

# Using Medicaid to Fund Community Health Workers in Community-Based Organizations

## Community Health Workers Promote Whole-Person Health

Community health workers (CHWs) are frontline public health workers who are trusted members of their communities or have an especially close understanding of the community served.<sup>1</sup> While their titles and roles vary, CHWs share a connection to communities via lived experience that, combined with their technical knowledge, makes them a critical workforce to advance equity. CHWs provide a wide range of services that increase access to culturally responsive care, address social determinants of health, and promote healthy behaviors.<sup>2</sup> State policymakers have the opportunity to expand access to evidence-based CHW services through [Medicaid](#), a public health insurance program for people with low incomes that covers 1 in 5 Americans.<sup>3</sup> When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to community-based organizations (CBOs) that may have greater difficulty receiving Medicaid funds than clinical entities. **This brief will describe why and how state policymakers should use Medicaid to cover CHW services in a way that is inclusive of CHWs employed by CBOs.**

## Community-Based CHWs Are Well-Situated to Serve Medicaid Beneficiaries

CHWs have been improving the health of communities for decades, and health care providers, payers, and patients can all greatly benefit from CHWs providing a wide range of services.<sup>4</sup> There is a significant [body of evidence](#) that CHW services promote positive outcomes for patients,<sup>5</sup> particularly when serving communities that are medically underserved or face social and economic barriers to health.<sup>6,7</sup> Studies have shown that CHW programs help manage chronic diseases,<sup>8,9,10,11</sup> improve mental health conditions,<sup>12</sup> lower health care costs,<sup>13</sup> and provide a return on investment.<sup>14</sup> The CHW workforce promotes health equity across a variety of settings and under different employers, including hospitals, managed care organizations (MCOs), community health centers, public health departments, and CBOs.<sup>15</sup> CHWs employed by health systems and MCOs typically focus on the patient population that receives care from the system, whereas CHWs employed in CBOs serve people who live in their vicinity and are not necessarily connected to a health system.

State Medicaid programs are increasingly covering services provided by CHWs for their demonstrated effectiveness in meeting the needs of low-income populations, which includes a large proportion of Medicaid-eligible individuals. In a recent survey of Medicaid budgets in all 50 states, more than half of states reported initiatives in place for Fiscal Year (FY) 2021 or planned for FY 2022 to expand their state's CHW workforce.<sup>16</sup> Because states administer their own Medicaid programs, they have considerable flexibility to define who is eligible, what benefits are available to enrollees, and how payments are structured. State Medicaid programs are not federally mandated to provide CHW services, but they can use several existing policy tools to authorize Medicaid payment for CHW services as an additional benefit. A summary of these tools can be found in the sidebar on the following page.

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## Medicaid Policies Should Include CHWs Employed by CBOs

As states make policy changes to cover CHW services through Medicaid, it is critical that Medicaid payments are accessible to CHWs working in a variety of employment arrangements, including CBOs. These organizations with critical links to the community often face barriers to accessing Medicaid financing for CHW services, as most CBOs do not have billing departments or a physician on staff. In managed care systems where MCOs contract with other organizations to provide services to Medicaid beneficiaries, CBOs may have limited ability to negotiate fair rates for CHW services. They also may struggle with a lack of capacity to ensure compliance with contract requirements.

### **CHWs employed by CBOs bring unique strengths that illustrate why it is so critical that Medicaid policy accommodate coverage of CHW services in community settings.**

First, CHW roles and corresponding services are often delivered across a combination of environments, including clinical and community settings. Many chronic and acute health issues are mitigated or exacerbated by elements of a person's culture and lived environment and thus require day-to-day management at the community level, in addition to clinical intervention. Both CBOs and the CHWs they employ have expertise in addressing, and often lived experience facing, the social, economic, and other factors that affect health outcomes.

