

Opportunities for Peer Support in the Affordable Care Act

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In March 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. This comprehensive health reform legislation aims to transform healthcare in the United States by increasing access to health insurance to previously uninsured Americans, improving the affordability of health insurance, reducing health disparities by focusing on vulnerable populations, increasing public health preparedness, expanding the healthcare workforce, improving the quality of healthcare delivery, and lowering healthcare expenditures. Of the nearly \$12.1 billion in ACA funding disbursed as of April 2012, \$8.1 billion (67%) has gone to private entities and \$4 billion (33%) has gone to state and local governments (Snyder, 2012).

How Does Peer Support Fit within the ACA?

Peer support services promote several key objectives of the ACA. Integrated into community-based care, peer support services have the potential to improve the quality of healthcare delivery, lower healthcare expenditures, and reduce health disparities. The community health worker (CHW) model has been shown to be effective in delivering peer support services in a variety of settings. The ACA formally recognizes the role of CHWs and offers several funding opportunities for CHW programs. This document outlines the specific ACA funding mechanisms for CHW programs, state models of CHW training and reimbursement, current challenges, and recommendations for grant seekers.

Community Health Workers have been around for over 60 years and have received increased recognition in the workforce within the past 10 years (Balzacar et al., 2011). In 2003, the Institute of Medicine recommended they serve as members of health care teams and the United States Department of Labor recommended an occupational classification for them in 2009 (Office of Management and Budget, 2008). CHWs differ from other health workers in that they offer a shared sense of experience and culture with members of their community, allowing them to serve as a liaison to the healthcare system and help patients navigate the health system (Nemcek & Sabatier, 2003).

CHWs have had a positive impact on a wide variety of health care issues including managing chronic diseases, improving birth outcomes, and maintaining child wellness (Balzacar et al. 2011). Across a variety of settings, CHWs provide credible, practical assistance in initiating and maintaining the daily behavioral patterns that are central to management of chronic disease. Such assistance is also a hallmark of care received in patient-centered medical homes (Fisher et al. 2012).

The increased recognition of CHWs in the workforce and evidence for their effectiveness has led to calls for more standardized training and certification programs. There is no current national standardized training curriculum for CHWs, but there have been several successful state level training and certifications programs developed in the past 10 years in Texas, Massachusetts and Minnesota (Rosenthal, 2010). Building off these successes and developing further state and federal programs will increase the positive impact CHWs can have on the healthcare system.

Definition of Community Health Workers in the Affordable Care Act (§5313)

An individual who promotes health or nutrition within the community in which the individual resides:

- A. By serving as a liaison between communities and health care agencies
- B. By providing guidance and social assistance to community residents
- C. By enhancing community residents' ability to effectively communicate with health care providers
- D. By providing culturally and linguistically appropriate health and nutrition education
- E. By advocating for individual and community health
- F. By providing referral and follow-up services or otherwise coordinating care
- G. By proactively identifying and enrolling eligible individuals in federal, state, and local private or nonprofit health and human services programs.

The full ACA document may be found at housedocs.house.gov/energycommerce/ppacacon.pdf. The following ACA provisions, with specific sections indicated by §, provide funding mechanisms for programs related to CHWs.

Reimbursable Routine Services

- ❖ **Chronic Health Homes (§2703):** Awards benefits for states to establish health homes to coordinate care for people with Medicaid who have chronic conditions. States receive a 90% enhanced Federal Medical Assistance Percentage for the first 8 quarters the program is effective.
- ❖ **Community Health Teams to Support the Patient Centered Medical Home (§3502):** States may apply for grants to establish health teams and provide health homes to support primary care practices. States may designate CHWs as qualified members of the health teams.
- ❖ **Patient Navigator Program (§3509):** Reauthorizes programs to provide PN services to assist patients overcome barriers to health services. Employing CHWs as patient navigators is heavily favored. In addition, state health insurance exchanges are required to establish PN programs.
- ❖ **National Diabetes Prevention Program (§10501):** Funds activities related to an innovative lifestyle coaching program conducted in a group setting through community organizations. FY2011 = \$10 million, FY2012 = \$10 million, FY2013 request = \$10 million.
- ❖ **Medicaid Incentives for the Prevention of Chronic Diseases (§4108):** Awards grants to states for programs that incentivize Medicaid beneficiary participation in tobacco cessation, weight control, and avoiding or managing diabetes. The purpose of these initiatives is to test approaches that encourage behavior modification and determine scalable solutions. 10 states have been selected to receive a total of \$85 million over 5 years.

Chronic Health Homes:

15 states have received federal approval for their State Plan Amendments (SPA). Find all of the approved SPAs www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html

A NYS Health Foundation Report advocates for the role of community health workers in health homes. nyshealthfoundation.org/resources-and-reports/resource/making-the-connection-the-role-of-community-health-workers-in-health-homes

Community Health Teams:

Discretionary funding dependent on annual budgetary process. Currently unappropriated.

