



CHW Sustainability Collaborative

How States Can Use Medicaid Managed Care Contracts to Support Community Health Workers

Community Health Workers Improve Health Care Value While Reducing Costs

Throughout the health care system, efforts are underway to improve health care quality and health outcomes, while also reducing costs. This transition to a health care system that rewards value presents an important opportunity for directly incentivizing interventions that reduce racial and ethnic health disparities and for improving the resources and infrastructure for delivering such interventions in underserved communities. However, if these changes to how health care is delivered and paid for are not designed or implemented with an explicit focus on health equity, they risk actually making disparities worse.¹

One intervention that can accomplish the goals of a value-based health care system while directly targeting health disparities is the integration of community health workers (CHWs).¹ CHWs provide a broad spectrum of

* For the purposes of this issue brief, we are using the term “community health workers” to also refer to *promotores de salud*, community health representatives, and other terms that are often used to describe CHWs.

support for individuals and communities, and the specific roles that a CHW may perform can vary widely. For example, some CHWs may be focused on helping clients manage chronic health conditions, while others may lead health education classes or help community members in advocating for better community resources and services.² Because CHWs are trusted members of their communities, they are able to bridge the gaps between the health care system, social services, and the people in their community, and they can help address the social factors that influence health, such as access to healthy foods and transportation.³ CHWs have a proven track record of success: they help increase uptake of preventive services like immunizations and cancer screenings, improve health outcomes for people with chronic conditions, and avoid costly emergency room visits and hospital stays.⁴

Despite their record of success, sustainable funding remains a significant barrier to expanding the work of CHWs and increasing their integration into the health care system. Many programs are implemented by community health centers and community-based organizations using grant support or their own operational budgets to fund the programs. This results in funding that is unpredictable, typically time-limited, and often insufficient when it comes to supporting the full breadth of services and supports that CHWs can provide. However, Medicaid offers several different pathways for more sustainably funding CHWs, including through Medicaid managed care contracts.⁵

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Medicaid Managed Care Is an Attractive Pathway for Sustainable Funding for CHWs

Medicaid managed care allows for the delivery of Medicaid health benefits and additional services through contracted arrangements between a state Medicaid agency and a managed care organization (MCO). In order to provide services, MCOs are paid a per-member, per-month payment for people who are enrolled in the managed care plan.⁶ Currently, over two-thirds of Medicaid enrollees nationwide receive most or all of their benefits through managed care, and many states are expanding their use of managed care to additional geographic areas and Medicaid populations.⁷

Medicaid managed care typically provides more flexibility than traditional Medicaid to cover additional services, and this flexibility can be leveraged to support CHWs.⁸ Additionally, Medicaid managed care contracts already require MCOs to meet certain care coordination and beneficiary engagement requirements, and CHWs can be effective in meeting these.⁹ This issue brief provides examples of Medicaid MCO contract language that is or could be used to support CHWs, and outlines considerations for CHWs and other advocates looking to build more sustainable funding for CHWs through Medicaid managed care.

Though Medicaid managed care provides a promising pathway to supporting CHWs for many states, advocates should be aware that as Medicaid MCOs, other health insurers, and more providers become increasingly

interested in CHWs, these other entities may not have a deep understanding of who CHWs are and what makes their work so unique. For this reason, it is important that advocates working to use Medicaid managed care contracts to support CHWs ensure that CHW definitions, core competencies, and roles are correctly captured and defined. In addition, CHWs themselves should be active participants in this process.

Much of the language included in this brief comes from Request for Proposals (RFPs) or similar documents that state Medicaid agencies have released, inviting health plans to bid or apply to be one of the state's Medicaid MCOs. These documents outline what information the health plan needs to submit, what types of services it must provide, and requirements it must meet in order to be selected as a Medicaid MCO. Engaging with state Medicaid agencies to include additional elements in these RFPs presents an important opportunity to influence the inclusion and support of CHWs in the contracts Medicaid MCOs will enter into with the state.