Second, when embedded in CBOs, CHWs are able to work closely with communities that are historically and presently underserved, and in some cases mistreated, by established health care institutions. The longstanding relationships between CBOs and their communities situates CHWs to address the barriers to trust that result from historic and continuing inequities. CBO-based CHWs can serve as navigators for the complex and often confusing U.S. health and social systems, including government-sponsored assistance programs. As CBOs undertake critical health promotion, education, and literacy work, CHWs also serve as trusted messengers sharing health information. These unique strengths of community-based CHWs highlight the importance of ensuring that Medicaid policies are inclusive of CHWs in various employment settings.

There are states that have successfully addressed these barriers and paid CHWs to provide services while employed by CBOs. States can do this in both fee-for-service and managed care payment models,<sup>17</sup> using a variety of Medicaid policy tools. Some states are investing in infrastructure for CBOs to bill for reimbursement or setting up systems in which CBOs contract with health systems and managed care organizations. States are using different Medicaid policy tools to successfully support CHWs in both community and clinical settings, such as North Carolina's 1115 waiver,<sup>18</sup> Oregon's state plan amendment,<sup>19</sup> and Pennsylvania's managed care contract requirements.<sup>20</sup> On the following page are two additional examples of states that have covered CHW services through Medicaid in a way that is inclusive of CHWs in community settings.

## Selected state policy tools for Medicaid coverage of CHW services

### **STATE PLAN AMENDMENTS:**

An updated agreement between a state and the federal government describing how that state administers its Medicaid program. SPAs can be used to reimburse certain CHW services, including preventive services.

### **SECTION 1115 WAIVERS:**

Experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. States have used these waivers to temporarily reimburse for defined CHW services.

### **MANAGED CARE CONTRACTS:**

Contracts between a state Medicaid agency and Managed Care Organizations (MCOs) may include requirements for services covered and other factors related to CHWs.

### **OTHER HEALTH SYSTEM TRANSFORMATION EFFORTS:**

States are exploring a wide range of other health care delivery models to improve outcomes while reducing costs, and many of these models have potential to incorporate CHWs as a key member of the workforce.

• For more information,  
• see NACHW's 2020 report  
• [Sustainable Financing  
of Community Health  
Worker Employment.](#)

### **Example Policy 1: Ohio Requires Managed Care Organizations (MCOs) to Contract with CBOs**



Some states, including Ohio, require that their Medicaid MCOs offer CHW services and require that they do so in a way that is inclusive of CBOs. Ohio's Medicaid MCOs are required to contract with local organizations that engage multiple CHW employers to provide a structured, measurable and value-based care coordination according to a specific model, called the Pathways Community HUB model.<sup>21</sup> These local organizations, called Pathways Community HUBs, are able to contract directly with payers, shouldering much of the administrative and compliance burden, and provide payments to CBOs for CHW services in community settings without the CBOs needing an internal billing infrastructure. While the Pathways Community HUB model is one evidence-based model, states can use managed care contracts requirements to incentivize or mandate that MCOs contract with CBOs to provide covered CHW services.

### **Example Policy 2: South Dakota Includes CBOs in Fee-For-Service Reimbursement**



In 2019, South Dakota used a State Plan Amendment (SPA) to allow reimbursement of certain CHW services by Medicaid on a fee-for-service basis. To be reimbursed for these services, the CHWs' employer must be enrolled with South Dakota as a "CHW agency." This enrollment process allows CBOs and other community-based CHW employers to be reimbursed for CHW services to Medicaid beneficiaries, as long as they are covered services ordered by a physician or other provider according to a care plan. While there are still barriers to CBOs coordinating with clinical providers and billing South Dakota Medicaid, the ability for CBOs to enroll as Medicaid providers is a promising example of how states can include community organizations in fee-for-service reimbursement for CHW services.

