Lessons for Advancing and Sustaining State Community Health Worker Partnerships

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Introduction

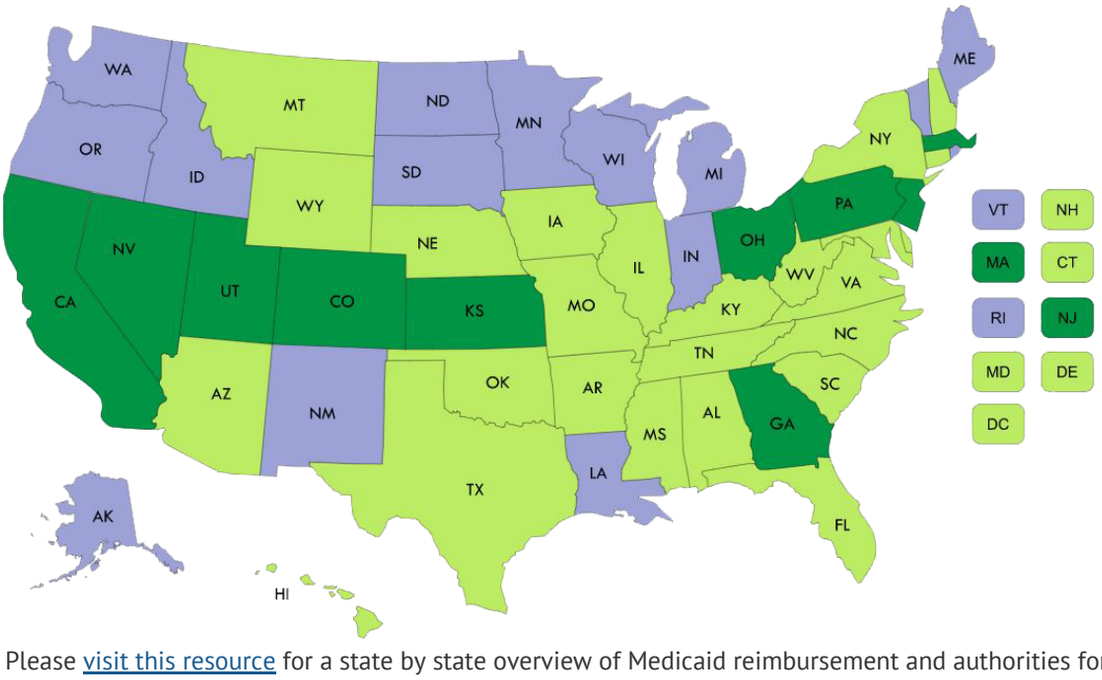
As states work towards a modernized public health system, while also grappling with significant workforce challenges in health care, many are identifying workforce strategies to build capacity, advance health equity, and improve health. Community health workers (CHWs) are one critical segment of the community-based workforce and are increasingly central to state workforce and equity planning.

NASHP recently updated a 50-state scan that identifies state approaches to supporting the CHW workforce and catalogues CHW Medicaid financing strategies (see text box 1). This updated resource was informed by a survey that was completed by state Medicaid officials, public health officials, and CHW association representatives as well as through publicly available information. Building off the survey results and targeted interviews, NASHP facilitated a roundtable discussion at the 2021 NASHP Annual Conference with 20 states and CHW colleagues. During the roundtable, state leaders shared their strategies to finance and partner with CHWs in order to provide higher quality and more culturally competent care.

This brief presents lessons learned for states to build, sustain, or expand partnerships with CHWs. Key considerations and examples that are discussed in more detail include:

- Engaging CHWs and other community-based stakeholders in policymaking to inform CHW programs and to identify needs and strengths of communities;
- Leveraging experience from the COVID-19 response and transitioning work with CHWs to advance other policies and financing approaches; and
- Investing in CHWs to ensure sustainability, including through reimbursement of services, building career paths, and strengthening CHW networks.

50-State Scan of Strategies to Support and Finance the CHW Workforce



Please visit this resource for a state by state overview of Medicaid reimbursement and authorities for CHW services, approaches to certification and training, CHW employers, how CHWs have been included in the COVID-19 response, and more.

