decisions about services and funding are based on evidence of effectiveness. One of the broad prevention-oriented research mandates contained in the law was to evaluate the effectiveness of evidence-based practices relating to prevention and community-based public health interventions and identify effective strategies for state and local systems to organize, finance, and deliver public health services.⁴³ The HHS secretary is working with federal agencies such as the CDC, the Community Preventive Services Task Force, and various other private and public partners to address this ongoing requirement. (The Resources section lists sources for information on evidence-based prevention strategies.)

Effective National Media Intervention

With funds from the Prevention and Public Health Fund authorized in the Affordable Care Act, CDC created a national multimedia tobacco education campaign, *Tips from Former Smokers*, that encourages people to quit smoking by featuring the impact of smoking-related illnesses on smokers and their families and friends. The campaign began in 2012 and was extended in 2013 and 2014. In response to the 2012 campaign, CDC reports that an estimated 1.6 million people made a quit attempt and more than 100,000 will be successful in quitting smoking.⁴²

Public Health and Prevention as the Foundation for Success of the Affordable Care Act

The ACA has created a foundation for addressing the triple aims of improving patient experience of care, improving population health, and reducing health care costs.⁴⁴ By doing this, the ACA aims to shift our health system from one that focuses on treating the sick to one that focuses on keeping people healthy.⁴⁵ With its emphasis on prevention and the health of entire populations, the public health system—in full and active partnership with the health care system—is and will continue to be an important part of this shift. The ACA has provided the public health system with opportunities to further demonstrate its central role in providing both clinical and community-oriented preventive services and, ultimately, to transform the way public health envisions and delivers preventive services.

Despite the advances made by the ACA in demonstrating the importance of prevention and public health, annual cuts to the Prevention and Public Health Fund are undermining the investment envisioned in the legislation. The long-term success of the ACA and overall improvements in population health will require:

- **Full investment in the Prevention and Public Health Fund.** Investments such as the Prevention Fund have the potential to improve health outcomes and reduce costs. The fund was created to help realize the potential of prevention, but annual cuts to the fund will delay or destroy the gains that can be made by incorporating prevention measures into our health system.
- **Sustained public health funding at the state and local levels.** Years of chronic underfunding and continuing cuts at the federal, state, and local levels have resulted in a weakening of the public health infrastructure. While

dedicated funding for state and local public health is one feature of the Prevention Fund, cuts to the fund have undermined federal reinvestments in the state and local public health system.

- ***A robust safety net for those who remain underinsured and uninsured.*** The cost of health care remains high and out of reach for many, even with the advent of the Health Insurance Marketplace. Gaps in health care coverage remain and the levels of noncoverage, while dropping, are still in the range of 15 %⁴⁶ and may be higher in some segments of the population.⁴⁷ Health disparities in access to quality, affordable health care and prevention services persist among historically underserved populations and those not covered under the ACA, including people living in states that did not expand Medicaid and undocumented individuals.
- ***Active integration and collaboration between health care and public health.*** Both the health care and public health systems must play a role in helping to improve access to quality, affordable care and reducing health disparities. Partnerships such as ACOs are just one way public health and health care are working together to achieve improvements in health while managing costs.

People Use Their Prevention Benefits!

The ACA provided Medicare coverage of an annual wellness visit and personalized prevention plan, a comprehensive health risk assessment, and incentives to complete behavior modification programs. HHS released a snapshot report in March 2011 summarizing the first two months of implementation. The report showed that Medicare Part B beneficiaries had made more than 150,000 annual wellness visits in less than two months using the free prevention benefit covered by the ACA.

Resources for More Information

The resources offered here can be used by public health practitioners to identify, implement, and evaluate effective evidence-based and promising practices. While not exhaustive, this list provides a good starting point.

- [National Prevention Strategy](#)—Provides strategic directions and topic-based priorities with recommendations for various health-related sectors.
- [Guide to Community Preventive Services](#)—Contains findings, literature reviews, and implementation tools from the U.S. Community Preventive Services Task Force on more than 20 topic areas.
- [Healthy People 2020](#)—Provides science-based objectives, resources, and implementation guides in more than 40 topic areas, with the goal of improving health by establishing benchmarks and monitoring progress toward reducing illness, disability, and death.
- [Health System Transformation and Improvement Resources for Health Departments \(CDC\)](#)—Lists information, resources, and training opportunities connected to changes in the health system, with a focus on state, local, territorial, and tribal governments.
- [American Public Health Association](#)—Lists a range of APHA's analyses and resources related to the creation and implementation of the ACA.
- [NPS Implementation Toolkit \(Association of State and Territorial Health Officials\)](#)—Contains implementation resources including evidence-based recommendations and case studies focusing on the National Prevention Strategy's strategic directions and priorities.
- [Public Health and Primary Care Together: A Practical Playbook \(deBeaumont Foundation/Duke University\)](#)—An interactive resource to help integrate the public health and primary care sectors in efforts to improve population health.
- [Leading through Health System Change \(Georgia Health Policy Center, National Network of Public Health Institutes, and the Centers for Disease Control and Prevention\)](#)—An interactive tool to assist public health leaders in responding to the changes and opportunities arising from the ACA.
- [Institute of Medicine](#)—Provides authoritative advice to decision makers and the public on public health and other health care topics.
- [Kaiser Family Foundation](#)—Develops data and analyses on health reform and other health care topics.
- [Resource Center for Evidence-Based Prevention \(National Association of County and City Health Officials\)](#)—Provides guidance for integrating various prevention initiatives such as the National Prevention Strategy, Healthy People 2020, and the Guide to Community Preventive Services into workable approaches to achieving community health.

- 1 CDC. Chronic diseases. <http://www.cdc.gov/chronicdisease/overview/>
- 2 Ibid.
- 3 APHA. Health reform basics. <http://www.apha.org/topics-and-issues/health-reform>
- 4 Organisation for Economic Co-operation and Development. Health at a glance 2013: OECD indicators. <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013-Chart-set.pdf>
- 5 APHA. Health reform basics. <http://www.apha.org/topics-and-issues/health-reform>
- 6 CMS. National Health Expenditure Accounts. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>
- 7 Institute of Medicine. For the public's health: investing in a healthier future. <http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx>
- 8 Patient Protection and Affordable Care Act, P.L. 111-148.
- 9 Shearer G. Prevention provisions in the Affordable Care Act. https://www.apha.org/~media/files/pdf/topics/aca/prevention_aca_final.ashx
- 10 U.S. Surgeon General's Office. Prevention resources. <http://www.surgeongeneral.gov/initiatives/prevention/resources/index.html>
- 11 National Prevention Council. National Prevention Strategy. <http://www.surgeongeneral.gov/initiatives/prevention/strategy/index.html>
- 12 Shearer G. Prevention provisions in the Affordable Care Act. https://www.apha.org/~media/files/pdf/topics/aca/prevention_aca_final.ashx
- 13 APHA. Prevention and Public Health Fund: dedicated to improving our nation's public health. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 14 APHA. The impact of the Affordable Care Act on state and local public health systems. http://www.apha.org/~media/files/excel/apha_aca_impacts_apr_2013.ashx
- 15 APHA. Prevention and Public Health Fund. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 16 Trust for America's Health. The truth about the Prevention and Public Health Fund. <http://healthyamericans.org/health-issues/wp-content/uploads/2013/09/Truth-about-the-PPHF.pdf>
- 17 APHA. The impact of the Affordable Care Act on state and local public health systems. http://www.apha.org/~media/files/excel/apha_aca_impacts_apr_2013.ashx
- 18 APHA. Prevention and Public Health Fund. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 19 HHS. The Affordable Care Act and immunization. <http://www.hhs.gov/healthcare/facts/factsheets/2010/09/The-Affordable-Care-Act-and-Immunization.html>
- 20 Ibid.
- 21 APHA. Prevention and Public Health Fund. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 22 Trust for America's Health. The truth about the Prevention and Public Health Fund. <http://healthyamericans.org/health-issues/wp-content/uploads/2013/09/Truth-about-the-PPHF.pdf>
- 23 Trust for America's Health. The truth about the Prevention and Public Health Fund. <http://healthyamericans.org/health-issues/wp-content/uploads/2013/09/Truth-about-the-PPHF.pdf>
- 24 APHA. Prevention and Public Health Fund. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 25 APHA. The impact of the Affordable Care Act on state and local public health systems. http://www.apha.org/~media/files/excel/apha_aca_impacts_apr_2013.ashx
- 26 Trust for America's Health. Prevention and Public Health Fund Allocations: <http://healthyamericans.org/health-issues/wp-content/uploads/2014/12/Prevention-Fund-Over-Time.pdf>
- 27 APHA. Prevention and Public Health Fund. https://www.apha.org/~media/files/pdf/topics/aca/apha_prevfundbrief_june2012.ashx
- 28 Trust for America's Health. Prevention and Public Health Fund Allocations: <http://healthyamericans.org/health-issues/wp-content/uploads/2014/12/Prevention-Fund-Over-Time.pdf>
- 29 Patient Protection and Affordable Care Act, P.L. 111-148.
- 30 Ibid.
- 31 Institute of Medicine. America's health care safety net: intact but endangered. <http://iom.edu/Reports/2000/Americas-Health-Care-Safety-Net-Intact-but-Endangered.aspx>
- 32 Institute of Medicine. For the Public's Health: Investing in a Healthier Future. <http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx>
- 33 Congressional Budget Office. Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent Supreme Court decision. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>
- 34 Congressional Budget Office. Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACATables.pdf>
- 35 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>