## **Conclusion and Recommendations**

To meet the health needs of marginalized communities, CBO-based CHWs should be part of the solution for equitable health coverage through Medicaid. If CHWs employed in clinical settings can access Medicaid funding yet CHWs employed in CBOs cannot, there is a risk of over-medicalizing the CHW workforce (restricting their scopes to screening and referral to clinical care) and missing an opportunity to strengthen community supports and reach populations that are historically marginalized and excluded. Below is a short list of recommendations for state policymakers; additional recommendations will be provided in a forthcoming policy paper.

**States that do not currently incorporate CHWs into their Medicaid programs** should make policy changes to cover CHW services. Medicaid programs can seek federal approval through various policy tools to leverage Medicaid funds for CHW services. State legislatures can also require their Medicaid agencies to cover CHW services and can provide funding when necessary.

**States that have already incorporated CHWs into their Medicaid programs** should ensure that CBOs that employ CHWs are able to receive Medicaid funding. States can ensure that funding is accessible to CBOs in both fee-for-service (e.g., by allowing CBOs to enroll as Medicaid providers) and managed care payment models (e.g., by requiring or incentivizing MCOs to contract with CBOs to provide CHW services to beneficiaries in the community).

**States that have already incorporated CHWs into their Medicaid programs** should address barriers that CBOs face that make it challenging to bill Medicaid, contract with health systems for CHW services, or negotiate rates. States can do this by making targeted infrastructure investments in these CBOs or in regional or statewide hubs that provide the needed infrastructure to connect community-based employers of CHWs with health care providers. States can also remove policy barriers facing community-based CHWs, such as requirements that CHWs to join clinical care teams or be supervised by non-CHWs (e.g., physicians) for their employers to receive Medicaid funding.

**All states** should ensure CHW leadership and participation in policymaking decisions affecting the CHW workforce. State planning efforts should include professional organizations such as the National Association of Community Health Workers (NACHW), state networks of CHWs, and other stakeholders so that Medicaid agencies can best support the CHW workforce.

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**Authors:** Lucas Allen, MPH and Pranali Koradia, MD, MSPH

**Contributors:** Mariel Alvarado, Jenae Logan, and team members at PIH-US

For additional information, contact Lucas Allen, Advocacy Manager, Partners In Health United States at [llallen@pih.org](mailto:llallen@pih.org)

