Medicaid Coverage of Community Health Worker Services

Interest among federal and state policymakers and other Medicaid stakeholders in expanding Medicaid coverage of services provided by community health workers (CHWs) has been growing given the potential role of CHWs in helping Medicaid beneficiaries access services. CHWs are individuals with strong ties to the communities they serve and who provide a range of services addressing the health and social needs of their clients. A review of publicly available information conducted by MACPAC in 2021 identified at least 21 states that authorize Medicaid payment for certain CHW services, in their state plan or under managed care arrangements. In most cases, state Medicaid programs allow coverage of a limited range of CHW-provided services or limit CHW services to specific populations.

Because of their community relationships, CHWs can facilitate connections and greater trust between the community and health care systems. They may be members of communities that are typically underrepresented in health care settings or may be specifically qualified to provide culturally competent care. CHWs are often seen as having an important role in promoting health equity and helping to address disparities, however, Medicaid coverage of CHW services is limited.

CHW services may include health promotion and education, patient outreach and follow-up, assistance in navigating the health care system, translation and interpretation services, and care coordination and case management. Training and education requirements vary widely depending on their specific role, employer, and other factors.

This issue brief begins with an overview of the various types of CHWs and the services they provide. It then reviews selected studies documenting the effects of CHW programs on health outcomes and costs. The brief describes state approaches to covering CHW services in Medicaid, including the various authorities they use to provide Medicaid payment, the services they cover, the populations served, and training and certification requirements.

Overview

The American Public Health Association definition of CHW is widely used: “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served” (APHA 2021). The defining feature of CHWs is their connection to their community and clients based on their shared socioeconomic and cultural background, often serving the communities in which they reside. For example, promotores(as) are CHWs serving Hispanic or Latino communities, and community health representatives (CHRs) are CHWs who serve American Indian and Alaska Native communities (Appendix Table A). The lived experience of CHWs may also be similar to those they serve, including, for example,

having similar health conditions or social needs, or having prior interactions with the criminal justice system. These shared experiences provide CHWs with a deep understanding of the challenges and barriers their clients face and position them to advocate on their behalf, connect them with culturally competent care and other resources, and build trust (CDC n.d., Lloyd et al. 2020).

Because CHWs often represent communities that are more likely to be underrepresented in the professional health care workforce, their presence within a health care organization can help foster trust and connection with the community (CDC n.d., Lloyd et al. 2020). CHWs can also help make colleagues and cultures in those health care organizations more attuned to the experiences of the communities they serve (Lloyd et al. 2020).

Lay or paraprofessional health workers, who are not members of or strongly connected to the communities they serve but who perform similar activities as CHWs, are sometimes considered CHWs (Appendix Table A). They often work with individuals and families to address health needs associated with a particular condition, and thus may be subject to training or certification related to the condition. This includes, for example, cancer patient navigators, which help individuals and families navigate the health care system to obtain timely services, and asthma educators who help individuals manage their asthma and improve their quality of life. There are many different titles for this type of CHW. One analysis found more than 100 different titles for CHWs (Sabo et al. 2017).

Settings and services

CHWs have historically been employed by community-based organizations and social agencies, although they are increasingly being used in clinical settings, such as federally qualified health centers (FQHCs), health departments, and hospitals (Malcarney et al. 2017). They provide a variety of services, which are mostly aimed at bridging the gap between patients and the health care system but also include social supports. These may include:

- health promotion, wellness coaching, and self-management education;
- cultural mediation (e.g., communicating norms and perspectives);
- interpretation or translation services;
- health system navigation (e.g., scheduling appointments, accompanying beneficiaries to office visits);
- advocacy on behalf of patients and their families;
- outreach before appointments, including appointment reminders;
- outreach to ensure adherence to treatments and medications;
- home visits;
- individual, community, and environmental assessments;
- arranging transportation;
- making connections to community resources or social services; and

- providing care coordination and case management.

During the COVID-19 pandemic, CHWs took on roles conducting outreach to community members who isolated in their homes, providing education on prevention measures, connecting people with COVID-19 testing and treatment resources, and those experiencing financial hardship with social services (CDC 2021, Peretz et al. 2020). CHWs have also participated in community-focused vaccine education and outreach efforts (Cohen Marill 2021).

