Community Health Worker Payment Model Guide

A guide of payment models for integrating and utilizing community health worker services to improve the health and wellbeing of communities

Report Developed By: Oregon Community Health Workers Association

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ORCHWA
Oregon Community Health Workers Association

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LETTER FROM ORCHWA'S EXECUTIVE DIRECTOR

The Oregon Community Health Workers Association (ORCHWA) is the statewide professional association for community health workers (CHWs) in Oregon. Our mission is to serve as a unified voice to empower and advocate for CHWs and our communities. We hold a vision of CHWs being recognized as valued professionals, while working together to advance community health, social justice, and equity.

The current global pandemic has illuminated systemic inequities and prompted quick intervention to support communities hit hardest. These interventions have included CHWs and have further highlighted CHWs as an integral part of an effective state and nation-wide response to meet community needs. As one of the oldest helping professions, CHWs root their work in relationship and deep connection to the individuals and families they serve. They hold expert knowledge of community driven process that incorporates the strengths, cultural wisdom, and amplifies self-determination; all necessary to effectively address barriers to health and wellness some communities face.

CHWs play an essential role in communities achieving optimal health by providing person and community-centered care, bridging communities with the health and social systems serving them, and in providing culturally responsive and linguistically appropriate care. Despite the continued efforts to expand CHW integration, challenges of how to sustainably pay for comprehensive CHW services continue to exist. This guide has been developed with the intent to aid CCOs, health systems, and health plans in adopting appropriate payments that account for CHWs as an integral part of care delivery and that reflect the high value they bring to systems, health outcomes, and the broader health of our communities. As the Executive Director of ORCHWA, I am excited by the potential to fully leverage the CHW workforce, and to work in partnership to improve the health and wellbeing of Oregonians.

Sincerely,

Jennine Smart

EXECUTIVE SUMMARY

Over the past several years the work of CHWs has grown in prevalence and is now being recognized as critical in addressing health inequities and improving health outcomes, particularly for those not well served by traditional Western health delivery systems.

Additionally, in Oregon, Coordinated Care Organizations (CCOs) are now required to include Traditional Health Worker (THW) services, including the services of CHWs, as an available component of healthcare delivery. ORCHWA has produced this guide to inform interested parties about effective payment models that fund and engage CHWs as a prominent member of a healthcare team.

This Payment Models Guide is intended to serve as a technical assistance tool by government entities, CCOs, health plans, health systems, community-based organizations, and individuals looking to identify sustainable payment models for payment of CHW services. In this guide we provide detailed descriptions, examples and case studies of a variety of payment models, including alternative payment models (APMs) such as those linked to quality and value, those designed with financial risk arrangements, and population-based payments. We will also discuss other funding mechanisms such as grants and payment models currently in use locally and nationally. We identify and discuss existing models used to pay for the services of CHWs based in various sites including Federally Qualified Health Centers (FQHCs), community-based organizations (CBOs), clinics, hospitals, and other sites, as part of CHW integration into health services. We have identified promising practices that currently exist within Oregon's CCOs and/or nationally and potential future reimbursement pathways for CHWs in Oregon.

Lastly, we provide examples of how different payment models may be appropriate in different settings and identify barriers and challenges faced by CHW employers to accessing payment through Medicaid and other public funding streams.

INTRODUCTION AND BACKGROUND

The Oregon Health Authority (OHA) executed contracts with 15 organizations, now functioning as CCOs, to provide services for the state’s approximately 1 million Oregon Health Plan

(OHP)/Medicaid members. Collectively known as CCO 2.O, the new contracts took effect January 2020 and include increased attention on the social determinants of health, health equity, and THWs - all in an effort to improve care and decrease costs of care for OHP members. In addition to THW services being a newly covered benefit for all OHP members, OHA set forth new requirements for CCOs that include, an annual assessment of payment for THW services rendered, member access to and utilization of THW services, and development of strategies to increase access to and utilization of THW services. All while working toward increasing sustainable payment for THW services that are informed by the OHA and THW Commission Guidelines.

Despite THW related requirements and widespread interest, CCOs, health systems, and other entities struggle with how to leverage the full scope of CHWs and to effectively integrate clinic or community based CHWs onto clinical care teams, in programs, and services. As an association that advocates for the best interest of CHWs, ORCHWA was funded to develop this CHW Payment Model Guide to be used as a technical assistance tool in the development of solutions to increase access to and sustainable payment for CHW services.

ABOUT THIS REPORT

This Payment Model Guide is intended to serve as a statewide technical assistance tool to help entities select a payment model that best meets cultural, regional, and geographic needs to increase access to CHW services and best support the CHW workforce. This report was specifically commissioned to serve CCOs, health plans and hospital systems, community-based organizations, and payers of CHW services throughout the state of Oregon: This Guide may also be helpful to others identifying or developing payment models or interested in learning more about CHW payment. While THWs are a noted focus of OHA, this tool will solely assess unique needs of the CHW workforce.

How This Report Is Organized

The report is organized to provide general information on the CHW workforce, current barriers and challenges to leveraging this workforce, core principles of an effective CHW workforce as it

relates to payment, a high-level framework for understanding and analyzing payment models, and recommendations for additional efforts to support and grow the CHW workforce in Oregon. Case studies have been included to highlight various payment models currently used to pay for CHW services and programs.

It is important to note the distinction between models designed to finance CHW programs and CHW payment models. Many resources conflate the two concepts. A CHW program's financing model offers guidance on identifying sustainable funding sources for a CHW program—this might include Diabetes Prevention Program funding or use of a CCO's administrative overhead. A CHW payment model offers a structure for paying a CHW or a CHW's employer for services rendered—this might include a fee-for-service contract built around a Medicaid fee schedule or an alternative payment mechanism where a clinic or CBO receives a per member-per month payment based on the number of members served by the clinic or CBO.

Equally important is the distinction between a CHW payment model and a CHW program or service model. As discussed above, a CHW payment model offers a structure for paying a CHW or a CHW employer for services rendered. A CHW program or service model offers a structure for the delivery of CHW services that may be paid for with different payment models.

This report focuses on CHW payment models and includes highlights of CHW program/service models in the case studies. While CHW finance models are beyond the scope of this project, we have included a brief discussion on some financing models that may be of interest to potential payers.

COMMUNITY HEATLH WORKER OVERVIEW

As acknowledged under ORS 414.025, CHWs are one of the five State of Oregon recognized THW worker types. CHWs are trusted community members and essential public health workers who share racial, ethnic identity(ies), language(s), and/or lived experience with the communities they serve. They are trusted members of the community who use a variety of methods to promote individual and population health and wellness, self-determination, and

racial equity. In Oregon they participate in popular education-based training to enhance their innate qualities and demonstrate competencies in ten core roles.

CHWs play a key role in improving health outcomes by working to address health-related social needs including health promoting activities, culturally- and linguistically-specific health education, cultural mediation, community organizing, advocating for health-promoting policies, system navigation, liaise between individuals and systems, and connect families and individuals to resources.

Partnering with CHWs further enables health systems and other systems to take a person-centered approach, while increasing access for underserved and marginalized communities. The provision of CHW services not only serve to enable other system professionals to work at the top of their licensure, but also demonstrate high return on investment, and reduction of health disparities. Over the past fifty years, nearly 850 studies demonstrate CHW services as a highly effective aid in the reduction of population health inequities, improve individual health outcomes and experiences of care, and reduce costs—across multiple settings and health issues. CHWs can fill gaps in system-wide efforts toward the Triple Aim+[1] with distinctive core roles and competencies that are not replicated by other health professions.

BARRIERS/CHALLENGES TO CHW INTEGRATION

Throughout history and around the world humans have created systems of social support within their own communities. Today these natural helping systems are remembered as necessary and understood as self-determined community responses to being denied access to the conditions for good health. CHWs have a long history of providing care and have always worked in pursuit of a more just society by promoting health in their communities.

