



Health Equity and Health System Transformation

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

## Who are community health workers and why are they important?

Community health workers (CHWs) are trusted members of their communities who, because of their relationships, are able to effectively provide education and support to improve the health of individuals and their communities as a whole. They can provide many different services, ranging from helping people buy health insurance to navigating the health care system to leading community-level health education classes.

CHWs are especially valuable in vulnerable, underserved communities that struggle with multiple barriers to good health and health care, such as limited English proficiency, unmet social needs, and obstacles to reliable transportation. These barriers help create health disparities. For example, communities of color are more likely to have conditions like asthma, diabetes, and certain cancers and are more likely to die from these conditions.

Many factors contribute to people's health status, but having access to care and using preventive services are critical to narrowing the health disparities gap.

CHWs can help people overcome barriers to health coverage and care by connecting them to a range of health care and social services. In this way, community health workers serve as a bridge between community members and the services they need.

People who do this kind of work go by many different names, such as “*promotores de salud*” in Latino communities or “community health representatives” in American Indian and Alaska Native communities. These titles often indicate important differences in how the workers and the communities they serve envision the role and its specifics. For example, many *promotores* feel that the term “community health worker” fails to recognize *promotores*' roles as community mobilizers and advocates on issues other than health care. Similarly, the term “worker” may not accurately describe CHWs who see themselves as serving their communities, not working at a job.

In this brief, we explain how community health workers improve people's health, reduce health care costs, and address barriers to care. We then discuss key questions regarding sustainable funding of CHW programs through Medicaid reimbursement for states that want to start or expand such programs. Then, we present case studies of three states (Massachusetts, Minnesota, and New Mexico), detailing how these states fund, train, certify, and integrate CHW programs. We end with what state advocates need to know to move forward with building or expanding CHW programs in their state.

Community health workers\* (CHWs) can improve people's health, lower health care costs, and address health disparities. But a lack of sustainable funding is a barrier to expanding CHW programs and integrating them into the health care system. Reimbursing CHW services through Medicaid is one way to address these challenges.

Advocates should work with CHWs to establish more sustainable funding through Medicaid and better integrate CHW programs.

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\*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.

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## What do CHWs do?

Examples of what CHWs do include:

- » Work in health care centers helping people overcome challenges related to limited English proficiency or low health literacy.
- » Go out into communities to lead health education classes to help people integrate healthier eating or exercise into their lives.
- » Provide more individualized attention in people's homes, such as tracking progress toward health goals, or helping to identify and address environmental factors that affect health.
- » Help ensure that people are enrolled in health coverage or that they are connected with other community resources, such as housing or utility assistance.

- » Build individual and community capacity for improving health.<sup>1</sup> For instance, advocate at the community level to increase literacy or improve the quality of housing.

## CHWs Help Improve People's Health

CHWs have a strong record of helping to improve people's health. Their role as a bridge between their community and the health care system helps connect people with primary care providers so they can get the care they need when they need it. Through health education and community outreach, CHWs encourage people to use important preventive services, such as mammograms, cervical cancer screenings, and immunizations.<sup>2</sup> Getting the appropriate preventive care can lead to early detection of serious illnesses and keep people healthy.

CHWs also help people effectively manage chronic conditions. For example, they help clients control their blood sugar, follow treatment plans, and lower their blood pressure.<sup>3</sup>

Given that communities of color face disproportionately higher rates of diabetes, heart disease, and other chronic conditions,<sup>4</sup> CHWs can play a valuable role in preventing and effectively managing these conditions to help reduce these health disparities.

## CHWs Help Reduce Health Care Costs

Early detection and effective, timely management of chronic conditions also helps people avoid unnecessary care and the complications that lead to costly emergency room visits and inpatient care. For example:

- » Studies in **Detroit, Seattle, and St. Louis** showed that CHWs providing home visits to families that have children with asthma resulted in fewer unscheduled or urgent medical care visits.<sup>5</sup>
- » In rural **Arkansas**, one CHW program for the elderly and adults with physical disabilities reduced state Medicaid costs by \$3.5 million, saving three dollars for every dollar invested in the program.<sup>6</sup>
- » A health center in **New Mexico** that used CHWs to provide intense individualized support for complex patients who had very high health care needs saw even greater savings, with four dollars saved for every dollar invested.<sup>7</sup>

## CHWs Address the Barriers to Health That Vulnerable Groups Face

CHWs are effective at improving health and reducing costs in part because they are able to address the non-clinical factors that affect people’s health—factors such as the environment; the neighborhood a person lives in; or his or her income, education, or diet—in a way that typical health care providers cannot. (These factors are also known as “social determinants of health.”) CHWs understand the specific barriers that community members face in terms of keeping their health insurance, getting access to care, or managing their health.

Because vulnerable groups, including racial and ethnic minorities, people who have low incomes, and people living in underserved areas, are more likely to experience health disparities, CHWs can be particularly effective in helping these groups overcome barriers to care. For example:



- » Black and Hispanic children are hospitalized for asthma at much higher rates than white children. In **Boston**, a CHW program decreased hospitalizations and emergency department visits by including home visits focused primarily on black and Hispanic children with asthma.<sup>8</sup>
- » Hispanic women have much higher rates of cervical cancer than white women, partly due to Hispanic women being less likely to get screened. In **Philadelphia**, *promotoras* hosted educational workshops, which led to significant increases in cervical cancer screening among Hispanic women.<sup>9</sup>



## Key Questions for Sustainably Funding CHWs through Medicaid Reimbursement

Advocates who are interested in establishing more sustainable funding for CHW programs through Medicaid reimbursement should first consider several key questions. These questions will help state advocates and their partners evaluate the best approach to funding and integrating CHWs in their state, and they can help advocates anticipate the limitations or challenges of particular approaches. See page 12 for examples of how three states fund their CHW programs.

### 1. How can CHW services be funded through Medicaid?

Historically, most CHW programs are run by community health centers and community-based organizations, which fund the programs either out of their own operating budgets or through specific grants. More recently, hospitals and health systems have incorporated more CHWs into their workforce and have funded them in similar ways. These kinds of funding sources are unpredictable, often time-limited, and generally insufficient to support the full breadth of services and supports that CHWs can provide.

Using Medicaid reimbursement to more sustainably fund CHW services addresses these funding challenges. CHW services can be paid for in different ways through Medicaid, and the source of funding has important

## What are “social determinants of health”?

The term “social determinants of health” refers to the conditions in which people are born, grow up, live, and work that affect their health and quality of life. For example, socioeconomic status, racial discrimination, exposure to violence, ability to get access to healthy foods, segregation, housing quality, and environmental conditions can all have a positive or negative impact on health.<sup>10</sup>

implications for which CHW services are reimbursable, who is eligible to be paid as a CHW, and how CHWs are integrated into the care team and the health care system.

There are several ways that states can fund community health workers through Medicaid:

- » State Plan Amendments (SPAs) for Reimbursing Preventive Services
- » Defined Reimbursement through Section 1115 Waivers
- » State Legislation and State Plan Amendments (SPAs) for Broader Medicaid Reimbursement
- » Reimbursement through Managed Care Contracts
- » Funding through Other Health System Transformation Efforts

### **State Plan Amendments (SPAs) for Reimbursing Preventive Services**

In 2013, the Centers for Medicare and Medicaid Services (CMS) changed a rule about who could be reimbursed through Medicaid for delivering preventive services. Previously, preventive services had to be provided by a physician or other licensed practitioner. Now, other non-licensed practitioners, such as CHWs, can provide and get reimbursed for preventive services, as long as those services are *recommended* by a physician or other licensed practitioners.<sup>11</sup> This is similar to needing a prescription from a doctor, except instead of medicine, this “prescription” is to receive a specific service from a CHW.

These services must involve direct patient care and must directly address the physical or mental health of the patient.<sup>12</sup> The services vary but can include preventive health counseling or investigating the source of a child’s elevated lead levels, for example.<sup>13</sup>

In order to take advantage of this change in reimbursement, states must submit a state plan amendment (SPA) to CMS that describes what education, training, or credentialing the state would require of CHWs, though at this time CMS has not put forth any specific requirements. The SPA must also define which preventive services CHWs will provide and how they will be reimbursed.<sup>14</sup>

Many states are now considering submitting SPAs for preventive services, but none is yet paying for these services in this way.<sup>15</sup>

### **Defined Reimbursement through Section 1115 Waivers**

States have often used this type of waiver to test different benefit designs or new models for delivering care, and some states have used these waivers to pay for using CHWs in models that focus on specific Medicaid populations. Though these waivers must be approved by CMS, states still have a significant amount of flexibility in what they can do.

- » **California** used CHWs in its waiver to expand the use of family planning services.<sup>16</sup>

**CHW services can be paid for through Medicaid in different ways, and the source of funding has important implications for the breadth and depth of CHW programs.**

» **Massachusetts** has used CHWs in a waiver for individuals who are eligible for both Medicare and Medicaid (known as “dual eligibles”) and in a waiver to help children in Medicaid with asthma. (See the Massachusetts case study on page 12 for more information on how Massachusetts is using its waivers.)<sup>17,18</sup>

### **State Legislation and State Plan Amendments (SPAs) for Broader Medicaid Reimbursement**

Medicaid can reimburse CHWs for delivering a broader set of services if states choose to expand their list of services. For example, **Minnesota** has taken this approach since passing legislation in 2007. CMS approved the state’s SPA that reimburses for health education that CHWs provide related to a person’s specific health condition.<sup>19</sup>

As in Minnesota, states interested in funding CHWs this way likely need to pass legislation that authorizes funding for this purpose, and in a SPA, define who is eligible to be reimbursed and what services they can be reimbursed for.

There is no federal standard of training or certification that CHWs need to meet under this model, and there isn’t clear guidance from CMS on what the limits of this model might be for reimbursable CHW-provided services. See the Minnesota case study on page 14 for more information on this funding option.

### **Reimbursement through Managed Care Contracts**

States can also use their contracts with managed care organizations (MCOs) to promote the uptake of CHWs in their Medicaid programs. Given that more than 70 percent of Medicaid beneficiaries nationwide are covered under managed care,<sup>20</sup> this option may be an attractive one for many states.

MCOs generally have more flexibility to cover services that are not covered under traditional Medicaid, which is another reason this option appeals to states. Through the process in which Medicaid programs must contract with Medicaid managed care plans, states can require managed care organizations to make CHWs available to beneficiaries, establish a minimum ratio of CHWs to beneficiaries, establish a minimum list of services that CHWs must provide, and establish other requirements.<sup>21</sup>

Some MCOs have also partnered with state Medicaid programs, health care providers, and others to test innovative ways of integrating CHWs into delivering care. For example, in **New Mexico**, one MCO provides a separate stream of money to fund a wide variety of CHW activities for specific populations.<sup>22</sup> (See the New Mexico case study on page 16 for more information on this program.)

## Funding CHWs through Other Health System Transformation Efforts

States are undertaking many different efforts to improve the quality of health care while reducing health care costs, often focusing on increasing the coordination of care and addressing the social determinants of health. Given the roles that CHWs generally fill, they are well-positioned to aid in these efforts.

Some of these new health care delivery models may also be a part of a state's Medicaid program. For example, the Affordable Care Act authorized states to create "health homes" to coordinate care for beneficiaries with chronic conditions.<sup>23</sup> Other transformation efforts, such as State Innovation Models (SIM), may extend beyond the Medicaid population. States with SIM grants are given funding and technical assistance to develop models of delivering and paying for care that involve not only Medicaid, but also private insurance, to improve the health system, improve quality of care, and reduce costs.<sup>24</sup>

## 2. Which services can be reimbursed?

Determining which services CHWs will provide that can be paid for is an important part of establishing how they will be reimbursed. Supporting CHWs' ability to fully use their unique skills, relationships, and understanding of the social context and to tailor their efforts to specific needs can enhance their ability to improve people's health, reduce costs, and decrease disparities. Thus,

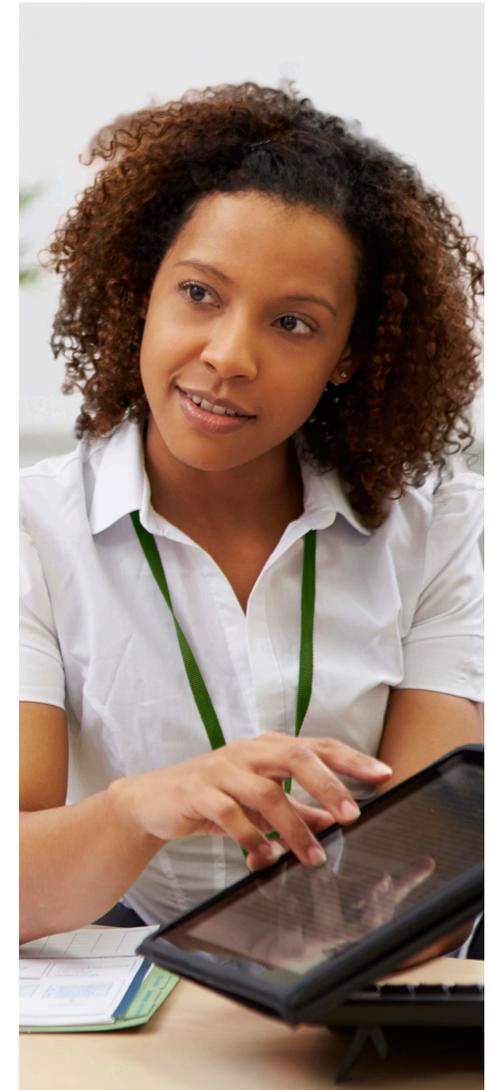
allowing CHWs to be reimbursed for a broad scope of services is the best way to maximize their positive effect on individual and community health.

However, some approaches to reimbursement will allow payment for only a narrow set of services delivered by CHWs. For example, using a state plan amendment (SPA) to reimburse CHWs for delivering preventive services has a very narrow scope: Services eligible for reimbursement must involve direct patient care and must primarily address an individual's health.

This scope excludes community-level efforts, such as outreach to increase enrollment in health insurance or social services, or community-based health promotion. It also excludes care coordination or case management activities and does not allow for reimbursement of activities intended to address broader social determinants of health, such as access to healthy food, even though those issues affect a person's health.<sup>25</sup>

Other types of funding, such as through an 1115 waiver or arrangements with MCOs, may allow reimbursement for a much broader scope of CHW-provided services.

- » CHWs are reimbursed under an 1115 waiver in **Massachusetts** that focuses on pediatric asthma. As part of this waiver, CHWs conduct home visits, where they help address challenges to medication adherence, identify environmental asthma triggers, and assist in advocating with landlords to address those triggers.<sup>26, 27</sup>



» A federally qualified health center (FQHC) in **New Mexico** receives an additional per-member, per-month payment (a fixed amount for each beneficiary) from an MCO to provide broad support for their complex patients who use the most services. CHWs support patients through a variety of education, advocacy, and social support services. This includes making home visits to assess patients' needs, helping them keep appointments, and providing education and support in managing their chronic diseases.<sup>28</sup>

Even if CHWs are limited to providing a more narrow set of preventive services, including them in the health care system can still add tremendous value. Using CHWs in this way can increase people's access to crucial preventive care, particularly for vulnerable communities with cultural, linguistic, and geographic barriers. But reimbursing CHWs for a broader scope of activities supports them in using their unique skills, cultural understanding, and trusted relationships to maximum benefit.

### **3. How are CHWs trained and certified?**

It is important that CHWs have the skills needed to safely and effectively assist their clients and that they are trained to manage the important and sensitive health information that people will share with them.

There are a wide variety of trainings available for CHWs that have been developed by community-based organizations, health centers, colleges and universities, and local and state health agencies. While there are

differences in these training programs, there are many fundamental skills and subject-matter trainings—often referred to as “core competencies”—that are common across many programs.

Although training and certification can help ensure CHWs meet standards for safe and effective care, it is important to recognize that much of their effectiveness is rooted in their deep connections with the vulnerable communities they serve, which is often because they are from those communities. This means that they may face some of the same financial, educational, language, geographic, cultural, and other barriers as the people they serve. Such barriers could put typical trainings and certifications out of reach for some.

**Advocates and state officials must walk a fine line between establishing appropriate training and certification standards and finding ways to include CHWs who might come from vulnerable communities.**

There are efforts underway in many states to establish certification processes for CHWs, often through state legislation.<sup>29</sup> The goals of such legislation are often to standardize the training and core competencies of CHWs; to advance workforce development; and to establish a pathway for CHWs to be reimbursed with traditional health care dollars, such as through Medicaid.

### Core Competencies Established by the Massachusetts CHW Board of Certification<sup>30</sup>

1. Outreach Methods and Strategies
2. Individual and Community Assessment
3. Effective Communication
4. Cultural Responsiveness and Mediation
5. Education to Promote Healthy Behavior Change
6. Care Coordination and System Navigation
7. Use of Public Health Concepts and Approaches
8. Advocacy and Community Capacity Building
9. Documentation of Provided Services
10. Professional Skills and Conduct

### Core Competencies in Minnesota's CHW Certification Curriculum<sup>31</sup>

1. Role of CHWs, Advocacy, and Outreach
2. Organization and Available Resources
3. Teaching and Capacity Building
4. Legal and Ethical Responsibilities
5. Care Coordination and Documentation of Provided Services
6. Communication and Cultural Competency

It is also important to consider how these requirements may exclude or create barriers for certain groups of people who are otherwise best qualified to be CHWs, and even for many people who are already working as CHWs. For example:

- » Certification programs that are administered through state universities and community colleges may not be accessible to people who don't have a high school diploma, who are not able to afford fees or tuition, or who have limited English proficiency.

- » Administering certification programs through colleges or universities may also limit the program to only those living near one of those institutions.
- » State certifications may also end up excluding people who are undocumented immigrants.

If a state is pursuing certification requirements, state advocates should work with CHWs, *promotores*, and other stakeholders to make sure any requirements are as inclusive as possible. For instance:

- » States can be explicit about certification being open to people regardless of immigration status and can offer the courses and training materials in different languages.
- » Funding could also be made available for those who are unable to pay any fees associated with certification.
- » To ensure greater access than might be possible through offering a curriculum exclusively through colleges, states should consider offering it online and through community-based organizations.

Advocates can also develop innovative models of certification in partnership with CHWs and the communities they serve. One model to consider is establishing an option to certify organizations, rather than just individual CHWs, who then select and train the CHWs who are best suited to serve their specific population. Foundations and others that have provided grants to fund CHW programs have typically relied on their grantee organizations to do this. This model could provide a pathway for CHWs who may be excluded from individual certification while still ensuring that CHWs are trained in the core competencies and skills needed.

It is also important that any certification process have a “grandparenting” provision to ensure that individuals currently working as CHWs are not excluded by new requirements. These provisions could waive any new requirements for those CHWs who have worked for a certain number of years or total hours. Some

grandparenting provisions require these hours worked to be under the direct supervision of a physician, though this would exclude CHWs who were based in non-clinical community organizations.

#### **4. How CHWs Are Funded Affects Their Integration into Care Teams**

To maximize CHWs’ effectiveness, states should work to ensure that CHWs are integrated into the team of physicians, nurses, and other providers that are involved in patient care—known as a “care team.” Including CHWs in a care team, rather than adding on CHW services as separate from medical care, allows the team to develop more effective, comprehensive care plans that take into account people’s individual needs within their particular communities. Integrating CHWs also allows the care team to provide a broader range of the support required to improve people’s health.

The way that CHW services are reimbursed can affect how well CHWs are integrated into the care team. For example, some payment methods, like the preventive services SPA, position physicians (or other licensed providers) as gatekeepers that must authorize CHW services for them to be paid, like a referral.<sup>32</sup>

Other approaches, such as the program at Hidalgo Medical Services in **New Mexico** (see the New Mexico case study on page 16), establish CHWs as full and equal members of the care team, with patients automatically referred to the CHW Family Support Services Department. With their own department and

their own funding stream, CHWs are empowered to address the wide range of factors affecting patient health that clinical providers might overlook.<sup>33</sup>

It is important that efforts to sustainably fund and integrate CHWs engage with other provider groups so that these providers appreciate the value of CHWs. Some providers may not understand the wide variety of

roles that CHWs play, or how, if effectively integrated into medical practices, they can help the whole care team deliver better care and improve outcomes.

Outreach to and education of providers is especially important for CHWs who work in community-based organizations, as they have less direct contact with health care providers.