- 37 Patient Protection and Affordable Care Act, P.L. 111-148.
- 38 National Association of County and City Health Officials. Public health and prevention provisions of the Affordable Care Act. <http://www.naccho.org/advocacy/upload/PH-and-Prevention-Provisions-in-the-ACA-Revised.pdf>
- 39 Patient Protection and Affordable Care Act, P.L. 111-148.
- 40 The Food and Drug Administration (FDA) released draft guidance on implementing this ACA provision, but the guidance was subsequently withdrawn in January 2011. The FDA published two proposed rules in the Federal Register on nutritional labeling for vending machines and chain restaurants and accepted comments on both rules until July 5, 2011. As of summer 2014, neither of the final rules has been issued. See <http://www.fda.gov/Food/NewsEvents/ConstituentUpdates/ucm240574.htm> and <http://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201404&RIN=0910-AG57>.
- 41 Patient Protection and Affordable Care Act, P.L. 111-148.
- 42 Trust for America's Health. The truth about the Prevention and Public Health Fund. <http://healthyamericans.org/health-issues/wp-content/uploads/2013/09/Truth-about-the-PPHF.pdf>
- 43 Ibid.
- 44 Institute for Healthcare Improvement. IHI Triple Aim Initiative. <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>
- 45 APHA. Health reform basics. <http://www.apha.org/topics-and-issues/health-reform>
- 46 Kaiser Family Foundation. State health facts: health insurance coverage of the total population. <http://kff.org/other/state-indicator/total-population/>. See also Claxton G, Levitt L, Brodie M, Garfield R, Damico A. Measuring changes in insurance coverage under the Affordable Care Act. <http://kff.org/health-reform/issue-brief/measuring-changes-in-insurance-coverage-under-the-affordable-care-act/>
- 47 Kaiser Family Foundation. State health facts: health insurance coverage of nonelderly 0-64. <http://kff.org/other/state-indicator/nonelderly-0-64/>



The American Public Health Association champions the health of all people and all communities. We strengthen the profession of public health, promote best practices and share the latest public health research and information. We are the only organization that influences federal policy, has a 140-plus year perspective and brings together members from all fields of public health. Learn more at www.apha.org.

HEALTHY OUTLOOK: *Public health resources for systems transformation.*

How the Affordable Care Act Supports Public Health Solutions to Prevention Challenges

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



HEALTH DEPARTMENTS ADDRESS LARGE-SCALE PROBLEMS that negatively affect the health of entire populations. The ACA supports public health by providing additional funding to states and localities and by offering opportunities to build on current strengths in delivering community preventive services. This table highlights some of the ways the ACA supports public health approaches to reducing common prevention challenges.

	TOBACCO USE CESSATION	CHRONIC DISEASE PREVENTION	SUBSTANCE ABUSE	HEALTHY AND SAFE ENVIRONMENT
Description of Prevention Challenge	Use of tobacco can cause cancer, heart disease, stroke, lung disease, and diabetes. ¹ The health system helps people stop using tobacco and works to prevent people from starting tobacco use.	The cost of treating chronic diseases accounts for the majority of health expenses in the U.S. In 2012, 117 million adults had at least one chronic disease. ²	In addition to health problems for the user, substance abuse contributes to violence and other public health issues. ³	The environment affects health. Environmental risk factors include exposure to hazardous substances and lack of access to healthy food and water. ⁴
Examples of Public Health Solutions	CDC created a national multimedia tobacco education campaign, Tips from Former Smokers , that encouraged people to quit smoking by featuring the impact of smoking-related illnesses on smokers and their families and friends.	The New York State Department of Health Cancer Services Program provides screenings for the uninsured.	Policies such as increasing taxes on alcohol, limiting the hours and locations of sales, and enforcing ID requirements are effective in addressing excessive alcohol consumption.	Increasing the use of health impact assessments and integrating health criteria into decision making aid in efforts to reduce environmental risk factors.
Ways the ACA Is Supporting Public Health	The ACA builds on tobacco cessation education campaigns by requiring health insurance policies to cover tobacco use screenings and cessation treatments at no cost.	A primary goal of the ACA is to reduce chronic disease. It does this by increasing insurance coverage and also supporting and funding community preventive services .	The ACA requires health insurance policies to cover services to help beneficiaries stop substance abuse.	The ACA establishes grants for states and communities to create healthier environments. For example, Broward County, Florida , was awarded a grant to make streets more accessible for pedestrians and cyclists.
Useful Resources	- CDC Best Practices for Comprehensive Tobacco Control Programs - American Legacy Foundation - Association of State and Territorial Health Officials National Prevention Strategy Implementation Toolkit - Robert Wood Johnson Foundation	- CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)	- National Registry of Evidence-based Programs and Practices (NREPP)	- Healthy Community Design Initiative - Healthy Communities Program - National Environmental Public Health Tracking Network

	HEALTH EQUITY	NUTRITION	PHYSICAL ACTIVITY	INJURY AND VIOLENCE PREVENTION
Description of Prevention Challenge	Despite medical and technological advances, significant differences in health outcomes and longevity among people and communities persist. ⁵	Not all communities offer access to nutritious and affordable food, such as fresh fruits and vegetables, and this negatively affects health. ⁶	Most adults do not meet physical activity guidelines. In 2012, only 49.6% of adults reported that they get the recommended amount of aerobic physical activity. ⁷	Violence and injuries are the leading causes of death among young people. ⁸
Examples of Public Health Solutions	King County, Washington, passed a law and developed a decision-making toolkit to help local government work toward health equity.	The Minnesota Department of Health has created a Farm to School program to make fresh fruits and vegetables accessible to students.	Granville County, North Carolina, wanted to reduce obesity and increase physical activity among its residents. It created more walkable communities by building greenways.	The Washington State Department of Health created a guide for injury and violence prevention that includes injury data, goals, and strategies.
Ways the ACA Is Supporting Public Health	Programs that support community preventive services receive funding from the ACA. The law also broadens the categories of providers reimbursed by Medicaid.	The ACA empowers consumers to make nutritious choices through public education efforts. For example, the ACA requires restaurant chains to label their menus .	The ACA awarded grants for communities to support physical activity and active transportation . It also provided funding to start workplace wellness programs .	Injury and violence reduction measures in the ACA support community-based early childhood home visiting programs and initiatives to reduce falls among older adults.
Useful Resources	- National Stakeholder Strategy for Achieving Health Equity - HHS Action Plan to Reduce Racial and Ethnic Health Disparities	CDC National Action Guide	Physical Activity Guidelines for Americans	NPS Implementation Toolkit

