Washington State
Health Care Authority

Community Health Worker State Interview Findings

Exploring strategies for Medicaid reimbursement

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Background

Following advocacy from the Behavioral Health Integration subcommittee, the Children and Youth Behavioral Health Workgroup, and the Washington Chapter of the American Academy of Pediatrics' First Year Steering Committee, SSB 5693 Sec 211 (103) was signed into law. This legislative proviso directed Health Care Authority (HCA) to administer a two-year grant for community health worker (CHW) services within pediatric care beginning January 1, 2023. Additionally, HCA was directed to explore avenues for sustainably supporting the CHW role and associated services, including but not limited to a State Plan Amendment and Federal Demonstration Waiver.

Learn more about the CHW grant on HCA's Community Health Worker (CHW) Grant webpage.

CHW State Interviews

There has been growing interest nationally for Medicaid coverage of services provided by community health workers (CHW) with several states submitting Medicaid State Plan Amendments[1] for CHW services within the last year. HCA staff met with representatives from seven[2] other states to gather lessons learned and insights to inform Washington's approach to Medicaid reimbursement for CHW services. Key questions included history of CHWs in the state, inclusion in primary care teams, supports for CHWs, data and evaulation, and financing. Findings will be shared with CHWs and key community partners in Spring 2023 to gather feedback and guide next steps.

Process

To prepare this report, HCA interviewed seven state teams who represented the Medicaid agency in the state, as well as key partners (Appendix C). HCA also met with the Centers for Medicare and Medicaid Services (CMS) for informal technical assistance (TA). Review of state-specific materials, including State Plan Amendments, provider manuals, and other resources, were incorporated.

In selecting states to interview, HCA selected those that were pursuing or had approved State Plan Amendments for CHW services. Though there are multiple avenues for Medicaid authority and financing of services, focus on options for fee-for-service (FFS) models were prioritized as CHWs are currently authorized and incorporated in Washington Apple Health (Medicaid) through managed care (MC) adminstrative budgets and cost-based reimbursement for federally qualified health centers (FQHC). In meeting with each state, HCA shared community health worker questions for state leads prior to hosting a virtual 60-minute meeting, with the exception of one state where two shorter meetings were held.

Key Findings

Successes

A key contributor to success was the development of CHW services and programs in partnership with other state agencies, community health worker associations, and community organizations. States highlighted the critical importance of these collaborations to ensure that services reflected the CHW role as well as informing clear guidance that was accessible to those who would be most impacted. Further, states elevated the need for ongoing partnership with entities that provide and support workforce development as well as certification processes.

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[1] Each state enters an agreement with the federal government called a Medicaid State Plan which describes the state's Medicaid coverage, methods for reimbursement, and service details. State Plan Amendments (SPA) are the method for indicating a plan to change or add new information to the Medicaid State Plan. SPAs must be reviewed and approved by the Centers for Medicare & Medicaid Services (CMS). For more information, visit medicaid.gov.

[2] Two additional state meetings are planned after the publication of this report.

Challenges

Three common challenges arose:

- Challenges around the intersection of comparable or similar community-tailored roles
- Credentialling and certification
- Medicaid uptake for CHW services

A thread that carried through many challenges was concern for shared language and understanding of the CHW role and how misunderstanding may be a barrier to valuable integration of CHWs within various teams across the health system.

Comparable Community-Tailored Roles

Key factors contributing to challenges related to comparable community-tailored roles:

- Lack of an agreed upon CHW scope of practice, qualifications, and service activities and functions
- Inconsistent language and titles used when referring to CHWs
- Prevalence of other existing community-tailored and paraprofessional roles

Given these factors, states shared experiences of tension across different community-tailored roles that did not want to fall under the umbrella of CHW, or, on the opposite end of the spectrum, a desire for CHW covered services to become a catch all to add onto other roles for reimbursement.

Credentialling and Certification

Similar to the complexities with comparable community-tailored roles, credentialling and certification included multiple layers of challenges that Medicaid agencies faced, including:

- Lack of an established credentialling body and credentialling process for CHWs
- Numerous and variable CHW training and certification programs

In many states, CHWs are already working within health care systems and community-based organizations without standard credentialling and certification requirements. This legacy has contributed to variability both in the ways CHWs have been defined and incorporated into these settings, as well as variance in the level of training CHWs have received.

