Public Health Reports
2022, Vol. 137(3) 597–603

DOI: 10.1177/00333549211006072
journals.sagepub.com/home/phr
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# Community Health Worker Sustainability: Funding, Payment, and Reimbursement Laws in the United States

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**Keywords**

community health workers, law, regulation, insurance, health, reimbursement, Medicaid

The number of community health workers (CHWs) in the United States is expected to increase 13% in the next decade (from 127 100 to 144 100 by 2029).[1-3] CHWs function as patient navigators, health promoters, health educators, patient advocates, and outreach workers or find employment or volunteer work in various other positions.[1,3,4] In these capacities, CHWs are frontline health workers who connect people with needed health and social services in their communities and address the social determinants of health and inequities experienced by their clients.

CHWs' broad reach and varied responsibilities allow them to fill the needs of the communities they serve, but the broad scope of CHW activities also creates barriers to defining the CHW workforce. The CHW section of the American Public Health Association provides the following definition: "A [CHW] is 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."[5] This necessarily broad definition encompasses the diversity of roles found across the CHW workforce. Yet an ambiguously defined workforce can present challenges for rapidly evolving fields such as the CHW field, including barriers to establishing payment mechanisms for CHW services. Establishing those payment mechanisms and providing compensation assurances to this growing profession are critical to continuing the momentum in recognizing CHWs as critical players in advancing population health in the United States.

Efforts have been made to define CHWs and integrate them into the health workforce, although much work remains to be done. CHW models in the United States have become increasingly formalized through federal and state policy, including policies aimed at funding CHW activities. Reimbursement for provided services is regarded as a preferred payment structure for sustainably funding CHWs.[6,7] In 2014, the Centers for Medicare & Medicaid Services (CMS) established a rule expanding preventive services to cover reimbursement for CHW services; the coronavirus disease 2019 (COVID-19) pandemic has prompted calls for further expanding CMS coverage for CHW services.[8-10] In addition, the Patient Protection and Affordable Care Act promoted certain care coordination and service delivery models (eg, patient-centered medical homes and accountable care organizations), which provided a framework for integrating CHWs into care teams.[11,12]

Despite changes to CHW funding at the federal level, payment structures for CHWs vary from state to state.[13-15] As a result, compensation for CHW services is inconsistent, fundamentally shaping the role that CHWs play and the tasks that they perform across states. CHWs may receive funding from various sources, including grant funding, nonprofit contributions, general revenue, and reimbursement for services rendered.[16,17] Identifying consistent and sustainable funding mechanisms for CHW services is critical to supporting and sustaining a robust CHW workforce.[7,18] Stable funding enables skilled CHWs to stay in their roles

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longer, allowing them to build knowledge of community resources and contacts. In addition, stable funding gives organizations confidence that they can integrate CHWs in care teams without workflow disruptions caused by funding fluctuations.

A 2016 review of state CHW laws conducted by the Centers for Disease Control and Prevention (CDC) revealed that states have taken various approaches to using laws to establish funding mechanisms for CHW services.[15] States can establish funding mechanisms for CHWs in laws in numerous ways, including grants, state programs, Medicaid reimbursement, or other social service or entitlement programs. Not all of these funding mechanisms are created equal. Grants and other programs that depend on annual or periodic appropriations are often less reliable for ongoing sustainability than social service entitlement programs such as Medicaid. In this rapidly evolving CHW field, this research updates and expands on the CDC review of CHW funding laws from 2016. Specifically, it examines whether states are funding CHWs to perform specific activities or excluding CHWs from overtime compensation, in addition to identifying general types of funding mechanisms (eg, Medicaid).

## Methods

We followed accepted policy surveillance research guidelines for our analysis of CHW laws and maintained a research protocol.[19,20] We used Westlaw to identify statutes and regulations relating to CHWs in effect on February 11, 2019, limited to US states, Guam, Northern Mariana Islands, Puerto Rico (Westlaw's English database), US Virgin Islands, and the District of Columbia.

### Search Methods

CHWs operate under multiple titles.[5,21] To capture information on laws pertaining to CHW activity, we compiled a list of search terms identified through the National CHW Training Center and a broad search of CHW organizations. Subject matter experts, including CHW subject matter experts at CDC, reviewed our search terms. We used the following search string to identify CHW laws: adv: (Community lay/3 health outreach/3 rep! Promotor! Worker Advis! Navigat! Aide) CHW CHR "health advocate" "health Promoter" "enrollment counselor" "enrollment entity" "care navigator" "patient navigator" "health educator."