1 CDC. Smoking and tobacco use. <http://www.cdc.gov/tobacco/index.htm>

2 CDC. Chronic diseases and health promotion. <http://www.cdc.gov/chronicdisease/overview/index.htm>

3 HealthyPeople.gov. Substance abuse. <http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse>

4 HealthyPeople.gov. Environmental health. <http://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health>

5 HealthyPeople.gov. Disparities. <http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx>

6 CDC, National Center for Chronic Disease Prevention and Health Promotion. State Indicator Report on Fruits and Vegetables, 2013. <http://www.cdc.gov/nutrition/downloads/State-Indicator-Report-Fruits-Vegetables-2013.pdf>

7 CDC. Exercise or physical activity. <http://www.cdc.gov/nchs/fastats/exercise.htm>

8 CDC. 10 leading causes of death by age group, United States—2011. http://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2011-a.pdf

HEALTHY OUTLOOK: *Public health resources for systems transformation.*

Summary of Selected Prevention Provisions in the Affordable Care Act

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ACA INVESTMENTS IN PUBLIC HEALTH		IMPLEMENTATION UPDATE
National Prevention, Health Promotion and Public Health Council (ACA Section 4001)	Leads and coordinates the federal government's prevention and health promotion activities and seeks to establish a coordinated multisector national prevention strategy. The council must provide annual reports on its progress to Congress.	These investments in public health are paying off. For example, health educators in Virginia use Prevention and Public Health Fund dollars to host chronic disease self-management classes . The Community Preventive Services Task Force has developed resources designed to help public health workers implement strategies to improve the health of the populations they serve. In addition, the National Prevention, Health Promotion and Public Health Council recently released the 2014 National Prevention Strategy .
Prevention and Public Health Fund (Section 4002 and others)	Invests in prevention and public health programs to improve health and reduce health costs. The fund provides for six major prevention programs to be administered by the U.S. Department of Health and Human Services (HHS): (1) school-based health centers (Section 4101), (2) Medicaid incentives for prevention of chronic disease (Section 4108), (3) community transformation grants (Section 4201), (4) healthy aging and living well (Section 4202), (5) epidemiology and laboratory capacity grants (Section 4304), and (6) maternal, infant, and early childhood home visiting programs (Section 2951).	
Community Preventive Services Task Force (Section 4003)	Charges the director of the Centers for Disease Control and Prevention (CDC) with convening an independent "Community Preventive Services Task Force" to review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions. The recommendations of the task force will be published in the Guide to Community Preventive Services, and its work will be coordinated with the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices.	
Worksite Wellness (Section 4303 and others)	Invests in several facets of worksite wellness programs, including (1) requiring the CDC to evaluate employer-based wellness best practices and provide education and outreach to promote the benefits of worksite health promotion to employers (Section 4303), (2) providing grants to small employers that establish wellness programs (Section 10408), and (3) allowing employers to offer employees specified rewards to cover a portion of the cost of coverage for participating in wellness programs and meeting health-related standards (Section 1201).	
Immunizations (Section 4202)	Authorizes HHS to negotiate contracts with vaccine manufacturers and directs the CDC to establish a demonstration program to award grants to states with the aim of improving the provision of recommended immunizations for people of all ages and targeting evidence- and population-based interventions toward those at high risk.	
PUBLIC EDUCATION CAMPAIGNS		IMPLEMENTATION UPDATE
National Prevention and Promotion (Section 4004)	Directs the HHS secretary to convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign.	The ACA's public education campaigns are ongoing. The federal government has issued proposed regulations for menu labeling. The public is supportive of labels on restaurant menus, and labels help people consume fewer calories and fat in restaurants.
Oral Health (Section 4102)	Creates a national public education campaign on oral health care. The campaign targets children, pregnant woman, the elderly, people with disabilities, and ethnic and racial minority populations.	
Menu Labeling (Section 4205)	Requires nutrition labeling on standard menu items at chain restaurants with more than 20 locations and on food sold from vending machines.	

COVERAGE OF PREVENTIVE SERVICES		IMPLEMENTATION UPDATE
Coverage of Preventive Services for Private Plans (Section 1001)	Requires all health plans offered on a health exchange to cover and not impose any cost-sharing requirements on certain evidence-based clinical preventive services and items, including well baby and well child care services.	Merely having insurance does not improve health. Public health practitioners have the opportunity and challenge of educating newly insured people about the need to access primary and preventive care. This resource, titled From Coverage to Care , is designed to help health care providers guide newly insured people to health care services. Unfortunately, some preventive services for women's health are being challenged in court. This points to a need for continued funding for family planning and contraceptive services, which are often provided through public health agencies.
Medicare (Sections 4103–4105)	Provides coverage without a copayment or deductible for an annual wellness visit and a comprehensive health risk assessment. Eliminates cost sharing and coinsurance for preventive services covered by Medicare.	
Medicaid (Sections 4106–4107)	Gives states the option to provide diagnostic, screening, preventive, and rehabilitation services and prohibits cost sharing for such services as well as vaccines. Requires states to provide tobacco cessation services for pregnant women and eliminates cost sharing for these services.	
RESEARCH AND DEMONSTRATION		IMPLEMENTATION UPDATE
Individualized Wellness Plans (Section 4206)	Tests the impact of providing at-risk populations with an individualized wellness plan designed to reduce the risk of preventable conditions. Wellness plans include nutritional counseling, physical activity, alcohol and tobacco cessation counseling, and stress management plans.	The ACA has been successful in decreasing the number of uninsured people, but some parts of the law focused on research and demonstration have not received any funding. For example, evaluation of wellness plans and implementation of the “Healthy Aging, Living Well” program have not been funded. However, the ACA supported the work of the Preventive Service Task Force, which developed the Guide to Clinical Preventive Services, 2014 .
Delivery of Public Health Services (Section 4301)	Evaluates the effectiveness of evidence-based practices relating to prevention and community-based public health interventions, with a focus on priorities outlined in the National Prevention Strategy and Healthy People 2020, and identifies effective strategies for state and local systems to organize, finance, and deliver public health services.	
Evaluation of Community-based Prevention and Wellness Programs (Section 4202)	Creates the “Healthy Aging, Living Well” program to improve the health status of the pre-Medicare-eligible population (those 55–64 years old) and Medicare beneficiaries. The goal is to help control chronic disease and reduce Medicare costs through evidence-based public health interventions and clinical treatments designed to reduce risk.	
Other ACA Evaluation Provisions	Other evaluation-oriented provisions in the ACA include (1) collection of data on race, ethnicity, gender, primary language, and disability status in all federal surveys (Section 4302); (2) convening an Institute of Medicine conference to explore pain management and how specific races, genders, and ages are affected (Section 4305); (3) appropriation of funds for a previously authorized childhood obesity demonstration project (Section 4306); (4) development of methodologies by the Congressional Budget Office for estimating the budget impact of prevention and wellness programs (since benefits often accrue beyond a 10-year budget window) (Section 4401); (5) analysis of the impact of health and wellness initiatives on the health status (e.g., absenteeism, productivity) of the federal workforce (Section 4402); and (6) a review by the USPSTF of the scientific evidence on the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services (Section 4003).	

Understanding and Implementing Community Preventive Services

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



STATE AND LOCAL HEALTH DEPARTMENTS PROVIDE A RANGE of community and clinical preventive services to the general public and specific populations (e.g., children, those who are underinsured, and those without insurance coverage). The Affordable Care Act (ACA)¹ represents an opportunity and a challenge to state and local health departments regarding the types and extent of preventive services they offer. New and expanded funding through the Prevention and Public Health Fund has allowed some jurisdictions to pilot different approaches or evaluate their current approaches to the delivery of preventive services in both clinical and community settings. However, continuing budgetary pressures at all levels of government have limited the types of preventive services health departments have the resources and workforce to provide.

