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Charting the Course for Community Health Workers: Identifying Challenges and Opportunities to Secure Medicaid Reimbursement for CHWs in State Medicaid Programs

Introduction

Patients across the United States face challenges accessing health care and managing their health needs, contributing to high rates of disease and preventable illness.[1,2] Even when patients are able to see a doctor, the social factors that often cause poor health can continue to go unresolved, leading to a cycle of expensive health care appointments that fail to get at the root cause of health problems.[3] The burden of these challenges falls most heavily on low-income people and people of color, who on average fare more poorly than the rest of the population on virtually all health and socially determined measures.[4,5]

Improved integration of the community-based health care workforce, such as community health workers (CHWs), is an evidence-based, cost-effective way to help communities address challenges they face in accessing the critical health and social services that can improve health and well-being while lowering health care costs.[6] However, historically CHWs have faced an unstable, patchwork system of funding.[7] Medicare recently began paying CHWs for community health integration and principal illness navigation services, and some state Medicaid programs allow coverage of a limited range of CHW-provided services, but strengthening funding for CHW services remains a challenge that requires a "braided" approach, leveraging and improving upon multiple funding sources to ensure CHWs can continue to serve communities and individuals. (see figure, CHW Funding: Patchwork Vs. Braided, on page 2).

As the largest source of health insurance in the country, Medicaid offers a unique opportunity to both expand access to CHW services for patients and provide greater sustainability to the community health workforce. Medicaid programs, which cover 75.6 million low-income, pregnant, elderly or disabled Americans, are targeted to the populations most likely to benefit from access to CHWs and have the flexibility to expand coverage to include CHW services.[8] Unfortunately, efforts to expand access to CHW services through Medicaid have posed significant challenges given the inherent differences between the CHW model of care, which emphasizes community-based and culturally competent care delivery, and the strong emphasis on physician-based care delivery in the design of the U.S. health care system. Policymakers should focus on improving existing conditions around Medicaid reimbursement for CHW services, such as increasing CHW payment rates, expanding the types of CHW services covered by Medicaid, and supporting CHWs as they navigate complex billing processes. In the longer term, policymakers will need to advance policy solutions that better integrate the delivery of community-based services by community-based providers into the design of U.S. health care payment and delivery to drive the system toward a whole-person health care approach.

Background

The role of community health workers

Community health workers, known as "promotores de salud" in Spanish-speaking communities, are front-line public health workers who are trusted members of a particular community or have a highly developed understanding of the community being served.[9] The majority of CHWs are women of color who have experience navigating the health care system and advocating for their patients' care.[10] Because of their unique position within the community, CHWs are able to help patients address the social factors that drive negative health outcomes by providing culturally congruent care, health education, care coordination for patients with chronic health conditions, and advocacy for patients navigating the complexity

CHW Funding: Patchwork Vs. Braided

PATCHWORK

(not standardized, not available across the U.S., not comprehensive):

- Limited Medicare coverage
- Medicaid programs for specific services (some states)
- Short-term inconstant state and federal grants

VS

BRAIDED

(standardized, available across the U.S., comprehensive):

- Reliable and comprehensive Medicare and Medicaid coverage
- Private coverage for CHW services
- Contracts with major health systems to deliver CHW services to patients
- Reliable state and federal funding
- Other additional grants

CHWs Are a Solid Investment

For every $1 spent on CHWs, there is up to a $3 return.

of the health care system.[11] CHWs are also uniquely positioned to bridge the gaps between marginalized communities and health care and social services systems.[12]

CHWs can be employed by a variety of organizations but most commonly work at hospitals, public health departments and community-based organizations (CBOs). A substantial body of research indicates that access to CHWs can improve health outcomes and reduce health care spending for patients and federal and state governments,[13] with a return of up to $3 for every $1 spent on CHW programming.[14]

Medicaid coverage of CHW services

Federal and state lawmakers in recent years have increased access to CHW services, including through the expansion of Medicare and Medicaid coverage of select CHW services.[15] As of January 11, 2024, nearly half of all state Medicaid programs provide some form of reimbursement for CHW services.[16] (For more information on the importance of sustainable financing, please see our publication, "A Hard Day's Work: Promoting Sustainable Financing for Community Health Workers.") Because states have broad flexibility to design their own Medicaid programs, each state has taken a different approach to adopt CHW coverage. While this paper focuses on Medicaid coverage of CHW services, experts acknowledge that CHWs require a blend of multiple funding streams to support a diversity of CHW activities and reduce the vulnerabilities of overreliance on a single source of funding.[17] Nevertheless, Medicaid has the potential to be a vital source of financial support and stability for the community health workforce.