As part of our validity checks, we compared our search string with the search string used in the 2016 CDC state law analysis.[15] This check revealed 2 possible CHW terms that were not captured: community health representative and community care coordinator. We supplemented our captured laws with 2 targeted searches using these terms.

**Box.** Coding questions

- Does the state have a specific funding mechanism for community health workers (CHWs)? (yes/no)
- Does the state have a Medicaid law or other public assistance law relating to CHWs? (yes/no)
- Does the state have a specific funding mechanism for supporting CHW workforce development (eg, supervision, training)? (yes/no)
- What types of activities are described in the state payment, reimbursement, or funding law?
  - Maternal–child health
  - Clinical trial navigation
  - AIDS early intervention projects
  - Mental health services
  - School-based services
  - Health education and promotion services
- Are CHWs specifically excluded from certain types of payment or reimbursement (eg, overtime)? (yes/no)

### Scoping

We reviewed each law captured by our Westlaw search for its relevance. We included any law that expressly used common CHW terminology (eg, CHW, promotor[a/e]s). We also included any law with context suggesting that the person or position (1) was involved in community engagement or outreach and (2) was involved in health education or access to health services or social services. However, we excluded laws that referenced certified health education specialists, which have a national credentialing framework.[22]

### Coding

We developed our coding scheme on the basis of findings from a literature search and an initial review of CHW laws. CHW subject matter experts, including CDC and Network for Public Health Law experts, reviewed an initial coding criteria draft (Box). We used a "naïve" coder (a political scientist with experience coding state legislation) to evaluate the validity and objectivity of our coding scheme using 5 jurisdictions, selected from the initial, middle, and final states coded. At least 2 researchers (C.S., M.L., D.W.) independently scoped and coded each jurisdiction with CHW laws in a custom Microsoft Access database. We resolved coding disagreements at coding meetings with a licensed attorney or CHW subject matter expert who resolved ambiguous cases. In determining whether a law addressed a funding mechanism, we gave special attention to the law's position in the statutory or regulatory code. For example, a law describing CHW activities located in a chapter authorizing a grant program for HIV-related services would be presumed a funding mechanism absent contrary context.

