

Threading the Needle: Strategies to Elevate the Role of Community Health Workers in Emerging Models of Care for Dual Eligibles

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Executive Summary

Individuals dually eligible for Medicare and Medicaid, known as “dual eligibles,” represent one of the most vulnerable populations under the purview of America’s public insurance programs. Characterized by advanced age and functional limitations, dual eligibles present complex health care needs that have historically been mismanaged by the separate Medicare and Medicaid entities. Recent legislation at the federal and state levels introduced new policy opportunities for Medicare-Medicaid integration. California’s integration effort is known as Cal MediConnect.

In California, the dual eligible population is linguistically and culturally diverse, which presents both challenges and opportunities for the implementation of Cal MediConnect, including the need for culturally competent care. Community health workers, non-licensed members of the community that act as a bridge between the formal health care system and community members, may be able to meet this need. As members of the marginalized communities they serve and as a labor force that emerged in the shadow of the formal health care systems, community health workers themselves are also vulnerable.

This paper proposes a partnership between the dual eligible population of Los Angeles County and the CHW labor force, mediated by the emerging care delivery and financing systems for dual eligibles in Los Angeles County. Interviews with members of various stakeholder sectors revealed a lack of communication between CHWs and health plans, the potential use of CHWs as enrollment counselors or as a part of interdisciplinary care teams, and the difficulty and unlikelihood of CHW inclusion in formal health care systems under Cal MediConnect. Recommendations include CHW initiated communication with health plans, coalition building, and lobbying efforts on the part of CHWs.

Introduction: Dual Eligibles and Community Health Workers—A Potential Partnership

Individuals eligible for Medicare and Medicaid have some of the most complex health needs in America.¹ In California, and especially in Los Angeles County, people with these needs are also linguistically and culturally diverse, thus creating a need for culturally and linguistically competent care.² Community health workers (CHWs) often share the cultural and linguistic qualities of community members who are dually eligible, and therefore can help them understand and connect with a fragmented and evolving health care delivery landscape.

Recent policy efforts in California to integrate the financing and delivery of Medicare and Medicaid services offer mutually beneficial opportunities for these populations – CHWs could be trained as effective advocates and health literacy translators of the health system changes inherent in integrating these major public programs, and beneficiaries could get culturally appropriate support from CHWs knowledgeable about this health system change. To give a human touch to this scenario, below are two case studies of people who are dually eligible for Medicare and Medicaid and the experiences they encounter in the current system of care.

The Face of Dually Eligible Beneficiaries: Dave and Earsy

Dave, a 34-year-old California resident, has schizophrenia/schizoaffective disorder. Dave struggles to remember his own address, telephone number, or the day of the week. He has been hospitalized several times following manic episodes but has remained stable for over three years due to the constant care provided by his life partner, Doug.³

¹ *Dual Eligible Beneficiaries: An Overview.*

² Cutler, Rich, and Yee, *Advocate's Guide to California's Coordinated Care Initiative*; Rubino and French, "Re-Engineering the Los Angeles County Public Health Care Safety Net: Recommendations from a Blue Ribbon Health Task Force."

³ "Caught In the Middle."

Earsy, a 77-year-old mother of nine and grandmother of 27, requires daily assistance. Earsy, once a caregiver herself, suffered a diabetes-related stroke that left the right side of her body paralyzed. As a result, Earsy needs helps with activities of daily living (ADL), like bathing, dressing, and eating.⁴

Dave and Earsy both qualify for Medicare and Medicaid by virtue of their disabling conditions, low-incomes, and in Earsy's case, advanced age. Doug and Earsy are known as "dual eligibles."⁵ The dual eligible population, comprised of low-income older adults and younger people with disabilities, relies on the public insurance programs Medicaid and Medicare to meet their health care needs.⁶ In theory, dual eligibles like Dave and Earsy have one of the most comprehensive health care packages available. However, in practice, it is extraordinarily difficult to mobilize this coverage in a seamless way due to the lack of coordination and communication between the two programs.

Dave and Earsy face difficulty navigating the complicated bureaucracies of Medicare and Medicaid. Dave has visited the emergency room to refill prescriptions on multiple occasions because he cannot find a private provider that accepts dual eligibles, as it can be difficult for providers to obtain reimbursement due to the complicated billing processes.⁷ Earsy and her family struggle to identify which program covers which services, often leading to delayed care—it has taken multiple years for Earsy to see an ophthalmologist.⁸ The process of navigating the

⁴ "After a Stroke."

⁵ Ibid.; "Caught In the Middle."

⁶ "Dual Eligibles and Integration Efforts."

⁷ "Caught In the Middle."

⁸ "After a Stroke."

two systems results in frustration and confusion. According to Dave’s caregiver, Doug, figuring out all the complexities of care and who pays for what creates “a very stressful situation.”⁹

The Broader Effects of Fragmentation and Policy Solutions

Consequences of this fragmentation reach beyond the lived experience of dual eligibles, as exemplified in Dave and Earsy’s stories. Dual eligibles understandably necessitate more costly services than their Medicare or Medicaid only counterparts, but the combination of complex health needs and lack of coordination has resulted in remarkably high costs for both Medicare and Medicaid.¹⁰ These costs have not gone unnoticed. The *Patient Protection and Affordable Care Act (ACA)* recognized the importance of Medicare and Medicaid coordination for the future solvency and sustainability of these public health insurance programs.¹¹ In response to the need for coordination, the ACA created the Medicare-Medicaid Coordination Office (MMCO), under the authority of the Centers for Medicare and Medicaid Services (CMS), to explore Medicare-Medicaid integration options.¹²

After a long history of misaligned incentives, fragmentation, and a lack of communication, states are facing the opportunities and challenges of coordinating care for dual eligibles through the integration of Medicare and Medicaid services. Immediately following its creation, the MMCO requested proposals from the states for dual eligible integration demonstration projects.¹³ California was one of fifteen states chosen to receive federal approval and funding for a dual eligible integration project.¹⁴ California’s duals integration project, called Cal MediConnect, will use managed care organizations (i.e., “groups of doctors, clinics,

⁹ “Caught In the Middle.”

¹⁰ “Dual Eligibles and Integration Efforts.”

¹¹ Altman, “Pulling It Together.”

¹² Medicare-Medicaid Coordination Office, “About the Medicare-Medicaid Coordination Office.”

¹³ *Cal MediConnect MOU*.

¹⁴ “State Innovation Models Initiative”; *Cal MediConnect MOU*.

hospitals, and pharmacies that work together to provide care for their members”¹⁵; e.g., Anthem Blue Cross Plan of California) to restructure the financing and delivery of health services for dual eligibles in eight counties across the state.¹⁶

There are over one million dual eligibles in California.¹⁷ Almost 60% of California’s dual eligible population is female and 76% are age 65 or older.¹⁸ In terms of race/ethnicity, about half of the population is white with the remainder defined as Hispanic (16%), black (10%), Asian (20%), and other (3%).¹⁹ Over half of California’s duals population does not speak English as their primary language.²⁰

Los Angeles as a Testing Ground for Community Health Worker Inclusion

Los Angeles County, which houses over one third of California’s duals population, presents interesting opportunities for care coordination.²¹ The rich linguistic and cultural diversity of Los Angeles County provides fertile ground for the scaling up of an emerging labor force under Cal MediConnect—the community health worker (CHW). CHWs emerged in response to a need for culturally and linguistically competent care in immigrant communities to aid their interactions with the formal American health care system. CHWs are informal, non-licensed members of the community that act as a bridge between the formal health care system and community members.²² CHWs can relay important care instructions in linguistically and culturally appropriate ways, help manage chronic conditions, and provide general health care

¹⁵ “Managed Care Organizations.”

¹⁶ Kaiser Family Foundation, “State Demonstration Proposals to Integrate Care and Align Financing And/or Administration for Dual Eligible Beneficiaries”; Cutler, Rich, and Yee, *Advocate’s Guide to California’s Coordinated Care Initiative; Cal MediConnect MOU*.

¹⁷ *Medicare-Medicaid Enrollee State Profile: California*.

¹⁸ Cutler, Rich, and Yee, *Advocate’s Guide to California’s Coordinated Care Initiative*.

¹⁹ *Medicare-Medicaid Enrollee State Profile: California*.

²⁰ Cutler, Rich, and Yee, *Advocate’s Guide to California’s Coordinated Care Initiative*.

²¹ *Ibid.*

²² “APHA: Community Health Workers.”

education.²³ As a bridge between the beneficiary and the formal health care system, CHWs can ensure better health outcomes and cost efficiency for the program as a whole.

As members of the marginalized communities they serve, CHWs themselves are a vulnerable population.²⁴ In addition to their inherent vulnerability, CHWs face a lack of job security as a labor force that has emerged in the shadow of the formal health care system. As their numbers have grown, public health scholars and CHW advocates have argued for greater inclusion in the formal health care system as a way to provide greater security for this workforce.²⁵ CHW advocacy resulted in national recognition of the value of the labor force in 2010, when the ACA called for Medicaid reimbursement for CHW services.²⁶ The recognition of CHWs under national legislation promises new opportunities for the potential formalization of the labor force, which could result in increased integration under formal health care systems and thus, greater job security, benefitting the labor force and the marginalized communities it serves.

