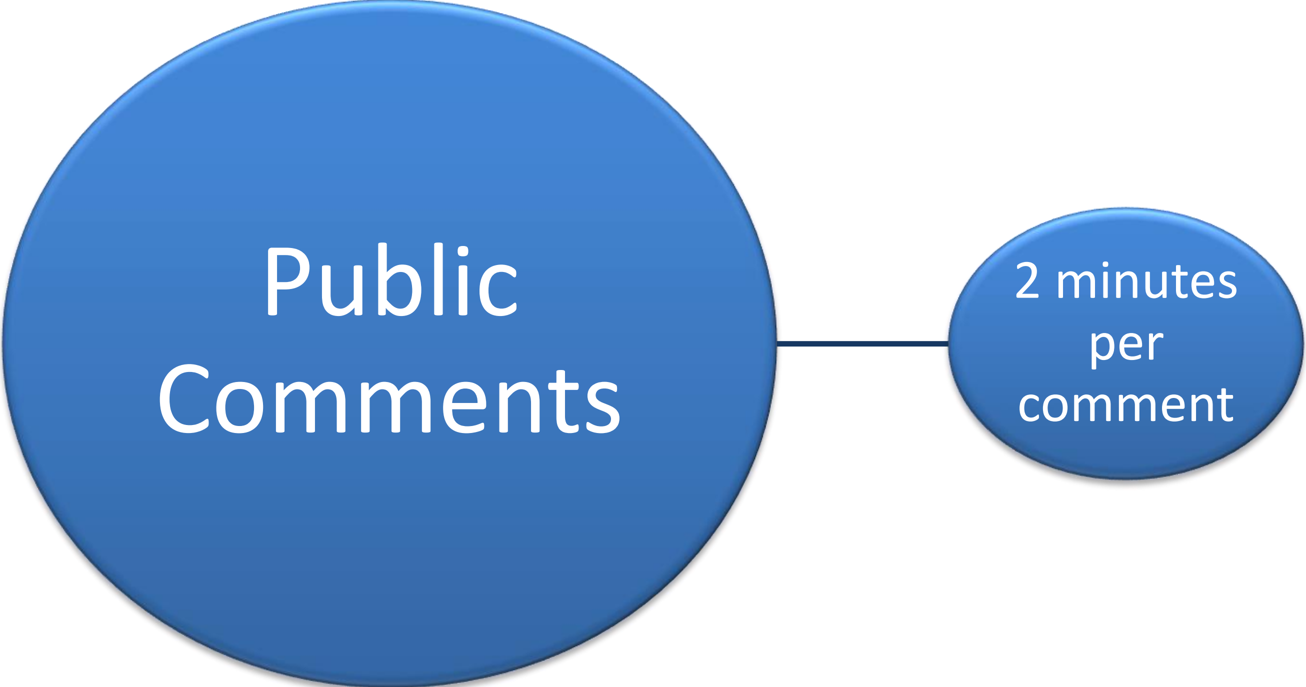
Healthcare Innovation Steering Committee

March 9, 2017

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. Member Appointments for CAB and Quality Council	5 min
5. Primary Care Payment Reform Updates and Discussion	30 min
6. PCMH+ Presentation	45 min
7. CHW Updates	20 min
8. Adjourn	



Public Comments
2 minutes per comment

Approval of the Minutes

Member Appointments for CAB and Quality Council

Consumer Advisory Board Member Appointments

- **Denise Smith**, Healthcare Policy Planning Specialist, UConn Health Disparities Institute
- **Alan Coker**, Whole Health Action Management (WHAM) Facilitator, and Wellness Recovery Action Plan (WRAP) Facilitator

Quality Council Member Appointments

- **Tiffany Donelson**, CT Health Foundation
- **Elizabeth Courtney**, Consumer Advocate
- **Amy Chepaitis**, RTI International, Inc.
- **Jaquel Patterson**, Community Health Resources
- **Gokhan Egilmez**, University of New Haven- ALTERNATE
- **Marcia Proto**, CT Center for Nursing Workforce- ALTERNATE

Primary Care Payment Reform Updates & Discussion

Purpose of Today's Presentation

- Introduce Primary Care Payment Reform Models
- Describe how Primary Care Payment Reform can support SIM goals
- Introduce a new Primary Care Payment Reform opportunity, called Comprehensive Primary Care Plus (CPC+)
- Discuss the opportunities and concerns these models present from a consumer perspective

Dr. Neil's Primary Care Practice

What does Dr. Neil want to do?

Patient Engagement and Support	Care Team Diversity
Phone contact	Nurse care manager
E-mail/text support	Social Worker
Telemedicine visits	Licensed BH clinician
Home visits	Pharmacists
E-consult	Nutritionist/dietician
Remote monitoring	Care coordinator (community health worker focus on community linkages)
Group visits (illness self-management, prevention, lifestyle enhancement)	Health coach (community health worker)
Tweet/chats/on-line support groups	Patient navigator
Patient/family advisory council	
Communication with child care/school	
Transportation	

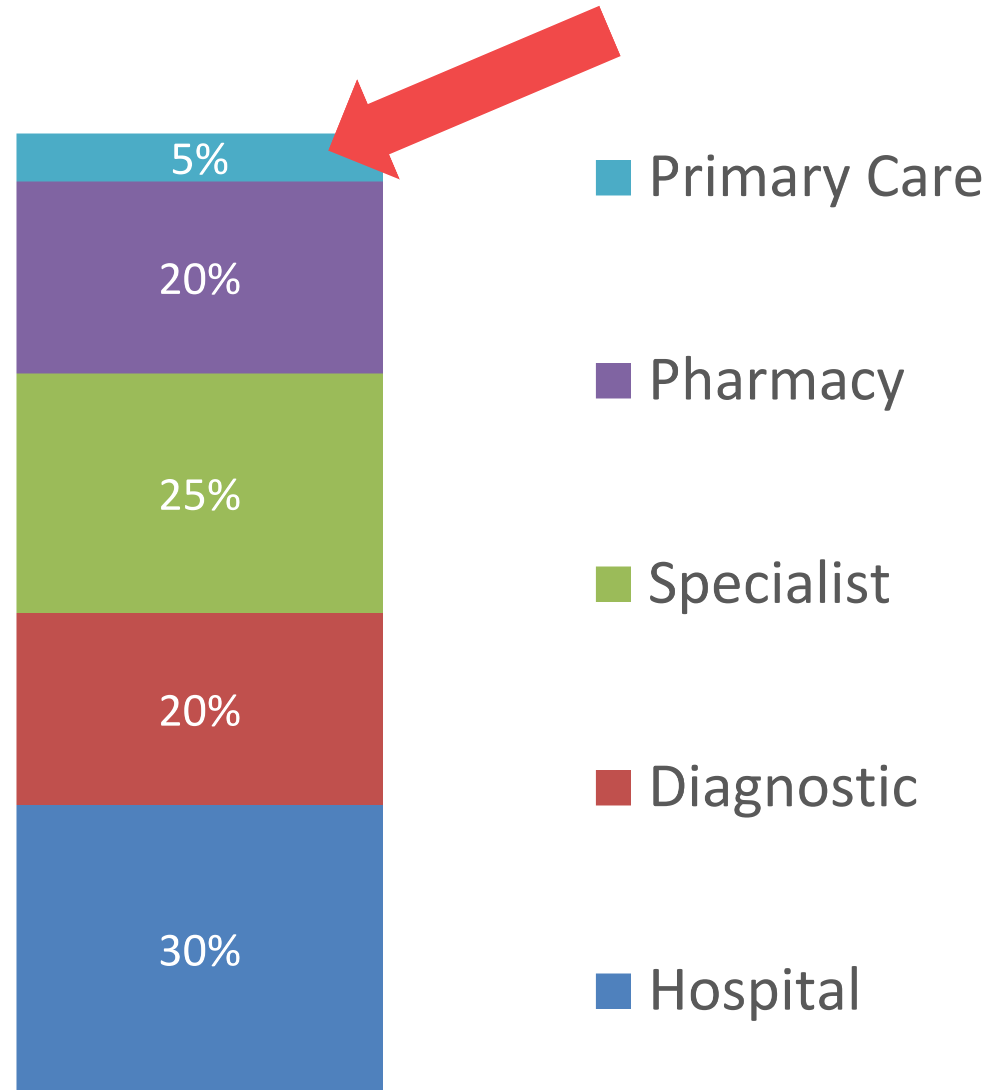
QUALIDIGM

Why can't Dr. Neil deliver care in the way she would like?

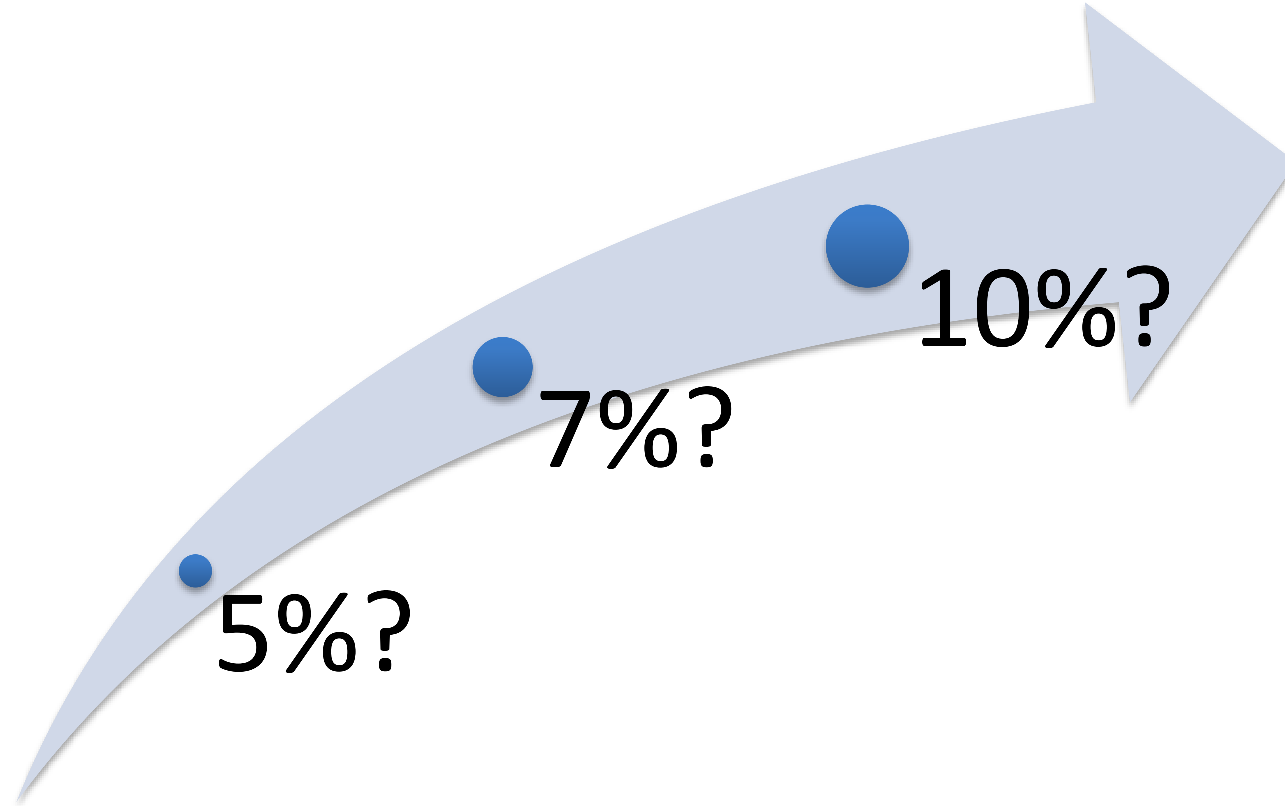
Primary Care Providers are limited in the way they can deliver care due to:

- **Low payment** compared to other areas of healthcare
- **Low flexibility** on how they can use their payments for care delivery

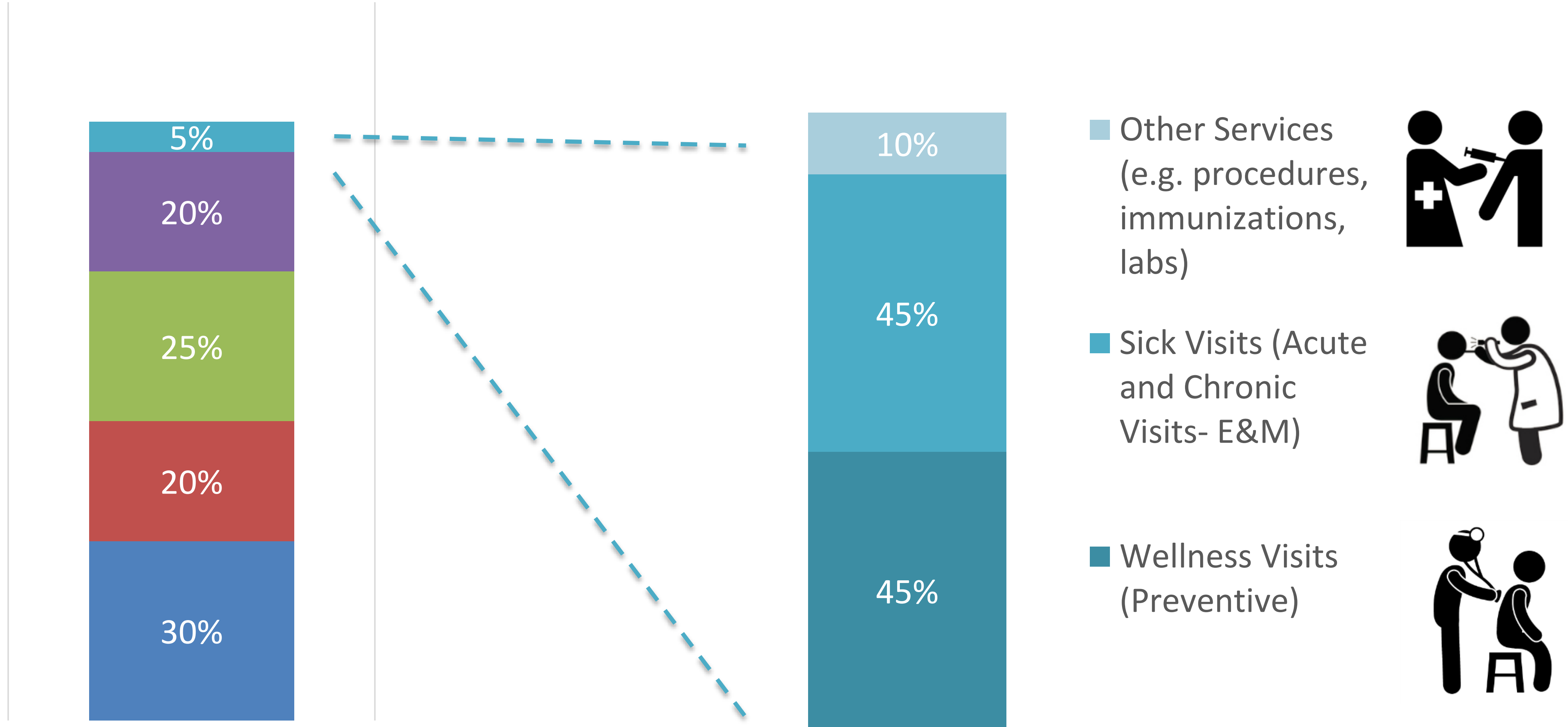
What % of healthcare spending goes into Primary Care?



How much should we be paying for primary care?



How do Primary Care Providers typically get paid?



How has Dr. Neil gotten paid for most of her career?

Category 1

Fee for Service – No Link to Quality & Value

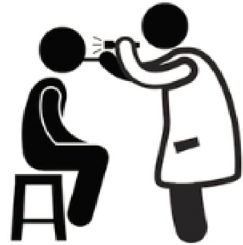
+ Low Risk

- No Up front payments

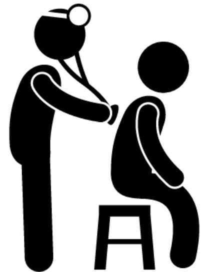
- Only 5% Healthcare spending on Primary Care

- No Flexibility

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

How flexible?

Only paid for visit-based services

How does Dr. Neil currently get paid?

Category 2

Fee for Service – Link to Quality & Value

+A little flexibility

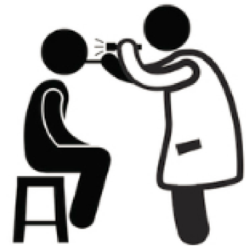
+ Low Risk

+ May have up front payments

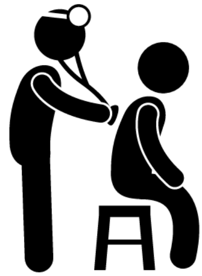
- No significant increase in Primary Care spending

- Flexibility limited

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

Bonus Payments for Quality Care- **received at the end of the year**

How flexible?

Bonus Payments can support non-visit based activities, but they are limited

How might Dr. Neil get paid?

Category 3

APMs Built on Fee-for-Service Architecture

+More flexibility

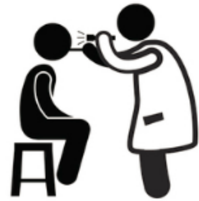
+ Medium Risk

+ May have up front payments

- No significant increase in Primary Care spending

- Flexibility still limited

Types of Payment



Each Sick Visit

Each Wellness Visit

Each service like Immunizations

Shared Savings Payments for Quality & Cost- **Received at the end of the year**

How flexible?

Shared Savings can support non-visit based services like email, and staff like CHWs and BH specialists. However, long wait to receive them and not guaranteed.

How would Dr. Neil like to get paid?

Category 4

Population-Based Payment

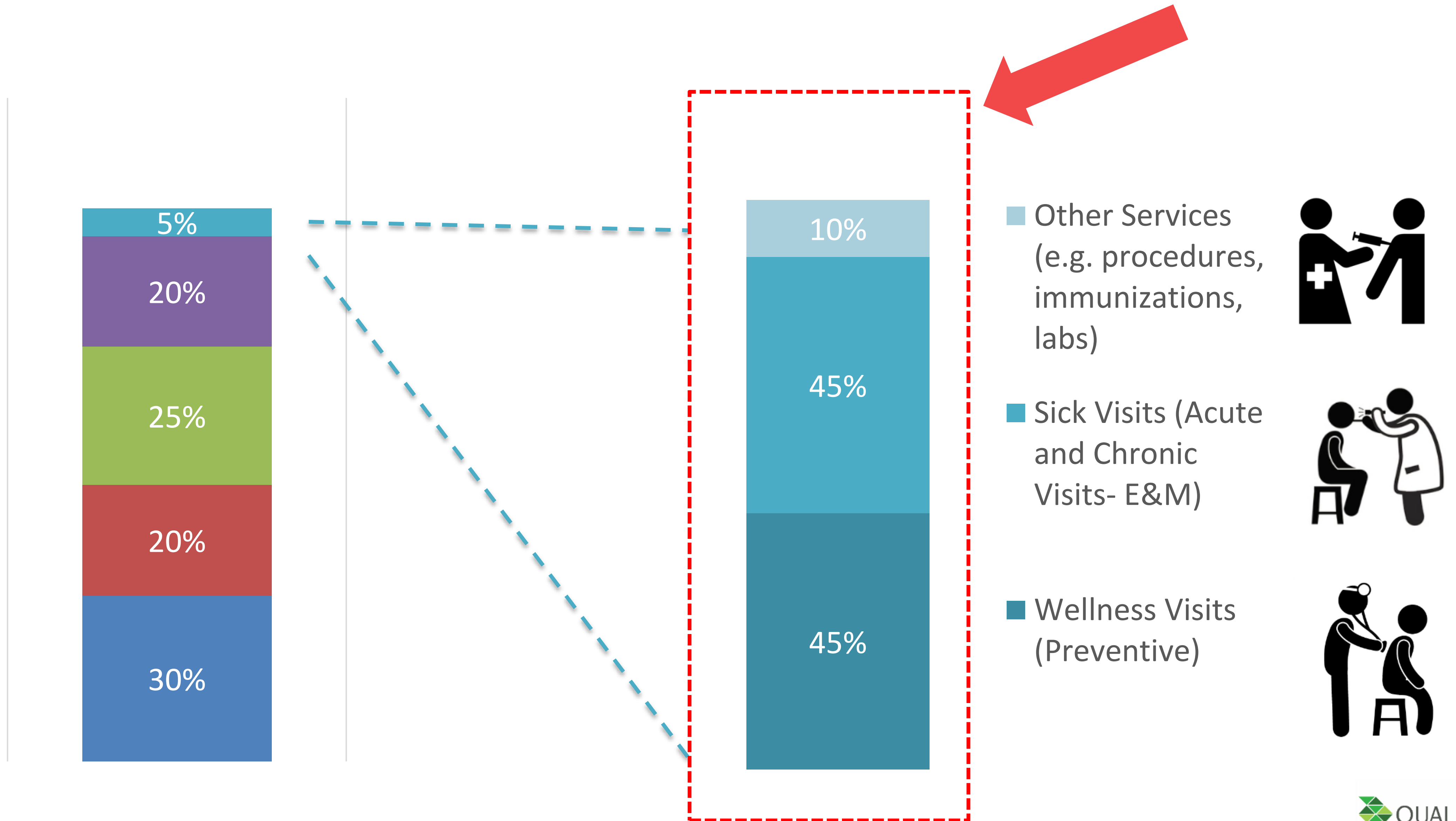
+Most flexibility through bundled payments

