



National Navigation Roundtable



Patient Navigation in Cancer Care

Review of Payment Models for a Sustainable Future



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I. Introduction

Despite significant expansions of health care coverage and health care spending reaching \$3.3 trillion in 2016, the United States continues to exhibit lower life expectancies and poorer overall health outcomes when compared to other high-income countries.¹ Additionally, not all Americans have equal access to health care or experience similar health outcomes due to ongoing health inequities based on race, ethnicity, socioeconomic status, geography and education.

Patient navigation is a critical strategy for reducing inequities, eliminating breakages in the continuum of care, and enhancing access to treatment. It is particularly valuable when operating in the context of cancer and other complex illnesses, especially for medically and socially complex patients. By taking proactive steps to integrate patient navigation services into current and emerging payment models, health care payers and policy makers can better ensure sustainable and widespread access to patient navigation services, thereby improving the efficiency and quality of cancer care across the nation.

The Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers define patient navigation in the cancer setting as:

[I]ndividualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care from pre-diagnosis through all phases of the cancer experience.²

By addressing many of the disparities and social determinants of health associated with cultural and socioeconomic differences, patient navigators can foster trust and empowerment within the communities they serve.³ Patient navigators have been shown to be instrumental to increasing cancer screening rates among racial/ethnic minorities,^{4,5,6} facilitating access to federally qualified health centers (FQHCs),⁷ and providing access to disease prevention education.⁸ Navigators also assist patients in confronting barriers related to cultural beliefs,⁹ language,¹⁰ financial and insurance issues,¹¹ transportation, childcare, and community resources.¹²

Despite the known benefits of patient navigation and examples of well-established, internally funded navigation programs, full integration of navigation services into

health care delivery systems remains a challenge, in large part due to a lack of widespread, sustainable external funding for these services. This resource seeks to provide an initial framework for addressing these funding issues by providing:

- 1 An overview of existing payment models that have been used to support patient navigation or similar services in the United States**
- 2 Recommendations on next steps for leveraging and expanding these payment models**

DEFINING PATIENT NAVIGATORS

The concept of patient navigation has significantly grown and evolved since the launch of the first navigation program with breast cancer patients at Harlem Hospital in 1990 by surgical oncologist Dr. Harold P. Freeman.¹³ Over the past 30 years, patient navigation has spread beyond cancer into other chronic diseases, and has grown in popularity in the health care industry. The definition and practice have evolved so that various health care workforce members address diverse patient populations and needs in numerous settings.¹⁴ Consequently, a variety of similar navigator roles have emerged across our health care system. The simplified framework that follows provides an overview of the various roles associated with these categories of navigators as they apply to cancer care. While an additional category of navigators, known as insurance navigators, or “enrollment specialists,” has become prominent since the implementation of the Affordable Care Act, insurance navigators play a distinct role in the health care system and therefore have been excluded from this framework.

TABLE 1. SIMPLIFIED NAVIGATOR FRAMEWORK

	Community Health Worker	Patient Navigator	Clinical Navigator
Knowledge	General knowledge on health issues such as cancer, diabetes, obesity, heart disease, stroke, HIV/AIDs, and other chronic diseases	Knowledge of cancer screening guidelines, diagnostic processes, treatment options, survivorship issues & related physical, psychological, and social issues	Knowledge of cancer clinical impacts and ability to intervene, to manage symptoms, and/or assess functional status or psychosocial health
Documentation	Document activities within a client record	Document patient encounters, barriers to care, and resources or referrals within a client or medical record	Clinical documentation in medical record
Focus of Patient Evaluation Activities	Focus on community's needs and health behaviors	Based on barriers to care, social determinants of health, health disparities, focus on ensuring timely completion of scheduled care	Clinical outcomes and quality indicators
Qualifications	Training as a community health worker, some accreditation programs available	Minimum high school or equivalence, bachelor of social work (BSW), plus training in a patient navigator program.	Professional degree such as an associate's degree in nursing (ADN), bachelor of science in nursing (BSN) or master's degree (MSW) in social work

While there are some notable distinctions between categories of navigators, all navigators (community health workers, lay patient navigators, and clinically licensed navigators) share core responsibilities that include providing resources, social support, informational counseling, patient advocacy, and outreach to vulnerable populations. For the purposes of this resource, the term “patient navigator” or “navigator,” will generally be used as an umbrella term encompassing all of the categories listed above.

Additionally, it is worth noting that the term “care coordination” is often used as an adjunct to patient navigation. Care coordination refers to the management and organization of care for typically high-risk patients with multiple chronic diseases. However, one of the key roles and responsibilities of patient navigators, per the Patient Navigation and Chronic Disease Prevention Act (H.R. 1812) of 2005, is to “[a]ct as contacts, by assisting in the coordination of healthcare services and provider referrals...”¹⁵ Thus, for the purposes of this resource, patient navigation will encompass all clinical and non-clinical services provided, including care coordination, throughout the cancer care continuum.

PATIENT NAVIGATORS

In the current health care landscape, health care payers and providers are under significant pressure to improve individual and population health outcomes. Emerging evidence indicates that navigation can play an important role in achieving these goals.¹⁶ For example, studies have shown that navigators have a positive impact on patient care across a variety of outcome measures, including: process of care measures, patient-reported outcome measures (PROMs), and clinical outcome measures. These impacts are summarized in Table 2. Notably, many of these measures overlap with those endorsed by quality standard institutions and programs, such as the National Quality Forum and the Merit-Based Incentive Payment System (see starred measures), indicating that patient navigation can both broadly improve patient care and help health care providers and payers to meet specific metrics and quality requirements.

TABLE 2. SUMMARY OF IMPACT OF NAVIGATORS ON HEALTH OUTCOMES MEASURES

Outcome Measure	Definition	Example Measures	Outcomes with involvement of Patient Navigators
Process of Care	Specific steps in the patient care continuum that lead – either positively or negatively – to a particular outcome	<ul style="list-style-type: none"> • Number of scheduled appointments • Number of kept appointments • Documented number of barriers per patient and actions per barrier • Adherence to diagnostic resolution and reduced barriers ★ Reduced time to treatment ★ Adherence to recommended screening and follow-up 	<ul style="list-style-type: none"> • Increased appointments scheduled, clinic visits, arrivals and fewer no-shows when patients contacted by navigators^{17, 18} • Reduced time to diagnostic resolution and improved timely diagnostic follow-up^{19, 20, 21} ★ Navigated patients more likely to initiate treatment within 30-60 days from diagnosis^{22, 23} ★ Increased adherence to recommended cancer screening^{24, 25, 26} ★ Increased adherence to recommended cancer care²⁷ ★ Increased smoking cessation²⁸
Patient Reported Outcomes	Report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else	<ul style="list-style-type: none"> ★ Patient satisfaction ★ Quality of life ★ Patient distress ★ Various condition-specific validated questionnaires 	<ul style="list-style-type: none"> ★ Improved quality of life²⁹ ★ Increased patient satisfaction³⁰
Clinical Outcomes	Broadly agreed, measurable changes in patient health	<ul style="list-style-type: none"> ★ Disease staging, survival or mortality rates ★ Hospital readmission rates ★ Surrogate outcome measures (e.g., A1c, viral load, estimated Glomerular Filtration Rate etc.). 	<ul style="list-style-type: none"> ★ Improved A1c³¹ ★ Increased percentage of patients with blood pressure or cholesterol target reached³² ★ Decreased hospital readmission among older high risk, safety-net patients³³ ★ Decreased emergency department and admissions among patients with advanced cancer³⁴

★ = National Quality Forum (NQF) endorsed measures³⁵ and Merit-based Incentive Payment System (MIPS) Qualified Clinical Data Registry (QCDR)³⁶

THE CASE FOR NAVIGATION: IMPACT OF PATIENT NAVIGATORS ON HEALTH CARE COSTS

As US health care spending continues to rise, there is also growing pressure to demonstrate the value of innovative services by tracking their impact on health care costs. Current evidence indicates that navigation programs decrease unnecessary health care resource use by reducing the need for costly health care interventions such as hospitalizations, ED visits, and intensive care unit admissions.^{37, 38, 39} Additionally, studies that have considered the specific cost effectiveness or cost savings associated with navigation services show positive trends.^{40, 41, 42} Results from a cost-effectiveness (CE) analysis of the Chicago Cancer Navigation Project (CCNP),⁴³ a CE study of a navigation program to improve cervical cancer screening among Hispanic women in San Antonio, Texas,⁴⁴ and a CE analysis of a capitated navigation program for Medicare beneficiaries with lung cancer⁴⁵ all supported the cost effectiveness of navigation programs in breast, cervical, and lung cancer, respectively. Other health care cost analyses performed on government funded navigation programs such as the Center for Medicare & Medicaid Innovation (CMMI)-funded Health Care Innovation Awards (HCIA),⁴⁶ and the National Cancer

Institute (NCI) Patient Navigation Research Program (PNRP)⁴⁷ have also shown promising trends in the impact of navigation services. Table 3 defines the common outcome measures used in these cost-effectiveness studies and provides a brief summary of results from the current literature.

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The insurance is changing so quickly you can't keep up with all the changes. Even if you have insurance – your own policy. And you never know all the different places that you can go and ask for assistance or information. [It would be] very helpful to have someone who thinks, 'Well let's just ask this person about this because if it exists, they know where it is.'

– Patients' Experience with Navigation for Cancer Care



TABLE 3. SUMMARY OF IMPACT OF NAVIGATORS ON HEALTH CARE COST OUTCOME MEASURES

Outcome Measure	Definition	Outcomes with involvement of Patient Navigators
Total Costs/ Expenditures	An amount of money, time, or effort that is spent regarding services and health care provided to patients	<ul style="list-style-type: none"> Navigation programs decrease health care resource use by decreasing need for hospitalizations, ED visits, and intensive care unit admissions.^{48, 49, 50, 51} Navigation leads to a decrease in lifetime breast cancer-attributable costs by \$590 in patients who receive diagnosis earlier by 6 months compared to usual care.⁵² CHWs, in the CMMI-funded HCIA, were found to lower total costs (by \$138 per beneficiary per quarter).⁵³ Although navigation adds additional costs of \$275 per patient, the probability of diagnostic resolution was higher for navigation versus usual care.⁵⁴
Incremental Cost-effectiveness Ratio (ICER)	Statistic used to summarize the cost effectiveness of a health care intervention. Defined as the difference in cost between two possible interventions, divided by the difference in their effect. Interventions that cost less than \$50,000 per QALY are generally viewed as favorable, and interventions that cost more than \$50,000 are not generally considered cost effective.	<ul style="list-style-type: none"> Navigation is most cost-effective for breast cancer in women between the ages of 50 and 54 at an ICER of \$47,889 compared to women between the ages of 40 and 49 (\$95,346 per life year).⁵⁵ Navigation has resulted in a per-capita gain of 0.2 years of life expectancy and was highly cost-effective with an ICER of \$748 for Hispanic women screened for cervical cancer.⁵⁶ Capitated patient navigation program at an amount of \$84 per beneficiary per month for Medicare beneficiaries with lung cancer supported CE with an ICER of \$9,145⁵⁷
Quality-adjusted Life Year (QALY)	A generic measure of disease burden, including both the quality and the quantity of life lived. Or a year of life adjusted for its quality or its value. A year in perfect health is considered equal to 1.0 QALY.	<ul style="list-style-type: none"> Capitated navigation program at an amount of \$84 per beneficiary per month for Medicare beneficiaries with lung cancer supported CE with 0.47 QALYs⁵⁸ Hispanic males in colorectal cancer patient navigation program will have 0.3 more QALYs compared to usual care with 6 months increased life expectancy.⁵⁹

Thus, current research indicates that navigation decreases overall health care expenditures, is cost-effective despite initial implementation costs, and can improve patient quality and quantity of life.

II. Exploring funding and payment options for patient navigators

The growing body of research on the positive impacts of patient navigators reinforces the need to expand access to patient navigation services across the United States. To do so, payers and policy makers must promote funding models that allow health care institutions to consistently maintain patient navigation programs over time. Currently, navigation programs that are not well-established and internally funded are frequently supported through short-term grant funding. To ensure long-term sustainability, patient navigation services must ultimately be fully integrated into the health care delivery system and recognized as a covered service by both public and private health insurance payers.⁶⁰

The unique features of patient navigation programs can present certain challenges to achieving this level of integration. Historically, public and private health insurance systems have been designed to pay for clinical services provided by licensed health care providers. In contrast, patient navigation improves patient care by looking beyond clinical services to address broader barriers, such as scheduling, insurance access, and social determinants of health. As of 2018, only a handful of

states have an active credentialing system for community health workers (CHWs) or lay navigators. Some states are concerned that credentialing requirements could create barriers to entry that would keep otherwise well-qualified individuals from assuming a CHW role, especially those from underserved communities who have language skills and cultural competency to serve the “hardly reached.”

However, these challenges are not insurmountable. This section provides an overview of payment models that have been used to support patient navigation, or patient navigation-like services, in both the short and long term. While we recognize that some health care systems have chosen to fund patient navigators out of their own budgets, this resource will focus on models that provide external funding for patient navigation. By examining these models, and relevant examples of each, policy makers and payers can begin to develop strategies to provide widespread, sustainable funding for patient navigation programs. In doing so, they can better equip cancer care providers across the nation to cost-effectively improve care, meet critical metrics, and address longstanding disparities in the health care system.



SHORT-TERM FUNDING MODELS

While integration into long-term funding streams such as public and private health insurance systems is ultimately more sustainable over time, short-term funding remains a vital resource for launching, demonstrating, and scaling patient navigation programs. Short-term funding also serves an important role as a necessary stop-gap until more sustainable models become broadly available.

1. PRIVATE GRANTS

Project grants from nonprofit organizations, private foundations, pharmaceutical companies, etc. are the most common sources of funding for patient navigation programs. For example, the American Cancer Society (ACS) introduced the first patient navigator program for cancer at Harlem Hospital in 1990.⁶¹ Since that time, ACS has continued to support navigation programs throughout the United States. The challenge to these private grants is the potential for shifts in priorities of the foundation. For example, the Avon Foundation supported cancer patient navigation for several decades, but has currently shifted their programmatic support to other focus areas.

ACS Patient Navigator Program

Payer Institution: In 2005, ACS formally launched the ACS Patient Navigator Program.⁶²

Intervention: Patient navigators assist cancer patients, survivors, and their caregivers in navigating the cancer experience.

Model Description: Pharmaceutical companies such as AstraZeneca, Merck, and Bristol-Myers Squibb have provided funding to help expand the patient navigator program.

Status: There are currently approximately 80 ACS patient navigators across the US, located in various publicly and privately funded institutions.^{63, 64}

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I linked them to resources, and not just linked them but really tried to encourage them to take action on those referrals.

– Patient Navigators’ Reflections on the Navigator-Patient Relationship

2. GOVERNMENT GRANTS

Government agencies under the United States Department of Health and Human Services (HHS), such as the National Cancer Institute Center to Reduce Health Disparities (NCI/CHCRD) and the Centers for Medicare and Medicaid Services (CMS), have also invested significant resources to fund patient navigation research and service delivery programs. This funding is usually within the context of research to evaluate the science of patient navigation, and while it may provide support for some navigation services, it was not designed to provide long-term support.

Patient Navigation Research Program (PNRP)

Payer Institution: In 2005, the NCI allocated \$20 million to launch the Patient Navigation Research Program (PNRP).⁶⁵

Intervention: The PNRP focused on developing and testing patient navigation interventions for follow-up and treatment initiation of four cancers: breast, cervical, prostate and colorectal. Navigator types included CHWs, lay patient navigators, and clinically licensed navigators including nurses and social workers.

Model Description: In collaboration with ACS, nine trial sites from around the country were selected to receive five-year research grants to test the efficacy of a patient navigation intervention.

Status: The five-year funding period for PNRP has ended. Results from the program demonstrated increased rates of resolution of abnormal cancer screening findings, increased rates of treatment initiation, improved quality of life, and greater satisfaction with the health care system.^{66, 67, 68, 69} The program specifically saw the greatest benefits among racial and ethnic minority populations, and patients with economic disparities.^{70, 71}

SHORT-TERM FUNDING MODELS *(continued)*

University of Alabama at Birmingham (UAB) Patient Care Connect Program (PCCP)⁷²

Payer Institution: The University of Alabama at Birmingham (UAB) received a \$15 million three-year Health Care Innovation Award (HCIA) from CMS to establish the Patient Care Connect Program in the Deep South (Alabama, Florida, Georgia, Mississippi, and Tennessee).

Intervention: Lay patient navigators supported and directed patients to appropriate resources to overcome barriers to accessing care. Each site team operated under the supervision of a registered nurse.

Model Description: The program was designed to serve Medicare beneficiaries with complex or advanced-stage cancers, including those with psychosocial barriers to appropriate care, many living in medically underserved inner city and rural communities.

Status: The PCCP has become a model for improving cancer care quality, decreasing unnecessary hospitalization, and enhancing patient satisfaction.^{73, 74, 75, 76} UAB announced a partnership with a private health care consulting company, Guideway Care, to expand the reach of PCCP.⁷⁷ Financial terms of the partnership have not been disclosed at this time.

Cancer Prevention and Treatment Demonstration (CPTD)⁷⁸

Payer Institution: In 2006, CMS launched the \$25 million funded national Cancer Prevention and Treatment Demonstration (CPTD) projects aimed at reducing disparities in screening, diagnosis, and treatment of cancer among racial and ethnic minority Medicare-insured beneficiaries.

Intervention: Each project included a screening intervention group that received navigation services to help ensure appropriate screens for breast, cervical, colorectal and prostate cancer.

Model Description: A total of six projects were funded for four-year grants. Demonstrations had three sources of funding for each project site: (1) startup payments, (2) payment for administration of CMS-mandated participant surveys, and (3) capitated monthly payments for patient navigator services (negotiated amounts with CMS varied per site). Patient navigation was tested via the treatment (patients newly diagnosed with cancer) and cancer screening arms of the program.

Status: CMS evaluation found no significant differences in Medicare expenditure costs between intervention and control groups. No impact was found for navigators in the treatment arm due to small sample size. However, intervention group members reported considerable satisfaction with navigation services. Notably, only one site (Hawaii's Molokai General Hospital) succeeded in improving screening for all four cancers. In February 2017, with support from Sen. J. Kalani English, the Hawaii Senate passed SB 1238 to provide \$200,000 for a two-year project extension at Molokai.⁷⁹

Benefits and Challenges of Short-term Funding Models:

Short-term funding does come with a number of advantages. Grants are able to provide maximum flexibility in the types of navigation services, startup costs, and roles they are able to fund, as grants do not typically face the same legal or regulatory restrictions that apply to many long-term models. Additionally, grantors typically do not expect a return-on-investment or face risk beyond the amount of the grant. As a result, grants are more likely to fund innovative but unproven interventions. Consequently, short-term funding models such as private and government grants have been crucial to the initial implementation of patient navigation programs.

However, grant funding is also subject to serious limitations. Grants are typically time-limited, and therefore do not guarantee program sustainability beyond the grant period. It is crucial for policy makers and payers to proactively identify and collaborate with successful grant-funded models to develop strategies for transitioning to longer-term funding streams, such as integration into public and private insurance systems, to ensure that navigators can continue to effectively serve their patient populations beyond the grant period.

LONG-TERM FUNDING MODELS

Although short-term funding currently remains the most common model for funding patient navigators, there are a number of examples in which patient navigation services have been integrated into health insurance payment models. This section provides an overview of some examples where this transition is already occurring. By examining these models, health care payers and policy makers can develop strategies to support the long-term sustainability of navigation services.

1. FEE-FOR-SERVICE MODELS

The traditional “fee-for-service” (FFS) model has historically dominated the US health care payment system. In an FFS model, providers submit reimbursable claims based on the number of services, or procedures, carried out for a patient over a period of time. FFS models therefore provide a guaranteed, sustainable stream of funding for services included in the relevant fee schedule. However, the FFS approach has increasingly been criticized as creating incentives to provide inefficient and overly costly care.⁸⁰ Due to these critiques, many payers and policy makers have emphasized the need to shift away from the FFS model. However, FFS still accounts for much of the market, making it an important option for funding patient navigators. This section provides an overview of examples in which FFS reimbursement structures have been used to support navigation, and similar services, in our Medicare and Medicaid systems.

Medicare FFS Codes

Despite recent efforts to move to more quality-based funding models, Medicare continues to be a largely FFS system of care. Medicare is currently reimbursing some services similar to patient navigation through FFS, such as diabetes self-management training (DSMT) and chronic care management (CCM). Such reimbursement approaches could also work for patient navigation services.

Diabetes Self-management Training (DSMT) (Diabetes Educators)⁸¹

Payer Institution: Section 4105 of the Medicare Balanced Budget Act of 1997 permitted the Centers for Medicare and Medicaid Services (CMS) to reimburse health care facilities and organizations for DSMT services when provided to qualified Medicare Part B beneficiaries by an accredited, quality education program.

Intervention: DSMT equips patients with the knowledge, skills, and ability to perform self-care tasks. The diabetes educators that provide DSMT services work closely with the patient and care team, similar to patient navigators.



Model Description: To qualify for reimbursement, these DSMT services must be part of a plan of care prepared by a physician or qualified non-physician practitioner (QNPP). Beneficiaries are covered for a total of 10 hours of initial training within a continuous 12-month period and two hours of follow-up training each year after that, as needed.

Status: As of mid-2016, 46 states and the District of Columbia required coverage in private health insurance for diabetes management training.⁸² In addition, Medicare and most state Medicaid programs also cover DSMT.

Chronic Care Management (CCM)⁸³

Payer Institution: Beginning January 1, 2015, CMS, under the Medicare Physician Fee Schedule, began to separately identify and value clinical staff time and other resources used in providing CCM.

LONG-TERM FUNDING MODELS *(continued)*

Intervention: CCM services are performed by a physician or non-physician practitioner and their clinical staff for patients with multiple chronic conditions expected to last at least 12 months or until death.

Model Description: Under the CCM payment policy, eligible professionals may bill for care management that is furnished outside of office visits. Only physicians and certain non-physician practitioners (certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants) may directly bill for CCM services, though other staff may also bill on an incident-to basis. Only one practitioner may be paid for CCM services for a given calendar month. This practitioner must only report either complex or non-complex CCM for a given patient for the month and not both. Additionally, this code can only be used for patients with multiple serious chronic conditions, which is not inclusive of all cancer patients, or patients in need of cancer screenings.

Status: Reimbursement for CCM is ongoing and has been associated with reduced Medicare costs, an enhanced ability to connect patients with community-based resources, and decreased hospital readmissions.

