Michigan Community Health Worker Alliance

In partnership with the Michigan Association of Health Plans

2016 Michigan Health Plan Survey: CHWs & Population Health

Data from the Health Plan Survey

September 29, 2016

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SURVEY REPORT

Background

As part of the 2016 State of Michigan Department of Health and Human Services Medicaid Managed Care Contract, Medicaid managed care plans are required to hire or contract for the services of at least one community health worker (CHW) per 20,000 health plan members[1]. With over 1.6 million Medicaid beneficiaries in the state[2], health plans will need to pay for 80 CHWs per year for the next five years.

The contract defines a CHW as follows:

> Frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs 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.

In addition, on July 1, 2016, the State of Michigan launched an Affordable Care Act Health Homes innovation. Known in Michigan as MI Care Team, this initiative pays for services for complex Medicaid or Healthy Michigan Plan patients with both behavioral and physical chronic diseases in ten Federally Qualified Health Centers, statewide[3]. A CHW is a mandatory member of each MI Care Team.

In response to these policy changes, the Michigan Association of Health Plans (MAHP), the Michigan Association of Health Plans Foundation (MAHPF) and the Michigan Community Health Worker Alliance (MiCHWA) partnered to develop and conduct a survey of managed care plans to assess how they are addressing population health needs with their members an and how they are meeting the CHW-related requirements of the Medicaid contract. All but one Michigan Medicaid health plan is a member of MAHP.

Methods

MiCHWA, MAHP, MAHPF and members of MiCHWA's Financing Models Ad-Hoc Group (including MAHP, MAHPF, several health plans, health systems, community-based organizations and others interested in CHW sustainability), partnered to design a survey of health plans. Survey content related to population health and use of CHWs, including payment for CHW services. The survey was converted into an electronic format and distributed online by MAHP to its members. Members were given six weeks to respond, with reminders during meetings and via email. This report provides key findings and data from the survey. This report includes each survey question followed by a summary of the results for that question. Unless otherwise noted, all survey response comments are reported. The survey instrument is located in the appendix.

Data analysis included simple counts and calculation of percentages. Because skip logic was not employed in the electronic survey, skip logic was applied manually during analysis. For example, if a respondent said "yes" to a stem question such as question 3, then we analyzed their responses to the related set of questions that followed. If a respondent said "no" to a stem question such as question 3, and proceeded to answer the follow-up questions related to that question, those responses were

[1] http://www.michigan.gov/documents/contract_7696_7.pdf
[2] http://www.michigan.gov/documents/mdhhs/JE02032016_517568_7.pdf
[3] http://www.michwa.org/wp-content/uploads/1569-MiCT-P_510092_7-1.pdf

excluded. Open ended responses are presented in quotation marks.

RESULTS

The survey received responses from eight separate Michigan health plans, after eliminating duplicate or unidentifiable responses. Table 1 presents respondents by prosperity regions served[4] and type of coverage offered.

Table 1: Health Plans Surveyed

Health Plan I.D.	Regions Served	Types of Insurance
1	2-6, 8, 10, & Upper Peninsula	Medicaid & Medicare
2	10 & 6	Medicaid & Commercial
3	10	Medicaid
4	2-10	Medicaid & Medicare
5	2-10 & Upper Peninsula	Medicaid & Medicare
6	2, 4, & 8	Medicaid, Medicare, & Commercial
7	All Regions	Medicaid, Medicare, & Commercial
8	4, 7, & 9	Medicaid & Medicare

Key Findings: Addressing Population Health

The Medicaid Managed Care Contract seeks to address population health and defines population health as follows:

> Management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum[1].

The first part of the survey asked respondents about population health needs among their member populations, challenges they face in addressing these needs, agencies with which they contract to address these needs, and technical assistance interests related to population health.

[4] Per the Medicaid contract rules, plans were required to bid on at least one of ten prosperity regions, regions created by Governor Rick Snyder's administration.

1. Please rank on a scale of 1-5 the level of need among your members (1 being the least, 5 being the highest)

On a scale of 1-5, the mean scores among respondents ranged from 3.13 - 4.63, with the highest level of need for "connecting to resources" (4.63).