This issue brief describes community preventive services, reviews tools and resources that can be used to support community prevention at the state and local levels, and discusses the ongoing need for these services within the context of a transforming system.

What Are Community Preventive Services?

Preventive services are interventions and activities that prevent disease or injury or promote health.²

Clinical preventive services (also referred to as primary care preventive services³) are generally delivered one on one to a patient by a health care practitioner in some form of clinic (e.g., hospital, community health center, or state or local health department)⁴ (see the Organization, Services, and Funding of Health Departments, and Implications of the Affordable Care Act issue brief). Examples of clinical preventive services include screenings for sexually transmitted infections, cancer, and tuberculosis, as well as vaccinations and health counseling. Some clinical care preventive services, such as immunizations, may be delivered in a nonclinical setting such as a school or pharmacy.

Community preventive services are interventions and activities that support, supplement, or enhance the provision of clinical preventive services.⁵ Community preventive interventions are typically targeted to groups of people in a community setting or in a health care system.⁶ The community being served can be defined in a variety of ways: geographic location, age, culture, disease or injury risk, or risky health behavior.⁷ While they also provide clinical services, state and local health agencies and other community-oriented organizations are the primary providers of community preventive services.

:: Community and Clinical Preventive Measures Are Mutually Supportive

While community and clinical preventive measures are different, they are mutually reinforcing. A clinical care provider may direct patients to community preventive measures that support the clinical care delivered by the provider.⁸ Similarly, community preventive measures support clinical care interventions by:

- Offering programs in community or health care settings to which providers can refer their patients for support and education (e.g., quitlines that support clinic-based smoking cessation counseling).⁹
- Supporting and reinforcing individual clinical preventive services with community prevention efforts that have the potential to reach large numbers of people (e.g., messages about healthy diets and physical activity for diabetic patients).¹⁰

As the primary providers of community preventive services, state and local health agencies and other community-oriented organizations have a unique and vital role in implementing the prevention aims of the ACA and in realizing the ultimate goal of improving the health of all people.

Developing a Plan for Implementing Community Preventive Services

The ACA's focus on using evidence-based preventive measures has further highlighted the need for health departments and other community-oriented organizations to identify successful and cost-effective measures they can implement in their communities. They can also use the ACA as an opportunity to reevaluate the public health approaches they currently use and determine how new approaches and partnerships can strengthen and transform their health systems to promote prevention and overall population health.

Before a community prevention initiative is implemented, however, an agency or organization must engage in a process of assessment and planning to carefully determine its needs, goals, available resources, and the types of community preventive measures that have been shown to be effective in addressing the targeted need. The following is a simplified process that a health department or other organization can undertake when engaging in a community preventive service or initiative:¹¹

- **ASSESSMENT**—Determine if and what action is needed by assessing community needs and resources.
- **PLANNING**—Identify the necessary people and resources to undertake the activity.
- **ENGAGEMENT**—Identify potential collaborators and facilitate collaborations with and among individuals, businesses, and organizations in the community.
- **IMPLEMENTATION**—Implement and manage the activity.
- **EVALUATION**—Collect data and evaluate the outcomes of the activity.
- **SUSTAINMENT**—Maintain gains by building capacity, creating policies, and conducting quality control activities.

There are many specific examples of planning and evaluation processes associated with particular types of interventions (e.g., an interactive campaign designed to prevent alcohol use by teens) that can be used as a guide. The next section discusses sources that an agency or organization can use to identify evidence-based interventions.

How the ACA Helps Public Health Practitioners Identify Effective Community Preventive Services

Research into the effectiveness of public health interventions has rapidly developed over the past several decades, and there is a growing body of literature addressing evidence-based community interventions.

This section briefly reviews the National Prevention Strategy (NPS), along with the national prevention priorities it sets out, and then describes several sources for identifying and assessing specific community preventive measures.

:: National Prevention Strategy

The Affordable Care Act created the National Prevention, Health Promotion and Public Health Council (National Prevention Council). The council's task is to coordinate and lead federal efforts related to prevention, wellness, and health promotion and advance a national prevention agenda.¹² The National Prevention Council issued the NPS in June 2011¹³ and has published annual status reports from 2010 to 2014.¹⁴ The goal of the NPS is to “increase the number of Americans who are healthy at every stage of life.”¹⁵ Public health practitioners can use this resource not only to guide their own targeted prevention activities but also to reach out to other partners with the goal of educating them about the steps they can take to incorporate prevention concepts and actions into their policies and daily activities. The NPS incorporates sources familiar to public health practitioners—such as the Guide to Community Preventive Services (The Community Guide) and Healthy People 2020 (HP 2020), discussed below—for identifying and vetting different proven prevention strategies.

:: Sources for Identifying Community Preventive Services

There are a number of sources for identifying potential community preventive services, including multiple-topic compilations, single-topic compilations, and individual scientific and scholarly papers. The Guide to Community Preventive Services and Healthy People 2020 are examples of multiple-topic compilations that contain information on prevention measures determined to be effective or promising in achieving their stated prevention goals. Table 1 summarizes The Community Guide and HP 2020. The Guide to Clinical Preventive Services¹⁶ is a parallel to The Community Guide and is used to identify clinical/primary care preventive interventions¹⁷ (see the Resources section at the end of the document).

COMPARING THE COMMUNITY GUIDE AND HEALTHY PEOPLE 2020

	The Community Guide	Healthy People 2020
Where can the document be accessed?	The Community Guide is available at www.thecommunityguide.org .	HP 2020 is available at www.healthypeople.gov .
Who developed it?	Developed and overseen by the Community Preventive Services Task Force (CPSTF) and supported by the Centers for Disease Control and Prevention (CDC).	Developed through a multiyear process led by federal agencies, with comments solicited from the public.
What are the goals of the document?	To help users identify and choose policies and programs to improve health and prevent disease. ¹⁸	To (1) identify health improvement priorities; (2) provide a better understanding of health determinants, disease, and disability; (3) set measurable goals and objectives for progress; (4) engage various sectors in efforts to improve policies and practices; and (5) identify data, research, and evaluation gaps. ¹⁹
What does the document contain?	Evidence-based reviews of community preventive measures to identify effective policies and programs. ²⁰	Science-based, 10-year national objectives for improving health. ²¹
How are the document's recommendations developed?	The CPSTF conducts systematic reviews of scientific studies to develop recommendations and findings. ²²	Draft objectives are prepared by federal agencies, opened for public comment, and reviewed by the Healthy People Federal Interagency Workgroup. ²³
What topics does the document address?	More than 20 topics and different types of intervention approaches (e.g., behavior change, disease prevention, and environmental change). ²⁴ Community Guide topics directly address or partially overlap with the recommendation areas identified in the NPS.	More than 40 topics. Includes objectives with baseline and target measures, evidence-based intervention strategies, and consumer health information. ²⁵ HP 2020 topics directly address or partially overlap with the recommendation areas identified in the NPS.
Are there aids for implementing the recommendations?	The Community Guide Toolbox incorporates a five-step process: (1) assessing and evaluating community needs, (2) planning the intervention, (3) engaging stakeholders, (4) implementing the intervention, and (5) ensuring that the intervention is sustainable. ²⁶ These steps apply to all topic areas.	HP 2020 includes implementation information with evidence-based resources, case studies on community preventive services, and a framework ("MAP-IT") to "mobilize partners, assess community need, create and implement a program plan, and track community progress." ²⁷
Who should use this document?	Public health practitioners, decision makers, and stakeholders seeking to assess the evidence base for programs and interventions, effectively allocate resources, reduce spending on preventable illness, and increase productivity. ²⁸	Public health and health care practitioners researching interventions and individuals seeking guidance on personal health matters.

The Central and Transformative Role of Community Preventive Services

The role of prevention is becoming more firmly rooted in the nation's understanding of managing health care costs, preserving health, and living a healthy and productive life. The community preventive services that public health agencies and other community-oriented organizations provide are an important and integral part of delivering care to and promoting health in the population. Community preventive services support and reinforce the preventive and other health services offered by clinical providers.

State and local health departments were confronted with years of budget and personnel cuts during the recent recession. The Prevention and Public Health Fund has provided new funding for prevention and public health activities. However, supporters of public health have been challenged to preserve the Prevention and Public Health Fund along with the funding of other programs funded by Congress. Ensuring ongoing funding through public health budgets and identifying new funding sources are still necessary to support public health departments in providing community preventive services.

The Affordable Care Act has fostered changes in delivery of and payment for health services, focusing on prevention as a key mechanism for controlling costs and improving the overall health of individuals and communities. The ACA has provided public health agencies and organizations with the opportunity to think more expansively about how to achieve their immediate community health goals as well as transform their health systems by creating effective prevention initiatives and ongoing partnerships between the public health and health care systems and other sectors in their communities. (For more on how the ACA supports expansion of community preventive services, see [How the ACA Supports Public Health Solutions to Prevention Challenges](#).)”

Resources for More Information

The resources offered here can be used by public health practitioners to identify, implement, and evaluate effective evidence-based and promising practices. While not exhaustive, this list provides a good starting point.

- [National Prevention Strategy](#)—Provides strategic directions and topic-based priorities with recommendations for various health-related sectors.
- [Community Health Improvement Navigator \(CDC\)](#)—Provides resources to help people form coalitions to improve community health.
- [Guide to Community Preventive Services and Community Guide Toolbox](#)—Contain findings, literature reviews, and implementation tools from the U.S. Community Preventive Services Task Force on more than 20 topic areas.
- [Healthy People 2020 and Healthy People 2020 MAP-IT Framework](#)—Provide science-based objectives, resources, and implementation guides in more than 40 topic areas, with the goal of improving health by establishing benchmarks and monitoring progress toward reducing illness, disability, and death.
- [Health System Transformation and Improvement Resources for Health Departments \(CDC\)](#)—Lists information, resources, and training opportunities connected to changes in the health system, with a focus on state, local, territorial, and tribal governments.
- [American Public Health Association](#)—Lists a range of APHA’s analyses and resources related to the creation and implementation of the ACA.
- [NPS Implementation Toolkit \(Association of State and Territorial Health Officials\)](#)—Contains implementation resources including evidence-based recommendations and case studies focusing on the National Prevention Strategy’s strategic directions and priorities.
- [Public Health and Primary Care Together: A Practical Playbook \(deBeaumont Foundation/Duke University\)](#)—An interactive resource to help integrate the public health and primary care sectors in efforts to improve population health.
- [Leading through Health System Change \(Georgia Health Policy Center and National Network of Public Health Institutes\)](#)—An interactive tool to assist public health leaders in responding to the changes and opportunities arising from the ACA.

Resources for More Information (cont.)

- [*Institute of Medicine*](#)—Provides authoritative advice to decision makers and the public on public health and other health care topics.
- [*Resource Center for Evidence-Based Prevention \(National Association of County and City Health Officials\)*](#)—Provides guidance for integrating various prevention initiatives such as the National Prevention Strategy, Healthy People 2020, and the Guide to Community Preventive Services and other sources into workable approaches to achieving community health.

- 1 Patient Protection and Affordable Care Act, P.L. 111-148.
- 2 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 3 U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/>
- 4 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 5 Ibid.
- 6 Ibid.
- 7 Ibid.
- 8 Ibid.
- 9 Ibid.
- 10 Ibid.
- 11 Ibid.
- 12 Shearer G. Prevention provisions in the Affordable Care Act. https://www.apha.org/-/media/files/pdf/topics/aca/prevention_aca_final.ashx
- 13 National Prevention Council. National Prevention Strategy. <http://www.surgeongeneral.gov/initiatives/prevention/strategy/>
- 14 Ibid.
- 15 Ibid.
- 16 U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/>
- 17 The Guide to Clinical Preventive Services, which is published by the U.S. Preventive Services Task Force (USPSTF), contains recommendations for primary care clinicians and health systems. The USPSTF, with support from the Agency for Healthcare Research and Quality (AHRQ), conducts scientific evidence reviews of a broad range of clinical preventive health care services (e.g., screening, counseling, and preventive medications) to develop its recommendations.
- 18 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 19 U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov/2020/default.aspx>
- 20 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 21 U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov/2020/default.aspx>
- 22 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 23 U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov/2020/default.aspx>
- 24 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>
- 25 U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov/2020/default.aspx>
- 26 Community Preventive Services Task Force. Community Guide Toolbox. <http://www.thecommunityguide.org/toolbox/index.html>
- 27 U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov/2020/default.aspx>
- 28 Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>



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Expansion of Medicaid Reimbursement for Preventive Services: Opportunities for Public Health

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



THE AFFORDABLE CARE ACT¹ (ACA) NOT ONLY ESTABLISHED health care delivery system and payment reforms but also focused the nation on the importance of prevention in tackling the cost of health care and preserving health. Preventive services in both clinical and community settings are an important part of achieving the aims of the ACA and the larger goal of promoting healthy and productive lives for all. State and local health departments provide a range of community and clinical preventive services to the general public and specific populations (e.g., children, the underinsured, and those with no insurance coverage).

The ACA represents an opportunity and a challenge to state and local health departments regarding the types and extent of preventive services they offer. How to fund and adequately staff both clinical and community preventive activities can be significant challenges to agencies as they face continuing budgetary pressures. One option for health departments to consider is that of seeking additional or alternative ways to fund their clinical and community preventive services through reimbursements from private or public insurers such as Medicaid (see the Public Health and ACA Payment Delivery Systems Reform issue brief). This issue brief focuses on Medicaid's reimbursement rules for preventive services and how they can be used as a tool in changing the way health departments and other health agencies provide and pay for preventive health services.

The ACA and Medicaid Reimbursement for Preventive Services

On July 15, 2013, the Centers for Medicare & Medicaid Services (CMS) updated the definition of “preventive services,”² and the change went into effect on January 1, 2014. Before, only preventive services “provided by a physician or other licensed practitioner” were eligible for reimbursement by Medicaid.⁴ CMS now allows Medicaid to reimburse for preventive services that are “recommended by a physician or other licensed practitioner,”⁵ thereby allowing preventive services to be delivered by a person who is not a physician or otherwise licensed by a state. This change makes the language in the rule consistent with amendments made by the ACA. States have discretion as to whether to seek Medicaid reimbursement for nonlicensed practitioners, but they must receive CMS approval before reimbursement is allowed.^{6,7,8}

The CMS rule change did not affect the types of preventive services eligible for Medicaid reimbursement. The eligible services are those that “(1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and mental health and efficiency.”³

Who Is Eligible to Receive Medicaid Reimbursement for Providing Preventive Services?

The changed definition in the Medicaid reimbursement rule now makes it possible for a wider range of health practitioners to be reimbursed for preventive services, including services that are provided by practitioners not required to be licensed under their states' laws (nonlicensed practitioners). The rule allows some public health practitioners to be eligible for Medicaid reimbursement. Nonlicensed public health practitioners include community health workers (CHWs), community health advocates, community health representatives, peer health promoters, lay health educators, care coordinators,^{9,10} (among these terms, community health worker is most frequently used). The revised rule makes it possible for more public health practitioners to participate in the implementation of the ACA's goals and, ultimately, in health system transformation.

