Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

June, 2021 Joint Committee on Finance Paper #343

Doula Services, Community Health Worker Services, and Community Health Benefit (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 265, #17 and #18, and page 266, #19]

CURRENT LAW

Federal law establishes certain services that states are required to fund under their MA programs, as well as other services that states may fund, at their option. These federally-defined services are commonly referred to as state plan services, since states indicate in plans submitted to the Centers for Medicare and Medicaid Services (CMS) which of the optional services their MA programs will cover. Examples of mandatory state plan services include physician services, inpatient and outpatient hospital services and nursing home services. Examples of optional state plan services include dental services, physical therapy, and prescription drugs. Some optional services allow latitude for states and CMS to deliver social or supportive services that go beyond those that are typically included in traditional health insurance plans. This includes "other diagnostic, screening, preventive and rehabilitative services" and "other practitioner services."

In addition to funding state plan services, states may fund other services not defined in federal law. However, states that choose to fund such services must seek waivers of federal law to enable them to receive federal matching funds to support these services. Wisconsin has several active waivers, including for the provision of many long-term care services.

DISCUSSION POINTS

1. This paper discusses three proposals to establish new MA benefit categories: (a): services provided by doulas, who are trained to provide support before, during, and after childbirth; (b); services provided by community health workers, who are trained to help connect members of their own community to needed services impacting health; and (c) services to address medical and non-medical determinants of health, including housing supports, access to healthy foods, and chronic

disease management.

2. Although Wisconsin does not currently cover these services under MA, it does cover certain related services. The MA prenatal care coordination benefit provides health education and connections to medical, social, and other services for pregnant women with a high risk for adverse pregnancy outcomes, although this benefit does not typically offer the sustained direct support throughout the pregnancy and delivery that doulas provide. The prenatal care coordination benefit provides reimbursement for services provided by public health educators, however, which are similar to community health workers in that neither role requires a formal medical credential and both provide outreach aimed at preventing adverse health outcomes. Peer support specialists play a similar role for people with substance abuse disorders or mental illness, providing supportive services that do not require a professional medical or counseling license. MA reimburses peer support specialists through the county-option comprehensive community services benefit, which provides rehabilitation services to people with severe substance abuse or mental health conditions.

3. All three proposals discussed in this paper are similar in the sense that they are non-clinical services for individuals who may face social or economic conditions that contribute to poor health outcomes. In addition, all three services may already be provided outside of MA, through a variety of programs discussed below, including local public health programs, county social services, or nonprofit organizations. Providing these services through MA would likely expand their reach and would allow the state to access federal Medicaid matching funds to cover a portion of the cost. Under the state's standard matching rate, federal funds cover approximately 60% of the cost of Medicaid state plan or waiver services. The remainder of this paper provides a more detailed description of the three proposed new MA benefit categories.

Doula Services

4. Assembly Bill 68 and Senate Bill 111 would provide $1,015,200 ($406,700 GPR and $608,500 FED) in 2022-23 to reimburse certified doulas for childbirth education and support services, including emotional and physical support, provided during pregnancy, labor, birth, and the postpartum period (Alternative A1). Coverage would be estimated to begin July 1, 2022.

5. The administration's fiscal estimate for doula coverage is based on reimbursement policies and data from Minnesota's doula benefit. Minnesota reimburses doulas $47 per visit for up to six visits, plus $488 for attending the birth. It is assumed that 6% of pregnant women enrolled in BadgerCare Plus, approximately 1,300 per year, would access doula services, at a cost of $770 each.

6. Doula certification typically requires attending workshops and trainings, completing coursework and examinations, and receiving positive reviews from medical professionals and new parents after attending several birthings. Training curricula cover health during pregnancy, labor, and the postpartum period, medical resources, strategies for effective physical and emotional support, breastfeeding, postpartum depression, cultural competence, and other topics.

