Financing of Community Health Workers: Issues and Options for State Health Departments

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Key principles for expanding CHW financing in any state

1. There are no “silver bullets” for CHW “reimbursement.” Identify and pursue strategic objectives based on conditions in your own state.

2. Campaigns for expanding coverage for CHWs should keep eyes on the prize—equity, improved care, more expansive, holistic approaches to care.

3. **Pilot efforts** that document improved quality, health, and cost outcomes at any level can lead to system or policy innovations.

4. Stakeholder efforts should track and **connect local program innovations with state level policy**.
1. Assessing the context for CHW financing in your state

A. Overall health system: Medicaid program, managed care, health reform status, etc.
B. State of CHW integration into health systems.
C. Stage of CHW infrastructure (training, credentialing, CHW definition and scope of practice, core competencies, etc.).
D. Features of stakeholder networks, engagement, and leadership (state health department support, CHW association, coalitions, etc.).
2. Identify and pursue strategic objectives

A. Identify target(s)—who has decision-making power?
B. Learn about their needs and interests.
C. Choose concrete objectives based on those needs and interests.
D. Clarify priorities involving:
   • State or institutional policy.
   • Education/engagement activities.
   • Practice/implementation models.
3. Relate business case to evidence base

A. Identify convergence between CHW effectiveness evidence and the interests of decisionmakers.

B. Perceived value from the decisionmaker’s perspective will drive investment decisions.

C. Clarify what information decisionmakers need, when they need it, and in what form.
Distinctive capabilities of CHWs in healthcare

• Establishing close relationships with patients based on shared life experience and unique community knowledge.

• Building trust: overcoming power distinctions and mistrust of institutions.

• Fostering candid and continuous communication.
Distinctive capabilities of CHWs in healthcare (continued)

- Managing Social Determinants of Health (SDOH):
  - Providing context to team members on “whole picture” of patient’s life.
  - Serving as “SDOH expert” on the team.
  - Assisting patient/family in dealing with non-medical issues affecting health status and access.
  - Mobilizing community to deal with macro-level issues.
CHWs help advance health equity and achieve “Triple Aim” objectives
CHWs bridge healthcare and public health
CHWs bridge health providers and communities
CHWs work across the continuum of prevention strategies

CDC “Health Impact Pyramid”
Factors that Affect Health

Thomas Frieden, AJPH, January, 2010

- Smallest Impact
- Largest Impact

- Counseling & Education
- Clinical Interventions
- Long-lasting Protective Interventions
- Changing the Context to make individuals’ default decisions healthy
- Socioeconomic Factors

Examples
- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation
- Fluoridation, trans fat, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

- AsthO 75 years
- 1942 - 2017
CHW Impacts: Health equity

• Core values based in equality, justice, and empathy.

• Improve health outcomes and reduce disparities for:
  • Racially and ethnically diverse patients/clients.
  • Patients with high cost, complex conditions.
  • Linguistic minorities.
  • Immigrants and refugees.
  • Low-income communities.
  • Rural communities.
CHWs increase access to:

• Health insurance.
• Primary care.
• Preventive education, screenings, and treatment, including immunizations.
• Mental health/behavioral health services.
• Community/social services.
CHWs improve quality of healthcare services

- Chronic disease management and prevention.
- Patient engagement and satisfaction.
- Outcomes of integrated care teams including CHWs.
- Care coordination.
- Rx adherence.
- Care plan utilization.
- Patient self-management.
- Health literacy and self-efficacy.
- Culturally competent/responsive provider practices.
CHWs help contain costs

• Reduce costs of high utilizers.
• Improve birth outcomes.
• Improve diabetes management.
• Improve asthma management.
• Increase cancer screening rates.
• Improve blood pressure and other Cardiovascular Disease measures.
• Reduce unnecessary Emergency Room utilization.
• Reduce hospital readmissions.
Trends favor the case for CHW value

• **Healthcare delivery reform:**
  • Care coordination - complex patients, chronic disease management.
  • Social determinants of health - low-income, vulnerable populations.
  • Building connections - clinical and community.
  • Integration of behavioral and physical health.
  • Population health.

• **Changes in payment systems:**
  • Fee-for-service most challenging.
  • Capitated, global, bundled payments more flexible.
  • Most incentivizing: value-based, shared savings/risk payment arrangements.
Payment mechanisms: Strategies and options

• Medicaid—policy level change and MMCOs:
  • 1115 waivers (including DSRIP, dual eligible).
  • State Plan Amendments.
  • Administrative payments.