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Services CHWs Offer in Their Communities

Care coordination

Chronic disease management assistance

Community education

Health system navigation

Mediation between patients and providers

Translation and interpretation services

Medicaid fee-for-service payments for CHW services

Despite efforts to improve payment, CHWs continue to face significant barriers to receiving Medicaid reimbursement for their services.[18] One major challenge to establishing sustainable reimbursement for CHWs is that the U.S. health care system continues to rely on fee-for-service (FFS) economics as the predominant payment model for how health care is reimbursed. FFS is used to pay doctors, hospitals, nursing homes and other health care providers across all payers, including Medicaid. In this model, health care providers are paid for each individual service they provide with few ties to health care quality or patient outcomes.[19] FFS payment incentivizes providers to make money by doing more high-profit or high-margin procedures rather than allowing providers to generate revenue based on keeping people healthy and reducing health disparities.[20,21] FFS payment has historically failed to cover services that address health-related social needs, despite research demonstrating that socioeconomic and environmental factors are the largest driver of variances in health and health outcomes.[22] FFS payment provides a very narrow view of health and health care by signaling to providers they can only be reimbursed for delivering clinical care that drives a small percentage of health outcomes.[23]

Partly as a result of the design of FFS payments in Medicaid, CHWs report that they face low reimbursement rates, unstable financing, a heavy administrative burden related to billing and compliance requirements, and disrespect from health care providers.[24]

These factors have contributed to CHW shortages and subsequent barriers to accessing cost-effective services that improve health for patients, especially those who are part of historically marginalized communities.[25]

Pathways in Medicaid for expanding access to CHW services

Because the federal government gives states substantial flexibility in designing and administering their Medicaid programs, states can take a variety of approaches to expand beneficiary access to CHW services. The main approaches states have adopted include:

- **State plan amendments (SPAs):** State plans are agreements between the state and the federal government on how a state will administer its Medicaid program. When a state wants to create new benefits or make other significant program changes, it must submit an SPA to the Centers for Medicare & Medicaid Services (CMS) for the agency's review and approval. States can use SPAs to include CHW benefits in traditional FFS reimbursement systems or require coverage through state-run alternative payment models that move away from volume-based FFS payments and instead incentivize the provision of high-quality, efficient care.[26] Importantly, SPAs do not need to be federally budget neutral, meaning the federal share of Medicaid costs associated with SPA changes can rise beyond what the federal government would have otherwise spent, potentially allowing states to receive additional federal matching dollars for a CHW benefit. As of January 2024, 15 states have used SPAs to establish reimbursement for select CHW services.[27]
- **Section 1115 demonstration waivers:** States may submit section 1115 demonstration waiver proposals to CMS to temporarily waive certain federal Medicaid requirements in order to test novel approaches to achieve Medicaid program goals. Medicaid section 1115 demonstrations are time-limited and must be budget neutral, meaning the federal government will not contribute more to a state Medicaid program to cover the costs of a demonstration than it would have otherwise spent. As of January 2024, five states use section 1115 demonstration waivers to reimburse for CHW services.[28] States can use section 1115 waivers in a variety of ways, such as covering specific CHW services, or incentivizing managed care adoption and delivery of CHW services.[29]
- **Medicaid managed care arrangements:** Managed care organizations (MCOs) are health care organizations that state Medicaid agencies contract with to deliver services to beneficiaries. Some states provide CHW services through requirements written into the contracts they establish with MCOs. If a state includes CHW services in its state plan, then CHW services may be incorporated into the medical components of an MCO's capitated rate, which is the lump sum payment an MCO receives to cover the health care costs of a patient population.[30] If a state does not require coverage of CHW services, the state may encourage MCOs to offer these services to beneficiaries as a "value-added service," which is an extra benefit that MCOs can offer to encourage enrollment in its plan. In 11 states, MCOs are either contractually encouraged or required to pay for CHW services. Even though MCOs receive capitated payments to cover patient costs, most providers paid through MCOs are paid using FFS.[31]

