Partners In Health
UNITED STATES

Medicaid Financing for Community Health Workers

May 2023

Executive Summary

Community health workers (CHWs) are a key workforce in promoting health equity and wellbeing by connecting communities to health and social services, being trusted messengers in their communities, and accompanying individuals as they navigate their health needs and a complicated health system. While CHWs in the U.S. have been inadequately supported and underfunded, state and federal policymakers increasingly recognize the critical role CHWs can play in facilitating coordinated, whole-person care. Many states have begun to integrate CHWs into their Medicaid programs, using existing policy tools to fund CHW services. It is critical that states do this in a way that does not co-opt, but rather supports the existing CHW workforce and builds on the work CHWs have been doing for decades. As states consider policy changes to integrate CHWs into Medicaid, this paper outlines five key principles that every state can follow to support CHWs and promote health equity:

1. **Cover a wide range of CHW services**
   To maximize CHWs' impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.

2. **Ensure that CHWs employed by community-based organizations (CBOs) are included**
   When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers.

3. **Promote CHW leadership and participation in policy decision-making processes**
   State policymakers should build authentic partnerships with CHWs, CHW professional organizations, and national CHW leaders to ensure that policy changes support the workforce.

4. **Adopt payment models that value CHWs**
   Medicaid payment models should properly value CHWs and provide adequate financing to support CHWs in providing covered services.

5. **Support and grow the CHW workforce**
   In Medicaid policies and beyond, states should work alongside CHW leaders to effectively implement Medicaid financing policy and invest in strengthening and growing the CHW workforce.

This paper provides examples of states that are following these principles and lists specific recommendations for state policymakers. These five principles, and the examples of states that are putting them into practice, can serve as a guide for state policymakers to best support CHWs through Medicaid financing and promote health equity.

Introduction: CHWs Promote Whole-Person Health

The U.S. health system is inequitable, fragmented, and focused on high-cost hospital care to the detriment of public and community health. Compared to other high-income countries, the U.S. spends more on health care as a share of the economy yet has the lowest life expectancy and highest chronic disease burden.[1] Many factors contribute to these poor outcomes, including inequitable access to health care and social determinants of health (SDOH), which are the conditions in which people are born, grow, work, live, and age, and are the wider set of forces and systems shaping the conditions of daily life.[2] These SDOH affect 80% or more of a person's health outcomes,[3] but remain neglected in health care delivery and financing. The historical and ongoing realities of structural racism in the U.S. manifest in these social determinants of health, and in racial and ethnic health inequities found in the broader health system. These challenges illustrate the need for a health system that is better able to provide coordinated, whole-person care that can promote wellness and connect patients not only to health care services, but also to social services that can improve health.

Community health workers (CHWs) play an essential role in forming a community-centered health system that can better address SDOH and health inequities. Community Health Worker (CHW) is an umbrella term for a frontline public health worker who is part of the community-based workforce and whose work encompasses a variety of public health and social service functions. The American Public Health Association (APHA) defines CHW as:

> "... **a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.** This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[4]

CHWs can include a wide range of public health roles, including *promotoras/es de salud*, community health representatives, peer health educators, and many more. CHWs' identity, community knowledge, and training allow them to be trusted messengers and accompany individuals, particularly those most deeply impacted by systemic injustices, as they navigate their health needs and a complicated health system. Through their work in bridging people to clinical care, accompanying individuals in their health care journey, advocating for their community's health needs, and matching individuals to critical social supports, CHWs are integral to achieving equitable, whole-person, community-based care in a complicated and fragmented landscape.

CHWs and Accompaniment

Partner In Health's (PIH) approach to working with CHWs is rooted in the principles of "accompaniment," which is both a philosophical stance and a rubric for programmatic design. By committing to "walk alongside" those we serve, PIH programs have been able to invest in interventions that have achieved some of the most dramatic improvements in equitable outcomes in global health delivery. CHWs are at the center of PIH's work in the U.S. and globally, and serve as "the backbone of our work." Starting in Haiti in the 1980's,[5] PIH has since expanded its CHW work across the globe to include over 11,000 CHW colleagues across more than 10 countries. For example, by improving health systems while also investing in social supports such as food, transport and housing, PIH programs have worked to achieve some of the highest rates of clinical control for diabetes and hypertension in Southern Mexico, significantly higher survival and retention rates for HIV patients in Malawi, a notable uptake of recommended COVID-19 testing and vaccination in a migrant worker community in Immokalee, Florida,[6] and and some of the highest cure rates in drug-resistant tuberculosis in multiple countries, from Peru to Lesotho.

Recognizing the need to expand and scale such services in order to achieve universal health care, PIH has been increasingly transitioning from a disease-specific approach to a household model. This allows CHWs to visit assigned houses regularly, and service as a bridge for every person in that house to services that will help them improve their health. This global experience illustrates why it is critical to support CHWs in the U.S. in providing a wide range of services beyond the four walls of the clinic.

CHWs have been a proven force in reducing health burdens and narrowing gaps in health outcomes, both in the United States and globally. During the COVID-19 pandemic, they played a critical role in the emergency response, assisting with local care resource coordination and contact tracing, and functioning as trusted messengers to slow the spread of misinformation and increase vaccine uptake—particularly in under-resourced communities and communities of color.[7,8,9] In the U.S., numerous papers have documented their effectiveness in improving health outcomes, from chronic disease management,[10] including diabetes control,[11] to preventing inpatient readmission.[12] Studies have shown that CHW programs help manage and improve health conditions including asthma,[13] hypertension,[14] HIV,[15] diabetes,[16] mental health conditions,[17] and chronic diseases.[18] One randomized control trial found that CHWs in an outpatient setting increased likelihood of obtaining primary care, improved mental health outcomes, and reduced likelihood of multiple 30-day readmissions from 40% to 15.2% amongst the patients they engaged.[19]

Studies have also demonstrated that CHWs can promote access to preventive care,[20] reduce health inequities,[21,22] lower health care costs[23] and provide a return on investment (ROI).[24] For example, the Arkansas "Community Connectors" CHW program showed a 3:1 net savings on total cost of care for participants[25] and in Nevada, hiring CHWs showed fewer acute admissions, readmissions, emergency department and urgent care visits, while showing an ROI of approximately 2:1 net savings per patient.[26] Another study in Pennsylvania showed savings of as much as $2.47 in Medicaid savings for every dollar spent.[27] These models likely underestimate the true impact of CHWs, because many of the contributions that CHWs make, especially in addressing community-level issues, are not captured by traditional ROI models.