Potential Utilization of Community Health Workers Under Cal MediConnect

Medicare-Medicaid integration under Cal MediConnect in conjunction with the national recognition of CHWs creates an important opportunity for dual eligibles, the CHW labor force, and Cal MediConnect health plans in Los Angeles County. This report explores the potential utilization of CHWs in the emerging systems of care for dual eligibles in Los Angeles County by addressing the following research questions:

²³ Balcazar et al., “Community Health Workers Can Be a Public Health Force for Change in the United States.”

²⁴ Landers and Stover, “Community Health Workers--Practice and Promise”; Rosenthal et al., “Community Health Workers: Part of the Solution”; Witmer et al., “Community Health Workers.”

²⁵ Balcazar et al., “Community Health Workers Can Be a Public Health Force for Change in the United States”; Tulenko et al., “Community Health Workers for Universal Health-Care Coverage,” November 2013.

²⁶ Davis, “Issue Brief on Leveraging Community Health Workers Under California’s State Innovation Model (SIM) Initiative.”

- *In the changing health care financing and delivery system for the dual eligible population of Los Angeles, what are the opportunities to integrate CHWs?*
- *What institutional and program changes must be in place for CHWs to be “scaled up” and institutionalized to serve the dual eligible population of Los Angeles?*

BACKGROUND

Background for this report includes: 1) an overview of the dual eligible population and their experience with Medicare-Medicaid; 2) the policy efforts to integrate Medicare and Medicaid at the federal and state levels; 3) an overview of the CHW labor force, their value in providing culturally competent services, and opportunities for CHWs under recent Medicare-Medicaid integration efforts.

Dual Eligibles: A Vulnerable Population with Complex Needs

Individuals eligible for Medicare and Medicaid have some of the most complex health care needs among Americans and are subject to understanding these two behemoth public programs to get their needs met. This section describes the challenges of these two large government programs working together and the critical needs of this population.

Eligibility Requirements for Medicare and Medicaid: Qualifying for Dual Eligibility

Medicare and Medicaid are public health insurance programs. Medicare is a federal health insurance program paid for by two trust accounts. These trust accounts are funded primarily through payroll taxes from most of America’s labor force.²⁷ Medicaid is a safety net health insurance program for low-income populations. The federal and state governments jointly fund Medicaid.²⁸ Dual eligibles are individuals that qualify for both Medicare and Medicaid.²⁹

²⁷ “How Medicare Is Funded.”

²⁸ “History of Medicare and Medicaid.”

To qualify for Medicare, individuals are either age 65 or older with sufficient work history (or is/has been married to someone with qualifying amount of time), are under age 65 with a disability and have been receiving Social Security Disability Insurance for more than two years, or have end-stage renal disease (i.e., kidney failure) or Amyotrophic Lateral Sclerosis (i.e., Lou Gehrig’s disease).³⁰ On the other hand, Medicaid eligibility, particularly for long-term care services, is income and asset dependent, as it provides safety net health coverage for certain categories of individuals.³¹ Therefore, those who qualify for both Medicare and Medicaid based on their eligibility statuses (i.e., low-incomes, are functionally impaired, and often are advanced in age) have substantial vulnerabilities.

Characteristics and Specific Health Needs of Dual Eligibles

Dual eligibles by definition are low-income older adults and low-income younger people with disabilities.³² Despite this general characterization of dual eligibles, there are many subgroups within the broader population that have varied and specific needs. These groups include frail older adults, younger people with mental and/or physical disabilities, and low-income older adults that are generally healthy.³³ By virtue of the combination of Medicaid and Medicare eligibility requirements, dual eligibles tend to be older and sicker than the general Medicaid population and poorer than the general Medicare population.³⁴ Additionally, dual eligibles are more likely than the general population to have characteristics associated with

²⁹ Reaves et al., *Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage*.

³⁰ Ibid.; “Medicare Program Overview.”

³¹ Centers for Medicare & Medicaid Services, “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance.”

³² “Dual Eligibles and Integration Efforts”; Reaves et al., *Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage*.

³³ *Integrated Care for People With Medicare and Medicaid*.

³⁴ Ibid.

poverty, including being older, female, identifying as a racial/ethnic minority, and having low educational attainment.³⁵

The higher rates of poverty and illness contribute to the higher costs associated with the dual eligible population. Dual eligibles represent a disproportionate amount of Medicare and Medicaid spending.³⁶ At 17% of the Medicare population, duals account for over 29% of the spending.³⁷ A similar situation exists for Medicaid spending; duals comprise 14% of the total Medicaid population but account for 40% of program spending.³⁸ High rates of spending among dual eligibles are due in part to their specific health needs. For instance, the use of long-term services and supports (LTSS) or nursing home care are costly and contribute significantly to the high rates of spending.

The greater use of benefits like LTSS and nursing home care is the result of the complex health needs of the dual eligible population.³⁹ Chronic disease management and mental health services are chief among these care needs. Dual eligibles over the age of 65 are more likely to suffer from multiple chronic diseases such as diabetes, heart disease, and dementia compared to the general Medicare population.⁴⁰ Duals under the age of 65 are more likely to suffer from mental illness and mental and physical impairment than their Medicaid-only counterparts.⁴¹ Higher degrees of impairment require a wider range of more intensive services. For instance, almost a quarter of the dual eligible population requires some level of assistance with activities

³⁵ *Dual Eligible Beneficiaries: An Overview.*

³⁶ “Dual Eligibles and Integration Efforts.”

³⁷ Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program*; Prael et al., “Challenges in Merging Medicaid and Medicare Databases to Obtain Healthcare Costs for Dual-Eligible Beneficiaries.”

³⁸ Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program.*

³⁹ *Integrated Care for People With Medicare and Medicaid*; Altman, “Pulling It Together.”

⁴⁰ Davenport, Hodin, and Feder, *The “Dual Eligible” Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid.*

⁴¹ *Ibid.*

of daily living (ADL), like bathing, dressing, and eating.⁴² All of these disadvantages compound when added to the defining characteristics of the dual eligible population, making it one of the most vulnerable populations under the purview of America’s public health coverage programs.

Division of Services: Medicare Coverage versus Medicaid Coverage

Medicare and Medicaid are two separate public insurance programs and, as such, cover different services. Medicare acts as the primary payer for dual eligibles.⁴³ It covers a variety of acute and post-acute care services, however, there are gaps in the range of services that Medicare covers. Medicaid often provides those services that are limited or excluded from Medicare coverage, including but not limited to: inpatient and outpatient hospital services; physician and nurse practitioner services; nursing home care; and home health services.⁴⁴ Importantly, Medicaid also covers most long-term services and supports (LTSS) (e.g., extended nursing home care, home care) and dental and vision services—services excluded from Medicare.⁴⁵ Appendix B delineates the specific services covered by Medicare and Medicaid for dual eligibles.

To further complicate the care delivery and financing system, Medicare has four separate parts. Medicare Part A is hospital insurance. It covers inpatient hospital services, stays in skilled nursing facilities, hospice care, and some home health services. Medicare Part B, which is supplemental medical insurance, covers outpatient services, certain doctors’ services, medical supplies, and preventative services. Medicare Part C includes Medicare Advantage Plans, which are Medicare health plans offered through private health insurance companies that contract with

⁴² Komisar, Feder, and Kasper, “Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles.”

⁴³ Rowland and Lyons, “Medicare, Medicaid, and the Elderly Poor”; Reaves et al., *Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage*.

⁴⁴ Reaves et al., *Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage*.

⁴⁵ Ibid.; Centers for Medicare & Medicaid Services, “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance.”

Medicare to provide Part A and Part B benefits. Medicare Part D adds prescription drug coverage to Medicare Parts A and B. The combination of Parts A and B is “original Medicare.” Most people over the age of 65 are eligible for Part A, with deductibles and co-pays required when using services. Parts B, C, and D require monthly premiums of some form. For individuals who are dually eligible, Medicaid covers any premiums, co-pays, and deductibles from Medicare, an important aspect of the Medicare-Medicaid combination that serves duals.⁴⁶

Fee-for-Service Models Create Frustration for Beneficiaries

A majority of people eligible for Medicare and Medicaid receive services through a traditional fee-for-service model (i.e., beneficiaries use Medicare A, B, and D as separate service platforms given a state’s Medicaid program does not use a managed care platform).⁴⁷ In a traditional fee-for-service model, any time a beneficiary accesses a health service, ranging from a routine visit to the doctor to a hospitalization, the specific provider bills the government, seeking reimbursement for the service under either Medicaid or Medicare.⁴⁸ Under this model, the beneficiary must first identify a provider that accepts Medicare and/or Medicaid, no small feat considering provider reluctance to accept dual eligible beneficiaries due to complicated billing processes.⁴⁹ Providers then bill Medicare and Medicaid separately with Medicaid being the payer of last resort. This creates complicated approval and denial processes in order for both programs to pay for services.⁵⁰

⁴⁶ Medicare; Gold, Wang, and Jacobson, *Medicare Health Plans and Dually Eligible Beneficiaries*.

⁴⁷ Crandall, “Dual Eligibles.”

⁴⁸ Gold, Wang, and Jacobson, *Medicare Health Plans and Dually Eligible Beneficiaries*; Graham et al., *Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California*.

⁴⁹ Crowley, Musumeci, and Reaves, *Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders*.

⁵⁰ Burton, Chang, and Gratale, *Medicaid Funding of Community-Based Prevention*.