7. Doulas can fill gaps in the current healthcare system to improve outcomes in communities that are currently underserved. In particular, the administration promotes doula services as one strategy to address racial disparities in adverse maternal and child outcomes. Black women

experience 1.75 times greater risk than White women of significant complications from labor or delivery, and five times the risk of dying in childbirth or from complications, based on DHS data. DHS and Centers for Disease Control and Prevention (CDC) data also indicate that Wisconsin's Black infant mortality rate, 14.6 deaths per 1,000 live births, is among the highest of any state in the nation, 30% above the nationwide average of 10.5 deaths per 1,000 live births to Black parents and approximately three times the rate for White infants in Wisconsin.

8. People giving birth in rural areas also face disparities in care. Analysis published by the National Conference of State Legislators (NCSL) in 2021 finds "maternity care deserts" in many rural areas, where people face transportation barriers and shortages of obstetricians and other prenatal care providers. Research published by CDC and the Minnesota Department of Health in 2013 found that these rural access barriers correlated with higher risk factors, such as smoking while pregnant, and worse birth outcomes, including increased rates of preterm births. These reports recommended increasing access to doulas to improve rural maternity care, and Minnesota added Medicaid coverage for doula services in 2013.

9. The same NCSL analysis cites research demonstrating that continuous support from doulas during childbirth can decrease the use of pain relief medication during labor, decrease incidence of cesarean deliveries, decrease the length of labor, and prevent negative childbirth experiences.

10. By providing relatively low-cost preventative and supportive care, advocates for doula coverage argue that doulas can reduce the need for higher-cost procedures, creating savings as well as better health outcomes. A systematic review published by the Cochrane Library in 2017 found that, across 27 different studies of the impacts of doula care, on average doula services achieved a 25% reduction in caesarean births. Vaginal births not only have better health outcomes, they also cost Medicaid programs approximately $4,500 less per birth, according to 2013 analysis by Truven Health Analytics. Currently, approximately one out of three Medicaid births is caesarean. Doulas may also create savings by helping to prevent more serious birth complications. The Truven analysis estimates that healthcare costs for a low birthweight or preterm birth, for example, average $55,000.

11. Research published in the *Wisconsin Medical Journal* in 2013 found that, based on birth costs and outcomes in Wisconsin in 2010, doulas could be expected to save on average $420 per delivery they attend (2010 dollars). Depending upon utilization patterns and actual reimbursement costs, any savings resulting from avoiding adverse maternal and child outcomes could at least partially offset the cost of providing care.

12. Several states have begun providing doula services as a Medicaid benefit, including Minnesota and Oregon. Indiana provides doula services to Medicaid-eligible residents using Title V maternal and child health block grant funding, instead of as a Medicaid benefit. Some managed care organizations have begun providing doula services as well, such as one in Nebraska serving pregnant youth in foster care.

13. The Department indicates that some MA health maintenance organizations may employ doulas as part of performance improvement projects related to birth outcomes. However, because doula service is not an MA benefit category, the cost of these services is not included in the HMO

capitation rates, but is instead considered an HMO administrative expense. Consequently, utilization of doulas by HMOs is limited. If doula service is added as a MA benefit category, then these provider payments could be included in the HMO rate development process or could be reimbursed separately, outside the HMO contract.

14. AB 68/SB 111 would require DHS to seek federal approval, through a state Medicaid plan amendment or federal waiver, of the doula benefit. The Department would implement the benefit only if the federal government approves a plan amendment or waiver.

15. Although doula coverage would add a service that is currently unavailable under MA, there are existing MA initiatives that are intended to address adverse maternal and child outcomes. In 2011, for instance, MA established an obstetric medical home initiative to provide intensive prenatal and postpartum care coordination for women determined to be at high risk for adverse outcomes. This program is only available in certain parts of the state, in southeast Wisconsin counties and in Dane and Rock counties. MA also has a prenatal care coordination benefit for pregnant women who are at high risk for adverse pregnancy outcomes. The services include outreach, assessment, care plan development, care coordination and monitoring, and health education and nutritional counseling. If the doula coverage proposal is approved (Alternative A1), doulas may be incorporated in these program benefit categories or may be covered as a separate service. If the doula proposal is not approved (Alternative A2), DHS would continue to administer these programs for women who are considered to be at high risk for adverse pregnancy outcomes.

