



SUSTAINABLE FINANCING OF COMMUNITY HEALTH WORKER EMPLOYMENT: KEY OPTIONS FOR STATES TO CONSIDER

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OVERVIEW

About This Document

Interest in the CHW workforce has grown substantially over the last two decades. Appreciation of their value as part of health care, public health and community-based organizations is driving a related pursuit of approaches and methods to finance their positions sustainably. This document presents a collection of “Key Options” for **state level actors** to consider when they discuss, decide, or pursue strategies for CHW sustainable financing. For each option, a definition, key considerations, and advantages/limitations are presented. This document also presents real-life examples and resources. **A summary table of these Key Options is provided as Appendix A.**

While individual employer organizations may also find this Report informative, it is not oriented to their goal of sustainability for their **organization. These employer organizations** may be motivated by different goals, such as:

- Reducing health care costs or enhancing provider revenue
- Improving clinical outcomes or social justice impact
- Involving community-based organizations (CBOs) in public health

A useful document which **employers** may find more directly relevant to their needs is a Toolkit developed by the Kansas City

¹ Saleski E, McNeill T. Reimbursement Strategies for Employers of Community Health Workers: A Toolkit. KC Regional CHW Collaborative, Oct 2022.

Regional CHW Collaborative.¹

This document focuses heavily on the health care sector – health care providers and payers – and funding sources accessible to them. However, organizations across other sectors, including a wide variety of community-based organizations (CBOs), employ significant numbers of CHWs. They, too, can benefit from state-level pursuit of the options described in this report.

This document is based on a review of peer-reviewed journal articles, gray literature, and conversations with multiple groups who have addressed or implemented CHW sustainable financing.

How to Use This Document

Users of this Report may wish to review all the options presented in this document. Remember that no individual option on its own can achieve “full” sustainability for CHWs. Financing for long-term employment of CHWs is also complex because CHWs engage in diverse roles and areas of activity. Even when a provider or payer envisions a “generalist” role for CHWs, their contributions can have different impacts on costs, revenues, and other outcomes.

Accordingly, readers of this report should consider sustainable financing options that best align with (1) their unique objectives for clinical outcomes and social impact and (2) the populations they plan to reach or serve.

https://www.marc.org/sites/default/files/2022-11/CHW_Sustainability_Toolkit_FINAL_10-11-22.pdf

Definition of Sustainable Financing

For the purposes of this Report, organizations have achieved sustainable financing for CHW positions when they do not rely on time-limited funds, like grants or contracts; and when support for CHWs is part of the organizations' regular budgets. In that situation, the organizations routinely pay for CHW services along with all their other services. It is important to note that most sources of funding described here support *systems* of services and *not* individual professions. This latter point is relevant when advocating for CHW financing; making the case for CHWs is generally part of making the case for changes in service delivery systems.

3. Prospective Payment Systems to Federally Qualified Health Centers
4. Administrative Contract Requirements for Managed Care Organizations
5. Quality Improvement Cost for Managed Care Organizations or Medicare Advantage Plans

B. Medicaid High Level Policy-Change Mechanisms

1. Section 1115 Demonstration Waivers
2. Medicaid State Plan Amendments

Key Options for Sustainable Financing

Here is a guide to the main body of this Report:

- I. Federal Government Funds
 - A. Public Health Funds
 - B. Block Grants
 - C. 330 Grants
- II. State and Local Governments: Budgetary Line Items
- III. Health Care Providers: Internal Financing
- IV. Multiple Sources: Blended or Braided Funds
- V. Health Care Payers: Medicaid
 - A. Specific Policy Options under Medicaid
 1. Medicaid Health Homes
 2. Alternative Payment Models (APMs)

I. Federal Government Funds

I.A. Public Health Funds

These are funds from federal agencies to expand sustained investments in public health, improve health outcomes, and enhance health care quality.

Key Points

- Many federal agencies have funds, such as cooperative agreements and grants, that can be used or adapted to integrate CHWs into programs.
- The primary federal agencies that fund public health are the Centers for Disease Control and Prevention (CDC), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Health Resources and Services Administration (HRSA).
- Funds that may be used to support employment of CHWs are available

from federal agencies such as the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA).

Limitations/Challenges

These funds:

- Tend to be for short term (i.e., three to five years) program or project funding. An exception is the Community Health Representative (CHR) Program of the Indian Health Service, in operation since the 1960s. It has a dedicated line item in the federal budget covering about 1,500 CHRs.
- Depend on Congressional appropriations, and other factors such as eligibility requirements.
- Are categorical and focus on specific program goals, such as improving cardiovascular health, increasing participation in job training, or raising immunization rates. However, such funding does not address the full range of CHW capabilities or community needs.
- Lead to CHWs being laid off or reassigned, which results in:
 - The employer losing valuable skills and their investment in cultivating those skills.
 - Individual clients/patients losing their relationships with CHWs.
 - CHWs losing a job, which can mean starting over in an entry-level position.

Example

CDC has funded programs for CHW pilot projects to address infrastructure development, but they are short term only. These include the 1815/1817 chronic disease

innovation awards, 2103 health equity grants, and 2109 resilient community grants. Only a limited number of 2109 grantees elected to voluntarily take on a “policy and systems change” component, which includes a sustainability plan.

I.B. Block Grants

Block grants are non-competitive, formula-based funds given by the Federal government to and administered by state governments who, in turn, distribute the funds to state and local programs; the purpose is to fund a “block” of programs.

Key Points

- These grants are broader in scope than Federal categorical funds and have fewer Federal requirements. They allow state and local governments greater latitude in determining how funds are used and specific activities within their program areas, but are still tied to specific national priorities (e.g., preventive health and health services, maternal and child health, and substance abuse prevention) and parameters set by federal government.
- There is some potential for CHW support in federal block grant programs, such as:
 - Community Development Block Grants (CDBG) from the Department of Housing and Urban Development (HUD)²
 - Community Service Block Grants (CSBG)³ and Social Service Block Grants (SSBG)⁴ from the Administration on Children and Families (ACF)

Challenges/Limitations

- Block grants are not sustainable funding sources since they require local grant proposals for each project

² <https://www.hudexchange.info/programs/cdbg>

³ <https://www.acf.hhs.gov/ocs/programs/csbg>

⁴ <https://www.acf.hhs.gov/ocs/programs/ssbg>

period and are subject to Congressional appropriation.

- There are important policy considerations and divergent opinions on the benefits and drawbacks of block grants. Those who support them suggest they encourage efficient allocation of resources and program efficiency by shifting decision-making and accountability from the federal government to state and local governments, and that they promote innovative programs and services that may not be supported by other Federal funding. Those who oppose block grants point out that communities with the greatest political influence end up with the most benefits while communities most in need are often overlooked; the latter are the communities most commonly served by CHWs. Such inequities may result in part from the lack of close oversight and stringent guidelines from the Federal government on block grants.

I.C. Health Resources and Services Administration (HRSA) “330” Grants

A large source of federal funding to Federally Qualified Health Centers (FQHCs) is from HRSA for the Health Center Program, which is authorized in Section 330 of the Public Health Services Act. Commonly known as the “330 Grant,” annual funding for the Health Center Program comes from two funding streams: Congressional appropriations and the Community Health Center Fund (CHCF). Appropriated funds generally subsidize care for the uninsured. The CHCF is the larger of the two streams, and is generally devoted to expansion of FQHC facilities and services.

⁵ Enabling services are defined as “non-clinical services that aim to increase access to healthcare and improve health outcomes,” and include services such as health education, interpretation, and case management. See Park HL. Enabling Services at Health Centers: Eliminating Disparities and Improving Quality. New York, NY: New York Academy of Medicine, September 2005. Downloaded 4/13/20 from

Key Points

- Nationally, about 44 percent of FQHC’s annual funding comes from Medicaid and another 18 percent of comes from 330 grants; together, these two represent nearly two thirds of FQHCs’ funding sources.
- Though there are no official statistics on this practice, CHWs’ salaries and expenses (e.g., transportation and language services) may be funded under “enabling services.”⁵
- Payment models are being developed that can embed CHWs in clinical services.⁶

Challenges/Limitations

Current priorities and pressures on HRSA funding within FQHCs can sharply limit their ability to divert these funds to support CHWs. FQHCs also commonly support “outreach workers,” which are CHW-like positions with a limited range of duties, mainly around promoting the health centers’ services in their surrounding communities.

II. State and Local Government Funds

CHW sustainable financing can be supported by state and local government funds when their general appropriations include a specific line-item for CHWs’ work and services. Becoming a line-item entails being explicitly and specifically written and allocated into the state or local government agency’s budget on a continuous, long-term basis.

<https://www.aapcho.org/wp/wp-content/uploads/2012/03/ES-Metlife-Report.pdf>

⁶ <https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/21269204/california-seeks-to-pilot-apms-with-fqhcs>

Key Points

- These funds may pay for CHW employment directly or contracted with community-based organizations that hire CHWs.
- Budget line items are advantageous because they are relatively stable once established.

Challenges/Limitations

- State and local governments generally receive the largest percentage of their public health revenue from the following Federal agencies: the U.S. Department of Agriculture (USDA), followed by the Centers for Disease Control and Prevention (CDC), and then the Health Resources and Services Administration (HRSA).
- Federal funding to state and local governments ebbs and flows. It often takes a reactive approach, with significant increases after public health emergencies associated with specific diseases like Zika or, more recently, COVID-19. Drastic budgetary reductions can occur after the immediate danger from such crises subside; during these times, funding for CHW positions and services can be vulnerable.
- It can be difficult to obtain initial funding for ongoing budget line-items. Significant support, championing, and compelling practice- and research-based evidence are often necessary to establish the CHW budgetary line item.

III. Health Care Provider “Core Budget” Funds

A small but growing number of health care organizations use their own “internal” funds to provide for CHW positions and services, in anticipation of offsetting reductions in other costs, or enhanced

revenue, providing a financial return on investment (ROI).

Key Points

- Often, provider organizations use grant funds and/or internal resources to demonstrate or pilot an intervention that includes CHWs and evaluate its financial impact. Once there are documented cost savings or other valued outcomes, CHW positions can be included as part of the provider’s ongoing operating budget.
- Health plans/provider systems serving mostly low-income and/or disenfranchised populations (e.g., FQHCs and safety net hospitals) have been hiring CHWs for years, prior to recent Medicaid and other system changes. These efforts are intended to improve access to health care for these populations, and to engage these populations in improving their own health. Some safety net hospitals, in particular, have also achieved net reductions in the cost of uncompensated care.
- A possibly persuasive finding: a meta-evaluation of the Center for Medicare and Medicaid Innovation’s Health Care Innovation Award (HCIA) grants in 2018 found that, of 6 categories of innovations, only those involving CHWs had significant cost savings.⁷

Challenges/Limitations

- Internal commitments by employers are of course subject to the overall financial condition of the organizations, and to changes in senior management personnel.
- Initial acceptance of an internal financing plan may require a local demonstration or pilot; research or evaluations conducted elsewhere are often not fully persuasive to healthcare executives. Pilot projects may be funded by short term grants.

⁷ Bir A et al. Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative: Annual Report Year 3.

Research Triangle Park, NC: RTI international, February 2018.