Community health workers are generally members of the communities they serve or have a keen understanding of those communities.^{14,15} These public health workers, who may be paid or may serve in a voluntary capacity, supply health services (e.g., blood pressure monitoring); provide education, outreach, and informal counseling; and act as liaisons between community members and health and social service providers.^{16,17} CHWs may also advocate for the overall health needs of the community and work to improve the cultural competency of health providers and services.^{18,19} In many cases, they share the same language, ethnicity, socioeconomic status, and experiences with the communities they serve.²⁰

Incorporating the services of CHWs into the health system has been shown to reduce chronic illness, produce better adherence to medication schedules, increase patients' involvement in their health care, improve the overall health of the community, and reduce health disparities and health care costs.²¹ According to one study of Medicaid patients with diabetes, the use of CHWs saved about \$2,000 per patient.²² Another study of an outreach program targeting underserved men showed that for every \$1 spent on CHWs, the return on investment was \$2.²³

The ACA and Community Health Workers

- The Affordable Care Act incorporates grant programs to help promote the use of CHWs.
- The Centers for Disease Control and Prevention (CDC) has created a new grant program to support the development of the community health workforce.¹¹
- The Center for Medicare & Medicaid Innovation (CMMI) provided \$1 billion through the Healthcare Innovation Challenge Awards to foster innovation, including the use of CHWs.¹²
- One of the projects funded by CMMI, "Optimizing Health Outcomes for Children with Asthma in Delaware," combines primary care and community preventive services, including the use of CHWs, to reduce the number of asthma-related emergency room and hospital admissions among children participating in Medicaid.¹³

:: Examples of Medicaid Reimbursement for CHWs

Even before the revised Medicaid rule, some health departments and health care systems had been using nonlicensed practitioners such as CHWs and seeking reimbursement for Medicaid-eligible preventive services, as follows.

- **CHW USE IN MEDICAID MANAGED CARE PLANS:** New Mexico, like some other states, requires the state's Medicaid managed care plans to provide CHW services.²⁴ The state worked with its largest managed care

organization (MCO) to establish a billing code for the CHW services provided by the Medicaid managed care program, enabling the state to track the use of the services.²⁵ The state now requires that all MCOs participating in the managed care program provide CHW services.²⁶

- **CHW USE THROUGH MEDICAID STATE PLAN AMENDMENTS:** In 2008, CMS approved Minnesota's state plan amendment (SPA) to reimburse care coordination and patient education services provided by CHWs through the state's Medicaid program.²⁷ The approval of the SPA was the culmination of a long-term effort to define a standardized curriculum for CHWs in the state's community colleges and foster the use of CHWs to improve health and control costs.²⁸ CHWs participating in the Minnesota Medicaid program are typically employed by health clinics or work outside a health care setting.^{29,30} They may work under the supervision of a physician, advanced practice registered nurse, or certified public health nurse, among others.³¹
- **DEMONSTRATING COST SAVINGS OF CHWS:** In Denver, Colorado, the use of CHWs saved \$2.28 in inpatient and urgent care costs for every \$1 invested in primary care services provided by a CHW.³² This demonstration of savings resulted in Colorado having a state plan amendment approved without the need to identify state matching funds, as otherwise required for SPA approval.³³

What Preventive Services Are Eligible for Medicaid Reimbursement?

The revised preventive services reimbursement rule broadens the types of practitioners eligible to provide Medicaid-covered preventive services.^{36,37} To be covered, these services must (1) be medical or remedial in character, (2) entail direct patient care, and (3) "be for the express purpose of diagnosing, treating or preventing illness, injury or other impairments to an individual's physical or mental health."³⁸ Nonmedical preventive services focused on environmental or social concerns are not covered under the revised preventive services rule.³⁹ Services that provide only items such as dust-mite-proof bedding, lead abatement products, or smoke detectors are not within the scope of the rule.⁴⁰ However, as discussed below, such social or environmental interventions might be covered if they have a health care benefit.

While the revised preventive services reimbursement rule broadens the "who" (the types of practitioners eligible to provide Medicaid-covered preventive services), CMS notes that it does not change the "what" (the types of preventive services offered).^{34,35}

:: Examples of Medicaid-Covered Preventive Services

Given the CMS requirements for covered preventive services, some types of services may be reimbursable by Medicaid, including care coordination, educational counseling, home visiting, lactation consulting, childhood developmental screening, and parenting education.⁴¹ For instance, a number of states have created comprehensive home visiting programs under their Medicaid programs.⁴² One such initiative is Michigan's Maternal and Infant Health Program, which is financed through direct reimbursements from Medicaid.⁴³

As noted, nonmedical services may be eligible for Medicaid reimbursement if they have a health care benefit.⁴⁴ For example, in meeting Medicaid's Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) requirements for children, some states have adopted the Bright Futures Guidelines, which incorporate a model of health promotion and disease prevention that may require addressing environmental factors as part of resolving a health issue.⁴⁵ This approach has been used in Rhode Island to cover the cost of lead abatement

and by Massachusetts' Pediatric Asthma Pilot Program to demonstrate how Medicaid can provide coverage for remediation of environmental threats to children.⁴⁶

Medicaid Reimbursement for Preventive Services: Implications and Opportunities

States have found new and innovative ways to obtain Medicaid reimbursement for preventive services supplied by nonlicensed practitioners and in nontraditional health care settings, as well as reimbursement for nonmedical services. The amended CMS rule will make it easier for states to expand the numbers of nonlicensed practitioners eligible for Medicaid reimbursement, but states will still have to closely comply with Medicaid requirements regarding the types of services provided, which have not been altered by the 2014 rule change.

The rule change implements an important shift embodied in the Affordable Care Act from a health system and society responding to illness to one that focuses on prevention.

More broadly, the use of nonlicensed public health practitioners such as CHWs has increased and evolved as the U.S. health system looks for ways to improve health outcomes and curb the cost of health care. Use of CHWs, regular access to preventive services, and insurance coverage are effective ways to improve health care outcomes, especially in the case of people who live in medically underserved communities or who are affected by other health disparities. Medicaid beneficiaries can receive preventive services they may not otherwise have been able to access as a result of high cost or a lack of providers in their communities.⁴⁷

:: Opportunities for Public Health Agencies

For public health agencies and other organizations offering preventive services, the revised rule represents an opportunity to think strategically about the ways they provide and pay for preventive health services. Nonlicensed practitioners, including CHWs, can be a tool to help achieve public health system transformation. Specifically, using CHWs and seeking Medicaid reimbursement for preventive services can:

- Provide an additional source of valuable preventive services in clinical and community settings.
- Expand and augment the public health workforce to achieve broader prevention and public health goals.
- Lead to more efficient use of community resources to achieve improvements in health outcomes and greater equity in access to care.

In order to implement or expand the use of CHWs or Medicaid reimbursement for prevention services, public health agencies and other organizations must evaluate the prevention services they provide, the types of practitioners who offer these services, and how practitioners and services may fall within the parameters for Medicaid reimbursement. The following are some ways states can consider using CHWs:

- Include the services provided by CHWs in Medicaid administrative cost claims.⁴⁸
- Incorporate CHWs into care teams or managed care models.⁴⁹
- Offer incentives for private insurers to use CHWs.⁵⁰
- Enact authorizing legislation to permit Medicaid reimbursement for services offered by CHWs.⁵¹
- Submit a state plan amendment seeking CMS approval of Medicaid reimbursement for nonlicensed practitioners such as CHWs.

Increased Reimbursement for Preventive Services Bolsters Health Systems Transformation

Medicaid's reimbursement rules for preventive services are one way in which public health agencies and other organizations may provide and pay for preventive health services. The 2014 rule change allows public health departments and public health practitioners to diversify the preventive services they provide and acquire new sources of funding for those services. It also provides an opportunity for public health departments to think more strategically about their role in health system transformation.

Resources for More Information

The resources offered here can be used to locate information and resources about Medicaid reimbursements for preventive services and for the services of community health workers. While not exhaustive, this list provides a good starting point.