## State Case Studies

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### Massachusetts



**FUNDING:** State grants; defined reimbursement through Section 1115 waivers; other health system transformation efforts

**SERVICES PROVIDED:** Enrollment in health insurance, care coordination, helping people manage chronic disease, addressing environmental health issues

**TRAINING/CERTIFICATION REQUIREMENTS:** Hired and trained by specific programs or health centers; CHW Board of Certification is developing a voluntary individual certification

**INTEGRATION INTO THE HEALTH CARE SYSTEM:** Varies

In addition to extending health insurance to almost all residents, the landmark health reform law that Massachusetts passed in 2006 also helped expand the CHW workforce. This law required the Department of Public Health to conduct a statewide study of CHWs and provide recommendations to develop a more sustainable workforce.<sup>34</sup>

The resulting report found that CHWs increased access to primary care through culturally-tailored outreach and enrollment efforts. Supported by grants from the state, CHWs had played a major community outreach role to help more than 200,000 previously uninsured individuals enroll in health insurance. It also found that CHWs improved the quality and cost-effectiveness of care by helping patients with chronic disease management, medication adherence, and navigating the health care system.<sup>35</sup>

The report also made several recommendations for strengthening the CHW workforce, including developing a professional identity, improving training, expanding financing mechanisms, and creating a state infrastructure to support the CHW workforce.<sup>36</sup>

Subsequent legislation on payment reform, passed in 2012, bolstered the funding and integration of CHWs. This law requires 80 percent of people in MassHealth, the state's Medicaid and CHIP program, to be in a global payment system (where providers are paid an amount designed to cover the total cost of care instead of paying for each service provided). One of MassHealth's payment reform efforts—the Primary Care Payment

Reform Initiative, which is a primary care payment model with payment incentives for quality—allows CHWs to deliver services.<sup>37</sup>

The payment reform legislation also requires private health plans to reduce the use of fee-for-service arrangements and to increase payments that are tied to the value of care as much as possible.<sup>38</sup> The 2012 law also established a Prevention and Wellness Trust Fund and a Health Care Workforce Transformation Fund. Though neither of these programs establishes sustainable financing for CHW services, they do provide grants to communities, some of which are using the grants to test new models of integrating CHWs into their work.<sup>39, 40</sup>

In addition, Massachusetts has paid for CHW services for specific populations in Medicaid through Section 1115 waivers. One demonstration, known as One Care, focuses on individuals with disabilities who are eligible for both Medicare and Medicaid (“dual eligibles”).<sup>41</sup> This program requires CHWs to coordinate care for individuals with high needs who typically use a lot of health care.<sup>42</sup>

A second demonstration program that requires the use of CHWs focuses on children with asthma who are covered by Medicaid. In this program, CHWs not only make home visits to help assess children's health, needs, and environment; but they can also help advocate with landlords to address environmental triggers and provide equipment to help reduce those triggers, such as vacuums with special filters.<sup>43, 44</sup>

## Minnesota



**FUNDING:** State legislation and state plan amendment for broader Medicaid reimbursement

**SERVICES PROVIDED:** Health education related to a person's specific health condition

**TRAINING/CERTIFICATION REQUIREMENTS:** Must complete a 14-credit certification program offered through several state colleges and universities

**INTEGRATION INTO THE HEALTH CARE SYSTEM:** CHWs must be supervised by certain licensed practitioners

Minnesota currently reimburses CHWs through its Medicaid program. The state passed legislation authorizing this reimbursement in 2007, after several years of workforce development efforts that served as building blocks for the law. These building blocks included the establishment of:

- » A CHW scope of practice, which outlines the roles and activities of CHWs
- » The Minnesota Community Health Worker Peer Network
- » A standardized CHW curriculum<sup>45</sup>

CHWs, advocates, and other stakeholders conducted surveys, focus groups, and other activities with financial support from foundations. These activities

helped to document the contributions of CHWs in Minnesota, promote greater use of CHWs, and plan for possible certification.

The standardized curriculum noted above, which is now offered at seven state colleges and universities, leads to a certificate that makes CHWs eligible for reimbursement by the state's Medicaid program.<sup>46</sup> This 14-credit program covers the roles of CHWs (outlined in the scope of practice), their legal and ethical responsibilities, and necessary documentation and reporting. It also educates CHWs on health promotion in core areas, including heart disease and stroke, diabetes, and mental health. The curriculum concludes with the completion of a practice-based internship.<sup>47</sup>

CHWs who had been working for at least five years under the supervision of certain providers were initially “grandparented” in but needed to receive the certification by January 1, 2010, to continuing being eligible.<sup>48</sup>

More than 600 hundred CHWs have received certification in Minnesota, though the number of CHWs getting reimbursed through Medicaid is still below expectations. Problems such as limitations on covered services that don’t encompass the full CHW skillset, a billing process that can be cumbersome, and issues with role clarity and integration could explain why there has not been greater uptake.<sup>49</sup>

CHWs must work under the supervision of a physician, registered nurse, advance practice registered nurse, dentist, mental health provider, or certified public health nurse.<sup>50</sup> The legislation authorized CHWs to provide face-to-face patient education on different

health issues, either individually or in a group setting. Minnesota hoped to also reimburse CHWs for providing care coordination services, but given the lack of a standardized model or definition of care coordination services, the state was unable to include it in their fee-for-service reimbursement model.<sup>51</sup>

Minnesota is using funding from their State Innovation Model (SIM) grant to create a toolkit to help employers integrate CHWs into their care teams. The state and advocates, including the Minnesota Community Health Worker Alliance, are working to incorporate this skilled and certified workforce into other health reform and system transformation efforts. CHWs could be a valuable addition to other models, such as accountable care organizations (ACOs), health homes, and as health insurance marketplace assisters and navigators.<sup>52</sup>

## New Mexico



**FUNDING:** Reimbursement through managed care contracts

**SERVICES PROVIDED:** Broad scope of services across the areas of navigation, access, chronic disease management, health literacy, and connection with non-health care supportive services

**TRAINING/CERTIFICATION REQUIREMENTS:** CHWs are hired by health centers and undergo training that covers the core skills and areas of knowledge needed

**INTEGRATION INTO THE HEALTH CARE SYSTEM:** CHWs are fully integrated into care teams as part of the Family and Support Services Department, which is a co-equal department within the clinic, and patients are automatically referred to receive CHW services

New Mexico's Medicaid program, known as Centennial Care, has promoted the use of CHWs within its managed care organizations (MCOs). Centennial Care has several contracts with MCOs, and current contract language specifies that these organizations provide CHWs for "care coordination activities." These activities include:

- » interpretation and translation
- » health education delivered in a culturally-competent manner
- » informal counseling on health behaviors
- » assisting beneficiaries with obtaining health care services and community resources<sup>53</sup>

These contracts establish the minimum that MCOs must meet, but the MCO has flexibility in how it employs CHWs and can choose to provide services that go beyond what is required in the contract. Some MCOs directly employ CHWs or contract with organizations that employ CHWs, while others cover the costs of CHWs as part of the care team or a patient-centered medical home through either a flat fee or per-member, per-month payments.<sup>54</sup>

Since 2005, one managed care organization, Molina Healthcare, has partnered with the University of New Mexico and Hidalgo Medical Services, a federally-qualified health center (FQHC), to use CHWs to provide intensive services to their complex, high-need patients

who use the most services. Although these patients make up only 5 percent of the patient population, they generated 50 percent of total health care costs.<sup>55</sup>

For these patients, CHWs provide intensive support in navigating the health care system and getting access to the right kind of health care. They also connect these patients with social services, help manage their chronic conditions, and address health literacy issues.<sup>56</sup>

