Summary of Proposed Demonstration Project

For this demonstration project, we propose to pilot a per-member/per month (PMPM), value-based model for MCOs to delegate certain care coordination functions to unlicensed providers (CHWs, peer support workers, etc.) to allow more localized care coordination services. MCO's would retain administrative and monitoring responsibilities but outsource certain on-the-ground care coordination functions to local service providers, thus providing sustainable funding for CHW services. The PMPM rate would be adjusted to a stratified population, tier 1 requiring the least intensive services, tier 2 moderate intensity, and tier 3 high-intensity services.

Introduction

A Community Health Worker (CHW) is a community member who works in community and tribal settings and serves as a connector between health-care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. As members of the communities they serve, CHWs bring cultural fluency and enriching relationships to their work in promoting community health. They work under multiple job titles in New Mexico, including promotoras, community health promotoras, navigators, outreach specialists, doulas, community health representatives, and more.

The term Community Health Worker (CHW) is used throughout this proposal. It is intended to encompass all job titles referring to unlicensed paraprofessionals who act as liaisons between community members and health-care systems; including work within Indian Health Service (IHS) and other tribal programs and agencies. In previous waivers, non-licensed providers (including CHWs, Peer Support Specialists, Community Support Specialists, Wraparound Specialists, and other job titles) have been justified and recognized in proposals; these paraprofessionals are included in the broad definition of CHWs used in this proposal.

This definition is intended to include individuals who are certified by the appropriate state agency or licensing board. Through certification, they are allowed to provide the functions defined below that are within their scope of practice. If a task is within their scope of practice and recognized by the appropriate agency or board, they should be allowed to provide this service.

CHWs have been an integral part of New Mexico's health care workforce and social systems for over half a century. In 2003, an estimated 500 CHWs were employed in various capacities in the state (Senate Joint Memorial 076 Report on the Development of a Community Health Advocacy Program in New Mexico. (2003). https://nmhealth.org/publication/view/memorial/546). Today, that number is estimated at closer to 5,000.

Most recently, CHWs have played – and continue to play – a critical role in New Mexico's response to the COVID-19 pandemic. COVID-19 illuminated existing health disparities, and

CHWs have stepped into the equity gap as frontline health-care providers and to address immediate public health needs. The expansion of need required full use of their intended scope of practice for CHWs, including telehealth, telephonic, and face-to-face encounters; emergency response duties including contact tracing, investigations, testing, education, and participation in different non-traditional settings. Their deep expertise in their local communities means they are uniquely able to connect community members to clinical, public health, and safety-net resources, translate confusing messages into actionable information, create paths to health-care, social services, resources, and other necessities, and provide education about COVID-19 prevention and safety. The importance of the CHW role has never been more apparent.

This proposed demonstration seeks to use the existing CHW workforce to redefine care coordination, expand access, and improve integration of services while implementing new targeted strategies to address specific gaps in care service that can be filled uniquely by CHWs. It aligns with the following key initiatives of the Centennial Care 2.0 waiver:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

Service Description

Centennial Care 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and community-based services (HCBS). MCO are contractually obligated to provide care coordination to members. MCO's receive a per-member/per month (PMPM) rate from Medicaid, and a percentage of that funding can go to administrative funds, a portion of which are used to employ CHWs.

While MCOs are providing care coordination services, they are doing so mostly from centralized locations (i.e. Albuquerque) using licensed providers as care coordinators. Without intimate knowledge of local resources, culture, and relationships, care coordinators are often unable to

provide culturally appropriate comprehensive services for their clients. Effective care coordination requires knowledge of a patient's community and circumstances, stated and unstated belief systems, preferred language, and its resources and strengths. Shortages of licensed health-care providers exist statewide and are most acute in rural areas, compounding the problem. With the exception of Los Alamos, all counties in New Mexico are designated as Health Professional Shortage Areas (HPSAs) by the Health Resources and Services Administration (HRSA).

CHWs can step into this gap and provide deep, localized understanding of the socioeconomic, geographic, and cultural barriers to accessing medically necessary care and identify resources to address those barriers.

CHWs are trained, qualified, and able to address barriers to necessary medical care, including:

- Geographic distance from health services, compounded by lack of reliable transportation. This results in the inability to attend medical appointments or pick up prescriptions,
- Lack of phone and internet access. This results in the individual going to the emergency department instead of scheduling a medical appointment, impedes communication, and makes use of telehealth platforms impossible
- Cultural/language communication barriers results in the individual not following medical professionals' recommendations
- Low health literacy at the personal, organizational, and community levels, which impedes access to actionable health information, makes it difficult for patients to understand medical instructions, and leads to often dangerous miscommunication
- Distrust of the health-care and social services systems, government, and other institutions often precludes people from accessing care and services
- Inappropriate use of health-care resources, including emergency, urgent, and primary care
- Social drivers of health, including socioeconomic, educational, current and historical trauma. The majority of counties in New Mexico have a social vulnerability index (SVI) of greater than 0.9 (Centers for Disease Control and Prevention [cartographer]. Social Vulnerability Index [map]. Retrieved from https://svi.cdc.gov/map.html).

Staffing Requirements and MCO Delegation

The New Mexico Human Services Department, Medical Assistance Division, Managed Care Policy Manual clearly includes community health workers in many care coordination roles: "The role of community health workers (community health advisors, community health representatives, lay health advocates, promotoras, outreach educators, peer health promoters and

peer health educators)" is to supplement and support the care coordination function required in managed care."

The performance of the Comprehensive Needs Assessment (CNA) is the primary responsibility of the MCO other than when delegated as allowable by the State. The MCO will implement policies and procedures that will define and specify the qualifications, experience and training of each member of the care coordination team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator.

CHWs are uniquely qualified to fulfill many of these roles. For this demonstration project, we propose to pilot a PMPM, value-based model for MCOs to delegate certain care coordination functions to unlicensed providers (CHWs, peer support workers, etc.) to allow more localized care coordination services. MCO's would retain administrative and monitoring responsibilities but outsource certain on-the-ground care coordination functions to local service providers, thus providing sustainable funding for CHW services. The PMPM rate would be adjusted to a stratified population, tier 1 requiring the least intensive services, tier 2 moderate intensity, and tier 3 high-intensity services.

Proposed Care Coordination Functions for CHWs

The following are required primary-care coordination functions that can be performed by unlicensed, certified CHW staff employed by the MCO or subcontracted to local provider organizations, know as "extenders," who employ or contract with CHWs:

1. Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and are not currently identified for Care Coordination Level 2 or 3 services;
2. Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
3. Administering the Centennial Care Community Benefit Service Questionnaire (CBSQ) as applicable (see CBSQ Section);
4. Conducting semi-annual or quarterly in-person visits with the member;
5. Conducting quarterly or monthly telephone contact with the member; and
6. Assisting licensed staff with development of a Comprehensive Care Plan (CCP) development and updates.

Other care coordination activities that will enhance the Care Coordination program may be subcontracted to "extenders" such as community health workers. These functions include:

1. Health Education

   a. Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.
   b. Educate members with identified disease management needs by providing specific disease management interventions and strategies.
   c. Educate the member about his or her ability to have an Advance Directive and ensure the member's decision is well documented in the member's file.
   d. Educate the member about non Medicaid services available as appropriate (e.g. Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant Mental Health).
   e. Reflect cultural considerations of the member and conduct the care plan process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

2. Ongoing care coordination: Ongoing care coordination functions shall include all elements defined in the contract including the following:
   a. Identify gaps and address the needs of the member, including gathering of information to assist in the development and/or update the care plan as needed.
   b. Ensure when a member's level of care coordination increases or decreases that continuity of care is always maintained.
   c. Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.
   d. Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member's goals and foster independence.
   e. Coordinate and provide access to specialists, as needed; relevant long term specialty providers, relevant emergency resources, relevant rehabilitation therapy services, relevant non-Medicaid services, etc.
   f. Educate the member regarding service delivery through Medicare and/or Medicaid.
   g. Measure and evaluate outcomes designated in the care plan and monitor progress to ensure covered services are being received and assist in resolution of identified problems.
   h. Achieve coordination of physical, behavioral health and long term care services.
   i. Maintain consistent communication and contact with member's PCP, specialists, and other individuals involved in the member's care
   j. Maintain and monitor the member's Community Benefit and provide assistance with complex services.
   k. Consider member and provider input to identify opportunities for improvement.
   l. Collaborate and/or cooperate with representatives of the Independent Consumer Support System (ICSS)

In addition to Care Coordination services listed above, other possible care coordination functions for CHWs from Medicaid Reimbursement Categories include:

- Peer services
- Screening
- Community/Rehabilitative Supports

Scope of Work for CHWs in New Mexico

As members of the communities they serve, CHWs provide culturally responsive support to clients while helping licensed providers to understand and respond to their patients' needs. They are able to reach people in New Mexico's U.S-Mexico border region communities and other rural, frontier and urban communities throughout the state.