As CCOs and health systems move towards more patient-centered and whole-person care, there has been a growing interest and commitment to leveraging the CHW workforce. Despite

[1] Triple Aim+: Health equity, lower costs, better care, and better health.

this growing interest and new contractual requirements, CCOs and health systems continue to struggle to fully integrate CHWs into their workforce and in a manner that supports the full range of skills and services that make CHWs so effective. Further complicating these challenges, many are now acknowledging the need for, and benefit of, having clinic AND community-based CHWs for their members. Some of the challenges encountered include:

- Lack of understanding or misinformation on the role and scope of CHWs which can lead to; a hesitancy to employ CHWs and inaccurate expectations on scope of work and services provided by CHWs.
- Lack of standardized data collection and tracking efforts that lead to an inability to measure outcomes and exacerbate challenges in paying for the full scope of CHW services.
- Insufficient CHW supervision and workforce development opportunities, particularly for non-clinic based CHWs.
- Lack of payment models for CHWs that provide a living wage and necessary supports to sustain the workforce.
- Inadequate payments for administrative costs to holistically pay for necessary infrastructure, training and support for the provision of robust CHW programs and services.

Finally, for many trusted community members who embody requisite qualities of CHWs—whether they have participated in formal CHW training or not—at least some, if not all of their labor goes uncompensated. An untold number of 'intrinsic' CHWs *(individuals who have requisite CHW qualities but have not participated in formal or recognized CHW training)* improve the health and wellbeing of their communities around the clock, without pay. Health systems are strongly encouraged to recognize and compensate CHWs for a broader range of their contributions to the Triple Aim+ that take place in neighborhoods and additional place-based systems of care and support.

Further, individuals who are employed as CHWs often work overtime in their communities on issues and with community members which employers may not consider "work-related." Trained, certified, or intrinsic; employed, unemployed, or volunteers, CHWs strengthen their communities through unpaid contributions of their time, experience, and expertise in childcare

centers and schools, faith and community-based organizations, small businesses, local governments, and health care settings.

CHWs must be paid a living wage that is commensurate with their lived and professional experience and expertise. CHW-health system integration approaches should not rely on unpaid CHW labor. Health systems are advised to institute policies and procedures that prevent and prohibit exploitation of CHWs labor and dedication to their communities commensurate with other health system employees and contractors.

CORE PRINCIPLES FOR AN EFFECTIVE CHW WORKFORCE

OHA offered guidance as CCOs move toward innovative payment models to increase CHW integration. With respect to the diverse needs and resources across each CCO service area, the THW Commission approved four recommended core principles[2] of THW payment models:

1) **Sustainable and Continuous**

2) **Comprehensiveness**

3) **Equity and Community-driven**

4) **Not Solely Contingent Upon Short-term Outcomes**.

This section addresses how the core principles from *Recommendations for THW Payment Models (Core Principles)* apply to the CHW workforce in particular. Health systems and CHWs are encouraged to adopt the following four core principles as they work together in pursuit of the 'Triple Aim+':

[2] The Payment Models Subcommittee is currently working with OHA to actualize a specific, comprehensive CHW payment mechanism that endeavors to exhibit the *Recommendations for THW Payment Models (Core Principles)*. This work is still in progress as of the date of this publication. For more information, see Section 5: Future State: CHW Value-Based Payment.

1. *Sustainable and Continuous* payment models cover the full cost of employing a CHW and remain stable over time. These payment models are continuous, and stable enough to provide CHWs with a living wage and comprehensive benefits, and cover the full administrative costs associated with employing, supporting, and developing CHWs. Sustainable and continuous payment models result in a stable and thriving CHW workforce, a CHW professional opportunities, and integration into the continuum of care and wellbeing across care settings.

Payment models sufficient enough to provide a living and sustainable wage and cover program costs

2. *Comprehensive* payment models support CHWs to practice at the top of their certification. This means their job duties and position descriptions should be based on the THW Commission-approved CHW scope of practice. Employers should also support CHWs to enact their full range of core roles including individual-level (e.g. one-on-one health education and referrals for health-related social needs) and upstream community and policy-level interventions and activities that impact the social determinants of health (e.g. community organizing, advocating for policies that improve health). CCOs are encouraged to consider alternative payment methodologies, such as per-member-per-month, capitated, and global payments, as these methods provide the flexibility needed to support the full CHW scope of practice, as compared to fee-for-service and grants.

Payment models must cover the full range of services provided by community health workers

3. Payment models that support *Equity and Community Driven* CHW services are preferred. Health systems are encouraged to leverage the expertise of local culturally specific CBOs that employ CHWs. There are a variety of approaches to integrating CHWs, including hiring CHWs directly or contractual partnerships between culturally specific CBOs and health systems. Both approaches benefit the CHW workforce and the communities they serve by providing access to culturally responsive and linguistically appropriate services.

Payment models should investment in culturally responsive and linguistically appropriate services

Contracts between health systems and CBOs further enable redistributed resources to communities most impacted by disparities—the very communities CHWs come from and serve. Through mutually beneficial contracts between health systems and CBOs, health systems can integrate CHWs into their service delivery and increase capacity in CBOs that serve Black, Indigenous, communities of colors, communities with lived immigrant or refugee experience, LGBTQIA+, and other communities where mortality and morbidity rates are disproportionately higher than white communities.

4. Payment models for CHWs must recognize the long-term outcomes and contributions, *Not be Solely Contingent on Short-term Outcomes*. The ultimate goals of the CHW workforce, are to support communities most affected by disparities, to take steps toward improved health and a more just society. CHW interventions span all levels of the socio-ecological model[3]—working in collaboration with, in service to, mediating, and liaising between individuals, families, small groups, organizations, entire communities, and at local, state, and federal policy levels. As frontline public health professionals whose work is rooted in a preventive rather than curative paradigm, health systems leaders should value CHWs for their knowledge, skills, and qualities that qualify them to address root causes and social determinants of health, not just for their ability to produce short-term return on investment or to hurry along particular health outcomes among "high risk"[4] individuals. Over the past sixty years, in peer-reviewed and grey literature, CHWs have produced evidence of their capacity to improve health, improve care, and reduce costs. ORCHWA asserts that these demonstrated contributions to the 'Triple Aim+' are the welcome side effects of CHWs' passion and focus on health and racial equity. *Health system leaders, including financial decision-makers should recognize CHWs as valued members of the care*

Payment models recognize and reward full scope of contributions and long-term outcomes

[3] Socio-ecological model is a theoretical framework to understand the interplay between individual, relationship, community, and society. The model is used to inform prevention and health promotion.

teams who improve the overall quality and value of healthcare by providing person-centered care and increasing the timeliness, efficiency, safety and effectiveness of care—all of which are aspects that improve equity, according to the National Academy of Medicine[5]

PAYMENT MODELS

Payment Model Overview

The Oregon Health Authority's THW Payment Model Grid assesses seven "payment mechanisms." In reality, these are broad categories, some of which describe CHW program financing mechanisms, and some of which describe CHW payment models. CHW program financing mechanisms described in the document are included below with a brief description:

- Grants – grants are the most common mechanism for directing funding to infrastructure, CHW programs, and services. Organizations funded through these agreements may employ one of several CHW payment models (i.e., a grant where the funding is tied to payment for specific outcomes) and are often time limited. Reporting on grant performance, rather than health care claims, often serves as evidence of compliance with the agreed upon scope of work. Grants tend to provide organizations with flexibility in designing services to meet the needs of communities served, including the full scope of CHW services, and reporting and evaluation requirements. However, grants are often time limited and can be considered an unstable source of funding resulting in starts and stops in programs and services as grants end.

- Health Related Services (HRS)– HRS is a mechanism to offer CCOs the flexibility to pay for non-covered services that are offered to supplement covered benefits under Oregon's Medicaid State Plan with the goal of improving care delivery and overall member and community health and well-being. There are two primary categories of HRS including: 1) Flexible Services, which are cost-effective services offered to an individual member to supplement covered benefits and 2) Community Benefit Initiatives, which are community-level interventions focused on improving

[5] National Academy of Medicine (NAM), previously the Institute of Medicine, is the health arm of the National Academy of Sciences. NAM is an independent organization representing diverse professional fields to advance critical health related issues.