Table 2: Level of Need (social determinants of health) (Scale=1-5 with 5 highest need)

Scale average	Needs identified by respondents
4.63	Connecting to resources
4.38	Income
4.38	Connecting to a medical home and/or primary care provider
4.25	Transportation
4.12	Housing
3.88	Food security
3.88	Human services
3.75	Health services
3.75	Employment
3.5	Immunizations
3.5	Other
3.38	Education
3.13	Establishing/maintaining health insurance

2. What challenges does your health plan face in tackling population health issues?

Table 3: Challenges of health plans in tackling population health issues

Theme	Response
Difficulty locating and contacting members (n=6)	• "Bad phone numbers and addresses" • "Finding and engaging the member" • "Our population has frequent address and phone number changes making it difficult to outreach to members to assess potential barriers…" • "Establishing and maintaining contact" • "Contacting the member" • "Reaching the member due to wrong contact information"
Lack of resources including transportation, housing, food, employment, etc. (n=2)	• "We have issues with statewide transportation vendors resulting in access issues. We also have challenges due to lack of resources to address the needs of the homeless population, housing, food, transportation, and employment." • "Resources, in general"
Cultural differences (n=1)	• "Cultural challenges with the population"

3. Do you currently contract with external agencies for services that impact or address population health? (response categories: yes/no) (n=8)

- 100% (8/8) of respondents replied that they are currently contracting with external agencies for services that impact or address population health.

3a. If yes, what types of agencies do you contract with? (check all that apply) (n=8)

- 100% of respondents (8/8) indicated that they contract with non-faith-based community-based organizations.
- 87.5% of respondents (7/8) indicated they contract with federally qualified health centers (FQHCs) and local health departments.
- 75% of respondents (6/8) indicated they contract with medical practices.
- 62.5% of respondents (5/8) indicated they contract with hospitals/medical clinics (not FQHCs).
- 25% of respondents (2/8) indicated they contract with faith-based organizations.
- 12.5% of respondents (1/8) indicated they contract with academic/research organizations.
- Other agencies respondents noted are: Area Agencies for the Aging, Food Bank of Eastern Michigan, Michigan Community Health Worker Alliance (MiCHWA), and Visiting Physician/Nurse Practitioner organization.

4. Are you interested in support or technical assistance on addressing population health of your members? (response categories (yes/no/maybe) (n=8)

- No respondent answered “yes”.
- 87.5% of respondents answered that they are “maybe” interested in support or technical assistance on addressing population health of their members (n=7).
- 12.5% of respondents (1/8) answered “no” (n=1).

5. Are there specific topics you are interested in learning more about? n=3

- Of the eight respondents who responded to question 4, three respondents replied to this question. Their answers varied:
    - One respondent responded that they would like to learn more about supervision of CHWs, CHW roles, and productivity measurement of CHWs.
    - One respondent felt “they would be better positioned to react to a list provided [to them] of the types of technical assistance available.”
    - One respondent replied they are “still assessing [their] gaps,” but would like to learn more about “how to address the underlying issue of poverty” and “meeting the basic need issue.”

Key Findings: Utilization of and Payment for Community Health Workers

The second part of the survey asked health plans to discuss their utilization and current financing mechanisms for CHWs. The Medicaid Managed Care Contract does not dictate how each plan needs to pay for CHWs. Each plan can choose their own method and develop their own payment mechanisms. The survey asked about a) direct employment of CHWs by the health plan; b) contracting with individual CHWs, c) contracting with, or reimbursing external agencies for CHW services. Respondents to each of these options were then asked a set of follow-up questions regarding related to the specific response.

6. How is your health plan currently utilizing CHWs? (n=8)

a) 50% of respondents directly employ CHWs (n=4).
b) 12.5 % of respondents contract with individual CHWs* (n=1)
c) 50% of respondents contract or reimburse external agencies for CHW services (n=4).
* Note: the response to "b" may have been an error. No responses were provided for the related follow-up questions.

6.a. Direct employment of CHWS (n=5)

The survey asked respondents questions relating to direct employment of CHWs. These questions are listed below, followed by responses from the 5 respondents who indicated that they directly employ CHWs. Not all 5 respondents answered each follow-up question.

6. a. i. how many CHWs do you currently employ? (n=5)

- The five respondents reported that they directly employ one, four, eighteen, and twenty-two and twenty-five CHWs, respectively.

6.a.ii. What population(s) do your CHWs primarily work with? (n=4)

- Four health plans (4/5) that directly employ CHWs gave varied responses:
    - Medicaid populations only (n=1).
    - Medicaid, Medicare and Marketplace members (n=1).
    - All member populations (n=1).
    - All members in every lower Peninsula County (n=1).
    - High risk populations with multiple co-morbid conditions, behavioral health diagnoses, and history with lack of connection to a medical home

6.a.iii) Why did you choose to directly employ CHWs? (n=4)

- Four health plans (4/5) that directly employ CHWs gave varied responses:
    - "The decision to directly employ CHWs is related to our overall Person Centered Care Model which is comprised of care teams in which the CHW is an integral part."
    - "Greater ability to manage and coordinate activities and initiatives."
    - "Familiarity with community; able to relate with population."
    - "Training consistency, culture, and member relationships."