Background

CHW is an umbrella term that encompasses several categories of frontline public health workers—including Community Navigator, Promotora, Health Coach, Community Health Advisor, Community Health Aid, or Outreach Worker—who are often also trusted members of the community they serve. CHWs reach out to and engage with communities and individual community members, facilitate care coordination with health and health-related providers, enhance access to community-based services, address social determinants of health, and provide health education. Through their engagement with the people they serve, CHWs can also identify barriers to care and elevate community concerns—a function that has been particularly important during the COVID-19 pandemic and one that will be central to building more person-centered care. In communities that have been historically marginalized or that experience language and cultural barriers to accessing health services, CHWs are uniquely positioned to build trust, enhance health literacy in a culturally-informed manner, and help individuals navigate health and health-related systems. Evidence indicates that Medicaid spending on CHW services produces both improved health outcomes and a return on investment. The majority of CHWs are employed by community-based organizations (CBOs), but are also hired by health care providers, insurance companies, and by the state or local health department. State entities and Medicaid managed care organizations directly hire CHWs or contract with CBOs to offer CHW services to their members.

With the COVID-19 pandemic illuminating stark racial and ethnic health disparities and highlighting gaps in public health and healthcare infrastructure, state leaders are actively pursuing new or more substantial partnerships with CHWs, recognizing the central role they play in advancing equity, improving ties with communities, and extending the healthcare workforce. In so doing, state officials have identified common challenges, lessons, and opportunities in building out support for the CHW workforce. One important example is that CHWs are often under-compensated for their contributions, and it has been challenging to secure sustainable funding for CHW positions. As with other professions, building this workforce requires a strong career ladder with mentorship and professional development opportunities, as well as livable wages. Though there is increasing awareness of the value that CHWs offer, more clarity on their role in the broad health and health-related systems is needed across stakeholders and among policymakers.

Lessons and Opportunities for Building, Sustaining, and Expanding State Partnerships

While there is a wide variety of existing state models and differing historical contexts across states, many state policy leaders acknowledge that this is a critical moment for advancing CHW policy, given the essential roles CHWs have played in the COVID-19 response, the imperative to increase health equity and eliminate disparities, and the need to address significant health workforce shortages.

State policymakers surveyed and those participating in NASHP's roundtable on partnering with CHWs at the 2021 NASHP Annual Conference highlighted three key lessons learned for building or expanding partnerships with CHWs: Engage with CHWs and other relevant stakeholders to inform policymaking; Build on the momentum from the current COVID response and funding; Identify pathways for financially sustaining CHW programs.

Engaging with CHWs and Other Relevant Stakeholders to Inform Policymaking

State and CHW Association leaders reflected on the importance of engaging and partnering with CHWs and other community-based stakeholders in the policymaking process to inform CHW programs as well as to elevate the needs and strengths of communities. States acknowledged opportunities for alignment of CHWs with other care coordination and community engagement efforts across state agencies to ensure that new CHW partnerships and models strategically complement existing efforts (to identify gaps, minimize duplication, and inform best practice).

Some states are engaging the CHW workforce through CHW associations (see Text Box 2 for detail) or through state-led stakeholder engagement processes, seeking input on:

(i) Defining reimbursable services,
(ii) Setting standards for CHW qualifications for enrollment with Medicaid,
(iii) Utilization and eligibility considerations for Medicaid reimbursable-services,
(iv) Stakeholder education on the role of CHWs,
(v) Opportunities for partnership with managed care and existing care coordination services,
(vi) Workforce development needs, and
(vii) Community priorities in shaping stronger, more equitable programs.

NASHP's 50-state scan provides state-specific detail about how states are partnering with CHWs, CHW associations, and other community-based partners.

Text Box 2: CHW Associations as State Partners

CHW professional organizations and associations exist in many states or regions, and at the national level (National Association for Community Health Workers). These associations offer a network of professional support for CHWs and advocate on their behalf—critical services for an often under-represented and loosely connected segment of the workforce. CHW associations can be valuable partners for states looking to engage with CHWs, to:

- Strengthen the inclusion of community voice in policymaking,
- Better understand community needs and the policy priorities of the CHW workforce,
- Recruit, hire, and train the CHW workforce for the COVID-19 response and for larger public health workforce development initiatives,
- Learn more about which trusted CBOs are engaged in providing CHW services, and
- Find creative, sustainable solutions that ensure long-term support for CHWs.

Text Box 3: Rhode Island

Rhode Island is an example of a state that has partnered with CHWs for many years to inform policies and practices through the state's Health Equity Zones (HEZs). During the COVID-19 pandemic, the HEZ infrastructure was used to distribute federal relief dollars. The 175 CHWs and community outreach workers working with the HEZs played a critical role in identifying and lifting up community needs during the pandemic, as well as providing communities with information, distributing masks, and delivering meals to people in quarantine. CHWs also were able to screen community members for social determinants of health, chronic conditions, and other factors.