Effects of CHW programs

There is a substantial body of research indicating that the use of CHWs can improve health outcomes and produce other positive effects. Although few studies focus specifically on CHW programs serving Medicaid beneficiaries, some have found evidence of improved outcomes or cost savings for Medicaid. For example:

- A study of CHW home visits for Medicaid-enrolled children with asthma found that the program increased symptom-free days and reduced urgent health care use, and produced a positive return on investment (Campbell et al. 2015).
- A study of the Individualized Management for Patient-Centered Targets (IMPaCT), a standardized community health worker intervention aimed at addressing unmet social needs, estimated a return on investment of $2.47 for every dollar invested to an average Medicaid payer (Kangovi et al. 2020).
- A study of the Arkansas Community Connector Program, which used CHWs to identify people with unmet long-term care needs in three disadvantaged counties, and connect them to Medicaid home and community-based services (HCBS), found a 23.8 percent average reduction in annual Medicaid spending per participant during a three-year period. This resulted in $2.6 million in net savings for the Arkansas Medicaid program (Felix et al. 2011).

Additional studies focused on CHW programs serving low-income or other underserved populations show that CHWs can improve health outcomes in specific contexts. For example:

- Systematic reviews have found that when used as part of chronic care management interventions, such as blood pressure and diabetes education, CHWs can help improve disease control and reduce mental health symptoms such as depression and substance use disorder (Allen et al. 2014, Barnett et al. 2018).
- Several studies have found that interventions using CHWs helped to improve health outcomes among racial and ethnic minorities. For example, one study found that the Boston Children's Hospital's Community Asthma Initiative (in which nurses and CHWs provide home visits and asthma care management) reduced asthma morbidity among Black and Hispanic children (Woods et al. 2016). Another study found that a program using CHWs as patient navigators led to increased receipt of timely cancer care among low-income and minority populations (Freund et al. 2014). Additionally, in one randomized controlled trial, Hispanic patients at urban clinics assigned to CHWs had improved health status and habits, lower emergency department (ED) use, and greater odds of decreased body-mass index (Babamoto et al. 2009).

- Several studies have found that interventions involving CHWs led to fewer hospitalizations, hospital readmissions, and ED visits. For example, a randomized clinical trial found that hospitalized patients working with CHWs had significantly fewer readmissions and fewer missed outpatient visits 30 days post-discharge (Carter et al. 2021).
- Some studies have found other beneficial effects of CHW programs. For example, one randomized control trial found that a standardized CHW intervention in Philadelphia led to significant increases in patient-perceived quality of care along with modest improvements in patient activation (i.e., willingness and ability to engage in one's own health) and chronic disease control (Kangovi et al. 2018).

Medicaid Payment Authorities for CHW Services

States can provide Medicaid payment for CHW services under state plan or Section 1115 demonstration authority. Several states require managed care organizations (MCO) to provide certain CHW services or include CHWs in care teams. In addition, other states allow but do not require MCOs to provide such services.

Medicaid payment for CHW services can be authorized under multiple state plan benefits and requirements for enacting such coverage vary by the specific benefit. For example, states could authorize coverage under the preventive services benefit. A 2014 update to the regulatory definition of preventive services by the Centers for Medicare & Medicaid Services (CMS) allows coverage for preventive services provided by non-licensed providers, including CHWs, when those services are recommended by a physician or other licensed provider (42 CFR 440.130) (CMS 2013a).[1] States seeking to add coverage under the preventive services benefit would need to submit a state plan amendment (SPA) describing the specific CHW services to be delivered, the qualifications for practitioners who will deliver the services, any limitations on services, and the payment methodology for the coverage of the services. States may also cover CHW services under other benefits, such as the outpatient hospital services benefit (42 CFR 440.20). For this benefit, states are not required to identify CHW services in the state plan.

States can also include CHWs in programs authorized under the Medicaid health homes state plan option. This option, created under Section 2703 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) allows states to establish health homes to coordinate and manage care for people who have chronic conditions. Services are provided by designated health home providers or interdisciplinary teams of health providers and professionals (CMS 2010). Teams may include physicians and other professionals, such as nurse care coordinators, nutritionists, social workers, behavioral health professionals, and other professions deemed appropriate by the state (§ 1945 of the Social Security Act (the Act)). Several states have specified that teams can or must include a CHW in their health home SPAs (see below).

Additionally, some states cover CHW services using Section 1115 demonstration authority, either by allowing CHWs to provide services to beneficiaries, providing incentive payments for activities related to CHWs, or by providing funding for CHW infrastructure.[2]

State Approaches to Using CHWs in Medicaid

A scan of state policies and practices regarding use of CHWs in Medicaid conducted by MACPAC in 2021 identified at least 21 states that specifically allow Medicaid payment for CHW services.[3] In other states, CHW services may be available to Medicaid beneficiaries but are not being paid for by Medicaid. For example, hospitals, health centers and MCOs may employ or contract with CHWs using other sources of funding. Increased coverage of CHW services by Medicaid and other payers may increase demand for CHWs to a level that cannot be met by the current workforce.[4] Currently, more CHWs are needed to meet existing demand for their services (Kangovi 2020).[5]

Within certain limits, states have discretion to define the scope of services CHWs may provide, the Medicaid populations they can serve, and certification and training requirements. State choices may vary based on program or policy goals, existing payment and delivery systems, or other state-specific circumstances.

Coverage

In general, Medicaid coverage of CHWs falls under one or more of the following categories:

- Medicaid payment is authorized under the state plan for a specific set of services provided by CHWs under the supervision of, or recommended by, a physician or other licensed provider;
- States allow, recommend, or require that CHWs be members of interdisciplinary teams or provider networks serving beneficiaries, sometimes as part of larger programs serving beneficiaries with specific health needs (e.g., Medicaid health homes);
- States include specific requirements related to CHWs in their MCO contracts (or with other entities responsible for delivering care), or recommend or suggest that MCOs involve CHWs in providing certain services or performing certain activities.
- MCOs, accountable care organizations (ACOs) or other similar interdisciplinary care networks employ, contract with, or otherwise arrange for CHWs to provide services to their members, sometimes as part of strategies to meet targets tied to incentive payments.

State plan. Seven states allow CHWs to provide services under the state plan: Alaska, Indiana, Kentucky, Oregon, Minnesota, North Dakota, and South Dakota.[6] Generally, these states require CHWs to be employed by a Medicaid-enrolled provider, such as a hospital, clinic, physician, advanced practice nurse, or mental health professional, who can submit claims for eligible services provided by employed CHWs to either the state or the beneficiary's managed care plan, as applicable (DHS 2020, IHCP 2018). Examples are described below.

- Oregon refers to CHWs as a type of traditional health worker. Traditional health worker services provided must be performed under the supervision of licensed providers, must be within the provider's scope of practice, and covered by the state plan. Eligible services include self-care and self-management training, counseling in prevention or risk factor reduction, tobacco use cessation counseling, alcohol or substance use screening, home visits, and activity therapy related to the care

and treatment of a patient's disabling mental health problems (OHA 2020). Oregon also allows certain CHWs to provide targeted case management (TCM) services to beneficiaries enrolled in TCM programs.[7]

- Indiana allows CHWs to provide certain Medicaid services under the supervision of a qualifying provider. These include diagnosis-related patient education regarding self-management of physical or mental health conditions, cultural mediation between beneficiaries and their families and their health care provider, health promotion education to prevent chronic illness, and direct preventive services aimed at slowing the progression of chronic diseases (IHCP 2018).
- Minnesota allows payment for CHW-provided patient education related to the patient's diagnosed health condition. Services must be ordered by a qualified health care provider and be performed under the general supervision of that provider (DHS 2020).
- North Dakota allows community health representatives (CHRs) to provide TCM services for beneficiaries in need of long-term services and supports (Dobervich 2020, CMS 2012).

Several additional states have considered or are considering adopting similar policies. For example, California's state fiscal year (SFY) 2022 state budget authorizes and funds Medicaid payment for CHW services, and the state plans to submit a SPA to CMS making the policy effective in 2022 (Carney et al. 2021, Waters 2021).

Health homes. Five states allow use of CHWs in their health home programs as part of a care team: California, Maine, Michigan, Washington, and West Virginia. However, only one of these, Michigan, requires they do so (DHHS 2017). When included in care teams, common CHW responsibilities include meeting regularly with the care team to plan care and discuss patient cases, identifying and providing referrals to community social supports and resources for the patient, and providing education on health conditions and strategies to implement care plan goals.

The remaining states explicitly permit the use of CHWs, but they do not require CHWs to be included in the multidisciplinary care teams serving beneficiaries participating in health home programs. For example, California recommends that health home program teams include a CHW in order to provide administrative support to care coordinators, engage eligible beneficiaries, arrange transportation and accompany beneficiaries to office visits if needed, provide health management training, along with other services (DHCS 2019). An evaluation of California's program found that 10 of the 16 MCOs that implemented health home programs reported in readiness documents that they intended to use CHWs (Pourat et al. 2020). The extent to which CHWs are being used in these states is unclear.

Demonstration approaches. Section 1115 demonstrations that include CHWs generally seek to accomplish payment and delivery system reforms; these include delivery system reform incentive payment (DSRIP) or DSRIP-like programs.[8] Several states have integrated CHWs into interdisciplinary networks of providers eligible for performance-based funding or invested in building the capacity of the CHW workforce.[9] For example:

- California's Medi-Cal demonstration included several components related to CHWs. CHWs could be part of care teams under Whole Person Care (WPC) pilot programs, that focused on increasing

integration and improving coordination of care for beneficiaries who are frequent users of the health system. CHWs can be incorporated into multidisciplinary teams serving beneficiaries enrolled in WPC pilots. As of February 2020, 19 of 26 WPC pilots incorporated CHWs (CAPH 2020). CHWs continue to be included in California's recently approved Section 1115 demonstration that will transition WPC pilots into a new enhanced care management and community supports benefit for enrollees (CMS 2021).[10]

- In Massachusetts, eligible entities including accountable care organizations (ACOs) and community partners used DSRIP funds to hire or contract with CHWs (Houston et al. 2021).[11] The state has also used DSRIP funds to make investments in CHW and CHW supervisor training programs (see below).
- Washington provided incentive payments for achieving milestones related to increasing Indian health provider systems and capacity, including by building infrastructure for the education, certification, and integration of Community Health Aide Program (CHAP) certified providers into tribal health programs (CMS 2020).[12]

Managed care approaches. Some states are providing CHW services through their Medicaid managed care arrangements, in some cases requiring them.[13] For example:

- MCOs in Michigan are required to support the design and implementation of CHW interventions that address social determinants of health and promote prevention and health education. MCOs must maintain specific CHW-to-enrollee ratios (DHHS 2021).
- New Mexico mandates that all Medicaid MCOs provide CHW services to at least 3 percent of their members (Klein et al. 2020). This is one of several performance targets that new MCOs must meet in order to avoid a financial penalty of 1.5 percent of the capitation rate (Bailit Health 2020).
- In Oregon, contracts with coordinated care organizations (CCOs) include requirements to increase infrastructure for traditional health workers (a category which includes community health workers) and to create a plan for integrating these workers into beneficiary care teams (OHA 2019).[14]

Other states encourage or provide a specific option for MCOs to use CHWs for certain services or interventions, or as members of care teams, but do not require them to do so. For example, Florida specifies that MCOs may deploy interventions such as medication therapy management support services provided by CHWs through healthy behaviors programs (AHCA 2020). Texas MCOs may use certified CHWs or promotore(a)s to conduct outreach and member education activities (THHS 2021).

