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BRIEF / 12-07-22

State Approaches to Community Health Worker Financing through Medicaid State Plan Amendments

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Lessons from the COVID-19 pandemic have revitalized activity around community-led efforts to improve health outcomes and build community resilience. Across the country, state officials are prioritizing partnerships with community health workers (CHWs) as a key pillar in reaching low-income and underserved communities. Accumulating evidence (https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf) of the efficacy and cost-effectiveness of CHW interventions in increasing access to care in these communities, improving health outcomes and bridging gaps in health disparities has catalyzed state policy in this domain.

To facilitate state-to-state exchange of best practices in CHW-related policymaking and investments, NASHP hosts a Community Health Worker Learning Collaborative.[1] There is broad agreement in the collaborative that sustainable funding approaches for CHWs involve diversifying, braiding, and blending funding sources — overarching trends can be found in NASHP's state models tracker (https://nashp.org/state-community-health-worker-models/). Recent discussions have centered around Medicaid's role. This brief provides an overview of recent developments in Medicaid State Plan Amendments (SPAs).

States can use SPAs to shape Medicaid benefits to address enrollee needs and reimburse for CHW services as part of a sustainable financing approach. With a SPA, benefits must be offered statewide and without targeting populations. Twenty or more states have also used Section 1115 demonstration waivers and Medicaid managed care organization (MCO) contracts for similar purposes — each of these approaches has opportunities and limitations.

