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Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take during the COVID-19 Crisis and Beyond

Over the last several months, the pandemic has been a sobering reminder of the lack of strong community connections in much of our health care delivery and public health systems. The inequitable distribution of resources, unhealthy community conditions, and disproportionate burden of chronic illnesses have contributed to major racial and ethnic disparities in COVID-19 infections and deaths. And state contact tracing and COVID-19 testing efforts have failed to reach many vulnerable communities.[1, 2]

Community health workers (CHWs) have a record of success in addressing health disparities and improving health outcomes and they can play an important role in responding to public health crises.[3, 4] This invaluable workforce is needed now more than ever. In the immediate term, CHWs can play an essential role in states' COVID-19 response efforts, connecting health systems and public health agencies to the at-risk communities in which they are based.[5] They can take part in surveillance and contact tracing, provide community-level education, connect patients to health and social resources, and provide home-based services and supports to people who are in social isolation and quarantine.

Over the longer term, CHWs can reduce the burden of chronic illness and address the social determinants that have increased communities' vulnerability to COVID-19. CHWs can build communities' resilience to future infectious disease outbreaks by connecting patients to primary and specialty care and improving the overall quality of that care, particularly in remote and underserved areas where the capacity of the health care workforce and patients' access to the health system are limited.[6]

However, the lack of sustainable funding is a major barrier to expanding CHW programs and integrating CHWs into the health care system. Without sustainable funding, CHW programs are often limited both in longevity and in scope. In addition to short-term public health funding for COVID-19 response, Medicaid funding can address these challenges, especially within managed care or similar delivery systems where CHWs are funded using value-based payment mechanisms that reduce the financial risk for state agencies.

This report focuses on three key implementation steps for integrating CHWs into Medicaid and other state programs: 1. defining the workforce, 2. creating pathways for sustainable financing, and 3. maximizing impact.

As discussed below, states like Minnesota, New Mexico, and Oregon have experienced both challenges and successes in these three steps. Using these states as examples, this report proposes several key considerations for states at different stages of CHW integration. These considerations are intended to help them identify and overcome common barriers associated with integrating and operationalizing CHWs in Medicaid and other state health programs.

Medicaid and public health agencies that are looking to successfully integrate and sustainably fund CHWs must first accurately define this workforce for the purposes of recruitment and financing. In defining this workforce, states must recognize CHWs' expertise and unique capabilities.

Step 1: Defining the Workforce

What makes CHWs successful is their inherent experience, their unique role within the health care system, the broad scope of services they provide, and their expertise in identifying the needs of and connecting with at-risk communities. Because CHWs are trusted members of the communities they serve, they are able to bridge the gaps among the health care system, social services, and the people in their community, and they can help address the social factors that influence health. Medicaid and public health agencies that are looking to successfully integrate and sustainably fund CHWs must first accurately define this workforce for the purposes of recruitment and financing. In defining this workforce, states must recognize CHWs' expertise and unique capabilities.

One approach for identifying CHWs for recruitment and financing is to create a standardized process, such as certification, that clearly defines the workforce and recognizes their capabilities. In a Medicaid context, certification clearly defines which types of providers and services are Medicaid-reimbursable. These parameters for certification are often codified in state legislation and administered by a board or other partnership convened by the state health department or Medicaid agency. For Medicaid managed care organizations (MCOs), a standardized definition and scope of services for CHWs can facilitate recruitment and contracting.

As of this writing, at least 19 states have voluntary or mandatory certification processes for CHWs.[7] While certification is rarely a requirement for employment as a CHW in these states, it is often a prerequisite for direct Medicaid reimbursement or inclusion in Medicaid managed care networks.

States now have new flexibilities in the procurement and licensing of health care providers to expand their workforce in response to the pandemic.[8] States can take advantage of these new flexibilities to temporarily enroll CHWs as qualified Medicaid providers for COVID-19 response. For example, CMS is allowing states to use Section 1135 waivers to eliminate fees and in-state licensure requirements to streamline temporary provider enrollment in Medicaid.[9] Additionally, at the state level, Massachusetts has explicitly included CHWs in its definition of "health care providers" whose licensure (or certification) in another state qualifies them to provide services within their scope of practice in the state and is employing CHWs in its COVID-19 contact tracing program.[10, 11]

State Examples

MINNESOTA

Certification Process: Minnesota created a standard scope of practice that defines the roles of CHWs,[12] and then a statewide standardized curriculum for certification of CHWs through the Minnesota State College and Universities system. After developing this curriculum, Minnesota passed legislation that allowed for direct Medicaid reimbursement of certified CHWs.[13] CHWs must be certified to be reimbursed as qualified Medicaid providers.[14, 15]

Advantages: Early development of a CHW certification process created the infrastructure for Medicaid reimbursement of CHWs right after the state passed legislation for reimbursement of certified CHWs. The standardized certification program clearly lays out the roles and scope of practice of CHWs, which can help billing providers and MCOs understand the value of CHWs and what to expect when supervising and contracting them.

Limitations: Extensive training and its associated cost can prevent CHWs from becoming certified. For example, certification through qualified educational institutions is a 14 credit hour curriculum, which can span multiple semesters for part-time students.[16] The cost for prospective CHWs depends on the availability of financial aid and may be as high as $4,000.[17] In addition to the high costs, depending on colleges and universities for certification can be an especially high barrier for many CHWs who come from communities that have historically been denied access to higher education. CHWs must also pass a provider screening process and complete an enrollment application for reimbursement.[18] Processing enrollment can take anywhere from 30 days to six months.[19] Certified CHWs enroll as "non-pay to providers" and must operate under the supervision of a billing provider (such as doctors, dentists, advanced practice registered nurses [APRNs], clinics, Federally Qualified Health Centers [FQHCs], tribal health facilities, or hospitals) who submits the claim for Medicaid reimbursement either directly to the Medicaid agency or to their managed care organization (MCO).

OREGON

Certification Process: The state passed legislation[20] and implemented a Section 1115 waiver[21] to transform its Medicaid managed care delivery system by establishing community care organizations (CCOs). This legislation also requires that beneficiaries in CCOs have access to CHWs and requires the Oregon Health Authority to develop competency standards and training and education requirements for CHWs.[22]

Additional state legislation[23] established the Traditional Health Worker Commission within the Oregon Health Authority, which created a certification process for CHWs and the other traditional health workers in Oregon's CCOs.[24]

Advantages: The process for certification and the resulting defined scope of services can create a shared understanding of CHW capabilities and competencies to facilitate inclusion and compensation of CHWs in CCOs.

Limitations: The long and costly certification process can be a barrier to CHW participation. A lack of appropriate resources and staff to process certifications can cause delays.

NEW MEXICO

Certification Process: The New Mexico Department of Health's Office of Community Health Workers developed and now administers the state's certification process.[25] The state's Community Health Worker's Act[26] created a voluntary program for certification of CHWs, established in statute[27] and code[28] a definition of CHWs, created a board of certification that must include CHWs, and set requirements for certification.

Advantages: The scope of work is relatively broad and includes services related to community outreach; community and cultural liaison; system navigation, care coordination, and case management; home-based support; health promotion and health coaching; community assessment and mobilization; and clinical support.

Certification is voluntary, which means CHWs do not have to be certified for employment, including within MCOs.

The Office of Community Health Workers allows for a diversity of training programs, some of which offer financial aid. The office has also developed an online application and a no-cost online training.[29]

Limitations: Certified CHWs must provide services within the defined scope of work.[30] Requirements for CHW certification include a criminal history screening and an application fee, both of which may be barriers to participation.

Key Considerations for All States

- The standardized process for defining the CHW workforce should be a way for purchasers and payers to recognize and further develop the nationally recognized core competencies[31] that make CHWs effective in their unique clinical roles. This process should not limit CHWs' effectiveness by establishing a narrow scope of reimbursable services. Certification should account for the effective work CHWs are already doing in their communities and what they could be doing if they were sustainably funded. In other words, certification should be a formal recognition of CHWs' existing abilities.
- The certification process should facilitate CHW employment, not impede it. Therefore, it should be affordable and not overly complex or time-consuming. There should be flexibility for CHWs with skills and previous experience to be certified without completing an unnecessary or costly certification course. And CHWs should be able to complete certification courses both online and in person and should be able to attend on a flexible, part-time basis.
- CHWs should not be held responsible for the cost of certification, given the barrier that the cost of certification has posed for CHW program development in some states. Financial assistance should be readily available, and costs associated with certification should be covered by the CHW's employer or the certifying entity.
- CHWs should play a lead role in developing certification processes and other workforce standards. Entities that administer CHW certification should be comprised mainly of CHWs to ensure that the certification process appropriately defines and strengthens the CHW workforce. When setting up boards, commissions, or other certification entities, states should require that a substantial portion of members of these entities be CHWs. For example, the American Public Health Association recommends that at least half of the members of a governing board for CHW training standards and credentialing be made up of CHWs.[32]

Step 2: Creating Pathways for Sustainable Financing

A central question for states looking to integrate CHWs into their health systems is how to use Medicaid funds to support CHWs, and how to make that funding sustainable. As noted in Families USA's earlier analyses, most CHW programs that have been run by community health centers and community-based organizations have historically relied on either their own operating budgets or specific grants to fund CHW programs.[33] These sources of funding can be unpredictable, time-limited, and generally insufficient to sustain the full breadth of services and supports that CHWs can provide.[34]

There are multiple pathways for states to secure Medicaid funding for CHWs. States can pursue direct fee-for-service Medicaid reimbursement for CHWs, which requires states to designate CHWs as qualified providers for specific services. States can also use Medicaid managed care contracts to incentivize the inclusion of CHWs in a value-based payment and delivery system.[35, 36]

Compared to fee-for-service reimbursement, Medicaid managed care or value-based payment arrangements typically allow more flexibility to cover additional providers and services, which can include CHWs. These arrangements also provide a more predictable budget structure for a state agency that is considering CHWs. In a fee-for-service delivery system, Medicaid spending may increase to reimburse newly eligible providers and cover new benefits. But in a managed care delivery system, there are incentives to *shift* rather than increase spending to cover new providers and services that improve health outcomes and generate savings over time. CHWs can help managed care plans take advantage of these value-based incentives and generate savings for state Medicaid programs.

As noted on page 2, in response to the COVID-19 pandemic, CMS has made a number of disaster response flexibilities available to states, such as Medicaid state plan amendments, Section 1115 waivers, and Section 1135 waivers.[37, 38] States can use these new flexibilities to expeditiously allow CHWs to enroll as qualified Medicaid providers and expand their scope of Medicaid-reimbursable services, which include contact tracing, community outreach and education, care coordination, telehealth, home-based supports, and other activities.

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State Examples

MINNESOTA

Medicaid Funding Mechanisms: State legislation[39] and a Medicaid state plan amendment[40] allow for direct Medicaid reimbursement of certified CHWs for care coordination and patient education services.[41] MCOs that are established via Section 1115 waiver authority[42] are contractually required to cover CHW services.[43] CHWs are indirectly reimbursed for the select services defined in state law. The state pays MCOs a per-member, per-month capitated payment, which is used to pay CHWs who serve members of that MCO.

Successes: Legislation and the corresponding state plan amendment have enabled certified and supervised CHWs to be directly reimbursed for select services.

Challenges: Services such as case management, advocacy, and enrollment assistance are not Medicaid-reimbursable in the state, which significantly limits the capacity for sustainable financing. The limited scope of Medicaid-reimbursable services means fee-for-service reimbursement can be only a supplementary financing mechanism for CHWs. Most employers continue to rely on piecemeal funding, and the state continues to pursue other more comprehensive financing mechanisms, such as value-based payments.

OREGON

Medicaid Funding Mechanisms: There is no mechanism for direct Medicaid reimbursement of CHWs. Some CCOs, which are financed through a capitated payment structure, have managed care contracts that promote inclusion of CHWs.

CCOs can develop their own payment policies for CHWs. The Eastern Oregon Coordinated Care Organization created its own policy to reimburse certified CHWs on a fee-for-service basis.

As part of Oregon's Advanced Payment and Care Model, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive a value-based, per-member, per-month payment from Medicaid, which can be used to support CHWs on staff.

Successes: CCOs such as Jackson Care Connect,[44] the Eastern Oregon Coordinated Care Organization,[45] and Allcare[46] reportedly include CHWs in their networks. The Oregon Health Authority requires CCOs to have a plan for integrating and sustainably paying CHWs and requires CCOs to hire a traditional health worker liaison.[47] There is an opportunity to ensure inclusion and sustainable financing of CHWs within these CCOs, assuming the traditional health worker liaisons have expertise and decision-making powers.

Challenges: Deployment of CHWs in Oregon CCOs remains limited, and no single payment mechanism described above is sufficient to sustainably support CHWs as a significant part of care delivery.[48] Additionally, the scope of services CHWs provide within CCOs is limited.[49] CHWs within the Eastern Oregon Coordinated Care Organization are reimbursed only for patient education and self-management

training services and can only bill for up to two hours in a 24-hour period.

To address this challenge, advocates are pursuing value-based payment for CHWs, such as a per-member, per-month payment that covers a comprehensive scope of services and the associated costs of integration. Success will require buy-in and administrative capacity from both CCOs and state agencies.

As to the Advanced Payment and Care Model, using value-based payments to support CHWs is voluntary for both FQHCs and RHCs. While some health centers use these payments to support CHWs on staff, others use them minimally or not at all. Additionally, the Advanced Payment and Care Model's value-based payment methodology is designed only to finance CHWs as a modest extension of clinic staff, if at all.

New Mexico

Medicaid Funding Mechanisms: MCOs that are established via Section 1115 waiver authority are required to connect their members with CHWs and incorporate CHW integration costs into their capitated payments. MCOs in New Mexico have used their capitated payments to pay CHWs, either through an upfront per-member, per-month payment or through fee-for-service reimbursement.[50, 51] MCOs are required to annually increase the number of CHWs within their delivery systems and to increase the services they provide to members.[52, 53]

One of New Mexico's MCOs, Molina Health Care of New Mexico, negotiated with the state's Medicaid agency to establish a billing code for reimbursing CHWs as part of its capitated payment structure. Molina partnered with the University of New Mexico Health Sciences Center (UNM HSC), a major provider within its network, to recruit and train CHWs to provide care coordination and case management services. Molina also negotiated contracts with primary care providers in its network, including UNM HSC, that created a per-member, per-month payment for services provided by CHWs within its network.[54, 55, 56]

More recently, a newer MCO in New Mexico, Western Sky, has developed a set fee-per-encounter payment for members connected to CHWs in the University of New Mexico's emergency department. Western Sky's managed care contract with the New Mexico Human Services Department requires the MCO to make CHWs available to members for a variety of services and to ensure CHWs receive training.[57]

Successes: The per-member, per-month arrangement that Molina developed allowed CHWs to be paid for specialized services related to navigation and access, chronic disease management, and health literacy. Molina reported a $4 return on every $1 invested in CHW services.[58, 59] Evidence of this positive return on investment prompted the Medicaid agency to invest in developing and expanding this model, and to eventually require all Medicaid MCOs to hire CHWs to help manage high-risk patients, either directly or by contractual arrangements with providers in their networks.[60]

All Medicaid MCOs in New Mexico now include CHWs, and the number of CHWs included has increased annually. These successes resulted from the commitment and collaboration of three key stakeholder groups: MCOs (like Molina and Western Sky); community-based organizations and providers (like UNM HSC; and the state Medicaid agency.

Challenges: Molina is no longer operating a Medicaid managed care plan in New Mexico. However, it has expanded its successful CHW model to the other states where it is still operating Medicaid managed care plans.

Key Considerations for All States

- States have taken the approach of both requesting federal authorities for direct reimbursement and including provisions in their managed care contracts to require or incentivize the inclusion of CHWs. In practice, direct reimbursement for CHWs is often limited to a narrow scope of reimbursable services, whereas managed care contracts can use value-based payment arrangements to support CHWs in a more broadly defined role.
- Medicaid MCO contracts can play a key role in securing sustainable funding for CHWs within a predictable fiscal framework for a state's Medicaid budget. In states that are implementing CHW programs through Medicaid managed care, MCOs operationalize the inclusion of CHWs and supervising providers in their networks and can design their own payment methodologies to finance these providers. Demonstrating the value of CHWs in terms of the return on investment they generate for MCOs is one way to facilitate the development of a CHW program at scale.
- In several states, CHW programs have not gotten traction because of narrow service definitions and limited reimbursability. As described in detail below, to fulfill the potential impact of a robust CHW program on population health, Medicaid reimbursement for CHW services should encompass the full range of services that CHWs provide, including clinical services and nonclinical services that address social determinants of health.