Example

University of Pennsylvania Health System (Penn Medicine) employs 30 CHWs, whose salaries are financed internally through cost savings elsewhere in the system's operations. However, these positions are also subsidized by consulting revenue from the Penn Center for CHWs, which helps other provider organizations implement the Penn Center's IMPaCT model.⁸

IV. Blended or Braided Funds from Multiple Sources

- Braiding refers to coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level). Braiding keeps funding/financing streams in distinguishable strands, so each funder can track resources.
- Blending refers to combining different streams into one pool, under a single set of reporting and other requirements.⁹

Key Points

- State Public health leaders have long braided funds from multiple federal grants, such as the HRSA Maternal and Child Health block grant and SAMHSA and CDC grants. Braiding funds in this manner generally do not require federal approval because the funding streams retain their own identities and reporting requirements. Increasingly,

states are considering funding structures that braid funding across agencies, such as state permanent supportive housing programs that braid Medicaid funding for services with housing authority funding for rental assistance.¹⁰

- Some CHW employers have successfully partnered with multiple funders in fields other than health care. Social service agencies at the state and local level often need to work with the same families who depend on Medicaid for their health care; a home visit for a medical need can also be used to connect the family to resources related to parenting or financial literacy. Health care organizations are coming to recognize the public health principle that socioeconomic factors affect both a patient's health status and their ability to access health care and adhere to medical treatment plans. This can create opportunities for payers and providers to combine funding streams to work with the same population.

Examples

- For example, Baylor Scott & White health system, based in Dallas, Texas, expanded from employing one CHW in a diabetes program in 2007 to 30 in 2014 in multiple programs, to over 100 in 2020 in eight distinct program specialties, each with different funding sources ("braided"), including an ongoing contract with a county health department.¹¹
- Rhode Island's Health Equity Zones have combined funds from the HRSA Title V Maternal and Child Health Services Block Grant, as well as funding from Rhode Island's state minority

⁸ <https://chw.upenn.edu>

⁹ Trust for America's Health: Braiding and Blending Funds to Support Community Health Improvement: A Compendium of Resources and Examples: Issue Brief. TFAH, Sept 2018. <https://www.tfah.org/wp-content/uploads/2018/01/TFAH-Braiding-Blending-Compendium-FINAL.pdf>

¹⁰ National Academy for State Health Policy. States Develop New Approaches to Improve Population Health Through Accountable Health Models. Blog post, January 12, 2018. <https://nashp.org/states-develop-new-approaches-to-improve-population-health-through-accountable-health-models/>

¹¹ Presentation by Ashley Rodriguez, Baylor Scott & White Health System, March 25, 2019.

health general revenue. They reportedly also plan to integrate Medicaid payment for CHWs under the state’s new CHW benefit (see below under “Medicaid State Plan Amendments”).¹²

- The “Pathways-Community Hub” model, currently promoted by Care Coordination Systems, Inc., has pioneered the establishment of multiple revenue arrangements with diverse parties, including Medicaid MCOs, housing agencies, Head Start, law enforcement, schools, and charitable foundations, including the United Way. Each funding source has committed to a schedule of progress payments to the Hub on the basis of specific outcomes along a “Pathway” protocol defined for issues such as housing or birth outcomes; a CHW may be managing patients’ progress along up to 20 Pathways.¹³ For example, a payer may agree to pay the Hub one amount for enrolling an eligible woman in a birth outcomes Pathway; another amount for her first trimester prenatal care office visit; another for stopping smoking; another for completing a series of classes on childbirth or child development stages; and a final, substantial payment for a successful, full-term natural delivery.

V. Health Care Payer Funds: Medicaid

In theory, any health insurer might be interested in CHWs and could pay for them, but this report focuses mainly on insurers (health plans) participating in Medicaid.

The reason is simple: lived experience in common with the community or population served is key to the identity and qualifications of a CHW. Public health and healthcare policy

and financing are focused on low-income populations, as they face the greatest challenges in access to care and from socioeconomic drivers of health (SDOH). The origins of the CHW workforce in the U.S. can be traced to the anti-poverty, community health center, and migrant health movements of the 1960s and 70s. Community health workers emerged largely for the purpose of empowering low-income and marginalized community residents to participate in government-funded programs to improve access to health care and jobs. In the US, the focus of training and employment in the field has remained on disenfranchised populations and communities poorly served (“underserved”) by dominant healthcare systems and other service providers. Since most low-income people do not have affordable access to private, commercial insurance, efforts to build up financing of CHW positions have continued to rely on government or private philanthropic sources.

This report also does not address **Medicare**, since there is no significant role for states in determining the services that may be billed to Medicare. State insurance regulators do have some authority over Medicare Supplemental or Advantage plans marketed in their state, but state government does not participate financially in Medicare services. Readers may be advised to look for policy developments from CMS Medicare in the near future, since they issued a proposed new Physician Fee Schedule¹⁴ in July 2023 stating their intention to pay for CHW services.

Medicaid

As noted at the beginning of this report, Medicaid offers important opportunities as a source of sustainable financing of CHWs. CHWs and their ally state actors in numerous states around the country are achieving coverage for the workforce via Medicaid options. Nonetheless, Medicaid has important limitations as a source of

¹² <https://health.ri.gov/programs/detail.php?pgmid=1108>; see also <https://health.ri.gov/publications/toolkits/health-equity-zones.pdf>, pp 23ff

¹³ CPM Guide 2-27-17: Improving Health Outcomes by Linking Community-based Community Health Workers with Health

Systems. Familias en Acción and Kaiser Permanente. July 2018
¹⁴ Centers for Medicare & Medicaid Services. Physician Fee Schedule, Proposed Rule. July 14, 2023. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched>

support for CHW activities. Therefore, it should not be approached as the **sole** source of sustainable financing for CHW activities in any given state; it should be seen as a “necessary, but not sufficient” strategy.

Challenges/Limitations

- Medicaid cannot pay for the full range of activities and roles in which CHWs engage;
- It can only pay for services to Medicaid recipients/enrollees, leaving out millions of uninsured/underinsured individuals;
- Medicaid financing may be an awkward “fit” for community-based organizations (CBOs), which employ substantial numbers of CHWs and are a crucial part of the CHW landscape; and
- Early experience with Medicaid “reimbursement” for CHWs suggests that implementation may be more challenging, and take more time than many people anticipated.

Important note on general approaches to Medicaid funding:

Medicaid offers two distinct strategic approaches to supporting CHW activities:

1. Directly authorizing payment for them as a new recipient “*benefit*” or “*covered service*” and
2. Modifying payment methods to give providers and/or Medicaid Managed Care Organizations (MCOs) increased *flexibility in staffing* and/or *incentives* to engage CHWs as a means to achieve Medicaid program goals.

States are **not required** to include CHW services as part of the package of health care services all states must provide to Medicaid recipients. **They can add or authorize CHW services through several**

different policy change mechanisms described in the next Section. When states have done so, CHW services are usually “reimbursed” on a fee for service (FFS) basis, i.e., the employer of CHWs submits claims for units of service provided.

States are increasingly interested, however, in different payment models like all-inclusive “per member per month,” value-based and “shared risk” models, in which the employer is accountable for results or outcomes and does not report or bill on the basis of actual staff time. This gives the employer greater staffing flexibility, and allows them to benefit from the full range of activities performed by CHWs. (See below p. 9 for further discussion of payment models.) **Note that changing payment models under Medicaid also requires policy actions as described in the following Section.**

V.A. Specific Policy Options under Medicaid

The basic approaches just outlined can be pursued through a number of specific programmatic opportunities within Medicaid, described in this section. Implementation of any of these approaches may require federal (CMS) approval. See Section V.B. below (p. 111) for the “high-level policy mechanisms” (waivers and state plan amendments) used to obtain such approval.

V.A.1. Medicaid Health Homes

The Medicaid Health Home is like a Patient Centered Medical Home for beneficiaries with complex needs. This model allows states to provide comprehensive care coordination. Twenty states had Health Homes as of mid-2022. However, only five states were known to allow the inclusion of CHWs in their Health Homes programs as part of a care team: only one of these states

required they be included.¹⁵ This note is provided for completeness only; if a Health Homes proposal is being developed, policymakers may consider inclusion of CHWs, but a Health Homes State Plan Amendment should not be put forward for the primary purpose of enabling Medicaid support of CHWs. (see below p. 14 for background on State Plan Amendments generally.)

V.A.2. Medicaid: Healthcare reform-related alternative payment (APM) structures

Approaches to healthcare payment have changed along with the service delivery reforms described above. States and MCOs have gradually instituted “alternative payment models” (APM).¹⁶ The purpose is to move away from fee-for-service, which incentivizes increasing the quantity of services provided, and toward flexible models which reward positive health outcomes. These models include:

1. capitated or bundled payments
2. pay-for-performance or “value-based” payment,
3. quality incentives and
4. partial- to full-risk contracting.¹⁷

Providers who meet outcome or health status quality goals under APM may receive bonuses or benefit from related cost savings, and those who do not may face financial penalties. Alternative payment systems offer greater flexibility in staffing, which can and often does include CHWs. **This can accomplish the purpose of sustaining CHW positions without explicitly “paying for” CHWs.**

¹⁵ MACPAC Issue Brief: Medicaid Coverage of Community Health Worker Services. April 2022.

<https://www.macpac.gov/publication/medicaid-coverage-of-community-health-worker-services/>

¹⁶ <https://qpp.cms.gov/apms/overview>

¹⁷ For more background on APMs, see <https://qpp.cms.gov/apms/overview>

Some states are also incorporating Accountable Care Organizations and Accountable Health Communities into their health system transformations, with strong potential roles for CHWs. These models are a hybrid of a payment system and a care delivery structure, and provide a framework to integrate non-clinical population health strategies into their health systems.

V.A.3. Medicaid: Federally Qualified Health Centers: Prospective Payment Systems

Medicaid reimbursement to FQHCs in most states follows a different system than payment to other providers. Nationally, about 44 percent of FQHC funding comes from Medicaid, and another 18 percent from Health Resources and Services Administration (HRSA) Section 330 grants. FQHCs bill Medicaid in the form of per-visit flat fee reimbursement under a “Prospective Payment System” (PPS), with rates based on historic actual costs under a global budget divided by total clinic visits.¹⁸ Technically, FQHCs may incorporate the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid. Few do so currently.

PPS qualifying visits must entail an encounter with a licensed clinician. Contact with a CHW alone does not qualify as a reimbursable “visit.” Some centers engage in what they term “flipping visits:” when a patient meets with a CHW, the CHW immediately facilitates an appointment for a billable clinic visit related to the patient’s presenting health issue(s). Again, there are no solid data on the prevalence of this practice.¹⁹ Some more recent Medicaid SPAs allow FQHCs to

¹⁸ Rosenbaum S, Sharac J, Shin P, Tolbert J. Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained (Issue Brief). Kaiser Family Foundation, March 2019.

¹⁹ Remarks by Seth Doyle, Northwest Regional Primary Care Association, interview with Carl Rush, January 2018. Also Interview by Carl Rush with John Bartkowski, DrPH, CEO, 16th Street Community Health Centers Inc. (Milwaukee, WI), November 2015.

submit claims for CHW services **outside** the PPS system. Louisiana directs FQHCs to use different billing codes from other providers for this purpose. Nevada Medicaid authorizes a CHW contact as a billable “medical encounter” in their PPS system, so long as it does not take place on the same day as another billable encounter for the same patient.²⁰

V.A.4. Medicaid MCO contract requirements

Several states have experimented with integrating CHWs into health plan contracts, by explicitly allowing or mandating employment and financing of CHWs. Oregon’s CCO contracts (described below) also contain provisions for CHWs and other Traditional Health Workers. In

addition, New Mexico and Michigan have imposed specific requirements for employing CHWs.

At this writing, both Michigan and New Mexico stakeholders report that the State is open to negotiating new or expanded approaches to Medicaid support for CHWs. In Michigan, the state has not established guidelines or standards for services performed under this contract requirement. As a result, the types of personnel being hired and the tasks they are performing have varied considerably among MCOs. This has led to concerns that widely recognized definitions of CHWs and their roles are not always followed in practice. This suggests that clear standards or guidelines from the State are crucial to the implementation of such policies.²³

Examples of Medicaid MCO contract requirements explicitly covering CHWs:

New Mexico	Michigan	Oregon
<ul style="list-style-type: none"> State Medicaid managed care contracts must encourage use of CHWS for care coordination Managed care plan must describe the role of CHWS in patient education and list CHW services in their benefits package CHW care coordination costs are an additional service factored into the total cost of services to achieve the capitated payment rate 	<ul style="list-style-type: none"> State Medicaid 2015 managed care contracts rebid requires health plans to offer CHW or peer support specialist services to members with significant behavioral health and/or complex care needs Medicaid specifies a range of CHW services, including home visits, referrals, self-care education, patient advocacy Each plan must establish a payment method for CHW services Contract specifies required training for CHWs Requires at least 1 full time equivalent (FTE) CHW per 5,000 members²¹ 	<ul style="list-style-type: none"> Provides for “health related non-benefit (flex) services” CHWs are covered as a category of “traditional health care workers” Covers services “consistent with achieving Member wellness and the objectives of an individualized care plan” CHWs and Health Navigators are not mentioned by name in standard contract language for the CCOs²²

²⁰ Nevada Medicaid Services Manual, July 1, 2022, §2903.1

²¹ This proportion was originally 1 per 20,000, reportedly adopted arbitrarily, based on state-specific considerations, not on research, and should not necessarily be considered as a guide for other states or projects. The ratio was increased in 2018 (State of Michigan Standard MCO Contract, revised

September 2018).

²² <https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>

²³ Interview by Carl Rush with Edith Kieffer, University of Michigan, July 19, 2022

State Medicaid offices and their approved health plans have the flexibility to use Medicaid administrative expenditures for services that are not approved as “medically necessary.” In a May 2019 memo to the states, CMS indicated that it would require any expenditures for patient services to be treated as administrative if the services are not explicitly specified in the State Medicaid Plan.²⁴

V.A.5. Quality Improvement Cost for Medicaid Managed Care Organizations or Medicare Advantage Plans

This strategy is listed separately because it does not entail policy action by the State Medicaid program related to the health care services offered to beneficiaries.

It is common for health plans with Medicaid contracts to employ CHWs, or to pay other organizations for CHW services, and treat these as administrative expenditures, without a mandate from the state. Texas health plans in certain markets began experimenting with this approach in the early 2000s; anecdotal reports suggest that some states other than Michigan require MCOs to invest administrative dollars in CHWs.

- Some MCOs reportedly offer care management fees to providers as an incentive to conduct outreach, either to high-risk patients or all members. These fees could be devoted to the employment of CHWs.
- There may be limits to the willingness or ability of MCOs to expend administrative dollars on CHW activity. States commonly require health plans to expend a minimum percentage (commonly 85%) of their

premium revenue for the direct cost of providing medical care (“total claims cost”); this ratio is known as the “medical loss ratio” (or MLR).²⁵ This limits administrative spending to 15% of revenue. However, health plans reportedly do not expect spending on CHWs to become a large factor in total administrative expenses.

A 2017 CMS Medicaid rule change allows certain quality improvement expenditures by states and MCOs to be treated as part of the cost of care. Some CHW activities may qualify for this classification.²⁶ At this writing, a Texas bill mandating this approach had passed the House and sent to the State Senate.²⁷ This option does not require authorizing specific CHW activities as “covered services.”

V.B. Medicaid High Level Policy Mechanisms: Waivers and SPAs

This section refers to “high level” policy tools involving regulatory actions by the State Medicaid Office (and in some cases legislative action). Medicaid is fundamentally a healthcare payer, and CHWs do not provide clinical care. A major challenge for CHWs, then, is that the costs of their activities cannot be treated as “cost of care” without significant policy changes on the state’s part. (See previous section for discussion on the use of Medicaid administrative dollars for CHW services.)

Key Points

- Medicaid in federal statute is focused on paying solely for “medically necessary” services, which has meant primarily clinical services. It has also traditionally paid for services to individuals and has not addressed the costs of providing public health interventions targeting

²⁴ CMCS Informational Bulletin, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 15, 2019.

²⁵ Center for Consumer Information & Insurance Oversight. “Medical Loss Ratio.” See

<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio>

²⁶ Federal Register 2016, 81FR27522 (42 CFR §438.8)

²⁷ <https://legiscan.com/TX/bill/HB113/2023>

populations or communities.

- The Patient Protection and Affordable Care Act of 2010 (ACA) and other healthcare reform initiatives have begun to expand the scope of each of these categories. For instance, “housing assistance” can be seen as “medically necessary,” and there are openings to enable population health approaches, for example, for members affected by prevalent chronic conditions.²⁸
- Providers show increasing interest in adapting Medicaid funding to address social determinants of health (SDOH).²⁹ CMS has acknowledged the flexibility inherent in their regulations and mechanisms - such as waivers and SPAs - for covering SDOH in multiple recent advisory letters.³⁰ A 2022 survey of state Medicaid budgets found that over half of responding states (29 of 48) reported allowing Medicaid payment for services provided by CHWs.³¹

Considerations and Challenges:

- “Reimbursement” is a term that implies fee-for-service payments. In the context of the cost-control pressures of healthcare reform, asking for “reimbursement for CHW services” could be interpreted as a proposal for a new class of providers who can directly

bill for their own services. This in turn raises the specter of *increased* rather than decreased costs to payers.

“Coverage” may be a more timely term appropriate for emerging “alternative” payment systems in Medicaid.

- The 2020 addition of “Z codes” to the ICD-10 diagnostic coding system⁶, allows identification of socioeconomic drivers of health (SDOH) as part of a patient’s record. This change reveals greater attention to social factors in healthcare. Recent commentaries on Z-codes have touted their value in tracking patient needs and referrals for non-medical services, but have not dealt with payment for such services.³²
- Fee for service (FFS) claims for payment also require assignment of procedure codes for the services which CHWs are authorized to provide. Providers generally use one of two procedure coding systems: CPT or HCPCS.³³
- Public payers such as Medicaid have historically paid lower rates to providers than private payers. The financial constraints this has placed on many healthcare provider organizations can discourage their openness to experiment or take risks by adding new services or workforces, not to mention discouraging community-based organizations from engaging with Medicaid.

²⁸ See, e.g., National Academies of Sciences, Engineering, and Medicine 2019. Investing in Interventions That Address Non-Medical, Health-Related Social Needs: Proceedings of a Workshop. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25544>. Also Louisiana State University. Louisiana [Medicaid] Demonstration Community Health Worker Program Overview [RFP]. Public announcement document, 2018.

²⁹ American Hospital Association. Medicaid Financing for Interventions that Address Social Determinants of Health (Issue Brief). AHA, January 2019. See also Castelucci M. Insurers want to lead if CMS pilots payments for housing, social determinants of health. Modern Healthcare, December 15, 2018, and Friedman NL. Toward Addressing Social Determinants of Health: A Health Care System Strategy. The Permanente Journal, 2018; 22: 18-095. Published online 2018 October 22, 2018.

³⁰ SHO# 21-001. Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). January 7, 2021. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>
SMD #: 23-001 RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care.

January 4, 2023. Available at:

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

³¹ Haldar S, Hinton E, State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services. Kaiser Family Foundation, Jan 23, 2023. Available at <https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/>

³² Centers for Medicare and Medicaid Services (CMS). ICD-10-CM Official Guidelines for Coding and Reporting. CMS, FY2016, Downloaded April 13, 2020 from <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2-016-ICD-10-CM-Guidelines.pdf>. See also Millard M. New tool helps promote ICD-10 codes for social determinants of health data. Healthcare IT News: October 21, 2019. Downloaded 4/13/20 from

<https://www.healthcareitnews.com/news/new-tool-helps-promote-icd-10-codes-social-determinants-health-data>.

³³ CPT refers to Common Procedural Terminology, and HCPCS refers to Healthcare Common Procedure Coding System: https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/list_of_codes

V.B.1. Medicaid High Level Policy Mechanisms #1: Section 1115 Demonstration Waivers

Medicaid Section 1115 Waivers give states the flexibility to test new models of care delivery and payment mechanisms as pilot projects or “demonstrations.” There are other sections of Medicaid rules that authorize other kinds of waivers, but 1115 is the most common for these purposes. Precise data are not available at this writing but, based on the Kaiser Family Foundation’s 2022 State Medicaid Budget Survey, at least 15 states are believed to have 1115 waivers to pilot integration of CHWs into Medicaid in some manner.³⁴

Advantages and Limitations

- The approved changes are temporary - usually covering a demonstration period of 3-5 years, but states must go through a re-application process if they want to extend or in some way renew the changes.
- The cost of services covered under the waiver may not exceed the cost of existing services for the same purpose over the life of the waiver (“budget neutrality”).

- The history of numerous states’ use of this mechanism to finance CHWs as part of healthcare delivery transformation offers evidence of state Medicaid financing CHWs as part of improvements in the quality of both services and health outcomes.

Example: Massachusetts

- Massachusetts’ 1115 Waiver from 2017-2022 enabled a redesign of the state Medicaid program to incentivize the formation of Accountable Care Organizations (ACOs). Under the Waiver Medicaid paid for CHW core competency trainings, specialty topic trainings, and CHW supervisor trainings. Additionally, many ACO affiliated providers chose to add CHWs to care teams for high-cost patients.
- Massachusetts’ 1115 Waiver has been renewed for another five years and includes primary care sub-capitation payments. This payment method explicitly allows CHWs and peer support specialists to be paid as members of care teams.³⁵ In this instance, temporary financing available through the Waiver has resulted in a non-fee-for-service payment that covers CHWs.

³⁴ Haldar S, Hinton E, State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services. Kaiser Family Foundation, Jan 23, 2023. Available at <https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicare-coverage-of-community-health-worker-chw-services/>

³⁵ MassHealth. Fact Sheet: MassHealth’s Newly Approved 1115 Demonstration Extension Supports Accountable Care and Advances Health Equity. September 2022. <https://www.mass.gov/doc/1115-waiver-extensionfact-sheet/download>

Additional Examples of State Medicaid 1115 Waivers Paying for CHW Positions

Arkansas	Texas	Oregon
<p>Demonstration: “Community Connectors”—CHWs reached out to people receiving home-based care and referred them to community services and in-home non-medical support</p> <ul style="list-style-type: none"> • Private foundation funding used for non-federal Medicaid match (separate CMS approval required) • Showed 3:1 net return on investment, savings on total cost of care for participants vs. comparison group • State expanded for several years as part of regular Medicaid operations 	<p>Community Care Collaborative introduced as integrated system for low-income recipients in central Texas</p> <ul style="list-style-type: none"> • Waiver funding financed delivery system reforms in safety net health systems in exchange for sustained support for uncompensated care. A number of these grants supported CHW positions. • CHWs employed through over 300 local grants: such as navigation for Emergency Department users, care coordination and care transitions, chronic disease self-management support, and “neighborhood engagement” organizing in San Antonio. 	<p>State Health Reform legislation established 14 ACOs called “Coordinated Care Organizations” (CCOs)”to integrate primary and acute care”</p> <ul style="list-style-type: none"> • CCO’s receive a fixed global budget from the state, paid as monthly capitation • Enabling statute requires CCOs to offer services³⁶ by “Traditional Health Workers” including CHWs, Doulas, peer wellness specialists, and personal health navigators • State has rolled system into a State Plan Amendment at end of the demonstration.

V.B.2 Medicaid High Level Policy Mechanisms #2: Medicaid State Plan Amendments (SPAs)

- States submit SPA proposals to CMS to authorize program changes, make corrections, or update their state Medicaid plan with new information. Unlike an 1115 Waiver, a SPA, if approved, results in a permanent change in the state program offerings. Often, states have tested a reform under a waiver and subsequently made it permanent through a SPA. In the early 2020s numerous states have demonstrated a

preference for pursuing SPAs to strengthen state Medicaid financial coverage of CHWs. Ten such SPAs were approved as of late 2022.³⁷

Key Points

- A SPA authorizing payments for “non-licensed” personnel such as CHWs must describe the qualifications the state will require for such personnel. CMS does not require that the state have certification or other formal credentialing.
- The SPA application proposed change is not required to be budget-neutral as an 1115 waiver is, although it must include an estimate of the fiscal impact on federal

³⁶ CCOs are not required to **provide** THW services to all members, but must **offer** them to members as appropriate, and must pay for the services if members request them.