Medicaid MCO Contract Language for Supporting CHWs

Inclusion of CHWs in Contracts

Even contracts that don't explicitly require CHWs may still require the Medicaid MCO to provide certain functions or services that closely align with the roles and services that CHWs often provide. For example, contracts may include care coordination requirements or programs designed to build integrated health care teams. A case in point is Rhode Island, which specifies

in its RFP that a prospective Medicaid MCO must identify its approach for effective care coordination and care management with “clear attention to social determinants of health.”¹⁰ Given that CHWs often perform these roles in their work, a Medicaid MCO may be able to fulfill these requirements by working with CHWs. Looking for requirements in contracts with this kind of alignment provides a starting point for beginning the integration of CHWs. Advocates can point to such language to encourage Medicaid MCOs to support CHW programs, and they can work with state Medicaid agencies to strengthen this language in the future to more directly support the inclusion of CHWs.

Sometimes, RFPs will include questions about how the MCO is already using community health workers. For instance, in Virginia, the RFP asks how the health plan bidding to be a Medicaid MCO has already engaged CHWs.¹¹ Another approach, taken in Pennsylvania, asks prospective Medicaid MCOs to describe how they are “currently or plan to use community health workers to directly engage consumers” for the purposes of controlling avoidable hospital admissions and emergency room visits.¹² Posing such questions proactively encourages the use of CHWs by alluding to how the Medicaid agency views inclusion of CHWs as an important element in selecting Medicaid MCOs. A contract can also specifically require MCOs to work with CHWs, as in Michigan (see [Table 1](#)). Michigan also requires that Medicaid MCOs “maintain a CHW to Enrollee ratio of at least one full-time CHW per 20,000 Enrollees” and “provide that Enrollees have access to at

least one CHW in each of its contracted Prosperity Region service areas.”¹³ To ensure that any inclusion of CHWs in Medicaid MCO contracts does not lead to the MCO hiring individuals with little or no connection to the communities being served, advocates should also consider contract language that requires Medicaid MCOs to include CHWs by contracting with community health centers and community-based organizations who better know the communities being served, and who have a long history of working with CHWs.

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Table 1. Inclusion of CHWs in Contracts

Rhode Island <i>(General Care Coordination)</i>	Michigan <i>(CHW-Specific)</i>	Virginia <i>(RFP Question)</i>	Pennsylvania <i>(RFP Question)</i>
<p>“The care coordination and care management requirements emphasize various elements of care management programs including designated program staff, the conduct of Health Risk Assessments, development of person centered and strength based care plans, assurance of member involvement, clear attention to social determinants of health and management of health conditions, outreach to members, client engagement strategies, process flows, and IT tools being used to ensure effective management, monitoring and tracking of care coordination and care management programs.”¹⁴</p>	<p>“Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.”¹⁵</p>	<p>“How has your organization engaged community health workers or other types of workers to improve care?”¹⁶</p>	<p>“Describe the techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospital and emergency department admissions. Describe how you currently or plan to use community health workers to directly engage consumers.”¹⁷</p>

If CHWs are already explicitly included or required in contracts, it is important to look for ways to ensure they are effectively integrated into health care teams. For example, as part of Pennsylvania’s Community Based Care Management (CBCM) program requirements, the

RFP specifies CHWs as an example of non-licensed team members.¹⁸ Similarly, Virginia’s contract for managed long-term services and supports specifies that the required interdisciplinary care team (ICT) may include CHWs.¹⁹ **Table 2** presents the language used in RFPs in these two states.