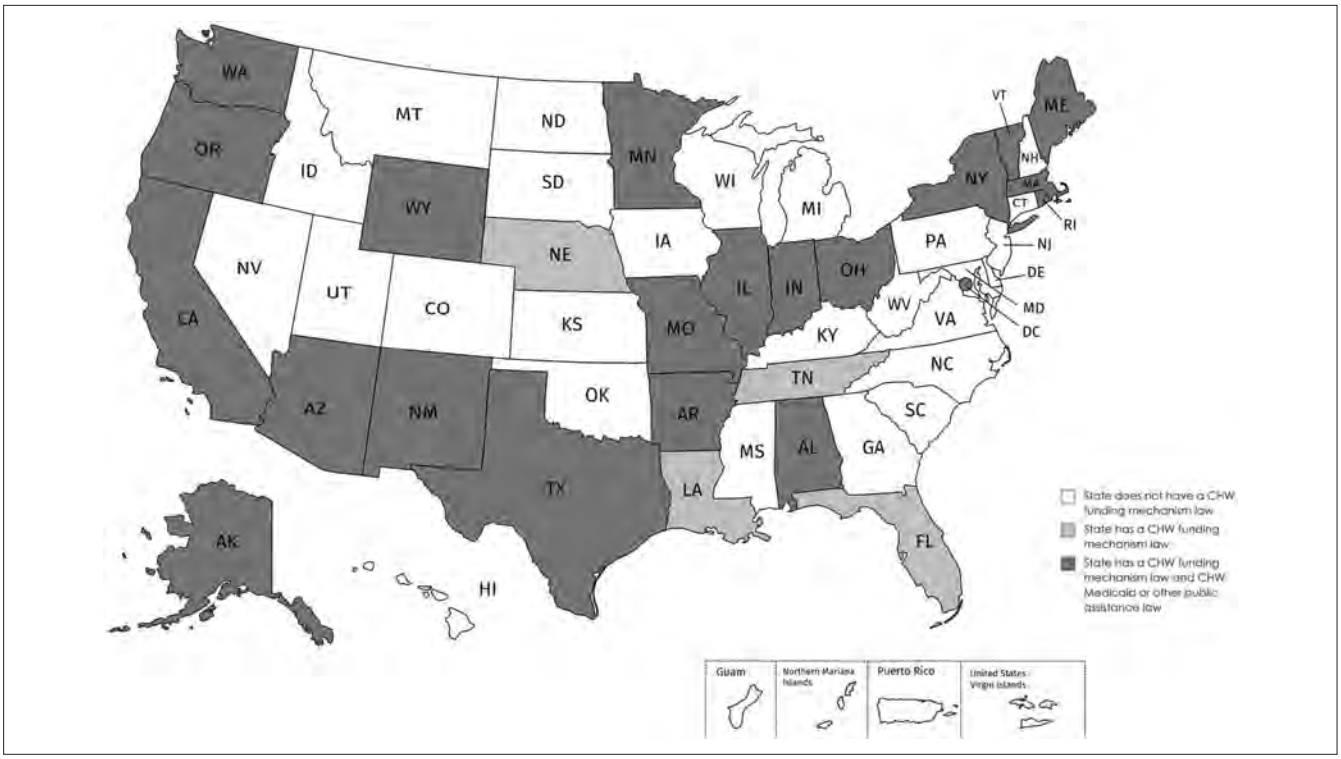


**Figure 1.** States with laws that provide funding mechanisms for community health workers (CHWs), United States, 2019. The following states have ≥1 law justifying the figure classifications that uses a nontraditional CHW term or title used in the law with context suggesting (1) community engagement or outreach and (2) involvement in health education or access to health services or social services: Alabama, Arkansas, California, District of Columbia, Florida, Illinois, Louisiana, Maine, Minnesota, Nebraska, New York, Rhode Island, Washington State, and Wyoming.

## Results

Our Westlaw search identified 1216 laws, of which 371 across 37 jurisdictions were within our scope. Puerto Rico was the only territory with a CHW law. The average intercoder agreement was 90.0%. We identified laws that provided a CHW funding mechanism in 24 states and the District of Columbia (Figure 1). Of these jurisdictions, 20 states and the District of Columbia had a Medicaid law that related to CHWs. Florida, Louisiana, Tennessee, and Nebraska were the only states with laws that described a funding mechanism that did not have a state Medicaid law governing CHW payment. (Florida, Louisiana, and Nebraska had laws that used uncommon or nontraditional CHW terms or titles.) Six states had laws that provided funding mechanisms for CHW workforce development (Figure 2). These laws provided workforce development funding for CHW training (Alaska, California, Illinois, Louisiana, Minnesota, Nebraska), supervision (Alaska), recruiting (California), and loan forgiveness (Louisiana). (California, Illinois, Louisiana, and Nebraska had laws that used uncommon or nontraditional CHW terms or titles.) Alaska, Arkansas, and New York had laws that excluded CHWs from overtime compensation. (New York had laws that used uncommon or nontraditional CHW terms or titles.) Sixteen states had laws that provided funding mechanisms for CHWs engaged in specific activities, including mental and behavioral health, clinical trial recruitment, school-based services, maternal–child health, HIV/AIDS services, and education and health promotion (Table).

## Discussion

A lack of stable funding is a primary barrier to fully using CHWs to connect vulnerable populations to preventive interventions, needed health and social services, and additional health care support; these services have become especially critical during the COVID-19 pandemic.[6,9,10,21,23] Our study provides useful information on this barrier by examining CHW funding mechanisms defined in state laws.

Legally defined funding mechanisms or funding requirements are not necessary for CHW employment.[16] However, substantial challenges to free-market solutions to CHW viability justify legally defined funding mechanisms. Although CHWs and CHW employers are free to charge individual clients for their services, charging clients for services requires a sufficiently large client base with the resources to make out-of-pocket payments, which is often unrealistic

