Nebraska Community Health Workers: Financing and Sustainability Models

Report of a Cross-Sector Workgroup, September 2019 to April 2020

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Executive Summary

Community Health Workers (CHWs) play an integral role in improving the health of communities. They are the vital link between health care and communities. Their role in assisting individuals, groups and communities to address chronic diseases, social determinants of health and health equity is invaluable.

Nebraska, like many states, recognizes the value of the CHW workforce and its impact on the health of individuals, groups and communities. Many states have identified how to measure the impact of CHWs on the health of communities through Return on Investment (ROI) and/or cost-savings studies. Many states have also developed and are implementing extensive training programs, with and without certification credentials, for their CHW workforce. Despite these efforts, states, health systems, and community organizations continue to be challenged with how to create and implement a sustained reimbursement infrastructure for a CHW workforce, relative to their time, expertise, and role within the health care team.

The primary objective of this study was to convene a cross-sector workgroup to undertake a study on behalf of Nebraska Department of Health and Human Services (NDHHS) Division of Public Health to analyze financing and sustainability business models for the CHW workforce and to make recommendations on promising practices and future action steps.

Douglas County Health Department (DCHD) was the lead for this project. Participants were contacted with an invitation to join this short-term workgroup and came from a cross-sector of individuals and organizations across Nebraska. Sectors represented included local public health, health systems (including Federally Qualified Health Centers), faith-based organizations, community based organizations, home health, academia, insurance payers (private and Medicaid Managed Care Organizations), NDHHS, and CHWs from a variety of workplace settings.

Research was conducted to identify current CHW financing/sustainability models that were being used by other state and local partners across the United States. As models were identified, information identified as pros and cons were added to assist in an additional layer of information as these models were being used and tested by other state/local partners.

DCHD also met with each Managed Care Organization (MCO) partner under the Nebraska Heritage Health plans to learn more about how they are using CHWs in their work and to determine their mechanism for payment specific to their CHW workforce. Contacts were made with Nebraska Total Care and WellCare of Nebraska an Anthem Company. DCHD was not able to connect with United Health care despite multiple attempts. DCHD also connected with BlueCross/Blue Shield of Nebraska (BC/BS). Nebraska TotalCare was the only MCO that has hired and is paying for their CHW workforce through their administrative funds. WellCare is working toward this capacity and BC/BS is waiting to see how Medicaid Expansion will look for Nebraska before launching into this arena.

Starting in September 2019 through March of 2020, two virtual meetings were held with the workgroup in addition to routine email communications. Based on a specific request from the CHW Financing/Sustainability workgroup to learn more about a State Plan Amendment (SPA), an informative meeting was held with NE DHHS Division of Medicaid/Long-Term (Dr. Carisa Schweitzer-Masek) and Division of Behavioral Health (Linda Wittmuss) on January 27, 2020. This meeting helped participants to better understand that, as any funding/sustainability model is identified the following considerations will need to be addressed (similar to the process used when the NDHHS Division of Behavioral Health established an SPA for Peer Support Specialist):

- Identify a niche in the service delivery realm that CHWs can fill regardless of specific populations being served;
- Develop the service definition for CHWs;
- Connect the CHW service definition to CHW core competencies;
- Develop and implement CHW training aligned with adopted core competencies;
- Identify accountability for the CHW workforce (supervision of CHW workforce);
- Develop and implement a "certification" process for Nebraska CHWs; and
- Establish metrics for evaluation, effectiveness, and value of the CHW workforce on improving the health of the community.

In April of 2020 a survey monkey tool was sent to all the workgroup members to identify CHW finance/sustainability recommendations, to be shared with NDHHS, based on the work conducted over the last seven months. Workgroup members (36 responses) prioritized the following CHW financing/sustainability options:

- 24 (66.67%) of respondents would recommend the encouragement of health systems, who are hiring CHWs, to identify cost savings and/or positive health outcomes (i.e. ROI data reports);
- 22 (61.11%) of respondents would recommend the development of a statewide workgroup to begin to explore, identify, and develop the requirements (as outlined in the bullets above) needed for any payer for the CHW workforce;
- 17 (47.22%) would recommend moving forward with a SPA/1115 Waiver for Nebraska;
- 13 (36.11% would recommend exploring working with NDHHS Division of Medicaid/Long- Term Care and Heritage Health to build in a requirement of one full-time equivalent CHW per number of covered lives (number to be determined); and
- 7 (19.44%) would recommend waiting to see how Medicaid Expansion rolls out in Nebraska before determining next steps for the CHW workforce.

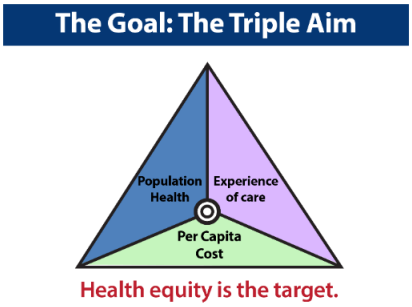
Based on the plethora of research conducted by DCHD, rich feedback gained from the highly engaged CHW Financing/Sustainability cross-sector workgroup, and the insightful feedback from Dr. Carisa Schweitzer-Masek, it is the workgroup's conclusion to recommend NDHHS Division of Public Health consider the first two bullet points above (as voted on by the workgroup members) as next steps in fulfilling the vision of establishing a long-term financial/sustainable model for the CHW workforce for the State of Nebraska.

Introduction

Community Health Workers (CHWs) have been an integral part of American society since the early 1970s and have gained national recognition since the early 2000s. Community Health Workers are identified under many job titles but the role of the CHW is defined by American Public Health Association (2009) definition: "A community health worker is 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 worker 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.
A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support and advocacy https://www.apha.org/apha-communities/member-sections/community-health-workers/.

Current research

There is strong research that identifies the critical role of the CHW in impacting the Triple Aim. The Triple Aim is a focused approach for health systems and communities working to: 1) reduce healthcare costs, 2) improve health outcomes and 3) improve quality of care, all while working to reduce health disparities and address health equity http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx.



https://www.astho.org/Programs/Clinical-to-Community-Connections/Documents/CHW-Evidence-of-Effectiveness/

Over the course of the last ten years there have been many states conducting research to measure the impact of the CHW workforce on the health of their communities.

According to Christiansen (2017), research from Nevada indicates costs savings with drug prescriptions for a variety of health diagnosis such as diabetes, cardiovascular disease, chronic renal failure and Chronic Obstructive Pulmonary Disease (COPD). http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/CHW/dta/Publications/CHW%20ROI%20Report%209-26-17.pdf.

Diaz (2012) reports research from Minnesota that captures Social Return on Investment as it relates to cancer research. The Wilder Research Center's 2012 cost-benefit analysis of CHW services in cancer research outreach found that for every dollar invested in CHWs, society received $2.30 in return in benefits, a return of more than 200%. https://www.wilder.org/sites/default/files/imports/ACS_ROI_in_CHWs-6-12.pdf.

Penn Medicine News reports (Kangovi, 2020) that the Penn Center for Community Health Workers, a leading academic medical center that has been integrating CHWs into their medical teams for a number of years, reports its CHW program yields $2.47 for every $1 invested annually by Medicaid. Individuals in this research study, who received support from a CHW, had at least two chronic medical conditions and were insured by Medicaid or were uninsured. https://www.pennmedicine.org/news/news-releases/2020/february/penns-community-health-worker-program-yields-247-for-every-1-invested-annually-by-medicaid

Research from UMass in Connecticut (London et al, June 2017) developed four models of care by CHWs for which they determined the role of a CHW would likely provide cost savings while improving health outcomes. One model focused on diabetes in the Latino population. The second model involved connecting individuals with complex health needs to health care services. The third model focused on children diagnosed with asthma and the fourth model focus was on individual cardiovascular disease and preventing further complications. All four studies were based on models in other states and each provided projected intervention costs in addition to project outcomes including savings to direct medical costs and a Return on Investment amount. https://www.cthealth.org/wp- content/uploads/2017/06/CHF-CHW-Report-June-2017.pdf

A research report from the Michigan Community Health Worker Alliance indicates multiple population outcomes, in addition to cost savings from multiple states. Dates of these studies range from 2008 to 2013 with a wide range of focus areas: asthma management, cancer, diabetes, heart disease, HVI and Mental Health/Depression. CHW programming reduced ED visits, hospitalization and missed days of work and/or school specific to asthma and diabetes. http://www.michwa.org/wp-content/uploads/MiCHWA_CHW-ROI.pdf

While data has begun to measure the impact of CHWs on the health of communities, one significant challenge has been for states, including Nebraska, to identify, develop and implement, for long-term sustainability, a robust finance model to support this workforce for the long-term.

The primary objective of this project was to explore potential finance/sustainability models that may work for Nebraska and to provide recommendations to the Nebraska Department of Health and Human Services in identifying, developing, and implementing a finance/sustainability model for the CHW workforce for Nebraska.

Methods

Prior to meeting with invited participants from across Nebraska, research was conducted to identify current financing models and the states currently implementing each funding model, allowing a case study approach (see Appendix A for this framework).

Additional research focused on specific options for consideration for financing and sustainability of the CHW workforce, plus identifying pros and cons of each model (see Appendix B for this framework).

Below is a list of the fourteen funding models for the CHW workforce identified across the United States and considered by the CHW Financing and Sustainability workgroup.