+Up front payments- no need to wait for shared savings or bonuses

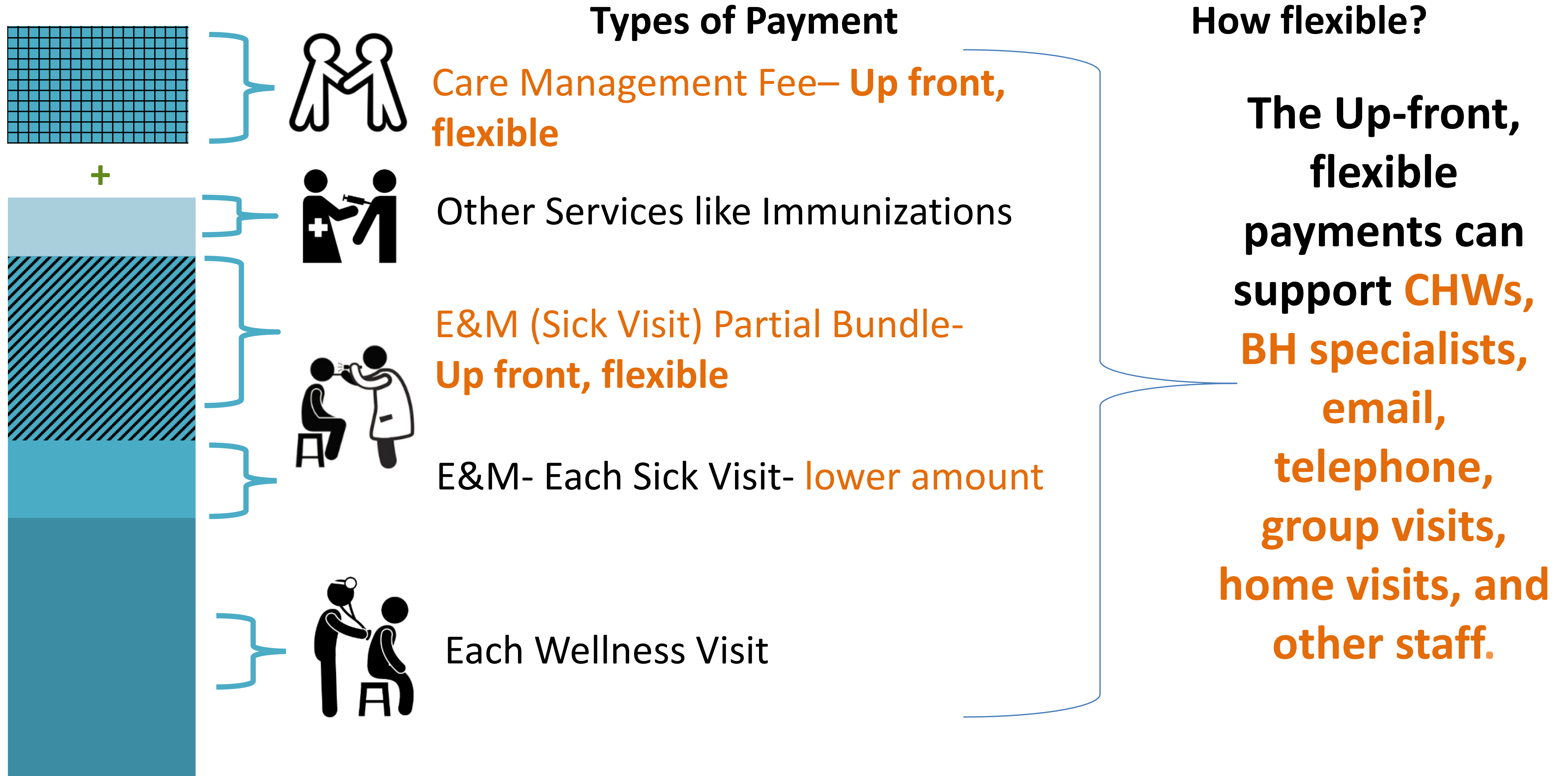
+Significant increase in Primary Care spending through care management fees

- More risk

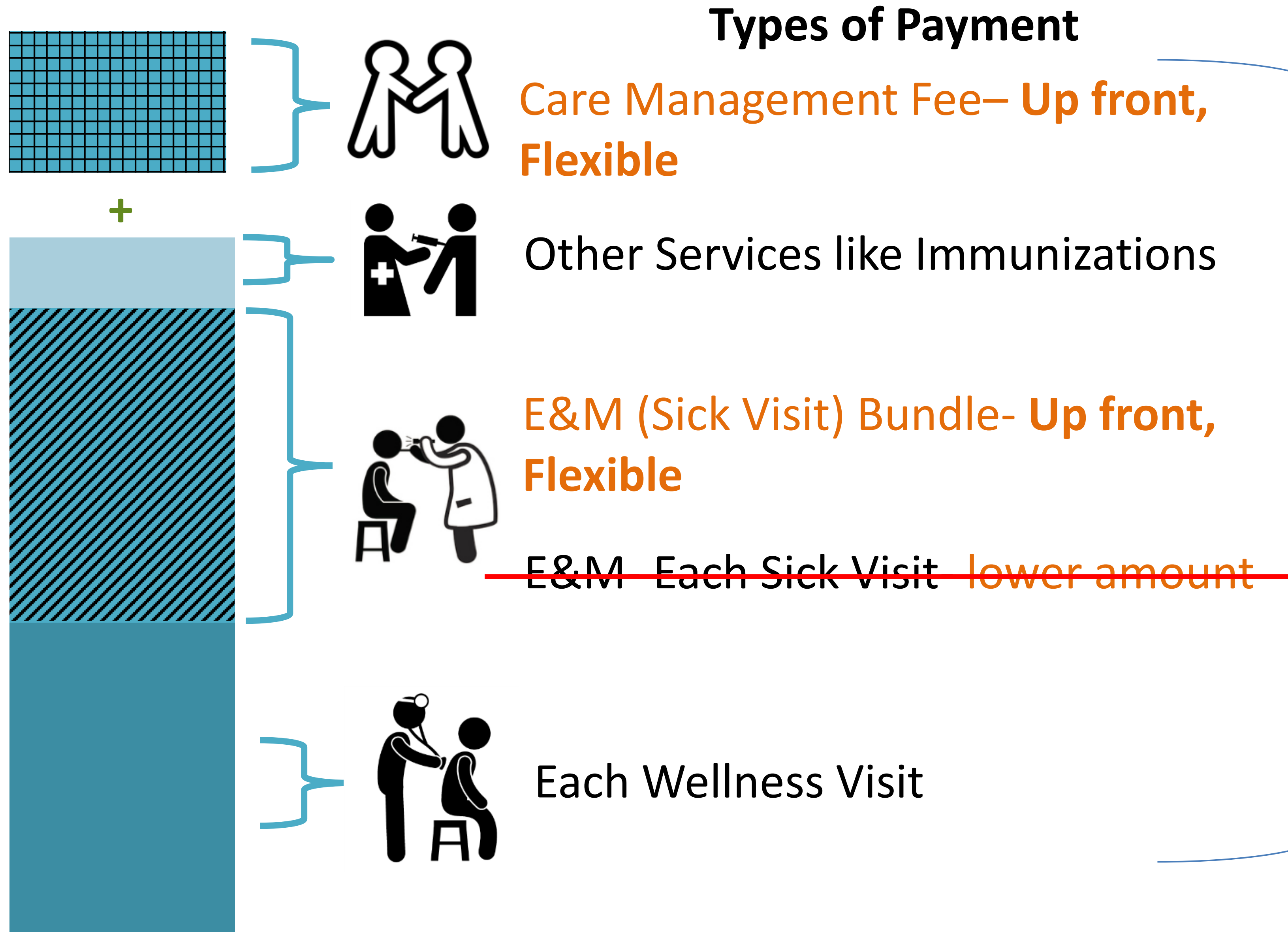
How do Primary Care Providers typically get paid?



Option 1: Partial E&M (Sick Visit) Bundle



Option 2: Full E&M (Sick Visit) Bundle

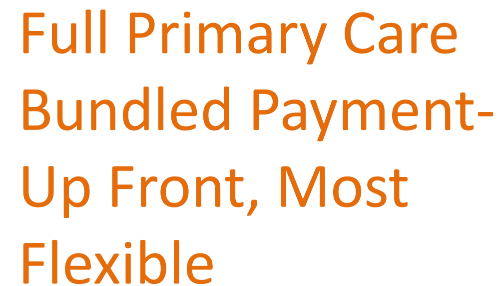


How flexible?

The Up-front, flexible payments can support CHWs, BH specialists, email, telephone, group & home visits, and other staff. There is even more flexibility in this model.