These data were shared with the Rhode Island Department of Health, allowing them to make policy changes as needed to address food insecurity and other needs. Medicaid reimbursement for CHW services has been added to the state plan, and some of Rhode Island's Accountable Care Entities also employ CHWs in managed care settings. State leaders are continuing to think about more flexible reimbursement for CHWs who do not work in clinical settings. The state has given public notice of their intent to add CHW services to their Medicaid state plan.

Building on Momentum from the COVID-19 Response

In both the survey and the roundtable, state leaders shared the invaluable contributions CHWs made during the COVID-19 response, noting additional data gathered about the impact of CHW involvement and lessons learned about how to effectively partner that could inform opportunities for continued collaboration. CHWs assisted with community health education about infectious disease, referrals to or distribution of testing, masks, and vaccines; and supporting the social needs of individuals—such as housing, food, employment, and transportation—that became more difficult for communities to support during COVID-19. States that already had CHW programs in place were able to more efficiently identify and address community needs, disseminate information and resources to communities, and bring community voices into their decision-making processes. States that did not already have a robust CHW workforce took steps during the pandemic to hire and train additional CHWs to augment their response. See 50-state scan for additional examples.

Text Box 4: New Mexico

New Mexico has maintained a CHW certification program for many years. When the COVID-19 pandemic began, the New Mexico Department of Health (NMDOH) worked with CHWs to create a set of materials particularly geared towards this workforce. The CHWs were an integral part of the vaccine equity team and helped NMDOH develop a Community Resource Center and a set of flipcharts about vaccination. Using funds from the Centers for Disease Control and Prevention for addressing COVID-19 health disparities, NMDOH will increase the workforce by hiring 100 additional CHWs to help drive this work. Based on the success of this effort, state leaders are working with their Medicaid program to find additional sustainable funding options for CHWs in the state. Currently, the state reimburses for CHW services through Medicaid MCOs, and MCOs were required to increase CHW contact with beneficiaries by 20 percent in 2017.

Text Box 5: North Carolina

During the COVID-19 pandemic, North Carolina invested around $50 million of pandemic relief funds to hire, train, and deploy more than 450 CHWs, building on previous initiatives with CHWs on certification and training. In contracts with vendors who are hiring CHWs in all 100 counties around the state, there is a set wage of at least $20 per hour with the option to increase as needed. Currently, as North Carolina looks ahead to more sustainable funding for CHWs, state leaders are considering leveraging capitated payment models for prepaid health plans that have been selected for Medicaid transformation to develop reimbursement for CHWs based on a set of health measures to incentivize whole-person care and health improvement.

Identifying Pathways for Financial Sustainability

States are seizing this unique moment to consider how to sustainably finance CHW programs and ensure that CHWs are adequately compensated and supported. Many states are looking at Medicaid as one source of sustainable funding—and they are approaching Medicaid reimbursement for CHWs in diverse ways, as catalogued in NASHP's 50-state scan, including through waivers or demonstrations, state plan amendments, and managed care contracting (see Table 1 for more information). Some states are incorporating CHW services in value-based payment (VBP) arrangements. Vermont, for example, incorporated community health worker services through their Community Health Team all-payer model as well as through medical homes, accountable care organizations, and other VBP models. Others are prioritizing establishing coverage parameters for CHW services before considering alternative payment options.

Medicaid coverage of CHW services requires states to define the covered set of services, CHW qualifications, and reimbursement methodology. In recognition of this, the National Committee for Quality Assurance (NCQA) and the Penn Center for Community Health Workers developed standards for recruiting, employing, and supervising CHWs. In some states, certification, licensure, or other standards are being used to identify individuals as eligible for enrollment as providers and for reimbursement under Medicaid. States often partner with certification boards, community colleges, and CHW associations to build training and certification programs as needed.

States are also using funding streams outside of Medicaid to pay CHWs. Aligning funding streams to support and develop networks of CHWs will be a cornerstone to sustainably building the workforce. State efforts to braid resources are evolving with additional federal, state, and private funding streams, and NASHP will continue to highlight opportunities for states to pursue long-term sustainability of CHW programs. New Jersey (see Text Box 7) provides one example of cross-agency partnership. The state's Department of Labor invested in a CHW training institute and subsequently partnered with the Medicaid program to advance a service reimbursement approach. The federal COVID-19 relief funding that states have received, including American Rescue Plan Act funds, are time-bound, but may offer a new set of opportunities for strategic investment in the public health workforce—including CHWs (see Text Box 5 for an example from North Carolina).

Identifying Pathways for Financial Sustainability

Table 1. Major Medicaid Coverage Pathways

States interested in providing Medicaid coverage for CHW services typically use the following Medicaid pathways.

Medicaid Mechanism	Details	Select Examples of Long-Standing Medicaid Reimbursement of CHW Services
State Plan Amendment	States may submit state plan amendments to the Centers for Medicare and Medicaid services to allow reimbursement for CHW services through Medicaid. The Center for Medicare and Medicaid Services (CMS) allows CHWs and other non-licensed providers to be reimbursed for preventive services when those services are recommended by a licensed practitioner. In addition, the Health Home state plan option was authorized under the Affordable Care Act to coordinate care for beneficiaries with chronic conditions. States may include CHWs as one of the providers that may be reimbursed for services as part of a Health Home.	In **Minnesota**, the Medicaid program reimburses for care coordination and health education services provided by CHWs under the state plan when ordered by a licensed practitioner (see Minnesota's CHW toolkit here). For reimbursement under Medicaid, CHWs are required to have a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum and be under the supervision of a licensed practitioner enrolled with Medicaid. **Michigan** Medicaid also operates a Health Home model for individuals with physical and behavioral health comorbidities that offers CHW services for individuals with concerns about social resources.
Section 1115 Demonstrations	States may apply for a Section 1115 demonstration to test a CHW benefit design. Section 1115 demonstrations provide broad flexibility for states to pursue innovative demonstration initiatives. States have used this mechanism to target CHW services to specific populations or specific health conditions.	In **Massachusetts**, Section 1115 Demonstration and Delivery System Reform Incentive Payment (DSRIP) funds supported MassHealth Accountable Care Organizations (ACOs) in hiring significant numbers of CHWs. CHWs are reimbursed through the ACOs, which are part of the managed care delivery system in Massachusetts.
Managed Care Contracts	Managed Care Organizations (MCOs) must cover state plan services where applicable. MCOs also have flexibility to offer some services which are not traditionally covered under Medicaid when they are determined to be cost-effective alternatives to covered services. They may also offer additional services using the administrative portion of their funding from the state. Some states require MCOs to offer CHW services or to directly employ CHWs. States may also choose to encourage coverage of CHW services through the use of performance measures and incentive payments.	**Michigan** requires in their contracts with Medicaid health plans (MHPs) that there is at least one CHW—either hired by the MHP or contracted through a CBO—for every 5,000 members and in every regional service area the plan is located in. The state provides an incentive for MHPs that meet the ratio requirement by contracting with a community-based organization or a clinic for CHW services.

Identifying Pathways for Financial Sustainability

Text Box 6: Illinois

In Illinois, the state legislature passed HB 158 during the spring 2021 legislative session and SB 336 during the fall 2021 veto session. The bills identifies persistent racial disparities and CHWs as one avenue to address these challenges. The legislation establishes the Community Health Workers Review Board to advise the Illinois Department of Public Health as it develops an Illinois Community Health Worker Certification Program. The law also makes CHW services reimbursable under Medicaid if the CHW is supervised by an enrolled Medicaid provider. Currently, the state Medicaid office is embarking on a stakeholder engagement process that will inform coverage of CHW services. Topics for discussion include:

- Defining CHW services and educating providers on their value,
- How a rate methodology and rates should be developed,
- Identifying best practices for implementing CHW services in a managed care organization (MCO) framework,
- Ensuring that CHW services complement existing care coordination, and
- Establishing referral pathways for CHW services.

The state Medicaid agency plans to submit a Medicaid state plan amendment to CMS to allow for Medicaid reimbursement of CHW services once the stakeholder engagement process is complete. Illinois Medicaid is currently funding CHWs through its Pandemic Health Worker Program, Healthcare Transformation Collaborative grants, and through Managed Care Organization administrative dollars.

Text Box 7: New Jersey

Using funds from an apprenticeship grant from the state's Department of Labor, the New Jersey Department of Health (NJDOH) established a Community Health Worker Training Institute. The institute provided a way to standardize training, focus on core competencies, and establish a baseline, livable wage for those who have completed the training. The institute is purposefully set up within a community college setting so that there is potential for additional career growth or an advanced degree for participating CHWs. In thinking about long-term support for CHWs and the training program, the NJDOH partnered with Medicaid and began having regular "sustainability meetings".

The state's most recent 1115 waiver renewal request includes a CHW pilot program that earmarks $25 million over the five-year waiver period for MCOs that want to implement and evaluate specific interventions using CHW services. NJDOH is also bringing other agencies to the table by extending the CHW training and core competencies to other outreach workers around the state.

Text Box 8: South Dakota

In South Dakota, