Affordable Care Act and Connecticut State Innovation Model:
Recommended Payment Methods for Community Health Workers

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A collaborative project between the Yale School of Public Health and Southwestern AHEC, Inc.

Background

Community Health Workers (CHWs) are a growing and integral workforce in many states throughout the US. Such individuals have been shown to act as a valuable supplement to the healthcare system by reducing disparities in health access and containing costs, especially in hard-to-reach areas and underserved populations.[1] However, issues of legitimacy, centralization, and sustainability challenge the efficacy of this workforce. In Connecticut (CT) especially, the CHW program lacks clarity and, perhaps most importantly, a sustainable means of financially supporting CHWs. This lack of steady funding leads to stubbornly high attrition rates and missed opportunities for full-time employment of passionate individuals who can make a positive difference in communities where they live. Investigation into the potential payment methods for CHWs is of much importance in order to give way to a long-term, sustainable CHW program in CT. Southwestern AHEC, Inc. has a close relationship with CHWs in CT and desires evidence-based research of sustainable payment methods for CHWs that align with the Triple Aim of the Patient Protection and Affordable Care Act (PPACA) and the CT State Innovation Model (SIM-CT).[2,3]

Methods

A literature review was conducted to examine the cost-effectiveness of CHW interventions, to assess the guidelines of PPACA and SIM-CT, and to analyze current state payment methods for CHWs. Two 14-item interview questionnaires were developed for public and private payers in order to assess their perceptions on the feasibility of incorporating a variety of long-term payment methods for CT CHWs within their plans. We conducted interviews with six key informants who were identified through snowball sampling of CT health care stakeholders. Interviews were transcribed and inspected for main subjects and recurring ideas to formulate coding themes and subthemes. Notable quotes were extracted for relevant contextual examples. Investigators reviewed the frequency of coded themes and quotes to analyze the qualitative data.

Objectives

Our goal was to provide Southwestern AHEC with preliminary recommendations for sustainable payment methods from the payers' perspective to further the development of the CT CHW workforce. To do so, we identified the following objectives:

1. Gain insight into current payment systems that exist in CT and other states.
2. Assess the feasibility of providing payment for CHWs within several healthcare reform models.
3. Identify outcome measurements that effectively monitor CHW performance.

Definition of Acronyms

- **Accountable Care Organization (ACO)**: a network of healthcare providers who voluntarily coordinate and accept responsibility for the quality and cost of health services delivered to their Medicare patients.
- **Advanced Medical Home (AMH)**: a team-based primary care model in CT that provides comprehensive and continuous care to consumers over time.
- **Bundled payment:** single payment to a provider or providers, for multiple healthcare services with a defined episode-of-care.
- **Federally Qualified Health Center (FQHC)**: a healthcare organization designated by the US Department of Health and Human Services that provides comprehensive services (primary care, oral, mental health/ substance abuse) to an underserved area regardless of its patients' insurance status or ability to pay for care.[4]
- **Global payment (total care, capitation payment: general payment):** fixed payment adjusted for illness severity to providers for all or most of the care that patients require over a contract period.
- **Patient-Centered Medical Home (PCMH)**: a healthcare delivery model in which care is coordinated between the patient, doctor, and patient's care team to ensure continuous and integrated care.

Definition of Acronyms Continued:

- **Pay-for-Performance (P4P)**: a payment model that provides financial reward to providers who meet or exceed predetermined quality of care benchmarks for outcomes, utilization, and cost savings.
- **State Innovation Model (SIM-CT)**: a state healthcare innovation plan which strives to improve health, reduce disparities, improve quality and experience of care, and lower costs in order to promote the PPACA's Triple Aim.
- **Triple Aim:** increase accessibility to healthcare, improve cost-containment, and raise the quality of care.
- **Value-Based payment (management fee, shared savings):** provides information on Medicare's plans to confidentially and publically report physicians' cost and quality of care.

Key Findings

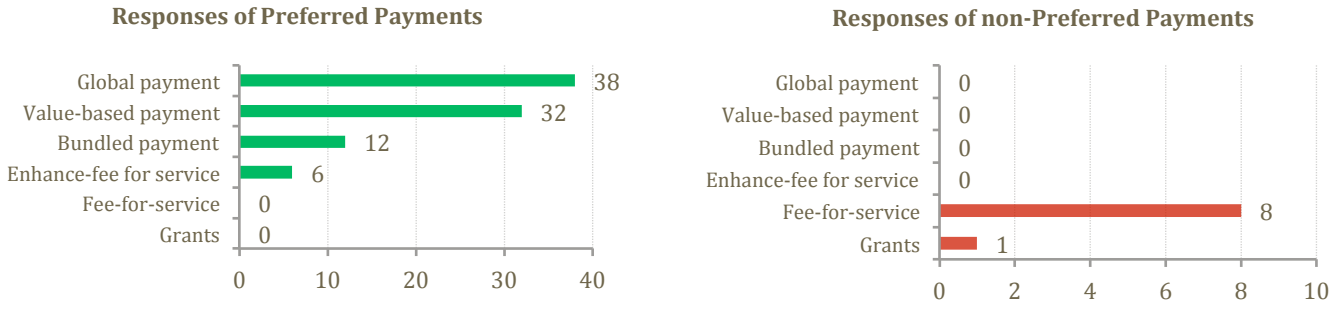
Interview Findings: Current Payment Methods for CHWs

- Short-term grants and funding are the current sources of compensation in CT.
- States including New York, Arizona, Tennessee, and Washington pay CHWs through management fees in Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) within Federally Qualified Health Centers (FQHCs).
- New Jersey CHWs operate within FQHCs through practices known as CAMcare Model and Camden Coalition.
- Texas, Arkansas, Minnesota, and Oregon have Medicaid programs that provide CHWs with sustainable funding.

