

Sustainable Financing for Peer Support Within Reach

Funding Models for Community Health Worker Programs

Despite increasing evidence for the contributions of community health worker (CHW) programs to achieving the Triple Aims – improving the experience of care, improving population health, and reducing per capita healthcare costs – uptake has been hampered by limited and inconsistent funding. In a national survey of CHW programs, the most often cited challenge was the capability to obtain reliable and permanent funding for services.

Programs nationwide are heavily dependent on temporary and/or condition-specific grants and contracts, leading to instability of services and job insecurity. Without dependable sources of funding, CHW programs will remain on the periphery of the American health care system as a popular idea that couldn't get off the ground.

In recent years, shifts in the health care landscape toward patient-centeredness, cultural competency, long term chronic disease management, and team-based medicine all point to CHWs as part of the solution. Health care leaders and policymakers at the state and federal levels have taken notice and are pushing for sustainable financing of CHW programs. In this spotlight, we will take a look at these financing models and some trends to watch for in the future.

WHERE DOES THE FUNDING COME FROM?

CHW programs are funded from variety of sources, both private and public. Nationally, federal and state grants are the primary financing sources, accounting for more than 50 percent of total funding. A state survey on CHW employment and training in 2002 found that four out of five CHW programs in Minnesota made use of government grants to pay for CHW positions. In addition to public and private grants, some CHW programs are funded through business profits and/or fund raising. A large proportion of the received funding is used to pay salaries for CHWs.

Most of these financing streams are short term, with funding periods of three years or less. For example, only half of CHW programs in San Francisco, California, were reported to receive funding from ongoing sources, while the rest relied on short-term grants or fundraising.

Because dependence on short-term financing is common, CHW programs often have to rely on multiple funding sources. A national survey by the Health Resources and Services Administration (HRSA) found that two thirds of CHW programs use more than one financing source from both public and private funders for their operations. The

usage of multiple funding sources is more common in states that have strong CHW programs, such as Minnesota, California and Texas.

HOW ARE CHW PROGRAMS FINANCED?

Currently, grants and contracts from charitable foundations or government agencies are the most prevalent and well-known funding sources for CHW programs. However, this funding model can be limited by requirements and restrictions to focus on specific populations or health issues. Most grants and contracts run three years or less which may disrupt program focus, program continuity, and job security, even though there may be possibilities for renewal. Therefore, it is critical for CHW programs to identify alternate sources of support that can ensure permanent funding and enable them to achieve their goals.

A study by the National Fund for Medical Education suggested three financing models that may potentially secure financial sustainability for CHW programs. They include: 1) public or private insurance, 2) government general funds, and 3) private sector organizations. Each financing model has a separate funding mechanism (Figure 1).

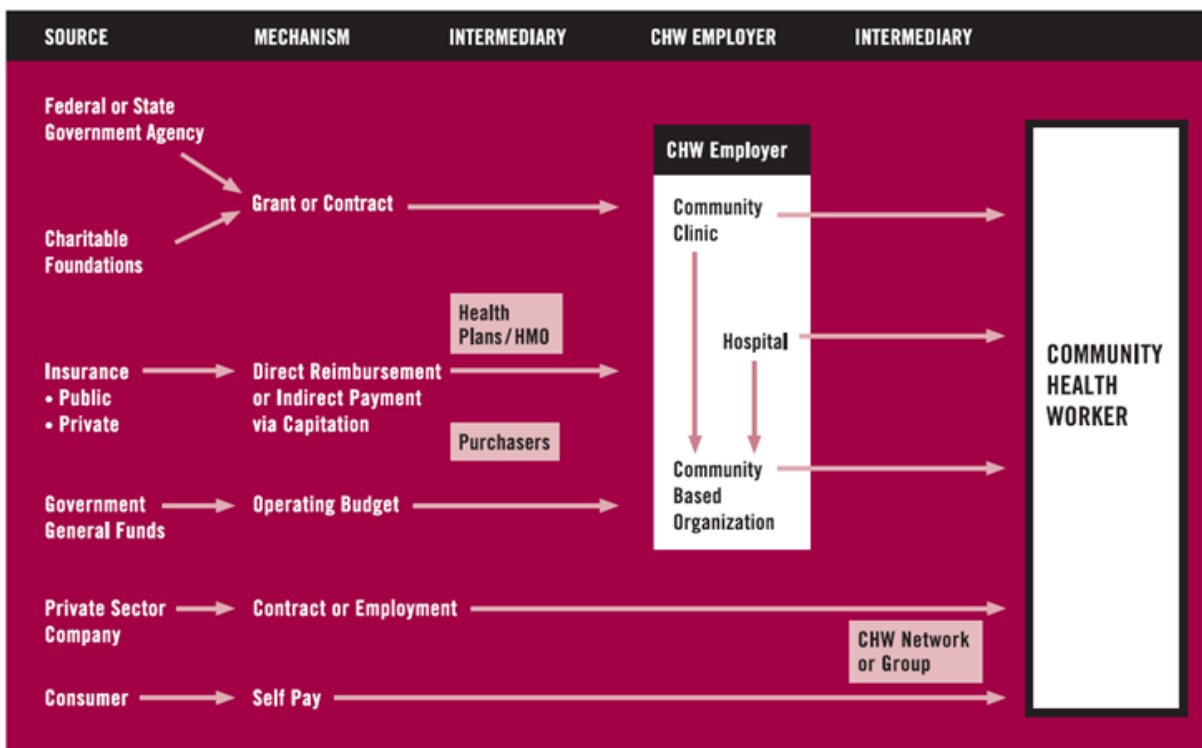


Figure 1: Flow chart of financing streams for CHW programs

Source: National Fund for Medical Education, 2006

Public or private insurance

In this model, payments can be made to CHWs by public or private insurance in the form of either direct reimbursement or indirect payment via capitation. Payment to CHWs may be part of a health care service that is contracted between the insurer and a clinic, or a Medicaid program reimbursement via capitation arrangement.

Recent changes in reimbursement regulations for CHWs who provide preventive services, as well as the expansion of Medicaid eligibility as part of the Affordable Care Act (ACA), have opened a window of opportunity for CHW programs to secure sustainable financing.

The Medicaid financing model is organized into four categories: 1) Medicaid Administrative Funds reimburse clinics or community-based organization (CBOs) that

offer CHW services for administrative services, such as staffing, cost control activities, improvement of information technology, interpretation services, and outreach and coordination activities; 2) Medicaid Managed Care permits a managed care organization which may either directly employ or contract CHWs via other CBOs to receive a capitated amount from the state for the number of Medicaid beneficiaries it covers; 3) Medicaid Section 1115 Waiver allows clinics or CBOs which provide CHW services to receive Medicaid reimbursement for their CHW services; and 4) Direct Reimbursement allows a state Medicaid office to identify CHW programs as billable providers and reimburse the programs directly for their CHW services.

Despite the advantage of reliable funding, however, the Medicaid funding model also carries

challenges for CHW program managers. Since few Medicaid funding models exist, the adoption, modification, and establishment of new Medicaid models can be very time-consuming. Also, reporting requirements for Medicaid programs can be burdensome due to requirements for cost data, progress reports, and certification for CHWs.

Examples of organizations that have successfully implemented the Medicaid funding model are:

- Health Plus, *New York City*
- Coordinated Systems of Care Community Access Program, *New Mexico*
- Family PACT Program, *California*
- Ingham County Health Department, *Michigan*
- Alaska Community Health Aide Program, *Alaska*

Government general funds

This strategy allows federal, state, city, or county governments to pay CHWs for their services directly or through CBOs, county hospitals, or health departments. Payments usually come from federal, state or local government general funds, ultimately from tax dollars. Unlike government agency grants or contracts, arrangements of this payment model do not have an intermediary, as in grant or insurance programs. Government budgets pay for CHW salaries, services, or programs directly.

Similar to the Medicaid model, a government general funds model can provide a stable source of funding. However, establishing this model is also very time-consuming and is likely to encounter a variety of political opposition. Furthermore, it often mandates data collection for quality improvement purposes.

Examples of CHW programs that have used government general funds are:

- Fort Worth Department of Public Health, Outreach Division, *Texas*
- Kentucky Homeplace, *Kentucky*
- San Francisco's Department of Public Health, *California*
- Hennepin County, *Minnesota*

Private sector organizations

In this model, payers are non-governmental organizations, including hospitals, managed care organizations, insurance companies, employers, or other healthcare-related businesses. These entities may contract directly with CHWs or through clinics or CBOs for their services. In this model, the funds come out

of the general operating budget, which means that stability is linked to the success of the private sector organization.

CHW programs supported by organizational operating budgets include:

- Christus Spohn Health System, Corpus Christi, *Texas*
- APS Healthcare Inc., *Maryland*
- Blue Ridge AHEC, *Virginia*

MOVING FORWARD

The importance of sustainable financing for CHW programs cannot be overstated. With the support of the Affordable Care Act, the increasing number of public and private-sector entities supporting CHW initiatives, the push for payment reform, and the growth of CHW advocacy across the country, sustainable financing seems to be within reach.

One of the first steps on the path to sustainability is to improve policies on CHW reimbursement, developing templates and formulas that reflect the fair payment of CHW services. Compensation for CHWs has not kept up with the value they bring to their clients and communities partly because the way benefits are measured (short-term clinical outcomes and cost savings) isn't always favorable to the work that CHWs do. Advocacy efforts should focus on expanding the range of reimbursable services to include ones that CHWs commonly provide and redefining the way in which CHW programs are measured and evaluated.

On the horizon, bundled payment and pay-for-performance models are expected to herald new opportunities for CHW financing.

In the meantime, one approach that experts recommend is to position CHW programs as a standard feature of care delivery and system innovations, which will channel financing to the programs through federal and state funding for those innovations.

Regardless of whether new financing mechanisms can reliably fund CHW programs, it's a safe bet to secure funding from multiple sources, including public and private sectors grants, revenues from CHW activities, and reimbursements for services.

READ MORE

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