Introduction
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 effective 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**

- **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.

**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.

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**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.

**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. CHCs and providers will provide incentives for 1) compliance with ADA-recommended strategies such as blood tests, eye exams and cholesterol tests, to prevent, treat, and manage diabetes and 2) for patients who go to the first session of smoking cessation, behavioral health counseling, and diabetes education. 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

**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
Capacity Building, Development, and Training continued...

- **Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training** (§5307): Authorizes grants, contracts or cooperative agreements for research, demonstration projects, and model curricula focused on providing training in the following areas: cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities.

- **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.


- **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.
State Initiatives on CHWs

With federal initiatives for CHWs underway, states have been evaluating policy initiatives to formalize the role of CHWs and integrate them into state health plans. Peer support advocates may find new opportunities in the states listed below. These states can also serve as models for others (Rush, 2012).

State policy initiatives have been established in Massachusetts, Minnesota, Florida, and Indiana.

New state initiatives are underway in California, Illinois, Mississippi, New Mexico, New York, Ohio, Rhode Island, and Texas.

Healthcare reform bills that include CHWs have been passed in Pennsylvania, Oregon, and Rhode Island.

Minnesota

*A State Model for Medicaid Reimbursable CHWs*

Minnesota is one of the few states that provide Medicaid fee-for-service reimbursement for CHWs. Minnesota first established a standardized CHW curriculum and certification program in 2003 through a partnership between the State and the Blue Cross and Blue Shield Foundation of Minnesota – a partnership that continued with a study on sustainable financing of CHWs.

In 2007, Minnesota obtained an 1115 Medicaid Waiver to allow state-certified CHWs to receive fee-for-service reimbursement under the state Medicaid plan. Minnesota Health Care Program beneficiaries can receive patient education and care coordination services from CHWs who have been accredited and are under the supervision of a physician, advanced-practice nurse, dentist, or public health nurse (National Health Care for the Homeless Council, 2011).

Oregon

*I incorporating CHWs in Health Care Reform Legislation*

Oregon’s reform bill HB 3650 was passed and signed in July 2011. It creates Coordinated Care Organizations under Medicaid that must provide assistance from CHWs in patient navigation of the healthcare system and linkage to community and social support services (Rush, 2012).

Oregon enacted legislation that identified three classes of healthcare workers as part of the care team for people on the Oregon Health Plan – community health workers, peer wellness specialists, and personal health navigators – then gained approval from the Centers for Medicare and Medicaid Services to set up a payment category. The Oregon Health Authority is responsible for establishing training and certification programs for these worker classes (Rubin, 2012).

California

*Developing a Statewide Plan*

California has developed an Action Plan for CHWs to address the need for expanded training opportunities, including development of standards, ultimately leading to credentialing in conjunction with community colleges.

To prepare for ACA funding opportunities, the state of California Health and Human Services Agency has created the CA Workforce Development Council to develop formal training curricula to improve and ensure the competency of CHWs (California Workforce Investment Board, 2012).

Resources for State Health Reform

Kaiser Family Foundation Health Reform Source healthreform.kff.org

The Commonwealth Fund: Health Policy Reform www.commonwealthfund.org

National Academy for State Health Policy www.nashp.org

Center for Medicare & Medicaid Innovation innovations.cms.gov
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.

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).
References


