

# Community Health Worker Workforce: Assessment of the Integration and Financing of Community Health Workers within Arizona Medicaid Health Plans

2019



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**A Final Report to the Arizona Department of Health Services**

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OF HEALTH SERVICES

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**Acknowledgements** We recognize the following organizations and individuals for their invaluable expertise and contribution to this project: Deb Gullet, Executive Director, Arizona Association of Health Plans and Nancy Wexler, Director, Innovation and Collaborative Care, Banner University Health Plans.

## EXECUTIVE SUMMARY

The **Community Health Worker (CHW) workforce**, defined as a frontline public health worker who applies a unique understanding of the experience, language, and culture of the population served, has entered the spotlight as **essential to health care systems**. CHWs are valuable members of health teams and play a vital role in addressing medical and social determinants of health among underserved populations.

In 2014, the Centers for Medicaid and Medicare (CMS) issued guidance to allow states to reimburse for preventive services offered by non-licensed professionals such as CHWs. Furthermore, reforms in health care in the United States have incentivized the shift toward a value-based reimbursement structure that rewards evidence of favorable medical and social outcomes.

Such health policy trends present tremendous opportunity to scale the CHW workforce throughout public health and healthcare systems in Arizona. In response to shifts supportive of the integration of CHWs into public health and health care systems, the Northern Arizona University, Center for Health Equity Research interviewed leadership of all Arizona Health Care Cost Containment System (AHCCCS) contracted health plans to assess innovations in CHW workforce integration and financing.

An estimated 4 AHCCCS Health Plans and 10 of 22 Federally Qualified Community Health Centers currently employ CHWs to link patients to community resources to promote self-management.

Arizona health plan leaders recognize that by utilizing their unique position within their community, coupled with skills and training, CHWs can play a significant role in improving patient outcomes and reducing system costs for health care. Many health plan leaders actively support their contracted provider networks to better integrate and finance CHWs to meet Healthcare Effectiveness Data and Information Set (HEDIS) measures.

### Interviews with Health Plans Leadership Explored CHW:

- Current and Projected Utilization
- Roles, Competencies and Skills
- Recruitment and Training
- Financing and Payment Models
- Healthcare and Workforce Policy

## KEY MESSAGES: HEALTH PLAN LEADERS

- **Value and capitalize** on overwhelming body of scientific evidence demonstrating CHW impact on access to and appropriate use of healthcare, medication adherence, management of chronic disease and mental health, and use of emergency services.
- **Utilize** the full range of CHW roles, competencies and scope of practice
- **Hire** CHWs based on their 'lived experience' and intimate knowledge and connection to community
- **Support** CHW Voluntary Certification (HB2324)
- **Desire** standardized and accessible CHW core competency training
- **Innovate** through value-based payment models to integrate and sustain CHW services
- **Require** AHCCCS billable codes for CHW services to fully incentivize the scale the CHW workforce

## HEALTH POLICY IMPLICATIONS

**AHCCCS Complete Care contracted health plan leaders are knowledgeable and highly value state and nationally accepted CHW core competencies. Such knowledge and commitment can contribute to further integration and scale of the CHW workforce within Arizona health plans.**

Leadership understand and prioritize the cultural, linguistic and lived experience characteristics of the CHW workforce and actively recruit, train and integrate CHWs into clinical and community-based teams to benefit health plan members. CHWs are considered to add value to members by conducting effective and culturally salient health plan member outreach. For many health plan leaders, such culturally informed outreach and education activities conducted in the home, over the phone and in the clinic have resulted in both anecdotal and empirical evidence of improved access to health care, use of prevention screenings, and appropriate use of the health care system, including avoidance of emergency room and hospitalization among members. CHWs were considered essential to increasing access to primary care, self-management activities and behavioral health support for highly vulnerable health plan members.

## **AHCCCS Complete Care (ACC) provides a window of opportunity to integrate the CHW workforce in Arizona health plans.**

Health plan leadership expect that the ACC will fundamentally expand the need for CHWs and the core CHW competencies, roles and skills as plans expand their services and seek creative approaches to meeting membership medical and non-medical needs. ACC contracted health plans with experience in the delivery of behavioral health care through Peer Supports – a subset of the broader CHW workforce – set precedent for beneficial policy adoption in which ADHS and AHCCCS standardized Peer Support workforce scope of practice and training, and established AHCCCS billable codes.

### **The Arizona Legislature recently passed HB2324, which authorized the voluntary certification of CHWs, creating opportunity for standardized training of the CHW workforce.**

The law will establish a 9-person advisory council made up of at least 50% CHWs, which will adopt CHW core competencies, training standards, continuing education requirements and other details related to CHW

certification in the state. Arizona health plans saw the benefit of the HB2324 legislative efforts for voluntary certification, specifically in the opportunity to recruit and retain highly qualified CHWs to meet member medical and non-medical needs of health plan members.

### **CHW Core Roles/Scope of Practice**

1. Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

*"We have found that for every social barrier that is removed through a community health worker and tracked through the community impact model, we save \$450 in reduced emergency room visits, reduced length of stay in a hospital and reduced rapid readmissions. At the same time, not only is there a cost savings but we have found that there is a significant lift in quality scores when those same social barriers are removed. Members are 1 ½ - 2 ½ times more likely to schedule and complete their primary care physician visits, they are nearly 7 times more likely to have a better adult BMI score, they remain more compliant with their diabetes treatment and so on. We have each measure documented on what the list is by removing a social barrier, which is one of the key roles that we ask the community health workers to play."*

*AHCCCS Health Plan Leader*

## **HEALTH POLICY RECOMMENDATIONS**

1. **Extend AHCCCS billing codes** for CHW services and scope of practice.
2. **Monitor CHW innovations** emerging from (1) the AHCCCS Complete Care contracts which integrate behavioral and physical health services and (2) the CHW voluntary certification legislation.
3. **Promote standardized CHW core competency training** among health plans and contracted provider networks.
4. **Share CHW advances** in training, supervision, hiring, financing and integration within health care teams.

This report was supported by the Cooperative Agreement 1U58DP004793, funded by the Centers for Disease for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention of the Department of Health and Human Services.

To cite this report: Sabo S. O'Meara L and Castro C. (2019). *Integration and Financing of the Community Health Worker Workforce in Arizona Cost Containment Care System Health Plans*. Flagstaff, Arizona: Center for Health Equity Research, Northern Arizona University.

## PURPOSE OF THE PROJECT

The **Center for Health Equity Research** at Northern Arizona University (CHER-NAU) through funding from the Arizona Department of Health Services (ADHS) and in collaboration with the University of Arizona, Arizona Prevention Research Center (AzPRC) aimed to engage Arizona health plan leadership in conversations about the integration and sustainability of the Community Health Worker (CHW) workforce within Arizona's Medicaid contracted health plans and provider networks. Information gathered provides **unprecedented insight into innovative strategies for integrating, sustaining and scaling of the CHW workforce** within the Arizona Health Care Cost Containment System (AHCCCS).

Specifically, conversations with health plan leadership explored CHW workforce:

1. Current and Projected Utilization
2. Roles, Competencies and Skills
3. Recruitment and Training
4. Financing and Payment Models
5. Healthcare and Workforce Policy

CHWs serve under a variety of titles, more than 100 to be exact, including Community Health Advocate (CHA), Patient Navigator, Peer Support Specialist, Community Health Representative and Promotor/a. For purposes of this work we use the umbrella job title, Community Health Worker as recognized by the US Department of Labor and define CHWs by the American Public Health Association, which is among the most widely CHW vetted and comprehensive definitions of CHWs, adopted by both the National Community Health Worker Association (NACHWA) and the Arizona Community Health Worker Association (AzCHOW):



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*A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.*

## APPROACH

NAU-CHER staff worked with two health plan experts and representatives from both the University of Arizona, AzPRC and the ADHS Office of Chronic Disease to develop an interview guide that explored current and projected utilization, recruitment, training, and financing of CHWs. NAU-CHER worked closely with the Arizona Association of Health Plans to recruit and explain the assessment to health plan leadership through regularly scheduled meetings of health plan leadership. Leaders were provided the interview guide and asked to identify members of their leadership team with adequate knowledge to answer the questions via a 60-minute telephone interview. NAU-CHER staff then worked directly with designated health plan liaisons to schedule an individual or group telephone interview, which was recorded, transcribed and analyzed for prominent themes.

Understanding that each health plan has a unique approach to the utilization of CHWs, interview findings are reported in the form of health plan case studies by topic of focus. Although this assessment is not considered human subject research by NAU, all information was kept confidential and is deidentified. A total of 6 health plans and 16 individuals were interviewed between March and May 2018.

## Interview Instrument Development

Guided by two health system experts and representatives from both the University of Arizona, AzPRC and the ADHS Office of Chronic Disease, NAU-CHER staff developed a semi structured interview guide to conduct qualitative interviews with participants. Adapted from similar work conducted with health care sectors of Massachusetts, the interview guide was piloted with one health plan leadership team, after which questions

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## Qualitative Analysis

NAU-CHER staff transcribed audio interview recordings and developed a codebook to outline and define major themes encountered in the interviews. Using a hand coding system, two staff members independently reviewed the transcripts and coded the interviews. Through a process of consensus, staff remembers reviewed the thematic analysis and summarized the results based by interview topic described in Table 1.

<b>Table 1. Health Plan Interview Guide</b>	
<b>I.</b>	<b>Familiarity and involvement with CHWs</b>
<b>II.</b>	<b>Utilization of CHWs in the Health Plan and contracted provider network</b>
	a) Roles for CHWs
	b) Motivation for using CHWs
	c) Qualifications / Identification / Recruitment
	d) Training CHWs
	e) Length of time using CHWs
	f) Challenges in hiring and/or integrating CHWs into Health Plan workforce
<b>III.</b>	<b>Determining the value of CHWs in care management</b>
	a) Importance of CHWs in improving <u>quality</u> of care
	b) Importance of CHWs in improving <u>cost</u> of care
	c) Most valuable contribution of CHWs to health plan/networks
	d) Evaluation of cost savings or quality of care improvement
	e) Timeframe for demonstrating impact of CHWs
	f) CHW influence in designation of High Value / Center of Excellence
<b>IV.</b>	<b>Payment models to support CHWs</b>
	a) Financing / How health plans pay to use CHWs as part of health care team
	b) How provider networks are using CHWs to achieve value-based incentives
	c) Interest in and financing of CHWs in community-based positions
<b>V.</b>	<b>Current Arizona law / policies relating to CHWs</b>
	a) Value of HB2324 to health plans
	b) Impact of AHCCCS Complete Care (ACC) on use of CHWs
	c) Views on the Arizona Community Health Worker Association Training Center
<i>For complete Interview Guide, see Appendix A</i>	

### I. Familiarity and Involvement with CHWs

NAU-CHER staff interviewed 16 individuals in leadership roles at 6 AHCCCS contracted health plans. All participants represented plans with AHCCCS Complete Care (ACC) contracts awarded October 1, 2018 affecting approximately 1.5 million Medicaid members in Arizona.<sup>1</sup> AHCCCS Complete Care (<https://bit.ly/2FMI46Q>) mandates the integration of physical and behavioral health services to better coordinate the provision of all aspects of member health care. Over half of health plan leaders interviewed were employed with the health plan for at least 5 years. Approximately 69% of health plan leaders interviewed were extremely familiar with CHWs and half considered themselves champions of CHWs and or had direct involvement with CHWs. One third of the health plans utilized a state approved training program for Peer Support Workers, one

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 third used external agencies and or community colleges to train CHWs, and half operated internal training programs.

<b>Table 1. Characteristics of Interview Participants and Health Plans</b>	
<b>Participant Characteristics</b>	<b>Participants (N=16)</b>
<b>Time with Health Plan</b>	N (%)
<1 year	3/16 (19)
1-5 years	2/16 (12)
5-10 years	5/16 (31)
10+ years	6/16 (37)
<b>Familiarity with CHWs</b>	
Extremely Familiar	11/16 (69)
Moderately Familiar	3/16 (19)
Somewhat Familiar	2/16 (12)
Slightly Familiar	0/16 (0)
Not at all Familiar	0/16 (0)
<b>Level of Involvement with CHWs (May choose more than 1)</b>	
Leader/Champion	8/16 (50)
Direct	8/16 (50)
Indirect	5/16 (31)
No Involvement	1/16 (6)
Other	1/16 (6)
<b>Health Plan Characteristics</b>	<b>Health Plans (N=6)</b>
<b>AHCCCS Complete Care (ACC) Contract</b>	6/6 (100)
<b>Training requirements for CHWs (May identify more than 1)</b>	
State-approved program (Peer Support Workers only)	2/6 (33)
Training through external organizations / colleges	2/6 (33)
Training internal to health plan	3/6 (50)
<b>Identification and Recruitment of CHWs (May identify more than 1)</b>	
Postings (Internal or External)	1/6 (17)
Referrals from current employees	4/6 (67)
Contracted outside organization	1/6 (17)
Partner organizations / Training programs	2/6 (33)

## II. Utilization of CHWs in the Health Plan and Contracted Provider Network

Utilization, roles, recruitment, training and the strategies and challenges to integrating CHWs into AHCCCS health plans and contracted provider networks are described.

### *CHW Roles in Health Plans*

Health Plan leaders described several CHW core competencies, roles and skills in which CHWs are engaged in currently. CHW competencies, roles and skills described by leaders match those identified by the Community Health Worker Core Consensus (C3) Project (Table 2). Beginning in 2016, through a highly participatory national consensus building strategy, the CHW Core Consensus (C3) project engaged CHWs and their allies nationwide (<https://www.c3project.org/>) to update core competencies, roles and skills outlined in the landmark 1998 National Community Health Advisor Study (NCHAS) (<http://bit.ly/2vUzqt4>). Building from NCHAS, the 2018 C3 Project confirmed many of the longstanding CHW core competencies, roles and skills and identified new roles related to evaluation and research not identified in the 1998 NCHAS. Ultimately, the goal of both the 1998 NCHAS and 2018 C3 was to engage the CHW workforce to outline the CHW core

2019 Assessment of the Integration and Financing of CHWs in Arizona Medicaid Health Plans competencies, roles and skills to assist public and private entities in developing CHW policies and positions.<sup>2</sup> Results of interviews with Arizona health plan leadership suggest health plans engage nearly the full range of CHW core competencies identified by C3. It is notable that only one health plan utilizes CHWs in the role of *Implementing Individual and Community Assessments* and none utilize CHWs in *Participating in Evaluation and Research* which according to C3 are newly evolving roles for the CHW workforce.

Table 2. Community Health Worker Core Competencies and Roles						
Roles <sup>1</sup>	Health Plan A	Health Plan B	Health Plan C	Health Plan D	Health Plan E <sup>2</sup>	Health Plan F
Cultural Mediation among individuals, Communities, and Health and Social Service Systems	X	X	X	X		X
Providing Culturally Appropriate Health Education and Information	X	X	X	X		X
Care Coordination, Case Management, and System Navigation	X	X	X			X
Providing Coaching and Social Support	X		X	X		X
Advocating for Individuals and Communities	X	X				X
Building Individual and Community Capacity	X	X		X		X
Providing Direct Service	X	X	X	X		X
Implementing Individual and Community Assessments						X
Conducting Outreach	X	X	X	X		X
Participating in Evaluation and Research						

1. *The Community Health Worker Core Consensus (C3) Project: A report on the C3 Project Phase 1 and 2. Together Learning Toward the Sky*; 2019. <https://www.c3project.org/>
2. Health Plan utilizes Peer Support Workers only.

**Health Plan A** previously employed CHWs as patient navigators, facilitating access to community or health care services and coordinating transportation assistance, primarily working with plan members by telephone. Currently, CHWs are employed as part of an interdisciplinary care team that works with high need members. CHWs on this team are highly integrated into the health care team and have a variety of roles including connecting members to community resources to address social determinants of health and providing health behavior support and education.