Medicaid agencies expressed challenges related to credentialling at a systems-level in establishing a credentialling process, including who would be the credentialling body. Further, states shared difficulties related to the politics in deciding which training and certification programs would be approved, CHWs opposing regulations, and how to mitigate potential incongruence with historical practices and new requirements.

Medicaid Service Uptake

Many states indicated slow uptake for CHW services in agencies and/or CHWs billing Medicaid for CHW services. One state shared zero dollars have been paid from Medicaid for CHW services, though CHWs have been in their State Plan since 2019 (South Dakota)[3]. States indicated workforce development needs as well as administrative burden related to billing Medicaid. Specific challenges shared, included:

- Maintaining evidence of qualifications
- Low reimbursement rate
- Medicaid enrollment
- Lack of billing experience (for new agencies or providers)

Best Practices

Findings from the interviews described above lead to several best practices for Medicaid coverage of CHW services:

1. Develop the services and benefit with the CHW workforce to ensure shared understanding and alignment.
2. Develop clear messaging around the limitations of Medicaid reimbursement to provide clarity on which CHW activities are and are not eligible.
3. Partner with community organizations and other state agencies who may be able to develop and fund tailored tools and resources for CHWs and employing agencies (e.g. stipends for training, school, and books, CHW supervisor training, templates and examples).
4. Work closely with CHWs and key partners to develop provider manuals and guidance.

Conclusion

CHW reimburseable services within Medicaid is an emerging opportunity. Further assessment of the key roles, functions and reimbursement methodologies as CHW programs become established will be important to clarify gaps and opportunities for workforce sustainability and reimbursement strategies.

[3] Through recent email correspondence, South Dakota shared they have begun to see providers billing for this service in July 2022.

Interview Results

Defining the CHW Role

States interviewed had varying answers regarding CHW scope of practice, qualifications, and credentialling methods. One state indicated that the CHW role was developed through the work of a state effort led by CHWs (Maine) while others focused on systems navigation and addressing social determinants of health (Rhode Island). Responses indicate a lack of clearly defined scope of practice, qualifications, and CHW-specific activities both within states as well as nationally.

State Approaches to Credentialling and Certification

	AK	CA	IN	LA	ME	NM	RI	SD
Credential	X						X	
Certification or Training			X	X	X	X		X
None currently, though anticipated		X						

Sustaining the workforce: Starting January 2023, South Dakota will begin to require certification for CHW services to be eligible for Medicaid reimbursement. The interviewee shared that credentialling and certification can bring validity to a workforce. Recognizing that sustainability for the CHW workforce will require more than Medicaid funding, they shared that validating a workforce may support other payers adopting CHWs within their benefits.

CHWs within Medicaid System

Medicaid Financing Models

HCA staff identified states that have pursued CHW financing outside of managed care (MC) administrative funding to assess options for fee-for-service (FFS) models. Two states indicated an intent to use alternative payment methods (APM), such as value-based purchasing (VBP), to reimburse for CHWs (Maine, Rhode Island). Further inquiry would be needed to better understand which states are using encounter rates, specifically through federally qualified health centers (FQHC) and rural health clinics (RHC).

	AK	CA	IN	LA	ME	NM	RI	SD
Encounter rate	X							
FFS		X	X[4]	X		X	X[5]	X
APM and VBP					X			
Waiver							X[6]	

[4] Next year, formally incorporating into MC extended benefits.

[5] Once more utilization data, intend to build into MC. May eventually use to develop VBP models.

[6] Specific to Children and Youth with Special Health Care Needs (CYSHCN).

Finance design based on service aim: In exploring a fee-for-service (FFS) model versus other payment options, South Dakota considered what they want to promote about the CHW role: assisting beneficiaries in overcoming barriers managing their health. Feedback from CHW employers and partners indicated FFS would better support this individualized, patient-centered model of care. Further, South Dakota and other states expressed lack of utilization data as a barrier to modeling a bundled rate.

Creating a CHW Benefits through Medicaid State Plan Authority

To date, CHW services are typically captured within either preventive services or other practitioners' services of Medicaid State Plans. The table below lists approaches taken by states interviewed. Appendix B provides additional information to resources such as State Plan Amendments, provider manuals, and other resources.

Section	States
Tribal reimbursement (section 4.19-C)[7]	Alaska
Preventive services	California, Rhode Island, South Dakota
Other licensed practitioners' services	Indiana, Louisiana

Considerations from CMS TA

In addition to interviewing state that are in the process or have approved State Plan Amendments for CHW services, HCA staff requested an informal technical assistance (TA) call with CMS. CMS indicated that states have flexibility in defining CHW qualifications, including training curriculum, whether they are included under the Preventive or Other Licensed Practitioners' Services sections of the State Plan. Additionally, settings where services may be offered would not be limited based on CHW services being authorized under either preventive services or other licensed practitioners' services.

	Preventive Services	Other Licensed Practitioners' Services
Credentialing	May provide services as an unlicensed provider as long as services are recommended by a licensed provider	Providers must hold a license/credential OR be working under the supervision of a licensed practitioner
Services	Must fall within the following: • Prevent disease, disability, and other health conditions or their progression; • Prolong life; and • Promote physical and mental health and efficiency	Do not have to list specific services as they are provided under the scope of licensed practioner[8] Supervising practitioners would be responsible for ensuring CHWs are qualified and practicing within their scope and sign off on services provided
Payment	Able to be paid directly to CHW	Payment would be made to supervising provider

[7] Alaska services are within Tribal community health aide program (CHAP)

[8] If CHWs were to be practicing with an independent license under the authority of Other Practitioners' services, services would be defined by the scope of practice associated with the CHW license.

Additional Considerations

Considerations beyond the sections of the Medicaid State Plan that may be worth exploration in designing a CHW benefit include:

- Alignment with current CHW services and CHW workforce perspectives
- Equity and sustainability factors to credentialling
- Experience and capacity to contract and bill Medicaid for both individual providers (i.e. CHWs) as well as employing agencies
- Level of support and oversight desired for delivery of services

Procedure Codes

With the exception of Rhode Island, states interviewed consistently reported use of three self-management, education and training procedure codes when submitting claims for CHW services. Rhode Island reports using T1016 case management (with modifier HW when deliver in group settings).

California developed specific exclusions for CHW services, such as targeted case management, to create clarity around differentiating terms for services. They highlighted the importance of partnering with CHWs and other providers in defining services, such as case management and health navigation, and who can provide it.

Code	Title
98960	Self-management education and training, face-to-face, 1 patient
98961	Self-management education and training, face-to-face, 2–4 patients
98962	Self-management education and training, face-to-face, 5–8 patients

Limits to Medicaid reimbursement: States shared the desire for adding additional roles and services within Medicaid benefits beyond the three codes. One state shared the importance of communicating around what types of activities Medicaid can pay for, which are limited, versus the full range of supports CHWs may provide in different contexts.

Provider Enrollment and Billing

States varied in their approaches to provider enrollment and billing. One state indicated CHAPs[9] directly enrolling as a Medicaid provider, though not directly being reimbursed (Alaska). Other states indicated not requiring CHWs to enroll at all, instead relying on supervising providers to submit claims on behalf of the CHW (California, Indiana, Louisiana).

South Dakota developed a process for agencies to become a CHW agency, rather than having individual CHWs enrolling and billing for Medicaid services. All required materials (see table below) are submitted to the state Medicaid agency for approval.

[9] In Alaska Medicaid, CHAPs are the only CHW-like providers; Alaska's Tribal community health aide program is not a 1:1 for non-tribal CHW implementation

CHW Agency Requirements (South Dakota)
Agency must have their own taxonomy and type 2 national provider identifier (NPI)[10] **CHW does not have to enroll for a NPI*
Complete provider enrollment application, including CHW addendum
Provide CHW policies and procedures to verity within CHW scope of work and compliance with state and federal background check, gifting policies, and Medicaid payment policies
Agency is responsible for hiring and training CHWs prior to working with clients, including mandatory reporting and recipient's rights and responsibilities[11]
Orientation must be provided prior to CHWs going to recipients' homes unsupervised
Maintain record of all employees and training completed, including 6 hours of continuing education

Additional supports from CHW Collaborative: The South Dakota Medicaid agency shared limitations to the types of resources and support they can provide to agencies around developing policies and procedures. To fille the gap, the state CHW collaborative has provided support by developing fillable templates that align with Medicaid requirements that agencies can complete to submit with their enrollment application.

Maintaining Records of Qualifications

Two states hold agencies and supervising providers responsible for verifying and maintaining documentation that CHWs are qualified Medicaid providers (Indiana, South Dakota). Indiana shared that providers expressed a need for clarity regarding how to specifically document qualifications and how long to keep the records, due to concerns of being audited in the future.

Partnerships and Community Engagement

A key recommendation and factor for success across states centered around engagement with CHWs and other key partners. Highlights included:

- "Spent a lot of time and investment in developing the provider manual in partnership. We spent about a year working on it together." (California)
- Maine shared plans to partner with CHW advisors around key questions on how CHW services are delivered and how involved CHWs are in primary care.
- Both Maine and South Dakota emphasized the close partnership with the Medicaid agency and Department of Health.

Working with Tribes

Several states shared the value of partnering with Tribal communities and providers from the beginning to avoid missing nuances and needs within Tribal health settings.

[10] Agencies may not use pre-existing NPI for their agency. They must have a unique NPI attached to a CHW taxonomy code.
[11] Starting January 2023

- “As an addition to these questions it can’t be emphasized enough that the work you are doing needs to occur hand in hand with the Tribal health organizations in your state. Knowing how they are setting up their programs may assist in making sure your State Plan will adequately address community health providers in Washington and aligns with the intent of your Medicaid program changes.” (Alaska)
- California shared the importance of working with Tribes early in the process. They also shared feedback from Tribal communities around the need to include registered nurses as supervising providers within the State Plan.
- South Dakota included American Indian community health representative training to be sufficient for meeting CHW certification requirements.

Interview Limitations

Though states recognize the importance of data on CHW training, employment, key services and activities, and impact of health outcomes, there are limited evaluations currently available. States indicated an awareness that CHWs are employed by a variety of entities across community-based organizations, social services and health care that are funded through alternative sources rather than Medicaid, though clean and complete data on this topic is not yet available.

Many CHW Medicaid programs are in the process of being implemented, and it will likely be at least a year before these states have access to claims data to understand utilization. Given these limitations, state interviewees recognized that their current perspective on the topic may be incomplete and they will likely have comprehensive information to share in the future.

Evaluation metrics: Rhode Island anticipates examining CHW utilization metrics after the benefit has been in operation for more time. Metrics they hope to explore include: amount of direct services (i.e. meeting with families, outreach, screenings administered), outcome metrics, and delivery format (i.e. virtual, phone, in-person).

Appendix A

Community Health Worker Questions for State Leads

General

- How did Community Health Workers get started in your state?
    - Who were the champions? Where did you see the most success?
    - Was there any pushback/resistance? What were the greatest challenges?
    - What did initial uptake look like?
    - What are the primary functions of the Community Health Worker role within the pediatric primary care setting?
- Are CHWs credentialed in your state?
    - What is the credentialing process?
    - Who/what agency oversees the credentialling process?
    - How is credentialing/training tracked?
- Are there priority populations they serve? (children and youth)
    - How were these priority populations determined?
    - Are there eligibility requirements?
- Where are CHW services currently delivered? (i.e. FQHC, RHC, Family Clinics)
    - What are the general sizes of these settings?
- Are there roles & activities CHWs provide outside of direct contact/services with children and families?
- How have race, place, language, ability, and other equity concerns been brought into the work?
- Have you had workforce constraints for CHWs and the roles you have available? Have you worked to address these challenges? How?
    - Concerns are often elevated about CHWs being one of the lower paid members of the health care team, and more often being BIPOC, and/or facing additional and disparate barriers. What has the professional development, growth opportunity trajectory looked like for CHWs in your state? Have you invested in strategies and what has the outcome been? Or, are you considering strategies?

Primary Care Team

- How do CHWs partner with other pediatric care team members?
- What does collaborative care look like?
- Are there additional CHW activities for the CHW to support the care team (i.e. trainings, lunch & learns, feedback regarding care)?

Supervision & Support

- What is the supervision/reporting structure for CHWs in the pediatric primary care settings?
- What does organizational support look like?
- Are there additional supports available to CHWs in your state (i.e. learning collaboratives, professional associations)

Data & Evaluation

- Has there been any evaluation of CHWs in pediatric primary care work?
- What data/metrics are collected for CHWs in terms of measuring impact?
    - Amount of direct services (i.e. meeting with families, outreach, screenings administered)

    - Outcome metrics
    - Delivery format (i.e. virtual, phone, in-person)
    - How have race, place, language, ability, and other equity concerns been brought into the data and evaluation components of the work?

Financing

- What is the financing model for CHWs in pediatric primary care in your state? How does coverage/payor intersect with financing CHWs in pediatric primary care?
    - Fee for service? Which CPT codes utilized?
    - Medicaid? Other payors?
    - Grant funding? Who administered? Duration? Ability to renew?
    - Waiver?
    - Other funding sources?
- Are there other financing structures utilized for CHWs in other settings?
    - Value Based Payment? How was this modeled/costed?
- Are CHW services included in your state plan? Under what authority (e.g., Preventive Services, Other Licensed Providers)?
    - Which section?
    - Able to share?
- What has Managed Care's role been in supporting the adoption of CHWs?
    - Any lessons learned around partnering?

Appendix B

State Resources and Publications

Alaska

- **State Plan:** https://health.alaska.gov/Commissioner/Documents/medicaidstateplan/PDF_SP/MSP/Sec_4-19.pdf
- **Fee Schedule:** https://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp
- **Additional Resources**
  - Community Health Aide Program Alaska
    - Community Health Aide Program: https://akchap.org/community-health-aide/
    - Standards and Procedures webpage: https://akchap.org/chapcb/standards-and-procedures/

California

- **State Plan Amendment (2022):** https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf
- **All Plan Letter (2022):** https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf
- **Provider Manual:** https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/chwprev.pdf
- **Medi-Cal Coverage of CHW Services webpage:** https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31781_01.aspx

Indiana

- **State Plan:** http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1a_addendum.pdf
  - **Reimbursement:** http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19b_1-1f.pdf

Louisiana

- **State Plan Amendment (2022):** https://ldh.la.gov/assets/medicaid/StatePlan/Amend2022/22-0003/22-0003CMSApproval.pdf
- **Provider Manual:** https://www.lamedicaid.com/provweb1/providermanuals/manuals/ps/ps.pdf
- **Additional Resources**
  - Louisiana Community Health Outreach Network
    - Community Health Worker Core Competency Training Program: https://www.lachon.org/general-8-1
  - LSU Health Center for Healthcare Value and Equity
    - CHW presentation: https://ldh.la.gov/assets/docs/MQI/MQIMeetings/Feb22/MedicaidQualGroupPresentation.pdf

Rhode Island

- **State Plan Amendment (2022):** https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0012.pdf
- **Public Notice:** https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-09/21-0012-revised-clean-to-post-092721-notice-to-public_chw-6.29.21.pdf

- **Provider Manual:** https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-07/CHW%20Manual%207%2019%202022.pdf
- **Additional Resources**
    - Department of Health
        - CHW webpage: https://health.ri.gov/communities/about/workers/
        - CHW Workforce Report: https://health.ri.gov/publications/reports/CommunityHealthWorkersInRhodeIsland.pdf
        - CHW Sustainability Report: https://health.ri.gov/publications/reports/2021CommunityHealthWorkersInRhodeIsland.pdf
        - Rhode Island's Health Equity Zone (HEZ) Initiative: https://health.ri.gov/programs/detail.php?pgm_id=1108
    - Rhode Island Certification Board
        - Certifications webpage: https://www.ricertboard.org/certifications
    - Community Health Worker Association of RI: https://chwari.org/

South Dakota

- **State Plan Amendment (2022):** https://dss.sd.gov/docs/medicaid/medicaidstateplan/Amendment_Info/Community_Health_Worker_Providers_and_Certification.pdf
- **Provider Manual:** https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Community_Health_Worker_Services.pdf

Appendix C

State Interview Contacts

Alaska

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California

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