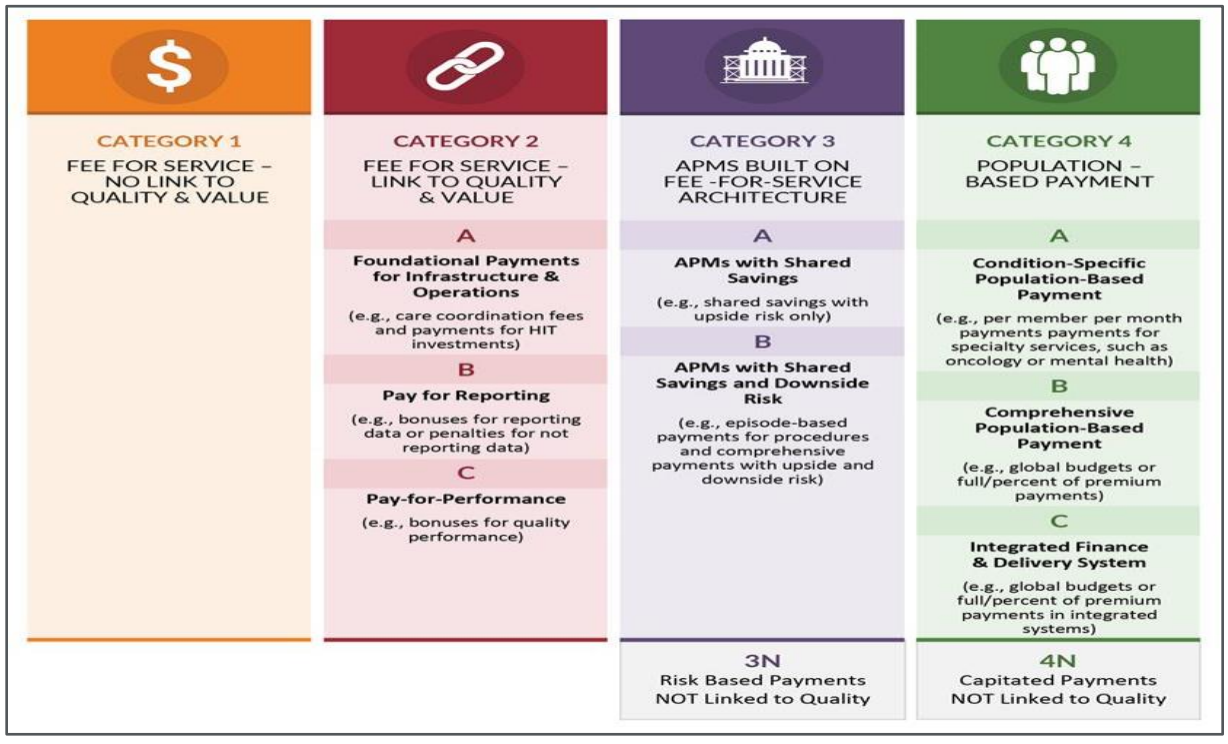
population health and health care quality. HRS could be, and in some regions is, a source of funding for CHW programs in non-clinical settings.

While each of these provide mechanisms for a CCO or a provider organization, such as a clinic, to identify funding that can be used to pay CHWs, none of them provides a payment model; that is, a model for a CCO or other insurer to pay a CHW for services. However, identifying possible sources of funding to support CHWs and CHW programs is vital to our success at developing a robust, sustainable, and integrated CHW workforce.

The Payment Model Grid also describes some categories of CHW payment models, including:

- Itemized fee-for-service (FFS)
- Direct employment

For purposes of this document, we recommend analyzing CHW payment models through a framework based on the Health Care Payment Learning & Action Network's Alternative Payment Model Framework. CCO contracts require them to build value-based payment models based on this framework.



Health Care Payment Learning & Action Network APM Framework, 2017, page 3.

The LAN framework shows a spectrum of payment models ranging from fee-for-service to integrated finance and delivery systems. CCO contracts require CCOs to pay for more services in Categories 3 and 4 over time.

The range of CHW payment models can be thought of on a similar spectrum, with payment allowing for more maximum sustainability as you progress towards the right.

Fee for service payments are where a CCO or other payer pays a CHW or the CHW's employer for each instance of a documented covered service that a CHW is allowed to perform under the Medicaid rules. CHWs would generally need to perform a high volume of these services to be able to earn a sustainable wage from a fee-for-service Medicaid contract.

Pay for performance is where a CCO or other payer pays a CHW or the CHW's employer for achieving certain process or health outcome measures.

Capitation is where a CCO or other payer pays a clinic or the CHW's employer based on the number of the members assigned to the clinic or CHW agency. To be considered a value-based payment, this must also include a connection to a quality measurement.

Direct employment can be a form of a fully-integrated payment model where the CCO or other payer either directly employs CHWs or makes payments to providers or CBOs to directly employ CHWs.

For the purposes of this analysis, payment models fall into one of two categories: 1) fee for service with no link to quality or value or 2) alternative payment models. Alternative payment models that include a quality measurement component are considered value-based payment models. Alternative payment models in Categories 2 – 4 of the HCP-LAN Framework have a quality component and, therefore, alternative payment model (APM) has become synonymous with value-based payment (VBP) model.

Payment Model Analysis Approach

This section explores and analyzes CHW payment models listed in the *Inventory of Existing THW Payment Models* issued by the THW Commission in 2019. Here, an expanded description and links to a case study are provided, as well as pros, cons, and comparisons to the ***Four Core Principles*** outlined in the previous section. Where applicable, barriers and recommended improvements to each payment model are described. Also included are additional suggested OHA-published guidance, information, and technical assistance for each payment model, as applicable and available.

Please note an analysis of contracts and grants are not included in our payment model analysis. While it is true that almost all CHW programs are grant funded, these are ***not*** payment models in themselves. Rather, grants are funding mechanisms for one entity to enter into a formal agreement with another to fund a program. There are pros and cons to grants described earlier in this analysis.

Table of Payment Models Analyzed in this Report

Payment Models			
	Alternative Payment Models		
Fee for Service	Pay for Performance	PCPCH Foundational Payments	Direct Employment
Itemized Fee for Service (FFS) not tied to quality or efficiency	*Performance Based Payment (VBP)*	*Per Member Per Month (PMPM)*	*Payer or Provider-based*

Analysis of Existing CHW Payment Models

Payment Model Scorecard Ranking Key

- Closely aligns with Core Principle
- Moderately aligns with THW Core Principle
- Not ideal for advancing THW Core Principle

Itemized Fee for Service Model

Payment Model	**Itemized Fee for Service** *(with no link to quality or efficiency)*
Brief Description	

Fee for service is a payment model whereby a payer pays a CHW or a CHW's employer for each instance of documented covered services that a CHW is allowed to perform under Medicaid rules. This payment model rewards providers for the volume of services provided and is not attached to quality or outcomes.

Services provided must be approved services based on covered benefits, have associated billing codes, and be provided by the appropriate level of provider who has a National Provider Identifier (NPI). It requires an organization or individual to have billing infrastructure to track, code, and submit billing for payment.

On August 31, 2020, OHA published a CHW billing guidance and added a small subset of CHW services to the minimum covered benefit for OHP Open Card. This means that Oregon's Medicaid program has adopted the FFS reimbursement model for CHW services. FFS billing for CHW services is available to payer and/or provider organizations, including CCOs, when criteria* are met, including:

- Employers can find and connect with CHWs who meet minimum State requirements.
    - CHW is registered on the OHA Traditional Health Worker Registry.
    - CHW is in full compliance with required certification.
- CHW is under the supervision of a licensed health care provider.
- The billing provider is a clinic or supervising medical provider.
  **Reimbursement is paid to the billing entity; CHWs are not independent Medicaid providers.*
- CHW has applied for and obtained a National Provider Identifier number.
- CHW is enrolled in Medicaid as a "non-payable rendering provider."
- CHW service(s) address covered diagnosis(es).
- CHW service(s) equate to covered treatment (CPT and HCCPCS) code(s).

Pros	Cons
▪ Requires extensive tracking of services provided that could aid in demonstrated ROI of clinical CHW services. ▪ Existing Fee Schedule with CHW billing codes ready for use. ▪ CHW employing entity able to receive reimbursement for approved services.	▪ No connection to quality of service or outcomes. ▪ Some concern about overuse of unnecessary services for payment. ▪ Reimbursement limited to approved service codes only and might discourage holistic services ▪ Potential to limit scope of CHW services by not reimbursing for full services scope. ▪ Requires billing infrastructure.

Four Core Principles Scorecard		
Sustainability & Continuity		▪ Reimbursement rates for services are insufficient to sustain CHWs or program costs
Comprehensiveness		▪ Approved services only represent a small fraction of CHW scope of services ▪ Rewards volume over quality or comprehensiveness
Community & Equity Driven		▪ Requires extensive billing infrastructure, not always attainable by small CBOs (especially culturally specific CBOs) ▪ Community-level CHW services are not included on Fee Schedule ▪ CHW services addressing social need and social determinants of health and equity are excluded from Fee Schedule
Non-Contingency		▪ CHW services in Fee Schedule are focused on short-term activities and don't capture long-term outcomes

Recommended Improvements
▪ Provide instructions for providers/CBOs on how to submit claims to CCOs and OHP Open Card when CHWs are providing services ▪ Explore adding additional CHW services to Fee Schedule that cover social needs and social determinants of health and equity CHW activities

Resources and Case Studies
Resources: ▪ Oregon Medicaid Fee-for-Service Reimbursement for Community Health Workers ▪ Eastern Oregon CCO CHW Policy ▪ https://www.oregon.gov/oha/HSD/OHP/Tools/CHW_Billing%20Guide.pdf Case Study: ▪ Link to Case Studies ▪ Additional case study: Minnesota Department of Health CHW Toolkit: Summary of Payment and Regulatory Processes

Alternative Payment Models

Payment Model	Performance-Based Payment
Brief Description	
Performance based payments reward health care plans and providers for achieving or exceeding established benchmarks for quality of care, health results/outcomes and/or efficiency. Pay for performance is often used to encourage providers to achieve a payer-defined quality improvement or performance target. Pay for performance models can include a Fee for Service component with incentives in the form of bonus payments or increases in rates in following years or payment penalties for not meeting performance standards. Pay for performance can also take the form where payment is tied solely to meeting performance standards. Pay for performance payment methods tend to fall into four primary categories: ▪ Process measures assessing the performance of activities that have demonstrated ability to improve positive health outcomes for patients ▪ Outcome measures that assess the impact of care on a patient ▪ Patient experience assessing quality of care the patient has received and their satisfaction ▪ Structures used in treatment for a patient and referring to facilities, personnel and equipment Pay for Performance or Performance based payment would fall into category 2 of the LAN framework. It can be considered a value-based payment since it has a quality performance aspect associated with it.	

Pros	Cons
▪ Pay for performance doesn't have to be linked to specific services in a Fee Schedule and therefore allows for more flexibility in designing care for members. ▪ Providers can utilize different providers to meet the needs of their members including CHWs. ▪ Pay for performance rewards quality, not quantity. ▪ CCOs can require clinics to employ CHWs as a process measure of a performance-based contract.	▪ Payment relies upon meeting performance standards so there is some risk of not meeting standards and therefore, not receiving full payment. ▪ Pay for performance models that tie payment to outcomes are generally limited to short-term outcomes that are easily documented versus longer term outcomes addressing social determinants of health and equity.

Four Core Principles Scorecard		
Sustainability & Continuity		▪ Depending on the reimbursement tied to performance standards, payments may or may not cover full costs of CHW programs.
Comprehensiveness		▪ Since focus is on outcomes, not services provided, programs are free to design their interventions and staffing to achieve the desired outcomes.
Community & Equity Driven		▪ Model can be tailored to allow CHWs to focus on quality and outcomes over quantity and offers flexibility and individualization in meeting member needs. ▪ Performance standards ***could*** be co-created with communities served.
Non-Contingency		▪ Since payment is tied to performance standards, the model does not work well for longer-term outcomes that CHWs contribute to.

Recommended Improvements
▪ Consider how longer-term and community-level outcomes can be connected to the use of foundational payments. ▪ Require community engagement efforts when developing performance standards for CHW programs with a pay for performance based payment.

Resources and Case Studies
Resources: ▪ https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/ ▪ https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Catagorization-Guidance.pdf Case Study: ▪ Link to Case Studies

PCPCH Foundational Payments

Payment Model	Per Member Per Month (PMPM)
Brief Description	

CCOs are required by contract to provide PMPM payments to patient centered primary care homes (PCPCH) as a supplement to other payments, including FFS or VBPs. The payments are based on the number of member's assigned to the PCPCH and the amount varies by which certification tier the provider holds. The payments are not typically risk adjusted and may not reflect the morbidity of the patient population or even the demographic makeup of the practice. PCPCH's use these funds at their own discretion and many use these foundational payments to cover the costs of a variety of supplemental patient programs, including CHW services.

These "infrastructure" payments can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, these types of FFS or per-member-per-month (PMPM) payments are considered an important—though preliminary—step toward payment reform. This is the most common funding mechanism that CCOs rely on to support the costs of clinic based CHWs at primary care practices. PMPM amounts are set at the discretion of the CCO. The Center for Medicare Services has promoted these payment mechanisms through pilot projects but these foundational payments are rarely paid by Medicare or Commercial insurers.

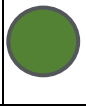
Pros	Cons
▪ Provides flexibility for the primary care provider to use the funds consistent with the needs of their patient population. ▪ Contract requirements ensure that all CCOs are providing foundational payments to PCPCHs ▪ Payments are more stable over time allowing for practices to develop programs and sustain investments	▪ Provider is not restricted or directed in use of the funds including the option of not using the funds to support patient care. ▪ PCPCH foundational payments do not fund community based CHW services ▪ PCPCH foundational payments exclude CHW services provided with specialist physicians and other providers serving patients with chronic conditions such as diabetes or substance use disorders. ▪ PMPMs may not be sufficient to fully support and sustain the program ▪ A provider or entity needs a large assigned population in order to support the overall costs of program development and on-going support.

Four Core Principles Scorecard		
Sustainability & Continuity		▪ PMPM provides a prospective payment to deliver care and offers entities some stability in funding.
Comprehensiveness		▪ Since payment is provided to manage the care of member, providers are free to design their interventions and staffing to achieve the desired outcomes
Community & Equity Driven		▪ No requirements or directives to ensure foundational payments are used to address community need or eliminate disparities
Non-Contingency		▪ Since the provider's use of foundational payments is discretionary, provider's may not be willing to invest in programs that produce longer -term outcomes that CHWs contribute to, this is known as the "wrong pocket problem" where the return on an investment is not realized by those making the investment.

Recommended Improvements
▪ Consider local data on what costs and utilization can be used to generate PMPMs for CHW services and programs.

▪ Consider how to connect this payment model to longer-term, population-based outcomes especially those related to social determinants of health, equity, and social needs.
Resources and Case Studies
Case Study: ▪ Link to Case Studies

Direct Employment

Payment Model	Direct Employment	
Brief Description		
The CHW is directly employed by the CCO, health system, community-based organization, or other system. Funding for the CHW is part of the organizational operating budget and may come from a variety of funding sources. CHWs and CHW programs are fully integrated into organizational programs and services.		
Pros		Cons
▪ CHW position may be funded by multiple and/or braided funding streams increasing position stability. ▪ Flexibility in program design to meet member and/or community identified needs.		▪ Depending on employer, there can be limited ability for CHW to provide services in the community. ▪ Commonly tied to a specific program to address which may limit scope of service and tailoring to individual need ▪ Variation of employer understanding of CHW scope of work, potentially increasing work outside of scope.
Four Core Principles Scorecard		
Sustainability and Continuity		▪ Can result in continuous employment if part of organizational operating budget ▪ More likely to contribute to a livable wage and cover full costs of CHW program (benefits and services)
Comprehensiveness		▪ Since payment is often not tied to specific services, tends to be more flexible in allowing CHWs to operate at full scope of practice

Community and Equity Driven		▪ Funds directed to community-based CHWs and CHW programs can support community and equity-driven CHW services.
Non-Contingency		▪ Program stability over long term is more conducive to measuring longer term contributions and outcomes of CHW services.