Table 2. Integration of CHWs into Care Teams

Pennsylvania	Virginia
<p>“CBCM activity can involve care coordination by licensed and non-licensed team members... Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive.”²⁰</p>	<p>“The ICT also may include any or all of the following participants:</p> <ol style="list-style-type: none"> 1) A representative from the Medicare plan, if applicable 2) Registered nurse 3) Specialist clinician 4) Other professional and support disciplines, including social workers, community health workers, and qualified peers 5) Family members 6) Other informal caregivers or supports 7) Advocates 8) State agency or other case managers.”²¹

Defining Community Health Workers

In order to ensure that the inclusion of CHWs in Medicaid MCO contracts supports the diversity of the workforce, the breadth of the work they do, and CHWs’ rootedness in their communities, advocates should pay close to attention to how Medicaid MCO contracts define CHWs. The American Public Health Association (APHA) has a widely-accepted CHW definition,²² though states and various CHW associations may have adopted their own, somewhat different definitions. Analyzing whether or not a CHW definition in a Medicaid MCO contract aligns with these other definitions is one way to assess the contract definition. In states where there is

a statutory definition of a CHW, managed care contracts may simply reflect this definition. This is true in Minnesota, where Medicaid coverage of CHWs was first enacted via legislation,²³ and then this statutory definition was subsequently incorporated into managed care.

Where there is no statutory definition, a state Medicaid agency may decide to include a definition of CHWs in its RFP, or a Medicaid MCO may be operating with its own definition that it uses in responding to the RFP and in using CHWs to provide services to its members. In these circumstances, it is imperative that the CHW community is still able to define itself. Advocates, Medicaid MCOs,

and Medicaid agencies should look to state and local CHW associations, as well as non-affiliated CHWs doing this work, to ensure that any definitions are not limiting or exclusionary in ways that could have negative consequences for the CHW workforce or that could lessen CHWs’ effectiveness. For instance, the definition in Washington state’s contract was explicit about its inclusion of community health representatives, which is the term used in American Indian and Alaska Native communities.²⁴

The CHW definition can also be used to reinforce that CHWs are rooted in their communities and that they work out in communities, and not only at clinics or hospitals. For example, in a Nebraska RFP, the description of CHWs includes a reference to their “intensive feet-on-the-street efforts” and “leveraging their local knowledge of the community.”²⁵ **Table 3** includes different examples of how CHWs are defined.

Table 3. Defining CHWs

Minnesota	Washington	Nebraska	APHA
<p>“Community Health Worker (CHW) means a person who meets the certification or experience qualifications listed in Minnesota Statutes, § 256B.0625, subd. 49, to provide coordination of care and patient education services under the supervision of a Medical Assistance enrolled physician, advanced practice registered nurse, Mental Health Professional, dentist, or a certified public health nurse operating under the direct authority of an enrolled unit of government.”²⁶</p>	<p>“Community Health Workers (CHW) means individuals who serve as a liaison/link/intermediary/advocate between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs include Community Health Representatives (CHR) in the Indian Health Service funded, Tribally contracted/granted and directed program.”²⁷</p>	<p>“Community health workers (CHWs) are non-clinical staff that collaborate with care managers and care navigators to locate and engage difficult-to-find members. Through intensive feet-on-the-street efforts and leveraging their local knowledge of the community and follow up with community organizations, providers or community groups to get updated contact information for our members, CHWs often have success locating and engaging our members.”²⁸</p>	<p>“A community health worker 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.</p> <p>A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”²⁹</p>

Identifying CHW Core Competencies

In addition to carefully defining CHWs, it is also important to consider how a contract identifies CHWs' core competencies. Core competencies outline what CHWs need to know and be able to do in order to be successful in this field of work. Many CHW associations and training programs have already identified core competencies, which may or may not align with any competencies included in a Medicaid MCO contract. For instance, in Michigan, the core competencies listed in the contract are similar,³⁰ but vary slightly from

those designated by the Michigan Community Health Worker Alliance (MCHWA).³¹ As shown in **Table 4**, the key difference between the two is the inclusion of mental health by the MCHWA, and a slight variation in a competency related to navigating resources. Including local CHW associations in the MCO contracting process ensures any competencies included in the contract will align with those included in trainings or certificate programs that the CHWs in that state have already completed.

