



HARRISON INSTITUTE FOR PUBLIC LAW
GEORGETOWN LAW

**Strategies for Integrating
Community Health Workers
into
State Medicaid Programs**

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April 2007

This paper is a preliminary effort to identify issues for discussion and further analysis. It presents the views of the authors and does not represent Georgetown University or our collaborators. We will revise this paper as we receive comments. To send comments or request subsequent versions of this paper, please contact Robert Stumberg at stumberg@law.georgetown.edu.

Introduction and Background

The United States healthcare system presents a number of challenges for today's policymakers, and chief among their concerns is the growing tension between the desire to improve quality of services and the need to continue to manage growth in the system's costs. In the context of the nation's most poor and underserved populations, these concerns are particularly salient because of the wide gaps in access to care and the disparities that exist across various cultural and socioeconomic groups. Typically, the government has sought to address the needs of underserved populations with a system of public services and insurance programs, the largest of which is Medicaid—state-administered insurance program for low-income individuals that is jointly funded by the federal government. Medicaid provides a safety net for many vulnerable individuals; however, with over 53 million beneficiaries and costs beyond \$300 billion, administrators must constantly seek to refine states' programs in ways that maintain expenditures without undermining the ultimate goal of providing health care coverage for those most in need.ⁱ

To successfully operate within those parameters, administrators and other healthcare decision-makers must examine how the system of providers and delivery of care connects to the Medicaid program's goals of increasing and improving access to quality services, and then they must evaluate how the two components reinforce each other with regard to the success and development of health initiatives. State administrators have traditionally found ways to incorporate widely recognized and firmly established categories of healthcare providers (i.e., doctors, nurses), but the system has yet to fully achieve fully desirable outcomes in terms of improving access and quality of care, managing chronic illnesses, and cutting program costs. Many attribute these shortcomings, in part, to the disconnect and gaps that exist between the

bundle of services many providers like doctors and nurses provide and the unique set of needs that Medicaid enrollees and other low-income and underserved individuals have. As the nation's healthcare system shifts toward more holistic, patient-centered approaches to health care, there is greater emphasis on meeting the needs of individuals, and there are a few trends worth noting: Home and community based care continues to expand; more healthcare professionals recognize the importance of cultural sensitivity; acceptance of non-traditional providers grows; and a number of categories of health care providers have emerged as vital contributors in the system of health care delivery. The workforce of community health worker (CHW) workforce is among the categories of emergent health care providers, and policymakers should look incorporate the CHW workforce as another partner in the effort to enhance states' Medicaid programs and consider strategies for integrating community health workers' skills into the broader Medicaid arena.

Community Health Workers: Who Are They? How Do They Fit?

Community health workers are frontline public health workers who are trusted members of the community and/or who have an unusually close understanding of the community served. That relationship allows CHWs to serve as intermediaries between the community and health and social services to facilitate access to services and improve the quality and cultural competence of service delivery. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.ⁱⁱ CHW programs, like Medicaid programs, strive to meet the health needs of underserved populations. When one considers how the many determinants of health—particularly, social and economic

determinants—contribute to the disparities in health that disproportionately affect individuals within the population of Medicaid beneficiaries, CHWs have much to contribute by using their unique skill-set and expertise to aid Medicaid-eligible individuals.

In fact, research indicates that CHWs succeed in improving outcomes in a cost-effective manner.^{iii iv v} For example, researchers found that a CHW program targeted toward African American Medicaid patients with diabetes resulted in average annual savings of \$2,245 per patient and a 40% decline in emergency room visits.^{vi} Once Medicaid programs begin to partner with community health workers and provide reimbursement for their services, the directors and practitioners of CHW programs and other institutions can then work to improve services and delivery and to implement new initiatives. The steady funding also helps stabilize the CHW workforce so that community health workers can work continually in places where they have established a community's trust and can work efficiently to improve healthy outcomes.

Medicaid Reimbursement and Community Health Workers

When people consider how providers and services fit into a state Medicaid program, they most likely think of direct reimbursement. As the name implies, direct reimbursement is the most straightforward mechanism for receiving Medicaid funding: A state Medicaid office reimburses a provider institution for billable services administered by a recognized Medicaid provider. Although direct reimbursement seems simple enough, Medicaid has restrictions on what services it pays for (service requirements), the individuals who can participate (eligibility requirements), and the health care providers it will reimburse for services (provider requirements). Federal codes and regulations do not currently recognize community health workers as a category of provider that can bill directly for reimbursement from state Medicaid

programs. This lack of federal recognition does present some hurdles to directly reimbursing for community health workers services, and only the state of Alaska recognizes community health workers as a billable provider for direct Medicaid reimbursement. That arrangement owes much to the many characteristics of health care delivery in Alaska that make the circumstances so unique: Many Native American communities and rural inhabitants live in extreme isolation, and so the recognition of CHWs as billable providers grew out of both necessity and an elaborate model of contracts and agreements between state governments, federal governments, and tribal authorities.^{vii viii}

Although it is unlikely most states can easily duplicate the Alaska model, states can overcome regulatory hurdles in to direct reimbursement in the long-run. As community health workers continue to organize and to rally around workforce development and professionalization, federal recognition may seem less out of reach. Absent recognition as a billable provider and direct reimbursement, policymakers have alternative strategies for drawing CHWs into Medicaid programs.

Waivers

Since community health workers do not fit neatly within a recognized provider category, a waiver of some of the provider and service requirements can facilitate CHW integration into the Medicaid system and can allow states to experiment with new programs and ideas on a limited basis.^{ix} States have a few options when deciding how to use a Medicaid waiver to achieve desired outcomes:

- **Research and Development (R&D) Waivers.** Under §1115 of the Social Security Act, states often use R&D waivers to fund pilot projects, to test new ideas in beneficiary coverage, and to expand the normal scope of Medicaid on a small scale. The waivers are initially approved for five years, and then the waiver can apply for three-year renewal.

- **Freedom of Choice (FC) Waivers.** Section 1915(b) of the Social Security Act allows states to use FC waivers to enroll people in Medicaid managed care programs. Waivers apply for two years and states have the opportunity apply for renewal for another two years.
- **Home- and Community-Based Services (HCBS) Waivers.** Under §1915(c) of the Social Security Act, states can use HCBS waivers to cover services provided in the home or community that Medicaid normally would reimburse if the beneficiary received the care in a hospital or institution. Waivers apply for three years and can be renewed for another five years.
- **Combination Waivers.** States can combine the two types of waivers offered under §1915 of the Social Security Act—FC and HCBS waivers—so that they can provide home-based services in a managed care setting. States can implement the two waivers at the same time, but states must apply for administer each waiver separately.

A Medicaid waiver is an appealing tool for Medicaid reform because it allows states to work with community health workers on measures aimed at improving quality and delivery of care without having to contend with spikes in program cost. States most frequently seek R&D waivers and HCBS waivers, and federal administrative policies help ensure that improvements to Medicaid programs do not come with unwieldy increases in federal Medicaid spending: Research and development waivers must meet requirements of *budget neutrality* such that the federal government does not spend more under a waiver agreement than it would spend had it not granted the waiver. Likewise, home- and community-based waivers carry a *cost neutrality* requirement that limits average, per-beneficiary cost for services under a waiver program to no more than the per-beneficiary cost for services through a non-waiver program.^x

Medicaid waivers often result in programs that expand family planning services or services for people with HIV/AIDS. California’s Family PACT (Planning, Access, Care and Treatment) Program, for example, offers statewide, public family planning services for low-income adolescents and women under an R&D waiver. Community health workers provide counseling and administer technical services (e.g. pregnancy tests) to Family PACT participants, and the Medicaid program reimburses their services on a per-unit basis (e.g. per test).^{xi} Since its

inception in 1999, Family PACT has dramatically expanded health care access for low-income Californians in need of family planning services and led to following outcomes: reduced cases of cervical cancer, pelvic inflammatory disease (PID), and Chlamydia; averted 200,000 unintended pregnancies per year; and resulted in a total cost-savings of billions of dollars annually.^{xiii} Other states have used waivers to establish similar programs that also include CHWs as part of the system of Medicaid providers and services. States that have yet to incorporate the services of community health workers into their waiver programs can seek to add such provisions when renewing the waiver.

Managed Care & Capitation

Medicaid managed care presents another set of opportunities for integrating community health workers into a state's Medicaid program, and reimbursement through a Medicaid managed care organization may eliminate some of the administrative burdens associated with other options for integrating CHWs. Typically, managed care organizations receive capitated amounts of money from the state based on the number of enrollees that the particular health plan covers. Once the plan meets all of its requirements, and as long as activities still fall within the parameters of federal, state and local regulations and the terms of the contract with the state, plans generally have freedom to make their own spending. This freedom allows a Medicaid managed care organization that employs CHWs to directly use the funds from the state Medicaid office to pay for community health workers' salaries. State Medicaid offices can also approve billing codes that community-based organizations can use to receive payment from the Medicaid managed care organization with which they enter contractual agreements for community health worker services.