Recommended Improvements

- Develop statewide guidelines and recommendations on salary floors for CHWs in clinical and community-based settings that will ensure a living wage.
- Develop recommendations on ancillary budget supports for CHWs to ensure ongoing professional development and adequate support and alignment with supervision promising practices.

Resources and Case Studies

Resources:
https://ciswh.org/wp-content/uploads/2017/06/Medical-Home-Multnomah.pdf

https://publicsectorconsultants.com/wp-content/uploads/2017/01/ColumbiaUniv_Financing_CommHealthWrkrs_PolicyBrief.pdf

SELECTING THE BEST MODEL

Selecting the right payment model depends on multiple factors, there is no "one size fits all" solution. What works for one community, payer, or geographic location may not work for another. However, to determine the payment model best suited for your community, ORCHWA supports use of the ***Four Core Principles*** put forth by the THW Commission: 1) Sustainability & Continuity, 2) Comprehensiveness, 3) Community & Equity-Driven, and 4) Non-Contingency. ORCHWA supports identification of CHW service offerings and programs that are developed in partnership with CHWs and encourages the adoption of payment models that:

- Provide sufficient resources to pay CHWs a living wage and cover necessary CHW program costs to ensure adequate support and ongoing professional development
- Are long-term and sustainable
- Provide flexibility that allows and supports CHWs practicing at the top of their certification, including reimbursement for CHW full scope of services

- The model should support the Triple Aim+
- Allow for individual ***AND*** community-level work regardless of insurance status
- Allocate or reallocate resources and power into those communities most impacted by structural racism and other oppressions

EMERGING CHW PAYMENT MODELS

National and state-level programs are rewarding health systems that integrate patient-centered approaches to quality improvement. This has gained traction and become a core value of primary care encouraging health systems to adopt more holistic assessment of member health and develop individualized and comprehensive services.

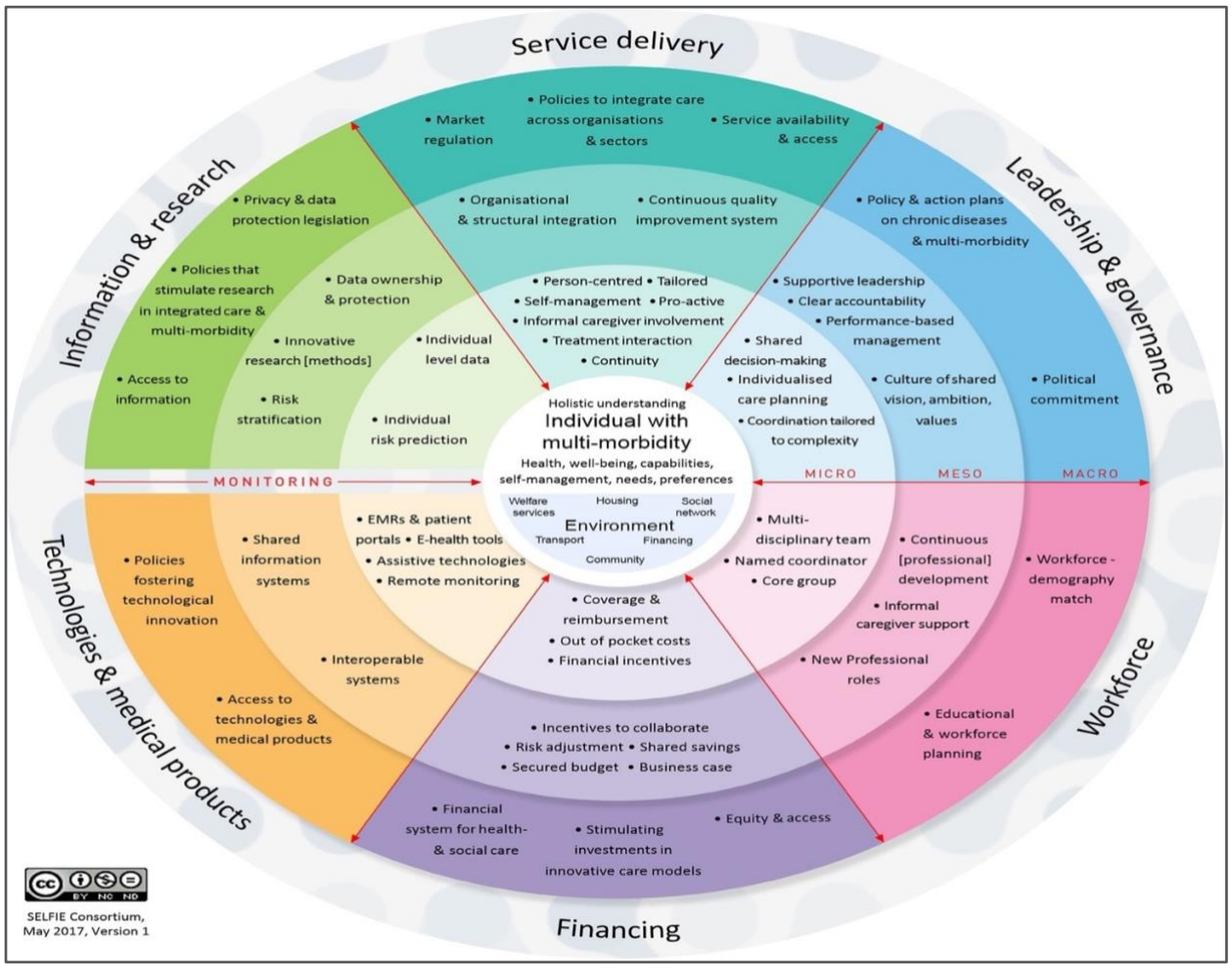
The World Health Organization offer a six-part framework for measuring and incentivizing the next generation of integrated health care, improvement, and transformation. Individual members and families are at the center of the indicator and measurement framework, surrounded by Service Delivery, Leadership & Governance, Workforce, Financing, Technologies & Medical Products, and Information & Research. This framework is useful in contextualizing CHWs as a workforce essential to integrated health systems. Individualized patient-centered services are evidenced in New Mexico's CHW integration efforts (see case studies) New Mexico has emerged as more transformational in CHW payment and integration in Medicaid programs which has now expanded to additional states (Albritton & Hernández-Cancio, 2017). This signals widespread adoption of emerging capitation models of paying for CHW services with:

- Member engagement based PMPM payments; and
- Outcome-based PMPM payments for high value health care, as defined by high-quality member care experience.

In Oregon's health systems, CHW payment models will be determined by the values and driver of toward CHW integration that each organization is trying to address. Similarly, VBP models will be shaped by how "value" is defined, and by whom. Nevertheless, integration-based CHW payment models could serve as a glide path toward desired future-state VBP models, including those that account for the THW Core Principles, and:

- Appropriately and consistently fund CHWs positions and programs, including adequate investment in ancillary services.
- Develop metrics informed by CHWs and the communities being served.
- Build capacity within the CHW workforce and culturally specific CBOs.
- Measure input and process indicators appropriate for evaluating CHW-health system integration.
- Reward provider organizations that make long-term investments in building the organizational infrastructure that enables care teams to meet quality outcome benchmarks.

The aforementioned are intended to support integrated models of community-centered care that intentionally and meaningfully involve CHWs. Payments for CHW integration measures could set a foundation to aid in CHW program improvement and over time could be included in CCO quality metrics and eventually correlated to system-level outcomes.



World Health Organization Six-Part Framework

RECOMMENDATIONS FOR GROWING & SUSTAINING THE CHW WORKFORCE

Solving the dilemma of identifying the most appropriate payment models for CHW services and programs is essential, yet it is only one of several outstanding challenges that need to be addressed in order to grow and sustain a CHW workforce in Oregon. We must collectively figure out how to address the workforce development and infrastructure gaps that continue to act as barriers to our success. We have outlined some of the gaps below as well as recommended strategies for addressing them.