Community Health Workers

16. AB 68/SB 111 would provide $14,232,000 ($5,701,600 GPR and $8,530,400 FED) in 2022-23 to fund coverage of community health worker services under MA (Alternative B1). Coverage would be estimated to begin July 1, 2022.

17. A community health worker (CHW) is a member of a particular community working to help improve the health of their own community by bridging the gaps between community members and health services, promoting services that address their particular needs, and providing culturally competent, accessible care. They respond to both medical and non-medical drivers of health, including access to healthy food, chronic health conditions, and housing security. They typically do not require specific medical credentials, but rather are trained to provide services such as outreach, case management, and chronic disease management coaching. CHWs can make use of their community connections and common experiences to understand patients' unique needs and preferences, tailoring care to be more effective.

18. As in the case of doulas, the administration proposes to provide CHW coverage as a means to address the social and economic conditions affecting some MA beneficiaries and that are associated with disparate health outcomes between groups. State death records show that White residents live on average 15 years longer than Black residents in Wisconsin. Native American residents are approximately three times as likely to die by suicide as Black residents, and lesbian, gay, and bisexual youth attempt suicide at seven times the rate of heterosexual youth. Black men face four times the risk of dying by stroke as White men do, and the disparity for women is a factor of seven; these are the third-largest disparities in heart disease mortality by state in the country, per CDC data.

19. A growing number of policymakers and organizations across the country utilize CHWs, and several programs rely on them in Wisconsin. In recent years, DHS has provided approximately $960,000 per year from a CDC grant for diabetes prevention and control to organizations that use CHWs for that purpose. The largest recipients of this funding are two programs that implement the evidence-based Pathways Community HUB model of CHW services: Great Rivers HUB operated by the Great Rivers United Way in western Wisconsin, and UniteWI serving Milwaukee. These CHW programs engage in activities beyond diabetes management as well, using funding from health systems, private donors, and other organizations, to pursue the full range of services CHWs can offer.

20. The Pathways Community HUB model is a well-researched system for using CHWs to identify the barriers healthcare services face in reaching particular communities, select proven pathways to connect community members with the care they need, and coordinate that care. The model includes training for CHWs; technology to help CHWs identify and track community members' needs, progress, and outcomes such as the results of referrals to other services; strategies for building a network with human service and clinical organizations in the community; and an accountable payment model based on outcomes.

21. The Great Rivers HUB began in 2017 as a partnership with Gundersen Health System, Mayo Clinic Health System-Franciscan Healthcare, and the Medical College of Wisconsin. It serves La Crosse County, with plans to expand into Monroe and Trempealeau counties. The program's eight CHWs focus on frequent emergency room patients (providing guidance toward other points of care and services to meet their underlying needs), pregnant women experiencing homelessness, families with elementary school children who frequently miss school, and patients with heart disease or diabetes. As one indicator of the program's performance, a local health system saw a decrease of 150 emergency room visits in a year, and an increase in primary care utilization, among 70 members served by the hub.

22. UniteWI implements the Pathways model in the Milwaukee area. Their CHWs specialize in coordinating prenatal care, managing chronic conditions including diabetes and hypertension, connecting residents to asthma care, navigating benefits, and providing healthy food to those experiencing food insecurity.

23. Many other organizations in Wisconsin employ CHWs or offer similar services, including non-profit organizations and health systems. The Bureau of Labor Statistics estimates 350 CHWs work across the state. The Wisconsin Community Health Worker Network facilitates coordination among organizations employing CHWs, supports training new CHWs, and helps link CHWs with health systems, public health departments, and community-serving organizations.