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## ENDNOTES

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- 1 American Public Health Association. Community Health Workers. Accessed at: <https://www.apha.org/apha-communities/member-sections/community-health-workers>
- 2 The CHW Core Consensus (C3) Project has articulated 10 core roles that CHWs serve. For more information, see: <https://www.c3project.org/roles-competencies>
- 3 Kaiser Family Foundation. "Health Insurance Coverage of the Total Population." Accessed December 14, 2022. <https://www.kff.org/other/state-indicator/total-population/>
- 4 For more information on how CHWs are well-situated to serve Medicaid beneficiaries and how state Medicaid programs can best support a wide range of CHW services, see the companion policy brief "Using Medicaid to Fund a Wide Range of Community Health Worker Services." See: <https://www.pih.org/sites/default/files/lc/LT-CHW-BroadScope.pdf>
- 5 Community Health Workers: Evidence of Their Effectiveness. Association of State and Territorial Health Officials and National Association of Community Health Workers. Accessed at: <https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf>
- 6 Shreya Kangovi, et al. "Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial." American Journal of Public Health. 107 no.10 (October 2017): pp. 1660-1667. <https://pubmed.ncbi.nlm.nih.gov/28817334/>
- 7 Marshall H. Chin, et al. "Interventions to Reduce Racial and Ethnic Disparities in Health Care." Medical Care Research and Review. 65. Supp. 5. (October 2007): pp: 7S-28S. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2366039/>
- 8 Jonathan D. Campbell, et al. "Community Health Worker Home Visits for Medicaid-Enrolled Children With Asthma: Effects on Asthma Outcomes and Costs." American Journal of Public Health. 105 no.11 (November 2015): pp. 2366-2372. <https://doi.org/10.2105/AJPH.2015.302685>
- 9 Jeannette M. Beasley, et al. "A Community Health Worker-Led Intervention to Improve Blood Pressure Control in an Immigrant Community With Comorbid Diabetes: Data From Two Randomized, Controlled Trials Conducted in 2011-2019." American Journal of Public Health. 111 no.6 (June 2021): pp.1040-1044. <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2021.306216?journalCode=ajph>
- 10 Walter Palmas, et al. "Community Health Worker Interventions to Improve Glycemic Control in People with Diabetes: A Systematic Review and Meta-Analysis." Journal of General Internal Medicine. 30 no.7 (July 2015): pp. 1004-12. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471021/>
- 11 Kyounghee Kim, et al. "Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review." American Journal of Public Health. 106 no.4 (April 2016): pp. e3-e28. <https://pubmed.ncbi.nlm.nih.gov/26890177/>
- 12 Addie Weaver and Adrienne Lapidus. "Mental Health Interventions with Community Health Workers in the United States: A Systematic Review." Journal of Health Care for the Poor and Underserved. 29 no.1 (February 2018): pp. 159-180. <https://pubmed.ncbi.nlm.nih.gov/29503292/>
- 13 RTI International. "Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative: Third Annual Report." (Center for Medicaid and Medicare Services, 2018). Accessed December 14, 2022. <https://downloads.cms.gov/files/cmmti/hcia-metaanalysisthirdannualrpt.pdf>
- 14 Shreya Kangovi, et al. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment." Health Affairs. 39 no.2 (February 2020): pp. 207-213. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981>
- 15 Community-based organization is a broad, umbrella term used to represent a variety of non-governmental, not-for-profit organizations. CBOs are autonomous, organized to some degree, and work for and with a given constituency or community. A variety of organizations can fall under the umbrella term CBO, including non-profit organizations, NGOs, civil society organizations, neighborhood groups, community centers, recreational clubs, special interest/identity groups and alliances, youth/education centers, third sector organizations, places of worship, mutual aid groups, social service agencies, and others. For the purposes of this document, we consider CBOs all organizations that are embedded in, composed of, and fill critical needs for their communities.
- 16 Kathleen Gifford, et al. "States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022." Kaiser Family Foundation. October 27, 2021. Accessed December 14, 2022. <https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-social-determinants-of-health/>
- 17 Under the fee-for-service model, the state pays providers for each covered service that they provide for a Medicaid beneficiary. Under managed care models, the state pays a set capitated payment (often calculated per-member, per-month) to a managed care plan in exchange for the plan providing all Medicaid services that are included in the plan's contract with the state. While Medicaid programs historically used fee-for-service, states have increasingly adopted managed care models and the majority of Medicaid beneficiaries are now in managed care plans. For more information, see <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>
- 18 Danielle Garrett and Siena Ruggeri. "Addressing Social Needs Through Medicaid: What Consumer Advocates Can Learn from North Carolina and Oregon." Center for Consumer Engagement in Health Innovation. February 2020. Accessed December 14, 2022. <https://www.healthinnovation.org/resources/publications/body/Addressing-Social-Needs-Through-Medicaid-NC-and-OR.pdf>
- 19 Danielle Garrett and Siena Ruggeri. "Addressing Social Needs Through Medicaid: What Consumer Advocates Can Learn from North Carolina and Oregon." Center for Consumer Engagement in Health Innovation. February 2020. Accessed December 14, 2022. <https://www.healthinnovation.org/resources/publications/body/Addressing-Social-Needs-Through-Medicaid-NC-and-OR.pdf>
- 20 For more information on Pennsylvania's MCO contract requirements, see <https://www.dhs.pa.gov/HealthInnovation/Documents/PA%20CBO%20Training%20Module.pdf> and <https://www.dhs.pa.gov/HealthInnovation/Documents/12.14.20%20CBO%20FAQ.pdf>
- 21 For more information, see: <https://www.pchi-hub.org/>