Table 4. CHW Core Competencies

Michigan RFP Contract Core Competencies	Michigan Community Health Worker Alliance Core Competencies
<ul style="list-style-type: none"> • “Role advocacy and outreach • Navigating community resources • Legal and ethical responsibilities • Teaching and capacity-building • Communication skills and cultural responsiveness • Coordination, documentation and reporting • Healthy lifestyles”³² 	<ul style="list-style-type: none"> • “Role advocacy and outreach • Organization & resources: community & personal strategies • Legal and ethical responsibilities • Teaching and capacity-building • Communication skills and cultural responsiveness • Coordination, documentation and reporting • Healthy lifestyles • Mental health”³³

Identifying the Specific Roles or Services Provided by CHWs

In addition to defining CHWs and understanding their core competencies, many contracts will list specific roles that CHWs can or must perform, or specific services they can or must provide to Medicaid MCO members. This, too, is an important element for ensuring effective integration of CHWs and for ensuring they are being utilized to their fullest potential. If a contract does not

explicitly include CHWs, there may be specific roles or services under more general care coordination or member engagement requirements, which advocates can still point to in advocating with Medicaid MCOs to support CHWs who are effective at, and already provide, these services. **Table 5** highlights examples of how different contracts and RFPs identify roles and services provided by CHWs.

CHWs provide a broad spectrum of support for individuals and communities, and the specific roles that a CHW may perform can vary widely. Because CHWs are trusted members of their communities, they are able to bridge the gaps between the health care system, social services, and the people in their community, and they can help address the social factors that influence health, such as access to healthy foods and transportation.

Table 5. CHW Roles and Services

Colorado	Michigan	New Mexico	Nebraska
<p>“[A]ctivities within the scope of the Contractor’s Care Coordination plan include, but are not limited to:</p> <ul style="list-style-type: none"> • Home visits • Transportation and accompanying Members to appointments • Accessing financial, human services and community programs, • Assistance with nutrition, grocery shopping, housing and domestic safety • Supported transitions from corrections, foster care, and similar programs • Expedited access to mental health and substance abuse treatment services”³⁴ 	<p>“Examples of CHW services include but are not limited to:</p> <ul style="list-style-type: none"> • Conduct home visits to assess barriers to healthy living and accessing health care • Set up medical and behavioral health office visits • Explain the importance of scheduled visits to clients • Remind clients of scheduled visits multiple times • Accompany clients to office visits, as necessary • Participate in office visits, as necessary • Advocate for clients with Providers • Arrange for social services (such as housing and heating assistance) and surrounding support services • Track clients down when they miss appointments, find out why the appointment was missed, and problem solve to address barriers to care • Help boost clients’ morale and sense of self-worth • Provide clients with training in self-management skills • Provide clients with someone they can trust by being reliable, nonjudgmental, consistent, open, and accepting”³⁵ 	<p>MCOs must make CHWs available to:</p> <ul style="list-style-type: none"> • “Offer interpretation and translation services; • Provide culturally appropriate Health Education and information; • Assist Members in navigating the managed care system; • Assist in obtaining information about and access to available community resources; • Provide informal counseling and guidance on health behaviors; and • Assist the Member and care coordinator in ensuring the Member receives all Medically Necessary Covered Services”³⁶ 	<p>RFP: “Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately.”</p> <p>Response: “Our locally based CHWs personally connect with members and influence their behavior by providing education and the resources they need to access timely and appropriate care. Through the personal interactions that CHWs cultivate with members, they are able to identify reasons members are not receiving appropriate care and work to overcome barriers.”³⁷</p>

Conclusion

Community health workers have a proven track record of improving health outcomes for marginalized communities. Yet sustainable funding remains a significant barrier to more widespread use of CHWs. CHWs and other advocates can use the examples of contract language in this brief as a starting point for their advocacy with either state Medicaid agencies or directly with Medicaid MCOs. Community health workers should be substantially represented and play leadership roles in these efforts, which will help ensure that any contract language or other support from Medicaid MCOs is done in a way that supports the CHW workforce, leverages the unique community relationships CHWs have, and has the greatest impact on the health of the communities they serve.

Endnotes

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⁵Families USA, *Blueprint for Health Care Advocacy: How Community Health Workers Are Driving Health Equity and Value in New Mexico* (Washington, DC: Families USA, November 2017), available online at <http://familiesusa.org/product/blueprint-health-care-advocacy-community-health-workers-in-new-mexico>.

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¹⁴Rhode Island Executive Office of Health & Human Services, *op cit.*

¹⁵Michigan Department of Health and Human Services, *op cit.*, pages 60-61.

¹⁶Commonwealth of Virginia Department of Medical Assistance Services, *op cit.*, page 99.

¹⁷Pennsylvania Department of Human Services, *op cit.*, page 23.

¹⁸Pennsylvania Department of Human Services (PDHS), *HealthChoices Physical Health Services Request for Proposal* (Harrisburg: PDHS, July 21, 2016): second link under “Original Files,” Exhibit B3, page 3, available online at <http://www.emarketplace.state.pa.us/Solicitations.aspx?SID=RFP%2006-15%20REISSUED>.

¹⁹Commonwealth of Virginia Department of Medical Assistance Services (VDMAS), *Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports* (Richmond: VDMAS, January 1, 2018), page 99, available online at http://www.dmas.virginia.gov/Content_atchs/mltss/CCC%20Plus%20MCO%20Contract%20January%202018.pdf.

²⁰Pennsylvania Department of Human Services (PDHS), second link under “Original Files,” *op cit.*

²¹Commonwealth of Virginia Department of Medical Assistance Services, *Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports*, *op cit.*

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²⁷Washington State Health Care Authority, *Washington Apple Health 2015-18 Managed Care Contract*, *op cit.*, page 6.

²⁸Nebraska Department of Health and Human Services, *op cit.*

²⁹American Public Health Association, *op cit.*

³⁰Michigan Department of Health and Human Services, *op cit.*, page 55.

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³²Michigan Department of Health and Human Services, *op cit.*, page 55.

³³Michigan Community Health Worker Alliance, *op cit.*

³⁴State of Colorado Department of Health Care Policy and Financing (DHCPF), *Contract with Rocky Mountain Health Maintenance Organization, Inc. for ACC Payment Reform Pilot Program, Exhibit M* (Denver: DHCPF): page 2, available online at <https://www.colorado.gov/pacific/sites/default/files/Rocky%20Mountain%20HMO%20Base%20Contract.pdf>.

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³⁶State of New Mexico Human Services Department (NMHSD), *Centennial Care Request for Proposals* (Santa Fe: NMHSD, 2012), page 132, available online at [http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Request%20for%20Proposals%20\(RFPs\)/Closed%20RFPs/Centennial%20Care%20RFP%20and%20Contract%20\(8-28-12\)\(FINAL\).pdf](http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Request%20for%20Proposals%20(RFPs)/Closed%20RFPs/Centennial%20Care%20RFP%20and%20Contract%20(8-28-12)(FINAL).pdf).

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A selected list of relevant publications to date:

Reforming the Way Health Care Is Delivered Can Reduce Health Care Disparities (May 2014)

How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities (July 2016)

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This publication was written by:

Raven Gomez, Campaign Associate, Families USA

Ellen Albritton, Senior Policy Analyst,
Families USA

Sinsi Hernández-Cancio, Director of Health Equity,
Families USA

The following Families USA staff contributed to
this publication (in alphabetical order):

Nichole Edralin, Senior Designer

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FAMILIESUSA 
THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800
Washington, DC 20005
202-628-3030
info@familiesusa.org
FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA