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NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

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# SUSTAINABLE FINANCING
## OF COMMUNITY HEALTH WORKER EMPLOYMENT

BRIEF
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The National Association of Community Health Workers (NACHW) unifies the voices of Community Health Workers to support communities in achieving health equity and social justice.


www.nachw.org

# BACKGROUND

With growing recognition of Community Health Workers' effectiveness (CHWs - includes promotores de salud and community health representatives), has come increased frustration with the limitations of most methods to fund CHW activities.

Starting with the earliest federal support from the Migrant Health Act of 1962, CHWs have mainly been funded under "program" or "project" grants and contracts which are historically:

1) short-term (two to three years),
2) 2) subject to appropriations or private philanthropic decisions, and
3) 3) focused on narrow goals such as increasing job training participation, reducing infant mortality, or raising immunization rates).

Even funding from the Centers for Disease Control and Prevention Program 1815/1817 innovation awards to state and local health departments, often used for CHW pilots and infrastructure development, are not intended as long-term support.

The impact of these funding methods on CHWs and employers can be devastating. Short term funding mean employers risk losing valuable relationships with CHW employees and damage trust with clients and community members.

For the CHW, it often means loss of employment, re-assignment or "starting over" in a new entry level position. Narrowly focused project goals often limit CHWs' realization of their full roles, competencies and qualities and their latitude to implement activities that effectively address community needs. One exception can be found in the Community Health Representative (CHR) Program of the Indian Health Service, which has maintained sustainable financing since the 1960s through a dedicated line item appropriation covering about 1,500 CHRs.

***Read the full report at [www.nachw.org](http://www.nachw.org)***

***This report summarizes approaches to financing programs engaging and supporting CHWs, which have been proposed by multiple organizations and research studies from 2001 to the present.***

## 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.

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).

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.

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## MAJOR STRATEGIC OPTIONS (continued)

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 from the Department of Housing and Urban Development[1] ; and Community Service Block Grants[2] and Social Service Block Grants[3] from the Administration on Children and Families.

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).

***Sustainable Financing:***

***systems of budgeting for CHW positions without program or project grant or contract applications. Funding may be sustained through continuous revenue streams that explicitly provide for or "cover" CHW services or within the employer's overall revenue picture without a specific revenue source being dedicated to CHW services.***

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.

## STRATEGY VERSUS POLICY TOOL

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.

## 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: Strategies for Sustainable Financing of CHW Employment** 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.

View documents describing the experiences of states grappling with "sustainable financing" issues in the **NACHW Resource Document Database.**

[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

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| APPENDIX A: STRATEGIES FOR SUSTAINABLE FINANCING OF COMMUNITY HEALTH WORKER EMPLOYMENT | | |
|---|---|---|
| **SUMMARY** | **PROS** | **CONS** |
| **State Medicaid Policy Actions: High Level Policy Mechanisms** | | |
| • Section 1115 Demonstration Waivers;<br>• Dual Eligible Programs (individuals eligible for both Medicare and Medicaid);<br>• Medicaid State Plan Amendments (SPA). | • Can embed CHW services in core Medicaid operations<br>• Process offers considerable latitude for creative design of services<br>• Waiver process offers a means to pilot test for feasibility and cost savings | • Administrative and regulatory requirements can be complex, including CMS approval<br>• Legislation may be required<br>• May require treating CHW activities as equivalent to clinical procedures<br>• Challenges of matching standard billing (CPT) codes to a range of CHW activities |
| **State Medicaid Policy Actions: MCO Contracts** | | |
| • Medicaid health plan contracts may include permission, incentives or mandates to include CHWs in services to their members.<br>• States may allow health plans to offer these services as optional or "value added" services.<br>• The State may or may not offer enhanced payment rates to MCOs for coverage of optional services. | • Assures uniform application across providers and payers (MCOs)<br>• Can provide mechanism for common reporting/evaluation standards | • Plans may need to be convinced to go along with inclusion of requirements in development of standard MCO contract<br>• Requirements may need to be very simple when first proposed |
| **CHW Expenditures Covered Voluntarily by Health Plans** | | |
| • A number of health plans have proactively employed or paid for CHW positions based on business goals and corporate values.<br>• This practice is apparently fairly widespread but operating at modest scale in most cases.<br>• There are no data yet indicating that "medical loss ratio" calculations are limiting these initiatives. | • Requires little or no approval from State or CMS<br>• CHWs can perform virtually any activities that do not require a clinical license | • Health plans must be convinced of value in terms of outcomes vs. cost<br>• Theoretically may increase admin cost and decrease "total claims cost" (adversely affecting MLR)<br>• Little accountability in terms of reporting what CHWs actually do |
| **Healthcare Reform-related Alternative Payment Structures** | | |
| • Bundled payments for episodic or encounter-based payments for conditions such as asthma, which involve multiple services (may or may not be global);<br>• 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<br>• Risk contracts: cost of CHWs offset by other savings. | • Can offer providers/employers wide flexibility in staffing of services<br>• Provides explicit linkage and accountability between CHW activity and desired outcomes | • May present challenges in uniform reporting of activities and outcomes<br>• Proposals will be closely scrutinized for feasibility/ credibility of cost saving potential |
| **Internal Financing by Providers in Anticipation of 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. | • Very few regulatory constraints<br>• Can usually be scaled easily by employers upon acceptance of early results | • May result in wide variation of participation (and results) among providers<br>• Proposals will be closely scrutinized for feasibility/ credibility of cost saving potential<br>• Subject to fluctuations in overall employer financial wellbeing |
| **Federally Qualified Health Centers (FQHC): Prospective Payment Systems** | | |
| • Incorporates the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid.<br>• Expenses may be treated as part of FQHC "enabling services" under HRSA 330 grant funding, along with transportation and language services. | • May qualify as "enabling services," thereby not necessary to be billable as patient encounters<br>• Would integrate CHWs into annual financial calculations | • CHW-only patient encounters not currently billable as "visits"<br>• May require renegotiation of annual costs and PPS rate calculation, which can be sensitive |
| **Blended or Braided Funding** | | |
| • 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. | • Diversification can help shield services from fluctuations in budgets and grant restrictions<br>• Greater flexibility to provide assistance that is not directly related to clinical care | • Requires application and/or negotiation with multiple payers<br>• Deliverables and reporting can become complex; accountability for multiple outcomes, overlapping funding periods |