Funding Models for Community Health Workers

Fee-for-Service: is a traditional payment and delivery system whereby the payer (Medicare, Medicaid, BCBS, Aetna, etc.) pays each provider a fee for each service. Health care providers (based on how they are defined) receive a separate fee (as determined by the Payer) for each service they deliver (London, 2017).
https://commed.umassmed.edu/sites/default/files/publications/UMass%20MACHWA%20alternative%20payments%205-11-17.pptx_.pdf

Pay for Performance: is defined as providers receiving bonus payments for meeting specific quality improvement goals or targets. For example, a provider might receive a bonus for increasing by 10% the share of patients with diabetes who have good glycemic control (HbA1c < 7%) or ensuring 95% of patients with asthma have an Asthma Action Plan. Within this payment structure Healthcare Providers (through the receipt of bonus payments) can invest in services that help achieve these outcomes (London, 2017).
https://commed.umassmed.edu/sites/default/files/publications/UMass%20MACHWA%20alternative%20payments%205-11-17.pptx_.pdf

Bundled Payments/Episode-based payment model: here a single payment to cover the cost of services to treat one episode of care (i.e., a knee replacement surgery, or a year's worth of asthma care) is delivered by multiple providers. The Provider has flexibility to spend payments on CHW and other services. The challenge is that episodic care does not have clear boundaries (like a knee replacement) and there is no consideration for complications or managing deviations in patient outcomes. It is also difficult to figure out what costs/services to include in the bundle. Many of those who have attempted to develop and implement this model have found it very difficult to administer and implement (London, 2017).

https://commed.umassmed.edu/sites/default/files/publications/UMass%20MACHWA%20alternative%20payments%205-11-17.pptx_.pdf

Global Payments: offer a fixed-dollar payment ("capitation") for all the care that a group of patients receive in a given time period, such as a month or year. Providers are at financial risk for both the occurrence of medical conditions (whether people get sick) as well as the management of those conditions (providing services). Because of the large financial risk, global payments are usually paid to a large organization like an Accountable Care Organization (ACO). One positive aspect about this funding model is the flexibility to provide services that best meet patients' needs (London, 2017).
Source: Adapted from "Payment Reform: Bundled Episodes vs. Global Payments: A debate between Francois de Brantes and Robert Berenson." Timely Analysis of Immediate Health Policy Issues, September 2012.
https://commed.umassmed.edu/sites/default/files/publications/UMass%20MACHWA%20alternative%20payments%205-11-17.pptx_.pdf

Statewide Assessment (one State example): Vermont assesses health insurers a fee of $17,500 per every 1,000 patients to support Community Health Teams (CHTs) across the state. The CHTs include CHWs and other health professionals and are responsible for outreach, care coordination, and connecting residents to needed services. Vermont's CHTs have been successful in reducing hospital and emergency department utilization, while improving health and health care (London, et al, 2016).
https://commed.umassmed.edu/sites/default/files/publications/Sustainable%20Financing%20ME%20CHWs%20-%20UMass%20Report%20Nov%202016%20Final.pdf

Tax Assessments: assessments can be added onto existing health plans or local property taxes, such as has been done in Bernalillo County, New Mexico, that allow regions to employ community health workers (Lapedis et al. 2018)
https://poverty.umich.edu/10/files/2018/03/chrt-lapedis.pdf

Medicaid (State Plan Amendment): In 2013, the Centers for Medicare and Medicaid Services (CMS) changed a rule about who could be reimbursed through Medicaid for delivering preventive services. Previously, preventive services had to be provided by a physician or other licensed practitioner. Now, other non-licensed practitioners, such as a CHW, can provide and be reimbursed for preventive services, as long as those services are recommended by a physician or other licensed practitioners. This is similar to needing a prescription from a doctor, except instead of medicine, this "prescription" is to receive a specific service from a CHW.

These services must involve direct patient care and must directly address the physical or mental health of the patient. The services vary but can include preventive health counseling or investigating the source of a child's elevated lead levels, for example. In order to take advantage of this change in reimbursement, states must submit a state plan amendment (SPA) to CMS that describes what education, training, or credentialing the state would require of CHWs, though at this time CMS has not put forth any specific requirements. The SPA must also

define which preventive services CHWs will provide and how they will be reimbursed (Albritton, 2016).
https://familiesusa.org/wpcontent/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf

Defined Reimbursement through Section 1115 Waivers: States use this type of waiver to test different benefit designs or new models for delivering care, and some states have used these waivers to pay for using CHWs in models that focus on specific Medicaid populations. Though these waivers must be approved by CMS, states still have a significant amount of flexibility in what they can do. For example, California uses CHWs in its waiver to expand the use of family planning services. Massachusetts uses CHWs in a waiver for individuals who are eligible for both Medicare and Medicaid (known as "dual eligibles") and in a waiver to help children on Medicaid with asthma (Albritton, 2016).
https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf

Delivery System Reform Incentive Program (DSRIP) Waivers (under an 1115 Waiver): According to the National Academy for State Health Policy (Kartika, 2017), 12 states have implemented Delivery System Reform Incentive Payment (DSRIP) programs that "restructure Medicaid funding into a pay-for-performance arrangement in which providers earn incentive payments outside of capitation rates for meeting certain metrics or milestones based on state-specific needs and goals." New York's and Washington's DSRIP programs in particular include projects that incentivize participating provider entities to provide CHW home visits to their members. In New York, "8 out of 25 participating Performing Provider Systems (PPSs) have implemented a project that expands asthma home-based self-management programs and includes home environment assessment, remediation, and education." Similarly, Washington's Accountable Communities of Health (ACHs) can choose to implement a DSRIP project on chronic disease prevention and control and pay CHWs to conduct home visits for asthma services using DSRIP funding (Kartika, 2017). https://nashp.org/wp-content/uploads/2017/11/CHW-Home-Improvement1.pdf

Medicaid Administrative Funds: According to a 2011 Policy Brief provided by the National Health Care for the Homeless Council "the Medicaid program not only provides funding for services but also for administrative services needed for "the proper and efficient administration of the state plan." The Secretary of Health and Human Services (HHS) ultimately defines what is considered an eligible administrative claim under a state plan but outreach, eligibility determination, coordination and translation services have all previously been approved. Public Health Departments and community groups throughout the country use administrative funds for CHW programs providing outreach and enrollment services to eligible but unenrolled populations. To the extent that CHW programs focus on administrative services identified under the state plan, they can be reimbursed by Medicaid as administrative cost."
https://nhchc.org/wp-content/uploads/2019/08/CHW-Policy-Brief.pdf

Medicaid Expansion: The same 2011 policy brief by the National Health Care for the Homeless Council states that "Medicaid eligibility will expand to include all individuals with income at or below 133% of the Federal Poverty Level, which will include most individuals experiencing homelessness. While CHW programs are not recognized as reimbursable providers other avenues, under Medicaid (1115 Waivers, SPA, Medicaid Administrative funds, etc.), may be options that States can explore for CHW funding."
https://nhchc.org/wp-content/uploads/2019/08/CHW-Policy-Brief.pdf

Per-member, per-month payments: Per Lapedis (2018) "Per-member, per-month payments to primary care practices and Medicaid managed care organizations that employ community health workers for care navigation and education support" may be a mechanism for CHW financing and sustainability.
https://poverty.umich.edu/10/files/2018/03/chrt-lapedis.pdf

Health Care Providers: According to London et al (2016): "Health care providers, especially networks of hospitals and affiliated clinics, can work together to identify patients who could benefit from a CHW intervention, especially patients who have poorly controlled chronic conditions and face barriers to accessing health care and social supports. These health care providers could implement a CHW intervention focused on their patients' needs, and seek funding through alternative payment arrangements with health plans." Health care providers could then hire CHW directly or contract with a community-based organization to provide the CHW intervention to their patients.
https://commed.umassmed.edu/sites/default/files/publications/Sustainable%20Financing%20ME%20CHWs%20-%20UMass%20Report%20Nov%202016%20Final.pdf

Grants/Private Funders: According to the National Health Care for the Homeless Council (2011), this model continues to be the most common form of compensation arrangement in the U.S. for the CHW workforce. Under this model, government and charitable funds are allocated to CHW employers (e.g., community-based organizations, health systems, and community clinics) to pay CHW salaries or administer CHW programs. "The primary advantage of these funding sources is their relative availability, with most CHW programs beginning with one grant and patching together additional grant opportunities over time. However, there are numerous disadvantages. Both the CHW positions and the relationships built with patients can be disrupted when short-term grants end. While other funding sources might be available, these often have different requirements and goals than the previous grant, which can cause service fragmentation. Frequent applications and progress reports can burden administrative staff. Lastly, a subsequent funder may choose a new target population or health condition that the community may not identify as a priority need. Despite these drawbacks, private or public grants are still immensely important to CHW programs." https://nhchc.org/wp-content/uploads/2019/08/CHW-Policy-Brief.pdf

The National Academy for State Health Policy (NASHP) provides a current snap shot of the various approaches, by state, as to how the CHW workforce is being funded:

https://nashp.org/state-community-health-worker-models/. In addition to identifying how states are currently financing CHW, NASHP also provides the status of education for CHWs, certification, state CHW Legislation, statewide CHW organizations, and CHW roles descriptions within the state.

For the purposes of this project any state that was not currently doing any type of reimbursement or funding for CHWs was removed from the list of consideration (Alabama, Hawaii, Iowa, Illinois, Indiana, North Carolina, Ohio, South Dakota and Virginia) as this workgroup began to explore potential funding models.

Additionally, any state currently funding CHWs solely through grants, foundations or private partners was excluded since these funding sources are not recognized as long-term and/or sustainable (Arkansas, California, Connecticut, Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, Montana, Nebraska, New Hampshire, Nevada and Utah).

**Disclaimer: the Community Health Worker landscape is constantly changing and documents shared via this report reflect the time frame of the documents discovered and used during the discussions with workgroup partners (August 2019 through April 2020).

Additional research conducted prior to meetings with the workgroup participants involved learning about each of the above financing/sustainability options and identifying known or potential pros/cons of each in order to support workgroup analysis. See Appendices A and B for synopses of both state programs and financing models identified.

Participants

It was the intent of this project to identify, engage and involve many community partners and stakeholders across Nebraska. Invitations were sent to the following sectors and unique partners:

Local Public Health	Local Public Health Departments Health Directors Nebraska Association of Local Health Departments (NALHD)
Federally Qualified Health Centers	Health Center Association of Nebraska (HCAN)
Health Systems	CHI Health, Methodist Health System, Nebraska Medicine, Boys Town National Research Hospital, Children's Hospital and Medical Center, Bryan Health, Nebraska Hospital Association
Nebraska Department of Health and Human Services	Division of Public Health Division of Behavioral Health Division of Medicaid and Long Term Care
Academia	Creighton University, University of Nebraska Medical Center College of Public Health, Metropolitan Community College
Community Health Workers	Douglas County CHW Support Group Public Health Association of Nebraska CHW Section
Insurers	Heritage Health Managed Care Organizations (WellCare, United Healthcare and Nebraska Total Care) Blue Cross/Blue Shield
Community Based Organizations	
Faith-based Organizations	

Approach

This project was led by staff from the Douglas County Health Department (DCHD). Prospective participants were introduced to the project initially through an email sent on August 20, 2019. The email invited participants to join in meetings over the next several months to learn about potential financing and sustainability models for CHWs, explore options that may fit for Nebraska, and ultimately provide recommendations to the Nebraska Department of Health and Human Services (NDHHS) for next steps in growing sustainability for the CHW workforce in Nebraska.

