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SUSTAINABLE FINANCING OF COMMUNITY HEALTH WORKER EMPLOYMENT

BRIEF
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Sustainable financing of CHW employment: Translation Report

Definitions and Problem Statement

As interest in CHWs has grown, various stakeholders have expressed frustration with the limitations of most current methods of funding CHW activities. Starting with the earliest federal support from the Migrant Health Act of 1962 (the beginning of the Health Centers movement), CHWs have mainly been funded under “program” or “project” grants and contracts, which are:

- A. often short-term (two to three years),
- B. subject to appropriations or private philanthropic decisions, and
- C. commonly focused on fairly specific goals, such as increasing participation in job training, reducing infant mortality, or raising immunization rates. When available, this type of funding does not afford CHWs or their employers the latitude to apply the full range of CHW capabilities to community needs.

Loss of program or project funding, on the other hand, commonly leads to CHWs being laid off or assigned to another available project or program. For the employer, this means a loss of valuable skills and their investment in cultivating those skills, as well as loss of relationships developed with the community and with individual clients/patients. For the CHW, it often means loss of employment and can mean “starting over” in a new entry level position.

Even funding from the Centers for Disease Control and Prevention (CDC) grant funds, such as the 1815/1817 innovation awards to state and local health departments and predecessor programs, have been used for pilot projects and infrastructure development, but they are not intended as long-term support (although grantees are required to develop a sustainability plan). An exception has been the Community Health Representative (CHR) Program of the Indian Health Service, which has been in operation since the 1960s and has a

dedicated line item appropriation covering about 1,500 CHRs.

What is “sustainable” financing? The term (sometimes described as “long term” funding) is commonly used to describe systems of budgeting for CHW positions which are not dependent on applying for program or project grants or contracts. “Sustainable” CHW positions may be funded either through (a) ongoing revenue streams that explicitly provide for or “cover” CHW services or (b) incorporating CHWs into ongoing budgeting within the employer’s overall revenue picture without a specific revenue source being dedicated to CHW services.

Major Strategic Options for Sustainable Financing

Conversations among policymakers and CHW advocates in most states about financing CHWs focus heavily on **Medicaid**, since CHWs have historically been most effective at meeting the needs of low-income and minority populations. Medicaid is also a large and growing percentage of state budgets, and states are looking for ways to control costs and improve outcomes from the program. However, other options exist for supporting the work of CHWs. This report summarizes approaches to financing programs engaging and supporting CHWs, which have been proposed by multiple organizations and research studies since at least 2001.

No single strategy works in every situation, because strategies depend on the situation and factors specific to that scenario (e.g., employing organization’s preferences for cost reduction, cost avoidance, revenue enhancement, and their prioritization and tradeoffs for non-financial outcomes such as clinical results and social justice impact). Furthermore, CHWs may perform diverse roles or interventions, each of which may have a different impact on costs, revenues and other outcomes. So, there is no “one size fits all” financing model for long-term employment of CHWs, even if the CHW function is envisioned as a

“generalist” position. As such, states should be considering a few long-term financing strategies which provide a good fit with the populations they are targeting and their unique objectives for clinical outcomes and social impact.

It should also be noted that similar **ongoing funding streams do not exist for non-medical (social welfare) services** or community mobilization and advocacy. While health care payment models are being developed that embed CHWs in clinical services (often as members of care teams), payment options are currently much more limited and challenging for community based CHWs who are not employed in health care systems. There is promise, however, in more holistic models of health care financing, such as “accountable health communities,” which embrace broader concepts of community development as contributing to health. There is some potential for CHW support in federal block grant programs, such as Community Development Block Grants (CDBG) from the Department of Housing and Urban Development (HUD)¹; and Community Service Block Grants (CSBG)² and Social Service Block Grants (SSBG)³ from the Administration on Children and Families (ACF). However, these technically are not considered “sustainable” sources, since they require grant proposals for each project period and are subject to Congressional appropriation.

So, while this document is focused mainly on health care financing streams, it is with full recognition of the potential benefits of investment by the health care system in socioeconomic development at the community level, from housing to job creation, under the rubric of social determinants of health (SDOH). It should also be emphasized that community-based organizations (CBOs) can be and often are the appropriate choice as the actual employers of CHWs, and this discussion is **not focused exclusively on health care providers as employers of CHWs.**

Stakeholders should also recognize the conceptual distinction between a sustainable financing “strategy” and the **policy tools** that may be applied in implementing that strategy. For example, a Medicaid 1115 waiver may be used as the policy tool for any number of strategies, from authorizing fee for service reimbursement for specific CHW

services to classifying such services as “quality improvement” activities by a Medicaid managed care organization (MCO). So, the waiver itself is not a strategy.

Lastly, it must be recognized that from the point of view of CHWs and their advocates, building payer and employer interest in long-term support for CHW roles (establishing the “business case”) is an inevitable requirement for implementing a sustainable financing strategy. This report was not intended to address the process of building the “business case.” However, a brief bibliography of current resources on the topic is provided as Appendix B.

Outline of CHW Financing Options Covered

The options in this paper are organized according to the following topics:

- A. High level policy mechanisms available under Medicaid:**
 - Section 1115 Demonstration Waivers;
 - Dual Eligible Programs (individuals eligible for both Medicare and Medicaid);
 - Medicaid State Plan Amendments (SPA).
- B. Medicaid Managed Care Organizations (MCO) contract requirements**
- C. CHW services covered voluntarily by Medicaid MCOs or Medicare Advantage plans as part of administrative or quality improvement cost**
- D. Healthcare reform-related alternative payment structures: expenditures for CHWs are treated as:**
 - Bundled payments for episodic or encounter-based payments for conditions such as asthma, which involve multiple services (may or may not be global);
 - Supplemental enhanced payment for specific purposes (e.g., for care coordination services (per member per

¹ <https://www.hudexchange.info/programs/cdbg/>

² <https://www.acf.hhs.gov/ocs/programs/csbg>

³ <https://www.acf.hhs.gov/ocs/programs/ssbg>

month wrap-around services for target populations, possibly risk-adjusted)); or

- Risk contracts: cost of CHWs offset by other savings.

E. Internal financing by providers in anticipation of reduced costs or enhanced revenue, including internal Return on Investment (ROI)

- Provider organizations use grant funds and/or internal resources to test an intervention that includes CHWs. Once the net cost savings and other valued outcomes have been documented in relation to the intervention, CHW positions can be included in an ongoing operating budget without a designated source of payment.

F. Federally Qualified Health Centers (FQHCs): Prospective Payment Systems

- Technically, FQHCs may incorporate the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid. Few do so currently.
- CHW expenses may also be treated as part of FQHC “enabling services” under HRSA 330 grant funding, along with transportation and language services.

G. Blended or braided funding

- A deliberate strategy of combining multiple funding resources can reduce dependence on any one source (such as Medicaid).
- Blended (or braided) funding allows for integration of resources that are not associated with provision of clinical services.
- Blended funding also allows for diversity of CHW activities despite restrictions imposed by any one funding source. Grants can continue to play a role,

because the program as a whole is not highly dependent on their continuation.

High Level Policy Mechanisms Available under Medicaid

This section refers to “high level” policy tools involving regulatory actions by the State Medicaid Office (and in some cases legislative action).

Medicaid has traditionally and statutorily focused on paying solely for “medically necessary” services, which has meant primarily clinical services. It has also traditionally paid for services to individuals and has not addressed the costs of providing public health interventions targeting populations or communities. The Patient Protection and Affordable Care Act of 2010 (ACA) and other healthcare reform initiatives have begun to expand the scope of each of these categories. For instance “housing assistance” can be seen as “medically necessary,” and there are openings to enable population health approaches, for example, for members affected by prevalent chronic conditions.⁴ Providers show increasing interest in adapting Medicaid funding to address social determinants of health (SDOH) in a variety of ways.⁵

Several overarching considerations should be kept in mind when discussing Medicaid financing for CHWs:

- “Reimbursement” is a term that implies fee-for-service payments. In the context of the cost-control pressures of healthcare reform, asking for “reimbursement for CHW services” could be interpreted as a proposal for a new class of provider who can directly bill for their own services. This in turn raises the specter of *increased* rather than decreased costs to payers. “Coverage” may be a more timely term appropriate for emerging payment systems in Medicaid.

⁴ See, e.g., National Academies of Sciences, Engineering, and Medicine 2019. Investing in Interventions That Address Non-Medical, Health-Related Social Needs: Proceedings of a Workshop. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25544>.

Louisiana State University. Louisiana [Medicaid] Demonstration Community Health Worker Program Overview [RFP]. Public announcement document, 2018.

Castelucci M. Insurers want to lead if CMS pilots payments for housing, social determinants of health. Modern Healthcare, December 15, 2018.

⁵ American Hospital Association. Medicaid Financing for Interventions that Address Social Determinants of Health (Issue Brief). AHA, January 2019.

