Community Health Workers Are the Future of Health Care: How Can We Fund These Positions?

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Community health workers (CHWs) are essential members of health care teams, particularly in diverse and rural communities.[1] They are dedicated individuals with a unique set of expertise and skills. Ideally, they should be reimbursed through permanent funding streams that allow them to be included in the daily workflows of health care facilities and included in long-term planning.

Options for reimbursement for CHWs must be considered in terms of both the evolving health care delivery system and the changing models of reimbursement in the United States (US). The objective of this article is to present some of the complexities involved in achieving the goal of sustainable reimbursement for CHWs from our perspective as health care administrators in federally qualified health centers (FQHCs) in the state of Hawai'i.

CHW Reimbursement Under Fee-for-Service

Although the landscape in the US is changing, the fee-for-service reimbursement model is still the dominant payment model.[2] There are options for reimbursing CHWs for their work under the fee-for-service model, but several complexities must be addressed. In order for a service to receive reimbursement under the fee-for-service model, there must be clear definitions of which patients are eligible for the service, and what the service entails.[3] These definitions allow for the determination of an appropriate fee.

The American Medical Association (AMA) is responsible for defining existing and new Current Procedural Terminology (CPT) codes that define a specific service or procedure through the CPT Editorial Panel.[4] These codes codify the procedures and services health care providers and organizations perform. Physicians develop new CPT codes and assign relative value units (RVUs) to them, indicating their time, skill, and intensity as a way to determine payment value. The Centers for Medicare and Medicaid Services (CMS) controls the pricing of RVUs, but physicians can increase their income by changing the RVUs or adding new codes. The 394 new or changed codes for 2020 focus on the needs of doctors, not patients, and will likely increase health care costs.[5-7] Services described for non-physician providers usually results in undervaluing the services. Support for team-based care under this model thus remains fragmented into specific services meeting strict criteria because of the payment structures in the background.[8] Dieticians and diabetes educators require certification and credentialing with insurance and are subject to restricted hours per year per patient who must have certain diagnoses and conditions to be eligible for their services. Tele-ophthalmology retinal imaging (code 99228) is valued at approximately half of what the same procedure is when completed as part of an eye visit (99250). Services outside of the specific CPT codes either are charged to the patient or non-covered. If the RVUs for portions of this team-based care are undervalued, there is little incentive to provide the service whereas over-valued services incentivize over-utilization. This can happen with the services provided by CHWs as with any other health care provider.[9]

For example, Medicare and many private health insurance plans have recently added coverage for services such as diabetes education and dietician counseling on a fee-for-service basis, thus providing stable funding for several valuable members of the primary care team.[10-12] However, the diabetes education service is very specifically defined as including 10 educational hours covered by Medicare benefit, in which 1 hour can be individual service and the remaining 9 hours must be group services unless the group class is unavailable or individual barriers are noted on the referral.[13] Only patients with diabetes who have an HbA1C level that is above a certain level and have not recently had diabetes education are eligible.[13] The payment is limited to certified diabetes educators (who hold advanced degrees and have passed the certification exam). Clearly, these rules limit the number of patients with diabetes who qualify for diabetes education and exclude CHWs from being reimbursed for performing the service. The current service is undervalued, making it challenging to sustain the service.

In this landscape, in order for CHWs to receive reimbursement, their services need to be clearly defined. In our experience, CHWs' services are unquestionably valuable to the patient and the payer, yet because CHWs currently fill many roles and meet both individual and community needs, it is difficult to delineate all the services that they can provide or that will be needed in a straightforward manner, especially under the CPT/RVU payment structure. And although CHWs all have common ties, such as being from the communities they serve and having a strong desire to serve their communities, the roles and responsibilities of CHWs on health care teams and in communities vary from one setting to another.

The second step towards reimbursement under the fee-for-service model is defining which patients are eligible to receive CHW services, and how frequently and for how long the patients may receive these services. This is also complex because many individuals could benefit from the services of CHWs for many different reasons, all leading to better quality health care and improved health outcomes. An example of the limitation is the chronic disease management codes (99490, 99491, 99487, 99489), which allow for reimbursement for chronic care management for certain, "complex" patients. To be eligible, the patient is required to have multiple chronic conditions and be at significant risk of death, acute exacerbation/decompensation, or functional decline. While eligible patients meeting this CPT code can certainly benefit from the services provided by CHWs under this code, the value of the CHWs extends to a much broader population than defined by these CPT codes.[14] For instance, a patient with advanced cancer, but no other conditions would not qualify as an eligible patient. Thus, a CHW/cancer navigator's services could not qualify as a covered service.

The third step is to calculate the precise cost of CHW services. As noted above, if a service is undervalued by a health plan, the reimbursement will be inadequate and CHWs will not be sustained as members of the health care team without additional funding. If the services are overvalued, with the amount of reimbursement being higher than the cost of providing the services, there will be incentives to overutilize CHWs to increase revenue, and overall costs may increase.[9]

Completing all of these steps could lead to a way to reimburse CHWs under the current fee-for-service model, but the model is still problematic. Under the fee-for-service model, there is a strong incentive for health care teams to focus their work on delivering revenue-generating services, which may not always be the same services that best serve patients and the community.[15] While there is tremendous resistance by physicians to abandon the CPT coding and the associated fee-for-service payment methodology, the current methodology is understood to be a root cause of over utilization of services.[9]