The first meeting was held via go-to-meeting on September 17, 2019 (see Appendix C for meeting agenda/minutes). Action items from this first meeting were to further explore the State Plan Amendment for Oregon (SPA) (outcomes measures/health impact); connect with Nebraska Managed Care Organizations (Nebraska Total Care, WellCare and United Health Care) and conduct an environmental scan specific to their CHW workforces; connect with private payers (i.e., BlueCross/BlueShield, etc.) to conduct a similar environmental scan; and to connect with NDHHS and public health staff on any Return on Investment Studies with CHWs as may have been conducted in the course of a grant from Centers for Disease Control and Prevention (commonly referred to as a 1422 grant) entitled, "State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke" during the period October 2014 through September 2018.

The anticipated October 17, 2019 meeting with the CHW Finance/Sustainability workgroup was cancelled while DCHD engaged in the follow-up action steps from the September 17 meeting.

The second meeting with the CHW Financing/Sustainability workgroup was held November 7, 2019, again via go-to-meeting (see Appendix D for meeting agenda/minutes). Based on action items from the September 17, 2019 meeting, and upon discovery that Oregon no longer has an active SPA for CHWs in place, DCHD was asked to find out why the Oregon SPA is no longer in place. Additional action items from this meeting, as centered on multiple questions from the workgroup on components and requirements of a State Plan Amendment, included further exploration about what would be involved in a Statement Plan Amendment if Nebraska were to consider this as a potential finance/sustainability option for the CHW workforce.

During the time frame of November-December 2019, DCHD reached out BlueCross/BlueShield and all three Managed Care Organizations (MCOs) in Nebraska to schedule a time to meet with each for a CHW environmental scan. DCHD conducted preparation activities for these meetings in January of 2020.

DCHD staff met with BCBS on January 6, 2020, Nebraska Total Care on January 10, 2020 and on January 23, 2020 with WellCare of Nebraska an Anthem Company. There was no connection with United Healthcare despite numerous attempts by DCHD. DCHD asked each of these entities about their work with CHWs, their current funding structure for the CHW workforce, and how they saw those efforts expanding over the next several years. Appendix E

summarizes and overview of the information obtained from these interviews.

DCHD staff also contacted Dr. Carisa Schweitzer-Masek (Deputy Director, Population Health for the NDHHS Division of Medicaid/Long-Term Care) regarding the process for a SPA for Nebraska. Dr. Schweitzer-Masek suggested a meeting with staff from her team, staff from Division of Behavioral Health, and anyone else who may be interested in learning more about the SPA process.

DCHD staff scheduled a meeting with this group for January 27, 2020. A great deal was discussed and learned at this meeting, the most significant being the multitude of requirements involved not only for a State Plan Amendment but for any payer specific to the reimbursement of the CHW workforce for services to covered persons. Appendix F presents the January 27, 2020 meeting agenda and minutes. This meeting helped participants to better understand that any funding/sustainability solution for Nebraska CHWs will need address the following topics, similar to the process used when the NDHHS Division of Behavioral Health established an SPA for Peer Support Specialists. These critical topics are:

- Identify a niche in the service delivery realm that CHW can fill regardless of specific populations being served;
- Develop service definition for CHW;
- Connect CHW service definition to CHW core competencies;
- Develop and implement CHW training aligned with adopted core competencies;
- Identify accountability for the CHW workforce (supervision of CHW workforce);
- Develop and implement a "certification" process for Nebraska CHW; and
- Establish metrics for evaluation, effectiveness, and value of the CHW workforce on improving the health of the community.

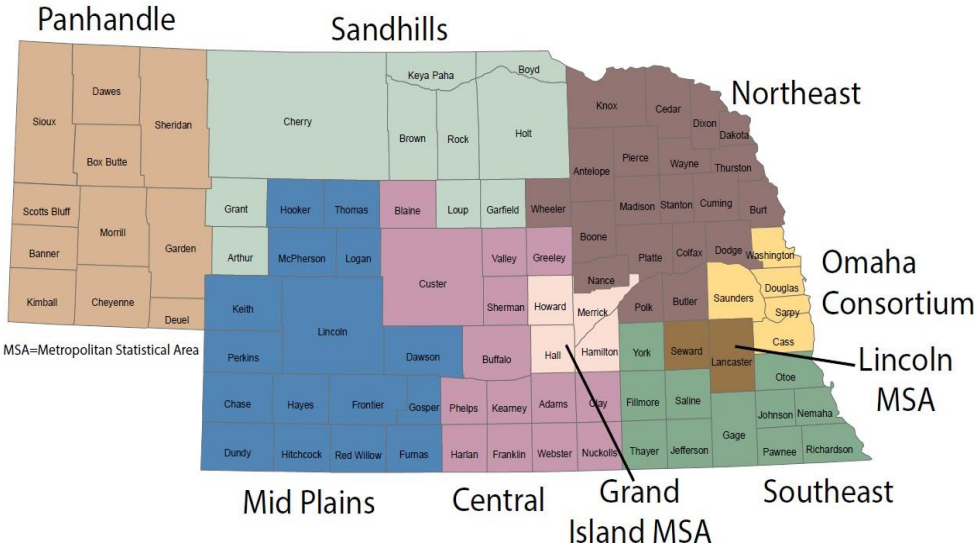
Additional outreach and educational efforts included an invitation from the Nebraska Association of Local Health Directors (NALHD) to speak to all Nebraska Local Health Directors regarding the efforts to identify sustainable funding opportunities for the CHW workforce and to provide recommendations to NDHHS specific to next steps in these efforts. DCHD staff met with the NALHD group on January 28, 2020.

DCHD staff sent an email communication to the CHW Finance/Sustainability workgroup on February 27, 2020 with meeting minutes from both the November 7, 2019 and January 27, 2020 meetings, with plans for follow up discussion. DCHD planned a follow up meeting for March 17, 2020 but unfortunately this meeting was cancelled due to the COVID-19 outbreak affecting many Nebraska communities.

Due to the ever-changing landscape of COVID-19, DCHD staff were unable to schedule any additional follow-up meetings with the workgroup. On April 13, 2020, DCHD sent out an electronic survey to the CHW Financing/Sustainability workgroup to gather feedback on recommendations to NDHHS based on research shared, meetings held, and documents reviewed. The survey was anonymous but respondents could share their contact information if they were interested in being involved in this work moving forward. The survey closed on Wednesday April 22, 2020.

CHW Workgroup Recommendation

Highlights from the survey reveal that there were a total of 36 respondents with all geographic regions being represented (see Appendix 7). The highest response rates (26 or 59.09%) came from the Omaha Consortium region, three responses were from NDHHS and at least one response from each of the other regions.



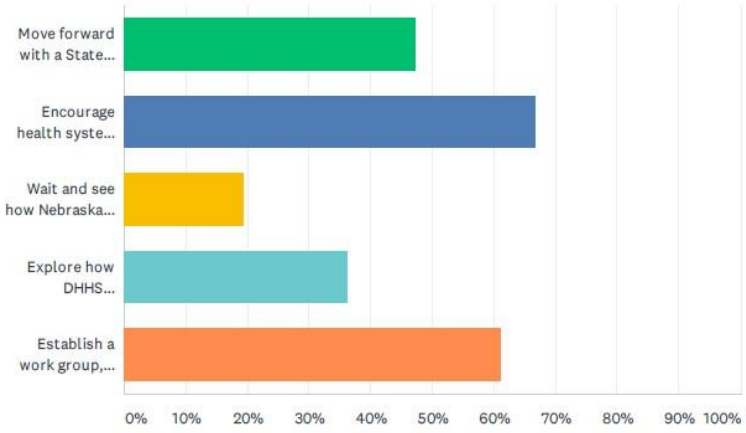
There was a wide range of involvement by respondents with the majority (27 or 65.85%) reporting that they read and reviewed meeting minutes and supporting documents.
With the focus of this survey being to determine recommendations to NDHHS Division of Public Health the following question was asked: "Based on information shared at the CHW Financing/Sustainability meeting (including follow-up emails), please identify your recommendations to NDHHS Division of Public Health as to next steps (check all that apply)." Thirty-six (36) respondents provided feedback and prioritized financing and sustainability options reviewed as follows:

- 24 (66.67%) of respondents would recommend the encouragement of health systems, who are hiring CHWs, to identify cost savings and/or positive health outcomes (i.e. ROI data reports);
- 22 (61.11%) of respondents would recommend the development of a statewide workgroup to begin to explore, identify, and develop the requirements (as outlined in the bullets above) needed for any payer for the CHW workforce;
- 17 (47.22%) would recommend moving forward with a SPA/1115 Waiver for Nebraska;
- 13 (36.11% would recommend exploring working with NDHHS Division of Medicaid/Long- Term Care and Heritage Health to build in a requirement of one full-time equivalent CHW per number of cover lives (number to be determined); and
- 7 (19.44%) would recommend waiting to see how Medicaid Expansion rolls out in Nebraska before determining next steps for the CHW workforce.