Information on the CMS Rule Change

- [CMS. Medicaid Final Rule. 78 Federal Register 42160 \(July 15, 2013\)](#)
- [CMS. Informational Bulletin: Update on Preventive Services Initiatives \(November 27, 2013\)](#)
- [CMS. Medicaid Preventive Services: Regulatory Change. \(April 2014\)](#)

Expanding Medicaid Reimbursement

- [Trust for America's Health. Expand Medicaid and Private Insurer Coverage of Community Prevention Programs \(January 2013\)](#)
- [Nemours. Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models \(June 2013\)](#)

Evidence-Based and Shared Practices on the Use of CHWs

- [Agency for Healthcare Research and Quality](#)
- [Centers for Disease Control and Prevention](#)
- [Healthy People 2020](#)
- [Guide to Community Preventive Services](#)

- 1 Patient Protection and Affordable Care Act, P.L. 111-148.
- 2 CFR §440.130(c).
- 3 Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Programs: essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; exchanges: eligibility and enrollment; final rule. 78 Fed Reg 42160 (July 15, 2013). This rulemaking included updates to the language in 42 CFR §440.130(c).
- 4 The language of 42 CFR §440.130(c) prior to the amendment effective January 1, 2014, was as follows: "Preventive services' means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to—(1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency" (emphasis added).
- 5 The language of CFR §440.130(c) after January 1, 2014, reads: "Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to— (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency" (emphasis added).
- 6 If states choose to amend their Medicaid plan, they have the authority to set the qualifications of nonlicensed practitioners, the services they offer, and the methodology of reimbursement.
- 7 Centers for Medicare & Medicaid Services. Medicaid preventive services: regulatory change. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>
- 8 CFR §440.130(c).
- 9 CDC. Community health workers/promotores de salud: critical connections in communities. <http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf>
- 10 DeBiasi A. Medicaid support for community prevention. <http://www.astho.org/Prevention/Million-Hearts/Integrating-Community-Health-Workers/>
- 11 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 12 CMS. Healthcare Innovation Awards: Delaware. <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Delaware.html>
- 13 Ibid.
- 14 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 15 APHA, Community Health Workers Section. Definition of a community health worker. <http://www.apha.org/apha-communities/member-sections/community-health-workers>. The Community Health Workers Section has adopted the following definition of a CHW: "A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."
- 16 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 17 APHA, Community Health Workers Section. Definition of a community health worker.
- 18 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 19 APHA, Community Health Workers Section. Definition of a community health worker.
- 20 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 21 CDC, National Center for Chronic Disease Prevention and Health Promotion. State law fact sheet: a summary of state community health worker laws. http://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf
- 22 Ibid.
- 23 Ibid.
- 24 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 25 Ibid.
- 26 Ibid.

- 26 Ibid.
- 27 Ibid.
- 28 Ibid.
- 29 Ibid.
- 30 Because Minnesota's activities predate the 2013 CMS amendment, in this case CHW services are covered by Medicaid only when they are provided and billed under the supervision of a physician, registered nurse, certified public health nurse, or other practitioner licensed by the state. See also note 14.
- 31 Minnesota Department of Human Services. Provider manual: community health worker.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357
- 32 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models.
http://www.nemours.org/content/dam/nemours/www2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 33 Ibid.
- 34 Centers for Medicare & Medicaid Services. Medicaid preventive services: regulatory change.
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>
- 35 CMS. Informational bulletin: update on preventive services initiatives. <http://www.medicare.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf>
- 36 Centers for Medicare & Medicaid Services. Medicaid preventive services: regulatory change.
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>
- 37 CMS. Informational bulletin: update on preventive services initiatives. <http://www.medicare.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf>
- 38 Centers for Medicare & Medicaid Services. Medicaid preventive services: regulatory change.
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>
- 39 Ibid.
- 40 Ibid.
- 41 Trust for America's Health and Nemours. Medicaid reimbursement for community-based prevention.
<http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention>
- 42 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: myths, state successes overcoming barriers and the promise of integrated payment models.
http://www.nemours.org/content/dam/nemours/www2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf
- 43 Ibid.
- 44 Ibid.
- 45 Ibid.
- 46 Ibid.
- 47 Centers for Medicare & Medicaid Services. Medicaid preventive services: regulatory change.
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>
- 48 CDC, National Center for Chronic Disease Prevention and Health Promotion. State law fact sheet: a summary of state community health worker laws.
http://www.cdc.gov/dhdp/pubs/docs/chw_state_laws.pdf
- 49 Ibid.
- 50 Ibid.
- 51 Ibid.

Glossary

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ACCOUNTABLE CARE ORGANIZATIONS (ACOs): Networks of providers that coordinate care for patient populations. ACOs receive bonuses for meeting quality and cost targets (and, in some cases, incur penalties for not meeting targets).^{1,2} They are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that support coordinated care and high-quality, efficient service delivery.³

BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: A program that allows Medicare to pay one specified amount for all of the health care a patient receives. For example, rather than paying an individual patient's surgeon, nurses, primary care physician, and physical therapist separately for treating one health condition, Medicare renders a single payment that the providers divide among themselves. Providers must coordinate their care to maximize quality and efficiency.⁴

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS): The agency within the U.S. Department of Health and Human Services that oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The Center for Medicare & Medicaid Innovation (CMMI), created by the Affordable Care Act to oversee many of the health reform law's delivery and payment reform efforts, is part of CMS.

CENTRALIZED HEALTH DEPARTMENT: A form of health department governance wherein the state has extensive legal and operational control over local health departments. Four states use this form of governance.⁵

CLINICAL SERVICES: Health services that are delivered to a patient by a provider in a medical office or some other part of the health care system.

COMMUNITY-BASED CARE TRANSITIONS PROGRAM (CCTP): A program that tests models designed to reduce hospital readmissions by helping high-risk Medicare beneficiaries transition from a hospital to another health care setting.⁶ CCTP participants are community-based organizations that provide transition services from one care setting to another. For example, CCTP partners provide information to patients and their families after discharge to help them understand subsequent steps to follow.⁷ There are currently 102 organizations in the CCTP.⁸

COMMUNITY HEALTH WORKER (CHW): According to APHA’s Community Health Worker Section, “a community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA): A process in which data are collected and analyzed to understand health in a community. CHNAs often focus on health risk factors, mortality, morbidity, social determinants of health, health inequity, and the role of the public health system. Communities can use the results of CHNAs to improve the health of their residents.⁹

COORDINATED CARE: Care that is integrated across all settings of the broader health system, including specialty care, hospital and home health care, and community services and support. Such coordination is particularly important when patients transition between different care sites, such as when they are discharged from a hospital to another care setting such as a skilled nursing facility.

DECENTRALIZED HEALTH DEPARTMENT: A form of health department governance that allows local health departments to operate autonomously. Twenty-seven states use this form of governance.¹⁰

EPISODE-OF-CARE REIMBURSEMENT: A type of payment system in which payers reimburse providers based on diagnosis or length of treatment episode. The Bundled Payments for Care Improvement Initiative is a type of episode-of-care reimbursement system.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC): FQHCs are safety net health care providers that receive federal funding for meeting certain criteria, such as serving all patients regardless of their ability to pay.

FEE-FOR-SERVICE REIMBURSEMENT: A payment system in which payers reimburse providers for each service rendered.

GLOBAL PAYMENTS: A payment system in which payers reimburse providers an amount based on the number of people served, regardless of the services each person receives.

GUIDE TO COMMUNITY PREVENTIVE SERVICES: A resource developed to help users learn about and implement effective community prevention measures.

HEALTH CARE SYSTEM: The subset of the overall health system that is focused on delivering services to individual consumers, including preventive services and primary, surgical, and long-term care.