*"They do a lot of resource finding [...] a lot of the social determinants they are focused on, but also chronic disease support and management, goal setting, SMART goal setting with patients around their medication adherence, their disease management, their wellness and making sure they make their appointments, making sure they know how to use the medical system, they might accompany people to a medical or behavioral health appointment and then they support the other roles of the team. They are the support system for the nurse practitioner, the clinical pharmacist, the behavioral health specialist and the nurse..."*

Within the provider network of **Health Plan A**, CHWs are mainly employed in federally qualified community health centers (FQCHCs) and patient centered medical home models of care (PCMH), working in the clinical setting as health coaches, a patient advocates, and in the community in preventative health care. **Health Plan B** employs CHWs in a variety of roles including patient navigation, patient advocates, members of the interdisciplinary health care team, health educators and in conducting outreach. Much of their work involves in-person interactions with members, connecting them with community and health resources to address social barriers to health. **Health Plan F** also utilizes CHWs as integrated members of their care management and

2019 Assessment of the Integration and Financing of CHWs in Arizona Medicaid Health Plans member engagement teams. Their roles include navigational support, assessing and addressing social determinants of health (e.g. transportation, housing, food insecurity, and employment), advocacy and outreach. The interviewed members of **Health Plan F** leadership were not aware of the full extent to which CHWs are utilized within their contracted provider network, mentioning only an FQCHC that has a *promotora* program involved in identifying and addressing gaps of care among a high-risk member Latino population.

**Health Plan C** utilizes Peer Supports and employs Community Engagement Specialists who provide outreach and health plan membership benefit navigation support to members. At the provider level, there is one contracted FQCHC in their network that has a small CHW program focused on patient outreach and improving access to care among primarily Latino health plan members. In response to the ACC contract, **Health Plan C** expects to create positions for CHWs within behavioral and physical health sectors of their plan. **Health Plan D** employs Peer Supports and does not currently employ CHWs, as it was previously a behavioral health plan only. Currently, Peer Supports work with members in a variety of areas, including outreach, facilitating access to healthcare and community services, support for members who are homeless or have recently exited the justice system, as well as providing health education and advocacy. Due to the success experienced through their current peer support program, Health Plan D will pilot an entirely volunteer-based CHW program to assist primarily Latino health plan members in the areas of prevention and management of diabetes. **Health Plan E** also employs Peer Supports, who work with providers to assist members experiencing serious mental illness, substance use disorder, unemployment or criminal justice involvement.

## Motivation for Utilization CHWs

Motivations to utilize the CHW workforce vary among Arizona contracted Medicaid plans. Some are encouraged by the AHCCCS ACC initiative to integrate behavioral and physical health, and the unique and trusted relationships CHWs are demonstrated to have with the community served. Others discussed a strong desire to support and empower plan members in their own disease management, an area CHWs have also demonstrated success. Plans with FQCHCs within their provider network are highly motivated to utilize CHWs because of FQCHC success with CHW models of

outreach, education and care. ACC health plans coming from behavioral health management are motivated to engage CHWs because of their history and success with Peer Supports, a workforce currently recognized by the Arizona Department of Behavioral Health Services (DBHS).

**Health Plan A** cited AHCCCS goals to increase member outreach, and stipulated deliverables of the ACC contract, as a reason for establishing navigator-focused CHW positions. The motivation for integrating CHWs into the care management team for high needs clients was a strong desire to support and empower members in their own disease management. On the provider level, leaders in **Plan A** spoke primarily about FQCHCs, whose use of CHWs is a natural progression from the *promotora* programs that historically existed in the communities where these clinics are based.

*“[...] this position [CHW] was the foundation of the whole program because we’re dealing with people’s ongoing needs and we’re trying to help get them, you know improve their self-efficacy over time so they’re better able to better interact with their healthcare providers and better manage*

## WHO ARE PEER SUPPORT WORKERS?

Peer Support Workers are distinct from CHWs, and considered to be essential members of treatment teams in the behavioral health arena. According to the definition provided by the Substance Abuse and Mental Health Services Administration (SAMHSA),

*“Peer Support Workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, Peer Support Workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process”.*<sup>3</sup>

AHCCCS Policy 963 establishes requirements for the provision of peer support services within the AHCCCS programs, including qualifications, supervision, continuing education and training/credentialing of Peer and Recovery Support Specialists (PRSS).  
(Source: <https://bit.ly/2UNOIPC>)

*their own conditions. So for us this was an essential, this was an essential role in that interdisciplinary team."*

**Health Plan B** leadership described the importance of existing scientific evidence, which has demonstrated the impact of CHWs' unique skills to "improve health outcomes and reducing healthcare costs." The health plan was also motivated by the demonstrated success of Peer Supports in behavioral health management and their desire to replicate that into the non-behavioral health care realm.

*"We carry that concept [of peer support] forward into the non-behavioral care side and tap into lived experience and high levels of community engagement and understanding in order to be able to engage our members, understand their health issues and social issues within our community and truly bring in the strength and assets within our community into and integrate with our healthcare delivery system."*

Leaders from **Health Plan C**, which primarily employ Peer Supports, described expectations set by the Arizona DBHS as a major driver to develop and formalize their peer support program, a program they continued after its demonstrated success. The small *promotora* program in their network was established as a result of advocacy on the part of a FQCHC staff member. **Health Plan E** also mentioned the influence of their contract requirements with AHCCCS and the Arizona DBHS as motivators to establish their peer support program. Similar to **Health Plan C**, this plan continued its peer support program based on proven benefits in the areas of care improvement and cost reductions. **Health Plan D** leaders cited CHWs' and Peers' unique knowledge of the target population as their primary motivation for integrating these positions into the health care team.

*"I think our motivation in using community health workers is it's one of the most effective public health tools that can change human behavior and there's lots of evidence to show that."*

**Health Plan F** leaders cited several motivating factors for integrating CHWs. First was the belief that the CHW's unique understanding of the community makes CHWs especially valuable in their ability to engage and support members. Second, was the influence of the demonstrated success of peer support programs. Finally, plan leadership view the CHW workforce as a way to reduce the cost of care through a more affordable resource in the care management team.

## **CHW Qualifications - Identification - Recruitment**

Health plans primarily recruit CHWs through referrals from current employees and from partner organizations or training programs. Various programs require an assortment of skills including some degree of certification, computer skills, communication skills, experience in a health care setting, and familiarity with the culture and community resources.

**Health Plan A** leadership identified a variety of skills they look for in a CHW, including customer care experience, computer skills, basic familiarity with medical records, communication skills, and being both bilingual and bicultural. In terms of recruitment, the plan specifically mentioned FQCHCs that often identify outstanding existing employees and provide them with the training to become CHWs. **Health Plan F** leaders also identified several key skill areas they look for in CHWs including some sort of degree or certification related to health or social services (e.g. CNA, or BA in social work), some experience in the health care setting, familiarity with the culture and resources of the community served, and knowledge of or desire to learn about both motivational interviewing and trauma informed approaches. The recruitment process for CHWs starts with internal job postings, as well as external sites connected to the health plan, and taking referrals from current CHWs.

**Health Plan B** seeks applicants who have lived experience in the areas of health care navigation, care giving, or community services. The plan prefers to hire CHWs with CHW certification, and emphasized their willingness to support an employee becoming certified. Recruitment primarily happens through community partners, word of mouth, and certification programs that use their plan as a practicum site.

Leaders at **Health Plan E**, which does not employ CHWs, described the basic qualifications for Peer Support Workers as having “lived experience,” meaning personal experience – as opposed to formal training – with the criminal justice system, with alcohol or substance use and or history of mental illness; being over the age of 21, and having a fingerprint clearance card. Similarly, **Health Plan C** leaders spoke specifically about Peer Support Workers, whose basic qualifications must include having lived experience, a fingerprint clearance card, be over the age of 21, and have good computer and communication skills. They identify potential peers mainly through current Peer Support Workers or case managers. The *promotoras* in the FQCHC in which they contract with were identified by the program organizer because of their active role in the community. The health plan has recently contracted with an outside company that hires, trains, and pays for CHWs serving members in one of their service areas. **Health Plan D**, which also does not currently utilize CHWs but plans to do so in the future, stated that they would look to a community partner that specializes in CHWs, such as AzCHOW, to take the lead on determining the specific qualifications for CHWs. In addition, they would prefer for all their CHWs to have certification, for liability reasons. On a basic level, they would require CHWs to have a valid driver’s license, computer skills, and communication skills. For future recruitment, the health plan would like to coordinate with CHW training programs in community colleges and universities.

## CHW Training

Training requirements for CHWs vary widely among health plans. Peer Supports require a credential through a state-approved training program. Several plans prefer to hire CHWs with formal certification, however it is not required. While one plan provides extensive internal training for CHWs, others described a more basic training (or retraining for current employees) on health plan systems and community resources.

**Health Plan F** requires extensive internal training for CHWs, using evidence-based curricula developed by their national team. CHWs take part in a two-week training specifically on the roles of a CHW, followed by a three-week preceptorship. Each month the CHWs participate in grand rounds with the health plan’s national medical director and receive training on a specific topic such as depression. CHWs receive extensive safety training and trainings related to disease management, health behavior, and community resources. The health plan also uses “field-based ride-alongs” to train new CHWs through direct observation of experienced CHWs – an opportunity also available to health plan leaders and management. **Health Plan B** did not discuss any internal training they provide to CHWs, simply saying that they prefer to hire CHWs who have formal certification. **Health Plan A** leaders mentioned only that within some contracted FQCHCs existing employees are often recruited and re-trained to become CHWs.

**Health Plan E** currently only employs Peer Support Specialists, who are required to go through a state approved peer support training program, one of which is offered internally at the plan. Once credentialed, Peer Support Workers must go through basic employee trainings in areas such as HIPAA. **Health Plan C** leaders discussed their training requirements for their current peer support program and for their future CHW positions. Since 2012, the state has required that all Peer Support Workers must have passed the state-approved training in order to have their services billed through Medicaid. In regards to CHWs, the health plan is currently working with several Arizona community colleges to develop and improve their curriculum for CHW certification to include behavioral and mental health components. In addition, the health plan is financing the training for more than 50 people to attend the CHW programs at these community colleges. The plan would also require all CHWs to be trained on their electronic medical record system. Similarly, **Health Plan D** leaders stated that they would be looking to hire CHWs with formal certification in the future. Beyond that, they would require a basic health plan and health system orientation.

*“...Say we hire someone certified so for us they fulfill the community health worker training but for us on the health plan side there’s also health plan training, navigating the health system...”*

## Challenges in Hiring and Integrating CHWs into Health Plan Workforce

Challenges in hiring and integrating CHWs within the plans was also discussed. Challenges included lack of understanding among providers of CHW competencies and training needs, reliable transportation among

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 CHWs, and the need to recraft CHW positions to accommodate non-traditional candidates, such as those without a formal education, or past involvement with the justice system. Systems challenges for integration included the lack of AHCCCS billing codes for CHWs, lack of understanding of CHW competencies and roles among health care teams at the plan and provider levels, and locating individuals with the right combination of CHW competency and confidence to integrate into the health care team. Table 3 below summarizes the various challenges health plans cited related to the integration and hiring of CHWs. (Note that not all plans experience every challenge.)

Table 3. Challenges in Integrating and Hiring CHWs within the Health Plans and Provider Networks	
<b>Challenges in Hiring</b>	<ul style="list-style-type: none"> <li>- Lack of understanding among providers of CHW competencies and training needs</li> <li>- Reliable transportation among CHWs</li> <li>- Needing to recraft CHW positions to accommodate non-traditional candidates</li> </ul>
<b>Challenges in Integration</b>	<ul style="list-style-type: none"> <li>- Lack of AHCCCS billing codes for CHWs</li> <li>- Lack of understanding CHW competencies and roles among health care team</li> <li>- Locating individuals with the right combination of CHW competency and confidence to integrate into health care team</li> </ul>

**Health Plan A** leaders identified two main areas of challenges regarding hiring and integrating CHWs. First, at the provider level, there is a lack of “consistent understanding of competencies of training,” which impacts the training and supervision of potential CHWs. The other challenge at the plan level has to do with identifying “the right people” for the position who have the ideal combination of competency and confidence to effectively integrate their role into the health care team. Finding candidates with access to reliable transportation was also cited as a barrier. **Health Plan F** leaders identified two primary challenges, including setting appropriate educational qualifications for the position and improving health care team member understanding of a CHW’s roles and responsibilities. Due to initial hiring challenges, the health plan increased their minimum educational requirement to an associate’s degree and provide education to health team members “to review the roles, the functions and how they would integrate and work together.” Leaders from **Health Plan B** discussed how the challenge of hiring “non-traditional” candidates – such as current or former military service members, those with a disability or without formal education and training in health care – for CHW positions, has resulted in a good deal of innovation and creativity at the plan level.

*“I wouldn’t call them challenges, just things that we process through and we hire individuals that represent the consumers that we provide services to. We have had to recraft the position so that some of those positions are part time and many of the individuals that we hire are non-traditional so we’ve had to adjust our employment practices to be able to accommodate special needs in a much more highly specialized fashion.”*

**Health Plan D** leaders explained that the main challenge in utilizing CHWs is the lack of recognition in the state AHCCCS and Medicaid systems. Without billing codes available for CHW activities, the health plan struggles to find a “sustainable way to finance” CHWs within their provider network.

*“Community health workers aren’t currently recognized in the state and so that honestly causes a lot of challenges for us internally to really develop programs.”*

**Health Plan E** leaders discussed several challenges related to hiring and integrating Peer Supports into their health plan and provider network, including the difficulty some candidates have in obtaining a finger print clearance card, the generally low pay scale of Peer Support Workers in the state, and the stigma attached to having lived experience related to substance abuse, mental illness or other areas outside the mainstream. Leaders from **Health Plan C** described their main challenges related to hiring Peer Support Workers occurring at the provider level. Because there is a lack of

2019 Assessment of the Integration and Financing of CHWs in Arizona Medicaid Health Plans understanding of the competencies and roles of Peer Support Workers, they are often not utilized to their fullest potential. Consequently, the health plan has created a detailed clinical practice guideline for Peer Support to educate agencies in their provider network.

### III. Determining the Value of CHWs in Care Management

Health plans discussed the importance of CHWs in improving quality of care and in reducing the cost of care. The most valuable contribution of CHWs included identifying and removing social barriers to care, saving member lives, normalization of the health care experience, meaningful outreach and engagement, and encouraging behavioral change. Health plans encountered value in CHWs’ ability to advocate on behalf of health plan members and develop a trusting relationship vital to meaningful engagement of their members. Table 4 below outlines the range of contributions provided by CHWs, as described by the health plans. (Note that not all plans described experiencing all of the benefits.)