24. Several published studies support the view that CHWs can be an effective way to improve the health of their communities. One study, published in April, 2014, by *JAMA Internal Medicine*, found that CHWs positively impact measures of overall health, including decreasing hospital admissions and increasing access to primary care. They also demonstrate results in studies focused on specific conditions, including decreasing high blood pressure (see *Preventative Medicine*, July, 2003), reducing diabetics' hemoglobin values (see *Journal of General Internal Medicine,* July, 2015), and reducing hospital readmissions for patients living with chronic diseases by 60% (*JAMA Internal Medicine*, above).

25. North Carolina provides CHW services as a Medicaid benefit under a waiver, and Minnesota and Indiana cover CHW services when delegated by a licensed medical professional. Other states offer or are developing CHW benefits as well, as part of ongoing shifts away from paying for volume of care and toward paying for quality and health outcomes.

26. The federal Centers for Medicare and Medicaid Services commissioned a study of 72 innovative payment and service delivery models that had received federal support, including several using CHWs. The analysis found the CHW strategy to be the most cost effective, and the only component among those studied that yielded consistent net savings, in this case, $552 per beneficiary per year. Savings are generated through better management of chronic diseases, reduced emergency room utilization, reduced readmissions after hospital care, and other preventative interventions, although results varied between specific implementations.

27. While this and other research can be used to demonstrate positive health outcomes associated with the use of CHWs and, in some cases, net savings for medical services, the research may not be a reliable indicator of the outcomes that Wisconsin MA would see with the implementation of a CHW benefit under MA. It is possible that the research evaluations differ in a variety of ways from how the benefit would be implemented in Wisconsin. For instance, if the evaluation involves a service that is narrowly targeted to only the individuals who are most likely to benefit, while the criteria for the MA benefit were not as restrictive, the average impact across all individuals served may differ. As with all MA benefits, the Department would need to develop criteria for determining for which individuals and in what circumstances the CHW benefit would be available.

28. The administration's fiscal estimate for the CHW benefit does not assume any offsetting savings for other MA medical services. Instead, AB 68/SB 111 would increase MA funding based on the assumption that the equivalent of 200 full time CHWs would be reimbursement for providing services to MA beneficiaries per year. The actual cost would depend upon several factors that are presently unknown, such as the standards and policies that would be established by the Department for eligibility and quantity of services allowed.

29. The Department indicates that at least some CHW activities would be allowable under existing federal Medicaid authority. For instance, the list of Medicaid eligible services includes preventive services recommended by a physician or other practitioner and performed under the direction of that practitioner. Consequently, the Department believes that a CHW benefit meeting federal standards could be implemented with an amendment to the state's Medicaid plan. Any more expansive scope of CHW services would likely require the state to obtain a federal waiver. AB 68/SB 111 would require the Department to seek federal approval of the CHW benefit, but coverage would be contingent upon federal approval. The Committee could adopt the CHW benefit with the same condition (Alternative B1).

30. The Committee could decide that existing local public health, health system, and non-profit initiatives to support the use of community health workers are adequate and it is not necessary to create a new MA benefit for this service (Alternative B2).

Community Health Benefit

31. AB 68/SB 111 would provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $24,500,000 ($10,014,000 GPR and $14,486,000 FED) in 2022-23 for a new community health benefit under MA, which would provide reimbursement for nonmedical services that contribute to determinants of health (Alternative C1). The bill would require the Department to identify the specific services that would be covered and request any necessary federal waiver or other approval, and coverage would be contingent on federal approval. Coverage would be estimated to begin January 1, 2023.

32. The administration's funding estimate for the community health benefit assumes that approximately 12,500 individuals would be served on a monthly basis, at an average cost of $300 per person per month, for an annual total of $45.0 million. Based on the assumption that the benefit would begin in January of 2023, AB 68/SB 111 would provide $22,500,000 ($9,014,000 GPR and $13,486,000 FED) in fiscal year 2022-23 in the MA benefits appropriations. In addition to MA benefits, this item also would include $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $2,000,000 ($1,000,000 GPR and $1,000,000 FED) in 2022-23 for costs to implement and administer the benefit. These costs include contracts for development of policies related to benefit services, preparation and submittal of a federal waiver, and development of an assessment tool for determining eligibility.

33. Increasingly, public health experts have proposed that a wide variety of social and economic factors, beyond the quality and accessibility of medical services, have a significant impact on a person's health. Nonmedical determinants of health, as identified in the state health plan, *Healthiest Wisconsin 2020,* include a person's behaviors and habits, social and economic conditions they experience, and their physical environment. The attachment to this paper illustrates this model in more detail.

34. The proposed MA benefit would provide services that aim to improve health by addressing one or more of these nonmedical factors that influence health. Depending on final determinations by DHS and CMS, such services could include nutritional mentoring, housing referrals, stress management, wellness and family support, violence intervention, and more. The benefit would focus on identifying members' needs, providing referrals to available resources such as nonprofit organizations, and coordinating services.

35. The Department indicates that this benefit would complement and extend the CHW benefit discussed above by expanding the range of services with which CHWs can connect their clients. Depending on the barriers and medical needs experienced by a particular beneficiary, the service would seek to improve health outcomes by connecting them with a particular nonmedical service.

36. Advocates of this approach point to research on the links between health and access to employment, education, income, housing, and social support. As an example, a study published by the *Journal of the American Medical Association* in May, 2009, documented that an intervention providing housing supports to adults experiencing both homelessness and chronic health conditions reduced hospitalizations by 29% and emergency room visits by 24% among the population served.

In addition, a study published in *Health Affairs* in April, 2018, found that an intervention providing home-delivered, medically tailored meals to certain vulnerable low-income seniors had positive impacts on health, including reducing emergency room visits by 44%.

37. The Department cites the North Carolina Healthy Opportunities Pilot Program as a potential model for a Wisconsin community health benefit. North Carolina received approval of a federal waiver in 2018 that allows the state to initiate four demonstration projects to evaluate the impacts of Medicaid-funded benefits for nonmedical services to address four domains: housing, interpersonal violence/toxic stress, food, and transportation. As an example, in the housing domain the demonstration program will pay for navigation services to help individuals find suitable housing, but, for some beneficiaries, will also directly support housing stability by paying a security deposit and the first month of rent. In the food domain, the program could pay for healthy food boxes or medically tailored meals.

38. While the North Carolina demonstration is one potential model, the Department notes that Wisconsin's program would likely differ, due to differences in the state's existing Medicaid programs. The Department anticipates, for instance, that the benefit would generally not directly fund the cost of services, such as rental payments, but would instead focus on identifying individual needs and connecting individuals to existing public and nonprofit services. As included in AB 68/SB 111, the benefit would be defined as "services that contribute to determinants of health" and would direct the Department to identify the specific services.

39. The proposed community health benefit would be intended to use nonmedical services as a means to address social determinants of health as a means of improving health and reducing utilization of medical services. The Department currently has, or is in the process of implementing, a number of MA initiatives that have a similar intent. A few examples are described below:

- The Department's contract with MA health maintenance organizations (HMOs) includes various care management policies designed to address social conditions that affect health. For instance, for members enrolled on the basis of Supplemental Security Income (SSI) eligibility, the HMOs are required to provide intensive care coordination with attention to social determinants. As a part of this service, HMOs must maintain partnerships with social service organizations that address housing instability, health literacy, and traumatic life experiences.

- HMOs are also required to develop and implement performance improvement projects to improve the health of enrolled members. These projects take a variety of approaches, but typically focus on a specific clinical measure or health disparity and develop strategies to improve outcomes. HMOs may choose to utilize measures that would not otherwise be covered MA benefits. HMOs receive incentive payments for meeting target measures.

- The Department is implementing a hospital-based intensive care coordination pilot program for individuals with a history of frequent emergency room visits. Participating hospitals will receive a $250 payment for each participant, plus a portion of any estimated savings associated with a reduction in hospital services resulting from the program. Under the program, the hospital is expected to assist participants in connecting with health and social service resources, including housing and transportation.

• Under provisions of 2019 Act 76, DHS is required to submit a federal waiver or state plan amendment to provide intensive case management services to assist members who are experiencing homelessness. DHS is currently in the process of developing a federal application for this service.

40. While these initiatives are generally intended to address social determinants of health, the proposed community health benefit may provide authority for more comprehensive services or for other target groups that are currently unserved. However, since the specific services that would be covered and other details regarding of the benefit have not yet been determined, it is unknown what additional services would be provided that are not already available.

41. Given the proposed community health benefit would require a larger funding increase than the other MA benefit changes, and that many of the details relating to specific services and eligibility have not yet been developed, the Committee may determine that creating a more limited pilot program would be preferable to creating a statewide program at this time. In this case, one element of the community health benefit waiver could be to specify that the Department must limit services to pilot program areas and cap enrollment. For instance, to establish a pilot program limited to 3,125 individuals at a time (one-quarter of the estimated number of individuals used for the budget estimate) would require funding of $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $7,625,000 ($3,253,500 GPR and $4,371,500 FED) in 2022-23 (Alternative C2).

42. If the Committee provides funding and adopts a community health benefit, as proposed in AB 68/SB 111, the Department would develop a proposal for federal approval. Under current law, any federal waiver or other approval would need approval of the Committee prior to being submitted to the federal government. If a community health benefit is not approved (Alternative C3), the Department would not have funding and authority for the benefit, but could continue to use other measures, including the initiatives mentioned above, to address social determinants of health of MA enrollees.

ALTERNATIVES

A. Doula Service

1. Provide $1,015,200 ($406,700 GPR and $608,500 FED) in 2022-23 to fund MA coverage of doula services, with coverage estimated to begin July 1, 2022. Require DHS to apply for any necessary waivers of federal Medicaid law and submit any necessary state plan amendments to provide coverage of doula services under MA. Require DHS to reimburse certified doulas for childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, if federal approval is granted. Define a certified doula as an individual who has received certification from a doula certifying organization recognized by DHS.

ALT A1	Change to Base
GPR	$406,700
FED	608,500
Total	$1,015,200

2. Take no action.

B. Community Health Workers

1. Provide $14,232,000 ($5,701,600 GPR and $8,530,400 FED) in 2022-23 to fund coverage of community health worker services under MA, with coverage estimated to begin July 1, 2022. Requite DHS to submit to the federal Medicaid authority any necessary state plan amendments or requests for waiver to cover community health worker services under MA, but limit coverage under this benefit to those services receiving federal approval. Define a community health worker as a frontline public health worker who is a trusted member of or has a close understanding of the community served, enabling the worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and who 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.

ALT B1	Change to Base
GPR	$5,701,600
FED	8,530,400
Total	$14,232,000

2. Take no action.

C. Community Health Benefit

1. Provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $24,500,000 ($10,014,000 GPR and $14,486,000 FED) in 2022-23 to fund a new MA benefit, subject to federal approval, for nonmedical services that contribute to determinants of health. Coverage would be estimated to begin January 1, 2023. Direct the Department to determine which specific nonmedical services that contribute to determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit. Specify that DHS is not required to provide these services as a benefit if the federal Department of Health and Human Services does not provide federal matching funds for these services.

ALT C1	Change to Base
GPR	$10,514,000
FED	14,986,000
Total	$25,500,000

2. Provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $7,625,000 ($3,253,500 GPR and $4,371,500 FED) in 2022-23 to establish a community health benefit under MA on a pilot basis, with enrollment limited to 3,125. Include the other statutory changes from Alternative C1.

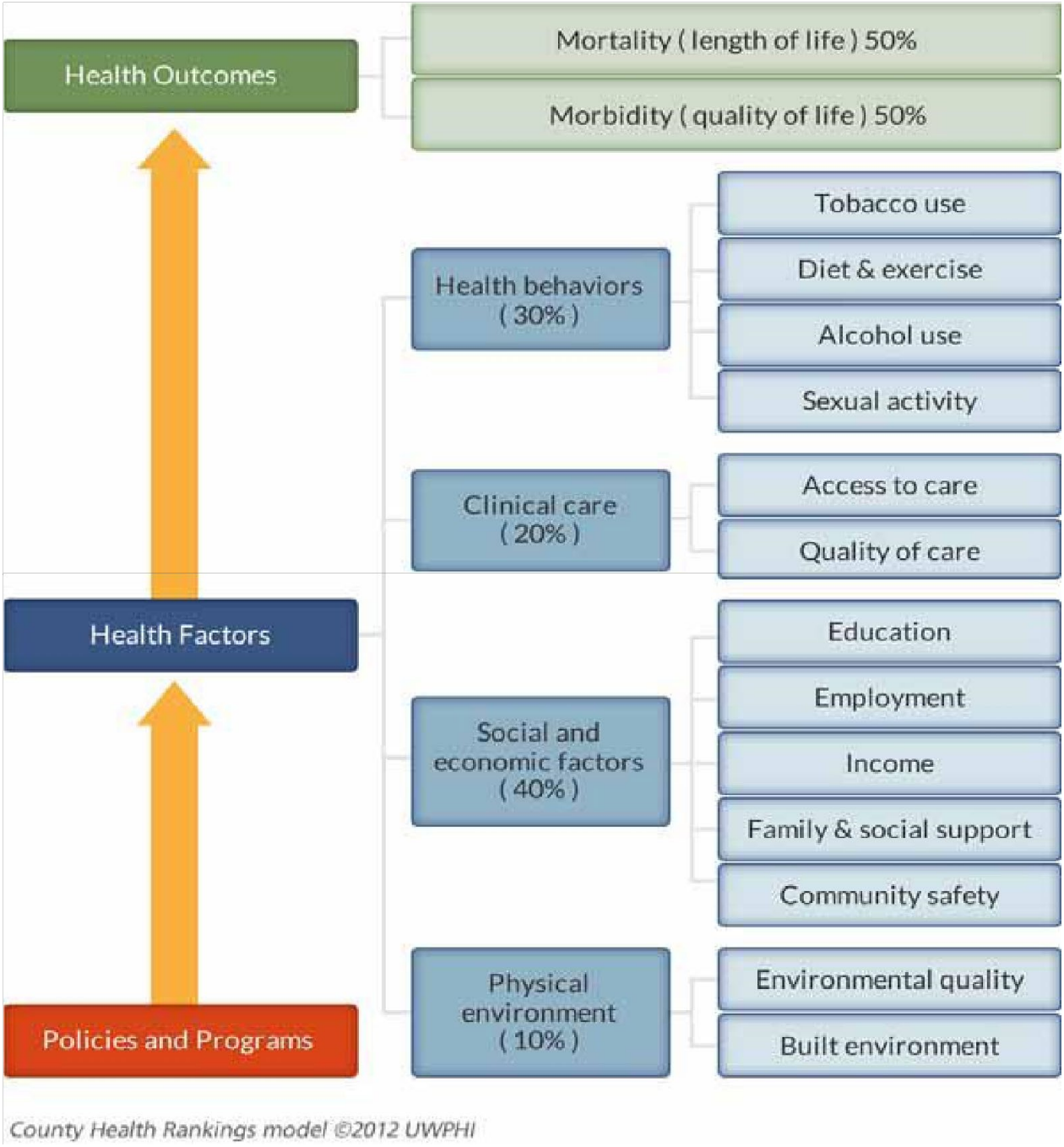
ALT C2	Change to Base
GPR	$3,753,500
FED	4,871,500
Total	$8,625,000

3. Take no action.

Prepared by: Carl Plant
Attachment

ATTACHMENT

Model of the Determinants of Health



Source: University of Wisconsin School of Medicine and Public Health, *Mobilizing Action Toward Community Health, County Health Rankings.* Accessible at http://www.countyhealthrankings.org/about-project/background.