- The 2020 addition of “Z codes” to the ICD-10 diagnostic coding system⁶, allowing identification of social determinants of health (SDOH) as part of a patient’s record, is a hopeful sign for both Medicaid and Medicare, but it should be noted that a diagnosis is not the same as an order for a “billable” service. The crucial step is assignment of procedure (“CPT”) codes for services which CHWs are authorized to provide. Recent commentaries on Z-codes have touted their value in data analytics and in referring patients for non-medical services but have not dealt with payment for such services.⁷
- Public payers such as Medicaid have historically paid lower rates to providers than have private payers. The financial constraints this has placed on many healthcare provider organizations can discourage their openness to experiment or take risks by adding new services or workforces.

Section 1115 Demonstration Waivers

- The 1115 Waiver predates the Affordable Care Act (ACA), but today it is commonly used by state Medicaid offices to gain CMS approval for system reforms to meet Triple Aim goals of healthcare reform (e.g. improved patient experience of care, better health, reduced costs).
- The approved changes are temporary—usually covering a demonstration period of 3-5 years, but they are renewable.
- 1115 Waivers are intended to give states the flexibility to test new delivery and payment mechanisms
- A limitation is that the cost of services covered under the waiver may not exceed

⁶ Centers for Medicare and Medicaid Services (CMS). ICD-10-CM Official Guidelines for Coding and Reporting. CMS, FY2016, Downloaded April 13, 2020 from <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf>

⁷ Miliard M. New tool helps promote ICD-10 codes for social determinants of health data. Healthcare IT News: October 21, 2019. Downloaded 4/13/20 from <https://www.healthcareitnews.com/news/new-tool-helps-promote-icd-10-codes-social-determinants-health-data>.

the cost of existing services for the same purpose over the life of the waiver (“budget neutrality”).

- **Delivery System Reform Incentive Payments (DSRIP)** are a special form of 1115 Waiver originally used for funding hospital safety net care. DSRIP grants as part of Waivers now provide major funding for innovative health system reforms.
 - As of January 2020, thirteen states have been approved for DSRIP waivers to date: Alabama, Arizona, California, Massachusetts, New Hampshire, New York, New Jersey, Kansas, New Mexico, Oregon, Rhode Island, Texas, and Washington.
 - California, Oregon, Rhode Island and Texas DSRIP waivers have been renewed; NM, NJ and KS waivers have expired; Massachusetts has re-applied as part of a total redesign of the state Medicaid program to incentivize formation of Accountable Care Organizations (ACOs).
 - New York’s DSRIP waiver included several CHW initiatives, including a partnership in Staten Island supporting a CHW apprenticeship program.⁸

“Project grant funding typically does not afford CHWs or their employers the latitude to apply the full range of CHW capabilities to community needs.”

Friedman NL. Toward Addressing Social Determinants of Health: A Health Care System Strategy. The Permanente Journal, 2018; 22: 18-095. Published online 2018 October 22, 2018.

⁸ American Hospital Association. Apprenticeships Answer Emerging Workforce Demands: Staten Island Performing Provider System. Workforce Capacity Case Study series, December 2019.

Examples of Medicaid 1115 waivers that enabled coverage of CHWs:

Arkansas	Texas	Oregon
<p>Demonstration: “Community Connectors”—CHWs reached out to people receiving home-based care and referred them to community services and in-home non-medical support</p> <ul style="list-style-type: none"> • Private foundation funding used for non-federal Medicaid match (separate CMS approval required) • Showed 3:1 net return on investment, savings on total cost of care for participants vs. comparison group • State expanded for several years as part of regular Medicaid operations 	<p>Community Care Collaborative introduced as integrated system for low-income recipients in central Texas</p> <ul style="list-style-type: none"> • DSRIP grants financed delivery system reforms in safety net health systems in exchange for sustained support for uncompensated care. A number of these grants supported CHW positions. • CHWs employed through over 300 local grants: such as navigation for Emergency Department users, care coordination and care transitions, chronic disease self-management support, and “neighborhood engagement” organizing in San Antonio. 	<p>State Health Reform legislation established 14 ACOs called “Coordinated Care Organizations” (CCOs)”to integrate primary and acute care”</p> <ul style="list-style-type: none"> • CCO’s receive a fixed global budget from the state, paid as monthly capitation • Enabling statute requires CCOs to offer services⁹ by “Traditional Health Workers” including CHWs, Doulas, peer wellness specialists, and personal health navigators • State has rolled system into a State Plan Amendment at end of the demonstration.

Dual-Eligible Programs

About 20 percent of individuals eligible for Medicare, mainly on the basis of disability, are also covered by Medicaid. Gaps in Medicare coverage are filled by the state’s Medicaid program for these individuals. Some states such as Massachusetts have implemented special care management programs for dual eligibles. Planning for dual-eligibles programs can be complex, and support from CHWs could be beneficial, especially in a capitated arrangement.¹⁰

Medicaid State Plan Amendments (SPAs)

States submit SPAs to CMS to request permissible program changes, make corrections, or update their Medicaid state plan with new information.