Some MCOs choose to use CHWs to fulfill certain federal and state requirements. This includes, for example, coordinating services provided by MCOs and those provided by community and social services providers.[15] In addition, some MCOs may use CHWs to undertake activities for addressing health equity and social determinants of health; both are areas that states are increasingly requiring MCOs to address (Gomez et al. 2018, McGinnis et al. 2018). In a 2017 survey of MCOs conducted by the Kaiser Family Foundation, 67 percent of respondents reported that they use CHWs to help address members' social determinants of health (Artiga and Hinton 2018). MCOs may choose to cover services provided by CHWs beyond the scope of the Medicaid benefit package and their contractual obligations (i.e., as value-added services) if they determine that doing so might help improve outcomes or produce savings (Gomez et al. 2018, McGinnis et al. 2018).[16]

CHW services may be treated in rate-setting in several ways. If states require MCOs to provide CHW services, the cost must be factored into the capitation rates. Where CHW services are specifically authorized in the state plan, associated costs should be categorized as part of the medical component of the capitation rates (McGinnis et al. 2018).[17] However, even where not specifically authorized in the state plan, expenses for certain services that CHWs perform, including those that fall under the coordination and continuity of care provision, may be categorized as medical expenditures (42 CFR § 438.208(b)(2)).[18] The cost of services for CHW services provided as value-added services are not factored in for purposes of calculating the capitation rate; they are not paid for by Medicaid, but rather by the MCOs themselves.[19]

MCOs may employ or contract with CHWs, or pay them or their employers on a fee-for-service or capitated basis, but it may be challenging to fit CHWs into typical Medicaid delivery and payment frameworks.[20] These frameworks were developed to pay for specific clinical services provided to patients during discrete encounters with providers. However, CHWs may work with specific clients and their families over a long period of time, helping them with a variety of health-related but non-medical needs.[21] Managed care arrangements or alternative delivery models emphasizing coordinated, team-based care, as well as models prioritizing primary or preventive care, may allow for more flexibility in determining payment methods that account for the scope of services CHWs provide and how they provide them.

Covered services

States vary in the CHW services they cover but the scope of what is covered is somewhat limited. Most states cover only a limited list of services. For example, as noted above, Minnesota only covers in-person patient education related to a patient's health condition, while Oregon and Indiana cover a slightly broader but still limited array of CHW services. States that allow CHWs to participate in multidisciplinary health teams such as health homes may give the health home or lead entity flexibility to determine how CHWs are used within certain parameters (CMS 2017). In addition, some states allow MCOs to determine what CHW services to provide. For example, Texas allows MCOs to use CHW for outreach and member education but does not further prescribe the specific activities or their focus (e.g., member education related to particular health conditions) (THHS 2021).

Target population

Many state Medicaid programs use CHWs as part of their strategy to address the needs or manage the care of specific populations. Examples of the populations commonly targeted by interventions or programs involving CHWs include:

- beneficiaries enrolled in a health home program, which include beneficiaries with two chronic conditions, one chronic condition and risk for a second, or serious mental illness (SMI);
- beneficiaries receiving targeted case management services, including specific groups of enrollees defined by the state (e.g., children with asthma, children with special health care needs, women and infants with risk factors for poor birth or perinatal outcomes, people with SMI, etc.);
- beneficiaries with complex behavioral or physical health needs; and,

- beneficiaries who are frequent users of health care services (e.g., those with frequent hospital admissions, repeated instances of avoidable ED use).

In some cases, states allow Medicaid payment for only certain CHWs, which may effectively limit the populations that can be served. For example, Alaska covers certified community health aide and practitioner (CHA/P) and behavioral health aide and practitioner (BHA/P) services under its physician services benefit. Because CHA/Ps and BHA/Ps by definition serve only specific communities (i.e., Alaska Natives residing in rural villages), their services are thus limited to beneficiaries residing in those communities (LaRoche 2019).

In other cases, states cover CHW services for all Medicaid beneficiaries given that services covered in the state plan must generally meet statewideness and comparability requirements.[22] For example, CHWs in Minnesota can provide diagnosis-related education services to any Medicaid enrollee as long as both the CHW and the service being provided meets applicable state requirements.[23]

Training and certification requirements

There are no federal Medicaid requirements for training and certification for CHWs. States that provide CHW services under the state plan are most likely to define certification and training requirements as a condition for receiving Medicaid payment. Requirements vary but often include certification from a list of approved entities, completion of specific training programs or curricula, or completion of a specified number of training or supervised practice hours. Some states exempt CHWs with prior experience from such requirements. Training and certification opportunities may be available through state CHW associations, educational institutions, or other entities.

