5-24-2010

# Implications of Health Reform for Community-Based Organizations

Georgia Health Policy Center

# PolicyBrief

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May 24, 2010

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*This brief is the third in a series on the Patient Protection and Affordable Care Act (Health Reform) and addresses elements that are significant to community health initiatives. Previous issues provided a high-level overview and covered state implications. The next brief will examine the impact on health care providers.*

## INTRODUCTION

Community-based organizations connect community members to prevention and wellness services, coordinate access to appropriate health care services, and link individuals to coverage. Passage of the Patient Protection and Affordable Care Act will impact the number and nature of individuals served by community-based organizations, but it is unlikely the need for such services will diminish. In fact, the law emphasizes local-level efforts aimed at wellness, health promotion, chronic disease prevention, and health care quality in a way that may provide new and enhanced opportunities for service organizations. Most of these opportunities will be made available through new and expanded federal grant programs authorized under the health reform law. Funding for certain programs is designated in the legislation, while for others it will be determined through the annual appropriations process.

## PREVENTION AND WELLNESS:

### COMMUNITY TRANSFORMATION GRANTS

Community Transformation Grants are competitive grants to implement, evaluate, and disseminate evidence-based, community-wide activities focused on reducing chronic disease (particularly in diverse populations).

Initiatives should emphasize policy, environmental, programmatic, and infrastructure changes necessary to promote healthy living and reduce disparities. Grantee organizations will be required to evaluate changes in chronic disease risk factors, develop models for replication of successful programs, and mentor other eligible organizations.

Eligible applicants include state and local governmental agencies, community-based organizations and national networks of community-based and local non-profit organizations with a history of, or capacity for, developing relationships with a diverse group of critical stakeholders. The law authorizes the grant program from Fiscal Year (FY)10 through FY14.

### GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES

Beginning in FY10, competitive grants will be awarded to support community health workers as they promote positive health behaviors and work to improve outcomes in medically underserved communities. While not required, programs are encouraged to collaborate with academic institutions and one-stop health care delivery facilities to implement a payment system that rewards community health workers for connecting underserved populations with the most appropriate services in a timely way.

Eligible applicants include public or non-profit organizations or consortia of organizations. Priority will be given to organizations with a track record of using community health workers and providing services to populations that are underserved, suffer from chronic disease, or have high infant mortality rates. The program is authorized by the law from FY10 through FY14.

### INCENTIVES FOR PREVENTING CHRONIC DISEASES IN THE MEDICAID POPULATION

States will be awarded grants to incentivize Medicaid beneficiaries to participate in evidence-based activities that help individuals form and improve healthy behaviors. The primary purpose of the program is to test the effectiveness of individual incentive approaches and determine whether there are solutions that can be applied to a broader population.

Grants will be awarded over a five-year period beginning in 2011. States may enter into arrangements with Medicaid providers, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities to carry out programs, and health education campaigns. $100 million per year is allocated for the five-year period to sustain the program.

### MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS

To promote improvements in maternal and child health, particularly for families residing in at-risk communities, grants will be made to organizations to deliver services through early childhood home visitation programs. One goal of the program is to reduce child abuse, neglect, and injuries. Organizations may use some of the funds awarded during the first six months for planning or implementation activities. Quantifiable, evidence-based approaches must be used and three- and five-year benchmarks should be created to ensure that the program results in measurable improvements.

States are required to conduct statewide needs assessments no later than six months after the bill's enactment to identify at-risk communities. If by the beginning of FY12 the state has not been funded, grants will be made to non-profit organizations. $1.5 billion is allocated to support this effort from FY10 through FY14 (see Figure 1 for annual breakdown).

### NATIONAL DIABETES PREVENTION PROGRAM

The Centers for Disease Control and Prevention (CDC) will establish a national diabetes prevention program targeted at adults with significant risk for developing the disease. CDC will determine eligibility of local organizations and award grants to community-based diabetes prevention program model sites. Eligible organizations include: state or local health departments; tribal organizations; national networks of community-based, non-profits focused on health and well-being; and academic institutions. The program is authorized from FY10 through FY14.

## COORDINATION:

### NAVIGATORS

Health Insurance Exchanges will be required to contract with professional associations and local organizations to provide Exchange Navigator services. In that role, organizations will be expected to:

- Conduct public education activities that raise awareness of qualified health plans;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals for any enrollee with a grievance, complaint, or question regarding a health plan to an office of health insurance consumer assistance, health insurance ombudsman, or the appropriate state agency; and
- Provide information that is culturally and linguistically appropriate to the population being served.

To be eligible, organizations will need to demonstrate existing relationships, or the ability to establish relationships, with employers, employees, consumers (including uninsured and underinsured consumers), and self-employed individuals likely to enroll in a qualified health plan. Grants will be made from the operational funds of the exchange(s) and not federal funds received by the state to establish the exchange.

The Public Health Service Act was amended to extend the Patient Navigator program. There is now an added requirement to ensure that recruited patient navigators meet minimum core proficiencies. Organizations must verify navigator expertise in the type of intervention they will be performing. $3.5 million is allotted for FY10 and the program is authorized through FY15.

### COMMUNITY-BASED CARE TRANSITIONS PROGRAM

Beginning in 2011, funding will be available to provide improved care transition services for high-risk Medicare beneficiaries. Potential transition services may include:

- Arranging timely post-discharge follow-up services, including information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition;
- Providing assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers; and
- Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

Eligible organizations include subsection (d) hospitals (psychiatric, rehabilitation, and hospitals with inpatients predominantly under 18 years old with an average stay of more than 25 days); hospitals with high readmission rates; and community-based organizations that provide care transition services through arrangements with subsection (d) hospitals. Eligible hospital entities are required to enter into partnerships with community-based organizations in order to participate. The program is expected to be conducted over a five-year period, or longer, if it is deemed necessary to further reduce health care spending. $500 million is allocated to the program for FY11 through FY15.

### COMMUNITY HEALTH TEAMS

Health teams composed of community-based, interdisciplinary medical professionals will be established to support primary care medical homes that are within hospital areas served by those entities. Key functions of these teams include:

- Establishing contractual agreements with primary care providers to provide support services;
- Assisting in the development of patient-centered medical homes;
- Collaborating with local primary care providers and existing state and community-based resources to coordinate disease prevention, chronic disease management, treatment transitions, and patient case management;

- Collaborating with local health care providers to develop and implement interdisciplinary, inter-professional care plans that integrate clinical and community preventive and health promotion services for patients; and
- Engaging health care providers, patients, caregivers, and authorized representatives in program design and oversight.

Those eligible to participate will be states, state-designated entities, Indian tribes, or tribal organizations. The program is authorized by the legislation and will be effective when funding is made available through appropriations.

### COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM

Grants will be available to promote comprehensive, coordinated, and integrated health care services for low-income populations. Funds may be used to:

- Assist low-income individuals to access and appropriately use health services, enroll in health coverage programs, and obtain a regular primary care provider or a medical home;
- Provide case and care management services;
- Perform health outreach using neighborhood health workers or other means;
- Provide transportation;
- Expand capacity, such as "telehealth," after-hours services, or urgent care; and
- Provide direct patient care services.

Eligible entities include groups of health care providers with a joint governance structure, including hospitals with high Medicaid patient volume and all federally qualified health centers located in the community. Priority will be given to networks that include a county or municipal department of health and have the capability and history of providing the widest range of services and care to low-income individuals. This program is authorized by the legislation for FY11 through FY15.

## QUALITY CARE:

### MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES

Beginning May 2010, grants or contracts to implement Medication Management Services will be provided to improve quality of care and reduce treatment cost. Medication Management Services are to be provided by a collaboration of licensed pharmacists with the purpose of treating chronic diseases. Targeted individuals for the services will include those who:

- Take four or more prescribed medications (including over-the-counter medications and dietary supplements);
- Take any "high-risk" medications;
- Have been diagnosed with two or more chronic diseases; or
- Have undergone transition of care, or other experiences that are likely to create a high-risk of medication-related problems.

To be eligible, an organization must provide an appropriate setting for Medication Management Services. The law recognizes that coordination of Medication Management Services might occur through local community health teams or in collaboration with primary care extension programs.

### PRIMARY CARE EXTENSION PROGRAM

The Primary Care Extension Program is designed to provide educational support and assistance to primary care providers. The aim is for providers to regularly incorporate preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based techniques into their practices by working with community-based health connectors or Health Extension Agents.

A Health Extension Agent refers to any local, community-based health worker who facilitates and provides assistance to primary care practices to implement quality improvement or system redesign; incorporate the principles of the patient-centered medical home to provide high-quality, culturally, and linguistically appropriate primary care services; and link practices to diverse health system resources.

