Community Health Councils

FUNDING COMMUNITY HEALTH WORKERS IN CALIFORNIA:

Using Medi-Cal to Transform Healthcare Delivery

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Introduction

Community Health Workers (CHWs), defined as "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served," connect historically marginalized communities to health providers and resources through outreach, advocacy, navigation, and education.[1-2] CHWs often come directly from the communities they serve and are uniquely equipped to address the social determinants of health to reduce racial and economic disparities in health outcomes.[2-3] The ability of CHWs to advance health equity has been especially evident during the COVID-19 pandemic. CHWs supported disproportionately impacted communities in accessing COVID-19 testing, clinical care, vaccines, and social supports, such as food assistance and housing. [4] To support CHWs as a workforce beyond the immediate COVID-19 response, policymakers must establish sustainable and equitable financing mechanisms.

In June 2021, Governor Gavin Newsom announced a revised budget proposal, which would include $16.3 million for CHWs to serve Medi-Cal beneficiaries by 2022.[5] In August 2021, the Department of Health Care Services (DHCS) formally announced their intent to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services to obtain federal authorization to reimburse CHWs in Medi-Cal, California's Medicaid program.[6] If the SPA is approved, CHWs will need to be supervised by a licensed provider and offer services related to the diagnosis, prevention, and treatment of physical and/or mental health conditions of Medi-Cal beneficiaries in both fee-for-service and managed care systems.[6] Throughout fall 2021, DHCS is working with California stakeholders to develop the SPA, soliciting recommendations on defining CHW services, certification, and supervision.

This report provides an overview of various financing mechanisms used to reimburse CHWs, with an emphasis on states that leveraged Medicaid SPAs or 1115 demonstration waivers. Based on this research, and key conversations with organizational partners, a set of recommendations were submitted to DHCS to inform California's SPA process. The following recommendations are further detailed later in this report:

- Certification and licensure processes must minimize barriers to participation
- Include community-based organizations as supervising entities
- Ensure community health centers can be reimbursed equitably for CHW services
- Establish payment rates that match a living wage and promote economic justice for CHWs

Community Health Workers in California

While this Medi-Cal reimbursement policy is in its early stages, California CHWs have worked in myriad ways for decades, with funding coming through community based organizations (CBOs), grants, and Medi-Cal pilot projects, among other avenues.[7] However, these disconnected funding streams create patchwork financing across counties and are often time limited, preventing CHWs from becoming fully integrated into health systems.[8] Numerous studies and reports have presented recommendations to remedy these challenges and incorporate the workforce into the Medi-Cal delivery system. These recommendations, including those outlined by Community Health Councils in 2017, address financing, evaluation, data collection, and the integration of CHWs into clinical teams. These recommendations have also laid the foundation for this significant next step for California. While there are additional bills and funding sources in place to support CHWs in a variety of capacities, using Medi-Cal as a revenue source will be crucial to establish the long-term stability of this workforce.

Financing Pathways and Lessons Learned

While finalizing California's SPA, DHCS can look to other states who have successfully amended their Medicaid programs to include CHWs to inform the policy-making process. Two of the most common policy tools used to formally incorporate CHWs in Medicaid systems are Medicaid SPAs or 1115 demonstration waivers, and to date, at least eight states have allocated Medicaid reimbursement for CHWs using these processes. SPAs are used for more permanent changes and require federal approval during a 90-day review period.[9-11] 1115 demonstration waivers request federal authority for pilot or demonstration projects that can be renewed after an initial five-year period.[11-13] Stakeholder engagement through public comment is strongly encouraged throughout both processes. The following examples highlight states that have established reimbursement for CHWs through SPAs and 1115 waivers, with lessons learned from both avenues that may inform California's process. For a full list of states and their CHW Medicaid programming, see Table 1.

State Plan Amendments

In South Dakota, a 2019 SPA used the Affordable Care Act (ACA) Preventive Services Authority to add CHWs as a reimbursable service supporting Medicaid beneficiaries with disease prevention and chronic condition self-management.[14] This SPA requires all servicing and billing providers to be enrolled through the state Medicaid program, reimbursement to be issued through enrolled CHW provider organizations, and CHWs to be certified through state approved curriculum, with at least six additional hours of training

each year post-certification.[15-16] Different types of CHW titles – CHW, certificate-level CHW, or community health representative – are also given based upon the type of certification achieved.[17] Additionally, each service must be documented, related to a medical intervention, ordered by a licensed practitioner, and delivered based on the patient's care plan in order to be reimbursed.[15-16] Throughout this process, the CHW Collaborative of South Dakota was established to provide statewide support and technical assistance for CHWs. The collaborative identified the following priority areas: defining a clear scope of work that can be recognized by Medicaid, identifying credentialing and training programs, creating a toolkit to assist healthcare providers with hiring processes, and advocating for career pathways to support CHW workforce sustainability.[14-16]

In Indiana, a 2018 SPA similarly built upon the ACA Preventive Services Rule to allow Medicaid reimbursement of CHWs for services recommended by a licensed provider.[18-19] To do so, Indiana explicitly defined CHWs services, competencies, certification, and employment specifications, among other guidelines, in the SPA for federal approval.[18-19] Best practices from Indiana's SPA process included engaging stakeholders frequently throughout planning and implementation, ensuring all actors have an understanding of processes, and creating clear career pathway opportunities to sustain the CHW workforce in the long term.[18]

In Alaska, a 2017 SPA allowed Medicaid reimbursement for certified community health aides and practitioners providing specific services and/or medications to beneficiaries.[20-21] Payment is made through a statewide encounter rate, which is calculated by dividing billable service costs by the number of visits per year, then directed to the Tribal Health Organization that hired the community health aide or practitioner.[20] Lessons learned include: ensuring ongoing consultation with health organizations to establish the encounter rates, reviewing rates yearly to adjust for inflation, specifying required data and services, and supporting ongoing data collection and reporting.[20, 22]

1115 Demonstration Waivers

In Minnesota, a 2007 1115 demonstration waiver, which eventually became a SPA in 2008, introduced a fee for service funding methods, using billing codes under the state Medicaid plan.[23-25] Reimbursement requires specific documentation corresponding to billing codes for CHW services that are delivered under a state-eligible, licensed practitioner's supervision.[23-25] Throughout this process, CHWs provide chronic disease management and health education based services, which are considered to be diagnosis related rather than a social service.[23-25]

In New Mexico, a 2017 1115 waiver renewal extended a mandate for Medicaid managed care organizations (MCO) to directly hire and contract CHWs, and required some MCOs, such as Centennial Care, to provide CHW services to a set percentage of beneficiaries.[23, 26-27] Payment for salaries, training, and services are billed as administrative fees, built into the plan's per member, per month rates and paid to the MCO, with some healthcare plans, like First Choice, covering CHW services directly.[23, 26-27] Through this mandate, not only are CHWs more sustainably financed, but more resources are dedicated to the hiring of CHWs.[28-30] Additionally, New Mexico found that incorporating evaluation to assess the return on investment of CHWs can further legitimize the need for robust financing.[26-28]

In Washington, a 1115 waiver demonstration allowed CHWs to be included in the state's Medicaid, value-based payment system and offer comprehensive care coordination services through Health Homes Programs (HHP).[21, 24] The HHP was developed through the ACA to provide holistic care for Medicare beneficiaries with multiple chronic conditions or behavioral health needs.[29-30] HHPs using a SPA have also been authorized in California, with CHWs recommended to be integrated as part of the care team, yet the program is not in place across all counties.[30-31] While this model is currently limited to a narrow Medicare demographic, it can be used as an example for integrating CHWs into care teams moving forward.[32]

Summary and Recommendations

Across these states, it is evident that sustainable financing is incentivized through increased public awareness and professional recognition of CHWs, with ongoing evaluation and data collection further legitimizing the need for funding. Additionally, most states require certification as a prerequisite for reimbursement, but this has the potential to establish new barriers regarding documentation status, language, cost, or history with the criminal justice system.[33]

With this in mind, Community Health Councils has proposed and submitted the following recommendations to DHCS:

Certification and licensure processes must minimize barriers to participation

The certification process or licensure requirement for CHWs to be reimbursed by Medi-Cal should minimize the barriers to the profession, ensure existing CHWs are not excluded, and provide multiple different avenues for learning and gaining credit. The certification process in California should not impose barriers related to cost, documentation status, higher education requirements, or discriminate based on history with the criminal justice system. Additionally, California should look to the South Dakota model of a CHW

collaborative, which oversees the scope of practice definition and identifies credentialing and training programs for CHWs in the state.[16]

Include community-based organizations as supervising entities

In a presentation on the proposed SPA, DHCS introduced the potential to include Community-Based Organizations (CBOs) as supervising entities, who would thus be able to bill Medi-Cal and be reimbursed for CHW services. We strongly support this proposal and urge DHCS to include it in the SPA. While this is subject to federal approval, including CBOs as full partners in the effort to support and expand the CHW workforce is essential. CBOs have long employed and contracted with CHWs directly, and not all CHWs are supervised by licensed healthcare professionals in traditional clinical settings. Ensuring that CHWs can continue their work with CBOs increases their proximity to the communities they serve, and the leadership roles they hold within those communities.

Ensure community health centers can be reimbursed equitably for CHW services

Community health centers serve a large portion of Californians who live under the federal poverty line or are unhoused, and CHWs are uniquely equipped to serve and support community health center patients. This is evident based on the outcomes of the Whole Person Care pilots. As reimbursement rates for community health centers are dictated by the Federally Qualified Health Center/Rural Health Center PPS (Prospective Payment System) rates, DHCS must work with clinics to create an equitable alternative payment methodology to ensure this benefit can be fully leveraged by all providers in Medi-Cal, including the clinics who overwhelmingly serve low-income Californians.