Given that providers are basically independent actors, they rarely speak with one another regarding individual patients. This shifts the burden of care coordination to the individual—medical records must be physically copied and toted from provider to provider if the beneficiary wants to ensure consistency of care, an extraordinary burden for a population characterized by multiple medical conditions, physical or mental functional impairment, increasing age, and poverty.⁵¹ The lack of care coordination often results in beneficiary confusion and frustration, delayed care, inappropriate utilization of health services, and unnecessary cost—a system that does not benefit the beneficiary, the providers, or the taxpayers.⁵²

Theoretically, dual eligibles have the one of most comprehensive health care packages available through public coverage or on the private market. In practice, however, it is extraordinarily difficult to mobilize this coverage in a seamless, coordinated way that best serves the needs of the beneficiary. Neither program is responsible for the totality of an individual's benefits and there is no systemic care coordination to assist in navigating the complex programs and services.⁵³ Thus, patients and their caregivers become *de facto* care coordinators, lay people burdened with the responsibility of navigating and coordinating efforts between two complex government programs. Aside from the obvious frustration that beneficiaries and their loved ones experience throughout this process, lack of care coordination results in poor health outcomes, inappropriate utilization of services, and unnecessary costs.⁵⁴ As one of the poorest, sickest populations in the United States, it is both inefficient and unjust to rely on the beneficiary to

⁵¹ Prela et al., “Challenges in Merging Medicaid and Medicare Databases to Obtain Healthcare Costs for Dual-Eligible Beneficiaries”; Justice and Holladay, “A Process with Promise.”

⁵² Neuman et al., “Analysis & Commentary”; Justice and Holladay, “A Process with Promise”; Crowley, Musumeci, and Reaves, *Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders*.

⁵³ *Integrated Care for People With Medicare and Medicaid*.

⁵⁴ Davenport, Hodin, and Feder, *The “Dual Eligible” Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid*.

wade through the various administrative barriers of two government health plans in order to receive much needed medical care.

Needless to say, the Medicare-Medicaid landscape is complicated, multi-layered, and heavily technical. Dual eligibles and their caregivers are expected to navigate these two public coverage programs largely on their own. It often results in frustration and confusion, and importantly, a denial or delay in service. For instance, in November 2011, the Los Angeles Times told the story of M.C. Kim, a 51-year-old Los Angeles dual eligible, who has had four heart attacks in just as many years. Each time he left the hospital unclear as to why his heart had failed. When Kim attempted to enroll in a cardiac rehabilitative treatment program, he was denied by Medicare and instructed to contact Medicaid. When he reached Medicaid, Kim was instructed to contact Medicare. Both programs ended up denying coverage for the cardiac rehabilitative program. “I was like a ping-pong ball...nobody wanted to take responsibility,” Kim said in reference to his health care coverage under the federal Medicare and federal-state Medicaid programs.⁵⁵

ACA Introduces New Opportunities for Medicare-Medicaid Integration

The current financing and care delivery models for dual eligibles are generally ineffective and inefficient. They have resulted in misaligned financial incentives, duplication of services, delayed care, and overwhelming frustration and confusion among some of America’s most vulnerable. The following section will discuss new national opportunities for Medicare-Medicaid integration under the *Patient Protection and Affordable Care Act* and California’s specific integration efforts.

⁵⁵ Gorman, “Red Tape Hampers Care for Patients Who Are Poor and Disabled.”

Medicare-Medicaid Integration Efforts Under the ACA

In 2010, President Barack Obama signed into law the *Patient Protection and Affordable Care Act* (ACA).⁵⁶ The passage of the ACA marks a watershed moment in American health care policy. The ACA established laws designed to improve accessibility, quality, and affordability of health insurance for all Americans while reducing wasteful spending and increasing efficiency of current health care systems.⁵⁷ To this end, the ACA created various provisions aimed at increasing coordination between Medicare and Medicaid.⁵⁸

The ACA marks the first widespread national policy effort to integrate Medicare-Medicaid services for dual eligible beneficiaries in the history of American health policy.⁵⁹ Long-term care reform advocates, public health scholars, and health policy economists have long advocated for increased coordination between Medicaid and Medicare services.⁶⁰ The recent shift towards integration is motivated in part by the high health expenditures duals represent and the health disparities represented in the demographics of this group.⁶¹

The ACA acknowledged this need with specific provisions in the law dedicated to Medicare and Medicaid. Section 2602 of the ACA establishes the Medicare-Medicaid Coordination Office (MMCO) and delineates the primary goals of the office, including the improved coordination of care in order to ensure that dual beneficiaries receive the services to

⁵⁶ Rosenbaum, “The Patient Protection and Affordable Care Act.”

⁵⁷ Ibid.

⁵⁸ Prela et al., “Challenges in Merging Medicaid and Medicare Databases to Obtain Healthcare Costs for Dual-Eligible Beneficiaries”; Justice and Holladay, “A Process with Promise.”

⁵⁹ Justice and Holladay, “A Process with Promise.”

⁶⁰ Prela et al., “Challenges in Merging Medicaid and Medicare Databases to Obtain Healthcare Costs for Dual-Eligible Beneficiaries”; Neuman et al., “Analysis & Commentary”; Justice and Holladay, “A Process with Promise.”

⁶¹ Neuman et al., “Analysis & Commentary”; Justice and Holladay, “A Process with Promise.”

which they are entitled.⁶² Section 3021 of the ACA created the CMS Innovation Center, a new entity charged with testing “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” for Medicaid and Medicare beneficiaries.⁶³

The Innovation Center and MMCO partnered to launch a large-scale demonstration project designed to help states create better systems of coordinated care for dual eligible beneficiaries.⁶⁴ Fifteen states were selected to receive a planning grant of up to one million dollars to create a model describing how the state would structure and implement an intervention that integrates care for dual eligibles.⁶⁵ California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin were selected to participate in the first phase of the demonstration project. States that successfully completed their design project and effectively engaged stakeholders and beneficiaries were selected for continued funding from the CMS and the Innovation Center to implement their demonstration project.⁶⁶

California’s Integration Efforts: Coordinated Care Initiative and Cal MediConnect

In 2010, California passed legislation that established a Medicare-Medi-Cal (California’s Medicaid) integration demonstration in response to the federal request for demonstration proposals. The law broadly called for increased care coordination across state and federal benefits, an emphasis on home and community based services (HCBS), a focus on increasing

⁶² Medicare-Medicaid Coordination Office, “About Medicare-Medicaid Coordination Office.”

⁶³ Center for Medicare & Medicaid Innovation, “About the CMS Innovation Center.”

⁶⁴ Altman, “Pulling It Together”; Kaiser Family Foundation, “State Demonstration Proposals to Integrate Care and Align Financing And/or Administration for Dual Eligible Beneficiaries.”

⁶⁵ Kaiser Commission on Medicaid and the Uninsured, “Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries.”

⁶⁶ Altman, “Pulling It Together.”

person-centered care, and the goal of optimizing the use of Medicare, Medi-Cal, and other state and federal resources.⁶⁷ In 2012, after state budget approval and CMS approval, California formally established the Coordinated Care Initiative (CCI).

The CCI expanded on the 2010 law and included three main components: the integration of Medi-Cal LTSS into Medi-Cal managed care, the mandatory enrollment of dual eligibles into Medi-Cal managed care, and the dual eligible integration demonstration, now known as Cal MediConnect. In 2013, CMS signed a Memorandum of Understanding (MOU) with the state, signaling federal approval of Cal MediConnect.

Design of Cal MediConnect: Managed Care Model

Cal MediConnect is essentially a managed care program that combines the Medicare and Medi-Cal benefits into a single, integrated health plan. As a managed care model, beneficiaries will get all of their care from a single health maintenance organization under contract with the state. These organizations agree to provide all health services to beneficiaries in exchange for a monthly “capitated” payment from the state.⁶⁸ While the payment will vary based on high-risk health characteristics of the individual enrollee, this payment does not vary month to month, regardless of the services actually utilized.⁶⁹

Organizations that receive capitated payments for care delivery are also known as risk-bearing entities. Managed care organizations, as a type of a risk bearing entity, carry the “responsibility (the “risk”) of care provided to their enrolled population as well as financial return for any savings obtained.”⁷⁰ Alone, this model incentivizes managed care organizations to

⁶⁷ *Cal MediConnect MOU.*

⁶⁸ “Managed Care.”

⁶⁹ *Ibid.*; “Bridging Medical Care and Long-Term Services and Supports.”

⁷⁰ “Bridging Medical Care and Long-Term Services and Supports,” 5.

focus on providing minimal services to their enrolled populations.⁷¹ However, the population served by Cal MediConnect has substantial needs, including LTSS. Historically, many of these organizations have not provided this type of care—LTSS is a new part of the service package. While it presents new challenges, shifting financial incentives from the state (who used to pay directly for this care) to managed care organizations will force them to consider other resources and services that will help individuals achieve daily living goals in order to create system efficiencies that will yield a financial return.⁷²

This new type of managed care model, which integrates LTSS, will greatly benefit dual eligibles as it will incentivize the health plans to offer resources and services that will help duals meet their daily living goals, thus bettering the management of their chronic conditions and overall health outcomes. This model holds the promise of benefit for the CHW labor force as health plans will be looking for ways to attain the best health outcomes in cost effective ways. CHW services and involvement in care coordination and management are both cost effective, comparable to formalized health provider services, and could help duals achieve daily living goals and manage their chronic conditions.