• Internal financing by providers.

• FQHC prospective payments.

• Global or other alternative payments:
  • Bundled payments for episodic or encounter-based payments.
  • Supplemental enhanced payment for specific purposes (per member per month wrap-around services for target populations).
Why is Medicaid important?

• Covers low-income populations served by CHWs.

• Influences other payers and providers — legitimizes services, workforces.

• Center for Medicare & Medicaid Services (CMS) is leading delivery and payment reform—provides demonstration funding, waiver flexibility.
Favorable Medicaid trends

- Waivers encouraged by new HHS Secretary.
- D$RIP Waivers growing in popularity (ACOs).

State Plan Amendments:
- Health Homes.
- Other (MN, ND) defining CHWs as a class of providers (MN Medicaid reimburses CHW services).
Medicaid administrative payments

- States and providers already have flexibility to use Medicaid administrative payment.

- Very common for health plans to employ/pay for CHWs as administration expense.

- CMS open to treating CHWs as cost of quality improvement efforts.
Medicaid Managed Care Contracts

Example: New Mexico

- Contracts **now require** use of CHWs for care coordination.

- Plan must describe role of CHWs in patient education and list CHW services in benefits package.

- Key point: CHW care coordination costs factored into cost of services.
Michigan Medicaid MCO re-bid RFP (2015)

- **Requires** plan to offer CHWs or peer support specialists to members with significant BH and/or complex care needs.

- Specifies a range of CHW services, including home visits, referrals, self care education, advocacy with providers.

- Each plan must establish payment method for CHW services.

- Requires at least 1 FTE CHW per 20,000 members.
Medicaid higher level policy tools: 1115 Waiver

- Demonstration programs approved by CMS to test new delivery and payment mechanisms:
  - Include changes to eligibility, benefits, cost sharing, and payments outside normal Medicaid rules.
  - Short-term but renewable (3-5 years).

- Commonly used by states to gain approval for system reforms to meet Triple Aim goals.
1115 Waiver example: Arkansas

- Demonstration of “Community Connectors” in home and community-based long term care.

- Private foundation funding used for non-federal match (separate approval).

- Showed 3:1 net return in total cost of care.

- State is expanding as part of regular Medicaid operations.
1115 Waiver example: Texas

- DSRIP grants financed delivery system reforms in safety net systems in exchange for sustained support for uncompensated care.
- Created a Community Care Collaborative as integrated system for low-income in central TX.
- CHWs employed in over 300 local grants: navigation for ER users, care coordination and care transfers, and chronic disease self-management support, “neighborhood engagement” in San Antonio.
Examples of CHW expansion models

- CMS lists “Pathways to Health” model as a recommended model for care coordination.
- Oregon requires CHWs and similar workforces be included and paid as part of their Coordinated Care Organizations (ACOs).
- Rhode Island Medicaid is set to cover asthma home visiting model as a part of benefits package—often a CHW-led model.
- Health Homes model in several states employ CHWs (Maine, Michigan, Missouri, New York).
Internal financing: ROI can be dramatic

Examples with net 3:1 or better:

• Molina Health Care: Medicaid HMO reducing cost of high utilizers.
• Texas hospitals: redirecting uninsured from EDs to primary care.
• Langdale Industries: self-insured industrial company working with employees who cost benefits programs the most.
Strategic Guidance Summary

• Integrate CHWs into existing systems and reforms rather than trying to create dedicated funding streams built around the goal of employing CHWs.

• Use existing flexibility in managed care; health plans are already innovating on their own.

• Show payers and providers how CHWs can meet objectives they are already pursuing.
Strategic Guidance Summary (continued)

• Highlight the value of unique CHW capabilities in changing care models.

• Make the case for weaving costs of CHWs into payment systems based on credible projections of net cost savings.

• Many stakeholders need basic education on CHWs! Incomplete understanding or misconceptions can impede or undermine policy and systems change efforts.
Financing opportunities: Considerations for state health departments

- What opportunities exist now in your state for CHW sustainable financing?
- Who are your strategically selected targets/decision makers?
- What mechanisms may be available and suitable?
  - State Medicaid programs?
  - Health transformation demonstration grants?
  - Provider resources?
Financing opportunities: Considerations for state health departments (continued)

• What factors or trends in your state are favorable to integration of CHWs in Medicaid funded services?

• What factors or trends in your state could create barriers or resistance to integration of CHWs in Medicaid funded services?