Option 3: Full Primary Care Bundle

Types of Payment

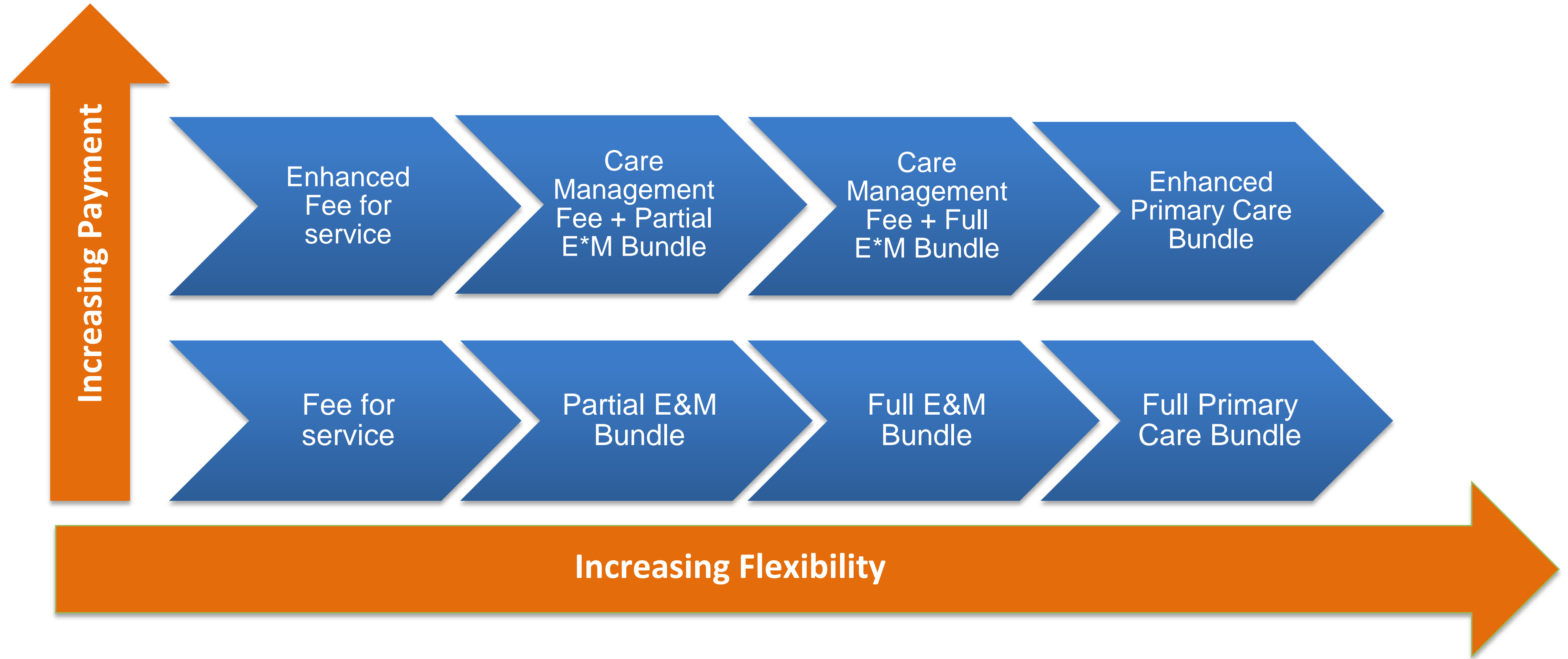


Full Primary Care Bundled Payment-Up Front, Most Flexible

How flexible?

Payments can support any services, activities or staff to support patients. This is the most flexible model.

The Range of Primary Care Payment Reform Models



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PCPMs- Why now?

- PCPMs have the potential to lead to **sustainable funding for SIM care delivery reform efforts**

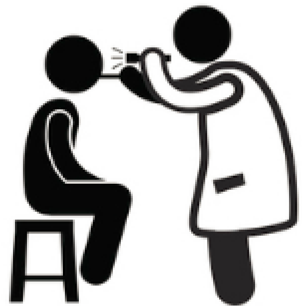
- We are currently researching models and **will be presenting recommendations** on a Primary Care Payment Reform Model for the State to pursue

- There is a **new opportunity** available through CMMI to participate in a PCPM, called **CPC+**

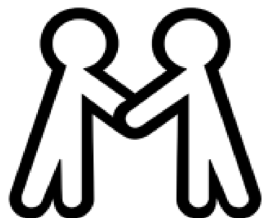
How does Primary Care Payment Reform Support the SIM Goals?

SIM Care Delivery Goals

Enable **Primary Care Practices** to provide patient-centered care



Enable **Provider Networks** to improve care delivery



Promote the use of **Community Health Workers** in Primary Care

SIM Payment Reform Goals

Pay primary care providers more for achieving certain outcomes through Shared Savings

An important first step, but not enough to fully enable and sustain care delivery goals

What have we learned from our research and meetings?

- It is difficult to change care delivery under a Fee for Service model. **More flexibility** is needed in payment models
- Providers need **payment up front**; can't simply wait for shared savings
- Primary care is responsible for coordination, prevention and chronic disease management, but **not enough money is spent on primary care**
- There is **interest among providers and payers** to move toward Primary Care Payment Models that provide increased flexibility and increased revenue, but there is **concern about risk**

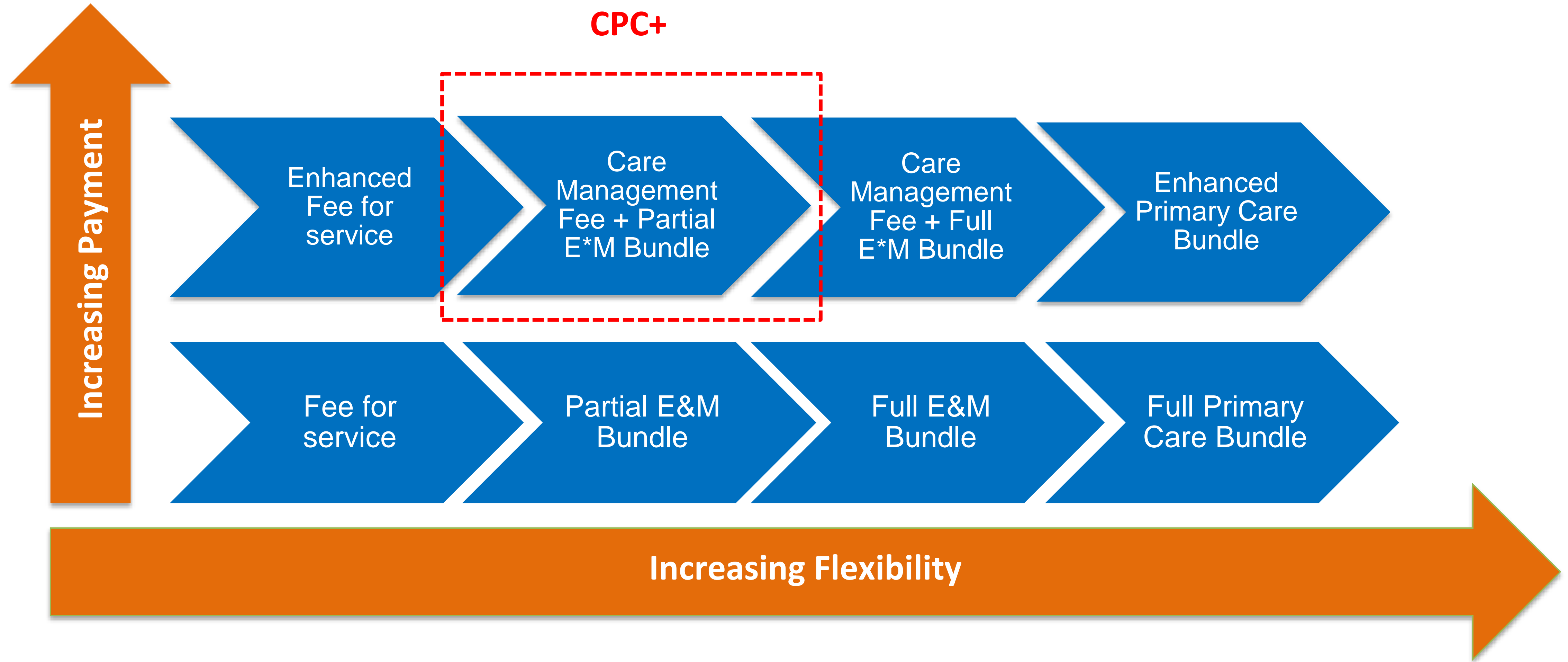
"I would love to diversify my care team to include social worker, navigators, etc. This would enable all team members to work at the top of their license. But this care is not reimbursed, under FFS"

QUALIDIGM

New Primary Care Payment Reform Opportunity- CPC+

- CPC+ is a federal opportunity for states or regions of states to participate in a Primary Care Payment Reform model
- CPC+ **includes Medicare participation** (which can often be difficult to get), and encourages **all payers to participate**:
  - Why? Because Primary Care Providers don't want to only provide telephone calls to patients with one type of insurance, or only offer a CHW to a patient with one type of insurance
- Primary Care Payment Models require up-front funding, with the idea that the system will save money over time. **CPC+ could help the state with some of that funding**.
- CPC+ is flexible in its requirements, which could enable us to make **strong recommendations** regarding the model that would **most benefit CT consumers**

Comprehensive Primary Care Plus (CPC+)- Where does it fall?



