HOW CAN INVESTING IN COMMUNITY-BASED, PRIMARY PREVENTION STRENGTHEN MEDI-CAL?

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Purpose

The current Administration has made significant progress in expanding health care coverage, and today's 1115 Waiver is an innovative approach to improving health equity for Medi-Cal members. These recommendations seek to identify opportunities and generate support for investing in creating healthy community environments that can further advance Medi-Cal's new approach to reducing health inequities and containing health care costs. This is a living document that will be updated with emerging policies and feedback from partners.

How Can Community-Based, Primary Prevention Help Medi-Cal Meet its Goals?

Community-based, primary prevention strategies take place outside of the doctor's office and focus on programs, policies, systems, and environmental changes that prevent illness and injuries from occurring in the first place. Examples include state policies that prohibit smoking in bars and restaurants; creation and maintenance of public parks and trails; and senior fall prevention programs at community centers. Medi-Cal will be more effective in advancing health equity and containing healthcare costs when California has an established source of sustained, dedicated funding for primary prevention programs that decrease health care utilization and inequities by keeping people healthy. See more examples of effective strategies here: *Community-based, Primary Prevention: Strategies in Action*.

What are Community Reinvestment Funds?

In 2023, the California Department of Health Care Services (DHCS) created a new funding-related stream, Community Reinvestment Funds (CRF), from a requirement that Medi-Cal managed care plans (MCPs) dedicate 5-7.5% of any profits to support, "local community activities that develop community infrastructure to support Medi-Cal members."[1] How this new pool of resources will operate is being defined now. It is critical that CRF be used to effectively address the community conditions that cause illness and to advance health equity in ways that our health care delivery system alone cannot solve.

RECOMMENDATION 1

Direct Medi-Cal Community Reinvestment Funds to community-based, primary prevention initiatives that advance health equity.

Today, community-based organizations (CBOs), local health jurisdictions (LHJs), and Tribal partners engaged in community-based, primary prevention programs are largely supported by insufficient stop-and-go grant funding. The result: Effective programs are unable to scale to meet community needs and successful projects often end altogether when grants expire.

ACTION 1.1 CRF spending should be invested in community-based, primary prevention strategies and allocated equitably among CBOs, LHJs and Tribal partners to implement initiatives that align with county CHIPs within these four draft DHCS spending categories for CRF: cultivate 1) Neighborhoods and Built Environment, 2) a Health Care Workforce, 3) Well-being for Priority Populations, and 4) Local Communities.[2]

Background

MCPs are now required to collaborate with LHJs to develop joint community health assessments (CHA) and community health improvement plans (CHIP).[3] These processes will be strengthened by inviting CBOs of varying sizes and Tribal partners to participate in identifying local drivers of inequities and solutions to address them. Many LHJs already utilize this best practice.

CRF funds that are invested in CBOs, LHJs, and Tribal partners should be informed by CHAs, aligned with CHIPs, have measurable outcomes, and be coordinated at the local level. Upstream, community-based, primary prevention objectives should be prioritized to have maximum impact in advancing health equity and containing health care costs.

ACTION 1.2 Require MCPs that must contribute CRF and are not meeting their performance targets to invest in community-based, primary prevention strategies in ways that will help achieve targets.

Background

DHCS' stated purpose for CRF is to support, "local community activities that develop community infrastructure to support Medi-Cal members." Yet, draft guidance from DHCS requires MCPs that are not meeting their performance standards to allocate 100% of their CRF to improving their performance.[4] Community-based, primary prevention strategies are essential to help MCPs reach their goals. For example, creating & improving community parks and increasing access to healthy foods in schools can promote physical activity and good nutrition,[5,6] complement medical treatment, and help MCPs meet targets such as decreasing blood pressure and A1C levels.

ACTION 1.3 In addition to the required 5-7.5% of profits, include a portion of MCP reserves in the calculus for Community Reinvestment after the MCP meets specified financial standards by adopting the State of Oregon's formula for managed care plan contributions to the Support Health for All through Reinvestment program.[7]

ACTION 1.4 Distinguish proposed spending category cultivating, "Well-Being for Priority Populations" from existing funding for Enhanced Care Management for priority populations under CalAIM. Modify language to cultivating, "Community Well-Being for Priority Populations through community-based, primary prevention programs and policies."

ACTION 1.5 Designate the DHCS Population Health Management Health Equity Division to oversee distribution of CRF to ensure an upstream, equity focused approach to Community Reinvestment.

RECOMMENDATION 2

Ensure representatives from CBOs of varying sizes, LHJs, Tribal partners, and Medi-Cal members are invited to participate in developing recommendations for CRF allocations and validating CRF Spending Plans.

ACTION 2.1 Invite representatives in equal numbers from these organizations to provide recommendations for CRF allocations and validate proposed Community Reinvestment Plans. Ensure conflict of interest guidelines are in place.

Background

Current draft DHCS guidance states that CRF spending plans must be informed by CHAs and encourages investments in CHIPs. In addition, MCPs are required to engage their Community Advisory Committees, which are currently composed primarily of Medi-Cal members, and other stakeholders for input on how CRF are allocated and to validate proposed CRF spending plans.[8] Creating a formal system for input from CBOs, LHJs, and Tribal partners will ensure a multi-sector perspective to the process.

RECOMMENDATION 3

Advocate that DHCS include community-based, primary prevention strategies in California's next 1115 Waiver.

ACTION 3.1 Invite representatives from CBOs, LHJs, and Tribal partners with expertise in community-based, primary prevention to participate in forums to plan the next 1115 Waiver.

References

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Partner Organizations

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