HEALTH EQUITY: The Office of Minority Health of the U.S. Department of Health and Human Services defines health equity as “the attainment of the highest level of health for all people. Achieving health equity requires

valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”¹¹

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA): A part of the U.S. Department of Health and Human Services dedicated to increasing access to health care “by strengthening the health care workforce, building healthy communities and achieving health equity.”¹²

HEALTH SAFETY NET: The system of providers, payers, and programs that offer care to the uninsured, Medicaid beneficiaries, and other vulnerable populations.¹³

HEALTH SYSTEM: The overall system of public health and health care services, which is designed to promote wellness and mitigate or prevent sickness and injury.

HEALTH SYSTEM TRANSFORMATION: The effort to increase quality, efficiency, cost-effectiveness, and coordination in all parts of the health system. This effort affects the public health system and the health care system and the way they interact with payers and each other.

HEALTHY PEOPLE 2020: A report developed by the federal government that sets health improvement priorities.

HOSPITAL ENGAGEMENT NETWORKS: Groups of hospitals that help to identify and disseminate known solutions for reducing health care associated infections.¹⁴ These networks are also responsible for establishing and implementing systems to track hospitals’ progress in meeting quality goals.

MANAGED CARE ORGANIZATION (MCO): MCOs attempt to reduce costs by limiting the number of health care providers beneficiaries can access. The set of providers that MCO beneficiaries can access is called a network. MCOs vary in the size of their networks, with larger networks usually costing more. Medicare and Medicaid each contract with MCOs to offer managed care options to their beneficiaries.¹⁵

MEDICARE PIONEER ACO: A Medicare ACO program that encourages participating networks to establish ACO contracts with Medicaid and private insurance payers in addition to Medicare.

MEDICARE PROSPECTIVE PAYMENT SYSTEM: A payment system in which Medicare reimburses providers at a predetermined, fixed rate.¹⁶

MIXED GOVERNANCE HEALTH DEPARTMENT: A health department wherein some public health services are provided by the state and others are provided by localities. Seventeen states use this form of governance.¹⁷

NATIONAL PREVENTION STRATEGY: A resource developed by the federal government that provides concrete recommendations on how to address common health prevention strategies.

PATIENT CENTERED MEDICAL HOMES (PCMHS): Individual primary care practices committed to providing comprehensive primary care for their patients. They also coordinate the care patients may need from other providers and involve patients in the management of their health. PCMHs focus on quality measurement and improvement, accessibility, and coordination of care between different providers and settings.¹⁸ Accordingly, they may offer features such as evening and weekend hours and staff to help patients access in-home care.

PAYER (THIRD PARTY PAYER): Public or private insurers that pay health care providers for services delivered to patients.

POPULATION HEALTH: “The health outcomes of a group of individuals, including the distribution of such outcomes within the group.”¹⁹

PREVENTION AND PUBLIC HEALTH FUND: A dedicated source of funding designed “to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs.”²⁰

PREVENTIVE SERVICES: Interventions and activities that prevent disease or injury or promote health. These services can be provided in either clinical settings (e.g., hospitals) or community settings (e.g., schools).

PUBLIC HEALTH SYSTEM: The subset of the overall health system focused on promoting and protecting population health and wellness. Public health system functions include tracking and analyzing health trends; ensuring the safety and cleanliness of air, water, and food; educating the public about health issues; designing and implementing health policies and programs; and convening stakeholders to address social and environmental factors that have an impact on health.

READMISSION REDUCTION PROGRAM: A program that compares a hospital’s readmission rates with national averages and penalizes excessive preventable readmissions. The program focuses on readmissions for three conditions: acute myocardial infarction, heart failure, and pneumonia. The penalty is up to 1 percent of a hospital’s potential payment. This program applies to most hospitals.

REIMBURSEMENT: The process health care providers use to receive payments from third-party payers such as insurance companies and Medicare.

SOCIAL DETERMINANTS OF HEALTH: The conditions in people’s environment that affect their health, quality of life, and health risks,²¹ as well as the systems in place to provide care.²²

VALUE-BASED PURCHASING: Under value-based purchasing, Medicare payments to most hospitals depend partly on the quality of care received by their patients. The program operates by withholding a small percentage of each Medicare payment to create a funding pool and then redistributing payments based on performance. Some hospitals receive a small increase in payments, while others see a small decrease.²³

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- 23 CMS. Frequently asked questions: Hospital Value-Based Purchasing Program. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/FY-2013-Program-Frequently-Asked-Questions-about-Hospital-VBP-3-9-12.pdf>

Resource Guide

This document is part of [Healthy Outlook](#), which is designed to assist public health departments in adapting to the challenges and opportunities presented by health reform. All documents are available at www.apha.org.



Health Systems Transformation Resources

- [Financing Prevention: How States are Balancing Delivery System and Public Health Roles](#) (National Academy for State Health Policy and ChangeLab Solutions)—Describes health systems transformation in eight states and identifies best practices shared by the states
- [Health System Transformation and Improvement Resources for Health Departments](#) (Centers for Disease Control and Prevention)—Lists information, resources, and training opportunities connected to changes in the health system
- [Public Health and Primary Care Together: A Practical Playbook](#) (de Beaumont Foundation and Duke University)—An interactive resource to help integrate the public health and primary care sectors in efforts to improve population health
- [Leading through Health System Change](#) (Georgia Health Policy Center and the National Network of Public Health Institutes)—An online tool designed to help public health practitioners adapt and plan for the future in response to the Affordable Care Act
- [Public Health 2030: A Scenario Exploration](#) (Institute for Alternative Futures)—A report that describes possible outcomes of systems transformation and provides recommendations on how to ensure a successful transformation

National Priorities and Prevention Resources

- [National Prevention Strategy Implementation Toolkit](#) (Association of State and Territorial Health Officials [ASTHO])—Contains implementation resources, including evidence-based recommendations and case studies relating to the strategic directions and priorities of the National Prevention Strategy
- [From Coverage to Care](#) (Centers for Medicare & Medicaid Services)—Includes resources designed to help new health insurance beneficiaries make the most of their health plans
- [Guide to Clinical Preventive Services, 2014](#) (Agency for Healthcare Research and Quality)—Provides recommendations on clinical preventive services for a wide variety of health conditions
- [Guide to Community Preventive Services](#) and [Community Guide Toolbox](#) (U.S. Community Preventive Services Task Force)—Contain findings, literature reviews, and tools to implement community preventive services

- [Healthy People 2020](#) and the [Healthy People 2020 MAP-IT Framework](#)—Provide science-based objectives, resources, and implementation guides for improving health by establishing benchmarks and monitoring progress toward reducing illness, disability, and death
- [Resource Center for Evidence-Based Prevention](#) (National Association of County and City Health Officials [NACCHO])—Offers guidance for integrating various prevention initiatives such as the National Prevention Strategy, Healthy People 2020, and the Guide to Community Preventive Services into workable approaches to improving community health
- [National Prevention Strategy](#) (U.S. Department of Health and Human Services)—Provides strategic directions and topic-based priorities with recommendations for various sectors
- [National Stakeholder Strategy for Achieving Health Equity](#) (Office of Minority Health)—Sets national priorities to help racial and ethnic minority groups achieve health equity
- [National Registry of Evidence-based Programs and Practices](#) (Substance Abuse and Mental Health Services Administration)—An online database of substance abuse and mental health interventions

Information on Health Departments

- [ASTHO Profile of State Public Health, Volume Three](#)—Provides information on the structure, funding, and services of state health departments
- [NACCHO 2013 National Profile of Local Health Departments](#)—Provides information on the structure, funding, and services of local health departments
- [NACCHO Findings from the 2014 Forces of Change Survey](#)—Survey results focusing on local health department budgets, services, billing, and accreditation and the role of these departments as health exchange navigators

General Resources

- [American Public Health Association](#)—Includes a listing of APHA's analyses and resources related to the creation and implementation of the ACA
- [Institute of Medicine](#)—Provides authoritative advice to decision makers and the public on public health and other health care topics
- [Kaiser Family Foundation](#)—Develops data and analyses on health reform and other health care topics



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