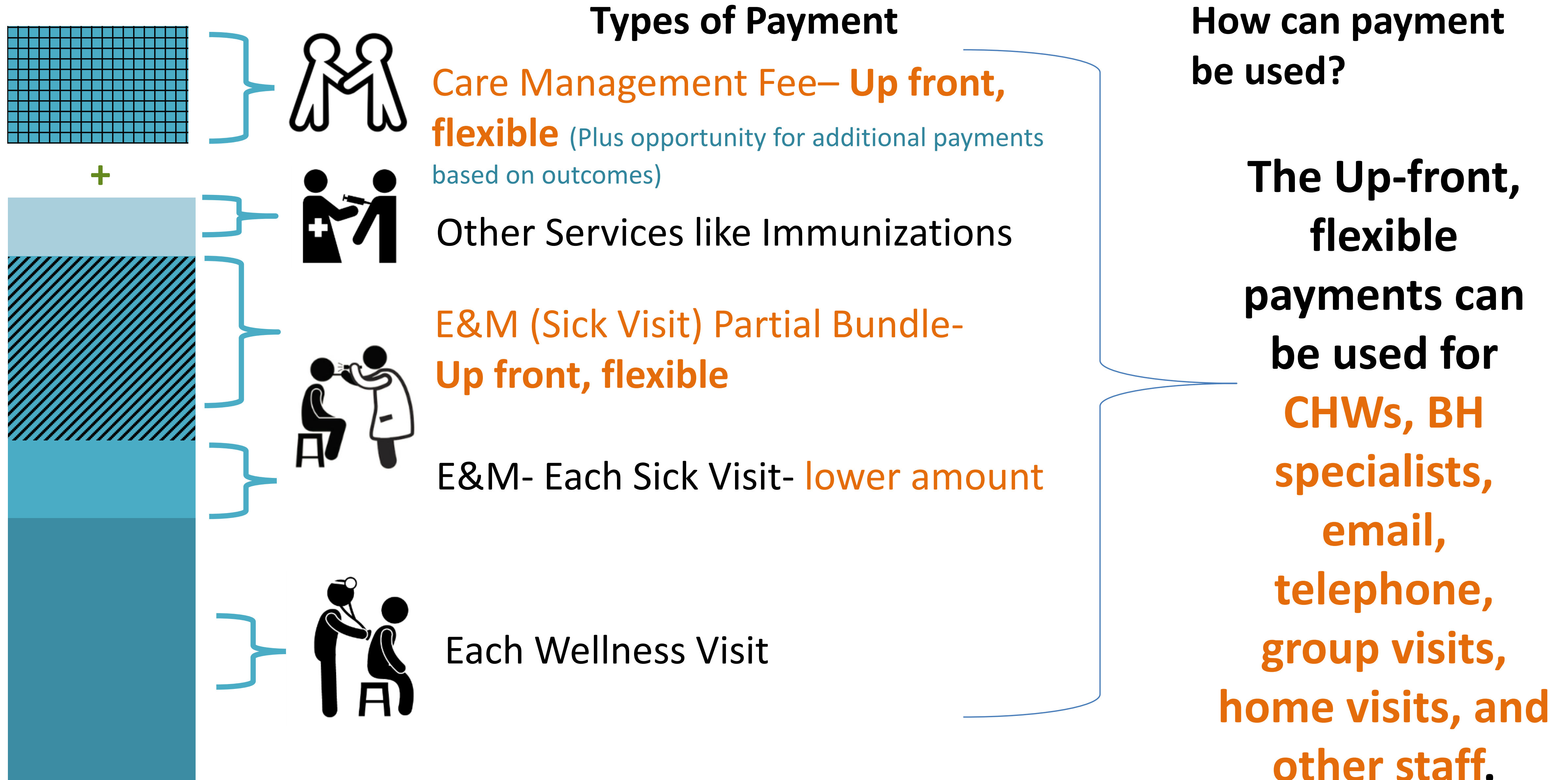
QUALIDIGM

How does CPC+ work?

Three Payment Innovations Support CPC+ Practice Transformation

	Care Management Fee (PBPM)	**Performance-Based Incentive Payment** (PBPM)	**Payment Structure Redesign**
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (Standard FFS)
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

Which Model does CPC+ fit into?



How will these models impact the consumer?

"You can't list your iPhone as your primary-care physician."

Fewer contacts that trigger deductible or require a co-payment

= **Less consumer out of pocket for new services**

New options for provider-patient engagement

= **More convenience for the patient**

More patient contact with the primary care team

= **Better health outcomes**

PCMH+ Update

Connecticut HUSKY Health:

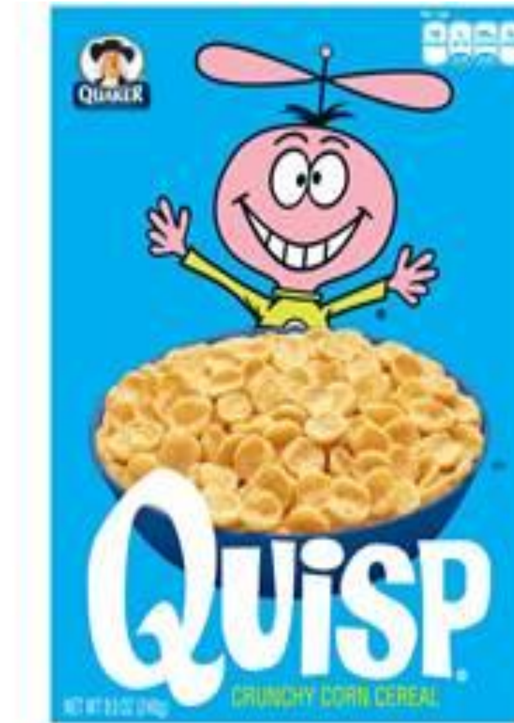
Person-Centered Medical Home + (PCMH+) Update

Presentation to the SIM Steering Committee

March 9, 2017

Person-Centered Medical Home +
(PCMH+)
Overview

Formerly known as the **Medicaid Quality Improvement and Shared Savings Program (MQISSP)**, DSS re-named the initiative "**PCMH+**", to make things easier for consumers to understand, and also to avoid endorsing sugary breakfast cereals . . .



PCMH+ . . .

- is a Connecticut Medicaid initiative whose aim is to build on the success of the current Medicaid PCMH program by enabling practice transformation, care coordination capacity, and further improved health and satisfaction outcomes for Medicaid members who are served by Federally Qualified Health Centers (FQHCs) and “advanced networks”

- launched, as planned, on January 1, 2017

- is using the existing Connecticut Medicaid Person-Centered Medical Home (PCMH) initiative, under which 43% of Medicaid members are being served, as an essential building block to expand upon current practice transformation work

- builds on existing supports for members (ASO-based member services and Intensive Care Management, ICM) and providers (primary care rate increase, PCMH payments, Electronic Health Record payments, ICM)

- is using the Department's current PCMH attribution model to identify where members have sought care, and then to prospectively assign beneficiaries to PCMH+ Participating Entities for the performance year

- will continue to ensure that Medicaid members have the right to seek care from any Medicaid provider, and afford them the option to opt-out of participation in PCMH+ at any time

PCMH+ Building Blocks

PCMH+

Enhanced care coordination activities

Upside-only shared savings arrangements

Use of Medicaid claims data to perform predictive modeling

Administrative Services Organization-Based Intensive Care Management

Person-Centered Medical Home practice transformation

- furthers the Department's interests in preventative health and advances care coordination to better support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence

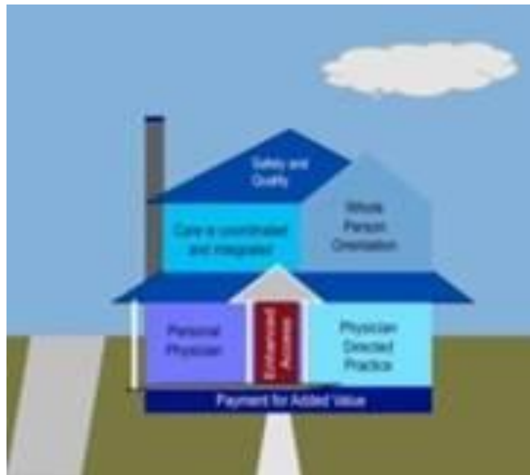
- include a package of strategies designed to prevent, detect and remedy under-service

- in addition to enabling shared savings arrangements with all Participating Entities, is making supplemental payments to participating Federally Qualified Health Centers (FQHCs) in support of enhanced care coordination activities focused upon:
  - behavioral health integration
  - cultural competency, including use of CLAS standards
  - children and youth with special health care needs
  - disability competency

See this link for more detail:
http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/enhanced_care_coordination_guide_11_30_16.pdf

- will make shared savings payments to all Participating Entities (both FQHCs and “advanced networks”) that exceed benchmarks on a core set of measures of quality and care experience, within each Entity’s savings for the performance year, if any, when evaluated against the comparison group (the **individual pool**)

- in addition to the individual pool shared savings payments described above, if the PCMH+ program overall generates savings for the performance year, DSS will make payments to entities that meet additional quality metrics (the **challenge pool**)



Person-Centered
Medical Homes

Community-based
care coordination through
expanded care team

"Upside-only"
arrangements in which
providers that meet
health and satisfaction
measures and produce
savings share in a
portion of those savings,
but do not absorb losses

PCMH+ Operational Update

All PCMH+ activities are tracking timely:

- **Model design:** In consultation with the Care Management Committee of the MAPOC, DSS has developed all major aspects of PCMH+ model design, including, but not limited to: provider qualifications, care coordination standards, quality measures, shared savings methodology, and a range of strategies designed to prevent, as well as to identify and remedy, under-service to Medicaid members

PCMH+ model design was guided by a number of important values:

1) protecting the interests of Medicaid members
2) improving overall health and wellness for Medicaid members
3) creating high performance primary care practices with integrated support for both physical and behavioral health conditions
4) building on the platform of the Department’s Person-Centered Medical Home (PCMH) program, as well as the strengths and analytic capability of the Medicaid program’s medical Administrative Services Organization (ASO)
5) enhancing capacity at practices where Medicaid members are seeking care, to improve health outcomes and care experience
6) encouraging the use of effective care coordination to address the social determinants of health

- All source documents are available on the face page of the MAPOC website at: https://www.cga.ct.gov/med/

- Please also see this link for the PCMH+ Request for Proposals, which includes extensive detail about PCMH+ requirements: http://www.biznet.ct.gov/SCP_Search/BidDetail.aspx?CID=40026

- **Stakeholder process:** DSS developed PCMH+ model design through monthly meetings and work group sessions, as well as subject specific webinars, with the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC)

- Materials memorializing the work of the Care Management Committee are posted monthly on the MAPOC web site at this link: https://www.cga.ct.gov/med/comm1.asp?sYear=2016

- **Issuance of procurement:** DSS' Request for Proposals for PCMH+ Participating Entities was released timely on June 6, 2016

- **Procurement results:** On October 4th, DSS extended invitations to negotiate contracts to the following entities:

  Advanced Networks: Northeast Medical Group, St. Vincent's Medical Group

  Federally Qualified Health Centers (FQHCs): Community Health Center, Inc., Cornell Scott-Hill Health Corporation, Fair Haven Community Health Clinic, Inc., Southwest Community Health Center, Generations Family Health Center, Inc., OPTIMUS Health Care, Inc., Charter Oak Health Center, Inc.

- **Contract status update:** DSS has executed contracts with **all nine** of the above-referenced entities

- **Medicaid authority:**

  - **Advance advisory process:** In early 2016, DSS launched an informal consultative process with CMS and other relevant federal agencies by circulating a detailed concept paper on PCMH+

  - **Drafting and notice of State Plan Amendment:** DSS with Mercer drafted, noticed for public comment, revised and formally submitted to CMS the required (SPA) needed to make supplemental payments (to FQHCs) and shared savings payments to eligible FQHCs and "advanced networks"

  - **Underlying authority:** The SPA relies upon primary care case management (PCCM) authority under section 1905(a)(25) of the Social Security Act

  - **CMS approval:** DSS received approval of the SPA from CMS on 2/2/17, retroactive to 1/1/17

- **Regulation:** On 1/17/17, the Department posted public notice for a proposed regulation to govern the PCMH+ program - the public comment period for the regulation is open and ends 2/17/17

- **Operational Policy:** As authorized by Conn. Gen. Stat. 17b-263, effective 1/1/17, the Department is implementing an operational policy, with the force of regulation, while the regulation is being adopted

- **Stakeholder process:**

  - **Member engagement:** In consultation with stakeholders, DSS developed a member communication that was issued in late November, 2016; a supported process for member opt-out; and member materials and information sessions

  - **Member opt-out:** Note that fewer than 2,000 individuals opted out of participation in prior to PCMH+ launch on January 1

  - **Dedicated web page:** DSS launched a PCMH+ web page: http://www.ct.gov/dss/pcmh+

- **Provider engagement:** In partnership with Mercer, DSS also developed provider materials and information sessions, which were held in December, 2016

PCMH+ overview for providers:

http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/pcmh_informationsession_providers_finaldraft_12_9_16update.pdf

Guide to enhanced care coordination activities:

http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/enhanced_care_coordination_guide_11_30_16.pdf

- **Member attribution:** CHN worked with DSS and Mercer to update Medicaid member attribution, remove individuals in excluded groups (e.g. those participating receiving long-term services and supports), and produce member attribution lists, which have been forwarded to all Participating Entities

- As of January 1, 2017, a total of **137,037 Medicaid members** were attributed to PCMH+

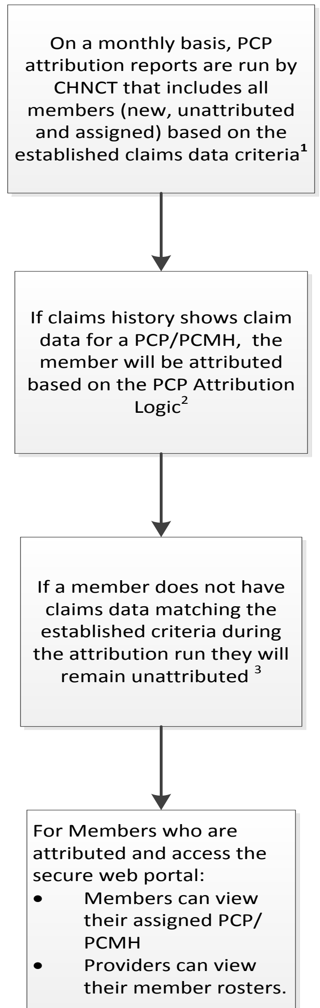
- **Provider portal:** attribution lists, and PCMH data, are being made available to providers through CHN's existing PCMH provider portal, available at this link: http://www.huskyhealthct.org/providers/providers_login.html

Unassigned Members to a PCP/PCMH

[2] **PCP Attribution Logic:**

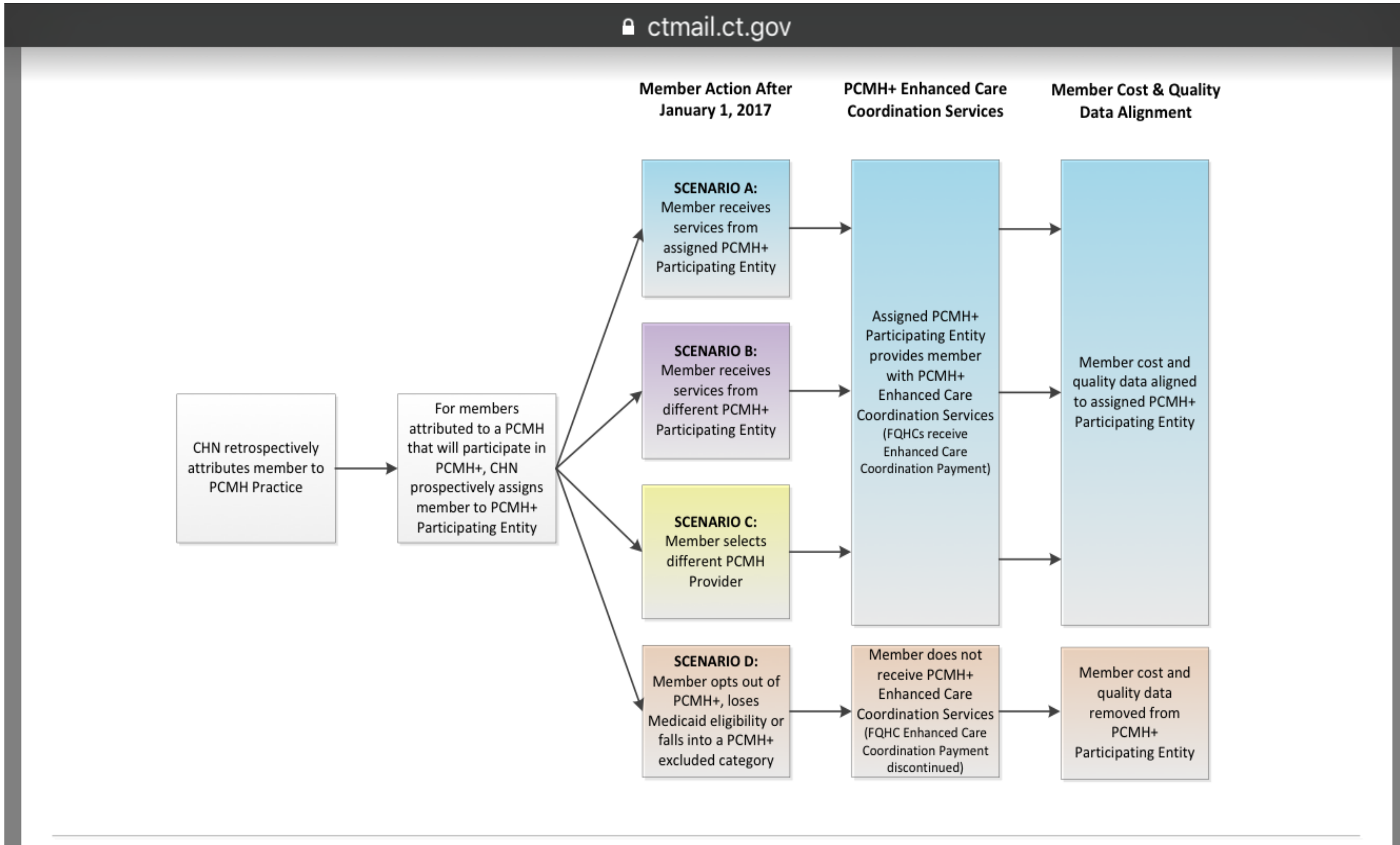
- Members new to the program or existing members not previously attributed have their claim data criteria run retro to 15 months prior to the date of the current attribution month.
- If the claim data criteria identifies a usual source of care during that time period, the member will be attributed to that PCP.
- If during this timeframe the member has seen multiple PCP's, they will be attributed to one of the PCP's using the plurality logic. The plurality logic is based on who has billed the most codes based on established claims data criteria.
- In the instance of a tie regarding the number of visits to a PCP, the PCP who has the latest preventative visit, based on date of service, will be the PCP the member is attributed to.
- If there have been no preventative visits billed by either provider, the PCP with the most recent claim (based on the claim DOS and claims data criteria[1]) would be the PCP the member is attributed to.
- If a PCP is no longer affiliated with a group, this provider is considered to be invalid by DSS and members cannot remain attributed to this PCP.
- All members attributed to this invalid PCP will be re-attributed to the group or the claims logic will look to see if a claim from another PCP has been received.
- If a claim from another PCP has been identified, the claim must have a later date of service then the previously attributed provider.

[3] **Please note:**
CHNCT will work directly with unassigned members to connect them with a PCP/PCMH if they come to CHNCT's attention through members services, utilization management or intensive care management.