Step 3: Maximizing Impact

Even in states that have mechanisms for financing CHWs, CHWs often have an overly narrow scope of practice or are limited in the billable services they can provide. This narrow role does not fit the interdisciplinary and community-based nature of CHWs, which is precisely what makes them so effective. A narrow scope of services can essentially undermine the progress of creating a CHW program in the first place.

Based on state experiences, because there are tight limits on what CHWs can bill for, there is a major risk of CHW programs never growing enough to improve population health or generate savings. This risk far outweighs any perceived risk of a "gold rush" of new CHWs taking advantage of a broad CHW scope of practice or billing framework and threatening Medicaid budgets. To maximize the impact of CHW programs, states should recognize and envision CHWs' many roles within the health system and broaden the scope of reimbursable services they provide.

One urgent setting for CHWs is in preparing for and responding to public health emergencies like COVID-19. For example, CHWs in West Africa played a key role in responding to the Ebola outbreak by providing community-level outreach, education, and surveillance related to the disease.[61, 62] In the United States, health systems should include CHWs in their emergency preparedness and response plans as outreach workers who can act at the community level to connect patients with services and to staff contact tracing and quarantining efforts.[63]

State Examples

Minnesota

Activation of CHWs: Fewer employers directly billed Medicaid for CHW services than expected following passage of the state legislation for Medicaid reimbursement. This slow uptake is possibly due to billing issues and the limited scope of reimbursable services. The state plan amendment to cover CHW services did not include a definition of care coordination that delineated these services from patient education in terms of procedure codes to use when billing Medicaid.[64] In addition, state guidance on submitting claims for reimbursement does not include specific codes for care coordination, only for self-management education and training.[65] And Medicaid reimbursement for CHW services is limited to patient education and therefore cannot cover all program costs or support full-time CHW employment.

Some CHW employers report that their return on investment from Medicaid reimbursement is high enough to hire CHWs only part-time. Other employers hire CHWs full-time but pay them out of their operating budgets to cover more comprehensive services, thereby avoiding the Medicaid billing procedures that provide only limited reimbursement.[66]

Billing for patient education services is limited to four half-hour units per day, and no more than 24 units per calendar month per recipient.[67] Early on, CHWs were unable to bill for patient education in large group settings,[68] which prompted the state to make available a new billing code for patient education in groups of more than eight people.[69]

Federally Qualified Health Centers were unable to take advantage of the new opportunity to bill Medicaid directly for CHW services because their upfront encounter rate was not adjusted to account for newly reimbursable CHW services, and FQHCs are prohibited from billing Medicaid directly for these CHW services.[70]

Recommendations: Using an alternative payment model, such as a per-member, per-month arrangement, could alleviate the long delays between claim submission and reimbursement that providers have reported.[71]

To improve fee-for-service reimbursement of CHWs, Minnesota's Medicaid program should expand the list of billing codes to include codes that can be submitted by certified CHWs for reimbursement of care coordination services, as intended in state law. These could include codes for health promotion, patient and family support, referral to social services, and transitional and chronic care management, among others.[72]

The state should maximize the duration and scope of reimbursable services for CHWs to include clinical support (such as screening and treatment for substance use disorders or infectious diseases like COVID-19), home-based services, and community-level interventions that address the social determinants of health. The state should pursue the necessary state plan amendments to make this possible.

Oregon

Activation of CHWs: CCOs are encouraged to provide flexible, health-related services such as care coordination, education, and housing and nutritional services.[73] But funding for these nonclinical health-related services remains a challenge due to CCOs' confusion about how to cover services not included in their capitation rates and for which there are no billing codes for fee-for-service reimbursement.[74] Existing billing codes do not capture the full range of services CHWs can provide, particularly nonclinical services for which no applicable codes exist.[75] However, current use of billing codes has been a good starting point for fee-for-service reimbursement of CHWs, and these codes may ultimately be helpful in developing a more comprehensive value-based payment model for CHWs.

Federally Qualified Health Centers and Rural Health Clinics that use value-based payments to employ CHWs do not pay CHWs for a comprehensive or standardized scope of services, which can result in limited roles for CHWs that do not align with their core competencies.

Recommendations: A value-based alternative payment model with a per-member, per-month payment could allow CHWs to provide all services within their capabilities. CCOs need guidance and support from the Oregon Health Authority to develop this payment model. The Oregon Health Authority, in coordination with the traditional health worker commission and CHW organizations such as the Oregon Community Health Workers Association, should provide appropriate resources (including applicable billing codes) and technical assistance to help CCOs create a payment model that allows CHWs to be paid for the full scope of services.

New Mexico

Activation of CHWs: The requirement that CHWs be included in MCOs and the positive return on investment in CHWs have allowed providers like UNM HSC to develop more initiatives to integrate and fund CHWs within New Mexico's Medicaid managed care system.[76]

In alignment with the relatively broad scope of work defined by the Department of Health,[77] CHWs in these initiatives could provide a variety of services that address patients' health and social needs. For example, in the CHW LEADs program, Medicaid MCOs refer high-risk patients to CHWs, who are paid on a per-member, per-month basis to assess and address these patients' health and social needs and connect them with additional services.[78, 79] Similarly, CHWs in the Community Access to Resources & Education (CARE NM) program receive a per-member, per-month payment from MCOs to locate hard-to-reach members, complete needs assessments, develop care plans to address health and social needs, connect members with primary care physicians, and educate members about appropriate utilization of the health system.[80]

Recommendations: Providers like the University of New Mexico Health Sciences Center, MCOs, and the state Medicaid agency should continue to share results of their CHW initiatives so other states can learn and replicate.

After securing Medicaid funding, states must continue to ensure that CHWs are fully integrated into care teams in roles that allow them to do the work that makes them so effective.

Key Considerations for All States

- Billing codes for CHW services are central to securing direct fee-for-service reimbursement for CHW services, even under managed care contracting arrangements. Therefore, state regulations and Medicaid state plan amendments must clearly detail the services that are Medicaid-reimbursable so that the billing codes associated with these services can be easily identified and used to pay for these services.
- At the same time, not all services and supports that CHWs provide can be captured in these billing codes. Indeed, for some services that CHWs provide in the field, no appropriate billing codes exist. One possible solution within a fee-for-service payment system is to create a relatively flexible billing category specifically for CHW services.
- Billing codes can also be useful outside the fee-for-service system for developing more global rates for value-based payment, such as per-member, per-month rates. Unlike fee-for-service reimbursement, which makes payment contingent on the volume of select services provided, global payment can give CHWs the flexibility to provide a broader scope of services that best meets their patients' needs.
- Alternative payment models, such as capitated payments to primary care providers, are a natural fit with CHW services and can support the comprehensive scope of services CHWs have the potential to provide.
- It is also important to account for the inclusion and financing of CHWs in FQHCs which are dedicated to serving low-income patients, most of whom are Medicaid-eligible. Medicaid payment for these health centers involves a unique prospective payment system that can complicate efforts to secure sustainable funding.

Lessons Learned

Medicaid can help states to fully fund and develop their CHW workforces during the COVID-19 response and beyond, but integrating CHWs in Medicaid is not without its challenges. States can begin by developing a process for defining the CHW workforce that recognizes CHWs' broad, flexible skillsets and facilitates their employment. CHWs should be at the center of states' certification processes, as is the case with other medical professionals. To secure sustainable financing for CHWs, state Medicaid departments can leverage state plan amendments, Section 1115 waivers, and/or managed care contracts to build payment methodologies that ensure that Medicaid funds a broad, fiscally predictable, clearly defined scope of services. After securing Medicaid funding, states must continue to ensure that CHWs are fully integrated into care teams in roles that allow them to do the work that makes them so effective.

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