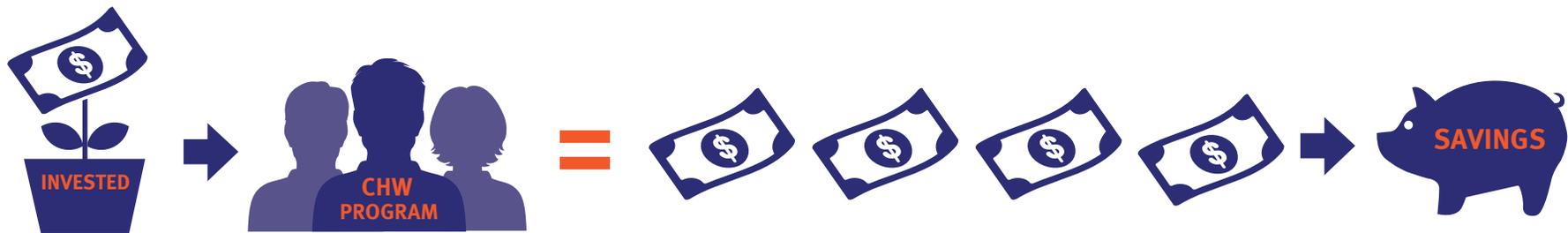
After six months, these patients had fewer visits to the emergency room, fewer inpatient admissions, and used fewer prescriptions. As a result, the program saved \$4 for every \$1 spent.<sup>57</sup>

Given its success, Molina expanded the program. It now uses CHWs to provide chronic disease management to the next 15 percent of patients who are the highest users of health care services and to provide community-level health promotion, education, and prevention to more of the FQHC's Medicaid patients. Molina Healthcare has also extended this partnership

to other FQHCs, and other MCOs are pursuing similar partnerships.<sup>58</sup>

The CHW program at Hidalgo Medical Services relies on an innovative payment and delivery model: CHW services are supported by an additional per-member, per-month payment from Molina Healthcare to Hidalgo Medical Services. For the patients who need the most intensive support and services, the per-member, per-month rate is \$321; for all other patients, it is \$6.<sup>59</sup>

This money supports the Family Support Services Department at Hidalgo Medical Services, which is co-equal with the Physical Health, Mental Health, and Dental Departments, and all patients receive an “automatic referral” based on their level of need. This design helps integrate CHWs as equal members of the care team and ensures that the services they provide are recognized as a core part of the care that Hidalgo offers.<sup>60</sup>



## Examples of Services CHWs Can Provide at Hidalgo Medical Services<sup>61</sup>

### Navigation

- Make home visits to assess a person's needs for health and social services and provide referrals
- Reduce preventable ER visits by helping patients use appropriate non-emergency services

### Getting access to care

- Encourage and help patients to get preventive care
- Reduce barriers to primary care, such as addressing transportation issues or trust barriers

### Chronic disease management

- Encourage adherence to treatments
- Teach concepts of prevention and disease management

### Health literacy

- Provide or facilitate interpreter services
- Provide culturally-tailored health education

## Next Steps for Advocates

It is important to remember that although it may seem as if CHWs have been in the news only recently, many communities have longstanding, successful CHW and *promotores* programs. Any effort to bring CHW programs into a state's health system must start with understanding the existing landscape of these programs in the different communities in that state, and it must be a truly collaborative process with CHWs and the communities they serve.

Advocates should recognize and respect that the characteristics of CHW programs can vary widely from community to community. Building on the real-life experience and expertise of existing programs can help ensure that efforts to establish sustainable funding through Medicaid reflect the institutional knowledge and best practices of those programs.

Many states and some cities also have CHW associations that advocates should engage, though it is important to recognize that those associations may not include all

CHWs. *Promotores*, community health representatives, and others doing similar work are sometimes not involved in these CHW organizations, but they should also be included in decision making.

Community health workers should be meaningfully involved in the process to obtain more funding for the services they provide. By establishing specific standards for involving CHWs in the process to secure reimbursement through Medicaid, states can ensure that CHWs have a voice at the table.

For example, the American Public Health Association adopted an official policy statement that called for any working groups or governing boards that deal with CHW workforce issues to be comprised of at least 50 percent CHWs,<sup>62</sup> a practice that the Pennsylvania Department of Health has adopted.<sup>63</sup> It is essential that CHW-related policies that states or groups develop and implement are clearly informed by the real experts: the CHWs themselves, and the communities they serve.

**Establishing sustainable funding and increasing integration of CHWs will enable them to improve patients' health, lower health care costs, and reduce health disparities. Partnering with CHWs is essential for state advocates as they seek reimbursement through Medicaid for CHW services. States and advocates must think through which services CHWs will provide, how they will be trained and/or certified, and how to integrate CHWs into the health care system.**

## Endnotes

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A selected list of relevant publications to date:

*Tackling Health Disparities While Reforming Payment and Delivery* (May 2015)

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