CHW Financing Landscape

CHWs are a critical workforce to help provide coordinated, high-quality health care and social services for communities that need them most. The U.S. Bureau of Labor Statistics estimates that there are 61,000 CHWs in the U.S., but this is likely an underestimate of the true CHW workforce due to the wide range of roles and job titles that CHWs may have.[28] CHWs are employed by hospitals, Federally Qualified Health Centers (FQHCs), community-based organizations (CBOs),[29] and other individual or community services providers.

The COVID-19 pandemic has further highlighted the critical role that CHWs can play in promoting public health and addressing social needs.[30] CHWs have provided a wide range of services to communities throughout the pandemic, including contact tracing, community outreach, education, care coordination, and connections to social supports.[31,32] This critical role was recognized by President Joe Biden who made a campaign pledge to add 150,000 CHWs to the workforce, and has taken steps to pursue this goal.[33] Significant federal investments through the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and the American Rescue Plan Act of 2021 have enabled state and local governments to train and hire CHWs. For example, the U.S. Centers for Disease Control and Prevention (CDC) has released grant opportunities to support the training and deployment of CHWs, particularly for COVID-19 response efforts,[34] and the Health Resources and Services Administration (HRSA) launched the Community Health Worker Training Program with $226.5 million in funds available to train 13,000 CHWs.[35] Outside of these funding opportunities, some state and local health departments use other grant funds or portions of their core operating budget to pay CHWs.

While critical, these funding opportunities are time-limited and do not represent the sustained investments needed to adequately support the critical work of CHWs. As policymakers dedicate fewer federal resources to COVID-19 response, there is a risk that successful, community-led CHW programs will run out of funds—a boom-and-bust pattern that has weakened the CHW workforce in the past.[36] Many states are already seeing pandemic-related CHW grants end, resulting in layoffs of CHWs who have cultivated valuable relationships and trust with communities. While exemplar CHW programs around the world often use sustained, direct government funding to train and hire CHWs,[37] the fractured and siloed nature of the U.S. health care system presents a barrier to financing CHW programs.

CHWs are Well-Situated to Serve Medicaid Beneficiaries

Recognizing the value and expertise of CHWs, policymakers are increasingly supplementing these time-limited funds with more sustainable, long-term funding streams that don't require entities to regularly apply for funds. The most prominent current trend in CHW funding in the U.S. is a movement towards covering CHW services through Medicaid. Medicaid is a public health insurance program that provides coverage for more than 1 in 5 Americans,[38] including eligible adults with low incomes, children, pregnant women, elderly adults, and people with disabilities. While CHWs services can be beneficial to everyone regardless of socioeconomic status, CHWs have historically been effective at meeting the needs of vulnerable populations that are more likely to be covered by Medicaid. As members of the community with shared lived experiences, CHWs often reflect the Medicaid patient population more closely than traditional health care providers.

Medicaid was established in 1965 as a state-federal partnership, allowing states to manage their own Medicaid programs. The federal government, through the Centers for Medicare & Medicaid Services (CMS), reimburses states to fund a significant portion of Medicaid services and provides oversight and parameters for how the states manage their programs. Because states administer their own Medicaid programs, they have considerable flexibility within these federal parameters to define who is eligible, what benefits are available to enrollees, and how payments are structured. CHW services are an optional benefit that state Medicaid programs are not federally mandated to provide, but there are several policy tools states can use to authorize Medicaid payment for CHW services.

Financing CHWs through Medicaid can control costs while improving care coordination, providing culturally responsive care, facilitating connections to services, and working towards other outcomes to promote health equity. CHWs can also support the movement to better address SDOH in Medicaid.[39] Over the past two decades, CMS has expanded the types of CHW services that states can cover through Medicaid[40] and has approved numerous state policies to cover CHW services. Under the Biden Administration, CMS' strategic vision for Medicaid includes 3 focus areas that can be advanced through greater involvement of CHWs: (1) coverage and access, (2) equity, and (3) innovation and whole-person care.[41] While the federal government and CMS can still do better to support, encourage, and remove barriers for states to cover CHW services through Medicaid, there is much that states can do under existing legal authorities.

> *"CHWs are a critical workforce to help provide coordinated, high-quality health care and social services for communities that need them most."*

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.