Cal MediConnect in Los Angeles County

Los Angeles County, comparable to the other seven demonstration counties, houses a large number of dual eligibles. Los Angeles County is home to over half of the state's Cal MediConnect eligible population.⁷³ Due to the sheer size of the population, the MOU established an enrollment cap of 200,000 enrollees for Los Angeles County, despite a population count of

⁷¹ “Bridging Medical Care and Long-Term Services and Supports.”

⁷² Ibid.

⁷³ Cutler, Rich, and Yee, *Advocate's Guide to California's Coordinated Care Initiative*.

over 280,000 dual eligible beneficiaries.⁷⁴ Los Angeles County's enrollment strategy will occur over a period of approximately one year. Beginning in April 2014, eligible beneficiaries will be given the option to opt-in to a Cal MediConnect health plan. Communication materials mailed to eligible individuals will facilitate voluntary enrollment. Beginning in July 2014, passive enrollment will begin. Under passive enrollment, the Department of Health Care Services (DHCS) will assign an individual to a participating Cal MediConnect health plan based on their history of provider utilization.⁷⁵

Participating LA County Health Plans: L.A. Care, Health Net, Care 1st, CareMore, Molina

Originally, only two health plans, L.A. Care and Health Net, were selected to participate in Cal MediConnect for Los Angeles County.⁷⁶ L.A. Care, the nation's largest public health plan, was created by the State of California to provide services for Medi-Cal eligible and other vulnerable populations in Los Angeles County.⁷⁷ L.A. Care is governed by a Board of Governors, which includes Medi-Cal consumers in addition to members of the professional health care and medical fields, ensuring stakeholder, not shareholder, accountability.⁷⁸ In contrast, Health Net is one of the nation's largest for-profit, publically traded managed health care companies.⁷⁹

Unfortunately, L.A. Care did not pass its Medicare-Medi-Cal readiness review in February 2014.⁸⁰ While L.A. Care received a passable grade on Medicare Part C regulations, the quality of other Medicare services offered by L.A. Care rendered the health plan unable to accept

⁷⁴ "Enrollment Strategy for Los Angeles County into Cal MediConnect: Updated."

⁷⁵ *Cal MediConnect MOU*.

⁷⁶ *Ibid.*

⁷⁷ *Fulfilling the Promise of Health Care to Vulnerable Populations: 10 Years of Innovation, Quality and Safety Net Support by America's Largest Public Health Plan*.

⁷⁸ *Ibid.*

⁷⁹ "About Us."

⁸⁰ "Enrollment Strategy for Los Angeles County into Cal MediConnect: Updated."

passive enrollment for Cal MediConnect.⁸¹ In light of these changes, DHCS approved three additional health care plans for Cal MediConnect participation: Care 1st, CareMore, and Molina Healthcare.⁸² If L.A. Care passes a new readiness review and improves its Medicare rating before October 2014, it will be able to begin accepting Cal MediConnect enrollees.⁸³

Community Health Workers as an Emerging Labor Force Under the ACA

The policy opportunities created by the ACA, such as the MMCO and Cal MediConnect at the state level, as well as increasing emphasis on primary, preventive, and person-centered care, provide a link between dual eligibles and the CHW community. CHWs are a vulnerable, yet valuable, labor force that emerged in response to a growing need for culturally and linguistically competent care. This section explains the emergence of the CHW labor force, the definition and role of the CHW, efficacy of CHW programs, training and funding issues for CHWs, and new opportunities for CHWs under the ACA. This section serves to contextualize CHWs and provide evidence for a mutually beneficial relationship between the CHW labor force and the dual eligible population, a relationship mediated by the emerging care delivery systems available under Cal MediConnect.

History: An Organic Movement in Response to a Need in Marginalized Communities

Community health workers (CHW) have a long and far reaching history. Documentation of community members assuming the role of helping other community members with health related issues dates back over 300 years in areas across the globe.⁸⁴ Examples include Chinese “barefoot doctors,” Latino *promotores*, and generalist village health workers in a number of

⁸¹ “State Officials, Advocates at Odds Over Size, Scope, Details of Duals Project - California Healthline.”

⁸² “Enrollment Strategy for Los Angeles County into Cal MediConnect: Updated.”

⁸³ “State Officials, Advocates at Odds Over Size, Scope, Details of Duals Project - California Healthline.”

⁸⁴ Grimm and Walker, *Challenges/Opportunities of Community Health Workers in Buffalo, NY*.

developing nations in Southeast Asia, Africa, and Central and South America.⁸⁵ In the United States, CHWs have been used since the 1960s, primarily in low-income and minority communities to address health disparities and social justice issues, their prominence ebbing and flowing with changes in the social, economic, and political climate.⁸⁶

In America, in particular, the CHW emerged as an organic outgrowth in response to a need for a bridge between the formal health care system and marginalized groups, especially immigrant communities.⁸⁷ Most immigrant communities are linguistically and culturally isolated, creating a gap between the formal American health care system and the health care needs of the community.⁸⁸ The divide between the biomedical interpretation of health integral to American medicine and an immigrant community's understanding of illness and appropriate treatment can be significant, often causing miscommunication and frustration for both formal health care providers and the immigrant patients.⁸⁹

Anne Fadiman's 1997 book, *The Spirit Catches You and You Fall Down*, is the quintessential argument for greater cultural competency in the formal health care system. In the book, the immigrant parents of a young Hmong girl, Lia, and her American doctors are in conflict over Lia's epilepsy treatment. Throughout the book, there are instances of linguistic barriers and cultural incongruence between the American health care system and the Hmong

⁸⁵ Lehmann and Sanders, *Community Health Workers: What Do We Know about Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers*; Xiuyun Li et al., "Revisiting Current 'Barefoot Doctors' in Border Areas of China"; Pallas et al., "Community Health Workers in Low- and Middle-Income Countries."

⁸⁶ Swider, "Outcome Effectiveness of Community Health Workers"; Peretz et al., "Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative"; Grimm and Walker, *Challenges/Opportunities of Community Health Workers in Buffalo, NY*.

⁸⁷ Brach and Fraserirector, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities?"

⁸⁸ Ibid.

⁸⁹ Ibid.

community. This conflict results in devastating health effects for Lia, as she ends up in a vegetative state.⁹⁰ Lia is an example of the possible consequences of the gulf between American health care providers and immigrant or linguistically and culturally isolated communities. Had Lia and her family had access to linguistically and culturally appropriate care, the course of her treatment and her ultimate health outcomes would most certainly have been different.

Vulnerability of the Community Health Worker

CHWs are a link between formal health care institutions and marginalized communities. They are typically members of these marginalized communities, and as such, are vulnerable individuals themselves. CHWs often struggle with the same issues as the communities they serve—poverty, racism, immigration status, and language barriers.⁹¹ As a labor force, CHWs emerged in the shadow of the formal health care system. The informal structure of the labor force fails to provide CHWs with recognition, status, job security, salaries, or benefits—all adding to the vulnerability of CHWs as individuals and a labor force as a whole.⁹² Full participation in emerging models of integrated care for vulnerable communities, including dual eligibles, has the potential to reduce the vulnerability of the CHW labor force.

Evolving Role and Definition of the Community Health Worker

The organic emergence of the CHW made it difficult to define their role and create an appropriate and adequately inclusive scope of work. It was not until 1998, when the University of Arizona issued the National Community Health Advisor Study, that a general scope of work was defined.⁹³ The study identified seven key responsibilities: cultural mediation between communities and health systems, informal counseling and support, advocating for individual and

⁹⁰ Fadiman, *Spirit Catches You*.

⁹¹ Landers and Stover, “Community Health Workers--Practice and Promise.”

⁹² Ibid.

⁹³ Koch, *Summary of the National Community Health Advisor Study, 1998*.

community needs, assuring people get necessary services, building individual and community capacity, providing culturally appropriate health education, and providing direct services.⁹⁴

In 2009, the American Public Health Association (APHA) issued a definition, widely regarded as the authoritative definition, of the CHW:

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW 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 CHW 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.

The scope of work identified by the University of Arizona and the APHA definition both highlight the importance of cultural competence, defined as the awareness, knowledge, attitudes, and skills necessary to interact with members of a particular community.⁹⁵ CHWs derive their cultural competence through shared ethnicity, culture, language or life experience.⁹⁶ These shared characteristics enable CHWs to build trusting relationships with community members so that they can bridge the social, cultural, or linguistic gaps between the health care consumer and the health care system.⁹⁷ These relationships with community members and the connection to the formal health care system enable CHWs to help health care users navigate complicated health care systems and can gather and provide information for other health professionals that might not

⁹⁴ Ibid., 6.

⁹⁵ Sperry, “Cultural Competence.”

⁹⁶ Pérez and Martinez, “Community Health Workers”; Arvey and Fernandez, “Identifying the Core Elements of Effective Community Health Worker Programs.”

⁹⁷ Balcazar et al., “Community Health Workers Can Be a Public Health Force for Change in the United States”; Findley et al., “Building a Consensus on Community Health Workers’ Scope of Practice”; Peretz et al., “Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative.”

otherwise be available.⁹⁸ CHWs build these relationships and gather information through outreach, education, home visiting, social support, community organizing, translation and interpretation, and advocacy efforts, thus increasing individual and community capacity.⁹⁹

Contributions: Cutting Costs and Engaging Underserved Communities

A growing body of research demonstrates the ability of CHWs to reduce health care costs, address health disparities, and improve quality and access to health care systems.¹⁰⁰ Cost is usually evaluated using metrics like the number of hospitalizations and emergency visits related to a particular medical condition. For example, New York City implemented a community-based asthma intervention program in 2005 that employed bilingual CHWs. CHWs provided culturally relevant education, including environmental home assessments and clinical and social referrals. Program participants experienced a 50% reduction in hospitalizations and emergency visits for asthma related conditions and asthma caregivers' confidence in controlling asthma rose to almost 100%.¹⁰¹ These results are typical of CHW integrated programs. Similar programs in Denver and Washington, D.C. have yielded analogous positive results.¹⁰²

Measures of access and quality are typically evaluated qualitatively.¹⁰³ Because of their grounded community approach, CHWs are able to “translate health system information to the community’s language and value system.”¹⁰⁴ This need for translation is indicative of the gap

⁹⁸ Grimm and Walker, *Challenges and Opportunities of Community Health Workers in Buffalo, NY*; Findley et al., “Building a Consensus on Community Health Workers’ Scope of Practice.”

⁹⁹ Grimm & Walker, *Challenges & Opportunities of Community Health Workers in Buffalo, NY*.

¹⁰⁰ Witmer et al., “Community Health Workers.”

¹⁰¹ Findley et al., “Building a Consensus on Community Health Workers’ Scope of Practice.”

¹⁰² Whitley et al., “Standardized Academic Education Prepares Competent Community Health Workers”; Peretz et al., “Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative.”

¹⁰³ Balcazar et al., “Community Health Workers Can Be a Public Health Force for Change in the United States.”

¹⁰⁴ Witmer et al., “Community Health Workers,” 1056.

between the needs of culturally and linguistically isolated communities and the formal American health care system. Linguistic and cultural translation of health system information allows CHWs to engage members of underserved populations at levels that formal health professionals may be unable to achieve, thereby increasing access to the health care system. Outreach and education provided by CHWs can encourage patients to access services they either did not know about or were uncomfortable to access.¹⁰⁵ CHWs improve quality of care by acting as a link between providers and the community, advocating for their needs and voicing their concerns on their behalf. As a link, CHWs also ensure continuity and consistency of care, thereby increasing quality of care.¹⁰⁶ Importantly, improved quality of care and increased access to health care systems can help reduce health disparities in the marginalized communities CHWs serve.¹⁰⁷

Training the Emerging Community Health Worker Labor Force

The CHW emerged as an organic outgrowth of a need in marginalized, linguistically or culturally isolated communities, and as such has been difficult to organize. As the role of the CHW evolved over time, it became clear that formalization and standardized training models might be a possible benefit for CHWs. Traditionally, CHW training has been informal, on-the-job training coupled with life experience.¹⁰⁸ CHWs derive legitimacy within the communities they serve from this emphasis on life experience and intimate knowledge of the community.¹⁰⁹ Recently, however, community organizations and academic institutions started offering CHW

¹⁰⁵ Witmer et al., “Community Health Workers.”

¹⁰⁶ Peretz et al., “Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative”; Pérez and Martinez, “Community Health Workers”; Witmer et al., “Community Health Workers.”

¹⁰⁷ Rosenthal et al., “Community Health Workers: Part of the Solution.”

¹⁰⁸ Findley et al., “Building a Consensus on Community Health Workers’ Scope of Practice.”

¹⁰⁹ Sabo et al., “Predictors and a Framework for Fostering Community Advocacy as a Community Health Worker Core Function to Eliminate Health Disparities”; Findley et al., “Building a Consensus on Community Health Workers’ Scope of Practice.”

training and certification programs. In the 1990's, City College of San Francisco implemented a CHW certification program, the first program in the nation to offer college credit and educational opportunities for CHWs.¹¹⁰ While City College of San Francisco is the only academic institution in California with a certification program, many community organizations have created CHW training programs.

For example, in Los Angeles, Esperanza Community Housing offers comprehensive CHW training programs tailored to the needs of South Los Angeles. Training is presented in the primary language of the trainees, which is typically Spanish, it is interactive, tailored to the target community's disease burden, and conducted in the target community.¹¹¹ These attributes of community based training programs are of importance in considering the deterrents and drawbacks of formalized training programs.

Potential Disadvantages to Formalization through Training

Some public health scholars argue that training jeopardizes the legitimacy unique to CHWs.¹¹² Professionalization and certification may create distance between CHWs and their community, negating the very quality that defines CHWs and gives them their value.¹¹³ If CHWs become professionalized and integrated into institutional structures, they become a part of the formal health care system. This designation alone might lessen the trust between patients and CHWs, as the relationship immediately transforms from a peer-to-peer relationship into one of

¹¹⁰ Berthold, Avila, and Miller, *Foundations for Community Health Workers*.

¹¹¹ "Health Programs | Esperanza Community Housing."

¹¹² Landers and Stover, "Community Health Workers--Practice and Promise"; Arvey and Fernandez, "Identifying the Core Elements of Effective Community Health Worker Programs."

¹¹³ Grimm and Walker, *Challenges/Opportunities of Community Health Workers in Buffalo, NY*; Witmer et al., "Community Health Workers"; Pérez and Martinez, "Community Health Workers."

professional-to-client dynamics.¹¹⁴ This type of relationship introduces new power dynamics, wherein the CHW becomes an authority rather than a trusted, knowledgeable peer.

In addition to the risk of losing a degree of trust, training, certification, and licensing programs carry with them the risk of deterring the very community members CHW programs target for their cultural competency and community-based legitimacy. For instance, members of linguistically segregated communities might be intimidated by formal, academic settings that would house certification programs, perhaps due to their lack of English language fluency.¹¹⁵ Despite the obstacles faced by non-licensed professionals in the health care world, for this particular labor force it would seem that licensure programs might negate the intended purpose that makes them valuable in the field.

Challenges to Sustainable Funding for Community Health Workers

Non-licensed professionals, such as CHWs, face significant obstacles in the formal health care industry, particularly concerning reimbursement from Medicare and Medicaid. The health care system and its financing mechanisms, including public and private insurance, have historically required licensure of health care workers and providers.¹¹⁶ Licensure programs ensure the legitimacy of providers. For instance, physicians must go to accredited medical schools and pass state board examinations in order to practice medicine. A license ensures that practitioners are qualified to treat or provide services to an individual.¹¹⁷ It serves to insulate

¹¹⁴ Grimm and Walker, *Challenges/Opportunities of Community Health Workers in Buffalo, NY*.

¹¹⁵ Davis, "Issue Brief on Leveraging Community Health Workers Under California's State Innovation Model (SIM) Initiative"; Grimm and Walker, *Challenges and Opportunities of Community Health Workers in Buffalo, NY*.

¹¹⁶ Balcazar et al., "Community Health Workers Can Be a Public Health Force for Change in the United States"; Witmer et al., "Community Health Workers."

¹¹⁷ "Medical Licensure."

financiers of medical care, the government in the case of Medicare and Medicaid, against the possibility of lawsuits from dissatisfied or injured consumers.¹¹⁸

Sustainable funding for CHWs has been a challenge since the emergence of CHW programs. Currently, most CHW programs, inclusive of training, materials, and salary, are grant-dependent. Typically, funding originates in a grant from private foundations and is usually tailored to a specific intervention for a specific medical condition, such as asthma or diabetes.¹¹⁹ Grant dependent programs often result in low wages, low job security, high turnover rates, and a lack of continued training or educational opportunities for CHWs.¹²⁰ These working conditions undermine the effectiveness of CHWs, negating the desired outcome of reduced health disparities in medically underserved communities. The short-term nature of grant funding often results in the loss of the CHW at the end of the grant term; this destabilizes crucial relationships between CHWs and community members, thereby defeating one of the most essential components of CHW interventions – community trust.

New Potentials for Community Health Workers from the ACA

The ACA calls for a greater emphasis on preventative and primary care. Previous health care policy viewed health as the absence of disease as opposed to a state of optimal well-being. This widespread model of health encouraged health care systems that placed a high priority on symptomatic treatment, which led to high health care costs, as medical conditions are usually

¹¹⁸ Ibid.

¹¹⁹ Martinez et al., “Transforming the Delivery of Care in the Post-Health Reform Era: What Role Will Community Health Workers Play?”

¹²⁰ Davis, “Issue Brief on Leveraging Community Health Workers Under California’s State Innovation Model (SIM) Initiative”; Balcazar et al., “Community Health Workers Can Be a Public Health Force for Change in the United States.”

more expensive to treat than prevent.¹²¹ In an effort to control these costs, the ACA seeks to move toward a more comprehensive health care system that promotes wellness.

In pursuit of this goal, the ACA includes public health provisions designed to reduce the social and financial cost of chronic disease and moderate some of the existing health disparities by addressing the social determinants of health.¹²² The new bill recognizes CHWs as health professionals and encourages the utilization of CHWs to “promote positive health behaviors and outcomes for patients in medically underserved communities.”¹²³ National recognition promises to scale up the CHW workforce and begin conversations among health professionals regarding their integration in health care teams.¹²⁴ Inclusion of CHWs as integral parts of primary care teams has the potential to result in better health outcomes, particularly for high-cost populations, such as dual eligible beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) recently clarified regulations regarding Medicaid reimbursement for preventative services. The modified regulations indicate that states can reimburse for preventative services “recommended by a physician or other licensed practitioner...within the scope of their practice under State law.”¹²⁵ Previously, regulations stated that states could only cover services *provided* by a practitioner. This important distinction between *recommend* and *provide* was a monumental moment for non-licensed health workers, including CHWs. The potential for reimbursement considerably lessens the obstacles that prevent CHWs from entering the formal health care system by providing a sustainable

¹²¹ Williams, McClellan, and Rivilin, “Beyond the Affordable Care Act- Achieving Real Improvements in American Health”

¹²² Rosenbaum, “The Patient Protection and Affordable Care Act.”

¹²³ Ibid.

¹²⁴ Tulenko et al., “Community Health Workers for Universal Health-Care Coverage,” November 2013.

¹²⁵ Burton, Chang, and Gratale, *Medicaid Funding of Community-Based Prevention*.

financing mechanism. Reimbursable services include: care coordination, educational counseling, home visiting, group health education, and general “community health worker services.”¹²⁶

Unfortunately, federal level amendments do not necessarily translate to more localized amendments and thus utilization of CHWs. Each state must submit a State Plan Amendment outlining what services will be covered, who will provide them, the required training, experience, or credentialing of various providers, the state’s process for qualifying providers, and reimbursement methodology.¹²⁷ California has yet to adopt a State Plan Amendment allowing for reimbursement of CHW services.¹²⁸

Potential Opportunities for Community Health Workers Under Cal MediConnect

Though California has not established legality for reimbursement of CHW services, there are other opportunities for CHWs under recent Medicare-Medi-Cal integration policies. Of particular importance to CHWs, the MOU between CMS and the state notes that “plans will have the discretion to use the capitated payment to offer HCBS [home and community based services]...as appropriate to the member’s needs.”¹²⁹ CHW services would be categorized as HCBS.¹³⁰ While plans are not obligated to provide these additional services, the MOU establishes legality regarding the use of capitated funds to pay for HCBS. Significantly, this shifts power from the federal and state level to the hands of the local plans, as it is at their “discretion” to use capitated payments to provide additional services.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ “Medicaid Reimbursement for Community Based Services.”

¹²⁹ *Cal MediConnect MOU; Musumeci, Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS.*

¹³⁰ *Cal MediConnect MOU; Musumeci, Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS.*

Care delivery under Cal MediConnect will focus on person-centered care. Under Cal MediConnect, each enrollee will be given an individualized care plan. According to the MOU, enrollees and/or their representatives must be actively involved in developing these care plans. Additionally, and of benefit to CHWs, plans must also offer interdisciplinary care teams (ICT) to all enrollees.¹³¹ The ICT is designed to ensure the successful integration of medical, behavioral, and supportive services. According to the MOU, an ICT may consist of the enrollee, family members or other caregivers, physicians, nurses, case managers, social workers, patient navigators, IHSS affiliates, and other professionals within the provider network. Importantly, “patient navigators”, a term similar to or interchangeable with CHW, was included in this list of potential ICT members.¹³²

Additional Cal MediConnect Provisions that May Support Community Health Workers

In addition to these required services, the MOU outlines certain beneficiary protections that may also serve the interests of the CHW labor force. The MOU states that those eligible for Cal MediConnect will receive enrollment assistance and options counseling to support their enrollment decisions.¹³³ As the scope of work of CHWs includes information dissemination and education, this could potentially be an avenue of utilization for the CHW as Cal MediConnect begins the implementation phase. Secondly, and of tantamount importance, is the MOU stipulation for person-centered, culturally appropriate care. According to the MOU guidelines, all necessary services must be provided in an “appropriate manner that recognizes cognitive and physical functional status, *language and culture* [emphasis added], and caregiver

¹³¹ *Cal MediConnect MOU.*

¹³² *Ibid.*

¹³³ *Ibid.*

involvement.”¹³⁴ The MOU also states that home and community based environments must be emphasized. As CHWs derive a great deal of their value from linguistic and cultural competency, this provision works in favor of the CHW argument for inclusion.

It is apparent that the framework of Cal MediConnect provides opportunities for CHWs under the emerging care delivery systems for duals. The shift towards patient-centered, individualized care, emphasis on beneficiary inclusion, and latitude given to the plans in the MOU work in favor of the inclusion of CHWs. Los Angeles County, with its high degree of linguistic and cultural diversity and history of CHW programs, is a prime location for considering the expanded role of CHWs in the duals demonstration.

METHODS

This study solicited interviews from nineteen people across the following sectors: philanthropic, legal advocacy, CHW advocacy, health plans, health care policy, senior advocacy, and disability advocacy. Potential respondents were contacted via telephone or email on the basis of involvement with or knowledge of dual eligible populations, Cal MediConnect and other integration efforts, or the CHW labor force. Interviews were semi-structured and examined the likelihood of CHW inclusion in formal health care systems under Cal MediConnect, the potential roles CHWs could fulfill in the emerging care system, and potential obstacles to the scaling-up of the CHW profession under Cal MediConnect. Of the individuals initially contacted, ten agreed to an interview. Respondents included one member of the legal advocacy community, three health plan affiliated individuals, two members of the philanthropic community, three members of the CHW advocacy community, and one health policy associated individual.

¹³⁴ *Ibid* 9.

All interviews were conducted via telephone and were audio recorded with a digital recording device for note taking purposes only, given the consent of the respondent. The digital recordings were uploaded to a password-protected personal computer and the recordings were deleted from the recording device. Notes taken during the interview were saved to the password-protected computer.

Notes from the original interview and audio recording were iteratively coded to identify the following general themes from the interviews: mutual benefit for CHWs and dual eligibles, the potential use of CHWs as enrollment counselors under Cal MediConnect, the possibility of CHWs as members of interdisciplinary care teams for Cal MediConnect enrollees, a need for increased communication between CHWs and health plans, and potential difficulty in CHW integration under Cal MediConnect. Specific findings under these general themes were identified and then analyzed and applied to the context of the changing health care delivery systems and policy landscapes of Los Angeles County.

FINDINGS

All ten respondents indicated a positive response to some measure of CHW incorporation. They believed that CHWs could provide benefits to the dual eligible population, however, they were unsure of the appropriate level of CHW involvement, the way in which CHWs would be incorporated, what measures were necessary to scale up involvement, and differed in opinions regarding the best space for CHWs in the existing health care structure.

Mutual Benefit for Community Health Workers and Dual Eligibles

Respondents from across the spectrum of represented sectors agreed that CHWs and the dual eligible population could benefit one another to some degree. As expected, respondents

from the CHW field concentrated on benefits to the CHW labor force and respondents associated primarily with the dual eligible community highlighted the benefits to the duals population.

Community Health Workers as a Resource for Dual Eligibles

All respondents agreed that CHWs could be a valuable resource for dual eligibles, given the specific characteristics of the duals population, including age, varying levels of functional impairment, and socioeconomic status. A legal advocate for aging Americans explained that the dual eligible population is particularly vulnerable due to the aforementioned factors. This legal advocate felt that an additional layer of communication provided by a CHW would serve the population well by ensuring the receipt of additional information in a palatable manner. A member from the philanthropic sector echoed this sentiment, stating that these “are some of the most vulnerable people the State [of California] serves” and later explained that these individuals would only benefit from added points of communication, particularly communication provided in a culturally competent manner, such as a CHW would provide.

Benefits to the Community Health Worker

Respondents from the CHW advocacy community highlighted the possible labor benefits of partnerships with Cal MediConnect health plans. One CHW advocate explained, “CHWs have traditionally served vulnerable populations...this would be a sensible transition for [the CHW labor force] and a new way to find work.” The respondent from the legal advocacy sector cited participation in the duals demonstration project as a way to gain legitimacy and increase awareness regarding the power and effectiveness of CHWs. Increased awareness, heightened levels of legitimacy, and new employment opportunities would ameliorate some of the labor issues, such as job insecurity, that plague the CHW labor force.

Community Health Workers as Enrollment Counselors/Navigators for Cal MediConnect

Multiple respondents cited the potential use of CHWs as information disseminators, particularly in relation to Cal MediConnect enrollment concerns. With proper training in Medicare and Medicaid policy and ongoing integration efforts, a respondent from the legal advocacy community noted that CHWs could “act as a conduit of information for the community...and act as informers for the project.” The idea of using CHWs as an “informer” came up in 8 out of the 10 interviews conducted. These respondents envisioned CHWs primarily as educators to be used in the enrollment phase of Cal MediConnect.

Los Angeles is Not Prepared to Respond to Potential Enrollee Concerns

According to a health policy affiliate experienced in Cal MediConnect stakeholder engagement, enrollment counselors are of particular importance in Los Angeles County, which, unlike other demonstration counties, will offer active enrollment.¹³⁵ This means that hundreds of thousands of dual eligible individuals will be notified of their Cal MediConnect eligibility and will be given the option to enroll. Undoubtedly, many eligible individuals will have questions regarding the enrollment process and benefit changes. According to interview responses, CHWs could step in to aid in this early process. Currently, Health Insurance Counseling and Advocacy Programs (HICAP) are responsible for all enrollment counseling, however, according to an informant, “they are not prepared...HICAPs are generally volunteer based and always short on resources.” It was suggested by a policy expert that CHWs might be able to quickly step in and help answer enrollment questions for Los Angeles’s dual eligibles.