Interview Findings: CHW Roles in Healthcare Delivery Reform Models

- PPACA and SIM-CT encourage the role of CHWs in PCMHs and ACOs.
- CHWs play the roles of health coaches, health literacy advocates, and care coordinators in ACOs of several states.
- Key informants expressed the highest level of interest in Pay for Performance (P4P), PCMHs, and ACO models.
- Public and national private payers agree that CHWs are important for cost containment; however, state private payers did not show interest in the work of CHWs.

Figure 1. Frequency Counts from Surveys of Key Informants' Preferences for Sustainable Payment Models for CHWs



Sustainable Payment Methods Preferred by Payers

◊ Five out of six key informants showed interest in value-based payment and agreed that CHWs should not be reimbursed through fee-for-service.

"Get away from fee-for-service." –Medicaid Representative

"The state will pay for a package of services and the provider has the option to include community health workers in the provision of those services, but it's not a direct payment [...] specifically for CHW services." –Medicaid Representative

◊ Half of the sample noted global payment as the optimal sustainable method.

"The strategy to adopt is to say payers are already advancing money that enables practices to expand their team to include care coordinators." –State Representative Official

"There are a lot of different variations on how [CHWs] are paid [...] It's usually some kind of a bundle payment either for an episode or sort of global payment for all the health needs of the covered population." –Medicaid Representative

◊ Medicaid in CT is considering the implementation of enhanced-fee-for service and performance payments for CHWs employed in Advanced Medical Homes (AMHs).

"Medical Homes [model] is a building block for ACOs. It's certain that the proliferation of Medical Homes is conducive to the deployment of CHWs." –State Official Representative

Measurement Outcomes Used to Evaluate CHW Efficacy

- Medicare and Medicaid measure care experience to evaluate CHW impact in CT healthcare programs.
  > *"It depends on what role they're playing, so they could measure healthcare experience, healthcare outcomes, and cost. They could look at things like missed appointments, appropriate utilization of services…they could measure health literacy; degree of engagement, [and how] other people [are] using the source of care."*
  >
  > –State Representative Official
- Payers recommended using health outcomes, such as quality of life, chronic illness management, appropriate utilization of services, hospital readmission rates, return on investment, and health literacy as measurements.
  > *"There are some clinical outcomes that [Medicare] regards as significant in particular in control of things like diabetes, hypertension, and asthma that they see contributing to long term serious health issues and of course, higher costs."* –Medicaid Representative
- Key informants expressed concern that P4P may not be an accurate measure of CHW value and efficacy of performance.
  > *"[Payers are] still in the mode of doing pilots on new things – such things to determine their value and efficacy. And so, as a broad-based approach to incorporating a new service delivery category community health worker and across the board I think we're a long way off from that."* –State Private Payer

Recommendations

Community Health Workers and CHW Advocates:

- ❑ CHWs and advocates should push for employment of CHWs under health reform programs, as their roles align with the goals of the Triple Aim.
- ❑ CHWs and advocates should encourage the use of global payment or value-based payment for sustainable funding of CHWs.
- ❑ CHWs and advocates should provide evidence of cost savings for CHW interventions to private payers.

For Connecticut Healthcare Stakeholders:

- ❑ CT healthcare stakeholders should refer to Oregon as a reference for payment models, since both states are moving away from managed care and have similar healthcare systems. MA and NY would provide excellent examples for building a professional CHW association.
- ❑ CT healthcare stakeholders should include providers in the determination of payment methods, since they would directly hire, work, and interact with CHWs.

Conclusions

The PPACA and SIM-CT encourage the roles of CHWs in the health care delivery system, as they embody the goals of the Triple Aim. On a national level, Medicare is using and encouraging the use of CHWs in many ACO pilots. In Connecticut, Medicaid and SIM are considering implementing CHWs through a sustainable payment method in the AMH model. Our study showed that various states, especially SIM states, are encouraging or have already implemented sustainable payment programs or are using Medicaid funds for CHWs.

Connecticut should consider the design of successful programs of other states in the development of its CHW workforce. Oregon, Massachusetts, and New York ought to be considered as valuable references for Connecticut healthcare stakeholders as they look toward future payment models for auxiliary health workers. Seemingly, the most preferred way to incorporate CHWs into healthcare delivery is through the use of global or value-based payment methods. Public and national private payers support the idea of providing funds for CHW services, but it will be a number of years before sustainable payment methods can be realized in Connecticut.

References

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