- *Disparities in clinic-based versus community-based CHW investments.* Supporting clinic-based CHWs may be easier and/or a more comfortable strategy for health and hospital systems, but often clinic-based CHWs that spend a majority of their time in a clinical setting are unable to fully connect with community members – this is additionally pronounced for underserved communities that have faced decades of discrimination and disparate treatment from healthcare and government institutions. For many of these communities, historical and contemporary experiences have created distrust of the system and serve as barriers to accessing the care they need and deserve. Investments in community-based CHWs and CHW programs are essential in reaching these populations.
- *Underinvestment in CHWs.* There are no guidelines nor standards when it comes to paying for CHWs this has resulted in disparate and low-wage salaries for some CHWs, especially those employed in community-based settings. Additionally, some CHWs are known to work in undercompensated or completely uncompensated positions. We recommend health systems statewide adopt government-based pay grades as a salary floor, to ensure CHWs receive living wage and comprehensive benefits.
- *Lack of meaningful and standardized measurement of CHW efforts and impacts.* Currently, among health systems, there is not agreement or standardized tool on how best to track CHW efforts and how to measure outcomes and impacts for the full scope of CHW services. This lack of standardized and comprehensive tracking further complicates payment and program successes. We recommend: 1. Aligning with national CHW workforce emerging efforts in collection and

tracking of standardized CHW activities. 2. Convening stakeholder group comprised of: CHWs, CBOs employing CHWs, health and hospital system partners, and government entities to identify, or adapt existing, Community Information Exchange that is compatible with Health Information Exchange. This would more readily allow documentation and demonstration of CHW efforts across the full scope of services and will increase measuring meaningful outcomes including those related to addressing social determinants of health and health equity.

- *Lack of community capacity to contract with health systems for CHW services.* Due to underinvestment in CBOs, especially culturally specific CBOs, many CBO partners do not have the infrastructure to contract with larger health systems and government entities. We recommend two potential strategies for addressing this including:
    - Targeting infrastructure investments into smaller culturally specific CBOs
    - Funding regional or a statewide CHW hub that can provide the infrastructure necessary for contracting, reporting and evaluation, and monitoring compliance for multiple CBOs. These hubs can also provide ongoing CHW workforce development and training support.
- *Lack of system education and understanding of CHW workforce.* The last several years have shown demonstrated interest and intent to expand CHW services in both clinical and community base settings. This has taken form in infrastructure investments, formalized certification process and programs, and increased training offering. While there has been attention toward initial training of CHWs there has not been the same demonstrated commitment to hiring and retention of the workforce. Accordingly, we recommend long-term investments and strategies to support stable CHW employment, adequately funded programs, adherence to CHW supervisor promising practices, intentional creation of environments at enable CHWs professional development opportunities at no or minimal charge to the CHW. Increased employment and retention require: CHW employer has a sufficient understanding, and supports, the role and scope of CHW services, and work in partnership with CHW.
- *Lack of funding for ancillary services.* Success of CHW programs and services are directly tied to fully funded programs that include training, provision of technical assistance, research and evaluation of short- and long-term outcomes, and funding of resources for CHW to connect member to. Funding for these services can be channeled through various sources as outcomes of

CHW efforts provide benefit to broader community and directly tie contractual obligations for CCOs, health systems, and statewide initiatives. Potential sources of revenue include:

- *Community Health Improvement Plan (CHP) & State Health Improvement Plan (SHP):* Strategies are developed to address regional and/or state SDOH needs. Funds allocated to advance CHP/SHP strategies provide regional benefit regardless of an individual's insurance status or insurance provider.
- *CCO Quality Dollars & State Quality Measures:* CCO could use quality incentive funds to reinvest in CHW infrastructure, programs, and services. Development of CCO incentive measures tied to SDOH, health equity, and/or CHWs could additionally serve as a driver to incentivize increased use of CHW services and allow addition funding allocation for CHW ancillary services.
- *CCO allocate portion of global budget:* CCOs prioritize CHW investment from global budget.
- *Health Related Services (HRS)*[6]*:*
  - Flex benefit
  - Community Benefit Initiative
- *Hospital community benefit dollars*
- *CCO and health system SDOH and health equity allocated funds*

Many of the above recommendations, to grow and sustain the CHW workforce, could be funded through a mix of state and health system resources aimed at community-level infrastructure investments while financing the CHW through health systems, other systems, and state and county program funds. It is important to note some of the existing limitations of insurance-based payment including, the restriction of the CHW to serving only the members who are insured by the insurer paying for services, potential complication of paying for community education, and inability to support family members who also need and benefit from

[6] HRS are funds intended to improve care delivery and overall member and community well-being. HRS are defined in two categories, flex benefits that are connected to the individual Medicaid covered member and are payable for non-benefit covered services. The second is community benefit initiative funds for community-level interventions and are focused on improving population health and health care quality.

assistance but may not be covered by paying insurer. Blended funding has the ability to mitigate some of those insurance-based payment limitations.

CONCLUSION

Formalized CHW workforce recognition, State requirement for CHW services to be a Medicaid covered benefit, and the developing infrastructure to expand access and "professionalization" of the CHW workforce, have led to Oregon being nationally recognized as a leader in CHW efforts. Oregon has developed a state certification process, certified training programs, and a state level commission to oversee THW efforts. The latest round of Medicaid contracts, known as CCO 2.0, include the strongest contractual requirements we have yet to see in requiring the integration and utilization of this vital workforce.

Despite those advances, Oregon still faces many obstacles in building and sustaining a robust CHW workforce. One of those barriers has been selecting a payment model that: provides sufficient payment to provide a living wage and covers the full costs of CHW programs; promotes CHWs to work in their full scope of practice; accounts for and appreciates CHW contributions to longer-term individual and community-level outcomes particularly relating to social determinants of health and equity; promotes quality over quantity; and centers equity and community-wisdom.

This report analyzed several frequently used payment models and compared them to the THW Commissions Core Principles for THW Models. Additionally, we have included several recommendations to aid in identifying the appropriate payment model. Based on our analysis, alternative payment models that include a value-based component more closely align with the Core Principles. These payment models could be extended into community-based settings through grants or contracts for CHW programs and services. In an effort to grow and sustain Oregon's CHW workforce we strongly recommend CCOs, health systems, and other potential CHW funders partner with THW led associations and workforce content experts to continue exploration of sustainable payment models that adequately and comprehensively support clinically and community-based CHW, community members, and the needs of all stakeholders.

APPENDIX

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Glossary of Terms

Alternative Payment Model (APM)	A payment approach that rewards providers for delivering high-quality and cost-efficient care. Oregon's APM program provides participating Health Centers with prospective per-member per-month (PMPM) payments, rather than the traditional encounter rates. This allows practitioners to engage their communities in more patient-centered health strategies.	https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf
Centers for Medicare and Medicaid Services (CMS)	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.	https://www.healthcare.gov/glossary/centers-for-medicare-and-medicaid-services/
Community Health Worker (CHW)	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
Community-Based Organization (CBO)	An organization that is driven by community residents in all aspects of its existence. This means: The majority of the governing body and staff consists of local residents, the main operating offices are in the community, priority issue areas are identified and defined by residents, solutions to address priority issues are developed with residents, and program design, implementation, and evaluation components have residents intimately involved, in leadership positions.	https://sph.umich.edu/ncbon/whatis.html
Community-Based Participatory Research (CBPR)	An approach to research that involves those who are the subject of the research in every phase of the research endeavor including design, hypothesis generation, data collection, interpretation, recommendation development and dissemination. Policy and social change are often the outcomes of this research. Itis common in the field of public health.	https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_fad3aaf52fc642e7984da849d50b10a7.pdf