The NMDOH Office of Community Health Workers (OCHW) has adopted the American Public Health Association (APHA) scope of work, which includes the following functions for CHWs:

- Health screenings
- Assessment of social drivers of health
- System navigation
- Translation services
- Transportation services
- In-home health attendant & respite care
- Community outreach and education,
- Health literacy
- Community-based health promotion
- Harm reduction
- Case coordination and case management including coordination and documentation of referrals and follow up with clients

The services can be provided face-to-face, by telehealth, or by phone with the patient (individually or in a group setting) in an outpatient, home or clinic, or other community settings.

CHWs support access to medically necessary care by providing services including:

1. Screening (social drivers of health, mental health, substance use, long covid, etc.)
2. Health literate communications
3. Prevention
4. Harm Reduction
5. Referrals
6. Culturally appropriate health education
7. Clinical Support Skills (including; but not limited to: vital signs, A1C, glucometer use, BMI measurement)
8. Advance care planning
9. Advocacy on behalf of a client
10. Helping a client enroll in insurance programs

CHWs work in many settings. As noted, MCOs employ CHWs to meet their care coordination goals. In addition, CHWs work in clinical facilities, including primary, specialty, and acute care; behavioral health, and hospitals including emergency departments. CHWs are increasingly positioned in community settings including homes, local and state agencies such as public health, health and human services departments, EMS/fire departments, K-12 schools, libraries, and faith-based organizations.

In tribal communities, CHRs are essential team members at Indian Health Service hospitals and facilities. CHRs have the cultural awareness and knowledge of how to properly access Native American communities.

Outcome Measures

To measure the impact of the proposed intervention, we propose to derive outcomes measures for this demonstration from two validated tools already used by MCOs and health-care provider organizations to measure care quality, outcomes, and patient satisfaction: HEDIS and CAHPS.

- Health Effectiveness Data and Information Set (HEDIS) is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) is utilized by MCOs to identify gaps in care and customer service as they relate to providers and members experiences with MCOs. CAHPS survey is conducted by a third party.

Select HEDIS measures, agreed upon by MCOs, OCHW, and NMHSD, will be used to assess the health outcomes, cost savings, and cost-effectiveness of this demonstration project.

Other proposed outcome measures include:

- Primary care utilization and costs
- Emergency department visits and costs
- In-patient hospitalizations: admissions, bed days, and costs
- Prescription (narcotic and non-narcotic)

Provider Qualifications: Certification

All categories of unlicensed providers referred to in this proposal must successfully complete a training course, including both didactics and field experience, which has been approved by the certifying or licensing agency for that profession. CHWs should be required to complete the didactic portion of their certification within six months of employment, and field experience

should be completed within one year. This provision is meant to avoid excluding community members who wish to work as CHWs while assuring they have the appropriate skills, competencies, and character to provide high-quality services.

To standardize the services provided under the CHW umbrella, including Community Health Representatives (CHR) within tribal communities, a minimal certification criteria for the CHW workforce is required for the ability to bill for services and for long-term sustainability. Likewise, other unlicensed providers referred to in this proposal are required to be certified in accordance with the appropriate state agency or licensing board. The general CHW certification process is described here.

The New Mexico Department of Health (NMDOH), Office of Community Health Workers (OCHW) falls under the auspices of the Public Health Division, Population & Community Health Bureau (P&CHB) and has developed a standardized, statewide training program and a certification process for community health workers (CHWs).

The formal recognition and utilization of CHWs as an essential part of a cost-effective health care system received legislative support with the passage of the Senate Bill 58 - Community Health Workers Act during the 2014 legislative session. This Act enables the New Mexico Department of Health to offer **voluntary** certification for CHWs in the state. Certification through grandfathering for CHWs who were practicing in the state before the passage of the Community Health Workers Act, (May 21, 2014) recognizes the experience and valuable contributions of CHWs for their longtime commitment to serving their communities.

While CHW certification is a key activity of the Office of Community Health Workers, the overall goal is to support the CHW profession and workforce development. Training, technical assistance, and promotion of career development is offered to all CHWs, regardless of certification status.

Core features of certification include:

- It is voluntary.
- A grandfathering process is in place to recognize and certify existing CHWs based on work or volunteer experience.
- Applicants who are new to the field are required to complete a training program approved by the New Mexico Department of Health before applying for state certification.
- All applicants are expected to demonstrate proficiency in CHW core competencies.
- Specialist certification is available for applicants who have training in department-approved specialty tracks.
- A background check is required of all applicants.
- Recertification:

    - Certificates are valid for two (2) years.
    - 30 hours of department-approved continuing education are required for recertification.
- The application fee for "generalist" certification is $45. Specialty certification for demonstrated additional education/training will be an additional $10 per specialty area

Several paths to CHW certification are available:

- CHWs who have extensive work or volunteer experience may apply for certification through a grandfathering process. The criteria to apply for state certification through the grandfathering process includes the following:
    1. Proof that applicant is at least 18 years of age by submission of a color copy of a photo ID (i.e.Government issued ID or Certificate of Indian Blood Card).
    2. Verification of proficiency in the core competencies through training and/or experience, signed by a current or former supervisor.
    3. Documentation of 2000 hours of work and/or volunteer experience as a CHW in the 2 (two) years prior to application or documentation of at least half-time paid or volunteer employment as a CHW in the 5 (five) years prior to application. The paid/volunteer experience must have occurred before 5/21/2014.
    4. Two letters of reference.
    5. Verification of specialty training certificates that you have successfully completed and may qualify you to be considered as specialist I, II, or III.
- Core competency training is a combination of qualities, practical skills, and knowledge essential to the provision of services by CHWs, demonstration of which is required for certification. The criteria to apply for state certification through the core competency training process includes the following:
    1. Proof that applicant is at least 18 years of age by submission of a color copy of a photo ID (i.e.Government issued ID or Certificate of Indian Blood Card).
    2. Verification of education, including documentation that the applicant has at least a high school diploma or certificate of high school equivalency.
    3. Verification of proficiency in the core competencies by providing a certificate of completion from a Department of Health, Office of Community Health Workers (NMDOH/OCHW) Certification Training Program or other NM endorsed training programs that contain an examination component for each of the core competencies. Copies of Certificates of Completion provided by the training organization are required.
- Certification Renewal process:
    1. Submit to the department a completed application in a form specified by the department to include proof of current certification.
    2. Submit to the department the designated application fee.

3. Provide proof of completion of at least 30 hours of department-approved continuing education.
4. Every other recertification period (every four years), if an applicant otherwise meets the eligibility requirements, then in accordance with this rule, submit a request to DPS or a DPS vendor for a current state and national criminal history screening.

Core Competencies required for certification include: The CHW Profession, Effective Communication, Interpersonal skills, Health Coaching, Service Coordination, Advocacy, Technical Teaching, Community Health Outreach, Community Knowledge & Assessment. Clinical Support Skills is optional for those who desire to enhance their skills or whose jobs require it.

Levels of Certification:

1. Generalist - an applicant who provides proof of completion of a department-approved training program that contains an examination component for each of the core competencies, or an applicant who meets the requirements for certification through grandfathering.
2. Specialist I - an applicant who meets the requirements for a generalist and who demonstrates additional education or training in at least one specialty area
3. Specialist II - an applicant who meets the requirements for a generalist and who demonstrates additional education or training in at least two specialty areas
4. Specialist III - an applicant who meets the requirements for a generalist and who demonstrates additional education or training in three or more specialty areas
5. Specialty areas include but are not limited to basic clinical support skills, heart health, chronic disease, behavioral health, maternal and child health or developmental disabilities.

The New Mexico CHW Certification Board is the governing entity that determines eligibility requirements for the established certification paths. Individuals who meet all eligibility requirements, including a background check, receive a Certified Community Health Worker (CCHW) certificate. A CCHW shall carry the CCHW card and present it upon request.

Cost Savings/Cost Effectiveness

The state of New Mexico has spent $736 million, including federal revenues, on care coordination under Centennial Care, yet little is known about its impact on cost savings or health outcomes (Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C., Maynes, C., Skipper, B., Powell, W., & Kaufman, A. (2012). Community Health Workers and Medicaid Managed Care in New Mexico. *Journal of Community Health*, *37*(3), 563–571. https://doi.org/10.1007/s10900-011-9484-1). Roughly five percent of Medicaid beneficiaries

account for nearly 60 percent of total program spending. Improving the quality of care for the program's most complex and costly patients is among the few viable options to curb rising costs over the long-term. (Kaiser Commission on Medicaid and the Uninsured and Urban Institute (2004) estimates based on MSIS.)

An ample and growing body of evidence indicates that CHWs are essential health-care team members who play an important role in care coordination and improving quality of care overall. They are the foundation for the "quintuple aim" of health care that is high-quality, cost-effective, patient-centered, satisfying to providers, and equitable. There is strong evidence that CHW services positively impact both health outcomes and return on investment. The high-touch health-care support provided by CHWs offers some of the highest value in health care.

In a paper published in 2012 in the *Journal of Community Health*, Johnson and colleagues describe the impact of community health workers (CHWs) providing community-based support services to enrollees who are high consumers of health resources in a Medicaid managed care system. The project, a partnership between Molina Health Care and UNM HSC Department of Family and Community Medicine (DFCM), showed a $4 savings per dollar invested when CHW supportive services were provided in a manner similar to this proposal.

The difference in cost from 6-months before to 6-months after CHW intervention for the 448 patients in the study sample was calculated. Costs were lower in all categories:Emergency Department—$425,551, inpatient—$872,694, nonnarcotics prescriptions—$699,129, and narcotics prescription—$42,091. The total cost differential was $2,044,465 less after the CHW intervention compared to beforehand. In addition, resource utilization in each category decreased substantially in the CHW intervention group, including in-patient, prescription and narcotic counts and cost.

This New Mexico-centered study is part of a body of evidence that shows CHWs play an important role in improving health through enhancing clinical outcomes and by addressing the social conditions that impact health status, called social determinants of health. "We found that every dollar invested in the intervention would return $2.47 to an average Medicaid payer within the fiscal year." (Kangovi, S., Mitra, N., Grande, D., Long, J., & Asch, D. (2020). Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment. *Health Affairs, 39*(2), 207 – 213).

The Medicaid and CHIP Payment and Access Commission (MACPAC) cites the following examples of studies that showed cost-savings for Medicaid in

particular:[1].(https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf)

- A study of CHW home visits for Medicaid-enrolled children with asthma found that the program increased symptom-free days and reduced urgent health care use, and produced a positive return on investment (Campbell et al. 2015).
- A study of the Individualized Management for Patient-Centered Targets (IMPaCT), a standardized community health worker intervention aimed at addressing unmet social needs, estimated a return on investment of $2.47 for every dollar invested to an average Medicaid payer (Kangovi et al. 2020).
- A study of the Arkansas Community Connector Program, which used CHWs to identify people with unmet long-term care needs in three disadvantaged counties, and connect them to Medicaid home and community-based services (HCBS), found a 23.8 percent average reduction in annual Medicaid spending per participant during a three-year period. This resulted in $2.6 million in net savings for the Arkansas Medicaid program (Felix et al. 2011).
- Additional studies focused on CHW programs serving low-income or other underserved populations show that CHWs can improve health outcomes in specific contexts. For example:
    - Systematic reviews have found that when used as part of chronic care management interventions, such as blood pressure and diabetes education, CHWs can help improve disease control and reduce mental health symptoms such as depression and substance use disorder (Allen et al. 2014, Barnett et al. 2018).
    - Several studies have found that interventions using CHWs helped to improve health outcomes among racial and ethnic minorities. For example, one study found that the Boston Children's Hospital's Community Asthma Initiative (in which nurses and CHWs provide home visits and asthma care management) reduced asthma morbidity among Black and Hispanic children (Woods et al. 2016). Another study found that a program using CHWs as patient navigators led to increased receipt of timely cancer care among low-income and minority populations (Freund et al. 2014). Additionally, in one randomized controlled trial, Hispanic patients at urban clinics assigned to CHWs had improved health status and habits, lower emergency department (ED) use, and greater odds of decreased body-mass index (Babamoto et al. 2009).

[1] MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

Reimbursement Methodology

For this demonstration project, we propose to pilot a PMPM, value-based model for MCOs to delegate certain care coordination functions to unlicensed providers (CHWs, peer support workers, etc.) to allow more localized care coordination services. MCO's would pay local service providers for CHWs to perform certain on-the-ground care coordination functions. The PMPM rate would be adjusted to a stratified population, tier 1 requiring the least intensive services, tier 2 moderate intensity, and tier 3 high-intensity services.

In addition, for services beyond care coordination, we propose that MCOs be allowed to provide PMPM to CHWs/provider organizations, including primary care clinics, behavioral health clinics, acute care facilities, Indian Health Services, and community providers, based on the number of new members the facility sees within the MCO. Clinics should be allowed to use CHWs to perform work as needed, within their scope. CHW services should not be limited to physician visits but provided under physician/licensed provider supervision. This value-based, PMPM bundling of payments should not replace any established billing codes for unlicensed providers.

Summary

In summary, CHWs are essential members of the health-care team working together to deliver high-quality, highly coordinated care for patients. They are essential to high quality, culturally and linguistically appropriate, effective care coordination. They act as a bridge between the patient, family, and other members of the health-care team including physicians, medical assistants, nurses, social workers, mental health practitioners, and others. Their skill set complements that of other health-care team members, rendering access to more effective medically necessary care. They provide comprehensive risk reduction for longitudinal care with case management, identify patterns of repeat patients, and help to redirect them to less costly, more beneficial resources such as primary care. Increasing CHWs role in care coordination through policy and funding mechanisms is a strategic investment in a more effective, efficient, and equitable health-care system for all New Mexicans.

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