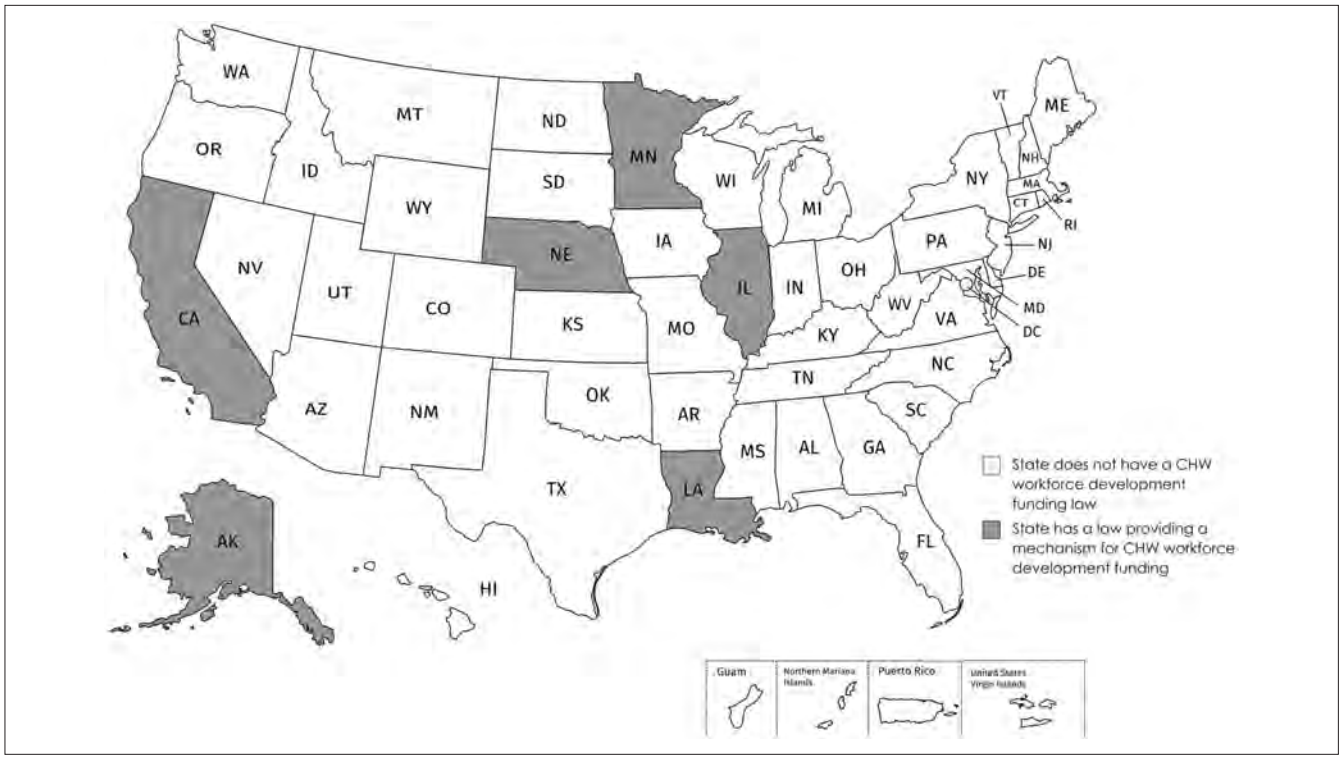


**Figure 2.** States with laws that provide funding for community health worker (CHW) workforce development, United States, 2019. The following states have ≥1 law justifying the figure classifications that uses a nontraditional CHW term or title used in the law with context suggesting (1) community engagement or outreach and (2) involvement in health education or access to health services or social services: California, Illinois, Louisiana, and Nebraska.

given the largely low-income CHW client base.[14,17] Private health insurance companies can cover CHW services, but private health insurance companies might require additional cost-effectiveness evidence justifying the added coverage expense; however, research on cost effectiveness is still nascent.[24-26] Similarly, CHW employers (eg, hospitals, federally qualified health centers, health insurance companies) might be willing to provide CHW services for free if the benefits justify the costs. However, the benefits of CHW services with a client might accrue to a diverse set of actors, including health care providers, health care facilities, payers, governmental entities, nonprofit organizations, and businesses. Consequently, it may be challenging for a single CHW employer to provide CHW services free of charge if that person is receiving only a portion of the benefit. Some CHW employers have responded by bundling CHW services with other reimbursable services.[27,28] State policy makers can use legally defined funding mechanisms to give employers clarity on supported CHW services and widely promote services with broad social and economic benefits.

**Table.** State funding or reimbursement for community health worker activities, United States, 2019

| Activity | States with a funding or reimbursement law for the activity |
|---|---|
| Mental and behavioral health | California,[a] Illinois,[a] Indiana, Maine,[a] Tennessee |
| Clinical trial recruitment | California[a] |
| School-based services | District of Columbia, Illinois[a] |
| Maternal–child health | Alaska, Arkansas,[a] California,[a] District of Columbia, Florida,[a] Illinois,[a] Minnesota, Oregon, Washington State |
| HIV/AIDS services | California,[a] New York[a] |
| Education and health promotion | Alabama,[a] District of Columbia,[a] Illinois, Maine,[a] Minnesota,[a] New Mexico, New York,[a] Texas, Washington State |

[a]Indicates use of an uncommon or nontraditional community health workers term or title used in the law with context suggesting (1) community engagement or outreach and (2) involvement in health education or access to health services or social services.