Competency(ies), CHW	Something that a CHW is capable of doing such as a skill gained through study or practice. Competencies includes skills and qualities. In this context, "qualities" mean personal characteristics or traits that can be enhanced but not taught. Patience, compassion, and persistence are examples of qualities.	https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_fad3aaf52fc642e7984da849d50b10a7.pdf
Coordinated Care Organization (CCO)	A network of physical, oral, and behavioral health care providers who work together in their local communities/services area to serve people insured under the Oregon Health Plan (Medicaid).	https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx
Core Roles, CHW	Also known as CHW scope of practice. They help to define and set the boundaries of the work of any profession. It should be noted, however, that states are not seeking to license CHWs; scope of practice definitions for CHWs are descriptive rather than regulatory.	https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_fad3aaf52fc642e7984da849d50b10a7.pdf
Current Procedural Terminology (CPT) Codes	Offer healthcare professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency. CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.	https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval
Culturally Specific Services	Culturally honoring services that are responsive to individual cultural health beliefs and practices, languages, health literacy levels, and communication needs.	https://thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf
Equity	Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.	https://www.who.int/healthsystems/topics/equity/en/
Federally Qualified Health Center (FQHC)	Community-based healthcare providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.	https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

Health Equity	The absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically. See also: Oregon Health Authority	https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3
Health Related Services	Non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. Health-related services include: • **Flexible services,** which are cost-effective services offered to an individual member to supplement covered benefits, and • **Community benefit initiatives,** which are community-level interventions focused on improving population health and health care quality. These initiatives include members but are not necessarily limited to members.	https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx
Health-Related Social Needs (HRSN)	Health-Related Social Needs: social barriers which affect people's ability to maintain their health and well-being. Examples include housing instability, housing quality, food insecurity, personal safety, lack of transportation and affordable utilities, etc.	https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf
Integrated Health Care	An approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient.	https://www.apa.org/health/integrated-health-care
Local Public Health Administrator or Authority (LPHA)	The public health administrator of the county or district health department for the jurisdiction in which the reported substantial exposure occurred. See also: U.S. Department of Health and Human Services (HHS)	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=54453
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The Covered providers must also share their NPI	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand

	with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.	
Oregon Health Authority (OHA)	The Oregon Health Authority is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. OHA is overseen by the nine-member citizen Oregon Health Policy Board working towards comprehensive health reform in our state.	https://www.oregon.gov/oha/Pages/Portal-About-OHA.aspx
Qualities (CHW)	Innate, personal characteristics or traits that can be enhanced but not taught, also called “attributes," which are essential to CHW competencies. Community membership, patience, and compassion are examples of qualities.	https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_2b0893bcc93a422396c744be8c1d54d1.pdf
Racial Equity	The condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. When we use the term, we are thinking about racial equity as one part of racial justice, and thus we also include work to address root causes of inequities, not just their manifestation. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them.	https://www.racialequitytools.org/glossary#racial-equity
Scope of Practice (CHW)	In Oregon, the Oregon Traditional Health Worker Commission defined an established set of boundaries for the work of CHWs. The CHW scope of practice is largely based on concerted national efforts of CHWs and CHW allies to study and build consensus on CHW core roles, skills, & qualities. Note that states are not seeking to license CHWs; scope of practice definitions for CHWs are descriptive rather than regulatory. See also: CHW core roles.	https://www.oregon.gov/oha/OEI/Documents/Traditional%20Health%20Worker%20Scope%20of%20Practice.pdf
Skill(s), CHW	The ability, coming from one's knowledge, practice, and aptitude, to do something well. A core role or a task that must be performed may be supported by multiple skills.	https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_fad3aaf52fc642e7984da849d50b10a7.pdf

Social Determinants of Health (SDoH)	The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities included the social environment, physical environment, health services, and structural and societal factors	https://www.cdc.gov/socialdeterminants/docs/sdh-white-paper-2010.pdf
Social justice	A concept premised upon the belief that each individual and group within society is to be given equal opportunity, fairness, civil liberties, and participation in the social, educational, economic, institutional and moral freedoms and responsibilities valued by the society	https://www.crrf-fcrr.ca/en/resources/glossary-a-terms-en-gb-1/item/22878-social-justice
Structural racism	Structural racism in the U.S. is the normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage white people while producing cumulative and chronic adverse outcomes for Black, Indigenous, People of Color communities. It is a system of hierarchy and inequity, primarily characterized by white supremacy – the preferential treatment, privilege and power for white people at the expense of Black, Latino, Asian, Pacific Islander, Native American, Arab and other racially oppressed people.	http://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf
Traditional Health Worker (THW)	Traditional Health Workers (THWs) are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for health plan members, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health. There are five State of Oregon recognized traditional health worker types: birth doula, peer support specialist, peer wellness specialist, personal health navigator, and community health workers.	https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx
Traditional Health Worker (THW) Commission	The Commission that promotes the THW workforces in Oregon's Health Care Delivery System to achieve Oregon's Triple Aim. The Commission advises and makes recommendations to the OHA, to ensure the program is responsive to consumer and community health needs, while delivering high-quality and culturally responsive care.	https://www.oregon.gov/oha/OEI/Pages/THW-Commission.aspx

Traditional Health Worker Registry	A registry of traditional health workers across the state of Oregon that have completed all required training for their specific worker type and passed background check. To receive Medicaid reimbursement for THW services, THW is required to be on the Registry.	https://traditionalhealthworkerregistry.oregon.gov/
Triple Aim+	Reduce disparities, lower costs, better care, and better health.	https://machw.org/employers/integrating/

Case Studies

Program	Bridges to Health Pathways Program (B2H)
Organization	Columbia Gorge Health Council
Setting	Multiple: Clinics, CBOs, public health departments, schools
Payment Model Used	Pay-for-Performance via Pathways Community Hub Model **Note this model includes various components as a potential approach to funding, incentivizing outcomes, and potential payment model*

Case Study Description: A collaborative between PacificSource Community Solutions, B2H program in Hood River and Wasco Counties offer a community-wide system of care coordination to community members with two or more health-related goals who also experience barriers to accessing community resources. The primary goals of B2H are to increase coordination of and access to services and community resources, and to support community members in taking action toward improved overall health and well-being.

As the Regional Hub, Columbia Gorge Health Council contracts with service organizations clinics, hospitals, schools, and health departments that employ Community Care Coordinators (CCCs, also called CHWs). CCCs work with eligible members to identify and address their health barriers by following standard *Pathways* (i.e. CHW workflows) that outline steps to address HRSN like housing, smoking cessation resources, health insurance enrollment, specialty care referral navigation, health education, transportation, food access, lead screening, prenatal services, employment, and education.

Program Successes: After four months of working with a CCC, 50% of participating members said they felt more confident in their ability to manage their own health conditions. In the same four months, 74% of participants said their quality of life had improved and 84% of participants said they felt better connected to services.

Payment Model Highlights: Agencies that contract with the Hub are reimbursed for performance in outcome and process indicators via *Pathways*. Payment to CHW employers is based on the number of *Pathways* completed, or barriers to improved health overcome. This pay-for-performance model of funding disbursement is believed to incentivize CHWs to work with members to address multiple barriers to community resources and improved health. While demonstration of desired outcomes has "required patience," the payment model rewards clinical and community organizations for addressing individual members' health-related social needs.

Contact Information	Bridges to Health Program B2H@gorgehealthcouncil.org

KEY POINTS

- Process and outcome indicators measured
- Rewards cross-sector collaboration to address members' health-related social needs.

After four months of working with a CHW,

- 50% of participants reported improved confidence to manage their health
- 74% reported improved quality of life
- 84% reported feeling better connected to services.

Program	EOCCO Community Health Worker Program
Organization	Eastern Oregon Coordinated Care Organization (EOCCO)
Setting	EOCCO-contracted clinics and additional provider entities
Payment Model Used	Fee-for-Service

Case Study Description: In 2015, EOCCO became the first CCO in Oregon to develop FFS CHW policy to reimburse contracted providers for health education services provided by CHWs. In this program, CHWs work in collaboration with healthcare teams and provide member education on effective self-management of medical, behavioral, and/or oral health conditions. The CHW services are provided individual or group, and take place in the members' home, outpatient clinics, or in community settings. The CHW engages in administrative tasks including charting, phone outreach, and community resource navigation, some of which may be reimbursed if integrated with the member's self-management skill building curriculum and conducted with the member. While educational curriculum may be slightly modified to address clinical needs, cultural norms and health or dental literacy of members, the curriculum meets recognized health or dental health care standards.

The CHW is a EOCCO-contracted provider and at the discretion of the contracted employer. Accordingly, the CHW role is task-driven, rather than title-driven. The program also specifies that additional healthcare professionals and personnel, such as Medical Assistants and non-emergency medical transportation drivers can perform the services as long as they are certified as a CHW by OHA and employed and supervised by an EOCCO-contracted provider/entity.

Program Successes: In partnership with EOCCO, Oregon State University (OSU) developed an 85-hour blended CHW training that consists of online modules, in-person sessions, and live virtual components. The program now offers several continuing education courses and a certificate program in CHW leadership. OSU and EOCCO studied four years of entry-level CHW training course enrollment data (n=151) and found that 25% of enrollees identified as Hispanic/Latino; 41% identified their profession as CHW; and 28% of enrollees were employed by a CBO. This study provides a preliminary picture of trainee enrollment and signals room for further diversification of the CHW workforce in eastern Oregon.

Payment Model Highlights: Prior to the expansion of OHAs FFS codes, 8/31/2020, EOCCO CHW Program reimbursed for contracted CHW services using CPT codes 98960, 98961, and 98962 (health education: individual face-to-face and group visits). Provider billing claims increased 453% from 2016-2017, providing a sense that CHWs have a generally "positive impact on members" or that members find CHW services useful.

KEY POINTS

- FFS payment for individual and group-level CHW roles in health education
- CPT codes can be used for CHWs: 98960, 98961, and 98962— health education (individual face-to-face and small groups)
- Reimburses CHW health education provided in home, outpatient, and community settings.

Benefits: Using FFS Model enabled provision of CHW services to members, standardized data collection to enable analysis of services administered and track CHW activities. *Challenges:* The model is challenged by ongoing inquiry as to how financial return on investment can be verified. FFS Model limited scope of services by only reimbursing for three approved activities. Payment model encouraged task driven as opposed to role driven activities.	
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Program	Integrated Primary and Community Support (I-PaCS)
Organization	Molina Healthcare of New Mexico
Setting	Medicaid Managed Care Organization
Payment Model Used	PMPM

Case Study Description: I-PaCS connects CHWs with community members who face discrimination and exposure to other forms of harm. CHWs work with eligible community members and care team members for one to six months on a range of issues, including health and social service system navigation, chronic disease management, and connections to resources for health-related social needs. CHWs also work within the larger community to address gaps in community resources.

I-PaCS consists of two key components:

1) The Primary Care Linked Strategy (PCLS), which supports individual-level CHW services that are partially funded with two PMPMs, depending on the eligible members' acuity (acuity is informed by health record data, SDoH assessments, and referrals).

a) "Comprehensive Patient Support (ComPS):" $6-$11 payments per member receiving primary care services per month. These payments partially finance non-intensive CHW services for eligible members

KEY POINTS

- Two PMPM tiers
- Engagement vs. outcome--based payments
- Multi-purpose use of PMPM
- Individual and community-level CHW core roles

b) "Intensive Patient Support (IPS):" $321 payments per eligible member engaged in intensive CHW services per month. These payments finance intensive CHW services for members who are living with multiple co-occurring health conditions and social needs.

2) The Community Health Improvement Strategy (CHIS) supports community-level CHW services that are partially funded with ComPS PMPM payments. CHWs and additional clinic staff who participate in CHIS use aggregate data from members' SDoH screenings to identify, prioritize, and address community health needs. CHWs share findings and work with CBOs and additional community leaders on a plan to address gaps in existing community resources. (Johnson et al., 2011).

Program Successes: Members who worked with a CHW for six months had fewer visits to the ED, fewer inpatient admissions, and used fewer prescriptions, resulting in a ROI of $4 for every $1 invested in the program. Participants reported they found CHW support useful to engage in preventive care like regular screenings for blood glucose and cholesterol levels, and for breast and cervical cancer (Johnson et al., 2011).

Payment Model Highlights: The flexibility of this payment model enabled de-linking CHW services from medical services and billing encounters. A range of separate PMPM payments provide continuous funds, enabling clinics to support CHWs to exercise a comprehensive range of core roles, including services for individuals and families as well as important community-level core roles that improve community health.

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- CHW services de-linked from medical encounters
- 4:1 return on investment
- Fewer ED visits and hospital admissions
- Increased preventive care

Program	Integrated Primary and Community Support (I-PaCS)
Organization	Molina Healthcare of New Mexico (Medicaid Managed Care Organization)
Setting	Primary care clinics (Hidalgo Medical Services & two other sites)
Payment Model Used	Capitation: PMPM without quality measures. Note: Could be modified as a VBP model.

Case Study Description: At Hidalgo Medical Services, CHWs are a valued and integrated partner on the care team. I-PaCS is "a population health model for clinics and communities to improve health outcomes & reduce healthcare costs through the integration of CHWs." In this model, members whose health is impacted by systemic discrimination and exposure to additional harms are referred to CHWs. Then, CHWs who are integrated members of primary care teams work with eligible members for up to six months on a range of issues, including health and social service system navigation, chronic disease management, and connections

KEY POINTS:

- Tiered PMPM payments for member engagement (vs short term outcomes).

to resources for health-related social needs. CHWs also work within the larger community to address gaps in community resources. I-PaCS consists of two key components:

1) The Primary Care Linked Strategy (PCLS) supports individual-level CHW services that are partially funded with two different PMPM payments, depending on eligible members' acuity (based on health record data, SDoH assessments, and referrals).

- "Comprehensive Patient Support (ComPS):" $6-$11 payments per member receiving primary care services per month. These payments partially finance non-intensive CHW services for eligible members
- "Intensive Patient Support (IPS):" $321 payments per eligible member engaged in intensive CHW services per month. These payments finance intensive CHW services for members who are living with multiple co-occurring health conditions and related social needs.

2) ComPS PMPM payments also fund the second component of the model, Community Health Improvement Strategy (CHIS), which supports CHWs and additional clinic staff to use aggregate data from members' SDoH screenings to identify, prioritize, and address community health needs. CHWs exercise community-level core roles as they share findings and work with CBOs and additional community leaders on a plan to address gaps in existing community resources. (Johnson et al., 2011).

Program Successes: MHNM expanded I-PaCS to additional clinics and other Medicaid MCOs in NM adopted the program or aspects of it. It has since been replicated in 10 states. A 2012 study examined the health care costs for 448 members accross 11 NM counties who were eligible for "intensive" CHW services in the six months before, during, and after they worked with a CHW. Members who worked with a CHW for six months had fewer visits to the ED, fewer inpatient admissions, and used fewer prescriptions, resulting in a ROI of $4 for every $1 invested in the program. Participants reported they found CHW support useful to engage in preventive care like regular screenings for blood glucose and cholesterol levels, and for breast and cervical cancer (Johnson et al., 2011 and Johnson et al., 2012).

Payment Model Highlights: *Note: this model of capitation payment could be modified to serve as a VBP model if PMPM payments for demonstration of quality outcomes are integrated—perhaps in future iterations. This model is one example of PMPM payments that are tied to both member engagement with CHWs and CHWs' engagement in community health improvement activities—not quality outcomes. In this particular model, "field-based CHW services are recognized as a value-add, where "value" is defined from a perspective that emphasizes member care and care experience. MHNM invested in the CHW model with the belief that higher quality care will actually cost less in the long-run—an assumption that has proved to be accurate. MHNM also allowed CHW services to be de-linked from medical

- Appropriate utilization of CHW services within the scope of practice
- Pays for individual and community-level CHW core roles
- De-links CHW services from from billable medical encounters, avoiding creeping and/or narrowing of CHW scope

Over 1 ½ years (n=896):

- $4:1 return on investment
- Fewer ED visits and hospital admissions
- Increased preventive care
- Participants reported favorable experiences

encounters, acknowledging that billing codes are not designed to fund CHW positions & program costs. Additionally, the model uses team-based care approaches that support appropriate utilization of CHW services while avoiding underutilization and misappropriation of CHW competencies by employers. Lastly, a range of separate PMPM payments provide continuous funding to clinics for CHW positions. These enable clinics to support CHWs to work at the top of their scope of practice in individual and family-level roles that address members' health-related social needs, as well as important community-level roles that address SDoH with collaborative, upstream approaches.	
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