The fee-for-service model also involves administrative costs for coding, documentation, and completing claims forms, and these processes may be particularly complex to complete for CHW services because of the dynamic roles that CHWs fill. Given the different roles that CHWs play in different practices and communities, the fee-for-service payment model will not cover all services provided or all patients who would benefit from the services.[16,17]

Value Based Payment Models

Although the fee-for-service model continues to be the most prevalent payment mechanism in the US, an increasing number of primary care providers in Hawai'i and elsewhere receive payment through alternative payment methods (APM).[18] In APM models, payments are linked to quality-of-care metrics or cost savings outcomes based on reaching optimal health goals (eg, a certain HbA1C level). In some cases, APMs are structured within the fee-for-service model. For example, fee-for-service payments may be withheld if quality goals, such as a low rate of preventable readmissions, are not met, and/or bonuses may be given for achieving quality goals (eg, a certain percentage of patients with diabetes who are well-controlled). Other APMs are structured under the capitation model, which is designed to give providers a set payment to cover all the services that their patients need during a specific time without controlling for the number of episodes of care, or utilize some form of global payments.[15]

Value-based payment is becoming the dominant payment mechanism for Medicare, which offers higher payments to providers who are members of accountable care organizations (ACOs) than to providers who use fee-for-service models. ACOs seek to integrate entities such as hospitals, providers, pharmacies, and ambulatory services into larger delivery systems to improve quality and reduce cost by decreasing inefficiency and waste.[14]

In ACO structures, payments are made for team-based care, rather than funneled through one provider or select members of the team. The concept of a bundle payment works well, in particular, for services paid for patients with chronic conditions. Chronic disease is best delivered by a team and should be paid to the team.[19] Team-based chronic disease management is advocated by multiple national organizations including the American Diabetes Association, CDC, and specialty societies.[13,20,21]

Another model is the bundled payments model. This system requires reporting individual services, but payments are not linked to specific services. Rather, bundled payments are linked to a set of services provided and the outcomes. Bundled services also work well for surgical procedures with required recovery (such as total knee replacement), but can be also be used to provide for diabetes services for a year. CHWs can thus be included as part of the care team within these payment structures.

The services of CHWs can provide considerable cost benefits in value-based payment models. CHWs can broaden the reach of health care teams by addressing the social determinants of health and working to remove both medical and non-medical barriers that directly or indirectly impact patient health.[22-25] CHWs provide a broad range of services including outreach/engagement, education and counseling, individual and community advocacy, basic health screenings, needs assessment, and improved coordination within the health team. By bringing their personal understanding of a community's culture and language, and identifying the challenges and obstacles that patients face, CHWs directly impact patient health outcomes, improve the patient experience, and facilitate appropriate referrals as part of care coordination.[25]

Additionally, CHWs can provide support for value-based care principles by helping to reduce utilization by addressing social determinants of health and increasing patient engagement.[26] Our current volume-based payment system fragments payments. Multiple providers (specialists, primary care providers, diabetes educators, therapists, behavioral health specialist, and dieticians) compete for limited reimbursement dollars.[26-27] In value-based payment models, effective care and allocation of resources can occur at the point of care and providers are incentivized to work together for payment, which is achieved from good health outcomes.

As we move towards value-based payment methods that reward quality health care at the most reasonable cost, teams are particularly important.[28] Recent payment transformation in Hawai‘i has focused on capitation of PCP services. Although capitation provides some flexibility for the physician to use discretion in delivering needed services, it has limitations. One is that this model incentivizes the physician rather than a team to transform the care of patients, and so it may not always result in high-quality care.[29] Capitation payments go to the physician whose take-home pay directly relates to the office overhead with most of the cost for salaries of the team-members. The current doctor-centric, acute care and episodic visit model is not designed for chronic care teams or effective chronic care management.[30] Among the many types of APMs, the ACOs and bundled-payment models are designed to both reward integrated delivery systems and pay teams for group outcomes rather than team members for individual activities.

Community-Clinical Linkages

In many health care organizations, there is still a significant lack of understanding of, and respect for, the services of CHWs, including limited recognition of CHWs' abilities to broaden care coordination and manage population health.[31] Many CHW activities have both direct and indirect benefits in building linkages from the community to the health center. By addressing patients' social needs or social determinants of health, CHW services can lead to healthier lives for patients and fewer costly encounters within the healthcare system.[32] When CHWs participate in health fairs and other community events, run programs at senior centers, and create partnerships with schools, they directly impact patients and their health outcomes by identifying risks, teaching skills, and assisting with obtaining needed services. They also build the relationships with individuals and the community that are required to deliver high-quality care. But to achieve all this, CHWs must be integrated into the overall delivery of care system, and this will require that provider/payer systems employ CHWs as part of care teams.

Conclusions

Currently, most CHW positions rely on grant funds as there is reluctance of health systems and health plans to reimburse CHW services, despite evidence that these services can provide positive outcomes.[33] Obstacles to hiring CHWs often relate to the costs of hiring and staffing, and the lack of standardization of CHW roles.[33] The true integration of CHWs into health care teams on a local and national level will require redesigning care processes within clinical settings and obtaining commitments from providers and payer systems to integrate CHW reimbursement as part of the cost of care.

The expansion of CHWs' roles comes at a time when the mechanisms for reimbursement of health care services are rapidly changing. As health care administrators, we wish to include CHWs as permanent members of our care teams, but often have to rely on grants or creative solutions to do so because of these complexities. Health administrators considering how to reimburse CHWs for their valuable contributions need to consider not only today's primarily fee-for-service model, but also take into consideration the prospective evolution of payment models that will likely occur over the next 5 to 10 years.

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