Though states have flexibility in how they pay for CHW services, a majority of states have chosen to finance these services through FFS payments.[32] This means CHWs, or the organizations or providers that oversee them, must bill Medicaid for each individual covered service that CHWs provide, with payments based on a predetermined rate established within the state's Medicaid fee schedule.[33]

While FFS is the predominant way states pay for CHW services in their Medicaid programs, some states are developing and testing novel reimbursement approaches, including the use of capitated payments and MCO contracts with CHW organizations that allow CHWs to serve their patients without having to bill for each individual service.[34] Additionally, a growing number of states are incorporating CHW services into state-run alternative payment models. Maine, for example, covers CHW services through PCPlus, the state's primary care alternative payment program.[35] Under PCPlus, providers are paid a lump sum to cover the primary care needs of their Medicaid patients, which must include access to CHW services.[36]

Barriers to sustainable Medicaid payment for CHWs

Despite progress in expanding Medicaid coverage for select CHW services, community health workers and the organizations that employ them continue to face challenges obtaining reliable and consistent reimbursement.[37,38] As previously noted, most Medicaid payments for CHW services rely on FFS economics, requiring CHWs and other community-based workers to fit into a health care payment system that was not designed for the delivery of community-based, nonclinical care. As a result, CHW programs remain insufficiently funded and poorly integrated into the U.S. health care system.[39]

To better understand how CHWs are affected when Medicaid programs cover their services, Families USA conducted two listening sessions with 14 CHWs across 11 states. The listening sessions surfaced key insights into how CHWs and the organizations that employ them are paid for services, the shortcomings and benefits of Medicaid reimbursement for CHW services, and innovative ideas for how to design Medicaid payments to better leverage the important and unique role that CHWs play in the health care system. The insights gathered from these listening sessions are discussed below.

Infrastructure and administrative burden

Under the current FFS system, CHWs or the organizations that employ them must bill Medicaid in order to be reimbursed for their services.[40] Across payers, billing for health care services requires robust infrastructure and investments in staff education, documentation and billing systems.[41] This is especially true for CBOs, which historically do not bill insurance, do not have staff with expertise in billing, and do not employ physicians who can guide or inform the billing process.[42] According to listening session participants, for many CBOs, attempting to bill and receive payment from Medicaid

for CHW services is the equivalent of learning a whole new language from scratch. While requirements to receive FFS payments for CHW services vary across states, frequently CHWs are mandated to enroll as Medicaid providers, establish relationships with billing providers, and/or obtain state CHW certification, all of which can be expensive and time-consuming.[43]

Prior to billing for a service, a CHW or CHW administrator must confirm whether the service provided is eligible for reimbursement, then determine what role the CHW's employer has in billing for services (if the CHW is employed by a CBO, large nonprofit organization or federally qualified health center), and provide appropriate billing documentation. On top of that, if a CHW or organization billing on behalf of a CHW seeks reimbursement for CHW services through a managed care arrangement, the CHW or employer may need to apply to provide services through one or more locally active MCOs and comply with each MCO's documentation and billing procedures.[44,45] CHWs, CBOs and other community-level providers also must obtain National Provider Identifiers (NPIs) to receive Medicaid reimbursement.[46] And they must also be able to navigate the appeals process if a claim gets denied.[47] As one CHW noted, even once their organization's systems are up and running, they still face high rates of denials and major coverage lapses as patients cycle on and off eligibility for Medicaid coverage.

Support and Sustainable Funding

A CHW from South Dakota noted that upfront funding from state Medicaid agencies gave their organization the resources to adopt and update necessary technology, learn billing practices, and navigate periods when they had numerous claim denials. Importantly, in addition to the upfront funding, they also need to continue receiving technical assistance and non-Medicaid grant funding to adequately serve their communities.

We also had a lot of issues with [our state's] Medicaid computer system. We had to, at one point, transfer to paper just to process everything. Referral source claims and adjusting our logic with our computer system were all challenges. Now that we are fully functional, we run into coverage lapses.

–Community health worker, South Dakota

Inadequate reimbursement and benefit design

When a state Medicaid plan or managed care organization designs a new benefit, it triggers a chain of decision-making about what services to cover and how much to pay for those services. A major challenge for states that attempt to cover CHW services under FFS is establishing codes that cover the breadth of these services and ensuring those codes promote CHW best practices.[48] Under traditional FFS payment, Current Procedural Terminology (CPT) codes are created for specific services and attributed to specific amounts of time spent on service delivery.[49] This process is misaligned with CHWs' broad scope of work and the wide variances in the amount of time CHWs spend working directly with individual clients. For example, see Martin's story on page 9.

As a result, payment for CHW services is often too low, and billing codes under FFS payment fail to capture the full scope of work that a CHW does to support the health of individuals.[50] In turn, several states that have adopted a CHW benefit under their state plan have seen low uptake of the codes and CHW shortages.[51,52] While Medicaid has the potential to be an important source of financing for CHWs, research indicates that growing access to Medicaid payment has had little effect on increasing hourly wages or stemming CHW turnover.[53] One CHW listening session participant from Minnesota, when considering the administrative burden associated with Medicaid reimbursement as well as the low payment rates, concluded, "There is not a lot of payoffs for choosing to do the Medicaid billing process."

Further complicating matters, some states limit reimbursable services to those that are provided in person, or they only cover services for specific populations.[54] Additionally, Medicaid typically will not pay for services provided to groups or for group sessions that include non-Medicaid beneficiaries, so CHWs who provide community-level education and group health supports may not be able to get Medicaid reimbursement for those activities.

Time descriptors, which assign a specific length of time to the billing code for a service, can also limit a CHW's ability to be fully reimbursed for the services that are most meaningful for patients. One CHW told Families USA that FFS billing affects a CHW's relationship with patients, stating, "I do not want CHWs to have to rush through patients every 15 to 20 minutes like other providers. We should have the time to be able to build organic rapport." In contrast with traditional FFS payment, some MCOs and value-based care models are more flexible in the way they pay for care and may be able to finance CHW positions and programs in ways that better account for the scope and variability of CHW practices, such as through capitated payments.[55]

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The importance of CHW integration, part I

Martin's Story

Meet Martin, a Black farmer living in South Dakota with his family. Martin is 57 and has multiple chronic health conditions, including Type 2 diabetes, high blood pressure and heart disease. Recently, Martin suffered a traumatic brain injury (TBI) from a farming accident. He takes multiple medications to control his chronic conditions and was referred to an occupational therapist, a physical therapist and a speech therapist to regain full function after the accident.

Due to the TBI, he is unable to drive to work or his medical appointments. His wife had to quit her job to drive him to the nearest medical center over 45 minutes from their home. His worker's compensation wages are the only source of income for his family, and he qualifies for South Dakota Medicaid.

Kayla, a community health worker at a local nonprofit that partners with the hospital where Martin receives his care, supports Martin with his goal of managing his health conditions. Kayla helped Martin organize his medication, and together they tried medication reminder strategies and reviewed directions from his providers. She supports Martin with scheduling specialist appointments, and she sometimes drives him to his appointments. She has also assessed the family's financial situation and helped him enroll in the Supplemental Nutrition Assistance Program (SNAP). Kayla has played an important role in building Martin's and his family's capacity to manage Martin's health conditions by educating him about his TBI diagnosis and other conditions and helping him coordinate and access the care and social services he needs to recover from the accident and support his family.

At the local church, Kayla offers community members education and information on heart and kidney disease prevention. After seeing how many families are struggling financially, Kayla now offers a workshop on how to access programs like SNAP and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

All the activities described above are well within Kayla's scope of work as a CHW. However, in South Dakota, Medicaid would not reimburse Kayla for providing Martin with care management services, driving Martin to his appointments, or helping Martin and community members enroll in government programs.[56] None of those services are included within South Dakota's CHW Medicaid benefit.[57]

Insufficient health care integration

To fully leverage the ability of CHWs to improve community health and well-being, CHWs must be meaningfully integrated into multidisciplinary care teams. In most states and within the federal Medicare program, a physician or other licensed clinical provider must oversee a CHW who is delivering covered services.[58] This means that clinical providers often hold the keys to Medicaid and Medicare payment for CHW services. This is problematic for multiple reasons, including that traditional medical providers are often unfamiliar with the scope of CHW services or how to authentically partner with CHWs.[59] This is particularly challenging given that, traditionally, FFS payments and the health care system at large are not designed to facilitate or reward collaboration within the health care system and often offer no payment for doing so, resulting in care that is disconnected from a patient's larger health and social needs.[60,61] One CHW employed by a community health center told Families USA they often work with new providers who have a limited understanding of a CHW's role and often fail to refer patients to CHWs or duplicate referrals for clients CHWs already serve. Recent evidence also indicates that CHWs feel that clinical providers can be dismissive and disrespectful.[62]

The impact of limited education on the role of CHWs goes beyond the behavior of individual providers. When managed care organizations and health systems fail to engage with CBOs or other community organizations that provide CHW services, patients miss out on important resources. While MCOs have more flexibility to cover CHW services, they may limit access to CHW services if they do not understand the valuable role CHWs play in the health care system.[63] Families USA spoke with a CHW administrator from California who confirmed that many MCOs fail to see the value of CHW services. Even when MCOs employ or collaborate with CHWs, research finds the scope of their work is often limited to making referrals and conducting social screenings.[64] This research demonstrates that the full potential of CHWs is yet to be realized across the health care system.[65]

When CHWs are active members of clinical care teams, they provide community-informed interventions, support patients holistically, and help providers to better care for patients.[66] For example, a CHW who actively works with a primary care provider can act as a cultural mediator, build trust with individual patients and the community, and problem-solve to eliminate barriers to patients' participation in clinical care plans. Martin and Kayla provide another example of why CHW integration is important, see their story on page 11.

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The importance of CHW integration, part II

Kayla and Martin

Kayla, Martin's CHW, works with Martin's primary care doctor, Dr. Smith. Dr. Smith is concerned by Martin's recent test results indicating that his blood sugar was elevated. Dr. Smith was unable to reach Martin so he notified Kayla of the situation, and she connected with Martin during a home visit they had scheduled for that afternoon. During the home visit, Martin and Kayla called the clinic and spoke with a nurse from Martin's care team. The nurse explained Martin's lab results to him and relayed his medication instructions and an important message from Dr. Smith about medication adherence. After the phone call, Kayla and Martin reviewed the medication instructions and discussed the importance of following them as instructed. Martin shared with Kayla that his refrigerator broke the previous week, and he could not afford a new one and has been unable to refrigerate his insulin or keep healthy food on hand. Kayla supported him in enrolling in a program that connects individuals with medically necessary household appliances. Martin's new refrigerator was delivered the next day. Due to Kayla and the care team's support, Martin did not miss any more doses and avoided going to the hospital.

Because Kayla and Dr. Smith worked together to support Martin's health, they had the opportunity to provide Martin with the appropriate support needed to follow his treatment plan. If Dr. Smith and Kayla had not been connected, this intervention may not have been possible.

Policy considerations for Medicaid reimbursement for CHWs

To address the barriers and shortcomings associated with Medicaid reimbursement for CHW services, it is critical that CHW payments are designed with the role of CHWs in mind.

In the short term, states should work within their existing systems to remedy the most glaring problems with Medicaid reimbursement for CHW services, such as low reimbursement rates, inadequate service coverage, and administrative burden. In the longer term, policymakers should focus on redesigning the economic incentives of the health care sector to better align with consumers and families by shifting toward population-based payment models that provide reliable, flexible funding for high-quality care that addresses the broad spectrum of health needs. Ultimately, policy solutions should reorient health care payment and delivery to the goal we all have — improved health for ourselves and our families that is affordable and economically sustainable.

CMS and state Medicaid agencies hold the keys to transform Medicaid programs to better support this critical workforce. State Medicaid agencies should consider the following policy recommendations:

Design and implement a robust Medicaid CHW benefit.