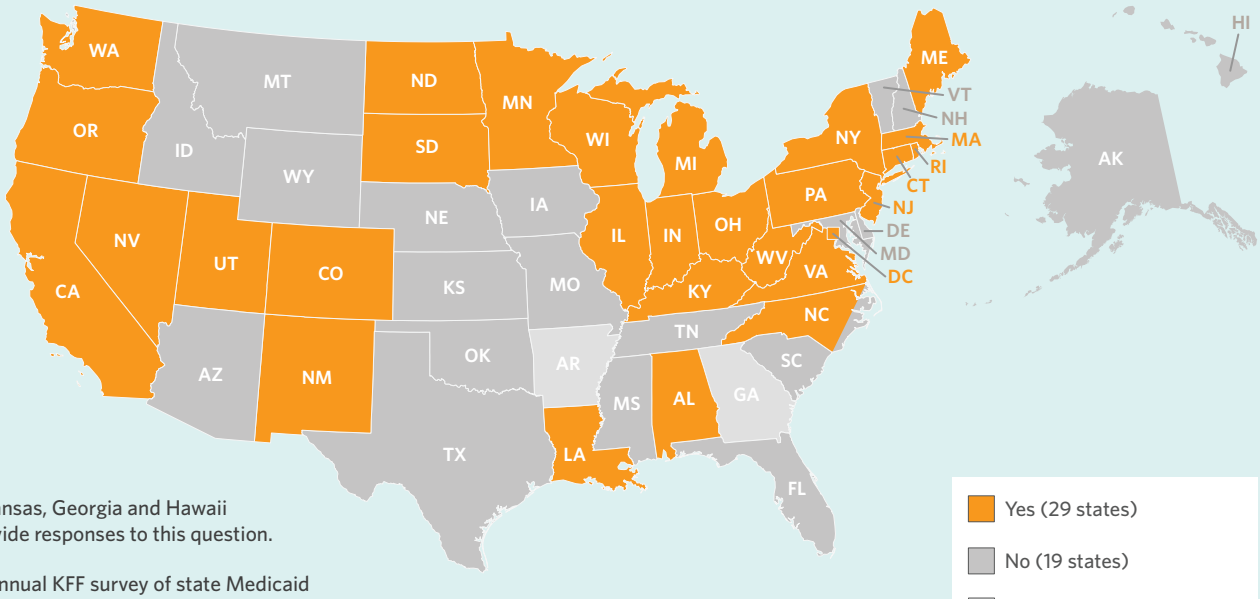
Managed Care Contracts: Contracts between a state Medicaid agency and Managed Care Organizations (MCOs) may include requirements for services covered and other factors related to CHWs.

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.

According to a national KFF survey, as of July 1, 2022, 29 of 48 states reported allowing Medicaid payment for services provided by CHWs.[42] State policymakers can use various policy tools to expand access to CHW services through legislative and/or executive action. State legislatures may pass legislation instructing the state Medicaid agency to make a policy change, and may include funding in the state budget to expand Medicaid coverage of CHW services. In some states, governors have used executive orders to direct the Medicaid agency to propose a State Plan Amendment (SPA) or other policy change to integrate CHWs. In other cases, the Medicaid agency can work across the state government to implement a policy change without a legislative directive.

States that Allow Medicaid Payment for Services Provided by Community Health Workers (CHWs) as of July 1, 2022 [43]



NOTE: Arkansas, Georgia and Hawaii did not provide responses to this question.

SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022.

Covering CHW services through Medicaid is not the only solution to sustainable financing for CHWs, and should not be approached as the sole source of funding for this workforce. Medicaid has limitations as a funding source for CHWs, given its historic focus on "medically necessary" clinical care, obstacles for paying for care coordination, limitations on providing room and board for beneficiaries, and status as a program for individuals, not communities. CHWs have been working in many sectors outside of health care and services that fit cleanly into Medicaid, and some CHWs and their employers may not be interested in participating in Medicaid. Since CHWs have a long history of working outside of the traditional health system, integration into Medicaid could risk moving CHWs further from their roots as agents of community transformation.[44] Policy choices in states that are integrating CHWs into Medicaid financing can have an impact on how CHWs do their work, including what services are covered and the settings in which those services are delivered. Medicaid financing must supplement, but not supplant, other sources of funding for CHWs to allow for non-Medicaid covered services to continue in communities that need them.

This paper highlights five key principles that every state can follow to support Medicaid financing for CHWs and promote health equity while reducing possible unintended consequences, and it offers recommendations for state policymakers. Each principle is illustrated by examples where states are putting that principle into practice in some way. The principles, recommendations, and examples below can serve as a guide for state policymakers to provide CHW services to Medicaid beneficiaries in a community-driven and equity-focused manner that values the broad roles CHWs play.

1 Cover a Wide Range of CHW Services

To maximize CHWs' impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.

Why this is important:

CHWs do not provide clinical services, but perform a wide breadth of activities that can address a patient's social determinants of health and improve health outcomes. The CHW Core Consensus (C3) Project[45] developed a list of ten core CHW roles illustrating the scope of practice (see sidebar). States funding CHW services through Medicaid have wide latitude to determine which services will be covered, but most states only cover a limited list of services.

When integrating CHWs into Medicaid or other health care funding streams, there is a tendency to limit covered services to only the most clinical-adjacent services. For example, Minnesota was the first state to allow direct Medicaid reimbursement for CHW services, using a state plan amendment (SPA) approved in 2008. Under this SPA, CHWs are paid for "diagnosis-related patient education and self-management"[46] under the supervision of a licensed medical professional, which narrows the scope of CHWs to patient education and leaves out several CHW activities that affect whole-person health, such as resource navigation or care coordination.

Narrower approaches omit several services that positively impact Medicaid beneficiaries and that CHWs who, with a shared lived experience and close relationship to the community, are uniquely positioned to provide. For example, when helping someone with their diabetes care, CHWs can provide more than education on medication management—they can accompany patients to help choose culturally appropriate low-sugar foods at the grocery store or even cook with patients. This accompaniment of patients on their journey to wellbeing can increase the likelihood of the patient making long-term changes to their lifestyle but may not be covered by Medicaid programs that restrict CHWs to more limited scopes of work. The effectiveness of CHWs throughout the COVID-19 pandemic response, providing contact tracing, community outreach, education, care coordination, and connections to social supports, shows just how critical this breadth of services is.[47,48]

As policymakers integrate CHWs into their Medicaid programs, they should preserve what makes CHWs unique and effective, and resist making them an extension of clinic-based providers funded by Medicaid. By covering a wide range of CHW services, state Medicaid programs can more effectively address social determinants of health and health inequities, positioning CHWs to ensure treatment of the whole person and advance community-level health, rather than limiting them to condition-specific activities for individual patients.

C3 Project Core CHW Roles

- Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems
- Providing Culturally Appropriate Health Education and Information
- Care Coordination, Case Management, and System Navigation
- Providing Coaching and Social Support
- Advocating for Individuals and Communities
- Building Individual and Community Capacity
- Providing Direct Service
- Implementing Individual and Community Assessments
- Conducting Outreach
- Participating in Evaluation and Research

How states can cover a wide range of CHW services through Medicaid:

State policymakers can better support CHWs to serve patients and communities by maximizing the range of services covered, using the C3 Project Core CHW roles as a guide. States can expand the list of covered CHW services in both fee-for-service and managed care payment models,[49] though fee-for-service models are likely to be more constrained when billing codes cannot account for all CHW activities. In addition to defining covered services broadly, states can allow coverage for collateral services and define "medical necessity" broadly so that CHWs can provide a wider range of services. Collateral services are activities that benefit a specific beneficiary but are not performed in their presence. For example, a CHW may help a beneficiary arrange transportation to a doctor's appointment over the phone. Medical necessity is used to determine whether CHW services (or other services) are necessary to be covered by Medicaid. Narrow definitions of medical necessity can restrict CHWs to services that address a specific medical condition, whereas broader definitions can allow CHWs to promote wellbeing through additional health promotion, coaching, and advocacy activities. Moreover, a letter to State Health Officers from CMS on January 6, 2023, clarifies guidelines to bill "In Lieu of Services" for activities that are outside the medical scope of practice, but are deemed medically necessary and could qualify for a State Plan Amendment, among other requirements.[50] States are using different Medicaid policy tools to successfully expand the scope of services CHWs can provide through Medicaid, such as Oregon's 1115 waiver,[51] California's SPA,[52] Michigan's MCO contract requirements,[53] and the two examples highlighted below.

Example Policy 1: New Mexico MCO Contract Requirements

New Mexico's Medicaid program utilizes managed care contract requirements to promote payments to CHWs for a broad array of services. The state's contracts with MCOs require that they directly hire or contract with CHWs to provide services to a gradually increasing percentage of their members (now 3%). The plans pay CHWs for "care coordination activities," which include health education delivered in a culturally responsive manner, informal counseling, navigation, and translation services, among others.[54] The contracts establish a minimum set of CHW services MCOs must cover, but also provides flexibility for MCOs to provide additional services. Evidence suggests that after incorporating CHWs with a braod scope of activities into management plans, plans see reduced costs, reduced use of ambulatory services, and improved access to preventive and social services.[55]

Example Policy 2: Rhode Island SPA Covers Wide Range of CHW Services

Rhode Island submitted a SPA to CMS in 2021 to add CHW services to Medicaid and received approval in 2022.[56] Due to this SPA, Rhode Island Medicaid now covers a wide range of CHW services, including health promotion and coaching, health education and training, health system navigation and resource coordination services, and care planning. In setting up the payment methodology for these covered services, the SPA clarifies that service time may include direct contact with a beneficiary or collateral services delivered on behalf of an individual beneficiary. The state's definition of medical necessity for CHW services is broad, including clinical indicators, evidence of social drivers of health needs, and barriers to access, such as "beneficiary expressed need for [CHW] support."[57] The wide range of covered CHW services in Rhode Island's SPA, as well as the state's inclusion of collateral services and broad medical necessity, can serve as an example for other states on how to cover a wide range of CHW services.

> *As policymakers integrate CHWs into their Medicaid programs, they should preserve what makes CHWs unique and effective, and resist making them an extension of clinic-based providers funded by Medicaid.*

Recommendations:

- All states should cover the broad range of CHW services, aligned with the C3 Project Core CHW roles.
  - States using managed care models can cover a wider range of CHW services in Medicaid contracts with MCOs, and other value-based payment models can further advance this goal.
  - States using fee-for-service models should reimburse as many CHW services as possible but will face limitations due to a lack of billing codes for a comprehensive set of CHW activities.
- States should define "medical necessity" for CHW services broadly, so that CHWs are able to spend time equitably addressing needs and goals identified by the beneficiary, rather than being constrained to clinic-related services to address a specific medical condition.
- States should cover collateral services, and not restrict covered services or billable service time to direct services in the physical presence of the beneficiary.
- States should ensure that Medicaid policy language and any state CHW certification (if applicable) allows for CHWs to maintain broad scope of practice, aligned with the C3 Project.

BELOW: Promotoras Victoriosas program members Alicia Cortez (left) and Argentina Sales (right) survey a community member in New Bedford to assess the health care needs and barriers to accessing quality health care. *Photo by Zack DeClerck / PIH*

2 Ensure that CHWs Employed by CBOs are Included in Medicaid Financing

When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers.

Why this is important:

A strength of the CHW workforce is the ability to promote health equity across a variety of settings and under different employers, including organizations that are trusted and close to the community. CHWs employed by health systems and MCOs typically focus on the patient population that gets their care from the system, whereas CHWs employed by CBOs serve people who live in their vicinity and are not necessarily connected to a health system.[58]

CBOs often face barriers to accessing Medicaid financing for CHW services, as most CBOs do not have billing infrastructure 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 lived environment, and thus require close management at the community level, in addition to the prescribed clinical interventions. CHWs working through CBOs have a deep understanding of the contextual factors and expertise in addressing these health issues at the community level, and often also have lived experience navigating these 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 community's position 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.

How states can include CHWs employed by CBOs in Medicaid financing:

There are states that have successfully addressed these barriers around payment structures and capacity issues and have paid CHWs to provide services while employed by CBOs in both fee-for-service and managed care payment models.[59] Some states are making investments to support the technological infrastructure for CBOs to bill for reimbursement, and others are setting up systems where CBOs can contract with health systems and managed care organizations. States are using different Medicaid policy tools to successfully finance CHWs in this way in both community and clinical settings, including North Carolina's 1115 waiver,[60] Oregon's SPA,[61] and Pennsylvania's MCO contract requirements.[62,63] Below are two additional examples of states that have covered CHW services through Medicaid in a manner that is inclusive of CHWs in community settings.

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

Ohio requires that Medicaid MCOs offer CHW services in a way that is inclusive of CBOs using the Pathways Community HUB (PCH) model.[64] Ohio's MCOs are required to contract with PCHs, which engage multiple CBOs to provide structured, measurable and value-based care coordination.[65] These local hubs are able to contract directly with payers, including MCOs, shouldering much of the administrative and compliance burden and also provide the payments to CBOs for CHW services without CBOs needing an internal billing infrastructure. While requiring the use of an evidence-based implementation model is one avenue to include community organizations, states can also use managed care contract requirements to incentivize or mandate that MCOs contract with CBOs to provide 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."[66] 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 another 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.

Recommendations:

- States should ensure that CBOs that employ CHWs are able to receive Medicaid funding for CHW services. 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 should address barriers that make it challenging for CBOs 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 join clinical care teams, or be supervised by non-CHWs (e.g., physicians) for their employers to receive Medicaid funding.
- States should work closely with CHWs and CBOs to understand and address barriers to Medicaid financing. States can also work with nonprofits to provide technical assistance and support to CBOs. Organizations such as **CHW Solutions** in Minnesota can support CBOs and other CHW employers with billing and other administrative issues.
- States should ensure that CHW services outside the four walls of the clinic that improve health outcomes for Medicaid enrollees are covered by Medicaid.

3 Promote CHW Leadership and Participation in Policy Decision-Making Processes

State policymakers should build authentic partnerships with CHWs, CHW professional organizations, and national CHW leaders to ensure that policy changes support the workforce.

Why this is important:

CHWs have been improving the health of communities for decades, and bring unique, trusting relationships with the communities where they live and serve. Their shared experiences with community members, skills and knowledge, and understanding of what works at a local level make them a key partner for any policymaker interested in promoting healthy communities. It is important for any state policymaker to partner with CHWs to understand the local context and the needs of communities, and to respect the self-determination of the workforce. Building partnerships with CHWs and providing continual opportunities for input throughout the policy life cycle is critical to successfully integrate CHWs into a state's Medicaid program in a way that is supportive of CHWs.

Centering CHW voices in policy discussions on Medicaid financing is a crucial step toward implementing all other principles discussed in this paper. Working closely with CHWs, CHW allies, and CHW employers in the state can help ensure that Medicaid financing can support the full breadth of CHW services and be inclusive of CHWs based in CBOs. A state's CHW workforce may include diverse occupational titles that identify with the umbrella term of CHW, such as *promotoras/es de salud* and community health representatives. While these titles share much in common, such as a close relationship with their communities, they may also have distinct needs that are important for policymakers to understand, and can best be informed by the workforce themselves.

How states can include CHWs in the policy decision making process:

Policymakers should develop relationships with CHW leaders in their state, including through their state and regional CHW networks. Many states have a CHW network, association, or alliance that convenes CHWs to support the profession and the workforce. The National Association of Community Health Workers (NACHW) maintains a list of CHW networks on its website,[67] and also provides briefings to state-level CHW groups and other stakeholders on the basics of Medicaid policy. The structure and age of these networks varies by state. State policymakers should authentically partner with these networks, such as by including them in community needs assessment processes, creating advisory boards, or writing these associations into the training process for CHWs, and seek opportunities to support them.

Certain practices that have been normalized in state policymaking can unintentionally exclude voices that are critical for policies affecting CHWs. For example, holding listening sessions only during the work day can exclude CHWs working during those times. Posting a request for information or call for input on a state website without further outreach to CHW groups is likely to miss valuable responses. Without designated membership slots, CHWs or CBOs may be underrepresented in advisory committees in favor of stakeholders with more resources. Policymakers should be vigilant about how these practices, communications, and assumptions might exclude key voices and should strive to create more inclusive processes. Including CHWs in the policy decision making process is more than simply inviting input or holding a listening session; it requires building equal partnerships with CHW leaders and centering their input in decisions concerning the workforce. States that build these partnerships authentically will have greater success in implementing policy changes.

A few states have convened CHW advisory councils or other similar bodies to develop recommendations for policymakers. The National Academy for State Health Policy convenes a CHW State Policy Network featuring CHW leaders, professional association representatives, and state policymakers to share best practices for developing these partnerships.[68] With regard to specific Medicaid policy decisions, states have taken different approaches to gather input from CHWs and other stakeholders. Rhode Island and California held a series of virtual convenings that were open to CHWs, while other states have begun by inviting input from selected CHW representatives before inviting broader public input.[69]

Example Policy 1: Rhode Island Supports CHW Leadership and Capacity

When dedicated CHW leaders were interested in forming a state CHW association in 2009, the Rhode Island Department of Health (RIDOH) provided funding to help launch the CHW Association of Rhode Island (CHWARI). This investment recognizes that a statewide CHW network can support a strong and vibrant CHW workforce that can better serve communities. CHWARI provides trainings, networking, and advocacy to establish a professional identity and collective voice for CHWs in the state.[70] Since forming the association, RIDOH and CHWARI have worked closely to bring together community partners and other state agencies to coordinate and inform policy. RIDOH also convenes a CHW Strategy Team, a statewide coalition of CHWs, CBOS, FQHCs, and other key stakeholders, for monthly meetings to discuss and champion CHW initiatives and goals.[71,72] The state health department's active support for the CHWARI has also helped them advance their broader goals, as CHWs are playing a key role in the state's health equity strategy, including Rhode Island's Health Equity Zone Initiative.[73,74] Now that Rhode Island has pursued Medicaid reimbursement for CHW services through a SPA, CHWARI is a key partner for implementation.[75]

Example Policy 2: Arizona Convenes Diverse CHW Leaders

Arizona is one of the most recent states to finalize a voluntary certification process for CHWs and to request approval for a SPA to integrate CHW services into its Medicaid program. The state has a diverse CHW workforce, including *promotoras* working in U.S.-Mexico border communities and Community Health Representatives (CHRs) working with American Indian communities. In 2013, the Arizona Department of Health Services (ADHS) helped convene CHWs and other stakeholders in a group that became formalized as the Arizona CHW Workforce Coalition. This group, which grew to include diverse stakeholders including the Arizona CHW Association (AzCHOW), CHRs, and *promotoras*, worked closely with the state health department on CHW sustainability, professional support, and other needs such as establishing a CHW Project Manager position in the department. In 2018, the Arizona state legislature passed HB 2324, which authorized a formal CHW Advisory Council made up of a majority of CHWs to advise the state on voluntary certification for CHWs, training, and other issues.[76] The Arizona CHR Coalition and the Arizona Advisory Council on Indian Health Care have also provided input on the needs of the CHR workforce.[77] The inclusion of diverse CHW stakeholders ensured that the implementation of the voluntary certification policy would work for CHRs, *promotoras*, and other CHWs in the state. When Arizona's Medicaid program proposed a SPA in 2022 to cover CHW services, they sought input from these CHW stakeholders and offered opportunities for public comment.