Medicaid FFS Models

While many state Medicaid programs now serve large portions of their patient populations via managed care or alternative payment models (discussed in more detail below), FFS models still serve a significant number of beneficiaries across the United States and often play an important role in establishing the baseline of services that must be provided to Medicaid enrollees, including those in managed care. As a result, incorporating navigation services into state FFS programs remains an important avenue for establishing more sustainable funding streams for patient navigators at the state level.

Community Health Worker (CHW) Services⁸⁴

Payer Institution: While many states are continuing to struggle to find ways to integrate and sustainably fund CHW services, Minnesota has established an FFS model for CHW reimbursement.

Intervention: To qualify for reimbursement, the CHW must complete the state's 14-credit certificate program, enroll in the Minnesota Health Care Plan as a Medicaid Provider, and also work under the supervision of a licensed medical professional.

Model Description: In Minnesota, home-based preventive services provided by CHWs can be reimbursed under Medicaid as long as the services qualify as diagnostic-related patient education. Beneficiaries can receive up to 12 hours of these services each month.

Status: Minnesota's program remains active. There does not appear to be publicly available data regarding relevant outcomes or utilization. However, anecdotal evidence suggests that utilization has been limited, potentially due to constraints on the types of services that can be provided under the approved billing code.

Benefits and Challenges of FFS Models:

In contrast to some of the alternative payment models described below, FFS models have a number of benefits for funding navigation programs. FFS systems provide guaranteed funding for patient navigation rather than relying on individual payers or health care providers to cover the cost of these services themselves. However, FFS models suffer from an overarching lack of flexibility. For example, in Medicare and Medicaid, changes to FFS coverage may require legal or regulatory changes at the state and/or federal level that can be difficult to accomplish. Additionally, FFS systems may have restrictions on the types of providers that can be directly reimbursed for their services, which can create difficulty in funding services provided by categories of patient navigators – such as lay navigators or CHWs – that may not meet the requirements of the providers eligible for reimbursement. Consequently, the issue of provider requirements has been an ongoing barrier to establishing FFS funding for patient navigators. Also, criteria that patients must meet for providers to use FFS codes that encompass some navigation activities may exclude some cancer patients or include them only once they have experienced a significant functional decline. Finally, as the system transitions away from FFS payment models, other approaches for funding patient navigation will be necessary.

LONG-TERM FUNDING MODELS *(continued)*

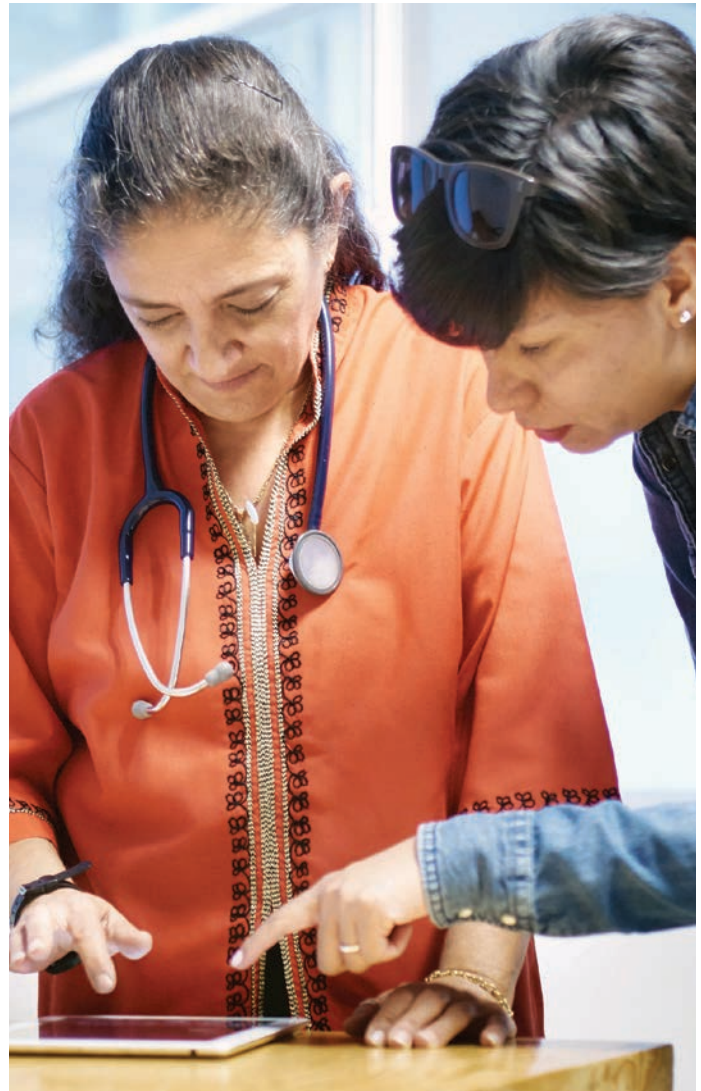
2. MANAGED CARE MODELS

In response to concerns regarding inefficiency, service fragmentation, and rising costs associated with FFS models, health insurance systems have increasingly shifted to managed care approaches. Thus, as of 2016, roughly 80% of Medicaid enrollees received Medicaid benefits through a managed care program.⁸⁵ In managed care models, managed care organizations (MCO) receive capitated payments to deliver services to patients for a set period of time (e.g., per-member, per-month). These payments are designed to cover both individual services and administrative costs. Medicare also uses a managed care framework to cover approximately one-third of its members in Medicare Part C (also known as Medicare Advantage).

Managed care is a particularly promising model for funding patient navigators and similar roles. Managed care models use capitated payments and contract requirements (e.g., quality metrics) to incentivize MCOs to improve health outcomes while controlling costs. As described above, navigators can play an important role in achieving both goals. Additionally, capitated payments typically provide greater flexibility to pay for services that would not otherwise be covered in traditional FFS systems.⁸⁶ This flexibility allows MCOs to overcome the challenges, described above, that have historically made it difficult to fund navigation services. For example, some Medicaid MCOs have paid for navigation services as part of their administrative expenses.⁸⁷ Alternatively, Medicaid MCOs can cover non-traditional benefits, such as navigation, as “value-added” or “in-lieu-of” services,⁸⁸ or potentially as part of their coordination and continuity of care obligations.⁸⁹ Within Medicare Advantage, insurers are required to provide some level of care coordination for every patient. However, insurers may be able to cover navigation services that extend beyond general care coordination and case management by including these services in Supplemental Benefits.⁹⁰ Therefore, managed care models are a particularly important option for policy makers and payers to consider when seeking to sustain navigation services.

Molina Healthcare of New Mexico⁹¹

Payer Institution: Molina Healthcare of New Mexico (MHNH) is one of seven New Mexico Medicaid Managed Care provider organizations that has explored the role of CHWs within contracted provider networks.



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I was at the end of my rope. My health insurance was running out and my financial resources had all but dried up. I didn't know what direction to go. I was not feeling good about what the future held. My patient navigator was very instrumental in laying out all the options available to me.

– Patient Navigators' Reflections on the Navigator-Patient Relationship

LONG-TERM FUNDING MODELS *(continued)*

Intervention: MHNH negotiated with the state Medical Assistance Division to establish a billing code for the program to reimburse CHWs.

Model Description: University of New Mexico Health Science Center (UNM HSC) Department of Family and Community Medicine (DFCM) and MHNH negotiated a standard two-year renewable contract under which UNM would invoice MHNH for the services of their CHWs, now called “client support assistants.” A contract began in May 2005 with an initial capitated payment structure of \$256 per member per month of service, which was raised to \$306 in 2007 and \$321 in 2009. The service was provided to MHNH-identified members who were high-risk with increased ED visits, poorly controlled chronic diseases, and high use of disease management referrals. The duration of service ranged from one to six months, depending on member needs.

Status: Building upon lessons learned from CHW interventions with high-risk patients, the Integrated Primary Care and Community Support (I-PaCS) initiative was launched in 2016.⁹² Acknowledging the success of the CHW model, New Mexico Medicaid required all managed care organizations to increase their CHW contacts with clients by 20 percent in 2017.⁹³

Benefits and Challenges of Managed Care Models:

As described above, managed care is inherently much more flexible than FFS models. This flexibility allows health care payers to fund navigation services without needing to seek policy changes at the state or federal level. As a result, managed care models can be a much faster and easier route to coverage than FFS. Additionally, the incentives built into managed care models (e.g., capitated payments and quality metrics) should make covering navigation services appealing to MCOs. However, unlike FFS coverage, managed care models do not necessarily guarantee funding for navigation. If a managed care model leaves the choice fully up to the MCO, these services may continue to go uncovered. Therefore, policy makers interested in sustainably funding patient navigators should also consider how they can use tools such as contract provisions to more strongly encourage, incentivize, or require coverage of navigation services.⁹⁴



ALTERNATIVE PAYMENT MODELS

Looking beyond managed care, payers and policy makers are also increasingly emphasizing the need to transition to even more efficient, value-based alternative payment models (APMs). These models (summarized below in **Table 4**) are typically designed to encourage a coordinated team approach in which health care providers (rather than just MCOs) are directly incentivized to improve patient health outcomes while controlling costs by delivering more efficient care. As with managed care models, the goals and approaches to patient care underlying these models align well with patient navigation services. Patient navigation is a high-value

care intervention that may be used in any type of APM. Thus, it is particularly important for payers and policy makers who are designing APMs to include patient navigators in model design. Although some of the case studies in this section highlight primary care-focused APMs, the flexibility of these models offers enormous promise for ensuring access to critical navigator services in specialty care as well. They also represent an opportunity for both clinical and lay navigators to overcome breakages in the care continuum that often take place between the primary care and specialty care setting.

TABLE 4. ALTERNATIVE PAYMENT MODELS FOR VALUE-BASED CARE

Model	Description
Accountable Care Organization (ACO)	An affiliation of health care providers and facilities that team up to coordinate and improve patient care through smart management and motivated personnel. ACO models often involve elements of shared savings or shared risk, in which the health care providers directly benefit or lose funds depending upon whether the ACO succeeds in controlling costs.
Patient-centered Medical Homes (PCMH)	A primary care physician leads and coordinates patient care teams to promote efficiency, responsiveness to the patient’s individual needs, and delivery of evidence-based, quality care.
Pay for Success	An approach in which private investors, health care providers, and health care payers enter into an agreement in which investors pay for upfront costs of an intervention and payers repay investors if pre-identified outcomes are achieved.
Bundled Payments	A system in which third party payers make a single payment to doctors and/or facilities for all services associated with a specific one-time procedure or episode of care, such as a hip replacement. The one-time payment must also cover the cost of possible complications.

A. ACCOUNTABLE CARE ORGANIZATION (ACO)

Cigna Collaborative Care⁹⁵

Payer Institution: Cigna has entered into 156 accountable care organization (ACO)-style shared-savings contracts with selected large physician groups in 29 states. The program has been operational since 2008, when it was launched as the “Cigna Accountable Care” initiative to benefit individuals covered by a Cigna health plan.

Intervention: In addition to standard fee-for-service payments, participating medical groups receive a semiannual care coordination/navigation fee, which varies based on the expected impact of activities planned in the first contract year (but was equivalent to \$1-\$2 per patient per month in 2010). Participating medical groups must agree to allocate a nurse to serve as an embedded care coordinator, or navigator.

Model Description and Potential to Include Patient

Navigation: If the medical group meets minimum quality targets and its total medical cost trend has improved by at least 2% relative to comparison practices in their area (which was the minimum savings threshold in 2010), Cigna increased the size of the medical group’s care coordination fee in the following year, with the size of the fee increase varying depending on the medical group’s performance on cost and quality measures. If performance was worse than a specific cost and/or quality benchmark, care coordination fees were reduced in subsequent years. Medical groups can use the care coordination/navigation reimbursements to embed navigators into their programming.

Status: The initiative is still ongoing and achieved a 5.7% reduction in net spending per patient for 2010 to 2011, relative to what spending would have been without the initiative.⁹⁶

Intel’s Connected Care⁹⁷

Payer Institution: Connected Care is Intel’s “accountable care organization (ACO) approach based on a Patient Centered Medical Home (PCMH) model” for its employees. The model was launched in 2013 in partnership with Presbyterian Healthcare Services (PHS) for its employees and dependents at Intel’s facility in Rio Rancho, New Mexico. Intel has since expanded the program to Oregon and Arizona, partnering with Kaiser Permanente, Providence Health and Services, and the Arizona Care Network.

Intervention: Nurse navigators are part of the services that employees can access at partner health systems. The navigators lead outreach efforts and work with PCPs to engage patients and ensure that highest-needs patients receive the highest-touch care.

Model Description and Potential to Include Patient

Navigation: The payment model is based on a global per-member-per-month (PMPM) target with shared savings and shared risk based on performance. A per-member per-month cost baseline is set, and shared costs/risks are realized when PMPM costs fall outside the established +/- 2% of target PMPM level. The PMPM payments are used to support nurse navigators.

Status: The program is still ongoing, but detailed evaluations are not available. Intel did release descriptive findings from Year 1 of its program in New Mexico that reported the model exceeded goals for member experience, evidence-based medicine, and “right time, right service” but did not meet cost goals.⁹⁸

Oregon Coordinated Care Organizations⁹⁹

Payer Institution: In 2012, the state of Oregon transformed its Medicaid program by establishing 16 “coordinated care organizations,” or CCOs, to provide comprehensive care for its Medicaid population. The state’s transformation was made possible through a \$1.9 billion five-year grant from CMS.

Intervention: The CCOs include use of “non-traditional” health care workers (peer wellness specialists; community health workers; patient navigators) to expand the health care workforce and address social determinants of health.

Model Description and Potential to Include Patient

Navigators: The Oregon Health Authority (OHA) uses a “bonus quality pool” to reward CCOs for the quality of care provided to Medicaid members. The CCOs are partnerships of payers, providers, and community organizations that work at the community level to provide coordinated health care for children and adult Oregon health plan enrollees. To earn their full incentive payment, CCOs have to meet benchmarks or improvement targets on at least 12 of the 17 incentive measures and have at least 60 percent of their members enrolled in a patient-centered primary care home. Navigators are funded with non-claims based payments.¹⁰⁰

Status: Oregon’s program is still active and a study published in the March 2017 issue of *Health Affairs*

journal suggests Oregon's approach to Medicaid delivery is a viable model to control Medicaid coverage costs.¹⁰¹ Overall, CCOs were associated with a 7 percent relative reduction in expenditures across the sum of five service areas (evaluation and management, imaging, procedures, tests, and inpatient facility care), attributable primarily to reductions in inpatient utilization.

Medicare Shared Savings/Accountable Care Organization (ACO) Program (MSSP)¹⁰²

Payer Institution: As a result of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) established a shared savings program to facilitate coordination and cooperation among providers to improve quality of care for Medicare fee-for-service beneficiaries.

Intervention: To participate in the program, eligible providers, hospitals, and suppliers can create or participate in an ACO.

Model Description and Potential to Include Patient Navigators: The program requires that ACOs promote evidence-based medicine, beneficiary engagement, quality and cost metrics, and coordinated care, which can include patient navigation services. Although patient navigators cannot be reimbursed as providers in the program, their services can help ACOs reach benchmarks

for shared cost savings and avoid penalties, creating incentives for participants to fund navigation services.

Status: There are currently 561 MSSP ACOs in the country providing care to 10.5 million beneficiaries.

Massachusetts Medicaid MassHealth Accountable Care Organization¹⁰³

Payer Institution: 1115 Medicaid Waiver

Intervention: Health care systems and groups of organizations submitted applications to participate as ACOs. Individual patients receive all their care in a single ACO.

Model Description and Potential to Include Patient Navigators: The program includes quality and cost incentive payments. It provides ACOs with startup funds for community health workers and other clinical and non-clinical personnel to perform care coordination, especially focusing on behavioral health and chronic disease management. Funds are also provided to partner with community organizations to address social determinants of health.

Status: There are 18 ACOs that began providing care to all Massachusetts Medicaid beneficiaries in spring 2018.



“

The patient navigator has helped my family in such a huge way. She contacted us to offer her assistance to try and find help in reducing my brother's co-pay insurance since it is so high.

– Patient using the ACS Patient Navigator Program

B. PATIENT CENTERED MEDICAL HOME (PCMH)

Blue Cross Blue Shield of Michigan Primary Care Transformation Project¹⁰⁴

Payer Institution: The Michigan Primary Care Transformation (MiPCT) Project began in 2012 as a three-year, multi-payer, statewide CMS project (Multi-Payer Advanced Primary Care Practice Demonstration [MAPCP]) aimed at reforming primary care payment models and expanding the capabilities of patient-centered medical homes (PCMHs) throughout the state. The demonstration was the catalyst for bringing together Medicare, Michigan Medicaid Health Plans, Blue Cross Blue Shield of Michigan, Blue Care Network, and Priority Health to improve upon the strong PCMH foundation in the state.

Intervention: The care coordination payments were made to the physician organizations to fund nurse care management services. Care management was reserved for appropriate high- and moderate-risk individuals with complex chronic diseases.

Model Description: The model uses a care coordination payment of \$3 PMPM (\$4.50 for Medicare), a practice transformation payment of \$1.50 PMPM (\$2 for Medicare), and performance incentives of \$3 PMPM.

Status: The program was evaluated by the Research Triangle Institute, CMS' national evaluator for the MAPCP demonstration. The evaluation concluded that MiPCT program savings for Medicare in Michigan were

estimated at about \$148 per full-year eligible Medicare beneficiary.¹⁰⁵ In 2017, the program, in collaboration with the Michigan Department of Health and Human Services, began transitioning into a state innovation model (SIM) to continue components of the MiPCT model.¹⁰⁶

Horizon Blue Cross Blue Shield of New Jersey Patient-centered Medical Home Program¹⁰⁷

Payer Institution: In 2010, Horizon Blue Cross Blue Shield (BCBS) in New Jersey, in collaboration with the New Jersey Academy of Family Physicians and the leadership of eight primary care practices, developed the PCMH program to benefit individuals covered by a Horizon health plan.

Intervention: Participating practices receive upfront payments from Horizon to support their PCMH transformation efforts and additional staff (including nurse care coordinators they are required to employ). Care coordinator nurses work directly with physicians and office teams to improve the coordination of treatment for patients and help engage and empower patients to take control of their health.

Model Description: Practices have an opportunity to receive outcome-based or shared savings payments (in addition to existing FFS payments) for improving patient health outcomes and patient experience and controlling unnecessary utilization and cost of care.



Status: As New Jersey’s largest health insurer, Horizon continues to expand patient-centered programs throughout the state. When Horizon members in traditional primary care practices were compared with over 200,000 members receiving care at practices participating in Horizon’s PCMH program in 2013, results showed that patient-centered practices achieved a 14% higher rate in improved diabetes control and a 12% higher rate in cholesterol management.¹⁰⁸ Increased rates of cancer screening and lower costs were seen in the intervention group.

Comprehensive Primary Care Plus (CPC+)¹⁰⁹

Payer Institution: In January 2017, CMS launched CPC+, a unique public-private partnership, in which practices are supported by aligned payers in 18 regions. Private payers include Blue Cross Blue Shield, Aetna, UnitedHealthcare, Care Source, and others.

Intervention: There are two primary care practice tracks with incrementally advanced care delivery requirements and different payment options in which practices can choose to participate.

Model Description: CPC+ has been designated as an advanced alternative payment model (AAPM) that includes three payment elements: (1) care management fee, (2) performance-based incentive payments, and (3) payments under the Medicare physician fee schedule. Care management fees are paid on a PMPM basis (\$15-\$28 average) and may be used to support patient navigation services.

Status: There are 2,932 primary care practices currently participating in CPC+ in 18 regions. The project is ongoing, and no data have been released regarding outcomes and impact.

C. PAY FOR SUCCESS

South Carolina Nurse-Family Partnership¹¹⁰

Payer Institution: In January 2016, the South Carolina Department of Health and Human Services (SCDHHS) launched a Pay for Success model of social impact investment that uses private sector dollars to fund public social projects.

Intervention: Mothers who enroll in Nurse-Family Partnership services receive individualized home visits from nurses from early in their pregnancy until their child’s second birthday.

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I think some of our clients might have been tempted to blow off an appointment because of fear or whatever. But [they went] because they knew we were going to be there waiting for them, and that we were going to be on top of them, and that we were going to be holding them accountable, and that they weren’t going to be alone. I think it increased the follow-through of them being at that next appointment whatever that appointment was.

– Patient Navigators’ Reflections on the Navigator-Patient Relationship

Model Description: The budget for the program is approximately \$30 million, with roughly \$17 million coming from private philanthropic investors and another \$13 million from federal Medicaid funds through a Section 1915(b) Waiver. The Medicaid funding is paid directly to Nurse-Family Partnership for services provided, while the private investors provide the upfront capital for hiring and training new staff. The payout for the investors will come from South Carolina state funds and depend upon the level of success found by independent evaluators.¹¹¹ However, the private investors have agreed that even the “full repayment” is capped at \$7.5 million.

Status: The project is currently ongoing. The Abdul Latif Jameel Poverty Action Lab (J-PAL) designed a Randomized Control Trial to provide rigorous evidence on the effects of NFP, and the results of the RCT will be used to calculate PFS success payments. Beyond the PFS contract period, J-PAL will also conduct a comprehensive, long-term evaluation of NFP’s impact on mothers and children.¹¹² While this program does not address cancer, this type of model shows promise for future programs more directly relevant to oncology patients.

D. BUNDLED PAYMENTS

CMS Medicare Oncology Care Model (Patient Navigators)¹¹³

Payer Institution: In 2016, the CMS Innovation Center (CMMI) developed a new payment and service delivery model to provide enhanced services to Medicare beneficiaries undergoing chemotherapy treatment for cancer.

Intervention: In addition to the payment methodology that incentivizes high-value care, there are six required practice redesign activities intended to move practices toward coordinated, patient-focused care, including provision of care navigation services.

Model Description: The oncology care model (OCM) is a five-year model that will end in 2021, and the hope is that it will promote high-quality and high-value care. The episode-based payment model targets chemotherapy and related care during a six-month period that begins with receipt of chemotherapy treatment. The OCM promotes whole practice transformation through the use of aligned financial incentives, including performance-based payments, to improve care coordination, appropriateness of care, and access for FFS Medicare beneficiaries undergoing chemotherapy. The OCM provides a per-beneficiary per-month payment of \$160 to cover enhanced care management services.

Status: As of March 2017, 190 practices were participating, with approximately 3,200 oncologists providing care for approximately 150,000 unique beneficiaries per year (approximately 20% of the Medicare fee-for-service population receiving chemotherapy for cancer).

Benefits and Challenges of APMs:

As noted above, the goals that drive these APMs – improved care coordination, improved health outcomes, and lower costs – align well with goals and strengths of patient navigation. As a result, APMs appear particularly well-suited to integrating and funding patient navigation services. Additionally, APMs benefit from greater flexibility than FFS models. APMs often use capitated payments to fund categories of services or episodes of care, giving health care providers in these models greater flexibility to use APM payments to fund roles or services that might not be covered under traditional FFS systems. These lump sum payments are also often supplemented by shared savings or other incentive funding, which health care providers can use as they see fit. However, as with MCOs, the mere flexibility to cover navigation services with capitated or incentive funds may not be enough to ensure inclusion in these models. To address this challenge, payers and policy makers can explicitly require or incentivize the use of patient navigators when designing new APMs (e.g., through laws or regulations establishing the APM or contract language with individual providers).



III. RECOMMENDATIONS/CONCLUSIONS

Patient navigation is a critical link in the care continuum for individuals living with cancer and other complex illnesses. Emerging evidence demonstrates that patient navigation can improve health outcomes, address barriers that drive health disparities, and reduce the need for high-cost services. Despite this evidence, many patient navigation programs continue to struggle to establish sustainable funding streams. Payers and policy makers have the power to reverse this trend. This final section provides a series of recommendations regarding proactive steps that payers, policy makers, and other stakeholders can take to leverage the payment models described above to support the sustainable funding and scaling of patient navigation programs across the nation.

1. ADOPT/PROMOTE A UNIFORM DEFINITION OF PATIENT NAVIGATION

As noted earlier, the concept of patient navigation has significantly evolved over the past 30 years and has come to encompass a variety of roles and services. As a result, the term patient navigator can carry different meanings for individual programs and stakeholder groups. This variability can present a barrier to establishing sustainable funding streams. Without a clear understanding of what it means to provide patient navigation, payers may hesitate to cover patient navigation services, cover only certain patient navigation components, or create inconsistent levels of coverage that vary by insurance program (e.g., Medicaid versus Medicare).

To avoid these challenges, the American Cancer Society National Navigation Roundtable (NNRT) recommends that health care payers and policy makers adopt a single, uniform definition of patient navigation and apply that definition consistently in all new payment models.

In particular, the NNRT supports the widespread adoption of the definition of patient navigation established by the Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers. These groups have jointly defined patient navigation in the cancer setting as:

[I]ndividualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care from pre-diagnosis through all phases of the cancer experience.¹¹⁴

Additionally, the NNRT does not recommend a particular model of navigation, since different settings might require different models; however, the NNRT does recommend that lay navigators in clinical settings receive supervision from a licensed social worker, nurse, or physician.

2. PROVIDE SHORT-TERM FUNDING TO SUPPORT RESEARCH AND SCALING

As noted above, short-term funding, in the form of private and government grants, remains a critical source of support for the design, evaluation, and scaling of patient navigation programs. Some short-term funding models, such as grants provided by the Center for Medicare & Medicaid Innovation (CMMI), can also provide a pathway to long-term funding for patient navigation programs. For example, the secretary of the Department of Health and Human Services has the authority under the Affordable Care Act to scale-up and sustain successful, cost-neutral or cost-saving demonstration projects originally funded through CMMI.

Therefore, payers and policy makers should continue to provide short-term funding opportunities (i.e., grants) for patient navigation programs.

In providing this funding, payers and policy makers should prioritize funding research that will reinforce the business case for integrating patient navigation into long-term funding streams. For example, payers and policy makers should prioritize research into cost savings associated with patient navigation, the impact of patient navigation on health disparities, and the impact of patient navigation on cancer treatment and survivorship.

3. IMPROVE FEDERAL/ STATE/COMMERCIAL COMMITMENT TO PROVIDING LONG-TERM FUNDING FOR PATIENT NAVIGATIONG

To truly sustain patient navigation services, payers and policy makers must ultimately show greater commitment to integrating patient navigation into long-term funding streams such as fee-for-service (FFS), managed care, and alternative payment models (APMS). While value-based models, such as managed care and APMS, are the most theoretically consistent with the values underlying patient navigation (e.g., reducing fragmentation of care, supporting collaboration, etc.), FFS models remain a core component of major health insurance systems such as Medicare and Medicaid. Therefore, payers and policy makers must take steps to integrate patient navigation into both FFS and value-based care.

A. FEE-FOR-SERVICE RECOMMENDATIONS:

To improve integration of patient navigation into FFS models, payers and policy makers should:

- **Establish reimbursement for specific, delineated navigation services when provided by licensed nurses or social workers, or lay navigators operating under supervision:** To effectively incorporate patient navigation services into FFS systems, payers and policy makers must enact policies that clearly establish patient navigation services as reimbursable benefits under public and private FFS systems. For example, patient navigation should be established as a reimbursable service under both Medicare and Medicaid. One avenue for change is legislation; lawmakers have introduced legislation as recently as 2018 to provide Medicaid coverage for patient navigation services.¹¹⁶
- **Establish billing codes for specific navigator duties:** In order for health care providers to receive reimbursement for patient navigation, they must also be able to properly bill for navigation services. In order to make billing possible, payers, policy makers, and other stakeholders should advocate for the creation of billing codes (i.e., current procedural terminology [CPT] and international classification of disease [ICD-10] codes) that are broad enough to cover all current patient navigation services.

B. MANAGED CARE/ALTERNATIVE PAYMENT MODEL RECOMMENDATIONS:

To improve integration of patient navigation into managed care and APMS, payers and policy makers should:

- **Seek a commitment from major payers – including CMS – to include patient navigation in future payment models:** As noted above, many managed care and alternative payment models currently provide some level of flexibility to pay for patient navigation services. However, without building explicit incentives or requirements into these models, navigation services may continue to be excluded from coverage. Therefore, a crucial step toward ensuring patient navigators are included in these models is to obtain a commitment from major payers, such as CMS, to explicitly include patient navigation, as defined in this paper, in future payment models. These payers can look to the case studies provided in this issue brief as examples of how to approach navigation services in these models.
- **Create a network of state-level experts who can advise on inclusion of patient navigation in payment reform and value-based payment models:** As with major payers, state-level experts can play a key role in providing the rationale for and method of including patient navigation in the design of value-based payment models. By creating a network of state-level experts who can best advise on how these services should be integrated into health care delivery, workflow, and financing, stakeholders can better ensure that laws, regulations, and contracts governing managed care and alternative payment models incentivize or require coverage of patient navigation. Experts and stakeholders can look to the case studies in this brief for guidance on potential approaches.



APPENDIX A. SHORT-TERM FUNDING MODELS

Model Type	Funding	Payer Institution	Location	Intervention	Model Description	Relevant Outcomes	Dates
Private Grants	American Cancer Society	N/A	National	Patient navigators	Navigators are trained to meet with patients, identify barriers to care, and work with institutional health care teams to support patients and assist staff with aspects of care that can be managed by non-medical personnel.	There are currently approximately 80 ACS patient navigators across the US, located in various publicly and privately funded institutions.	2005 - present
Government Grants	NCI Patient Navigation Research Program (PNRP)	N/A	National	CHWs, lay patient navigators, clinically licensed navigators	In collaboration with ACS, nine trial sites around the country were selected to receive five-year research grants to test the efficacy of a patient navigation intervention.	Results from the program demonstrated increased rates of resolution of abnormal cancer screening findings, increased rates of treatment initiation, improved quality of life, and greater satisfaction with the health care system.	2005-2010
	University of Alabama-Patient Care Connect Program (PCCP)	Medicare	Deep South (Alabama, Alabama, Florida, Georgia, Mississippi, and Tennessee)	Lay patient navigators	This program was designed to serve Medicare beneficiaries with complex or advanced stage cancers, including those with psychosocial barriers to appropriate care, many living in medically underserved inner city and rural communities.	PCCP has become a model for improving cancer care quality, decreasing unnecessary hospitalization, and enhancing patient satisfaction. In 2017, UAB announced a partnership with a private health care consulting company, Guideway Care, to expand the reach of the PCCP.	2012-present
	Cancer Prevention and Treatment Demonstration (CPTD)	Medicare	National	Patient navigator	Six projects funded for four-year grants. Demonstrations had three sources of funding for each project site: (1) startup payments, (2) payment for administration of CMS-mandated participant surveys, and (3) capitated monthly payments for patient navigator services.	One site, Hawaii's Molokai General Hospital, succeeded in improving screening for breast, cervical, colorectal and prostate cancer. In February 2017, with support from Sen. J. Kalani English, the Hawaii Senate passed SB 1238 to provide \$200,000 for a two-year project extension at Molokai.	2006-2010