Table 4. CHWs Contribution to the Quality and Cost of Care Among Health Plans and Provider Network (N=6)	
<b>Quality of Care</b>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>- Outreach and Engagement</li> <li>- Increase utilization of primary care</li> <li>- Increase utilization of preventative care</li> <li>- Decrease utilization of emergency services</li> <li>- Improve treatment adherence</li> <li>- Supportive in meeting Healthcare Effectiveness Data and Information Set (HEDIS)</li> </ul> <p><b>Social Determinants</b></p> <ul style="list-style-type: none"> <li>- Decrease involvement with justice system</li> <li>- Housing Support</li> <li>- Health Plan Member Advocacy</li> </ul>
<b>Cost of Care</b>	<ul style="list-style-type: none"> <li>- CHWs are of high value at a low cost</li> <li>- Improve adherence to treatment</li> <li>- Reduce use of emergency services</li> <li>- Reduce hospital inpatient admissions</li> <li>- Enhance early identification of high cost members</li> </ul>
<b>Most Valuable Contribution</b>	<ul style="list-style-type: none"> <li>- Identify and remove social barriers to care</li> <li>- Save member lives</li> <li>- Normalize health care experience</li> <li>- Meaningful outreach and engagement</li> <li>- Encourage behavior change</li> <li>- Health plan member advocacy</li> <li>- Trusting relationship with health plan member</li> </ul>

Only one health care plan has conducted a formal evaluation of the impact of CHWs, and focused on the impact of CHWs in removing social barriers to accessing health care:

*“We have found that for every social barrier that is removed through a community health worker and tracked through the community impact model, we save \$450 in reduced emergency room visits, reduced length of stay in a hospital and reduced rapid readmissions. At the same time, not only is there a cost savings but we have found that there is a significant lift in quality scores when those same social barriers are removed. Members are 1½ - 2½ times more likely to schedule and complete their primary care physician visits, they are nearly 7 times more likely to have a better adult BMI score, they remain more compliant with their diabetes treatment and so on. We have*

*each measure documented on what the list is by removing a social barrier, which is one of the key roles that we ask the community health workers to play."*

## **Importance of CHWs in Improving Quality of Care**

CHWs impacted the quality of care in two main areas: medical and social. In the first area, several health plan leaders described the positive impact CHWs have on member outreach and engagement, as well as on the utilization of preventative and primary care. The reduction of emergency services was also cited as a major benefit of CHW involvement. CHW impact on housing and justice involvement was also described. Health plan leaders emphasized the value of CHWs is difficult to measure by standard metrics and that their value is in part due to their unique understanding of the community served.

**Health Plan A** noted two main areas of value in terms of CHWs' work: "member outreach" and the completion of "certain preventative services." However, they emphasized that the positive impact that CHWs have on the quality of patient care often does not align within the "metrics that CMS or other large agencies have come up with." **Health Plan B** has found that CHWs have a significant impact on improving quality of care for members, particularly in the area of preventative services. They explained that their model for measuring the impact that CHWs have on quality of care looks specifically at what happens when certain social barriers (e.g. unemployment, lack of transportation, housing insecurity) are removed as a result of a CHWs efforts.

**Health Plan C** explained that one of the most important impacts CHWs have on quality of care is the way in which they help "normalize" the utilization of health care among populations that traditionally are reluctant to seek medical services. **Health Plan D** also discussed the impact of CHWs on member utilization of primary and preventative care, noting that increased utilization of these services tends to result in improved long-term health outcomes. Health plan described observing positive impacts in lowering emergency department admissions, reducing involvement in the justice system, and increasing housing for homeless plan members. **Health Plan E** leaders noted that the unique skills of CHWs and Peer Support Workers improves care for health plan members, specifically discussing how the lived experience of Peer Support Workers makes them extremely effective advocates for their clients within the health system and the community. Similarly, **Health Plan F** leaders stated that CHWs play a crucial role in the health care team and that their unique understanding of and direct interaction with health plan members improves the quality of care.

*"I think the idea that someone that is a little bit more of a lay person, a little bit more of a peer from the community that is field based that actually sees people face to face offers such a tremendous additional opportunity to the rest of the care team and I say the rest I mean the nurses and the physicians which are more office and less field based. You can't account enough for the value that comes from the direct intervention and seeing and meeting with people in their environment and in their home or at their work to try to get a better handle on the needs that they may have and to get a better understanding of what they are going through relative to the healthcare that we are trying to deliver to them."*

## **Importance of CHWs in Improving Cost of Care**

In discussing CHW impact on the cost of care, health plan leaders described a significant reduction in member costs due to increased utilization of primary and preventative services and reduced utilization of emergency and inpatient services. In addition, CHWs are believed to provide high value, low cost services as part of the health care team.

**Health Plan A** leaders signaled the CHWs contribution to valuable services at a lower cost;

*"As the price goes up then the value equation gets a little more challenged, because in some ways you're just trying to replace a higher cost, you don't need an RN or an LPN or someone with a given license to do the work, it might be done more effectively by a CHW, but part of that value equation is that they are a lower cost staff member."*

**Health Plan B** has found cost savings through the use of CHWs in large part because CHW activities tend to reduce utilization of expensive and sometimes unnecessary services such as emergency room visits, hospital inpatient admissions, and rapid readmissions. Leaders from **Health Plan D** have not formally evaluated cost savings of CHWs, largely because their reasoning behind utilization of the CHW workforce is focused on improving quality of care rather than cost. With that said, **Health Plan D** has observed a general reduction in cost around emergency department utilization and hospital inpatient admissions, as members working with CHWs are more likely to seek primary care and preventative services.

*"We have all of these health outcomes that we hold our providers to as far as how many of your members end up going to jail, how many of your members end up in the ER regularly, that sort of thing and our providers know they can greatly reduce all of those additional costs with a team of appropriately staffed peer or community health workers."*

**Health Plan C** leaders described evaluation efforts of their Peer Supports which have demonstrated reduced cost of care through proper use of preventative and primary services. Members involved with peer support services were shown to have fewer inpatient events, less justice involvement, and reduced use of emergency services. Similarly, **Health Plan E** leaders spoke specifically about the impact of Peer Support Workers on reducing costs for the health plan by improving adherence to treatment, reducing emergency services, and decreasing inpatient admissions.

*"It definitely reduces cost for a number of reasons, number one because it improves adherence and people tend to stay in treatment and follow through with their treatment more, so that reduces relapse, that reduces maybe the utilization for ED - emergency department services."*

**Health Plan E** leaders echo other observations of the link between CHW services and reduction of emergency department utilization and hospital inpatient events. This impact is a result of CHWs preemptively reaching out to high needs members and connecting them with preventative health care services and addressing social barriers before a crisis occurs.

*"So reaching out to them instead of waiting for them to come to us and so when I think about cost, identifying people that are higher cost and those are the folks that these teams are often times trying to identify and work with earlier rather than later. That's how they help reduce costs [...] If they can positively influence and impact those individuals in the ways we talked about earlier we can hopefully reduce that cycling through those very high cost settings which are not the best or the most appropriate places of care. "*

## **Most Valuable Contribution of CHWs to Health Plan and Provider Networks**

Conversations about CHWs' most valuable contribution focused primarily on CHW contribution to quality of care for members, specifically through member advocacy and engagement, removal of social barriers to care, and the normalization of the healthcare experience, including the encouraged use of primary and preventative care services. Leadership emphasized the power of CHWs to remove social barriers among members, which can literally "save member lives".

**Health Plan D** leaders recognized the greatest contribution of CHWs in the area of health equity, in CHWs ability to effectively advocate for individuals who are outside the 'mainstream member population' in terms of language, culture, religion and or country of origin. Similarly, **Health Plan F** stated that the most valuable contribution of their CHW workforce is the "meaningful engagement" that CHWs have with members, in particular with low-income members who are often highly mobile due to precarious housing and hard to reach situations. **Health Plan C** leaders explained that CHWs' greatest impact on quality of care is the way in which they help "normalize" the utilization of health care among populations that are traditionally reluctant or fearful to seek medical services, such as newly arrived immigrants and refugee populations. Leaders at **Health Plan B** cited the removal of social barriers for their clients as the most valuable contribution of their CHWs. Removing

these barriers reduces cost and improves quality of care. **Health Plan E** leaders stressed that Peer Support Workers have historically and continue to “save member lives” by helping them overcome social barriers and by providing peer-based support.

*“They are saving the lives of the people that they are working with in one way or another. They either help them find a purpose like a job and they feel alive and they want to be alive, reducing suicides, reducing overdoses, letting people know that they are not alone that they too can make it through this, so I would say the most valuable contribution is the lives of our members.”*

## **Health Plan Engagement in Evaluating CHWs on ROI and Quality Improvement**

Most health plans have not conducted Return on Investment (ROI) or quality improvement evaluations of CHWs. Some plans are working on collecting internal data in this area, but others do not see it as a priority – either because of the challenges associated with isolating and measuring the impact of CHWs or because they are currently satisfied making their program decisions based on observational and existing scientific evidence. **Health Plan B** is the only plan that has conducted formal evaluations of the impact of CHWs, looking at the impact of removing social barriers to accessing health care.

*“We have found that for every social barrier that is removed through a community health worker and tracked through the community impact model we save \$450 in reduced emergency room visits, reduced length of stay in a hospital and reduced rapid readmissions. At the same time, not only is there a cost savings but we have found that there is a significant lift in quality scores when those same social barriers are removed. Members are 1 ½ - 2 ½ times more likely to schedule and complete their primary care physician visits, they are nearly 7 times more likely to have a better adult BMI score, they remain more compliant with their diabetes treatment and so on. We have each measure documented on what the list is by removing a social barrier, which is one of the key roles that we ask the community health workers to play.”*

**Health Plan A** does not evaluate the specific impact of CHWs, as they are considered to be an integral part of the larger health care team.

*“We see the CHW as part of a team, not so much as an individual employee so then the challenge becomes how effective is that team? It’s really hard to measure the effect, the efficacy of each individual on that team.”*

**Health Plan C** also has not conducted formal internal evaluation of the impact of CHWs. They are making local decisions based on national and regional data on Peer Support Workers and CHWs, which demonstrate long term health behavior change and reduction in cost.

*“So it’s really just the claims are showing that people’s health behaviors are improving with working with Peer Support Workers. Of course, we’re talking in aggregate, there’s always outliers but almost across the board, if you’re looking at not only social determinants of health things like housing, employment, illegal involvement but also a lot of the HEDIS measures, again A1C, eye exams, things like that. People’s behaviors just improve by large and claims data backs that up.”*

Similarly, **Health Plan D** is currently collecting that data and monitors primary care utilization data versus health outcomes related to CHWs, specifically emergency department utilization, involvement in the justice system, and homelessness. **Health Plan F** has not yet conducted any cost savings analyses of the impact of CHWs, but instead monitors anecdotal evidence from member success stories, noting the challenge of isolating the impact of CHWs through standard measures.

*“...we’ve also tracked and captured a lot of incredible success stories, which when you think about it even if you can’t tie a dollar figure directly to it, it’s quite clear that the success stories will result as we track those individuals over time and we get that data will or should result in cost savings*

*– let alone just the impact, the life impact for the quality of life, that’s obviously a little more difficult to assess from a value equation if you will.”*

**Health Plan E**, which only utilizes Peer Support Workers, has not done any evaluations on the value of peers supports or CHWs within their health plan or network. They plan to conduct internal evaluations but are primarily looking to the statewide evaluation on Peer Support Workers to be conducted with all health plans. That state-led evaluation will contain quantitative claims-based data as well as qualitative data from member surveys.

## **CHW Influence in Designation of Center of Excellence (To a Provider)**

Health plans have the freedom to designate any program in their system as a Center of Excellence (see sidebar for definition). Health plans generally agree that a provider’s use of CHWs would influence their decision to designate Center of Excellence or high-value to that provider, however several pointed out that such a designation involves other factors such as meeting key health outcomes and achieving member satisfaction.

**Health Plan C** leaders explained that utilizing CHWs or Peer Support Workers is not a requirement for Center of Excellence designation, rather the health plan is focused primarily on whether the provider is meeting their HEDIS measures, achieving member satisfaction and demonstrating overall cost savings. Nonetheless, they recognize that having a robust peer support or CHW program will likely result in “the kind of

outcomes that are going to contribute to Center of Excellence status.” **Health Plan D** leaders agreed that the use of CHWs would influence the designation of a provider as a Center of Excellence, particularly because of how effective CHWs are as part of the care team in community health centers. Leaders from **Health Plan F** confirmed that a provider’s use of CHWs would positively influence their potential designation as a Center of Excellence or high-value. In discussions with new providers, the health plan generally suggests the use of CHWs as an effective strategy to increase member engagement. **Health Plan A** leaders also stated that if one of their providers were utilizing CHWs as part of their health care team that it would be a factor in their favor in terms of Center of Excellence or high-value designation. Leaders from **Health Plan B** described that the use of CHWs “would have the potential” to positively influence the designation of high-value or Center of Excellence, but it would depend “on what they were doing and what their outcomes were that they were looking to achieve and were able to achieve.”

**Health Plan E**, which currently only employs peers supports, explained that their providers with designated Centers of Excellence status all utilize Peer Support Workers and because of the AHCCCS Complete Care (ACC) contract, they plan on extending the use of peer and family supports throughout.

### **WHAT IS A CENTER OF EXCELLENCE?**

“Formally defined, a center of excellence is a program within a healthcare institution which is assembled to supply an exceptionally high concentration of expertise and related resources centered on a particular area of medicine, delivering associated care in a comprehensive, interdisciplinary fashion to afford the best patient

## **IV. Payment Models to Support CHWs**

Health care plans discussed a variety of models for the financing of CHW positions. Models included administrative or operations budget/dollars, grant funding, value-based payment arrangements, and AHCCCS Billing Codes for Peer Support Workers. Value-based contracts were described as allowing providers to achieve high quality outcomes through more creative means, such as hiring non-clinical staff like CHWs. Several plans were not aware of or do not monitor how providers were using CHWs to achieve value-based incentives because they do not mandate specific processes, but they recognized that value-based models could be a sustainable approach for full long-term utilization of CHWs. Plans also see the impact of AHCCCS

2019 Assessment of the Integration and Financing of CHWs in Arizona Medicaid Health Plans Complete Care (ACC) as an opportunity to greatly expand the use of CHWs in this new integrated seven-year contract and model.

## Financing Models

Health plans essentially described three models used to finance CHW positions. Table 4 below offers a summary of the payment models employed by health plans and provider networks to pay for CHWs. Health plan leaders indicated that their plan and provider networks often need to use multiple payment strategies depending on the CHW’s role and position in the health care team. The most common method for financing CHWs is through value-based payment arrangements with contracted health network providers. Some plans and providers employ CHWs using their operational budgets or short-term project-based grant funding. Peer Support Workers, primarily employed on the behavioral health side of the house, are funded either through AHCCCS billing codes for services, administrative dollars, or by grant funding for specific community-based projects. **Several plans cited the lack of a dedicated AHCCCS billing code for CHWs as a challenge to creating sustainable CHW programs that utilize the full CHW scope of practice.** All health plan leaders noted that it would be “very beneficial to see CHWs to have their own billing code,” to support development of future positions.

	Health Plan A	Health Plan B	Health Plan C	Health Plan D	Health Plan E <sup>1</sup>	Health Plan F
Administrative or Operations Budget/Dollars		X		X		X
Grant Funding	X		X			
Value-Based Payment Arrangement	X	X	X	X		X
AHCCCS Billing Codes (Peer Support Workers Only)		X	X	X	X	

<sup>1</sup> Health Plan employs Peer Support Workers only.

In **Health Plan B** CHWs are employees paid through their operations or administrative budgets. At the provider network level, CHWs are paid through value-based contracts or directly by a provider if that provider views the CHWs as a cost-effective way to achieve their desired outcomes. All behavioral health peer support positions are funded through the provision of AHCCCS designated billable services. Similarly, **Health Plan F** employs CHW through administrative budget. Within their provider network, value-based payment models provide the funding for CHW positions. **Health Plan D** also uses administrative funds in combination with value-based purchasing and expressed preference for value-based purchasing, as a more sustainable model of financing. Administrative funds are used occasionally to pilot programs, with the goal of ultimately moving toward value-based purchasing. Peer support services are billable to Medicaid while CHW services are not.

**Health Plan A** engages value-based contracts, in which the health plan partners with a primary care organization to fund a particular program and that program directly hires a CHW as part of its team. Alternatively, some Federally Qualified Community Health Centers (FQCHCs) within the health plan’s network fund CHW positions through grant funding. Similarly, **Health Plan C** utilizes value-based purchasing agreements or state or federal grants awarded directly to network providers. Leaders noted that grant-based funding is restrictive, resulting in CHWs positions that are short-term and frequently narrow in scope. Peer support services are billed directly to Medicaid, except in the case of outreach positions working with people who are not yet in the system. Such activities are currently funded through state or federal grants related to mental health or substance abuse.

*“So I mean if there was something that AHCCCS did, the legislature really, if they got CMS’s approval to have a specific code that could only be billed by community health workers then yeah,*

*you would see a flood of CHWs across the state. You know just one more opportunity for people to provide a larger service array, or agencies to provide a larger service array. Yeah but again, if that doesn't happen then really the only recourse is to come along side and shore it up as a health plan with different focused grants trying to accomplish specific things with the community health workers, and that's the thing about those grants, you really have to figure out what are you wanting to accomplish with it and the what a community health worker is, is not always very specific to one thing or another thing, it's more of a general you know connecting and navigating and normalizing services in the community. **So sometimes you lose a little bit of what a community health worker is when you have it run through grants that are very focused on very specific populations or things like that. Not to say it's a bad thing but I guess it's my longwinded way of saying I support CMS or AHCCCS getting that code, otherwise you get like CHW lite.**"*

**Health Plan E** currently only employs Peer Support Workers, who are full time employees at the plan level. At the provider level, Peer Support Workers are funded through their Medicaid contract by providing billable services, or through state or federal grants specific to a particular behavioral health issue.

## Value-based Models

The use of value-based models was quite common among interviewed health plans as an effective method of financing CHW positions. In a value-based model, payments to providers are tied to patient health outcomes, cost of care, and the quality of care achieved. (As opposed to a traditional fee-for-service model that rewards quantity over quality of care.) Although health plans do not mandate processes at the provider level, they are supportive of the use of CHWs within their provider network to achieve outcomes.

**Health Plan A** leaders described the benefit of value-based contracts as allowing providers to achieve high quality outcomes through more creative means, such as hiring non-clinical staff like CHWs. The health plan fully supports the use of CHWs in value-based models and provides resources to providers interested in learning more about CHWs. **Health Plan F** explained that they have value-based agreements with a number of providers and while they do not dictate how providers use their funds, they do encourage the use of CHWs. **Health Plan B** leaders stated that while they are not fully aware of how providers were using CHWs to achieve value-based incentives, the plan itself is "very engaged in expanding [their] value-based arrangements and would be interested in working with providers to set up value-based contracts." Similarly, **Health Plan C** leaders explained that they are also not monitoring how the providers in their network are using CHWs to achieve value-based incentives, in large part because the health plan does not mandate the specific process by which a provider in a value-based agreement chooses to achieve their outcomes. Nevertheless, if providers are seeing improved outcomes with the use of CHWs, they will benefit in value-based payment situations.

*".... I can see again agencies having better outcomes with CHWs that will be able to take advantage of value-based payment arrangements because of that, because they are making certain outcomes that they are looking for."*

Leaders at **Health Plan D** explained that while they are not currently using value-based purchasing to employ CHWs at their health plan, they "agree that that is the sustainable approach and are hopefully going to be moving in that direction in the future." Speaking hypothetically, they explained that the health plan funds certain incentives tied to outcome measures mandated by the Centers for Medicaid (CMS) and that CHWs are highly effective in helping to achieve those outcomes among hard to reach populations. Consequently, it is up to the health plan to ensure that the incentive amount is sufficient to "finance a robust CHW program." **Health**

### VALUE-BASED MODEL

According to the Centers for Medicaid and Medicare Services, value-based programs represent a significant reform in health care payment models: "Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. Our value-based programs are important because they're helping us move toward paying providers based on the quality, rather than the quantity of care they give patients."<sup>5</sup>

**Plan E's** provider network does not employ CHWs (only Peer Support Workers), but plan leaders described how the plan is moving toward and encouraging the use of more value-based purchasing agreements with providers.

*"We have value-based payment models that are in place with a number of large groups that are total-cost-to-care based, so if they have an impact on any aspect of cost to an individual they can potentially net benefit from that as part of those value-based payment models. [...] sometimes they'll [the provider] say that CHWs are part of their planned approach and if they don't raise that, we usually raise that as a potential best practice that they should be considering. If they do earn shared savings we don't typically dictate how they can spend those savings but we encourage them to consider the use of some of those savings that they earn and reinvest it back into their program and CHWs are one of those areas we make recommendations that they consider."*

## Financing of CHWs in Community-Based Positions

The use and financing of CHWs in community-based positions varies widely among plans. Funding models include value-based purchasing agreements, administrative dollars, and other alternative models.

**Health Plan B** leaders explained that they have administrative CHW positions that are in the community but that do not provide direct services. Such positions would be funded through their operations budget. Leaders at **Health Plan C** described their use of *promotoras* as outreach and engagement specialists as essentially community-based positions, which are funded through value-based purchasing agreements. **Health Plan F** leaders noted that while they currently have CHWs in certain community-based organizations in their network, the health plan cannot pay them directly. The most the health plan can do is "support [these positions] through sponsorships or other possible reinvestment requirements or opportunities [they] have." **Health Plan A** leaders stated that they are not able to say definitively at this point whether or not the plan would fund CHW positions in community-based positions.

Leaders at **Health Plan E** spoke exclusively about their use of Peer Support Workers in community positions – in various locals including within the justice system and schools – and how these positions are funded through AHCCCS billable codes. **Health Plan D** leaders expressed interest in having CHWs in their existing community and school-based programs where they already have case managers in place, seeing these community locations as a "natural fit for community health workers." However, leaders stated that in order to fund those type of positions, there would need to be a billing code available through CMS in order for providers to bill for those services.

## V. Current Arizona Law / Policies Relating to CHWs

Health plans discussed several topics related to Arizona law and policy currently affecting the CHW workforce, including HB2324, AHCCCS Complete Care (ACC) contracts, and the recent establishment of the Arizona Community Health Workers' Association (AzCHOW) Training Center. Health plan leaders discussed potential areas for growth and expansion of the CHW workforce, including the opportunity to provide CHWs with a dedicated AHCCCS billing code.

### HB2324 CHW Voluntary Certification

The Arizona Legislature recently passed HB2324, which authorized the voluntary certification of community health workers. The law, which took effect in August 2018, directs the Arizona Department of Health Services (ADHS) to implement a CHW certification program. The law also establishes a 9-person advisory council made up of at least 50% CHWs to advise the department about the certification program and provide recommendations regarding defining the core CHW competencies, minimum education and training qualifications, continuing education requirements and other details related to CHW certification in the state. Additionally, the law provides an exception to the minimum education and training requirements for CHWs who can document at least 960 hours of CHW experience in the past three years. It is important to note that even

2019 Assessment of the Integration and Financing of CHWs in Arizona Medicaid Health Plans when the certification program is in place, it will be voluntary and certification will not be required to practice as a CHW in the state. Interviews with health plans were conducted as the bill was moving through the legislature and just prior to the full passage of the bill.

#### **Benefits of HB2324 CHW Voluntary Certification:**

- A positive impact of CHW workforce development and recognition within their provider network
- Conveys legitimacy of the CHW workforce as a profession
- Establishes the foundation to standardize the CHW workforce
- Potential for AHCCCS to identify CHW serves as billable covered services
- Provides important statewide standardization for CHW training and data tracking
- Standardizes CHW core competencies and scope of practice

**Health Plan A** leaders noted that passage of such legislation would have a positive impact on CHW workforce development and recognition within their provider network.

*"We support it [HB2324] because if providers can have some assistance in hiring and having people come to them with core competencies and training and have this registry of voluntarily certified people we think that it will help with this workforce development."*

**Health Plan C** leaders explained that the passage of HB2324 would provide important statewide standardization in the CHW field, which would improve CHW training and data tracking. Leaders at **Health Plan B** stated that this bill would provide more structure for the CHW role and potentially allow AHCCCS to "expand its scope," moving CHW activities into the realm of billable covered services. Leaders suggested that if providers were able to bill for CHW functions outside of behavioral health services like Peer Support Workers are currently, it would give "additional opportunities for providers and others who have not been able to utilize CHWs." **Health Plan D** leaders described the importance of HB2324 in bolstering the legitimacy of the CHW workforce and approach, crucial for liability concerns. Additionally, they stated that this legislation is necessary for CHW advocates and its professional association, AzCHOW, to approach AHCCCS in their request for a billing code for CHWs.

*"I think it just provides another layer of legitimacy for this Public Health model that we know is effective and so it will be another way to expand workforce development and get community health workers hopefully out in the community earning a fair wage and able to spread effective health messaging. [...] I just think that now that we have the piece of legislation through to add legitimacy to this role in public health, it will be easier to go back to AHCCCS and ask for that billing code."*

**Health Plan F** leaders saw the benefit of HB2324 insofar as it provides core standardization around the prerequisites and competencies of CHWs, but they noted that they would also advocate for maintaining some flexibility in the field so that innovation is not curtailed. Leaders at **Health Plan E** explained that, while they do not currently employ CHWs, they may employ CHWs in the future and believe that standardized CHW training similar to what is required of Peer Support Workers would be very important.

*"I think the standardization and the training on the core competencies and you know scope of practice, it should be there for anything that someone is going to be trained on for their job. Whether its community health worker on the medical side or Peer Support, anything."*

#### **Impact of AHCCCS Complete Care (ACC) on Use of CHWs**

As previously noted, all of the interviewed health plans were recipients of the ACC contracts, effective October 1<sup>st</sup>, 2018 mandating the integration of physical and behavioral health services within these AHCCCS contracted health plans. Health plans expect that the ACC will fundamentally expand the need for CHWs and

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the core CHW roles, as plans expand their services and seek creative approaches to meeting membership medical and non-medical needs.

**Health Plan C** leaders explained that the ACC contract would likely result in more opportunities to hire CHWs, directly or through contracted outside companies, in order to provide more outreach to the expanded population of members in the new integrated model. **Health Plan F** leaders explained that the ACC will result in an expanded role for CHWs in the health plan as they integrate behavioral health benefits and engage with more members who are high need and difficult to reach. Leaders at **Health Plan B** predicted that the ACC would greatly expand the use of CHWs and have a significant impact on the health system as a whole.

*"... I really think in terms of just the shift, I think and maybe from my perception is that is for the health plan this will expand the usage of, it would just expand the usage of CHWs and how a member voice is greater incorporated into our delivery system."*

**Health Plan E** described the integrated healthcare approach will require the health plan to expand services that will require CHWs and additional Peer Support Workers. **Health Plan D** leaders described the positive impact the ACC will have on provider utilization of CHWs. Leaders from this plan predict that the seven-year term of the ACC contract will enable a secure environment for providers and health plans to explore innovative programming to improve care and address the social determinants of health.

*"I think the biggest impact of the ACC will be that it is a seven-year contract that will provide stability of contractors. That in turn, should promote a willingness to invest in and develop promising longer-term innovations such as developing CHW programs. The ACC also more specifically identifies care coordination as a goal of the program. I think successful contractors will see CHWs as a method and resource to improve coordination."*

## **Views on the Arizona Community Health Worker Association – Training Center**

The Arizona Community Health Workers' Association (AzCHOW) is a statewide professional organization that aims to provide a forum for CHWs and CHW advocates across the state to build "CHW capacity to address CHW workforce policy and sustainability issues that impact professional development and capacity to meet the needs of the communities served," as well as advocate in the political and policy spheres.<sup>5</sup>

The AzCHOW Training Center is a nationally recognized state-wide not for profit 501C3 that provides evidence-based core competency CHW and CHW specialty training and CHW supervisor and management training. Several health plans were not familiar with AzCHOW and its role as the statewide CHW workforce association or its training center but were interested in learning more and thought much could be gained with a partnership with AzCHOW. None of the plans currently have a formal relationship with AzCHOW.

**Health Plan C** leaders explained that while they are currently working with CHW training programs at several community colleges in the state, they would be interested in having a more direct relationship with AzCHOW. This partnership could include the health plan potentially contracting with AzCHOW to sponsor trainings for CHWs in their provider network. They also acknowledged that because AzCHOW is an established entity, organizations in the state look to it for determining a standard related to CHW training and supervision. Leaders at **Health Plan D** also discussed the importance of deferring to AzCHOW for CHW trainings because of their expertise in the area. Leaders of this plan described a possible relationship with AzCHOW in which the health plan could provide financial support for CHW trainings led by AzCHOW.

*"...when you're talking community health workers you're talking AzCHOW in the state. And so being that, I think it's very important community work that we work collectively with the community and understand that we aren't the specialists when it comes to community health workers so I would see us having an memorandum of understanding with AzCHOW, AzCHOW providing community health workers making sure community health workers have the required training"*

*certification, kind of you know they would be taking the lead on that where we would simply have an administrative relationship financially speaking."*

Leaders from **Health Plan E** explained that they could not speak for their health plan in terms of partnering with AzCHOW, but that they would recommend to the executive board that the health plan engage AzCHOW for future CHW training "since it's [training] evidence based, it's nationally recognized and everyone's getting the same information." **Health Plan F** leaders stated that because they do not fully understand the role of AzCHOW, they would need to have more information on how a relationship with the organization would be beneficial before pursuing a partnership. **Health Plan B** leaders did not discuss AzCHOW specifically, however leaders did comment on how similar CHW training centers in other markets around the country have provided an opportunity for training, engagement and recruitment of CHWs. Leaders also mentioned the value of providing practicum sites within the health plan for CHWs in training programs.

## Health Policy Implications & Recommendations

**AHCCCS Complete Care contracted health plan leaders are knowledgeable and highly value state and nationally accepted CHW core competencies. Such knowledge and commitment can contribute to further integration and scale of the CHW workforce within Arizona health plans.**

Leadership understand and prioritize the cultural, linguistic and lived experience characteristic of the CHW workforce and actively recruit, train and integrate CHWs into clinical and community-based teams to benefit health plan members. CHWs are considered to add value to members by conducting effective and culturally salient health plan member outreach. For many health plan leaders, such culturally informed outreach and education activities conducted in the home, over the phone and in the clinic have resulted in both anecdotal and empirical evidence of improved access to health care, use of prevention screenings, appropriate use of the health care system, including avoidance of emergency room and hospitalization among members. CHWs were considered essential to increasing access to primary care, self-management activities and behavioral health support for highly vulnerable health plan members.

**AHCCCS Arizona Complete Care provides a window of opportunity to integrate the CHW workforce in Arizona health plans.**

Health plan leadership expect that the ACC will fundamentally expand the need for CHWs and the core CHW competencies, roles and skills as plans expand their services and seek creative approaches to meeting membership medical and non-medical needs. ACC contracted health plans with experience in the delivery of behavioral health care through Peer Supports, a subset of the broader CHW workforce, set precedent for beneficial policy adoption in which ADHS and AHCCCS standardized Peer Support workforce scope of practice and training, and AHCCCS billable codes.

**The Arizona Legislature recently passed HB2324, which authorized the voluntary certification of community health workers creating opportunity for standardized training of the CHW workforce.**

The law, will establish a 9-person advisory council made up of at least 50% CHWs which will adopt CHW core competencies, training standards, continuing education requirements and other details related to CHW certification in the state. Arizona health plans saw the benefit of the HB2324 legislative efforts for voluntary certification, specifically in the opportunity to recruit and retain highly qualified CHW to meet member medical and non-medical needs.

### **Statewide strategies to support the CHW workforce:**

1. **Extend AHCCCS billing codes to reimburse for CHW services as in the case of Peer Supports.**

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2. **Monitor** CHW innovations emerging from (1) AHCCCS Complete Care (ACC) contracts and (2) CHW voluntary certification legislation.
3. **Promote** standardized CHW training among health plans and contracted provider networks.
4. **Share** CHW innovations in training, supervision, hiring, financing and integration within health care teams.

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