6.a.iv. Do your direct-employed CHWs provide health services? (examples include diabetic

foot checks, blood pressure screening, etc.) (n=4)

- There were four respondents to this question, all of whom reported that CHWs do not provide health services.

6.b. Contracting with individual CHWS (n=0)

- There were no responses to this question set. The one initial yes response to 6.b may have been in error.

6.c. Contracting with or reimbursing external agencies for CHW services (n=4)

Four respondents reported that they contract or reimburse external agencies for CHW services. One of these four also directly employs CHWs. All four respondents answered the follow-up questions.

6.c.i. How many agencies do you contract with for CHWs services? (n=4)

- The number of agencies that respondents contract with for CHW services varied. The range in the number of external agencies with whom the health plans contract is from 2 to 15. Responses were:
    - two external agencies
    - three external agencies
    - At least five external agencies. This respondent noted that they are "growing every day" when it comes to contracting with external agencies.
    - Fifteen external agencies

6.c.ii. What types of agencies do you contract with for CHW services? (n=4)

- All respondents indicated they contract with non-faith-based community-based organizations (n=4).
- 50% of respondents indicated they contract with local health departments (n=2).
- 25% of respondents indicated they contract with federally qualified health centers (FQHCs) (n=1).
- Other external organizations with contract are: Pathways and Healthier Communities.

6.c.iii. What type of payment model(s) are being used in contracting with agencies for CHW services? (n=4)

- 75% of respondents use outcomes-based or value-based payment for specific health outcomes per-member (n=3).
- 50% of respondents use service-based payment (n=2).
- 25% of respondents use per-member-per-month payment only for the CHW, per-member-per-month for the clinical care team, including the CHW, and bundled payment for services, including those of the CHW (n=1).

6.c.iv. What population(s) do these CHWs primarily work with? (n=4)

Populations lacking a connections to a medical home or missing services and those who are hard to reach is the common theme among the 4 respondents. Specific responses were:

- "difficult to reach" populations (n=1).
- "Medicaid members that we have difficulty reaching, or that are missing services, Medicaid and dual eligible members."
- "Medicaid; high ER utilizers; members not engaged with a medical home; and the

homeless populations." (n=1)
    - High risk populations with multiple co-morbid conditions, behavioral health diagnoses, and history with lack of connection to a medical home. (n-1)

6.c.v. Why did you choose to contract with external agencies for CHWS? (n=3)

- Three of the four respondents who use contracts gave various answers for choosing to contract with external agencies:
    - "access to a greater number of CHWs; [they] did not need to hire/train [CHWs]…."and to meet the need of our members." (n=1)
    - "to have the CHWs live where they work." (n=1)
    - "experience of external agencies" (n=1)

6.c.vi. Are your contracted agencies using specific billing codes for CHW services? If yes, which codes? (n=4)

- 50% of respondents (2/4) indicated that their contracted agencies use specific billing codes; 50% responded that their contracted agencies did not use billing codes.
- One respondent supplied code S9445. The other respondent supplied H2015, and H2016

6.c.vii. How often are payments issued to these agencies?(n=4)

- 75% of respondents (3/4) replied that payments are issued monthly.
- One respondent noted that they are still in the negotiation process. Another respondent noted that payments are issued when a claim is submitted.

Key Findings: Future Plans for Community Health Worker Utilization

7. How does your managed care organization plan to use CHWs in the coming year? (n=8)

- None of the eight respondents (0/8) plan to contract with individual CHWs in the coming year.
- 75% of respondents (6/8) plan to contract with external agencies for CHW services in the coming year.
- 62.5% of respondents (5/8) plan to directly employ CHWs in the coming year.
- 25% of respondents (2/8) plan to reimburse for services.

NEXT STEPS

MiCHWA regularly convenes a Policy and Finance Working Group. It also hosts a MiCHWA Financing Models Ad-Hoc Group that includes Policy and Finance Working Group members, MAHP, MAHPF, health plans, health systems, community-based organizations and others interested in CHW sustainability. MiCHWA is also partnering with the Michigan Public Health Institute on a Kellogg Foundation-funded project that aims to seek sustainable financing mechanisms for CHWs. Members of these groups will partner with MAHP to review report results and recommend next steps.