Patient Navigator Program:

The Maryland Navigator Program Report provides options for the state health exchange legislation and includes a scan of legislation in other states.

[dhmh.maryland.gov/exchange/pdf/MHBE Navigator Report Final.pdf](http://dhmh.maryland.gov/exchange/pdf/MHBE_Navigator_Report_Final.pdf)

National Diabetes Prevention Program:

The CDC awarded \$6.7 million to six organizations, including the Diabetes Prevention and Control Alliance (DPCA), which will expand the National Diabetes Prevention Program in Colorado, Tennessee, and Washington.

www.cdc.gov/diabetes/prevention

Medicaid Incentives for the Prevention of Chronic Diseases Example:

The Hawaii *Patient Rewards and Incentive for Supporting Empowerment Project* (HI-PRAISE) received \$1.2 million in the first year to improve early detection and diabetes self-management. The program will pay CHCs and private providers \$150 per patient for diabetes education during clinical visits and for referrals to services (CMS, 2012).

www.innovations.cms.gov/initiatives/MIPCD

Capacity Building, Development, and Training

- ❖ **Grants to Promote the Community Health Workforce** (§5313): Authorizes a CDC grant program to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers to educate, guide, provide outreach, and connect patients to appropriate healthcare agencies and community-based programs to increase access to quality healthcare.
- ❖ **Community Health Center Fund** (§10503): This mandatory appropriation provides \$11 billion over 5 years for community health centers to establish new clinics, expand existing facilities, and build workforce capacity.
- ❖ **Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs** (§10408): Provides grants for up to five years to small employers (less than 100 employees) that establish new comprehensive wellness programs. \$200 million has been authorized for fiscal years 2011-2015. FY2011 = \$10 million, FY2012 = \$10 million, FY2013 request = \$4 million.

Research & Demonstration

- ❖ **Prevention and Public Health Fund** (§4002): This mandatory appropriation invests in prevention and public health programs to slow the rate of growth in health care costs. FY2010 = \$500 million, FY2011 = \$750 million, FY2012 = \$1 billion, FY2013 = \$1.25 billion, FY2014 = \$1.5 billion, and FY2015 and beyond = \$2 billion.
- ❖ **Community Transformation Grants** (§4201): Awards competitive grants for implementation, evaluation, and dissemination of evidence-based community preventive health activities. FY2011 = \$145 million, FY2012 = \$226 million, FY2013 request = \$146 million.
- ❖ **Medicare's Hospital Readmission Reduction Program** (§3025): Imposes penalties for hospitals that have the high rates of return patients. Nearly one in five Medicare patients returns to the hospital within a month of discharge, costing the government billions of dollars. Peer support may be a viable approach for reducing hospitalizations.
- ❖ **Community-Based Care Transitions Program** (§3026): Tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. \$500 million in funding is available for 2011 through 2015.

Community Health Workforce:

Discretionary funding dependent on annual budgetary process. Currently unappropriated.

Community Health Center Fund:

Learn more about grant awardees and get the latest news on the ACA and CHCs at:

www.hrsa.gov/about/news/2012tables/120620nap.html

Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs:

Discretionary funding dependent on annual budgetary process. Currently unappropriated.

Prevention and Public Health Fund:

2010 awards included a State Supplemental for Health Communities and Diabetes Prevention and Control, as well as a Prevention Center for a Healthy Weight.

www.hhs.gov/open/recordsandreports/prevention

Community Transformation Grant Example:

The YMCA was one of seven national organizations to receive CTG funding. 10 local YMCAs received grants of \$65,000 each to develop programs such as the YMCA Diabetes Prevention Program.

www.cdc.gov/communitytransformation

Medicare's Hospital Readmission Reduction Program:

The Centers for Medicare & Medicaid Services will reduce payments to Inpatient Prospective Payment System hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.

www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

Community-Based Care Transitions Program:

102 sites are participating in this program, which will run through 2016.

innovation.cms.gov/initiatives/CCTP

State Implementation of Chronic Health Homes

The ACA created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care for people with Medicaid who have chronic conditions such as mental health, substance abuse, asthma, diabetes, heart disease, and obesity. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

States have flexibility in targeting health home services geographically, determining eligible health home providers, and designing payment methodologies. A possible model for a health home provider uses a health team that includes medical specialists, social workers, behavioral health providers, and community health workers. Designated providers should utilize peer supporters and/or CHWs.

State proposals for Health Homes have met federal approval in Alabama, Idaho, Iowa, Maryland, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin.

Oregon's Patient-Centered Primary Care Homes

Oregon received approval for its health home state plan amendment in March 2012. Health home services are offered statewide, and target individuals with two chronic conditions, one chronic condition and a risk of developing another, or one serious mental illness. Oregon estimates that 118,000 of its Medicaid beneficiaries meet the eligibility criteria for health home services (Nardone & Paradise, 2012).

The key components of Oregon's health homes emphasize the following points: non-physician health care providers can be part of teams; patients will have care plan; patients will develop self-management and prevention goals; and referrals and access to non-health care community resources and social support services (Integrated Care Resource Center, 2012).

To fulfill the requirement for providing *Individual and Family Support*, the health homes will utilize peer support, support groups, and self-care programs based on preferences for education, recovery, and self-management.

Guidelines for Chronic Health Homes

Health Homes are for people with Medicaid who:

- ❖ Have 2 or more chronic conditions
- ❖ Have one chronic condition and are at risk for a second
- ❖ Have one serious and persistent mental health condition

Health Home Providers can be:

- ❖ A designated provider (physician, group practice, health clinic, CHC, other provider)
- ❖ A team of health professionals
- ❖ A health team (medical specialists, nurses, pharmacists, nutritionists, social workers, behavioral health providers)

Health Home Services must include:

- ❖ Comprehensive Care Management
- ❖ Care Coordination
- ❖ Health Promotion
- ❖ Comprehensive Transitional Care
- ❖ Individual and Family Support
- ❖ Referral to Community and Social Support

Health Home Financing

States receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for specific health home services that is good for the first eight quarters the program is effective. The FMAP doesn't apply to underlying Medicaid services also provided to people enrolled in a health home.

Key Trends and Challenges

A Kaiser Family Foundation Issue Paper (Nardone & Paradise, 2012) reviewed six federally approved health home proposals and identified the following trends:

- ❖ States have relied on the chronic conditions named in the ACA to define their target populations
- ❖ States have taken different approaches to designating entities that qualify as health home providers
- ❖ The standard payment methodology seems to be per-member-per-month (PMPM) payments to health home providers
- ❖ A key issue is the appropriate role for health homes; for example, how they will fit into or coordinate with managed care organizations
- ❖ States are balancing many health reform priorities and Medicaid agencies are under a lot of pressure

This initiative offers a tremendous opportunity for peer support. Recognizing the unique role and value of peer support, states such as Oregon and New York are integrating these services into their health home models. Peer supporters are able to satisfy 3 out of 6 key health home services: health promotion, individual and family support, and referral to community and social support. Across the country, momentum is building for chronic health homes so watch for new developments in your state.

Challenges

The June 2012 Supreme Court decision that upheld the majority of the ACA was a major victory for health reform but the legislation continues to face political resistance and economic constraints.

In some cases, authorized provisions require the approval of discretionary funds as needed each year through the congressional appropriations process. Unfortunately, recent budget constraints have prevented the full funding of the workforce and public health programming provisions included in the ACA (Morrissey, 2011). With the Budget Control Act of 2011, the President will order across-the-board spending cuts for all nonexempt direct and discretionary spending programs. The Office of Management and Budget estimates the requirements will reduce discretionary nondefense discretionary spending by 8.2% (Redhead et al. 2012).

CHW programs are not recognized as reimbursable providers under Medicaid statute. States may be reluctant to approach the Centers for Medicare & Medicaid Services to amend state plans to include billable peer support services because it could negatively affect other programs (Daniels et al. 2011). Alternative avenues for Medicaid funding may be available through Medicaid administrative funds, Medicaid Managed Care Organizations, and Section 1115 waivers (National Health Care for the Homeless Council, 2011).

Stable funding through Medicaid or state appropriations will require standard administration and certification. Currently, views are divided on the level of professional certification that is appropriate for CHWs. Excessive regulation and training requirements might make the profession less accessible to members of underserved communities whose skill set lies more with knowledge of the community than with advanced education. On the other hand, professional accreditation offers more accountability, standards for outcome measurement, and potential for development (National Health Care for the Homeless Council, 2011).

Recommendations

While community health workers are explicitly mentioned in only one ACA provision, there are many opportunities for ACA funding through competitive grant disbursements to state and local governments, and private nonprofit organizations.

Many funds are available only to state and local governments. In order to take advantage of these opportunities, peer support advocates should collaborate with state governments throughout the process of planning and implementing federal mandates. Joint development of CHW training and certification protocols will increase the likelihood of receiving Medicaid reimbursement through the state. The models provided by Minnesota and California provide guidance on the successful integration of peer support into state policy.

Local governments that have been awarded Community Transformation Grants may also have opportunities for peer support programming, particularly in the areas of heart disease, weight management, and diabetes.

Congress and HHS are strongly interested in implementation over research. Proposals should focus on scaling up evidence-based approaches. Strong evaluation measures are needed to help demonstrate the impact of peer support services on patient outcomes and cost effectiveness.

The ACA invests heavily in community health centers over the next five years and many federally qualified health centers have already received funding for operational and program expenses. Serving as community-based health homes, these are exceptional platforms for the delivery of peer support services.

Share with Our Network

Peers for Progress will continue to monitor new grant opportunities as they become available so please visit our website and Twitter feed for the latest ACA news.

www.peersforprogress.org
[@peers4progress](https://twitter.com/peers4progress)

To share ACA news and opportunities with Peers for Progress and our network, please email us at yptang@email.unc.edu.

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