APPENDIX B. LONG-TERM FUNDING MODELS

Model Type	Payer Institution	Location	Intervention	Model Description	Relevant Outcomes	Dates
Fee-for-service	Medicare, public & private insurance plans	National	DSMT	Health care facilities and organizations are reimbursed for DSMT services when provided to qualified Medicare Part B beneficiaries by an accredited, quality education program with certified providers.	Diabetes education with decreased cost, cost saving, cost effectiveness, or positive return on investment. However, participation remains low at 58%.	1997-present
	Medicare physician fee schedule	National	CCM	Eligible professionals may bill CCM services for patients with multiple chronic conditions expected to last ≥ 12 months. Only one practitioner may be paid for CCM services. Only complex or non-complex CCM PMPM.	Associated with reduced Medicare costs, enhanced ability to connect patients with community-based resources, and decreased hospital readmissions	2015-present
	Medicaid	Minnesota	CHWs	Home-based preventive services provided by certified CHWs are reimbursed under Medicaid as long as the services qualify as diagnostic-related patient education.	No data available	2007-present
Managed Care	Molina Healthcare of New Mexico (MHNM)	New Mexico	CHWs	The State Medical Assistance Division established billing code for reimbursement of CHWs. A May 2005 contract with an initial capitated payment structure of \$256 PMPM of service was raised to \$306 in 2007 and \$321 in 2009. Duration of service ranged from 1 to 6 months, depending on member needs.	Acknowledging the success of the CHW model, New Mexico Medicaid required all managed care organizations to increase their CHW contracts with clients by 20 percent in 2017.	2005 - present

APPENDIX B. LONG-TERM FUNDING MODELS

Model Type	Payer Institution	Location	Intervention	Model Description	Relevant Outcomes	Dates
Accountable Care Organization	Cigna Collaborative Care	National*	Nurse care coordinator	Participating medical groups received a semiannual care coordination fee (\$1-\$2 per patient per month in 2010). Groups that met quality measures received increase in fees for subsequent years and vice versa for poor outcomes.	There was a 5.7% reduction in net spending per patient for 2010 to 2011, relative to what spending would have been without the initiative.	2008-present
	Intel's Connected Care	New Mexico, Oregon & Arizona	Nurse navigators	A per-member per-month cost baseline was set, and shared costs/risks were realized when PMPM costs fell outside the established +/-2% of target PMPM level.	Positive outcomes in member experience, evidence-based medicine and “right time, right service.” However, costs were higher in Year 1 due to increased member engagement, proactive primary care, and more pregnancies than predicted. The overall PMPM exceeded target.	2013-present
	Medicaid	Oregon	Peer wellness specialists, CHWs, and patient navigators	Pay-for-performance program using a “bonus quality pool” to reward CCOs for the quality of care provided to Medicaid members. To earn full incentive payment, CCOs have to meet benchmarks or improvement targets.	Overall, CCOs were associated with a 7 percent relative reduction in expenditures across the sum of services, attributable primarily to reductions in inpatient utilization.	2012-present
	Medicare	National	Potential for navigators	ACOs promote evidence-based medicine, beneficiary engagement, quality, and cost metrics and coordinated care, which can include patient navigation services. Although patient navigators cannot be reimbursed as providers, their services can help ACOs reach benchmarks for shared cost savings and avoid penalties.	There are currently 561 MSSO ACOs in the country providing care to 10.5 million beneficiaries.	2005 - present

APPENDIX B. LONG-TERM FUNDING MODELS

Model Type	Payer Institution	Location	Intervention	Model Description	Relevant Outcomes	Dates
Patient-Centered Medical Home	Blue Cross Blue Shield of Michigan Primary Care Transformation (MiPCT) project	Michigan	Nurse care coordinator	Care coordination payment of \$3 PMPM (\$4.50 for Medicare), a practice transformation payment of \$1.50 PMPM (\$2 for Medicare), and performance incentives of \$3 PMPM. Care coordination payments made to physician organizations to fund care management services were reserved for appropriate high- to moderate-risk individuals.	MiPCT program savings for Medicare in Michigan were estimated at about \$148 per full-year eligible Medicare beneficiary. In 2017, the program began transitioning into a state innovation model (SIM).	2012-present
	Horizon Blue Cross Blue Shield	New Jersey	Nurse care coordinators	Participating practices receive upfront payments from Horizon to support their PCMH transformation efforts and additional staff (including nurse care coordinators they are required to employ). Practices have an opportunity to receive outcome-based or shared savings payments (in addition to existing FFS payments) for improving patient health outcomes and patient experience, and controlling unnecessary utilization and cost of care.	Horizon members in patient-centered practices achieved a 14% higher rate in improved diabetes control and a 12% higher rate in cholesterol management. Breast and colorectal cancer screenings increased by 8% and 6%, respectively. Cost of care was also 4% lower, with a 4% lower rate in ED visits and a 2% lower rate in hospital admissions.	2010-present
	Comprehensive Primary Care Plus (CPC+)	National	Care management	Includes three payment elements: (1) care management fee, (2) performance-based incentive payments, and (3) payments under the Medicare Physician Fee Schedule. Care management fees are paid on a PMPM basis (\$15-\$28 average) and may be used to support patient navigation services.	2,932 primary care practices are currently participating in CPC+ in 18 regions. The project is ongoing, and no data have been released regarding outcomes and impact.	2017-present

APPENDIX B. LONG-TERM FUNDING MODELS

Model Type	Payer Institution	Location	Intervention	Model Description	Relevant Outcomes	Dates
Pay for Success	Nurse-Family Partnership (NFP)	South Carolina	Specially trained nurses	Social impact investment model with funding from private philanthropic investors and public government Medicaid. Medicaid funding is paid directly to NFP for services provided, while private investors provide the upfront capital for hiring and training new staff. Payouts depend on level of success.	This project is ongoing. The Abdul Latif Jameel Poverty Action Lab (J-PAL) plans to incorporate a rigorous randomized controlled trial (RCT) and long-term evaluation.	2016-present
Bundled Payments	CMS Medicare Oncology Care Model (OCM)	National	Care navigators	An episode-based OCM payment structure targeting chemotherapy and related care during a 6-month period that begins with receipt of chemotherapy treatment. Payment methodology incentivizes high-value care, and there are 6 required practice redesign activities, including provision of care navigation services.	As of March 2017, 190 practices were participating, with approximately 3,200 oncologists providing care for ~150,000 unique beneficiaries per year (~20% of the Medicare fee-for-service population receiving chemotherapy for cancer).	2016-present

Notes: DSMT = Diabetes self-management training; CCM = chronic care management; CHWs= community health workers; PMPM = per member per month; * = Cigna has launched in 29 US states so far; PCMH = patient-centered medical homes; CCO = coordinated care organizations; CMS = centers for Medicare and Medicaid services

FOOTNOTES

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