Examples of state training and certification requirements are provided below:

- Indiana recognizes any certification program that satisfies the state's list of CHW core competencies. Certification recognition also extends to individuals who have an academic degree in a related field, or have been through employer-based training programs that include training in health promotion, community health integration, and CHW core competencies (ICHP 2018).
- Oregon requires CHWs to complete an approved training program, or provide documentation of having worked or volunteered as a traditional health worker in Oregon prior to June 2019. These requirements may be waived for CHWs with at least 3,000 hours of prior experience (OHA 2022). CHWs must participate in continuing education activities and renew their certifications every 36 months (OHA 2022).
- South Dakota requires CHWs to complete the Indian Health Service's CHR basic training program, or other CHW training programs approved by the South Dakota Department of Social Services, the South Dakota Board of Technical Education, or the South Dakota Board of Regents. CHWs must complete six hours of training annually thereafter (CMS 2019a).

Some states delegate responsibility for ensuring CHWs are adequately trained to MCOs. For example, Michigan requires MCOs to ensure CHWs are trained in all privacy laws and have completed training in specific core competencies (DHHS 2021). MCOs, clinics, hospitals, and other providers that employ or

contract with CHWs may have specific training or certification requirements for CHWs, even if there are no state-level requirements.

Views on CHW certification and training are evolving as states, federal agencies, associations representing CHWs, advocates, and others are engaged in broader conversations around the professionalization of the CHW workforce (ASTHO 2016).[24] However, there is no consensus on what level of training or certification should be required (CHCS 2021). Some stakeholders view having defined or standardized certification and training programs as helpful in defining and elevating the CHW profession (Brooks et al. 2018, CDC 2014).[25] This in turn may encourage greater use of CHWs in care teams (Garfield and Kangovi 2019). However, some argue that rigid standards for certification and training can be time-consuming or costly, and may exclude potential CHWs who share lived experiences with their clients (for example, people with a history of substance use disorder or interactions with the criminal justice system) (Ruff and Fishman 2020).

Endnotes

[1] Prior to this change, preventive services (defined in 42 CFR 440.130 (c) as services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency), could only be provided by a physician or other licensed provider (CMS 2013b).

[2] Section 1115 allows the Secretary of the U.S. Department of Health and Human Services (HHS) waive almost any Medicaid state plan requirement under §1902 of the Act. The Secretary can also permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the Medicaid state plan.

[3] MACPAC identified states that explicitly allow for or require the use of CHWs in state plans, managed care contracts, or approved federal demonstrations for payment by the state Medicaid agency or through alternative payment models. In addition, some states authorize payment for other lay health care workers, such as peer support workers or asthma educators and assessors. Although these workers may share characteristics or responsibilities with CHWs, they are not required by definition to have strong ties to the communities they serve.

[4] There are a variety of challenges to increasing the CHW workforce. The patchwork of often temporary or unreliable funding available, coupled with low wages and salaries, may create challenges in recruiting and retaining CHWs. For some potential CHWs, certification or training requirements may also pose barriers to entry.

[5] HRSA has estimated that demand for CHWs to support activities like care coordination and referral management alone will require more than 67,000 full-time equivalent workers by 2030 (HRSA 2019). However, it is difficult to gauge the exact size of the CHW workforce in the United States, with estimates ranging from 59,000 (the official figure from the Bureau of Labor Statistics) up to 120,000 (Goodwin and Tobler 2008). Variation in estimates is due to a variety of factors, including differences in how CHWs are defined.

[6] Kentucky has not yet implemented state plan coverage of CHWs. Recently enacted legislation (House bill 525) directs Kentucky's Medicaid agency to submit by January 1, 2023, a state plan amendment implementing such coverage.