³⁷ Rush C, Higgins E, Wilkniss S. State Approaches to Community Health Worker Financing through Medicaid State Plan Amendments (Blog Post, Dec 7, 2022). National Academy for State Health Policy. <https://www.nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/>

- Medicaid funding resulting from the change.
- The application must specify the section(s) of Medicaid regulations the state relies on for authority to make the change.
 - A 2014 Medicaid rule change allows state Medicaid programs to cover preventive services delivered by non-licensed providers if they are “recommended by a physician or other licensed practitioner.”³⁸ Most states pursuing SPAs to cover CHWs have done so under this authority.
 - As of Summer 2023, there were thirteen SPAs explicitly addressing CHW services: five of these were approved in 2022 alone, the first such since South Dakota in 2019. SPAs in Arizona, Kansas, and Kentucky were approved in 2023, and New York stated publicly that it intended to submit a SPA later in 2023.

Advantages

- The State can permanently establish CHW services as a recipient benefit using a SPA.
- SPA applications are generally considered simpler to prepare and submit compared to 1115 Waiver applications.
- SPA applications must choose one or more sections of Medicaid regulations as the authority the state is invoking in submitting the application. Some choices of regulatory authority are more restrictive than others in terms of requiring supervision of CHWs by licensed clinicians.
- If the state does not administer or recognize some form of certification of individual CHWs, the qualifications specified in their SPA application will constitute a mandatory skill standard for this purpose, which can later be regarded as a default standard or requirement equivalent to certification for **all** CHWs

Examples of SPAs

Minnesota	Rhode Island	Maine
<ul style="list-style-type: none"> • Allows fee-for-service (FFS) reimbursement for certain services (basically health education) provided by CHWs who have received a certificate from a training program using a standard CHW curriculum created by the Minnesota State Colleges and Universities System. 	<ul style="list-style-type: none"> • Allows FFS billing directly to the State for a wide range of CHW services. • Uses a “carve out” meaning RI’s Medicaid managed care organizations (MCOs) are not involved. Creates a new category of “CHW Providers” with a separate provider manual and their own enrollment process: even current Medicaid clinical providers must enroll as CHW Providers in order to submit claims. 	<ul style="list-style-type: none"> • Maine (approved April 2022) was the first SPA that authorized payment to cover CHWs on a “per member per month” (PMPM) basis to primary care providers (PCPs), rather than FFS as most other states have done.³⁹ • Using Medicaid authority⁴⁰ for “primary care case management” (PCCM), Maine introduced “Primary Care Plus,” a capitated payment system for PCPs (with rates adjusted for population and risk categories), under which they will be required to engage CHWs in care management starting April 2024.

³⁸ 42 CFR 440.130 was used by South Dakota in 2019, followed by California and Rhode Island in 2022.

³⁹ Oregon is another exception but used the same

regulatory authority as other previous states.

⁴⁰ Section 1905(t) of the Social Security Act

Examples of SPAs continued		
Minnesota	Rhode Island	Maine
<ul style="list-style-type: none"> Covers a limited set of CHW services under a single billing code covering “diagnosis-related patient education and self-management” for individuals or groups. There are monthly caps for billable hours for a patient. The services must be ordered and supervised by eligible billing providers such as community health clinics, dentists, hospitals, physicians, or advance practice registered nurses (APRN). CHWs may not bill directly for their services. <p>Limitation/Challenges:</p> <ul style="list-style-type: none"> Although hundreds of CHWs have received the required education for this payment, uptake by employing providers was slow to develop. Constraints concerning the range of services that CHWs can perform and time spent per patient may make this opportunity less attractive to employers. However, Indiana introduced a similar measure in 2018, and South Dakota did so in 2019⁴¹. 	<ul style="list-style-type: none"> FQHCs may submit FFS claims for CHW services separate from their regular billing under a Prospective Payment System. Uses a case management billing code, an approach different from most other states.⁴² A wide range of services are billable under Health promotion and coaching; health education and training for groups; health system navigation and resource coordination; and care planning with interdisciplinary teams. Uses a broad definition of recipient eligibility or “medical necessity,” including health conditions, health-related social needs, indicators of health care access issues, and <i>recipient’s own determination that they need the assistance of a CHW</i>. Permits billing for “collateral” services, which are necessary but may be performed when not in the recipient’s presence. 	<ul style="list-style-type: none"> Some other states looking into the SPA approach are considering an alternate payment model (APM)⁴³ instead of fee-for-service, but report often lacking data on cost and utilization needed for APM rate-setting. <p>Limitations/Challenges:</p> <ul style="list-style-type: none"> It remains to be seen whether the PMPM payment rates are sufficient to cover sufficient CHW hours to meet patient needs, since the rates must cover other care management costs as well. Rates are based on estimates of the numbers of patients who require more intensive case management, i.e., some patients will require more attention than others. While the program allows for PCPs to partner with community-based organizations (CBOs) for CHW activities, details of such partnerships must still be worked out. Recipients are permitted to opt-out from the Primary Care Plus program at any time.

⁴¹ South Dakota Medicaid Billing and Policy Manual: Community Health Worker (updated September 2019). Downloaded from <https://dss.sd.gov/docs/medicaid/providers/billingmanuals/communityhealthworkerservices.pdf>

⁴² Health Care Procedure Coding System (HCPCS) code T1016.

⁴³ See above p. 9 for further discussion of APM. CMCS Informational Bulletin, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 15, 2019.

Conclusion

This report has examined a range of potential approaches to secure ongoing “sustainable” support for CHW positions and briefly described how they may be used. Appendix A on the next page provides a brief summary of the Options covered, along with some “pros and cons” about each. All the Options described are at least theoretically possible in any given state, but the choice of strategy in a state will be based on the level of stakeholder interest, current related policy measures already in place, budget realities and other considerations.

Readers are encouraged to refer to the NACHW CHW Document Resource Center (<https://nachw.org/chw-document-resource-center/>), filtering for subtopics under “Sustainable Financing” to find documents describing the experiences of groups in other states grappling with these issues.

Acknowledgements

This document is in part a compilation and expansion of material previously developed by Community Resources, LLC for other clients, including the Association of State and Territorial Health Officials (ASTHO), the National Academy for State Health Policy (NASHP), and several state governments. It is not based solely on documents in the Resource Center database.

The authors would like to acknowledge major contributions from Refilwe Moeti of the Centers for Disease Control and Prevention (CDC) in a significant reorganization of this report. The original 2020 version of the report was created under CDC funding for the NACHW Document Resource Center (DRC) through the National Association of Chronic Disease Directors (NACDD). We also acknowledge contributions from Kayla Craddock of NACDD in this revision; the new edition was not a deliverable in 2022-23 funding from CDC and NACDD.

Appendix A: Quick Reference to Key Financing Options

Key considerations	Pros (potential advantages)	Cons (potential drawbacks)
Federal government: public health, block grants, HRSA 330 funding		
<ul style="list-style-type: none"> • CDC, HRSA, SAMHSA and other agencies provide funding for sustained investments in categorical public health fields • HHS and HUD provide non-competitive grants to states annually; states have wide discretion on spending • HRSA provides annual direct “330” grants to FQHCs* for care to the uninsured and expansion of facilities and services 	<ul style="list-style-type: none"> • States have wide discretion in directing expenditures of public health and block grant revenues • The purposes of public health grants are increasingly seen as compatible with CHW roles 	<ul style="list-style-type: none"> • States and FQHCs have many competing priorities • Public health grants are largely categorical, meaning they can only support CHW activity directly related to the purposes of each program, e.g., chronic disease, which can lead to siloing • HRSA 330 funding represents less than 20% of FQHC revenue, whereas Medicaid is typically more than 40%
State and local government funds		
<ul style="list-style-type: none"> • Some states have appropriated funds from general revenue for CHW programs, e.g., Health Start in Arizona and Kentucky HomePlace • Local governments can allocate tax revenue for CHW services, and may do so for economic development purposes or to promote use of mass transit 	<ul style="list-style-type: none"> • State and local legislators can often see the benefits of CHW activity on a direct and personal level • Funds appropriated from state and local governments may have fewer “strings attached” than funding from federal programs 	<ul style="list-style-type: none"> • Much of the funding available to state and local governments is actually derived from federal grants • Funding of this nature is usually subject to annual appropriation from state and local legislatures • Allocation of funds may be competitive between localities
Health Care Provider Funds: Internal Financing		
<ul style="list-style-type: none"> • Providers or provider systems may invest in CHWs from their “core budget” if they can expect to see improvements in cost or revenue from other services, e.g., reducing readmission rates or improving birth outcomes 	<ul style="list-style-type: none"> • Very few regulatory constraints • Can usually be scaled easily by employers upon acceptance of early results 	<ul style="list-style-type: none"> • May result in wide variation of participation among providers • Proposals will be closely scrutinized for cost saving potential • Subject to fluctuations in overall employer financial wellbeing

* <https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicare-and-section-330-grant-funding-explained/>

Blended or braided funding: multiple sources		
<ul style="list-style-type: none"> Combining funds from multiple payers, some or all of whom may only support a limited range of CHW services or priority populations on their own. 	<ul style="list-style-type: none"> Diversification can help shield services from fluctuations in budgets and grant restrictions Greater flexibility to provide assistance that is not directly related to clinical care 	<ul style="list-style-type: none"> Requires application and/or negotiation with multiple payers Deliverables and reporting can become complex; accountability for multiple outcomes, overlapping funding periods
State Medicaid policy actions: Waivers and SPAs		
<ul style="list-style-type: none"> Can include embedding CHWs in healthcare reform-related alternative payment models (ACOs, value-based payment, etc.) 	<ul style="list-style-type: none"> Can embed CHW services in core Medicaid operations Process offers latitude for creative design of services Waiver process offers a means to pilot test for feasibility and cost savings 	<ul style="list-style-type: none"> Administrative and regulatory requirements can be complex Legislation may be required May require treating CHW activities as equivalent to clinical procedures Challenges of matching standard billing (CPT) codes to a range of CHW activities
<ul style="list-style-type: none"> CHWs can be better integrated into Prospective Payment Systems used to fund FQHCs 	<ul style="list-style-type: none"> CHWs may qualify as “enabling services,” not required to be billable as patient encounters Would integrate CHWs into annual financial calculations 	<ul style="list-style-type: none"> CHW-only patient encounters not currently billable as “medical visits” May require renegotiation of annual costs and PPS rate calculation
Medicaid MCO contracts		
<ul style="list-style-type: none"> Authorizing treatment of CHW expenditures as quality improvement Requiring expenditure of admin funds for CHW activities 	<ul style="list-style-type: none"> Assures uniform application across providers and payers (MCOs) Can provide mechanism for common reporting/evaluation standards 	<ul style="list-style-type: none"> Plans may need to be convinced to go along with inclusion of requirements in development of standard MCO contract Requirements may need to be very simple when first proposed
<ul style="list-style-type: none"> MCOs may also be persuaded to voluntarily expend administrative funds for CHW activities 	<ul style="list-style-type: none"> Requires little or no approval from State or CMS CHWs can perform virtually any activities that do not require a clinical license 	<ul style="list-style-type: none"> Health plans must be convinced of value in terms of outcomes vs. cost Theoretically may increase admin cost and decrease “total claims cost” Little accountability in terms of reporting what CHWs actually do