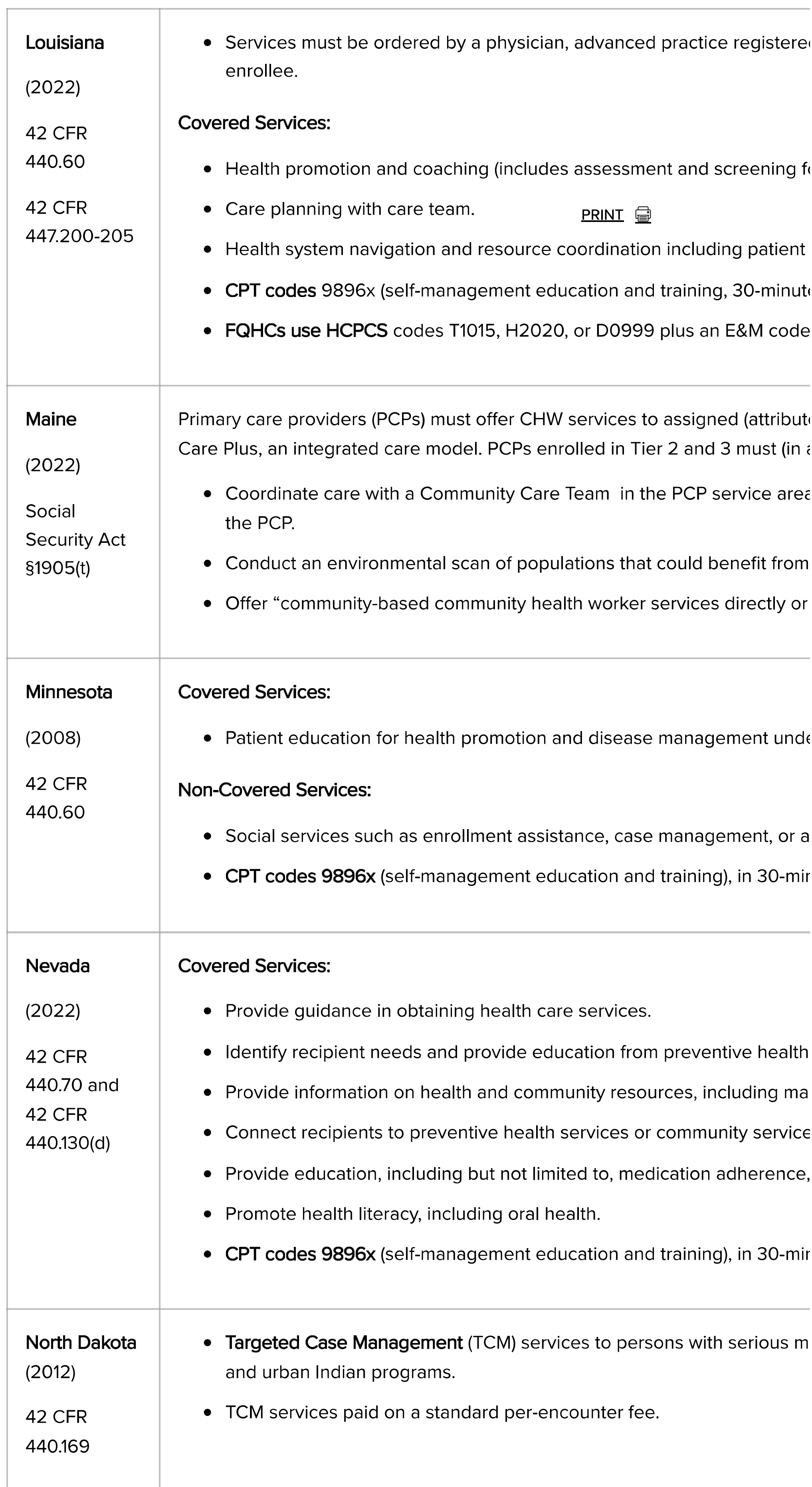
Recent Developments Related to CHW SPAs

Currently, SPAs (https://www.chcf.org/wp-content/uploads/2022/08/SummaryMedicaidStatePlanAmendmentsCHWs.pdf) are in effect in 10 states, with five approvals in 2022 (Rhode Island, Louisiana, California, Maine, and Nevada). The first such SPA was approved in Minnesota in 2008, and at least six other states are actively developing or considering new SPAs at the time of this publication. Table 1 provides detailed information.

Table 1: Community Health Workers Medicaid State Plan Amendments

All use existing payment mechanisms (MCOs or fee for service) except as noted.

State and Authority	Covered Services
California (2022) Preventive services: 42 CFR 440.130(c)	**Covered Services:** • Health education to promote the beneficiary's health or address barrie • Health navigation to provide information, training, referrals, or support • Screening and assessment to identify need for services. • Individual support or advocacy that assists a beneficiary in preventing
Indiana (2018) Other Practitioner Services: 42 CFR 440.60	• Services must be within the scope of practice of the supervising licens **Covered Services:** • Diagnosis-related patient education toward self-managing physical, m • Cultural brokering between an individual and members of a health car • Health promotion education to a member to prevent chronic illness. • Direct preventive services or services aimed at slowing the progress o • **CPT codes** 9896x (self-management education and training, 30-minut



Louisiana (2022) 42 CFR 440.60 42 CFR 447.200-205	• Services must be ordered by a physician, advanced practice registere enrollee. **Covered Services:** • Health promotion and coaching (includes assessment and screening f • Care planning with care team. • Health system navigation and resource coordination including patient • **CPT codes** 9896x (self-management education and training, 30-minut • **FQHCs use HCPCS** codes T1015, H2020, or D0999 plus an E&M code
Maine (2022) Social Security Act §1905(t)	Primary care providers (PCPs) must offer CHW services to assigned (attribut Care Plus, an integrated care model. PCPs enrolled in Tier 2 and 3 must (in a • Coordinate care with a Community Care Team in the PCP service are the PCP. • Conduct an environmental scan of populations that could benefit from • Offer "community-based community health worker services directly or
Minnesota (2008) 42 CFR 440.60	**Covered Services:** • Patient education for health promotion and disease management und **Non-Covered Services:** • Social services such as enrollment assistance, case management, or a • **CPT codes 9896x** (self-management education and training), in 30-mi
Nevada (2022) 42 CFR 440.70 and 42 CFR 440.130(d)	**Covered Services:** • Provide guidance in obtaining health care services. • Identify recipient needs and provide education from preventive health • Provide information on health and community resources, including ma • Connect recipients to preventive health services or community service • Provide education, including but not limited to, medication adherence, • Promote health literacy, including oral health. • **CPT codes 9896x** (self-management education and training), in 30-mi
North Dakota (2012) 42 CFR 440.169	• **Targeted Case Management** (TCM) services to persons with serious m and urban Indian programs. • TCM services paid on a standard per-encounter fee.

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Oregon **CHWs/Doulas** (2012): 1902(a)(6) / 42 CFR 440.60 **Doulas (2017):** 42 CFR 440.130(c)	• **2012:** Added CHWs, peer wellness specialists, personal health navigat practice of the supervising practitioner. • **2017:** Moved doulas to preventive services authority. • **Doulas** operate within typical scope of practice (https://www.oregon.gov/oha/oei/reports/Using%20Doulas%20to%20I %20Executive%20Summary.pdf). **CHWs** have broad scope and are pai benefits."
Rhode Island (2022) 42 CFR 440.130	**Covered Services** • Health promotion and coaching (includes assessment and screening f and/or coaching. • Health education and training for groups, covered when the CHW prov • Health system navigation and resource coordination (including helping care, adherence to treatment plans, and/or self-management of chroni relevant community resources. • Care planning with beneficiary's interdisciplinary care team. • **HCPCS billing code T1016** in 15-minute units with adjustments for new
South Dakota (2022) 42 CFR 440.130	• Health system navigation and resource coordination. • Health promotion and coaching. • Health education and training following established curriculum materia • Must follow a plan of care and be related to a medical intervention or h • **Non-Covered Services:** Advanced care planning; advocacy on behalf c shopping and cooking; companion services; employment services; exe services; medication, medical equipment, or medical supply delivery; p recipient's care plan; services provided prior to the recipient's care pla another covered Medicaid service; socialization; transporting the recip • **CPT codes** 98960 (self-management education and training, one patie 30-minute units), 98962 (self-management education and training, five

Note: Table does not include **Health Homes SPAs**, which have been created in 19 states (later terminated in eight states) to serve complex needs individuals with at least two chronic conditions (including behavioral health issues); one chronic condition and risk for a second; or a serious mental illness. It is believed that at least eight states authorized employment of CHWs in Health Homes, but at most one of those states required employing them. See www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html (http://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html).

Trends across Existing and Proposed SPAs

Authorizing approaches: Minnesota uses regulatory authority under "other practitioner services" (42 CFR 440.60). Some more recent SPAs have used a 2014 "preventive services" rule change (42 CFR 440.130) allowing states to authorize payment for

services by non-licensed individuals if such services are “recommended by” a licensed clinician. Some states have referred to other regulations. Maine is so far the only state to use authority under Social Security Act Section 1905(t), which defines primary care case management (PCCM).

For more detail about the content of each SPA, visit www.chcf.org/wp-content/uploads/2022/08/SummaryMedicaidStatePlanAmendmentsCHWs.pdf (http://www.chcf.org/wp-content/uploads/2022/08/SummaryMedicaidStatePlanAmendmentsCHWs.pdf).

Covered services: Current SPA language for CHWs generally defines up to three service categories: health education, health promotion and coaching, and care coordination or resource referral. However, states differ in the breadth of billable activity under these headings. Several states prohibit Medicaid payment for certain services, including advocacy, transportation, and assistance in applying for public benefits. Some states allow billing for CHW participation in team-based care/case management. Generally, an order, referral, or recommendation from a clinician is required to authorize a claim, and most include other conditions of medical necessity (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52775#:~:text=Medical%20Necessity%20%2D%20Rehabilitation,and%20provided%20must%20be%20reasonable.) that require the recipient to have a diagnosis of at least one chronic condition. A few states have begun to include screening for social determinants of health needs as a finding that can authorize CHW services. Rhode Island (in its provider manual guidelines (https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-07/CHW%20Manual%207%2019%202022.pdf)) treats certain criteria — such as inpatient admissions, emergency department episodes, and missed provider appointments — as an indicator of medical necessity. Minnesota does not require that a claim specify the patient’s primary diagnosis and allows use of the ICD-10 codes signifying SDOH (Z-codes). Maine does not explicitly define eligible CHW services, since they are not billed under fee for services, but their inclusion in a PCCM structure implies that they will play a supporting role in care management.

Payment approach and rates: Most current SPAs authorize fee-for-service billing, using existing claims processing structures to bill either the state or a Medicaid MCO. Billing is typically in 15- or 30-minute units of service. Rates range from an equivalent of about $32/hour to about $62/hour. Maine (approved in April 2022) is the first state to introduce a capitated payment system for primary care providers (adjusted for population and risk categories), under which they will be expected to engage CHWs in care management starting in April 2024. Some states are considering an alternate payment model but report often lacking data on cost and utilization needed for rate setting.

Billing codes: Most states use the same billing code family: **CPT Code 9896x**, which provides rates for services to individuals and in group settings. Rhode Island and Louisiana have introduced the use of HCPCS T-codes, and Rhode Island has also provided a rate adjustment for new patients.

Service limits: Most states have limits on the amount of billable time a CHW can spend with a patient/client/community member. The limits may be expressed in units of service per day, per month, and/or per year. Rhode Island offers an example of a state that has opted not to impose limits.

CHW qualifications and requirements: CMS does not require certification of individual CHWs for SPA approval, but the specification of CHW qualifications is required. There are states that recognize external CHW certification programs or certify CHWs through

the state, a process that includes defining CHW qualifications. In those states that do not recognize certification, Medicaid agencies themselves define CHW qualifications — generally with education and/or work experience.

How federally qualified health centers (FQHCs) are handled: In a newer trend, California, Louisiana, and Rhode Island SPAs allow FQHCs to submit separate Medicaid claims for CHW services (outside the PPS billing process), while Nevada will make CHW-only encounters billable under PPS when the CHW encounter happens on a day when no other billable encounters take place.

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Providing for participation by CBOs: In most states, community-based organizations (CBOs) employ a substantial number of CHWs. Many CBOs are not Medicaid providers. Some states with recent CHW SPAs, such as Rhode Island and California, have made extensive efforts to encourage and educate CBOs to become billing providers and learn the claims process. Maine offers PCPs the option to engage CHWs in "community-based services" though partnerships with CBOs under their new capitated payment system.

Key Considerations for States Developing and Implementing a SPA

The policy change process: In a few states, governors have issued executive orders that require seeking a SPA to expand reimbursement for CHWs. Legislative authorization is often required and could be embedded in budget or appropriations measures — as was the case for Minnesota, California, and Rhode Island. In several states, including Arizona, South Dakota, Illinois, Massachusetts, Maryland, and Nevada, legislative action on Medicaid reimbursement for CHWs has been bundled with related measures such as establishing credentialing or certification.

Engagement of CHW leaders: Learning collaborative participants agree that engaging CHWs in informing SPA development is key to establishing a successful program. This step can be challenging due to the highly technical content of Medicaid payment policy. Many states now have a CHW association or alliance that can provide representation. The National Association of CHWs (NACHW) (https://nachw.org/) offers state-level CHW leaders an introductory briefing on Medicaid SPAs. State approaches to gathering feedback from all the critical partners varies. Some states, such as Arkansas, Arizona, and Florida, start with selected representatives to work out an initial proposal and conduct more extensive outreach when concrete concepts are formed. A few states have initiated the process with a broad educational effort. States such as Rhode Island and California have scheduled multiple convenings/briefings to ensure wide attendance.

Newer trends in payment approaches: Several states have expressed interest in collecting sufficient data to inform actuarially sound rates for alternative payment models for CHW services that lend themselves to more flexible payment approaches. Recent proposals to shift Medicaid primary care funding to a capitated PMPM system in Massachusetts and Maine (all PCPs) and California (FQHCs only) may be informative.

Conclusion

With increased federal investment through agencies at the U.S. Department of Health and Human Services (including the Centers for Disease Control and Prevention, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration), many states are working to align their Medicaid approaches to covering CHW services with a broader braided or blended financing strategy that can cover the full range of CHW activities while reducing reliance on short-term grants alone. As states seek sustainable funding approaches to effectively engage the CHW workforce, they may consider the trends in SPA approaches outlined here.

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NASHP will continue to support state officials in peer-to-peer exchange of information via the CHW Learning Collaborative. State officials interested in learning more about NASHP's state network on CHW policy should email Elinor Higgins (mailto:ehiggins@nashp.org).

End Notes

[1] This collaborative is made possible with support from the Robert Wood Johnson Foundation and with input from a steering committee of national experts including Carl Rush, partners at the Association of State and Territorial Health Officials and the National Association of Community Health Workers.

[2] Rhode Island's definition of "medical necessity" appeared in all public documents before submission and later in the state's provider manual but was removed from the final approved SPA document along with a number of other details.

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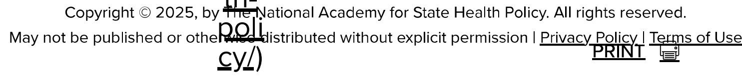

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