It is possible that the recent press and policy work surrounding the use of “patient navigators” to aid in ACA insurance enrollment is partly accountable for the prevalence of this

¹³⁵ “Los Angeles County | CalDuals.org.”

response. Additionally, the recognition of the complexity of health care has increased advocates' call for health care navigators, as manifest in interview responses.

Community Health Workers Historical Role as Community Educators/Navigators

Two CHW associated respondents noted the historical role of CHWs as community educators. One respondent stated, "It would be natural for CHWs to continue to serve that role [of educator], or a variation of it, under any new kind of program." While this is a viable option and certainly within the scope of work for a CHW, enrollment counseling is a limited, time bound employment option. CHWs are capable of serving this role, benefiting dual eligibles and aiding health plans in enrollment counseling, but it would not offer the same degree of benefit to the CHW labor force.

Community Health Workers Potential in Interdisciplinary Care Teams

Respondents from health plans, advocacy groups, and the philanthropic sector commonly envisioned the CHW as a potential member of an interdisciplinary care team. According to a health plan affiliated respondent, Cal MediConnect dictates that a care team manages the care of every client. The staff and size of the care team will vary depending on the complexity and level of care needed for particular clients. For clients with high need, characterized as multiple chronic conditions, a CHW could be of great benefit. Respondents unanimously agreed that a CHW could play a role in the care team; however, many differed in their opinion as to the level of involvement a CHW should have.

Community Health Workers to Provide Home Visits

A respondent from the philanthropic sector and a health plan affiliated respondent felt that CHWs could best be utilized as quasi-home care workers. While the CHW would not provide care in the way a home care worker might, respondents stated that CHWs could do

“home checks.” This might include visiting a patient upon their return home from the hospital to ensure that they have food, that there are no visible hazards in the home, and that the necessary medical equipment has arrived. Additionally, the respondent from the philanthropic sector noted that CHWs might also be expected to re-explain proper after-care and prescription or medical equipment instructions as providers of community based services.

Community Health Workers as a Supplement to Social Workers/Case Managers

Respondents from the legal and CHW advocacy communities envisioned CHWs as a supplement to social workers or professional case managers. A CHW associated respondent explained that patients might be more likely to trust a CHW because they are more likely to view them as a peer. According to this respondent, “Peer-to-peer relationships automatically have more trust so patients might be more inclined to listen to a *promotora* [CHW].” CHWs would act as a bridge and additional support to licensed case managers or social workers; they would not be responsible for managing or coordinating the care of an individual. Additionally, respondents from all represented sectors saw the CHW as translation support, providing information in a culturally sensitive and linguistically appropriate way, and thus supplementing the services provided by social workers or professional case managers.

The use of CHWs as members of care teams, both as in-home and case management supports, would be a more structurally stable position for the CHW labor force, compared to the enrollment counselor role suggested by many respondents. The respect garnered by the inclusion on care teams would legitimize CHWs without having to license the profession. CHWs would be able to stay within their scope of work, would gain recognition as a member of a team, and have a greater potential for long-term stability due to their structural integration. Including CHWs as

members of care teams is beneficial for both dual eligibles, which would benefit from CHW services, and the CHW labor force, which would benefit from added structural stability.

Need for Communication Between Health Plans and Community Health Workers

All interview respondents cited a lack of communication between CHW networks, health plans, and other stakeholders in the Cal MediConnect program. Respondents indicated that CHW networks do not necessarily “talk to health plans or policy people.”

Increased Communication Can Lead to Partnerships

Respondents across the represented sectors thought that increased communication between CHW networks and health plans was the first step to building future partnerships. Partnerships between existing CHW networks and advocacy groups could lead to eventual institutionalization of CHW positions, though the popular opinion among interview respondents was that it would be a long time before CHWs could become fully institutionalized. Many respondents felt that health plans would be more interested and willing to work with CHW organizations if they were aware of the potential cost savings that CHWs could offer, such as helping improve transitions of care, as this chasm can be the most costly experience in the health care system.

Community Health Workers Initiate Communication with Health Plans

All respondents, with the exception of one CHW affiliated respondent, stated that CHWs must initiate contact with health plans if they want to seek a partnership under Cal MediConnect, as it is unlikely that health plans will seek out CHW participation throughout the implementation of Cal MediConnect. Respondents suggested that CHW networks approach health plans with quantitative data that illustrate the ability of CHW programs to save money through better management of chronic conditions and reduced hospitalizations. The power of cost savings could

be very persuasive to health plans, particularly with the new financing scheme introduced through Cal MediConnect. Due to capitated payments, health plans will be looking for ways to get better health outcomes in the most cost effective manner. While CHW programs are not zero cost, particularly in the beginning, they can significantly reduce hospitalizations, the most costly of the services covered by the participating health plans.¹³⁶

Potential Difficulty in Community Health Worker Inclusion Under Cal MediConnect

There was doubt among respondents as to the likelihood of CHW inclusion under Cal MediConnect. A respondent from the philanthropic sector noted that Cal MediConnect is an “opportunity for a variety of different types of health care workers who have not normally been a part of traditional [health care] delivery to get involved,” but then stated that it is unlikely for “any worker participant that is not already professionalized to move quickly into an institutionalized financing and delivery system.” The focus on implementation and resistance to non-licensed health workers emerged as specific difficulties faced by the CHW labor force.

Professional and Health Plan Resistance to Non-Licensed Health Workers

Respondents across all represented sectors stated that there would be considerable resistance to formal inclusion in care teams because CHWs are non-licensed health workers. Recently, however, CMS released revised recommendations that indicate that states may reimburse for “preventative services *recommended* by a physician or other licensed practitioner” (emphasis added). This recognition of the value of unlicensed health workers by CMS and proposed mechanism of financing—Medicaid reimbursement—may lessen resistance to CHW inclusion. While this recognition from a federal level is powerful, each state must submit a state plan amendment if they want to take advantage of this option. California has yet to submit a state

¹³⁶ Davis, “Issue Brief on Leveraging Community Health Workers Under California’s State Innovation Model (SIM) Initiative.”

plan amendment. Until an amendment for reimbursement passes, CHWs will face considerable resistance from health plans as non-licensed workers.

Single Focus on Implementation and Roll-Out of Cal MediConnect

There is a positive trend for the incorporation of CHWs in the formal medical system, generally. Unfortunately, most respondents said that Cal MediConnect would not be a fertile testing ground for the scaling up of the labor force. Currently, much of the focus is simply on roll out and implementation of the existing policy. According to a member of the philanthropic sector, “Before implementation starts, Cal MediConnect still lives on a piece of paper. People are working very hard to breathe life into that piece of paper given the resources they currently have.” Attempting to include CHWs as members of care teams is adding yet another decision point into an already complicated implementation plan. Therefore, it seems unlikely that health plans will seriously consider the role of the CHW in the first stages of Cal MediConnect implementation. This does not mean, however, that CHW inclusion will not be considered in the future, after the flurry and stress of implementation has passed.

Limitations

This study was unable to solicit direct input from two key audiences: CHWs and dual eligible beneficiaries. Additionally a majority of respondents were in some way more directly associated with the dual eligible population, comparable to the CHW labor force. This skewed response could have affected the ultimate analysis of the feasibility of CHW inclusion or desire to participate in the emerging care delivery models for dual eligibles in Los Angeles County.

RECOMMENDATIONS

Several obstacles to CHW inclusion under Cal MediConnect were identified in the interviews. These recommendations seek to provide solutions to those issues identified.

Recommendations are organized in increasing order of ambition, beginning with plans for increased communication between CHW networks and health plans and ending with plans to create policy change at the state level.

Increase Communication Between Community Health Workers and Health Plans

Community Health Workers Must Initiate the Conversation

Interviews revealed a lack of communication between health plans and CHW groups, thus hindering CHW inclusion in formal health care systems under Cal MediConnect. To increase communication between health plans and CHW groups, CHW groups must initiate contact with health plans. Health plans are unlikely to investigate the effectiveness of CHW programs given competing priorities, such as federal and state compliance measures and general delivery and financing management of large scale health plans.

Community Health Worker Presentations at Annual Meetings: Focus on Cost Savings

CHW advocacy groups and CHW networks can plan to present at annual meetings for the participating Cal MediConnect health plans in Los Angeles County. In their presentations to the health plans, CHW groups should emphasize the cost savings of their programs, particularly concerning chronic disease management. Due to the grant dependent nature of most CHW programs, the data regarding efficacy and outcomes of CHW programs should be readily available, as grantors often require extensive reporting on the health and savings outcomes of programs they are supporting.

Community Health Worker Presentations at Annual Meetings: Framed as HCBS Providers

Additionally, presentations might frame CHWs as discretionary HCBS providers. By framing the CHW as a potential discretionary HCBS provider, CHW advocates can argue that CHWs be budgeted into the capitated payment per beneficiary. As part of the capitated payment,

CHWs stand to increase the efficacy of the delivery system, aid in meeting cultural competency and person-centered care standards, and thus, increase the likelihood of financial return for the participating health plans.

Creating Partnerships with Outside Stakeholders

As noted in interviews, CHWs do not currently engage in a meaningful way with multiple Cal MediConnect stakeholders. CHW groups must contact major stakeholders involved in Cal MediConnect in order to raise awareness of their effectiveness and thus gain support for their inclusion in the emerging care delivery and financing models for dual eligibles.

Contacting Senior and Disability Advocates to Raise Awareness Among Enrollees

In addition to contacting participating Los Angeles County health plans, CHW networks should reach out to senior and disability advocacy groups, fellow stakeholders under Cal MediConnect. In conversations with these fellow stakeholders, CHW networks can provide evidence as to their effectiveness in improving health outcomes for vulnerable populations and emphasize their unique ability to deliver culturally and linguistically appropriate education and services, thus improving access to and quality of health care services for their constituents.

Conversations with senior and disability advocacy groups should be constructed with the goal of increasing awareness beyond the advocacy groups to the dual eligible Cal MediConnect enrollees themselves. Partnerships established during these meetings can help facilitate communication between CHW groups and enrollees, which in turn can lead to duals requesting CHWs as part of their interdisciplinary care teams.

Building Power with Organized Labor

Moving forward, organized labor groups, like Service Employees International Union (SEIU), can be important allies for CHW networks in Cal MediConnect inclusion efforts and

beyond. While this study has established that Cal MediConnect, with its current “demonstration” designation, is an unlikely place to quickly professionalize and introduce the CHW labor force into the formal folds of the health care system, it remains that CHWs are an emerging health care labor force in need of a pathway to formalization.

CHW groups might partner with organized labor to increase visibility, garner resources, and most importantly, build power—vital steps in any journey towards inclusion in formal systems. Similar to the home health care organizing of the 1990s, which created a single employer through the state and established union representation, the currently fragmented CHW labor force should move towards creating this organizational infrastructure to ensure clear, accessible pathways to employment and employee rights through unionization. Future research and community based studies focused on the CHW labor force might explore further organizational tactics to be employed in the professionalization of CHWs.

Lobbying for Legislative Approval of Non-Licensed Health Workers

Legislative movement on the State Amendment for reimbursement for non-licensed health workers seems unlikely due to state budgetary constraints, thus making this the most ambitious of the recommendations.

Identify Coalition Partners for Lobbying Efforts

Partnerships and coalitions can be used to both lobby the health plans and the state legislature. Integral to the scaling up of the CHW workforce is California’s acceptance and passage of a bill that provides Medicaid reimbursement for non-licensed health workers. As previously established, California legislature has neglected to adopt this opportunity provided by the CMS due both to budgetary concerns and political resistance from the governor and in the legislature. CHW groups might build a lobbying coalition, comprised of various stakeholders

including senior and disability advocates along with organized labor, in order to more effectively lobby state legislators.

Hire Outside Policy Consultant Groups

In efforts to propose a state level amendment, it may be advantageous for CHW groups and supporters to hire or obtain the help of outside policy consultant groups. The proposed piece of legislation is of particular importance to the CHW labor force for obvious reasons. As previously discussed, to formalize the CHW position might jeopardize the legitimacy of the position. Reimbursement for non-licensed health workers lessens the pressure to create a formal licensing board for CHWs and removes the risk of distancing the CHW from the community. Adoption of reimbursement for non-licensed health workers would ensure greater opportunity for CHWs, beyond Cal MediConnect.

Conclusion: Community Health Worker Inclusion Under Cal MediConnect Unlikely

The process of duals integration is a complicated balancing act. The implementation of Cal MediConnect is a long series of decision points and the introduction of CHWs into the system to act either as enrollment counselors or members of care teams would be yet another decision point in an already overwhelming line of choices. The likelihood of CHWs being introduced under Cal MediConnect as health workers for duals is very low. Despite the generally positive feelings towards the CHW labor force, the reality of the policy situation disallows reimbursement in California, discouraging health plans from seeking services. The capitated payment model may provide some measure of financial incentive, however, CHW groups will have to initiate the conversations between themselves and the health plans to demonstrate their potential for bettering health outcomes while ensuring cost effectiveness.

This report explored the possible utilization of CHWs under Cal MediConnect and asked what institutional and structural changes would need to be made to accommodate the growth of the labor force. Through the interviews and review of existing policy, it became clear that there is a low likelihood of CHW inclusion under the current Cal MediConnect demonstration. If the demonstration is transformed to a permanent program, then that may be a good time to consider the use of various health care staff, CHWs included, to improve access, quality, and cost-efficiency of integrated models of care for the dual eligible population.

Appendix A: Glossary

Activities of Daily Living (ADL): basic tasks of everyday living (i.e., bathing, eating, dressing, toileting, transferring)¹³⁷

Cal MediConnect: California’s duals demonstration project; aims to integrate Medicare and Medicaid services under a managed care model in eight counties across the state¹³⁸

Capitated Payment: a fixed amount of money per patient per unit of time paid in advance to a health provider, such as a managed care organization, for the delivery of health care services¹³⁹

Centers for Medicare-Medicaid Services (CMS): a division of the U.S. Department of Health and Human Services that administers Medicare and jointly administers Medicaid with the state governments¹⁴⁰

Community Health Worker (CHW): non-licensed members of the community that act as a bridge between the formal health care system and community members.¹⁴¹

Coordinated Care Initiative (CCI): California law passed in 2012 that transforms the Medi-Cal care delivery system and begins the process of integrating Medicare and Medi-Cal for people in both programs¹⁴²

Dual Eligible Beneficiaries: individuals that qualify for Medicare and Medicaid; generally low-income older adults or younger people with disabilities¹⁴³

Fee-for-Service Model (FFS): payment system in which the individual health care services provider bills for each service provided; the default payment model where a provider is paid directly from Medicare or Medi-Cal rather than contracting with a health plan.¹⁴⁴

Health Insurance Counseling and Advocacy Program (HICAP): service of the California Department of Aging that offers free, objective Medicare counseling by volunteer counselors¹⁴⁵

Home and Community Based Services (HCBS): home and community-based services that provide assistance with daily activities that generally help beneficiaries remain in their homes¹⁴⁶

¹³⁷ Wiener et al., *Measuring the Activities of Daily Living: Comparisons Across National Surveys*.

¹³⁸ *Cal MediConnect MOU*.

¹³⁹ Physicians, “Capitation Payments - Understanding Capitation - ACP.”

¹⁴⁰ *Centers for Medicare & Medicaid Services*.

¹⁴¹ “APHA: Community Health Workers.”

¹⁴² “ADDIN ZOTERO_ITEM CSL_CITATION {“citationID”:“ztYBzvSheet.””

¹⁴³ *Dual Eligible Beneficiaries: An Overview*.

¹⁴⁴ Cutler, Rich, and Yee, *Advocate’s Guide to California’s Coordinated Care Initiative*, 5.

¹⁴⁵ “HICAP.”

¹⁴⁶ Cutler, Rich, and Yee, *Advocate’s Guide to California’s Coordinated Care Initiative*, 5.

In-Home Supportive Services (IHSS): provides services that allow a beneficiary to remain safely in the home rather than in a nursing facility or other institution (i.e., housecleaning, shopping, meal preparation, laundry, personal care services, accompaniment to medical appointments, protective supervision for those with mental impairments who require it)¹⁴⁷

Interdisciplinary Care Team (ICT): consists of practitioners from different professions who share a common patient population and common patient care goals and have responsibility for complementary tasks¹⁴⁸

Long-Term Services & Supports (LTSS): medical and non-medical services that provide sustained assistance to older adults and younger people with functional limitations; Medicaid is the primary payer of LTSS¹⁴⁹

Managed Care Organization: group of doctors, clinics, hospitals, and pharmacies that work together to meet the care needs of their members¹⁵⁰

Medi-Cal: California's Medicaid health program¹⁵¹

Medicaid: federal-state health care program for low-income individuals; includes long-term care coverage¹⁵²

Medicare-Medicaid Coordination Office (MMCO): federal office established by the *Patient Protection and Affordable Care Act* that serves people enrolled in both Medicare and Medicaid programs; seeks to streamline care, improve care quality, and make the system as cost effective as possible¹⁵³

Medicare: public health insurance program for people age 65 or older and younger people with functional limitations; covers the cost of health care but not the cost of all medical expenses or long-term care¹⁵⁴

Person-Centered Care: an orientation to the delivery of health care and supportive services that considers an individual's needs, goals, preferences, cultural traditions, family situation, and values; patient and their family are at the center of the care team, along with health and social service professionals and direct care workers¹⁵⁵

¹⁴⁷ Ibid., 6.

¹⁴⁸ "Interdisciplinary Teamwork in Health Care."

¹⁴⁹ "Medicaid Long-Term Services and Supports."

¹⁵⁰ "Managed Care Organizations."

¹⁵¹ "Medi-Cal."

¹⁵² Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*.

¹⁵³ Medicare-Medicaid Coordination Office, "About Medicare-Medicaid Coordination Office."

¹⁵⁴ Social Security Administration, *Medicare*.

¹⁵⁵ Feinberg, *Moving Toward Person- and Family-Centered Care*.

Appendix B: Division of Medicare-Medicaid Coverage for Dual Eligibles

Medicare	Medicaid
<ul style="list-style-type: none">• Part A: inpatient hospital services, skilled nursing facilities, hospice, and home health care• Part B: physician and other provider services, outpatient care, durable medical equipment, home health care, preventive services• Part D: prescription drugs	<ul style="list-style-type: none">• Pays Medicare cost sharing responsibilities (i.e., co-payments, deductibles)• Long-term services & supports• Dental/vision coverage

Source: *Medicare: A Primer* (Binder et al. 2012); *Medicaid: A Primer* (Herz 2012).

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