[7] CHWs certified in chronic disease self-management, or those working under the supervision of a licensed registered nurse or registered environmental specialist, may provide TCM services for beneficiaries enrolled in the state's program serving those with poorly controlled asthma or a history of environmentally induced respiratory distress. Additionally, CHWs, family advocates, and promotoras working under the supervision of a licensed registered nurse may provide TCM services for

beneficiaries enrolled in the state's nurse home visiting program, which serves perinatal women, eligible infants and children with risk factors for poor perinatal, birth, and other poor health outcomes (OHA 2020).

[8] DSRIP programs, authorized under Section 1115 demonstration authority, allowed states to make supplemental payments to providers that otherwise would not be permitted under federal managed care rules and to invest in provider-led projects to advance statewide delivery system reform goals. As of 2021, most DSRIP demonstrations have ended or are nearing the end of their demonstration period. CMS has encouraged states to develop plans to sustain these activities by incorporating value-based purchasing strategies into their managed care contracting, and has indicated that it does not plan to renew DSRIP demonstrations in their current form (MACPAC 2020).

[9] In authorizing Oregon's coordinated care organizations (CCOs), the state's Section 1115 demonstration includes goals and reporting requirements related to traditional health workers, including CHWs. Additionally, New Hampshire's Building Capacity for Transformation demonstration, which expired in 2020, provided performance-based funding to integrated delivery networks (IDNs) delivering care to beneficiaries. These networks were required to develop multi-disciplinary teams to serve individuals at risk for or with diagnosed behavioral health or chronic conditions, which were required to include a care manager or community health worker (CMS 2019b).

[10] The Medi-Cal 2020 demonstration ended on December 31, 2021. It was replaced by CalAIM, which was implemented on January 1, 2022.

[11] Community partners are community-based entities that work with ACOs and MCOs to provide care management and coordination to Medicaid beneficiaries with significant behavioral health needs or complex long-term services and support needs, or both (Houston et al. 2021).

[12] This effort is modeled on the CHAP in Alaska (CMS 2020). CHAP is a system of mid-level behavioral, community, and dental health professionals serving rural Alaskan villages. Community health aides and practitioners (CHA/Ps) are typically selected by their communities to receive CHA/P education and training, then return to provide culturally competent services in those communities alongside licensed providers (Appendix Table A). Currently CHAP operates in Alaska, but the Indian Health Service and tribes have discussed expanding the program, and in 2018, formed a tribal advisory group to expand the program to the lower 48 states (LaRoche 2019).

[13] MACPAC identified three states with such managed care contract requirements.

[14] Oregon's CCOs replaced MCOs in 2012. They are similar to MCOs in that they are responsible for delivering services to beneficiaries. CCOs have one global budget for behavioral health, physical health, and oral health services. They have budget flexibility to provide services outside traditional medical services. They are authorized under a Section 1115 demonstration.

[15] Federal Medicaid managed are rules, MCOs must provide community care coordination services, such as assistance with coordinating services delivered by the MCO with those received through community or social services providers (42 C.F.R. 438.208(b)(2)(iv)).

[16] Medicaid managed care rules allow MCOs to offer value-added services (42 CFR 438.3(e)1).

[17] In some cases, MCOs, or similar entities may receive incentive payments that can be invested in activities such as CHW activities (Lloyd 2020). For example, at least one of Oregon's coordinated care organizations (CCOs) that received quality and performance incentive payments used those funds to support training and certifications of CHWs.

[18] Some states (e.g., New Mexico) may categorize CHW costs as administrative when appropriate (McGinnis et al. 2018).

[19] Even so, expenses may count in the numerator of the medical loss ratio calculation.

[20] Some MCOs may also use pay for performance models, where CHWs or their employers receive payments for achieving certain process or health outcome measures (ORCHWA 2020).

[21] For example, in Minnesota, providers employing CHWs reported the payment rate for patient education activities — roughly $20 per 30-minute unit, with a cap on the number of hours CHWs can bill for — only allows them to deploy CHWs in a part-time capacity to break even on costs (MNCHWA 2018).

[22] An exception is states providing CHW services to TCM beneficiaries, as TCM services are not subject to statewideness and comparability requirements (§ 1915(g) of the Act).