As of June 2005, only two states did not offer Medicaid managed care plans. In many states, eligible individuals may enroll in Medicaid managed care on a voluntary basis, but in attempts to improve health outcomes, a number of states have also used freedom of choice waivers to make managed care enrollment mandatory. Health Plus, one of the fastest growing managed care organizations in New York City, employs approximately 35 CHWs as community health education associates whose responsibilities include conducting new enrollee outreach, facilitating health education classes, performing health risk assessments. Health Plus has over a quarter million members who benefit from CHW services, and the organization has expanded the size of its community health worker staff from the two CHWs it employed less than ten years ago to the 35 in currently employs.^{xiii}

Administrative Cost

The federal government will match up 50-75 percent of a state's administrative Medicaid expenses. These expenses include cost associated with staffing and operating state Medicaid offices , improving information technology, and interpretation activities. The federal government also matches money community based programs use for coordination and outreach activities.^{xiv} The administrative costs for Medicaid are among the lowest for health care payers in the United States, but when funds help facilitate the implementation of strategies and programs that improve health care experience for Medicaid enrollees reimbursement for those costs seems extremely significant.

The Blue Ridge Area Health Education Center (AHEC) and Denver Health both receive reimbursement for administrative costs associated with community health workers' services. Virginia's Blue Ridge AHEC employs bilingual CHWs as community health interpreters. Providers pay for the interpreting services, but Medicaid reimburses for up to 40% of the

administrative costs of providing the services. Denver Health is a public safety-net healthcare organization that has contracted with Community Voices-Denver to have CHWs conduct outreach with underserved residents and populations in Denver. The outreach focuses on increasing Medicaid enrollment, increasing access to services, health promotion and disease prevention. The program receives reimbursement for some of the administrative costs associated with CHW participation in facilitating Medicaid enrollment.^{xv}

Conclusion

The U.S. healthcare system is in a process of transition, and in order for states' Medicaid programs to keep with this emerging trends, policymakers must use innovative strategies to meet the needs of beneficiaries. In terms of requirements for Medicaid providers and services, the federal government has yet to fully shift its standards to capture previously underutilized providers and services that are of special use and benefit for the population of Medicaid enrollees. However, as a joint venture by states and the federal government, the laws and regulations for Medicaid program include a variety of mechanisms that provide states with the means to reform their individual Medicaid programs, even if the federal policymakers have yet to enact sweeping reforms at the national level.

As policymakers within states look to incorporate community health workers into their system of Medicaid, it is true that the federal regulations do not presently recognize CHWs for purposes of direct reimbursement. Even without the direct point for community health workers to enter into a state's Medicaid program, policymakers in many states and programs have successfully used other tools and strategies to incorporate CHWs and their services into the broader Medicaid system to the ultimate benefit of low-income and underserved individuals.

Policymakers continually seek new opportunities to address spiraling health care costs and disparities in health outcomes. When policymakers move beyond the surface of Medicaid, they will find that there are mechanisms in place that leave room for Medicaid programs to develop partnerships with community health workers that can work to fill gaps that exist between the services that currently recognized providers offer and the needs of the beneficiaries the Medicaid programs aim to serve.

MECHANISM FOR REIMBURSEMENT	PROGRAM (LOCATION)	DESCRIPTION
Direct Reimbursement	Community Health Aide Program (CHA/P) (Alaska)	Alaska recognizes community health aides/practitioners as a billable provider. Recognition is largely due to the unique qualities of Alaska (extreme isolation, multiple agreements between governments and tribal authorities, etc.). Tribal organizations can bill CHA/P services in a manner similar to other billable providers, and there is a published CHA/P fee schedule that contains a list of authorized services.
	Tri-County Rural Health Network (Arkansas)	Robert Wood Johnson Foundation funnels its \$500000 grant for Tri-County Rural Health Network's Community Connectors pilot program through the state Medicaid office, which then makes it possible to pull down federal matching administrative funds.
Waiver	Family PACT (California)	California secured a §1115 Demonstration Waiver to expand family planning services to low-income women and adolescents statewide. Family PACT receives per-unit reimbursement for the counseling and technical services provided by adequately trained and supervised CHWs.
Managed Care Organization	Health Plus ^{xvi xvii} (New York)	The government funds Health Plus plans and the state pays out a capitated rate for each enrollee, which allows Health Plus to use the money however it chooses within state regulations. Health Plus executives decided to employ approx. 35 CHWs. Majority of CHWs deliver targeted outreach to Health Plus enrollees; others provide general community education services in New York City. ^{xviii}
	Molina Health Care, Inc. (New Mexico)	<i>New Mexico Community Voices & UNM Health Sciences Center.</i> Community Voices and Molina linked with UNM so that UNM is reimbursed for referrals by CHWs working with Molina case managers. ^{xix} <i>Coordinated Systems of Care Community Access Program of New Mexico (CSC-CAPNM).</i> Molina covers the salary of two CHWs working at CSC-CAPNM member sites. Molina worked with NM state Medicaid office to establish billing code for CSC-CAPNM, and established a 2-year contract with CSC-CAPNM that allows CSC-CAPNM to charge Molina for CHW services to specific enrollee populations on a capitated basis. ^{xx}
Administrative Costs	Ingham Co. Health Dept. (Michigan)	Ingham Co. partnered with the Michigan Dept. of Community Health and received CMS approval to receive reimbursement that covers the costs of PITCH (People Improving the Community's Health). PITCH contracts with three community based organizations to have CHWs conduct outreach activities to promote public awareness and enrollment in Medicaid.
	Blue Ridge AHEC (Virginia)	Blue Ridge AHEC employs bilingual CHWs as community health interpreters. Providers pay for the interpreting services, but Medicaid reimburses for up to 40% of the administrative costs of providing the services.
	Denver Health (Denver, CO)	Denver Health is a public safety-net healthcare organization that has contracted with Community Voices Denver to have CHWs conduct outreach with underserved residents and populations in Denver. The outreach focuses on increasing Medicaid enrollment, increasing access to services, health promotion and disease prevention. The program receives reimbursement for some of the administrative costs associated with CHW participation in facilitating Medicaid enrollment.

REQUIREMENTS EXCUSED BY WAIVER TYPE

	§1115 R&D	§1915(b) FC	§1915(c) HCBS	§1915 Combo
statewide offering	X	X	X	X
freedom to choose providers	X	X		X
enrollment eligibility requirements	X		X	X
certain service requirements	X		X	X
comparable benefits for all beneficiaries	X			
limits on coverage to certain benefits	X			

ⁱ Smith, Vernon K. & Moody, Gregg. *Medicaid in 2005: Principles and Proposals for Reform*. Health Management Associates (prepared for the National Governors Association), February 2005.

ⁱⁱ This definition and workforce description is based on a definition recently submitted to the U.S. Department of Labor.

ⁱⁱⁱ Zuvekas, A. et al. *Impact of Community Health Workers on Access, Use of Service, and Patient Knowledge and Behavior*. Journal of Ambulatory Care Management, 1999.

^{iv} Swider, SM. *Outcome Effectiveness of Community Health Workers: An Integrative Literature Review*. Public Health Nurse, Nov. 2002.

^v Wistley, E. et al. *Measuring Return on Investment of Outreach of by Community Health Workers*. Journal of Health Care for the Poor and Underserved, 2006. (6-15).

^{vi} Fedder, DO et al. *The Effectiveness of a Community Health Worker Outreach Program in Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes and with or without Hypertension*. Ethnic Disparities, Winter 2003.

^{vii} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education, 2006. (20-21).

^{viii} *The Alaska Health Aide Program: An Integrative Literature Review and Visions for the Future Research*. U.S. Department of Health and Human Services, HRSA’s Office of Rural Health Policy in partnership with the Alaska Center for Rural Health, 2003.

^{ix} Hoverter, S. *Medicaid Waivers 101: A Basic Guide for Community Health Workers*. Center for Sustainable Health Outreach, March 2004.

^x For a fuller discussion of budget and cost neutrality as they relate to R&D and HCBS waivers, see: Sweeney, T. *Medicaid Reform Policy Brief #4: What Does Budget Neutrality Mean?* Atlanta, GA: Georgia Budget and Policy Institute, January 2006.

^{xi} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education, 2006. (19).

^{xii} Darney, P.D. and Brindis, C. *Final Evaluation Report of Family PACT*. San Francisco, CA: Bixby Center for Reproductive Health Research and Policy, August 2006.

^{xiii} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education, 2006. (17-18).

^{xiv} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education, 2006. (19).

^{xv} *Financing Community Health Workers: Why and How*. National Community Voices at the Center for Primary Care at Morehouse School of Medicine and Northern Manhattan Community Voices at Columbia University Center for Community Health Partnerships.

^{xvi} New York State Medicaid regulations require managed care organizations to conduct outreach to new Medicaid enrollees and make health education classes available to plan members.

^{xvii} <http://www.healthplus-ny.org>

^{xviii} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education. 2006. (17-18).

^{xix} *Financing Community Health Workers: Why and How*. National Community Voices at the Center for Primary Care at Morehouse School of Medicine and Northern Manhattan Community Voices at Columbia University Center for Community Health Partnerships.

^{xx} Dower, C., Knox, M., Lindler, V., O’Neil, E. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco, CA: National Fund for Medical Education. 2006. (17-18).