Specifically, states should:

- **Solicit input from CHWs from a variety of employment settings, geographic locations, racial and ethnic backgrounds, identities, and lived experiences to design, implement and evaluate community health worker benefits.** States can convene diverse CHW working groups to consult throughout the benefit development, design and implementation process, including around reimbursement rates, CHW certification requirements and covered services. **Further, state policymakers should review research and recommendations for designing CHW benefits**, including Community Health Worker Core Consensus Project recommendations for developing CHW benefits and the Community Health Worker Center for Research and Evaluation for evaluating CHW programs.
- **Ensure that FFS payment rates for CHW services are sufficient to support a robust community health workforce.** State Medicaid agencies should consider the recommendation of the National Association of Community Health Workers (NACHW) that CHWs should be paid a wage equivalent to at least $25 per hour. NACHW encourages states to ensure that payment rates consider the additional costs associated with CHW training and certification, developing the technology and infrastructure to bill for services, and supplies.[67]
- **Streamline Medicaid billing and managed care administrative processes to reduce burden on CHWs and their employers.** This could include bundling reimbursement codes, aligning MCO payment systems, and improving interoperability between clinical and nonclinical providers.
- **Design a comprehensive Medicaid CHW benefit that covers a wide range of CHW services.** Benefits, whether delivered through FFS or managed care, should enable CHW and CHW employers to work at the top of their training and be reimbursed for the full range of direct services they provide to Medicaid enrollees. As a starting point, states should consider Medicare's community health integration benefit, which covers a wide range of CHW services, including patient advocacy, education, health system navigation, care coordination and more.[68]
- **Allow CHWs to bill Medicaid independently** to expand beneficiary access to CHW services.

Leverage managed care to improve access to CHW services.

Specifically, states should:

- **Require MCOs to cover CHW services offered by a diverse range of CHW employers, including CBOs, federally qualified health centers, hospitals and others** to help eliminate funding barriers faced by CHWs based on their employer type.
- **Provide financial and technical assistance to nonclinical CHW employers to help with additional costs associated with participating in Medicaid.** For example, states should cover upfront investments needed to develop a billing system and help CHWs and their employers meet the requirements of participating in Medicaid.
- **Leverage managed care arrangements and other value-based care models to provide flexible and reliable payments for a broad range of CHW services.** Managed care arrangements and other alternative payments models should:
    - Explicitly require contracts with CBOs and other community-based providers to provide CHW services to Medicaid beneficiaries.
    - Support the delivery of a broad range of CHW services.
- **Develop CHW-patient ratio standards for managed care organizations.** Medicaid contracts with managed care organizations that include CHW-to-patient ratio standards can help ensure that MCOs are providing beneficiaries in need with access to CHW services. For example, MCOs in Michigan are contractually required to meet a defined ratio of CHW to members of 1-to-5,000.[69]

Cement the role of CHWs in our health care system.

Specifically, states should:

- **Facilitate partnerships among clinical health care providers, MCOs and CBOs. State Medicaid agencies should encourage collaboration among these groups to ensure CHWs are integrated into care teams.** For further guidance, state Medicaid agencies should look to benefits designed for other community-based service providers, such as doulas.
- **Support multiple funding streams for CHWs and community-based organizations, including state and federal grant funding.** To help facilitate this, states should streamline statewide funding applications, develop direct methods of communicating with CBOs to alert them to state and national funding opportunities, and provide technical support to CBOs around funding.[70]

- **Redesign the economic incentives of health care payment toward value-based care payment models that better support CHWs, CBOs and community-level providers.** The current FFS payment system in health care continues to be incompatible with the delivery of community-based services that address the social drivers of health. States should explore alternative payment methods that promote access to a broad range of CHW services. Specifically, states should move toward providing flexible, population-based payments under Medicaid that require collaboration with the community-based workforce, as seen in Georgia, Maine, New York, and other states.[71]

Conclusion

The U.S. health care system continues to fail to address the largest contributor to an individual's health: health-related social needs. As a result, people from across the country, and particularly members of marginalized communities, are unable to achieve their best health. State policymakers should utilize their authority to leverage and adapt state Medicaid programs to improve access to the services and support provided by the community-based workforce, specifically community health workers, to address the root causes of poor health and health disparities. To ensure Medicaid CHW reimbursement is truly impactful, efforts must center the voices and lived experiences of workforce members.

States are powerful purchasers of health care, and they have the ability to drive meaningful changes to health care payment and delivery through state Medicaid programs to provide high-quality health care that improves health and reduces disparities for their residents.

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