Nebraska Community Health Worker Finance - Sustainability Recommendations

Q3 Based on the information shared from the CHW Finance / Sustainability meetings (including any follow up emails), please identify your recommendations to DHHS Division of Public Health as to next steps. (check all that apply)

Answered: 36 Skipped: 8



ANSWER CHOICES	RESPONSES	
Move forward with a State Plan Amendment/Medicaid 1115 Waiver application to CMS (similar to other States such as Oregon, Minnesota, New Mexico and Texas)	47.22%	17
Encourage health systems, who are hiring and using CHWs, to identify cost savings and/or positive health outcomes (Return on Investment data report)	66.67%	24
Wait and see how Nebraska Medicaid Expansion rolls out with the Heritage Health Managed Care Organizations (MCOs) before we determine next steps (over the 2021 calendar year)	19.44%	7
Explore how DHHS Medicaid/Long-Term Care can work with MCOs to build a requirement of maintaining at least one full-time CHW per XXX number of covered lives (similar to the State of Michigan).	36.11%	13
Establish a work group, with statewide representation, to begin to explore, identify and develop what will be needed for all payers (MCO's, third-payers, etc.) to support the CHW workforce (i.e., develop metrics with evaluation plan, develop/identify consistent CHW training to meet service definition, determine criteria for certification, ect.)	61.11%	22
Total Respondents: 36		

Highlights from additional comments from respondents include but are not limited to:

- Health systems are interested in exploring and participating in CHW pilot programs with DHHS;
- Regions and health systems across NE will need flexibility in financing/sustainability strategies;
- Ensure that partners are addressing silos with CHWs at the state level;
- Consider layered funding approaches as back-up options;
- Consider the importance of one statewide CHW certification program; and
- Consider a statewide, sponsored CHW training program.

Nineteen (19) of the respondents committed ongoing involvement in work moving forward to develop a finance/sustainability model for the NE CHW workforce. Full survey results are available in Appendix G.

Strengths/Challenges/Considerations

Below are strengths/challenges and considerations as this project is finalized:

- Evidence of strong, sustained interest, from a wide cross-sector of partners who are anxious for Nebraska to develop a finance/sustainability model the CHW workforce;
- NALHD requested a personal connection by DCHD to better understand this project and how local health departments could continue to support the work;
- Average number of attendees at meetings and responding to emails averaged 40, of the 128 invited to be involved;
- Virtual meetings seemed to work well for state-wide cross-sector involvement; and
- The financing and sustainability landscape is constantly changing for every state. As an example, when the CHW Financing/Sustainability workgroup asked to have the Oregon SPA (dated 2012) researched it was then not available. Apparently Oregon has developed a new report dated November 2018 whereby Oregon has pulled the SPA and conducted a statewide assessment of the CHW workforce.
- The COVID-19 introduction into the United States (January 21, 2020) and then in Nebraska (on February 7, 2020 with quarantined individuals at the Nebraska National Guard training base in Ashland, NE).

Considerations for a finance/sustainability model for the CHW workforce will depend on a number of factors including but not limited to the following:

- The continued engagement of CHWs as respected participants and valued leaders in the work;
- Medicaid Expansion for Nebraska, scheduled to begin October 1, 2020;
- Progress on establishing and maintaining recognized, shared expectations and approaches for a CHW role description, core competencies, training standards, supervision, metrics, etc.;
- Health system integration and uptake of the CHW workforce; and
- Engagement of systems partners and stakeholders willing to do the heavy lifting of workforce and policy development for improved population health and equity (NDHHS, local coalitions, the Public Health Association of Nebraska CHW Section, etc.).

Conclusions

Reaching the vision of the Triple Aim, with a focus on health equity, will require the support and involvement of both health systems and the community with CHWs as an integral part of the vision. Building the capacity for long-term and sustained financial support for a health care workforce that includes and values the Community Health Worker will require partners across the state and from all sectors, with a shared vision. It is evident from the CHW

Financing and Sustainability Workgroup that health systems have a role inherent in their own capacity to hire and integrate CHWs into their healthcare teams. Also, the impact of the CHW workforce must be described through Return on Investment and/or cost-savings measures in order to resonate with payers and insurers.

It will be vital in Nebraska to continue broadly inclusive consensus work with statewide and cross-sector stakeholders, in order to develop and implement the components that will be required for any payer (Medicaid, Medicare, third-party payers, etc.) to consider long-term and sustainable funding for the CHW workforce. Community Health Workers themselves are integral to shaping the direction and leading this work forward.

Acknowledgements

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Kerry Kernen, MPA, MSN, RN is employed by the Douglas County Health Department and is the Division Chief of Community Health, Nutrition and Clinic Services. She currently chairs the Douglas County Community Health Worker Coalition.

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State Financing Models (National Academy for State Health Policy) https://nashp.org/state-community-health-worker-models/
Tool for discussions (NE) Finance/Sustainability Model (Fall, 2019)

Arizona	Funding for CHWs through community health centers, universities, and health care plans. Pursuing Medicaid and health insurance funding streams. Moving to value-based payment creates opportunity for plans to pay for CHWs. Funding from the HRSA Rural Network Development Planning Grant Program to develop a statewide network of stakeholders to support Arizona Community Health Outreach Workers Network in moving Arizona's CHW agenda forward.
California	Currently, health plans, community-based organizations, and other employers of CHWs generally pay for them through grant funding or operating funds (CHW work group report p. 19).
DC	CHWs are covered through payments to primary care teams participating in the Health Homes 2 Model for persons with multiple chronic conditions (My Health GPS) that includes CHWs among other providers. See also the National Center for Healthy Housing's case study on Medicaid Reimbursement for Home-Based Asthma Services in the District of Columbia.
Idaho	Healthy Connections, Idaho Medicaid's Primary Care Case Management (PCCM) program, incentivizes primary care providers (PCPs) to incorporate CHWs into their care coordination model by offering a higher per-member per-month (PMPM) case management payment. However, in the year that the program has been in place, no PCPs have opted to implement CHWs into their care coordination model as of June 2017.
Kansas	Some KanCare (Medicaid) MCOs employ CHWs. There is no state requirement for MCOs to use CHWs, but connections are highly encouraged.
Louisiana	All Louisiana Medicaid Managed Care Organizations (MCOs) employ CHWs.
Maine	Practices involved in Maine's Health Homes program must include a Community Care Team (CCT), and CHWs are explicitly listed (p. 4) as potential team members. The CCTs are reimbursed through Medicaid Health Homes. Maine's SIM grant (p. 8) included five CHW pilot sites.
Massachusetts	CHW positions are funded primarily through grants and health system operating and healthcare transformation funds. Additional sources include federal, state and local governments; health plans; and private and non-profit funding. The Delivery System Reform Incentive Payment (DSRIP) program in Massachusetts Medicaid's section 1115 demonstration includes funding that can support CHWs. Massachusetts Medicaid's demonstration program for dually eligible adults allows coverage for some CHW services. Pursuant to the 2012 payment reform law (Chapter 224), ACOs can pay for CHWs as part of multidisciplinary care teams in a global fee structure. The Prevention and Wellness Trust Fund supports CHW services, and the Health Care Workforce Transformation Fund supports the training of emerging health care workforces.
Michigan	In its Medicaid managed care contract, the state requires health plans to maintain a ratio of at least one full-time CHW per 20,000 covered lives; provide or arrange for the provision of CHW or peer-support specialist services to enrollees with behavioral health issues and complex physical co-morbidities; and establish a reimbursement methodology for CHW work that promotes behavioral health integration. In addition, CHWs are part of the interdisciplinary MI Care Teams under the Section 2703 State Plan Amendment. Many health plans have contracted with programs that do asthma trigger reduction work with CHWs as well as other work.

Minnesota	Health plans that contract with Minnesota's Medicaid agency to provide services to Minnesota Health Care Programs enrollees are required to cover diagnosis-related patient education on self-management services provided by certified CHWs working under clinical supervision. The state Medicaid program also reimburses CHWs on a fee-for-service basis as well as via managed care plan payments. CHWs also provide mental health patient education and care coordination pursuant to a Medicaid state plan amendment.
New Mexico	Through a Medicaid 1115 Waiver, Centennial Care has leveraged contracts with Medicaid managed care organizations (MCOs) to support the use of CHWs in serving Medicaid enrollees. CHW salaries, training, and service costs are MCO administrative costs and embedded in capitated rates paid to Medicaid managed care organizations.
Oregon	The State Plan Amendment (SPA) that created Patient-Centered Primary Care Homes (PCPCHs) explicitly includes CHWs in its description of providers for four of the six core Health Home services. CCOs currently provide care within Medicaid, but are being expanded to other groups. CCOs are required to include "non-traditional healthcare workers" like CHWs on their care teams. CHWs must be certified to qualify for Medicaid reimbursement. A health professional must supervise a CHW in order for Medicaid to reimburse for services provided.
Pennsylvania	Medicaid is the largest source of funding for CHWs in Pennsylvania, followed by Federal Grant Categorical Funding. CHW programs at behavioral health organizations are funded primarily through Medicaid. Medicaid managed care organizations consider CHW expenditures as clinical care costs. Pennsylvania provides Medicaid coverage for Peer Support Specialists (PSS) in the behavioral health field, and some PSS providers are considered CHWs. The Department of Human Resources oversees PSS.
Texas	The Health and Human Services Commission (Medicaid agency) contracts with MCOs and allows CHW costs to be included in administrative costs in order to receive reimbursement. A 2016 HHSC survey of Texas Medicaid found 18 of 19 MCOs employing CHWs or contracting for CHW services. CHWs are incorporated in a number of quality improvement projects under the state's 1115 waiver. Clinics and hospitals use waiver funds to hire CHWs. The Title V Maternal and Child Health block grant supports the Promotor(a) or Community Health Worker Training and Certification Program, and also supported Zika education for CHWs in 2017.
Vermont	CHWs are a standard part of Vermont's Community Health Teams (CHTs), which are an integral part of their SIM narrative. The CHTs are paid for by Vermont's Multi-Payer Advanced Primary Care Practice Demonstration pilot, which involves a monthly care management fee for beneficiaries receiving primary care from advanced primary care (APC) practices. Costs are shared among Vermont's major insurers, as well as Medicare and Medicaid. According to the National Center for Healthy Housing's case study on Medicaid Reimbursement for Home-Based Asthma Services, CHWs provide environmental assessments to identify ways to reduce asthma triggers.
Wisconsin	Medicaid health plans can fund CHW care coordination work via non-administrative funds as of January 2017. Medicaid funds Prenatal Care Coordination and Peer Support Specialists, some of whom are Community Health Workers. Wisconsin stakeholders have written the Business Case for Coordinated Team-Based Care, which includes CHWs.

https://nashp.org/state-community-health-worker-models/

Options	Explanation	Pros	Cons
Fee-for Service	Traditionally, commercial health insurers, Medicare, and Medicaid have paid hospitals, doctors, and other health care providers a fee for every service rendered. One approach to sustainable funding would be for these payers to make CHWs eligible for fee-for-service payments.		As billing codes are identified and used payment rates would need to be sufficient to cover costs associated with community-based work (i.e. travel expenses to visit patients in their homes). CHW would need time to build trust with client base which may not translate into a billable activity (i.e. social supports). Codes would direct the work of the CHW toward individual patient activities while community activities may hold greater potential for improving overall population health.
Pay for Performance	Across the country, insurers have been moving away from the traditional fee-for-service payment system toward paying for services in a way that rewards health care providers for delivering better care at lower cost. The fee-for-service payment system rewards health care providers for providing more services but not necessarily for providing better care. Pay-for-performance is one simple way to begin to reward health care providers for delivering better care at lower cost. Under this method, a health plan may agree to make bonus payments to a health care provider that meets certain quality targets, for example, if a greater share of its patients with asthma have well-controlled asthma. The health care provider could engage CHWs to help it meet its quality targets. The health care provider could then use the bonus payments it receives to cover the cost of CHW services and other interventions.		There is often a lag, between the time when the services are provided and when the provider receives the bonus payment. The provider would need to find alternative funding to defray the cost of CHW services in the short term.

Episode-based payment model	Compensate employers that help patients overcome identified risk factors (i.e. inadequate housing).		
Bundled Payments	Medicaid programs in a number of states, as well as some private payers, make monthly payments to clinical practices to cover a bundle of services such as outreach, case management, health promotion, and connection to social services. Some state Medicaid programs fund these services through a Health Homes initiative, which receives 90 percent of its funding from the federal government, as authorized under the Affordable Care Act of 2010, Section 2703. A number of state Medicaid programs explicitly authorize using these funds to pay for CHW services, together with other required services.		
Global Payments	More recently, many payers have begun contracting with Accountable Care Organizations (ACOs) that are at financial risk for managing their patients' care. An ACO typically receives a standard per-member, per-month (PMPM) payment amount, called a global payment or capitation, to care for all its patients. If the health care provider meets its quality targets and its revenues exceed its costs, it keeps the difference, and may even earn an additional bonus payment. This global payment method aims to hold health care providers accountable for providing high-quality care while containing costs. Could the NE Medicaid program encourage such an approach, as Oregon does. In Oregon, Coordinated Care Organizations (CCOs) are responsible for coordinating care for Medicaid members to improve members' health, improve the quality of health care services, and contain costs. Oregon authorizes CCOs to use a portion of their global payments for "flexible services," defined as health-related non-medical services that are consistent with the member's treatment	ACOs have a strong incentive to invest in services that have been shown to improve quality and contain costs. Most ACOs have the technical resources needed to analyze their patient populations and identify patients who could most benefit from CHW services, such as patients with poorly controlled chronic conditions and high emergency department	

	plan and are expected to improve health outcomes. Some Oregon CCOs are using flexible services funds to pay for CHW services	utilization. ACOs could fund a CHW intervention targeted to these high-risk patients.	
Statewide Assessment	Could Nebraska establish a statewide system for financing CHW and other preventive services? For example, Vermont assesses health insurers a fee of $17,500 per every 1,000 patients to support Community Health Teams (CHTs) across the state. The CHTs include CHWs and other health professionals and are responsible for outreach, care coordination, and connecting residents to needed services. Vermont's CHTs have been successful in reducing hospital and emergency department utilization, while improving health and health care.		
Tax Assessments	Tax assessment on health plans or local property taxes (i.e. Bernalillo County, NM that allows regions to employ CHWs)		
Medicaid	Heritage Health (NE) could establish an initiative to pay for CHW services. A recent change in federal rules makes it easier for state Medicaid programs to pay for CHW services. To fund CHW services, the state would need to amend its Medicaid State Plan to specify: the CHW services for which the state Medicaid program will pay; which patients can receive these services; the conditions under which the services can be provided; who can bill for these services; what method and rate Medicaid will use to pay for services; and a number of other provisions. Medicaid programs in two states support CHW services directly, while those in a number of other states make monthly payments to clinical practices to cover CHWs and other services.		Is there a real or perceived limitation to CHWs touching only those patients within individual plans only or only on their highest cost patients. May not employ CHWs to do prevention work. Roles may be limited to locating patients and making referrals versus building trust and long-term relationships that empower patients to better self-manage their health.

Health Plans and ACO's	Health plans and ACOs can use predictive analysis to identify their members who could most benefit from CHW services. For example, health plans and ACOs could target CHW services to members with high hospital and emergency department utilization, a diagnosis of one or more chronic conditions, indications of poor control of chronic conditions, and/or high risk because of social determinants of health. These organizations could then hire CHWs directly or contract with a community-based organization or clinic to provide CHW services to these high-risk members. A health plan could include the cost of CHW services in administrative expenses, or it could obtain approval from the purchaser to include CHW service costs as a medical expense.		At the plan level achieving positive financial return may take years and may only be measureable at the population level. By the time an individual health plan achieves cost-savings, the individual patients whose health improved may no longer be covered by the health plan that made the investment.
Health Care Providers	Health care providers, especially networks of hospitals and affiliated clinics, can work together to identify patients who could benefit from a CHW intervention, especially patients who have poorly controlled chronic conditions and face barriers to accessing health care and social supports. These health care providers could implement a CHW intervention focused on their patients' needs, perhaps based on one of the CHW models, and seek funding through alternative payment arrangements with health plans. Health care providers could then hire CHWs directly or contract with a community-based organization to provide the CHW intervention to their patients		
Community-Based Organizations	Community-based organizations (CBOs) often hire and train trusted individuals from the communities with which they work to become CHWs. CBOs can use the CHW models to initiate conversations with Health Plans, ACOs, and health care providers about the cost-effective services CHWs can provide in their communities.		
Grants/private funders			Unstable, not sustainable for long-term impact, inconsistent

Due to the variation in CHW care models, the varied interests of healthcare actors, and the dominant fee-for-service payment model, diverse but coordinated funding models may be the best solution. States can issue contracts for community health worker services—both direct services and community-based prevention services. Medicaid waivers could be used to test alternative payment models to sustainably fund community health worker services. And partnerships between health systems community benefit offices and organizations that offer community health worker services could also be pursued.

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State Community Health Worker Models: https://nashp.org/state-community-health-worker-models/

States Implementing Community Health Worker Strategies: For the Centers for Disease Control and Prevention's "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" Program (CDC, December 2014)

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MEETING| MINUTES

GROUP NAME:	Statewide Nebraska Community Health Worker (CHW) Finance and Sustainability Workgroup
PURPOSE:	Explore options and make recommendations to next steps re: CHW Finance and Sustainability model for the State of Nebraska
DATE:	Tuesday Sept. 17, 2019
TIME:	9:00am
LOCATION:	Tele-conference/Go-To Meeting
NEXT MTG:	Wednesday October 16, 2019 1-2:30pm

	AGENDA ITEMS	WHO	TIME
I.	Welcome *Meeting began at 9:02am with a welcome from Kerry Kernen. All attendees joined by go-to-meeting. Roster provided with meeting minutes and documents. Meeting will be recorded and audio file will be sent out with meeting minutes.*	K. Kernen	
II.	Review purpose of this workgroup *K. Kernen reviewed purpose of this workgroup: Explore and analyze finance and sustainable business models for the CHW workforce and make recommendations (and to whom) on promising practices and future action steps for the State of Nebraska* *K. Kernen shared the sectors that have been invited to this work group:* *Local Health Departments* *NE Department of Health and Human Services staff* *Health Systems* *Nebraska Hospital Association* *Federally Qualified Health Centers* *Health Center Association of Nebraska* *Ponca Tribe of Nebraska* *Managed Care Organizations (United Healthcare, Nebraska Total Care, WellCare of Nebraska)* *Private Insurers* *Faith-based Organizations* *Community Based Organizations* *Academia*	K. Kernen	

	Public Health Association of Nebraska (Community Health Worker Section) *If there are other sectors or individuals that should be invited or may be interested in this work please contact K. Kernen (Kerry.kernen@douglascounty-ne.gov) and she will add them to the meeting invites and email communication.* *V. Vinton offered to reach out to NE Appleseed to see if they would be involved in these discussions.* *Make sure we have the best contacts from MCOs to join these conversations.* *K. Kernen shared that the schedule for meetings will be monthly and provided meeting dates/times until the end of December. It may be that this group will decide to continue to meet but the final report (based on work accomplished by this workgroup) will need to be submitted to NDHHS shortly after the end of the year.*		
III.	Objective of this meeting *K. Kernen shared the objective for the meeting today is to begin to explore finance/business models to support the long term sustainability of the CHW workforce for Nebraska.*	K. Kernen	
IV.	Assumptions specific to the purposes of these discussions a. CHWs are a vital component of the healthcare team b. CHWs are identified by a multitude of varying titles and serve any number and type of populations c. CHWs function in both paid and volunteer capacities d. Certification will only be used as a component to discuss the standardization of occupational standards and will not be connected to the Finance/Sustainability model discussions e. Others? *K. Kernen reviewed the above assumptions and gained consensus on adopting these assumptions for the time being while discussing potential finance models. The assumption specific to Certification will more than likely be brought up at a later date depending on where these discussions go.*	K. Kernen	
V.	CHW Financing/Sustainability Options (document for discussion) *K. Kernen reviewed the CHW Finance and Payment Methods (Pros/Cons) document she developed based on research of*	Group	

other States and how they are building capacity for finance/sustainable business models for the CHW workforce. *Discussions from participants:* *a. There may be potential for a State Plan Amendment but realistically the timing wouldn't happen until July 2021 since 2020 will be focused on covering Medicaid Expansion. Several agreed to consider this as potential. Will need a connection with someone from Medicaid. What will this take? This will be a budget issue at the State level and competition for these funds—new budget cycle in July 2021.* *b. Heritage Health are using CHWs: Total Care: yes and United: yes but WellCare is not at this time as a potential merger is for consideration with Centene. Reminder that State Medicaid is not covering CHWs within the MCOs—this is being covered as part of their administrative costs. MCOs are training their own CHW workforce. WellCare investing in Resource Rooms for now. Unsure of how the MCOs are measuring impact of CHW with their members—connecting with potential ROI models.* *c. Shared outcomes from Maine and Massachusetts based on models: Diabetes, Asthma, Chronic Conditions, and Underserved with ROI focus. Would it be beneficial for NE to conduct pilots similar to these models with systems struggling with how to pay for these positions?* *d. Potential for health systems to fund CHW workforce in some way.* *Are they using Medicaid funds?* *Health system (Methodist)—continue to explore but finding more barriers to hiring on their own. Continuing to explore funding without knowing the ROIs which is challenging.* *Feedback from health system (CHI Health) continuing to explore through Community Link program over last 3-4 years. No payment support from payers but really looking at more cost savings but still struggling to find the best model.* *Any potential for health system piloting (and owning) one of the models and sharing this information with partners across the State? (Methodist willing to explore this as a potential).* *CHI is working through the screening process for social needs integration and how these are impacting health needs and how does the intervention best support health impact and cost savings. Not sure they can focus on one model at this time.* *Health Leads (out of Boston) CHI working with other health care organizations across the country (CACHE).*		

	f. Ensure we are having staff working at their highest scope of practice (connect to revenue generating and/or cost savings) and have we looked for opportunities to explore this shift in thinking. *e. DHHS (Michelle Bever and Melissa Leypoldt) have explored this in the past and have a white paper (CHW Financing) they can share. It may be dated but could be a place to start.* *f. Health Systems—connection with social workers (i.e. MCH population) and how are they funded? Are there any parallels with this?* *g. Transition from fee for service to value based service contracts—how are these decisions being made and how might the CHW workforce integrate. This group could advocate for how those funds could be used for greater health impact.*		
VI.	CHW State Financing Models (document for review) *K. Kernen reviewed document pulled from*	Group	
VII.	Next steps: • *K. Kernen to send power point slides and links to the documents shared during the meeting.* • *Explore what is happening in Oregon with their State Plan Amendment and are there any ROI reports.* • *Explore MCOs outside of NE and see what they are doing with CHW workforce financial supports* • *Explore what if any private payers (BCBS, Kaiser, etc.) are doing in this space.* • *Follow up with Jamie Hahn (DHHS 1422) to see if there were any ROIs connected with the 1422 grant and CHWs.*	K. Kernen	
VIII.	Adjourn *Meeting adjourned at 10:00am. Next meeting is Wednesday October 16th at 1pm via go-to-meeting.*	K. Kernen	

NOTES:

Supporting Documents:
CHW Finance and Payment Methods (pros/cons) NE discussion Tool
State Financing models (NASHP)
Power Point used for Sept. 17, 2019 meeting
Audio file from Sept. 17, 2019 go-to-Meeting
List of Attendees Sept. 17, 2019 Go-To-Meeting

MEETING| MINUTES

GROUP NAME:	Statewide Nebraska Community Health Worker (CHW) Finance and Sustainability Workgroup
PURPOSE:	Explore options and make recommendations to next steps re: CHW Finance and Sustainability model for the State of Nebraska
DATE:	Thursday November 7, 2019
TIME:	1:00pm
LOCATION:	Tele-conference/Go-To Meeting
NEXT MTG:	Friday November 22, 2019 9-10:3am

	AGENDA ITEMS	WHO	TIME
I.	Welcome *Meeting began at 9:05am with a welcome from Kerry Kernen. All attendees joined by go-to-meeting. Roster provided with meeting minutes and documents. Meeting will be recorded and audio file will be sent out with meeting minutes.*	K. Kernen	
II.	Review purpose of this workgroup *K. Kernen reviewed purpose of this meeting which is to continue to explore finance/sustainability options for the CHW workforce for NE with recommendation(s) to DHHS Division of Public Health with next steps specific to potential Finance/Sustainability models. K. Kernen continued to encourage participants to bring others to this group as they may be connected to the work.*	K. Kernen	
III.	Recap from September 17, 2019 meeting *K. Kernen provided a review of the September 17, 2019 meeting where a snapshot of potential finance/sustainability options were being explored or capacity built for within other States. Options for funding ranged from grant supports, private/foundation supports, State Plan Amendments, 1115 Waivers, health system funding and blended funded models.* *Based on the Sept. 17th meeting the workgroup asked for a deeper dive into what Oregon did with their State Plan Amendment, exploration of health systems engaging in internal ROI studies with current CHWs and seeing what, if any, private insurers are doing with financial support for CHWs.*	K. Kernen	
IV.	Objective of this meeting—further discussion specific to State Plan Amendments	K. Kernen	

V.	Review of CMS State-by-State Home State Plan Amendment Matrix (Aug. 2019) *See CMS document "State-by-State Health Home State Plan Amendment Matrix" dated Aug. 2019.* https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa-at-a-glance-matrix.pdf *Same document dated four years earlier. Difference is that Oregon was on the 2015 document but not the 2019 document. Not sure if the SPA for CHW is no longer in place for Oregon. Focus on Model Type and Target Population. Most SPAs are focused on chronic health conditions, mental/behavioral health or a combination of both. Review of document from various States and the Model Type that has been submitted and approved by CMS but nothing in State of Nebraska.* Review of National Center for Healthy Housing Document (2017): https://nchh.org/resource-library/technical-brief_advancing-the-role-of-community-health-workers.pdf *Helpful document with advancing role of CHW through State Plan Amendment. Documented requirements for SPA—preventative services rule change (define service provider). Must connect CHW to licensed practitioner for supervision and accountability. May need certification or credentialing connected with training. SPA will need to be State-wide. Governor approval with draw down of federal dollars so funding will need appropriations. Public Notice regarding changes and then submitted for CMS review. Must connect to services that prevent disease, disability and/or other health conditions or their progression.* Oregon State Plan Amendment: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-12-007.pdf *Review of Oregon State Plan Amendment 2012 specific to CHW and how they are covered. Highlights: supervision under licensed healthcare professional. Scope of work for CHW is identified. At some point this SPA was withdrawn.* Nebraska State Plan Amendments: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-16-0009.pdf *Submitted June 2017 to add Peer Support Services for children and adults. Douglas County has added Peer Support Specialists to our definition of a CHW. Peer Supports are defined with scope of work and by categories and this SPA is very specific to the Behavioral Health realm but has interesting synergies and overlaps with CHW in general. Provider qualifications are identified in the SPA and what Supervision looks like.*		
VI.	Knowns and Unknowns about Nebraska State Plan Amendment		

	If we were to explore this route for a SPA may be waiting for Medicaid Expansion details. *Timeline would be at least 2021 with more unknowns on what is involved.* *This does provide time to further exploration into what is all involved.* *Unknowns about legislative component.*		
VII.	CHW Financing/Sustainability Options—any further thoughts for exploration *No further discussion from the group.*	Group	
VIII.	CHW State Financing Models—any further thoughts for exploration *No further discussions from the group.* *Recommend: can we meet with State partners on learning more about what a State Plan Amendment would involve or look at other funding options with a deeper dive?* *Question: any sense on how easy might it be to get further movement in working with the State to consider a SPA? Response: Unknown at this time.* *Feedback: timeframe may be longer given Medicaid Expansion and will need to consider state funding with required match. Will involve DHHS and Legislation and possibly Revenue committee. Will run into new State budget and may be difficult with conversations around property. All that being said Nebraska Hospital Association is willing to be at the table for next step discussions with DHHS Medicaid/Long-Term Care.* *Group consensus: K. Kernen to meet with DHHS Medicaid/Long-Term Care to learn more about the process and all that would be involved.*	Group	
IX.	Next steps *K. Kernen will follow up with DHHS Medicaid/Long-Term Care to learn more about a SPA and all that would be involved. K. Kernen will report back to this group after meeting with them.* *K. Kernen to follow up with Oregon to see why they no longer have the SPA, from 2012, is no longer in place.*	K. Kernen	
X.	Adjourn	K. Kernen	

NOTES:

Environmental Scan of Heritage Health Managed Care Organizations and Community Health Worker workforce (February 2020)

	Nebraska Total Care—Ellen McElderry and Kristi Goldenstein (January 10, 2020)	WellCare of Nebraska an Anthem Company—Renee Claborn and Joi McClure (January 23, 2020)	United Healthcare (unable to reach despite numerous efforts)
Does your MCO have CHWs on staff	Yes—they function more like peer supports. They don't do anything in the medical realm	Not in Nebraska at this time. WellCare does have them in other States	
What is the training program for your CHW workforce?	It's a corporate program, for the State of Nebraska, with over 60 hours of training. There is no certification connected to the training.	NA	
What title does your CHW go by?	Community Health Service Representative	NA	
How do CHWs get their client/patient referrals?	Providers are screening by # of health related risk factors	Looking at the role of CHWs with Medicaid Expansion	
How many CHWs do you have on staff? What geographic area do they cover?	Four at this time with one open position. Positions are in Omaha, Lincoln and Kearney. Work is done both in the field and by telephonic services	None but the number hired will be contingent on the roll out of Medicaid Expansion	
How are your CHWs paid or how are their positions financially covered?	Part of the value-based services	Unknown at this time	
Are there any current challenges for your CHW workforce and	Challenges centered on the individual client level—	NA	

how is your MCO navigating through those challenges?	engagement and cooperation. Using a targeted approach (focus on Diabetics, health coaching, reduced ED usage and location services to find the member to engage with for case management		
Are there any anticipated changes for your CHW workforce with Medicaid expansion in the future?	The impact of Medicaid Expansion is unknown at this time.	NA	
What is your estimated # of covered lives across the State of Nebraska?	Estimate at 1/3 of the members covered by all if Heritage Health	Estimate at 1/3 of the members covered by all of Heritage Health	
If your MCO does not currently have CHWs on staff are there plans to bring this workforce on board in the future?	NA	Yes, will be exploring in the near future	

DCHD met with Dr. Esser (BlueCross/BlueShield) via phone on January 6, 2020. Per Dr. Esser, BCBS is very interested in exploring the potential for CHW as part of their healthcare team but are looking to see how Medicaid Expansion roles out in Nebraska before they take any steps in this area.

MEETING| MINUTES

GROUP NAME:	Statewide Nebraska Community Health Worker (CHW) Finance and Sustainability Workgroup
PURPOSE:	Exploration process of State Plan Amendment
DATE:	Monday January 27, 2020
TIME:	1:00pm
LOCATION:	Nebraska Hospital Association: 3255 Salt Creek Circle, Suite 100, Lincoln NE 68504
NEXT MTG:	None at this time

	AGENDA ITEMS	WHO	TIME
I.	Welcome: *K. Kernen welcomed participants in person as well as those on the phone. In person attendees: Linda Wittmuss (DHHS Division Behavioral Health), Dr. Carisa Schweitzer-Masek (DHHS Division Medicaid/Long-Term Care), Susan Bockroth (Nebraska Association of Local Health Directors), Kathy Karsting (DHHS Division of Public Health), David Slattery (Nebraska Hospital Association), Kerry Kernen (Douglas County Health Department). On the phone: Sara Morgan (DHHS Division of Public Health) and Keisha Bradford (Health Center Association of Nebraska.*	K. Kernen	
II.	Purpose and background of statewide Community Health Worker Finance/Sustainability workgroup and progress thus far: *K. Kernen and Kathy Karsting (DHHS) provided context with background and the purpose of this meeting. A Statewide CHW Finance/Sustainability workgroup has met several times (since Fall of 2019) to explore options and identify recommendations to DHHS as to next steps for how Nebraska might begin to consider and build a Finance/Sustainability Model for the CHW workforce. Research done has been focused on other States (not dependent upon grant/foundation/private funding) and their approach for building a Finance/Sustainability model for the CHW workforce. One option that presented for further exploration was a State Plan Amendment (SPA)*	K. Kernen/K. Karsting	
III.	Review objective of this meeting: explore process of a State Plan Amendment to provide information back to the statewide workgroup for consideration: *This meeting is a follow-up to learn more about a SPA process and if this might be considered as an option for further exploration and what will be involved if Nebraska would submit a SPA to Center for Medicaid/Medicare (CMS) specific to CHWs, for consideration. K. Kernen shared that she discovered that Oregon was approved for a SPA,*	K. Kernen	

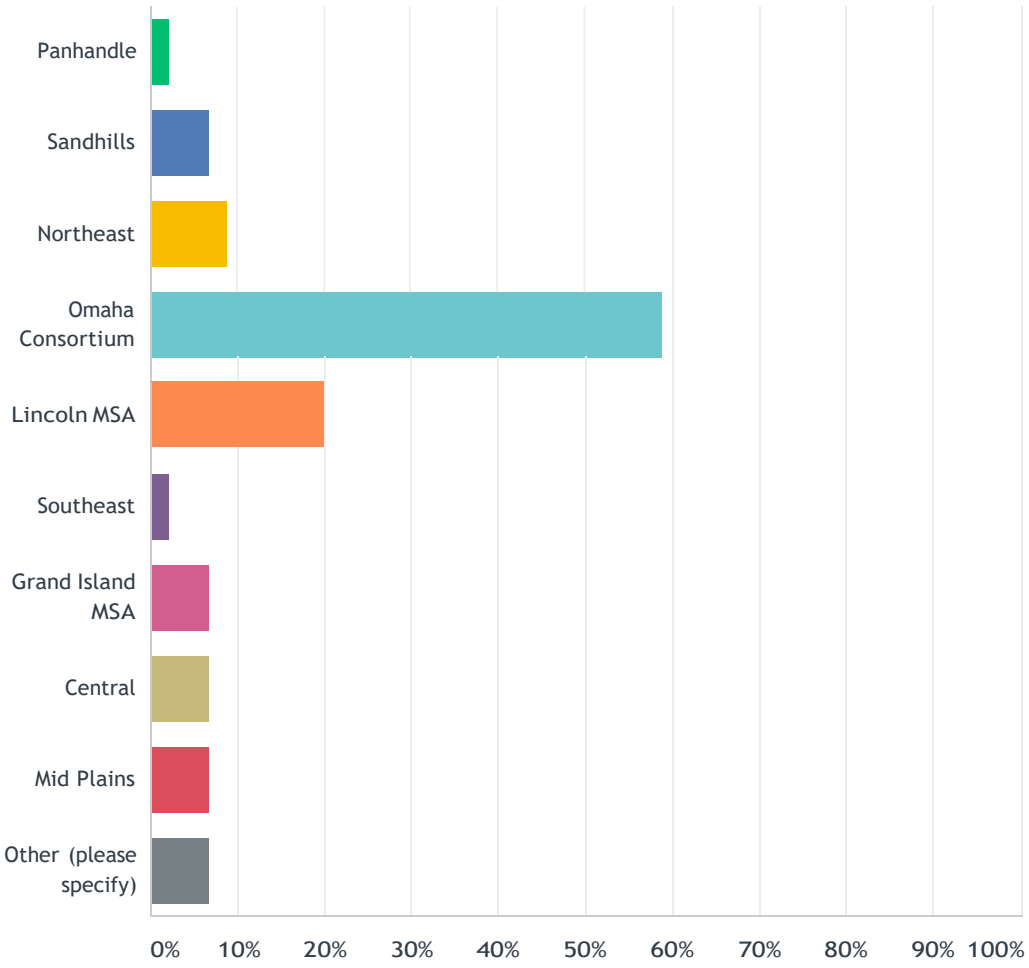
	specific to CHW, back in 2014. When conducting some follow up research it looks like this SPA has been pulled by CMS. K. Kernen has not been able to determine the reason for this.		
IV.	Introduction of Dr. Carisa Schweitzer-Masek, Deputy Director Population Health Division of Medicaid and Long-Term Care: *K. Kernen introduced Dr. Carisa Schweitzer-Masek from Nebraska DHHS Division of Medicaid and Long-Term Care to share all that will be involved as a SPA is considered.* *a. For a SPA to be considered for an application to CMS, Nebraska will need to identify what we want the CHW workforce to do. This action will help determine how to roll these specific functions under a "provider type" for reimbursement.* *b. In addition to their "role" and their function we willalso need to consider the training of the CHW and accountability. L. Wittmuss suggested reconciling these components with a Peer Support Specialists position since this role/function/training has been approved by CMS for reimbursement and funding.* http://dhhs.ne.gov/Pages/Peer-Support-Training-Certification.aspx *c. The State will need to determine where the CHW "brings value" and the environment in which they provide services will need to be considered since the CHW workforce is employed in a variety of settings.* *d. Whether we consider a SPA or an 1115 Waiver we will need to determine and be very clear on how we are evaluating the effectiveness of the CHW. Metrics are required.* *e. All of the above requirements (determination of specific functions of a CHW, training, accountability and evaluation/effectiveness with metrics) will be required for any payer (CMS/State Medicaid, third-party payer, etc.). The difference between a SPA and an 1115 Waiver is that a SPA is altering a state rule or policy within confines of a current Medicaid law and regulations whereas an 1115 Waiver allows a state to do (or not to do) something otherwise prohibited (or required). 1115 Waivers may be approved for experimental, pilot or demonstrations projects.* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html *f. The timeline to submit a SPA will take at least one-two years. First step will be to develop an evaluation plan with established metrics, tie in the training and possible certification (not required) and develop a policy and procedure. Once the SPA has been drafted with these components it will be open for public comment, the State alerts Nebraska Legislature and then CMS will provide a review.* *g. There is a possibility that we could add the CHW service onto an existing service but that would still require an SPA and we don't know quite where that might fit.* *h. Medicaid Expansion—we expect to see more social determinants of health being identified and addressed and this is where the MCOs will come into play and how they choose to use CHWs. CHWs may be considered a "care extender".*	Dr. Schweitzer-Masek	

	i. Reiteration: we need to determine the specific services CHWs are providing and connect them to identified core competencies. We can't have too many provider types (will need to be streamlined). Consider three things CHWs do to add to the population based health component. Suggestion is to look at the Peer Support Specialist Service Definition. http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Peer%20Support.pdf *j. Consideration of CHW registry (not required) since right now there are list of CHWs who have completed various types of CHW trainings across the State.* *k. Consider measurements (metrics) from currently established programs that are using CHWs (in some manner) such as evidence based home visitation programs and parent resources coordinators.*		
V.	Facilitated discussion of State Plan Amendment process and potential to CHW finance model for NE: *Key Take Aways from comprehensive overview from Dr. Sweitzer-Macek* *a. Can we identify a "niche" in the service delivery realm that all CHWs can fill regardless of specific populations being served* *b. Metrics—measurable value/measurable input* *c. Link CHWs to a service definition* *d. Determine need to "certification" versus "credentialed" versus "registry" since this links to how CHWs are identified as a "provider type"* *e. Terminology matters—"peer" versus "CHW"* *f. Explore partnerships with MCOs—do they have data they can share as they are using CHWs in their service delivery system, what barriers are they facing that local health departments might be able to assist them with.* *g. Follow similar steps the DHHS Behavioral Health did when they established the Peer Support Specialist position.*	Group Participants	
VI.	Next steps *K. Kernen will be providing an update from this meeting with all Local Health Department Health Directors on Jan. 28, 2020 at NALHDs next meeting.* *She will also share this information at the next CHW Finance/Sustainability planning meeting which has not been scheduled at this time.*	K. Kernen	
VII.	Adjourn	K. Kernen	

NOTES:

Q1 What region of Nebraska are you representing?

Answered: 44 Skipped: 0



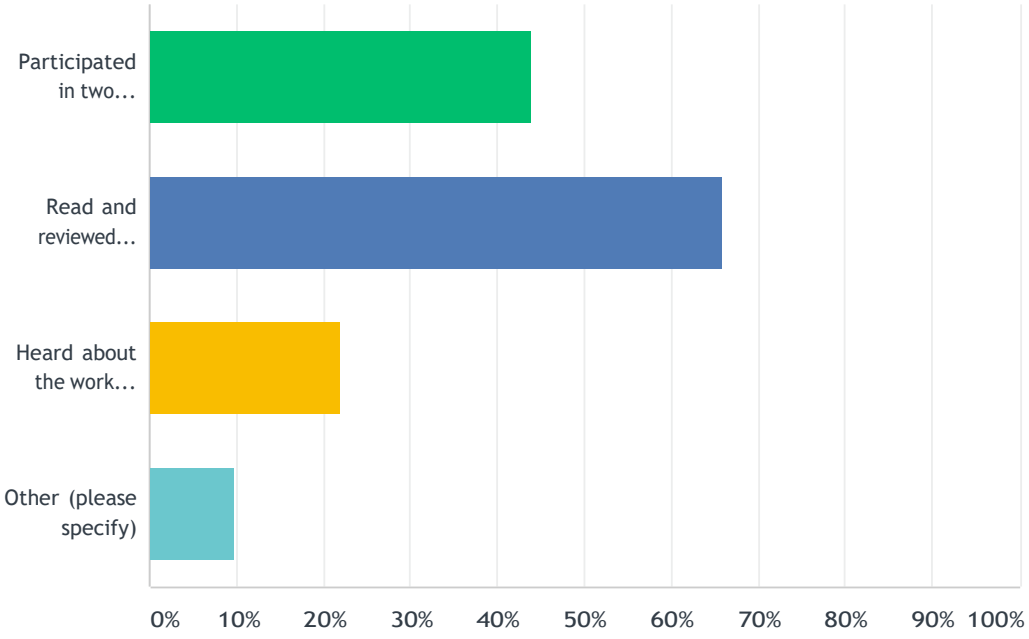
ANSWER CHOICES	RESPONSES	
Panhandle	2.27%	1
Sandhills	6.82%	3
Northeast	9.09%	4
Omaha Consortium	59.09%	26
Lincoln MSA	20.45%	9
Southeast	2.27%	1
Grand Island MSA	6.82%	3
Central	6.82%	3
Mid Plains	6.82%	3
Other (please specify)	6.82%	3

Total Respondents: 44	

#	OTHER (PLEASE SPECIFY)	DATE
1	statewide	4/21/2020 9:48 AM
2	State	4/16/2020 6:08 PM
3	Work across the state	4/15/2020 8:23 PM

Q2 How were you involved in the CHW Finance / Sustainability work group? (check all that apply)

Answered: 41 Skipped: 3

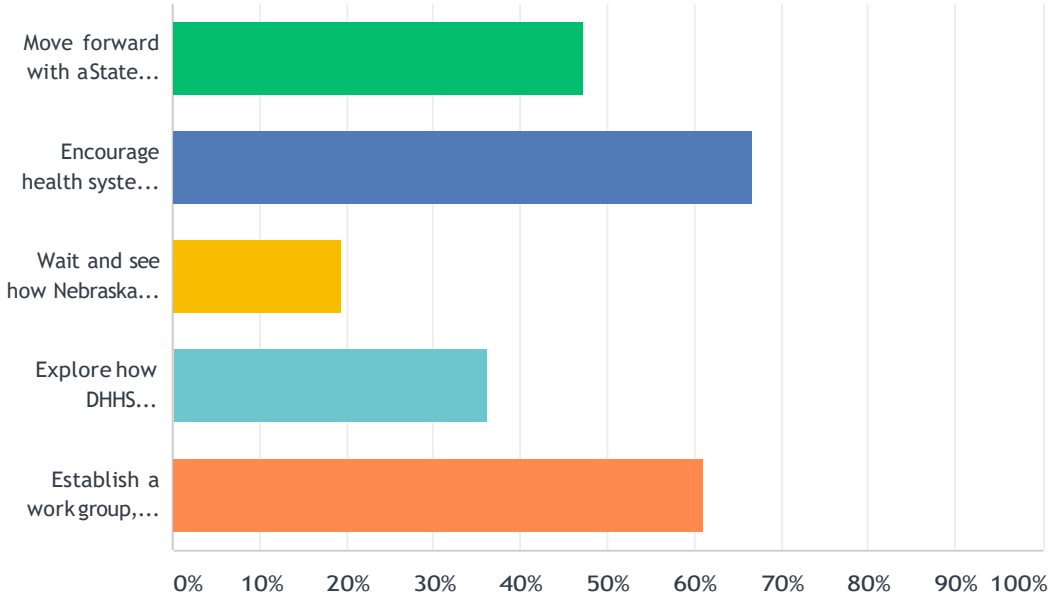


ANSWER CHOICES	RESPONSES	
Participated in two teleconference meetings (September 17th and November 22nd)	43.90%	18
Read and reviewed meeting minutes and supporting documents	65.85%	27
Heard about the work through another partner and/or meeting	21.95%	9
Other (please specify)	9.76%	4
Total Respondents: 41		

#	OTHER (PLEASE SPECIFY)	DATE
1	participated in 1 teleconference	4/21/2020 9:49 AM
2	Worked with the initial CHW Association efforts	4/15/2020 10:53 AM
3	I was able to attend one of the work group meetings. There was another individual at my organization whom participated prior to myself.	4/14/2020 7:47 AM
4	Attended planning meetings	4/13/2020 7:19 PM

Q3 Based on the information shared from the CHW Finance / Sustainability meetings (including any follow up emails), please identify your recommendations to DHHS Division of Public Health as to next steps. (check all that apply)

Answered: 36 Skipped: 8



ANSWER CHOICES	RESPONSES	
Move forward with a State Plan Amendment/Medicaid 1115 Waiver application to CMS (similar to other States such as Oregon, Minnesota, New Mexico and Texas)	47.22%	17
Encourage health systems, who are hiring and using CHWs, to identify cost savings and/or positive health outcomes (Return on Investment data report)	66.67%	24
Wait and see how Nebraska Medicaid Expansion rolls out with the Heritage Health Managed Care Organizations (MCOs) before we determine next steps (over the 2021 calendar year)	19.44%	7
Explore how DHHS Medicaid/Long-Term Care can work with MCOs to build a requirement of maintaining at least one full-time CHW per XXX number of covered lives (similar to the State of Michigan).	36.11%	13
Establish a work group, with statewide representation, to begin to explore, identify and develop what will be needed for all payers (MCO's, third-payers, etc.) to support the CHW workforce (i.e., develop metrics with evaluation plan, develop/identify consistent CHW training to meet service definition, determine criteria for certification, ect.)	61.11%	22
Total Respondents: 36		

Q4 What else would you like NE DHHS to know as we identify recommendations for next steps in this work?

Answered: 15 Skipped: 29

#	RESPONSES	DATE
1	Health systems are interested in participating in CHW pilot programs with DHHS.	4/24/2020 9:56 AM
2	Different regions and different health systems need flexibility in the finance-sustainability plan	4/20/2020 8:57 PM
3	Awareness of the viability of CHW's is critical	4/20/2020 1:22 PM
4	CHWs financial support for training.	4/20/2020 10:28 AM
5	Keep us in the loop.	4/17/2020 11:24 AM
6	Work internally and involve all programs at DHHS who are working to develop the CHW workforce. Don't create silos when you need all partners collaborating as much as possible on these issues.	4/16/2020 6:13 PM
7	Make sure there are backup options for funding.	4/15/2020 8:08 AM
8	The present health crisis demonstrates the need for community health workers who can provide care management in the home, potentially decreasing ED utilization and driving down healthcare costs by problem-solving lower cost solutions to social needs that often go undetected in typical clinical encounters.	4/14/2020 9:53 AM
9	According to the statewide CHW survey completed in 2019 81% of CHWs state certification would be beneficial and feel their role should be more clearly defined and should be promoted.	4/14/2020 9:38 AM
10	We need 1 state certification/approval process for Nebraska CHW's	4/14/2020 9:29 AM
11	Would be wonderful to have a NE DHHS sponsored CHW training/certification program.	4/14/2020 8:01 AM
12	With the current mess with the State Minority Health contract, we have lost any work to be done with our CHW. We are developing our own programs to utilize these CHW.	4/14/2020 7:56 AM
13	We should pursue a Medicaid state plan amendment even without the 1115 waiver...	4/13/2020 10:55 PM
14	how much this additional support is needed in our community.	4/13/2020 7:25 PM
15	We need to act quickly on the implementation of paid CHWs in Nebraska	4/13/2020 7:20 PM

Response Date	Q5: Would you like to be involved in the next steps (to be determined) moving forward? If yes, please provide your name and contact information.			
	Name	Email Address	Phone Number	Organization (if applicable)
2020-04-22 08:53:32	Arli Boustead	arli.boustead@alegent.org	402.343.4692	CHI Health
2020-04-14 09:48:17	Ashley Carroll	ashley.carroll@alegent.org	4023434691	CHI Health
2020-04-20 11:29:31	Chuck Sepers	csepers@ecdhd.ne.gov	4025639656	East Central District Health Department
2020-04-14 09:26:23	Doris Lassiter	dorislassiter@gmail.com	4025984193	Nebraska Center for Healthy Families
2020-04-20 10:20:33	Drissa Toure	drissa.toure@unmc.edu		UNMC-College of Public Health
2020-04-20 20:52:19	Katherine Kaiser	kkaiser@unmc.edu	402-618-0164	
2020-04-06 16:17:29	Kerry Kernen	kerry.kernen@douglascounty-ne.gov	402-444-1773	Douglas County Health Department
2020-04-14 07:45:17	Kristi Goldenstein	kristi.goldenstein@nebraskatotalcare.com	402-212-8298	Nebraska Total Care
2020-04-15 08:04:59	Lora Langley RN, BSN	loral@poncatribe-ne.org	402-649-2568	Ponca Tribe of Nebraska
2020-04-14 00:01:52	Nancie Velasquez	Nvelasquez@poncatribe-ne.org	402-748-3180	Ponca Tribe of Nebraska
2020-04-16 18:06:19	Natalie Kingston	Natalie.Kingston@nebraska.gov	402-641-0568	DHHS Women's & Men's Health
2020-04-17 11:21:52	Roger	roger@ncdhd.ne.gov	4023362406	NCDHD
2020-04-13 19:18:03	Sade Kosoko-Lasaki MD	Skosoko@creighton.edu	4029817296	Creighton University
2020-04-20 15:45:29	Sarah Sjolie	sarah.sjolie@gmail.com	4026168942	
2020-04-13 22:51:55	Sarah Swanson	Sarah.swanson@unmc.edu	402-559-4573	Unmc/mmi
2020-04-13 18:47:00	Sue Carson Moore	smoore8124@yahoo.com	402-689-0810	
2020-04-20 10:20:21	Teresa Anderson	tanderson@cdhd.ne.gov	3083855175	Central District Health Department,
2020-04-24 09:39:42	Amanda Williams	amanda.williams@nmhs.org	402-354-5907	Methodist Health System
2020-04-14 09:09:09	Victoria Vinton	vvinton@neactioncoalition.org	4028307769	Nebr. Action Coalition-Future of Nursing