Competitive grants will be awarded to states to establish Primary Care Extension Program State Hubs and Local Primary Care Extension Agencies. State hubs will be composed of the state health department, the state Medicaid agency, and schools that train primary care providers. Hubs will in turn contract with local-level organizations to provide local, primary care extension services. Funding of $120 million is allocated for both FY11 and FY12. Further funding for FY13 through FY14 will be determined through the appropriations process.

### HEALTH PROFESSIONS TRAINING & CONTINUING EDUCATION

The Department of Health & Human Services will collaborate with health professions schools and societies, licensing and accreditation entities, minority health experts, community-based organizations and others to develop and evaluate demonstration projects and model curricula on improving cultural competency, prevention, public health proficiency, reducing health disparities, and working with individuals with disabilities. The disseminated findings from these projects will likely inform training in health professions schools and continuing education programs. The law authorizes the program for FY11 through FY15.

*Note: Information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Details may change during this process.*

## CONCLUSION

The health reform law contains amendments to statutes and new provisions that recognize a role for community-based organizations and health initiatives in preventing chronic disease, linking the public to health care services and coverage, and participating in the development of the medical home model. There are many opportunities available through grants and contracts. The law will require community-based organizations to emphasize evidence-based approaches and practices, conduct evaluations, test models, and plan for sustainable results and outcomes. While programs have been authorized by the law, exact budgetary implications and operational details will not be known specifically until the budget appropriation decisions are made and the rules and regulations are written.

There are other provisions in the law that may have indirect implications for community-based organizations. For example:

- Stronger community benefit requirements and penalties may result in more hospital partnerships with community-based organizations;
- The introduction of bundled payments might yield additional opportunities for hospitals and other providers to engage community-based organizations in demonstration projects, especially as it relates to home-based primary care services;
- The National Centers of Excellence for Depression has been established and is required to collaborate with community-based organizations in the conduct of translational mental health research.

## FUNDING

The health reform law authorizes new and expanded federal grant programs to increase prevention and wellness services, enhance coordination, and improve quality of care. For some programs, funding is allocated under the health reform law. Other programs are authorized, but the funding will not be determined until the appropriations process is complete. See below for a snapshot of available grant opportunities, the time frame, and available funding as it is known at this time.

**FIGURE 1: POTENTIAL FUNDING AND GRANT OPPORTUNITIES AVAILABLE THROUGH HEALTH REFORM**

| GRANT OPPORTUNITY | TIME FRAME | FUNDING |
|---|---|---|
| **PREVENTION AND WELLNESS** | | |
| COMMUNITY TRANSFORMATION GRANTS | Authorized from FY10 through FY14. | Determined through appropriations process. |
| POSITIVE HEALTH BEHAVIORS AND OUTCOMES | Authorized from FY10 through FY14. | Determined through appropriations process. |
| PREVENTING CHRONIC DISEASES IN THE MEDICAID POPULATION | Authorized beginning January 2011 for a five-year period. | $100 million per year allotted |
| MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS | Authorized from FY10 through FY14. | $1.5 billion is allocated to support this effort:<br><br>$100 million FY10<br>$250 million FY11<br>$350 million FY12<br>$400 million FY13<br>$400 million FY14<br><br>*Approximately 3% of funding is reserved for technical assistance, research, and evaluation.* |
| NATIONAL DIABETES PREVENTION PROGRAM | Authorized from FY10 through FY14. | Determined through appropriations process. |
| **COORDINATION** | | |
| EXCHANGE NAVIGATORS | States must have exchanges in place by 2014. | Grants will be made from the operational funds of the exchange(s) and not federal funds received by the state to establish the exchange. |
| PATIENT NAVIGATORS | Authorized from FY10 through FY15. | $3.5 million allotted in FY10 |
| COMMUNITY-BASED CARE TRANSITIONS PROGRAM | Authorized from FY11 through FY15. | $500 million allotted |
| COMMUNITY HEALTH TEAMS | Effective when funding is available. | Determined through appropriations process. |
| COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM | Authorized from FY11 through FY15. | Determined through appropriations process. |
| **QUALITY CARE** | | |
| PRIMARY CARE EXTENSION PROGRAM | Authorized from FY11–FY14. | $120 million per year allotted for FY11 through FY12.<br><br>FY13 through FY14 determined through appropriations process. |
| HEALTH PROFESSIONS TRAINING & CONTINUING EDUCATION | Authorized from FY11 through FY15. | Determined through appropriations process. |