[23] Because of federal Medicaid requirements including statewideness and comparability, choosing to provide CHW services under state plan authority generally requires services to be available to all full-benefit beneficiaries. However, these requirements do not apply to health homes or targeted case management, meaning states using one of these approaches can restrict services to eligible beneficiaries (Spillman and Allen 2017).

[24] Some states explicitly define those requirements in their Medicaid state plan, while others do not. Outside of state Medicaid requirements, certification and training may or may not be required in order to be employed as a CHW, depending on the employer, care setting, specific responsibilities of the CHW, or other factors.

[25] Numerous organizations, at both the state and federal levels, have developed core competencies and core competency trainings for CHWs, and evidence-based standards for high-quality CHW programs. The goal of this approach is to create guardrails for hiring CHWs as opposed to rigid certification or training requirements (C3 Project 2018, Raths 2020).

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Appendix

There is no universally accepted definition of a community health worker (CHW) and different occupational titles may fall under the umbrella term. CHWs have strong ties to the communities they serve or serve a particular population.

Other workers have similar roles or responsibilities as CHWs, but do not necessarily come from the same communities or have the same strong community ties (Table A).

TABLE A. Examples of Community Health Workers

Title	Description
Community health workers	
Community health worker	The American Public Health Association defines a community health worker as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." A number of organizations rely upon APHA's definition. The National Association of Community Health Workers further specifies that CHWs "share life experience, trust, compassion, cultural and value alignment" with the communities they serve.
Community health aide/practitioner, behavioral health aide/practitioner, dental health aide/practitioner	Community health aide/practitioners (CHA/P) are unique to Alaska. They are members of Alaska Native communities (rural villages) selected by their communities to provide and refer clients to health care and other services. Other types of Alaska health aides include behavioral health aides/ practitioners (BHA/Ps) and dental health aides/practitioners (DHA/Ps). BHA/Ps are focused specifically on individual and community behavioral health needs, including substance use disorder. DHA/Ps focus on patient education and preventative services in oral health. CHA/Ps, BHA/Ps, and DHA/Ps must each meet specific training and certification requirements.
Community health representative	The Community Health Representatives (CHR) program is a federally established program, administered by tribal governments under legal arrangements with the Indian Health Service (IHS). CHRs are trusted members of the tribal communities they serve who may incorporate traditional native concepts in their medically guided approach. CHRs are trained by the National IHS CHR Program to provide services including health education and promotion, case management and coordination, and translation/interpretation.
Promotores/Promotoras de salud	Promotores or promotoras are CHWs who specifically work in Spanish-speaking communities. They serve both urban and rural communities that are typically low income. They link community members with social services, acting as a navigator and intermediary for health systems and other not primarily health-related services.

Title	Description
Occupations that share responsibilities or characteristics with community health workers	
Asthma educator	An asthma educator has specific expertise and certification in helping clients with asthma and their families manage their condition and improve their quality of life. CHWs, physicians, nurses, and other professions can become asthma educators through training and certification.
Health advocates	Health advocate is a general title for individuals who provide direct personalized services to patients and their families as they navigate health decisions. They can help patients and families understand and navigate health conditions and treatments, billing and claims processes, health insurance, legal issues, and end-of-life care.
Patient navigators	Patient navigator is a general title for people who help patients navigate the health system and receive timely care, including the screening, diagnosis, and treatment of a medical condition. Patient navigators are often employed by a hospital or health center, and help coordinate care with the medical professional by providing assistance in scheduling and communication, as well as with financial, legal and social support. Many patient navigators have a chronic disease focus area, such as cancer or diabetes.
Peer support specialists	Peer support specialists are trained lay-workers, similar to other community health worker roles. However, whereas CHWs are often selected for their connection to the community being served, peer health workers will share a medical diagnosis or treatment experience in common with the patients they serve. Peer health workers tend to be deployed for behavioral health and substance use disorder treatments.

Source. AAE 2021, APHA 2021, Daniels et al. 2017, IHS 2021, LaRoche 2019, MHP Salud 2021, Mohatt and Helfand 2020, NACHW 2022, NCI 2021, NIHB 2019, PNTC 2021, and WASHAA 2020.