[1] **Claims Data Criteria:**
Preventative code ranges: 99381-99387 & 99391-99397
E&M code ranges: 99201-99215 & 99401-99409
Revenue codes: 510, 514, 515, 517, and 519

PCMH+ Assignment Scenarios



PCMH+ Member Attribution by Participating Entity

Participating Entity Name	TIN Name	Attributed Members
Northeast Medical Group AN	NORTHEAST MEDICAL GROUP	7,509
St. Vincent's AN	FAMILY PRACTICE GROUP OF MIDDLESEX HOSPITAL	1,627
St. Vincent's AN	MILFORD PEDIATRIC GROUP	4,465
St. Vincent's AN	WESTERN CONNECTICUT MEDICAL GROUP	4,155
St. Vincent's AN	PULMONARY & INTERNAL MEDICINE OF FAIRFIELD COUNTY PC	59
St. Vincent's AN	GRIFFIN FACULTY PRACTICE	2,087
St. Vincent's AN	MHS PC INC	3,300
St. Vincent's AN	DRS GOLDFARB, RANNO AND ASSOCIATES LLC	280
St. Vincent's AN	ST. VINCENT'S MULTISPECIALTY GROUP INC	2,113
Fair Haven Community Health Center	FAIR HAVEN COMMUNITY HEALTH CENTER	7,811
Cornell Scott-Hill Health Center	CORNELL SCOTT- HILL HEALTH CENTER	13,781
Generations Family Health Center	GENERATIONS FAMILY HEALTH CENTER INC	8,000
Southwest Community Health Center, Inc.	SOUTHWEST COMMUNITY HEALTH CENTER INC	8,299
Community Health Center, Inc.	COMMUNITY HEALTH CENTER INC	44,917
Optimus Health Care, Inc.	OPTIMUS HEALTH CARE INC	21,304
Charter Oak Health Center	CHARTER OAK FAMILY HEALTH CENTER	7,330
	TOTAL	**137,037**

Please note that members served under the following are not eligible for PCMH+ and were excluded from attribution: 1915(c), 1915(k),1915(i); Money Follows the Person, HUSKY B, dual eligible Members, nursing facility, limited benefit, state-funded, hospice, behavioral health home

PCMH+ Next Steps

- Continued development of **under-service strategies**

- **PCMH+ Wave 1 assessment**:
  - Desk reviews
  - Quantitative data review
    - Member complaints
    - Member opt-outs
    - PCMH provider performance reports
    - LexisNexis health disparity reports
  - Input from key stakeholders

PCMH+ Next Steps

- For detail on evaluation, please see these documents:

PCMH+ Underservice Strategy Summary (February, 2017)

https://www.cga.ct.gov/med/committees/med1/2017/0223/20170223ATTACH_PCMH%20Plus%20Underservice%20Strategy%20Summary%20.pdf

HUSKY Health Quality Measures and Performance Results (February, 2017)

https://www.cga.ct.gov/med/council/2017/0210/20170210ATTACH_Health%20Quality%20Measures%20and%20Performance%20Results%20Presentation.pdf

Questions or comments?

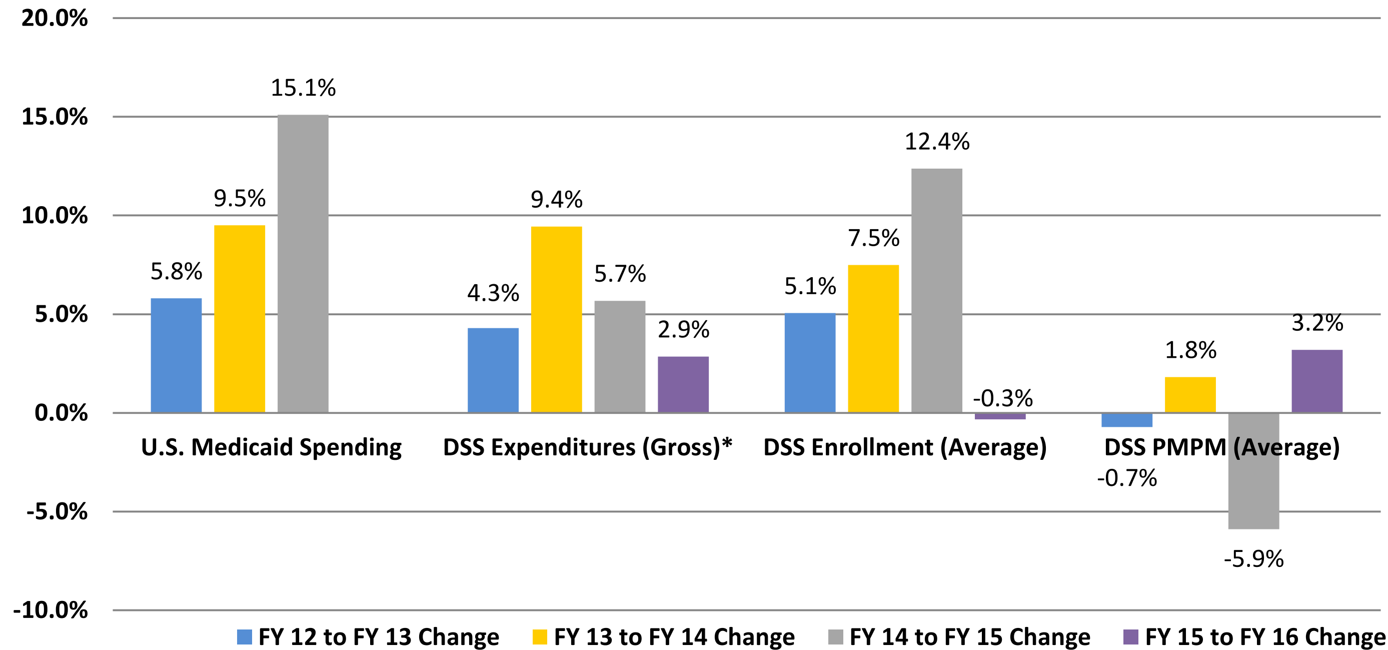
Appendix
HUSKY Health:
Context
Past, Present and Future At A Glance

Context

Person-Centered Medical Home Initiative:

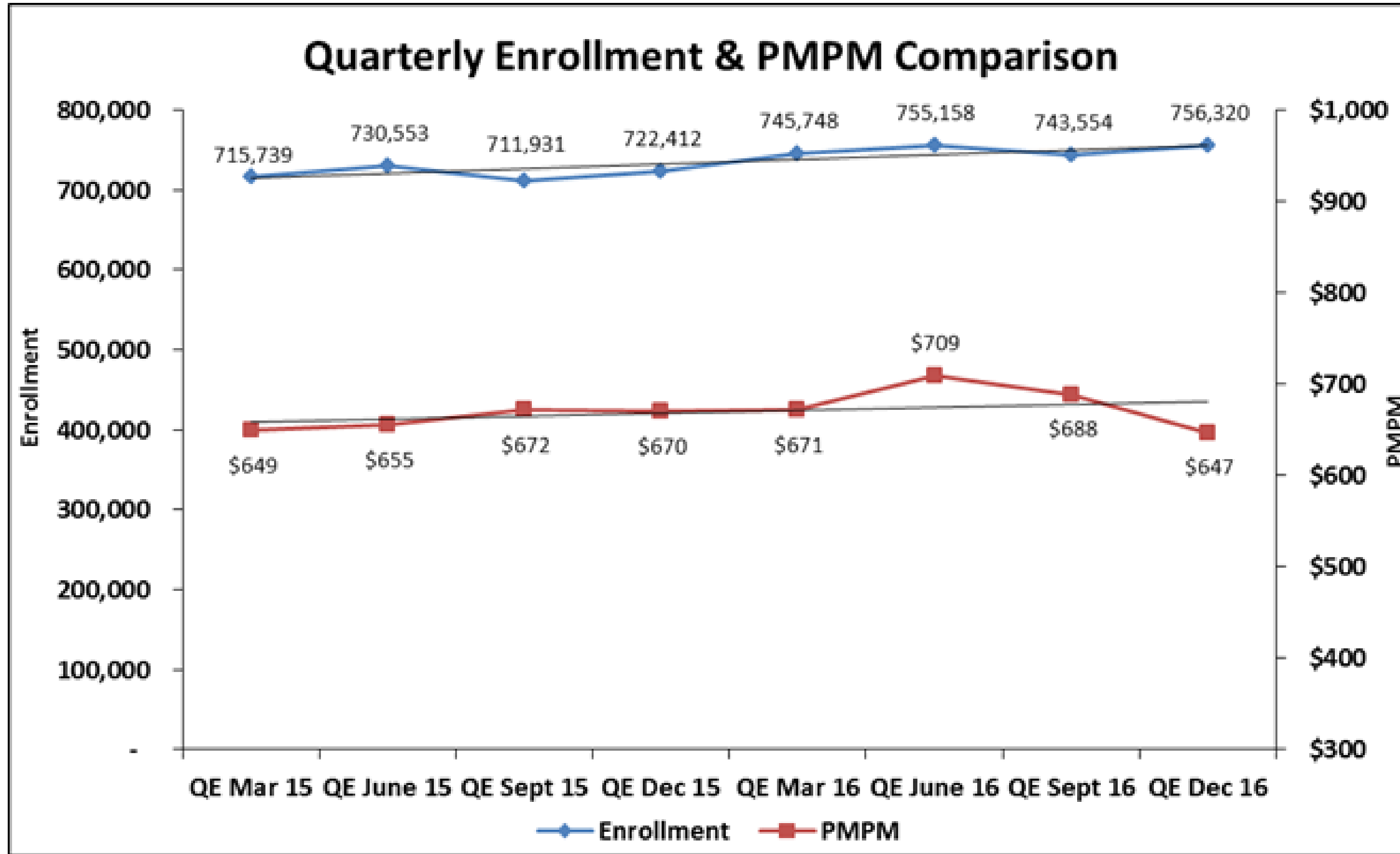
- As of February, 2017, **112 practices** (representing **464 sites** and **1,620 providers**) were participating
- These practices are serving **327,916 Medicaid members – over 43%** of all members

Comparison with National Trends



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **includes** all hospital supplemental and retro payments.*

Enrollment and PMPM



Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady.