Importantly, not all of the funding mechanisms described in these laws guarantee consistent funding for CHWs. Some states have created programs involving CHWs that are still subject to state appropriations (eg, Missouri's Show-Me Extension for Community Healthcare Outcomes program).[29] Other states have introduced grant programs that might have limited longevity.[30] These types of funding mechanisms are more fragile than entitlement programs, such as Medicaid, or other public assistance programs (eg, school-based programs, maternal and child health programs, other public health or welfare programs) that provide more stable reimbursements for services rendered.[7,31] Moreover, funding, payment, and reimbursement rates must be sufficient to support integrating CHWs into service models. CHW sustainability requires both stable and sufficient funding sources.

Of course, legal CHW funding mechanisms are challenged by the absence of a common terminology or qualifications for CHWs.[23] Different states use different terms to describe CHWs, and some states have laws that use inconsistent terms to describe CHWs. The absence of a common terminology for CHWs is a challenge to state codification of funding mechanisms in statutes and regulations.

Our findings show that states are making the policy determination that CHW services provide benefits (collective or individual) sufficient to justify state support through statutes and regulations. These findings suggest that legal funding mechanisms have expanded since the 2016 CDC study of CHW laws.[15] However, not all states have added CHW funding laws. Of the 38 states and the District of Columbia without a CHW Medicaid law identified by CDC, our data show that only 8 states and the District of Columbia adopted a new CHW Medicaid law, and at least 1 state has repealed legal funding mechanisms. In 2017, Maryland repealed every statutory provision cited by the 2016 CDC study.[32,33]

### *Limitations*

This study had 2 limitations. First, this study examined funding mechanisms described only in state statutes and regulations. Not all state policy actions are codified in state statutes or regulations. For example, state policies for Medicaid administration and policies related to managed care organizations are not always codified in statutes or regulations.[15] Consequently, our study does not capture information on payment rates for CHW services. Moreover, this study examined only state laws. With limited exceptions (eg, state Medicaid implementation), this study did not capture data on federal statutory or regulatory efforts to promote CHW financial sustainability.

Second, the absence of common CHW terminology is a known issue in the CHW field and a challenge for this research. We included laws that referenced a broad array of terms and titles that could apply to CHWs in this study; however, many state laws lacked definitions for these terms and titles. This broad scope and lack of legal definitions create some uncertainty in interpreting these results (as well as for CHWs leveraging these laws in the field). We distinguished between states that use traditional terminology (eg, CHW, promotor[a]s) and states that use uncommon or nontraditional CHW terminology to be more transparent with this uncertainty.

## Policy Implications

CHWs are frontline health workers who are instrumental in connecting people with preventive services and addressing the social determinants of health. When properly used, CHWs can create tremendous benefits to health care providers, health care facilities, payers, governmental entities, nonprofit organizations, and businesses. Yet many states do not have legal funding mechanisms to promote CHW use and ensure long-term sustainability.

Moreover, many states that have adopted CHW funding or reimbursement laws have challenges. Many states lack consistent terminology for CHWs, which can create confusion (eg, if a lay health worker or a health educator can be reimbursed for CHW services). Some states have created mechanisms to fund certain, highly specific CHW services but not others, which could limit the scope of CHW activities. Some state funding mechanisms are subject to legislative appropriations, which are vulnerable to cuts, if they are ever funded at all.

From our review of state CHW funding laws, it is apparent that states need to implement clear and stable mechanisms for funding, payment, or reimbursement for CHW services. Laws authorizing CHWs to bill for services through Medicaid or other existing public assistance laws provide a promising option for long-term CHW sustainability. We anticipate that states that have both enacted legal CHW funding mechanisms and provided funding for CHW workforce development will be in an improved position to take advantage of the anticipated growth in CHWs in the coming decade.[1-3]

### Acknowledgments

The authors thank Colleen Healy Boufides from the Network for Public Health Law and Siobhan Gilchrist and Colleen Barbero from the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention, for their assistance and collaboration in the design of our legal search and coding methodology.

### Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Support for this study was provided by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS). The views expressed in this article are those of the Southwest Rural Health Research Center and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the US government.

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