Establish payment rates that match a living wage and promote economic justice for CHWs

Establishing equitable Medi-Cal reimbursement is critical in advancing economic justice for CHWs. Across the state and nation, the CHW workforce is primarily made up of women of color and paid far less than other healthcare professionals.[34] As DHCS sets the rates corresponding with Medi-Cal billing codes in the SPA, the Department should ensure that these rates will provide economic security for CHWs, particularly given California's high cost of living.

Read the full recommendation letter here.

With attention to the lessons learned from other states, and a robust stakeholder engagement process, Medi-Cal financing of CHWs has the power to transform our healthcare delivery system and millions of lives across California.

Table 1. Community Health Worker Financing Mechanisms by State

State	CHW Programming	Financing	Reference
Alabama	CBOs	Private funding	The Wellness Coalition
Alaska	Community health aides	Medicaid SPA	2017 SPA
Arizona	Health plans, FQHCs	Operational budgets	2019 NAU Report
Arkansas	CBOs, CHW associations	Private funds, ops budget	AK CHW Association
California	Health plans, WPC, HH, CBOs	Medicaid pilots, grants	2017 CHC Report
Colorado	Regional Care Collaboratives	Private funding	CO RCCOs
Connecticut	FQHC, CBOs	CDC funding, grants	CT Health Foundations
Delaware	CBOs	Private funds, ops budget	2017 DE Report
Florida	CBOs, FQHCs, universities	Private funding	FL CHW Coalition
Georgia	CBOs	Private funding	GA CHW Initiative
Hawai'i	CBOs, universities	CDC funding, grants	2019 Literature Review
Idaho	Healthy Connections	Medicaid incentives	ID Healthy Connections
Illinois	Healthcare teams	Private funding	2020 IL Policy Brief
Indiana	Supervision by providers	Medicaid SPA	Health Coverage Program
Iowa	AmeriCorps CHW program	Private funding	IA Mercy One Program
Kansas	MCOs	Medicaid incentives	KanCare Health Plans
Kentucky	CBOs, health plans	Private funds, state budget	2021 KY Policy Brief
Louisiana	FQHC, CBOs, MCOs	Private, managed care plan	2020 LA CHW Report
Maine	Health Homes	Medicaid	State Innovation Models
Maryland	CBOs, HMO contracts	Private funding	ME Health Department
Massachusetts	CBOs, MCOs	Medicaid 1115	MassHealth
Michigan	MCOs	Managed care plans	2018 MCO Issue Brief
Minnesota	Health Plans	Medicaid 1115	MN Provider Manual
Mississippi	CHW associations	Private funding	MS Health Department
Missouri	CBOs, Health Homes	Medicaid pilots, grants	MO Health Foundation
Montana	Care coordination contracts	Private funding, contracts	2017 MSU Funding WS
Nebraska	Hospitals, state health dept.	Private funding	2020 NE CHW Report
Nevada	Clinics	CDC funding, grants	2021 Policy Brief
New Hampshire	Regional networks	Private funding	NH CHW Program
New Jersey	State CHW institute	Private funding	NJ Health Department
New Mexico	MCOs	Medicaid 1115	NM 1115 Waiver
New York	Optional Health Homes	Medicaid (partial)	NY 1115 Waiver
North Carolina	CBOs, state health department	Medicaid pilots, grants	2021 NC CHW Report

State	CHW Programming	Financing	Reference
North Dakota	Tribal community health reps.	Medicaid (partial)	2020 NACHW Report
Ohio	CBOs, health care teams	Private funding, contracts	2018 OH Assessment
Oklahoma	CBOs, state health department	Private funding	OK Health Department
Oregon	Coordinated care organizations	Medicaid 1115	2018 CHW Report
Pennsylvania	Behavioral health organizations	Medicaid (partial)	2015 CHW Assessment
Rhode Island	CBOs	Private funds, ops budget	2017 RI CHW Report
South Carolina	CBOs, MCOs	Private funding	2018 CHW Report
South Dakota	Health care teams	Medicaid SPA	SD Medicaid Billing
Tennessee	CBOs	Private funding	2018 CHW Report
Texas	MCOs	Managed care plans	2017 TX CHW Report
Utah	CBOs, ACOs	Private funds, ops budget	UT CHW Assessment
Vermont	Health teams	Medicaid	2019 CHW Report
Virginia	CBOs	Private funding	VA CHW Association
Washington	Health Homes	Medicaid 1115	WA Health Homes
West Virginia	Behavioral health care teams	Private funding	Rural Health Info Hub
Wisconsin	Care coordination work	Medicaid	2021 WI Budget
Wyoming	No formal CHW structure	No formal funding	WY Rural Health Dept

For more information, please visit the National Academy for State Health Policy State CHW Models dashboard.

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