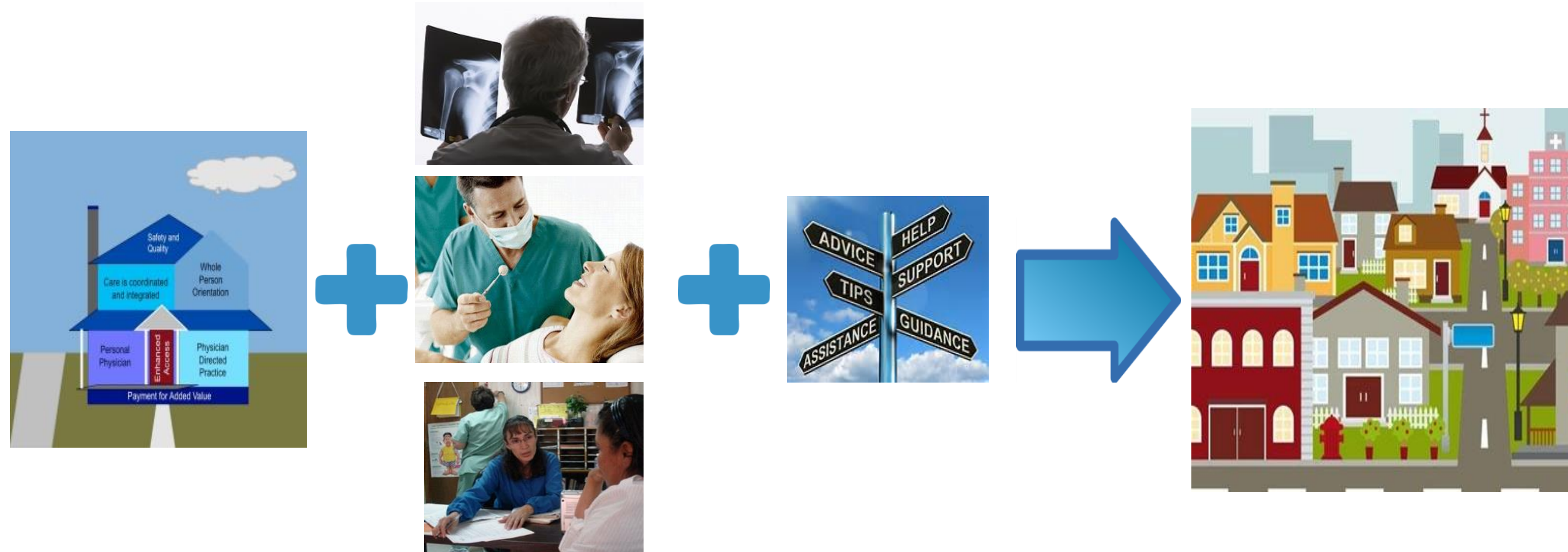
Past, Present and Future at a Glance

Past, Present and Future

	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods and Value-Based Payment (VBP) approaches
Financial trends	Double digit year-over-year increases were typical	Overall expenditures are increasing proportionate to enrollment; per member per month spending is trending down	Quality-premised VBP strategies will enable further progress on trends
Data	Limited encounter data from managed care organizations	Fully integrated set of claims data; program employs data analytics to risk stratify and to make policy decisions	Data match across human services and corrections data sets will enable more intelligent policy making

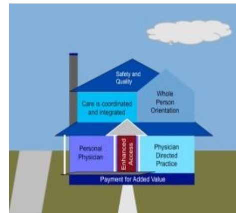
	Past	Present	Future
Member experience	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies	ASOs provide streamlined, statewide access points and Intensive Care Management; PCMH practices enable coordination of primary and specialty care; health homes enable integration of medical, behavioral health and social services	Health neighborhoods will address both health needs and social determinants of health (e.g. housing stability)
Provider experience	Provider experience varied across MCOs; payment was often slow or incomplete	ASOs provide uniform, statewide utilization management and ICM; providers can bill on a bi-weekly basis	Consideration of migration to health neighborhood self-management of provider relationships

HUSKY Health 2017 and ongoing



Health neighborhoods composed of PCMH practices, specialties, CHWs and non-medical services and supports

Development of additional value-based payment strategies



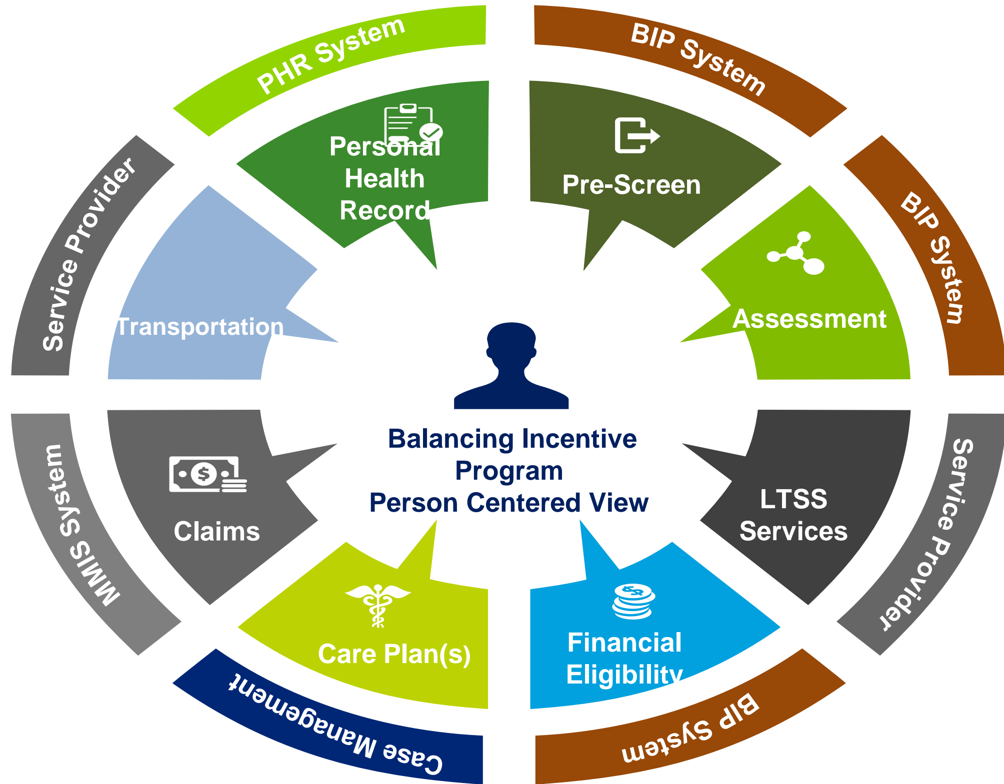
PCMH enhanced fees and performance payments

OB P4P

PCMH+

Shared savings arrangements

Episodes of care



Achievement of a person-centered, integrative, rebalanced system of long-term services and supports

CHW Advisory Committee Update

CHW Advisory Committee Accomplishments

- The CHW Committee has recommended the following:
  - Definition of Community Health Workers
  - Scope of Practice
  - A Certification Process overseen by DPH
- Two Design Groups were established to review the options and considerations around the definition and certification process.
- These recommendations are currently being compiled in a White Paper, to be shared with the Steering Committee prior to the April meeting.

CHW Definition

- "A Community Health Worker (CHW) is a front line public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.

- CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation."

CHW Scope of Practice

- The CHW recommended scope is based on the C3 recommendations.
- In addition to minor edits, several Sub-roles were added, including:
  - Facilitating the participant-provider relationship and effective communication (Care Coordination)
  - Identifying gaps in available resources and recommending improvements (Building Individual and Community Capacity)
  - Conducting psychosocial screening (Providing Direct Service)
- Several Sub-skills were added:
  - Ability to negotiate and advocate on behalf of participants (Under Communication Skills)
  - Ability to identify and access resources and overcome barriers (Service Coordination)
  - Ability to work in teams (Professional Skills and Conduct)

CHW Certification Principles

Based on an initial survey, and several meetings of both the CHW Committee and the Certification Design Group, the following were identified as core principles of a CHW Certification process:

- Ensures individual CHWs have achieved core competencies
- Develops a sense of professionalism amongst CHWs
- Can be recognized by employers or payers
- Does not prohibit experienced CHWs from continuing their work
- Does not hold CHWs to unfair standards
- Is not cost-prohibitive for CHWs
- Empowers CHWs to control their own future

CHW Certification Recommendation- Key Elements

The CHW Certification Design Group recommends that DPH establish a CHW certification program. Under this program CHWs will receive an individual 24-month certification from DPH and be placed on a CHW registry if they complete a) an approved training program and b) pass a standardized competency-based assessment.

Key Elements are as follows:

- DPH shall designate CHW training programs as “DPH approved”, based on a standardized curriculum review conducted by agency staff or a contractor.
- DPH shall establish a standardized competency assessment process that assesses both skills and knowledge by June 30, 2018. DPH shall ensure the assessment is reasonably accessible to individuals with language barriers and appropriately assesses cultural competency.
- The standardized competency assessment shall be administered by one or more DPH approved entities.
- DPH shall issue individual certifications to CHWs who have completed an approved training program AND demonstrated proficiency through the standardized competency assessment.

CHW Certification Recommendation- Grand-fathering

- DPH shall allow for grand-fathering: For the first two years, DPH shall issue certifications to CHWs who demonstrate knowledge of the core competencies and experience of the CHW field based on either a) completion of a designated number of hours as a CHW and recommendations from current or previous employers or b) passing the standardized competency-based assessment.

- DPH shall assess and determine the need for a pathway to certification based on CHW experience beyond the initial two-year grand-fathering period. Such a process may require completion of a designated number of hours as a CHW, recommendations from current or previous employers, and passing the standardized competency-based assessment.

- Certification shall be voluntary.

CHW Certification Recommendation- Re-Certification and Registry

- Certification shall be granted for 24 months. Re-certification will require evidence of the completion of continuing education hours and evidence of experience providing CHW services, either through employment or volunteer work as a Community Health Worker in the past 24 months.
- The continuing education and experience verification process shall be administered by DPH or its contractor.
- DPH shall establish a Certified CHW registry listing all of the individuals who have ever received certification and the status of such certification. The purpose of the registry is to enable employers to identify certified CHWs and to screen out individuals who may have lost certification for reasons of misconduct

CHW Certification Recommendation- Additional Recommendations

- DPH shall be established as the CHW certification authority under statute. Such statute shall designate a Certified CHW as one who has received an individual certification from DPH. Only CHWs who have received this certification may use the title "Certified CHW"

- DPH shall use the definition and scope of practice developed by the CHW Advisory Committee (based on the National C3 Recommendations for Community Health Workers) as the basis for developing curriculum standards.

- DPH shall establish a CHW Advisory Committee to advise it on development of the training program and competency assessment standards and corresponding certification procedures. At least 50% of the seats on the Advisory Committee should be reserved for CHWs from a range of backgrounds. The Advisory Committee shall also include representatives of DSS, DMHAS, CHWACT, CHW employers, a CHW training program, and a commercial payer.

CHW Advisory Committee Recommendations- Next Steps

- The Committee is developing recommendations around sustainable funding for CHWs. This process launched last week with a webinar on Primary Care Payment Reform.
- The Committee's recommendations regarding Primary Care Payment Reform models will be shared with the Steering Committee during a Special meeting later in March.
- The final Committee recommendations, including definition, scope of practice, certification, and sustainable funding, are being compiled in a White Paper. A first draft will be shared with the Steering Committee prior to the April meeting.

Adjourn