Recommendations:

- State policymakers should develop authentic partnerships with CHW stakeholders in their state. In addition to state and regional CHW networks, the National Association of CHWs (NACHW) is a key leader in advocating for CHWs nationwide.
- Working groups, advisory councils, and other bodies assisting with policy development should be composed of at least 50% self-identified CHWs. This 50% recommendation is used by the APHA[78] and by NACHW.[79]
- Policymakers should attentively listen to recommendations from CHW, CBOs that have traditionally worked with CHWs, and CHW networks and be accountable to implementing policies that reflect the authentic voices of community-based CHWs.
- Policymakers should support CHW leadership, ensuring that CHWs are in decision-making positions and in policy-making circles regarding the CHW workforce.
- State policymakers should provide ample opportunities for stakeholder engagement and public comment throughout the process of considering a Medicaid policy change, such as a SPA or 1115 waiver.
- State policymakers should seek opportunities to actively support state and regional CHW networks, including providing funding.

4 Adopt Payment Models that Value CHWs

Medicaid payment models should properly value CHWs and provide adequate financing to support CHWs in providing covered services.

Why this is important:

Intentionally integrating CHWs into Medicaid programs can provide a sustainable source of funding for CHWs, who often face low salaries[80,81] and a lack of job security. Workforce surveys have found that low pay can cause high turnover as CHWs leave the workforce, which makes it more challenging to develop long-term relationships and trust with communities.[82] Inadequate pay is also an economic justice issue, as the CHW workforce is primarily made up of women and people of color. Because CHWs often live in the communities most affected by systemic disinvestment and marginalization, investment in a strong, well resourced, and supported workforce is also an investment in those communities. The National Committee for Quality Assurance (NCQA) and Penn Center for Community Health Workers found that living wages and adequate compensation, reimbursement, and benefits were critical elements of successful CHW programs.[83] Adequate payment for CHW services is also critical to ensure the inclusion of CBOs in Medicaid financing, because employers of CHWs will only participate in Medicaid financing if the payments are sufficient to support their CHW program.

Most state Medicaid programs have traditionally used fee-for-service payment arrangements, in which providers receive a fee for each service they provide to beneficiaries. This payment structure is not well-suited for CHWs, because it rewards providing a high volume of services over providing coordinated, high-quality services that improve health over time. In addition, the core roles of CHWs are distinct from other Medicaid providers and difficult to categorize into discrete, billable units. CHWs also, by definition, spend significant time building relationships and trust with the community, and this time is not fully compensated in billing codes. For example, CHW's work often entails traveling to meet people where they are, which is key to breaking down barriers that Medicaid beneficiaries may face to accessing care. However, this travel time is not necessarily tied to one intervention or condition, and therefore not necessarily reimbursed. Many of the most valuable services CHWs provide are not valued under fee-for-service payment models.

States are increasingly implementing Medicaid delivery system and payment reforms, which can complement the goal of integrating CHW services into Medicaid and avoid some of the aforementioned pitfalls of fee-for-service models. As of 2019, nearly 70% of Medicaid enrollees were in managed care,[84] in which states contract with private health plans to provide comprehensive Medicaid benefits for a pre-set, per-member-per-month payment. Managed care payment arrangements can provide additional opportunities for Medicaid financing of CHW services, both when managed care organizations (MCOs) voluntarily provide CHW services and when policymakers require or incentivize CHW services in their contracts with MCOs.[85] The Centers for Medicare and Medicaid Innovation has been testing models of payment mechanisms and coordination, such as **Accountable Health Communities**, to create pathways that address social determinants of health, including deploying community health workers. In value-based payment arrangements, CHWs can be a critical component of the delivery of coordinated health care services to promote wellness.

How states can adopt payment models that value CHWs:

Because fee-for-service payment models have inherent limitations in properly valuing the work of CHWs, states should consider per-member-per-month and alternative payment models. For states that do opt for fee-for-service models, policymakers can set rates for CHW services at higher levels to account for non-billable services, like transport time needed to provide services in the community, and other needs. States have taken steps to account for non-billable time in setting Medicaid rates for CHW services.

States that use per-member-per-month, or capitated, payment models can also make improvements to properly value CHWs. For instance, states can include requirements in MCO contracts for CHWs to be provided adequate salaries, and they can set higher capitation rates to accommodate such salaries. Payment models that emphasize and reward coordinated care as well as preventive care are best at valuing CHWs.[86] The Pathways HUB model is an example of a nationally replicated CHW model that ties payments to quality measures to incentivize the provision of whole-person, coordinated care.

Example Policy 1: California Waivers and SPA to Address SDOH

California has used multiple policy tools to integrate CHWs into the state's Medicaid program (Medi-Cal) in a way that values their critical roles in a coordinated care delivery model. Through an 1115 waiver, Medi-Cal funded the Whole Person Care pilot program, which provided beneficiaries with coordinated services often facilitated by CHWs. Through a subsequent 1115 waiver, California launched the CalAIM (California Advancing and Innovating Medi-Cal) initiative to support nonclinical interventions for Medi-Cal beneficiaries. CalAIM requires Medi-Cal MCOs to develop new strategies to address SDOH, and most plans partner with CBOs and integrate CHWs to deliver these services.[87] California also added a wide range of CHW services to its Medi-Cal benefits though a SPA that was approved in 2022, including preventive health services, health education, health navigation, screening and assessment, individual support and advocacy, and violence prevention services.[88] This combination of initiatives is transforming Medi-Cal's delivery and payment system to better account for social determinants of health and value the services that CHWs and other non-clinical providers can offer to improve health. More information on how Medi-Cal's delivery and payment system reforms integrate CHWs is available in this **2022 Families USA paper** and this California Health Care Foundation **resource center**.

Example Policy 2: Oregon Coordinated Care Organizations Fund CHW Services

Oregon has utilized 1115 waivers for innovative Medicaid delivery and payment reforms that better integrate CHWs into the state's Medicaid program. Through an 1115 waiver approved in 2012, the state set up 16 coordinated care organizations (CCOs), which are a type of accountable care organization responsible for providing all services to Medicaid beneficiaries in a coordinated fashion. The CCOs are provided a per-member-per-month rate, with financial incentives to meet quality measures emphasizing prevention, coordinated care delivery, and improved health outcomes.[89] This payment structure gives CCOs the flexibility to hire or contract with CBOs to fund CHW services for Medicaid beneficiaries, and it incentivizes them to do so by rewarding coordinated, quality, and whole-person care. Oregon also required CCOs to create a plan for integrating CHWs into care teams and provided other support to foster CCO initiatives. In 2020, 13 out of 16 CCOs had operating CHW programs.[90] Additional lessons from Oregon's efforts to integrate CHWs into Medicaid through 1115 waivers have been compiled in a **2018 Families USA brief** and a **2021 paper**.

Recommendations:

- States should pursue payment models that give providers flexibility to deliver a wide range of services to address social determinants of health. Medicaid payment arrangements should promote quality, whole-person care, and fair wages for CHWs, and not simply incentivize volume.
- States that opt to use fee-for-service payment for CHW services should set reimbursement rates sufficiently high to account for non-billable services CHWs provide and to ensure that CHW positions can be adequately supported.

5 Support and Grow the CHW Workforce

In Medicaid policies and beyond, states should work alongside CHW leaders to effectively implement Medicaid financing policy and invest in strengthening and growing the CHW workforce.

Why this is important:

A lack of sufficient, sustained investment in CHWs and in community health overall has weakened the CHW workforce in the U.S. Partly due to this underinvestment, many health care providers, insurers, hospitals, and other health care actors do not understand or value the role that CHWs can play in promoting whole-person health. State policymakers have a key role in promoting the visibility of CHWs and providing (or funding) the education and technical assistance needed to successfully integrate CHWs into health delivery and payment systems. Without concerted efforts to support and grow a state's CHW workforce, a policy change to cover CHW services through Medicaid might face low uptake if providers are unaware of the policy or the value CHWs bring. In other words, simply allowing for Medicaid coverage of CHW services does not guarantee that these services will be available or utilized to promote health. State policymakers also have a role to play in supporting CHW workforce development, including setting CHW qualifications and requirements to include CHWs in Medicaid.

States also have a role to play in strengthening of the workforce through supporting existing or new CHW trainings and/or certification programs. CMS requires some specification of CHW qualifications for states to formally integrate them into Medicaid financing, and in many states this takes the form of voluntary certification. Some certification programs require set courses and others follow an apprenticeship path. The state of New Jersey established the Colette Lamothe-Galette Community Healthworker Institute as a partnership between the NJ Department of Health and the NJ Department of Labor that provides certification after a set number of hours of on-the-job training.[91] North Carolina has included a legacy track for CHW certification for people who have already been CHWs prior to the creation of new certification processes.[92] Other states set standards for CHW employers rather than certifying individual CHWs.

How states can support and grow the CHW workforce:

Growing the CHW workforce is essential to promoting a community-based health care system that promotes equity. In January 2021, PIH estimated that the United States needs a permanent increase of at least 540,000 permanent community health workers to meet needs in health equity that were exacerbated by the COVID-19 pandemic. Although this is a rough estimate, PIH assumes that this is an under-estimate of the actual need.[93] State efforts to support and grow the CHW workforce should always center the leadership of CHWs and preserve CHWs' values of self-determination and professional identity. States should work with CHW leaders and stakeholders to develop a plan and ensure that Medicaid policies are complementary to this broader strategy. Several resources are available for states on developing these strategies, including from the U.S. Centers for Disease Control and Prevention (CDC), Community-Based Workforce Alliance (CBWA), National Committee for Quality Assurance (NCQA), National Academy for State Health Policy (NASHP), and others. As with previously-stated priorities, states should work with CHW leaders to ensure that the process for ensuring CHW qualifications for Medicaid financing is supportive of the CHW workforce.

Within Medicaid policies, states can make an intentional effort to increase CHW positions and grow the workforce. Some states have done this by requiring Medicaid MCOs to meet a minimum ratio of CHWs per member. There is no consensus estimate for what ratio is adequate, but one state found that a ratio of 1 CHW per 5,000s members is a reasonable starting point to require MCOs to dedicate resources to CHW positions (either employed by the MCO or through contracts with CBOs).[94] States should work with CBOs, clinicians, insurers, hospitals, and other stakeholders to educate on the role of CHWs and guide effective implementation of Medicaid policies.

In addition, states can support accurate data collection through CHW-led workforce surveys. Understanding the landscape of CHWs and CHW employers in the state can give real-time information on the effect of current Medicaid policies on the ground and provide states data to strategically advance the public health workforce and related infrastructure. Surveys can also identify gaps in access, spur new Medicaid guidance to remove barriers in equitable care, inform the state on perceptions and attitudes towards CHWs, and give data on wages and costs. It is imperative that the surveys are led by CHWs themselves, who can most effectively identify the best ways to survey, the key participants that need to be surveyed, and the issues that most affect CHWs and the community being surveyed.