Unlike an 1115 Waiver, a SPA, if approved, results in a permanent or lasting change in the state program. Often, states have tested a reform under a waiver and subsequently made it permanent through a SPA.

For example, **North Dakota** secured CMS approval in 2012 for a SPA that authorized paying for Community Health Representatives¹¹ to deliver Targeted Case Management services to individuals with multiple chronic conditions, relying on their existing core skills plus specialization training. The state began implementing the SPA in 2016.

In 2014, a Medicaid rule change became effective, allowing state Medicaid programs to cover clinical preventive services delivered by non-licensed providers, if they are “recommended by a physician

⁹ CCOs are not required to **provide** THW services to all members, but must offer them to members as appropriate, and must pay for the services if members request them.

¹⁰ Verma S. Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare: SMD Letter 19-002, April 24, 2019.

¹¹ Community Health Representatives are CHWs employed in tribal health programs supported by the Indian Health Service.

or other licensed practitioner.” Authorizing such expenditures requires the state to submit a SPA. This rule change sparked a great deal of interest among stakeholders who recognize the value of CHWs because they are non-licensed providers. Since that time, a number of state Medicaid offices have explored the idea, but as of this writing no state has submitted a SPA requesting this change. Medicaid offices in several states have expressed concerns that coverage of non-licensed provider clinical preventive services would lead to additional expenses for Medicaid at a time when cost reductions are the expectation and/or requirement. They have also been occupied with many other aspects of ACA implementation. The hesitance of state Medicaid offices to pursue such a goal through a SPA has diminished attention to this strategy, but it remains a potential policy tool.

Minnesota: Minnesota is the first state that allowed direct reimbursement for CHW services under their state’s Medicaid plan. Following authorization by the state legislature, Minnesota filed a SPA in 2007 that CMS approved. It allows fee-for-service reimbursement for certain services provided by CHWs who meet specific educational requirements. For CHW services to be covered and reimbursed, the following qualifications apply:

- CHWs must receive a certificate from a training program using the standard CHW curriculum created by the Minnesota State Colleges and Universities System.
- CHWs are covered for a limited set of services: “diagnosis-related patient education and self-management” for individuals or groups. There are monthly time caps for CHW face-to-face education provided to any patient.
- The services must be offered and supervised by eligible billing providers such as community health clinics, dentists, hospitals, physicians or advance practice registered nurses (APRN). The CHWs may not bill directly for their services.

Although hundreds of CHWs have received the required education for this payment, uptake by employing providers has been minimal. The Minnesota example suggests that under fee for service (FFS) reimbursement (used by MCOs to pay billing providers) there are likely to be

constraints concerning the range of services that CHWs can perform and time spent per patient. However, Indiana introduced a similar measure in 2018, South Dakota did so in 2019,¹² and Kentucky is reportedly considering the same policy currently.

Medicaid Health Homes SPAs: The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (ACA), allows states to design “health homes” to provide comprehensive care coordination for Medicaid beneficiaries with complex needs. States received enhanced federally match funding during the first eight quarters of implementation to support the rollout of this integrated model of care. Health Homes are like Patient Centered Medical Homes, with the explicit requirement that they target patients with two or more chronic conditions and/or a behavioral health diagnosis. Multiple states have engaged CHWs in their Health Homes strategies.

Medicaid MCO contract requirements

Several states have begun to experiment with integrating CHWs into health plan contracts, either allowing or mandating employment or financing of CHWs. Oregon’s CCO contracts (mentioned above) also contain provisions for CHWs and other Traditional Health Workers. In addition, New Mexico and Michigan have imposed specific requirements for use of CHW services.

About 2/3 of Medicaid recipients are covered by managed care arrangements. It should be noted that Medicaid health plans in a number of states are investing in CHW services on their own, without specific mandates or incentives from the state.

¹² South Dakota Medicaid Billing and Policy Manual: Community Health Worker (updated September 2019). Downloaded from

https://dss.sd.gov/docs/medicaid/providers/billingmanuals/community_health_worker_services.pdf

Examples of Medicaid MCO contract requirements explicitly covering CHWs:

New Mexico	Michigan	Oregon
<ul style="list-style-type: none"> State Medicaid managed care contracts must encourage use of CHWS for care coordination Managed care plan must describe the role of CHWS in patient education and list CHW services in their benefits package CHW care coordination costs are an additional service factored into the total cost of services to achieve the capitated payment rate 	<ul style="list-style-type: none"> State Medicaid 2015 managed care contracts rebid requires health plans to offer CHW or peer support specialist services to members with significant behavioral health and/or complex care needs Medicaid specifies a range of CHW services, including home visits, referrals, self-care education, patient advocacy Each plan must establish a payment method for CHW services Contract specifies required training for CHWs Requires at least 1 full time equivalent (FTE) CHW per 5,000 members¹³ 	<ul style="list-style-type: none"> Provides for “health related non-benefit (flex) services” CHWs are covered as a category of “traditional health care workers” Covers services “consistent with achieving Member wellness and the objectives of an individualized care plan” CHWs and Health Navigators are not mentioned by name in standard contract language for the CCOs¹⁴

CHW services covered voluntarily by Medicaid MCOs or Medicare Advantage plans as part of administrative or quality improvement costs

This strategy is listed separately because it does not entail policy action by the State Medicaid program.

Administrative Expenditures in Medicaid

Managed Care: State Medicaid offices and their approved health plans already have the flexibility to use Medicaid administrative expenditures for services that are not approved as “medically necessary.” It is common for health plans with Medicaid contracts to directly employ CHWs, or to pay other organizations for CHW services, and treat these as administrative expenditures. Texas health plans in certain markets began experimenting with this approach in the early

2000s; there is no comprehensive source listing of other examples.

- Some MCOs reportedly offer care management fees as an incentive to conduct outreach, either to high-risk patients or all members. These fees could be devoted to employment of CHWs.
- CMS has urged states to impose requirements for the minimum percentage of a health plan’s expenditures that can be classified as the direct cost of providing medical care (“total claims cost”) as a percentage of their total premium revenues; this ratio is known as the “medical loss ratio”

¹³ This proportion was originally 1 per 20,000, reportedly adopted based on state-specific considerations, not on research, and should not necessarily be considered as a guide for other states or projects. The ratio was increased in 2018

(State of Michigan Standard MCO Contract, revised September 2018).

¹⁴ <https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>

(or MLR).¹⁵ However, this may not impose a significant challenge to expanded employment of CHWs, since health plans do not expect spending on CHWs to become a large factor in administrative expenses.

- A 2017 CMS Medicaid rule change allows certain quality improvement expenditures by states and MCOs to be treated as part of the cost of care. Some CHW activities may qualify for this classification.¹⁶
- One state (Pennsylvania) provides in Medicaid MCO contracts that companies may treat all expenditures for CHWs as “provision of care.”¹⁷
- In a May 2019 memo to the states, CMS indicated that it would require any expenditures for patient services to be treated as administrative if the services are not explicitly specified in the State Medicaid Plan.¹⁸

Healthcare reform-related alternative payment structures

States and MCOs have gradually instituted Medicaid or other payor alternative payment mechanisms (APM), including pay for performance and value-based payment, quality incentives and partial- to full-risk contracting, as a way to incentivize quality of care over quantity.¹⁹ It behooves health care provider organizations to consider any viable option to “make the numbers work” in such systems, with the advantage that APM systems offer great flexibility in staffing. Providers participating in an ACO or other risk contracts may wish to consider what offsetting savings could result from budgeting CHW positions

under these payment systems. However, markets in some regions may be too small to make such strategies work.

Internal financing by providers in anticipation of reduced costs or enhanced revenue, including internal Return on Investment (ROI)

Health plans and provider systems serving primarily low-income and otherwise disenfranchised populations (such as FQHCs and safety net hospitals) have been hiring CHWs and expanding their understanding of how to work with such communities for years prior to recent Medicaid and other system changes. The motivations have been the same: to improve access to and engagement of disenfranchised or vulnerable people and communities with healthcare and to improve their health, while covering added costs for CHWs through reduced cost in other areas (mainly acute care) or increasing revenues, mainly for primary care; hospitals in particular have been able to achieve net reductions in the cost of uncompensated care.

Provider decisions to pursue these kinds of ROI require reasonable assurance of future cost savings, often measured through internal pilot projects. It should be noted that a meta-evaluation of the Center for Medicare and Medicaid Innovation’s (CMMI) Year One Health Care Innovation Award (HCIA) grants in 2018 found that, of six categories of innovation (IT, PCMH etc.), only those involving CHWs showed significant cost saving²⁰. This may be persuasive to some potential providers.

¹⁵ Center for Consumer Information & Insurance Oversight. “Medical Loss Ratio.” See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio>

¹⁶ Federal Register 2016, 81FR27522 (42 CFR §438.8)

¹⁷ Personal communication from David Kelley MD, Chief Medical Office of Pennsylvania Medicaid, with Carl Rush, Harrisburg PA, November 2016.

¹⁸ CMCS Informational Bulletin, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 15, 2019.

¹⁹ For more background on APMs, see <https://qpp.cms.gov/apms/overview>

²⁰ Bir A et al. Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative: Annual Report Year 3. Research Triangle Park, NC: RTI international, February 2018.

Examples of employer internal investment in CHWs based on a pilot project:

New Mexico: Molina Healthcare Inc.	Michigan: Spectrum Health	Texas: Houston Area Safety Net Hospitals
<ul style="list-style-type: none"> • CHW outreach, education, advocacy, and referral services for high-risk patients piloted in NM. • Six CHWs were in 3 healthcare sites, including one Federally Qualified Health Center (FQHC), and overseen by a nurse and a care coordinator at the Medicaid MCO. • With grant funding from private foundations, Molina evaluated outcomes from CHWs' home visits, education and healthcare utilization support for high risk members. • Pre-post cost reduction (6-month comparison period) \$2 million; cost of intervention approximately \$520,000. • As a result of improved health, positive member feedback and cost savings the intervention began to pay for itself. Molina expanded the program statewide and to all 11 states in which they operate. Other MCOs in New Mexico also adopted the model.²¹ 	<ul style="list-style-type: none"> • Intervention based in large statewide multi-hospital system spanning urban and rural areas. • System evaluated impacts on patients and costs of initial CHW program in its Healthier Communities Division. • CHWs were hired primarily to provide outreach, education, support for care transitions, people with chronic conditions and disenfranchised communities. • Urban and rural pilots resulted in improved health and healthcare utilization, with resulting cost savings. • Spectrum has employed CHWs in a variety of roles within their system. They provide Technical Assistance on how to engage and integrate CHWs for new institutions as they enter Spectrum's system.²² • ROI calculation not revealed, but inpatient days reduced 49% and ED use 29% in pilot. 	<ul style="list-style-type: none"> • Led by CHRISTUS System, Memorial Hermann and Harris County Hospital District. • Faced by continuing high numbers of uninsured patients. • State funded pilot on diversion from children's emergency rooms (ERs) that suggested CHWs were effective at reducing ER use for non-emergent needs. • Multiple hospitals financed their own pilots using Community Benefits funds. • Pilots suggested an average net ROI of about 3:1 from reduced total cost of uncompensated care. • Model has been expanded to adult and pediatric ERs. • Results not published but reported in multiple presentations around Texas.²³

²¹ Johnson D et al. Community health workers and Medicaid Managed Care in New Mexico. *J Community Health*. 2011;37: 563-575.

²² Larson L. Making the case for community health workers. June 2016. Can be found at:

<http://www.trusteemag.com/articles/1083-program-makes-case-for-community-health-worker>

²³ Dols J. Return on investment from CHRISTUS Health CHW program. PowerPoint presentation, Houston TX, 2010

Penn Medicine (University of Pennsylvania Health System) employs 30 CHWs, whose salaries are financed internally through cost savings elsewhere in the health system's operations that are attributed to the CHW program; however, these positions are also subsidized by consulting revenue from the Penn Center for CHWs, which assists other provider organizations in implementing their "IMPACT" model.²⁴

Note: This report does not attempt to review all available ROI data for CHWs, but when stakeholders have identified a set of promising early-phase CHW interventions, one useful next step may be to apply actual epidemiological and provider data to ROI estimation models like those pioneered by London et al. for the State of Maine.²⁵

It should also be noted that "social" ROI²⁶ can include benefit to society as a whole, resulting from specific measures such as reduction in time lost for work or education due to improved health, or broader measures of cost-effectiveness such as quality-adjusted years of life gained (QALYs). A recent CDC literature review²⁷ used an arbitrary benchmark social value of \$50,000 per QALY and concluded that many studies of CHWs in diabetes and cardiovascular health show costs well below that level, from about \$17,000 per QALY for diabetes and cardiovascular disease (CVD) prevention, to under \$36,000 per QALY for diabetes management.

Federally Qualified Health Centers: Prospective Payment Systems

Nationally, about 44 percent of FQHC funding comes from Medicaid, and another 18 percent from Health Resources and Services Administration (HRSA) Section 330 grants. Medicaid reimbursement to FQHCs in most states comes in the form of per-visit reimbursement under a "Prospective Payment System" (PPS) based on historic actual costs under a global budget divided by total clinic visits.²⁸ Technically, FQHCs may incorporate the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid. Few do so currently.

PPS qualifying visits must entail an encounter with a licensed clinician. Contact with a CHW alone does not qualify as a reimbursable "visit." Some centers engage in what they term "flipping visits:" when a patient meets with a CHW, the CHW immediately facilitates an appointment for a billable clinic visit related to the patient's presenting health issue(s). Again, there are no solid data on the prevalence of this practice.²⁹

FQHCs also receive annual "330" grants from the Health Resources and Services Administration (HRSA) intended to support innovation and to subsidize care for uninsured patients. CHW expenses may be treated as part of FQHC "enabling services" under HRSA 330 grant funding³⁰, along with transportation and language services. Some centers indeed do so, but there are no official statistics on this practice.³¹

²⁴ <https://chw.upenn.edu/services/>

²⁵ London K et al. Sustainable Financing Models for Community Health Worker Services in Maine. University of Massachusetts Medical School, Center for Health Law and Economics, November 2016.

²⁶ "Social ROI" essentially includes socio economic impact as well as financial benefit in the numerator of a ROI calculation, with the denominator including investments by all parties, not just the entity which may see financial return. See Arrillaga-Andreessen L, Hoyt D. An Introduction to Social Return on Investment. Faculty Research Case Study S165. Stanford, CA: Stanford Graduate School of Business, 2003. Accessed 4/13/20 at <https://www.gsb.stanford.edu/faculty-research/case-studies/introduction-social-return-investment>

²⁷ Jacob V, Chattopadhyay S, Hopkins DP et al. Economics of Community Health Workers for Chronic Disease: Findings from Community Guide Systematic Reviews. *Am J Prev Med* 2019;56(3):e95–e106

²⁸ Rosenbaum S, Sharac J, Shin P, Tolbert J. Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained (Issue Brief). Kaiser Family Foundation, March 2019.

²⁹ Remarks by Seth Doyle, Northwest Regional Primary Care Association, interview with Carl Rush, January 2018.

³⁰ Enabling services are defined as "non-clinical services that aim to increase access to healthcare and improve health outcomes," and include services such as health education, interpretation, and case management. See Park HL. Enabling Services at Health Centers: Eliminating Disparities and Improving Quality. New York, NY: New York Academy of Medicine, September 2005. Downloaded 4/13/20 from <https://www.aapcho.org/wp/wp-content/uploads/2012/03/ES-Metlife-Report.pdf>

³¹ Interview by Carl Rush with John Bartkowski, DrPH, CEO, 16th Street Community Health Centers Inc. (Milwaukee, WI), November 2015.

Other financing models: “blended” or “braided” funding

Some CHW employers have successfully partnered with multiple funders in fields other than health care. Social service agencies at the state and local level often need to work with the same families who depend on Medicaid for their health care; a home visit for a medical need can also be used to connect the family to resources related to parenting or financial literacy. Health care organizations are coming to recognize the public health principle that socioeconomic factors affect both a patient’s health status and their ability to access health care and adhere to medical treatment plans. This can create opportunities for payers and providers to combine funding streams to work with the same population. For example, Baylor Scott & White health system, based in Dallas, Texas, expanded from employing one CHW in a diabetes program in 2007 to 30 in 2014 in multiple programs, to over 100 in 2020 in eight distinct program specialties, each with different funding sources, including an ongoing contract with a county health department.³² The “Pathways-Community Hub” model, currently promoted by Care Coordination Systems, Inc., has pioneered the establishment of multiple revenue arrangements with diverse parties, including Medicaid MCOs, housing agencies, Head Start, law enforcement, schools and charitable foundations, including the United Way. Each funding source has committed to a schedule of progress payments to the Hub on the basis of specific outcomes along a “Pathway” protocol defined for issues such as housing or birth outcomes; a CHW may be managing patients’ progress along up to 20 Pathways.³³ For example, a payer may agree to pay the Hub one amount for enrolling an eligible woman in a birth outcomes Pathway; another amount for her first trimester prenatal care office visit; another for stopping smoking; another for completing a series of classes on childbirth or child development stages; and a final, substantial payment for a successful, full-term natural delivery.

Conclusion

This report has examined a range of potential approaches to secure ongoing “sustainable” support for CHW positions and briefly described how they may be used. Appendix A on the next page provides a brief summary of the approaches covered, along with some “pros and cons” about each. All the options described are at least theoretically possible in any given state, but the choice of strategy in a state will be based on the level of stakeholder interest, current related policy measures already in place, budget realities and other considerations.

Readers are encouraged to refer to the NACHW CHW Document Resource Center, filtering for subtopics under “Sustainable Financing” to find documents describing the experiences of groups in other states grappling with these issues.

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³² Presentation by Ashley Rodriguez, Baylor Scott & White, March 25, 2019.

³³ CPM Guide 2-27-17: Improving Health Outcomes by Linking Community-based Community Health Workers with Health Systems. Familias en Acción and Kaiser Permanente. July 2018.

APPENDIX A: STRATEGIES FOR SUSTAINABLE FINANCING OF COMMUNITY HEALTH WORKER EMPLOYMENT

SUMMARY	PROS	CONS
State Medicaid Policy Actions: High Level Policy Mechanisms		
<ul style="list-style-type: none"> Section 1115 Demonstration Waivers; Dual Eligible Programs (individuals eligible for both Medicare and Medicaid); Medicaid State Plan Amendments (SPA) 	<ul style="list-style-type: none"> Can embed CHW services in core Medicaid operations Process offers considerable latitude for creative design of services Waiver process offers a means to pilot test for feasibility and cost savings 	<ul style="list-style-type: none"> Administrative and regulatory requirements can be complex, including CMS approval Legislation may be required May require treating CHW activities as equivalent to clinical procedures Challenges of matching standard billing (CPT) codes to a range of CHW activities
State Medicaid Policy Actions: MCO Contracts		
<ul style="list-style-type: none"> Medicaid health plan contracts may include permission, incentives or mandates to include CHWs in services to their members States may allow health plans to offer these services as optional or “value added” services The State may or may not offer enhanced payment rates to MCOs for coverage of optional services 	<ul style="list-style-type: none"> Assures uniform application across providers and payers (MCOs) Can provide mechanism for common reporting/evaluation standards 	<ul style="list-style-type: none"> Plans may need to be convinced to go along with inclusion of requirements in development of standard MCO contract Requirements may need to be very simple when first proposed
CHW Expenditures Covered Voluntarily by Health Plans		
<ul style="list-style-type: none"> A number of health plans have proactively employed or paid for CHW positions based on business goals and corporate values This practice is apparently fairly widespread but operating at modest scale in most cases There are no data yet indicating that “medical loss ratio” calculations are limiting these initiatives 	<ul style="list-style-type: none"> Requires little or no approval from State or CMS CHWs can perform virtually any activities that do not require a clinical license 	<ul style="list-style-type: none"> Health plans must be convinced of value in terms of outcomes vs. cost Theoretically may increase admin cost and decrease “total claims cost” (adversely affecting MLR) Little accountability in terms of reporting what CHWs actually do
Healthcare Reform-related Alternative Payment Structures		
<ul style="list-style-type: none"> Bundled payments for episodic or encounter-based payments for conditions such as asthma, which involve multiple services (may or may not be global); Supplemental enhanced payment for specific purposes (e.g., for care coordination services (per member per month wrap-around services for target populations, possibly risk-adjusted)); or Risk contracts: cost of CHWs offset by other savings 	<ul style="list-style-type: none"> Can offer providers/employers wide flexibility in staffing of services Provides explicit linkage and accountability between CHW activity and desired outcomes 	<ul style="list-style-type: none"> May present challenges in uniform reporting of activities and outcomes Proposals will be closely scrutinized for feasibility/ credibility of cost saving potential
Internal Financing by Providers in Anticipation of Return on Investment (ROI)		
<ul style="list-style-type: none"> Provider organizations use grant funds and/or internal resources to test an intervention that includes CHWs. Once the net cost savings and other valued outcomes have been documented in relation to the intervention, CHW positions can be included in an ongoing operating budget without a designated source of payment. 	<ul style="list-style-type: none"> Very few regulatory constraints Can usually be scaled easily by employers upon acceptance of early results 	<ul style="list-style-type: none"> May result in wide variation of participation (and results) among providers Proposals will be closely scrutinized for feasibility/ credibility of cost saving potential Subject to fluctuations in overall employer financial wellbeing
Federally Qualified Health Centers (FQHC): Prospective Payment Systems		
<ul style="list-style-type: none"> Incorporates the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid Expenses may be treated as part of FQHC “enabling services” under HRSA 330 grant funding, along with transportation and language services 	<ul style="list-style-type: none"> May qualify as “enabling services,” thereby not necessary to be billable as patient encounters Would integrate CHWs into annual financial calculations 	<ul style="list-style-type: none"> CHW-only patient encounters not currently billable as “visits” May require renegotiation of annual costs and PPS rate calculation, which can be sensitive
Blended or Braided Funding		
<ul style="list-style-type: none"> Combines multiple funding resources can reduce dependence on any one source (such as Medicaid) and allows for integration of resources that are not associated with provision of clinical services, diversity of CHW activities despite restrictions imposed by anyone funding source. Grants can continue to play a role, because the program as a whole is not highly dependent on their continuation. 	<ul style="list-style-type: none"> Diversification can help shield services from fluctuations in budgets and grant restrictions Greater flexibility to provide assistance that is not directly related to clinical care 	<ul style="list-style-type: none"> Requires application and/or negotiation with multiple payers Deliverables and reporting can become complex; accountability for multiple outcomes, overlapping funding periods

Appendix B

Brief bibliography of resources on the “business case” for long term support of CHW positions

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