Example Policy 1: Michigan's Employer Surveys and Addition to Michigan FY 23 Budget

Michigan's Department of Health and Human Services partners with the Michigan CHW Alliance (MiCHWA) to do biennial employer and community health worker surveys to have an accurate depiction of the CHW workforce in the state.[95] Data includes current wages, CHW certification, insurance coverage, sustainability concerns, programs offering different benefits, and social determinants of health data. A comprehensive look at the landscape allows for analysis of opportunities that could further strengthen and promote the visibility of the workforce, and provide a mechanism for monitoring the impact of current and future Medicaid policies in the community. To further support the workforce, Public Act No. 166 passed in 2022 by the Michigan State Legislature and signed by Governor Whitmer, includes $28.3 million for community health worker reimbursement through Medicaid, with plans to develop a SPA for the administration of funds.[96] More information on Michigan Employer Surveys can be found on the **Michigan CHW Alliance website**.

Example Policy 2: North Carolina CHW Initiative

With $14.7 million in CARES Act funding from August-December 2020 and $16 million in state and CDC funding from January-June 2021, NCDHHS was able to hire and manage over 500 CHWs and pay them living wages. With pandemic funding coming to a close, North Carolina Department of Health and Human Services as well as NC Medicaid are working with CHWs in the state to sustain the workforce as North Carolina undergoes Medicaid Transformation. In recent guidance, NC Medicaid added CHWs as care management extenders to their newly launched Tailored Care Management plan, with input from the North Carolina CHW Association (NCCHWA).[97] NC Medicaid also funds the development of CHW specialty training modules through the NC Area Health Education Centers to address key conditions and issues faced by Medicaid beneficiaries as well as practice support for advanced medical homes in the state that want to integrate CHWs into their workflows. The CHW workforce proved to be integral to the Covid-19 pandemic response in North Carolina, and both NCDHHS and NC Medicaid are partnering with CHWs to continue to strengthen the trained and ready workforce. More information on the NC CHW Initiative and specialty training can be found on the NCDHHS **CHWI web page** and the NC Area Health Education Centers website.

Recommendations:

- All states should increase and maintain additional funds for CHW programs and services. Medicaid financing must supplement, but not supplant, other sources of funding for CHW services. States should use multiple policy tools and funding streams to support the full breadth of CHW activities to advance the health of their communities.
- States should provide, or fund others to provide, education and technical assistance to health care providers, CBOs, and potential employers of CHWs on how any Medicaid policy change will be implemented and how CHWs can be integrated.
- States should develop workforce development plans within broader plans for CHW Medicaid financing. This entails setting reimbursement rates that are sufficient incentives for providers to hire CHWs and providing fair wages, support, and benefits. It may entail setting a required minimum ratio of CHWs per member for MCOs.
- States should work with CHW leaders, CHW employers, and other stakeholders to build a collaborative infrastructure that can support Medicaid financing for CHW services.
- Certification should be carefully considered in consultation with statewide CHW associations, and with legacy tracks for existing CHWs, limited cost burdens, and other factors that may prevent members of these vulnerable communities from a CHWs to begin with.
- States should raise awareness of the role of CHWs and services covered by Medicaid to the provider community and potential CHW employers. States need to educate stakeholders of the new CHW benefits available and how to utilize Medicaid financing.

Conclusion

Every state has a tremendous opportunity to promote health equity and improve health outcomes for Medicaid beneficiaries by financing CHW services through Medicaid. **PIH-US recommends that all states that do not currently integrate CHWs into their Medicaid programs work with CHW leaders to pursue policy changes to cover CHW services.** States that have already taken measures to integrate CHWs can use these principles and recommendations to better support the CHW workforce.

Medicaid is not and should not be the sole source of financing for CHW services, but it can be a policy lever for states to support their CHW workforce and promote health equity. We do not wish to prescribe any particular set of Medicaid policy tools, since there are pros and cons to each and the right approach depends on the state context and needs of CHWs. Regardless of the policy tools, state policymakers should adopt these principles to integrate CHWs into Medicaid in a way that is most supportive of the CHW workforce and best promotes health equity. For example, for states using Medicaid managed care, the best approach may be to add requirements to MCO contracts to include CHW services. Other states may prefer to start with an 1115 demonstration waiver, before using a SPA to make a permanent change integrating CHWs. In all of these approaches, state policymakers should work closely with CHW leaders and stakeholders to ensure that Medicaid financing can best support community-driven and equity-focused CHW services.

RECOMMENDED FURTHER READING

- Centers for Disease Control and Prevention: **Community Health Worker Resources**
- Centers for Medicare and Medicaid Services: **On the Front Lines of Health Equity: Community Health Workers**
- Families USA: **Community Health Worker Resources from Families USA**
- Medicaid and CHIP Payment Advisory Commission: **Medicaid Coverage of Community Health Worker Services**
- National Academy for State Health Policy: **State Approaches to Community Health Worker Financing through Medicaid State Plan Amendments**
- National Academy for State Health Policy: **State Community Health Worker Models**
- National Association of Community Health Workers: **Sustainable Financing of Community Health Worker Employment**

ABOUT PIH-US

PIH-US is the United States arm of Partners In Health (PIH), a nonprofit, social justice organization striving to make health care a human right for all people, starting with those who need it most. We draw on the experience of our global community to guide health systems strengthening in the U.S., all organized around PIH's core tenet: health is a human right, and the best way to achieve both equity of access and outcomes is to **provide excellent clinical care along with robust and transformative social supports to improve whole-person health**.

PIH-US, the United States arm of PIH, was formed in 2021 to drive an equitable emergency response to the COVID-19 pandemic centered around social support. When COVID-19 began to spread throughout the United States, PIH-US used lessons learned from the collective global experience to implement an impactful COVID-19 health care response in the U.S. Beginning with the MA Community Tracing Collaborative and care resource coordination, PIH-US centered social support at the core of its efforts working with those impacted by COVID-19. Through this work PIH-US has contributed to a number of efforts that are advancing the call to address the long-standing inequities faced by vulnerable communities.

ACKNOWLEDGEMENTS

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PIH-US wishes to thank our partners for discussing and contributing to the ideas in this paper. In recognizing their contributions, in no way do we imply endorsement of the paper or its policy recommendations by the individuals or organizations listed below.

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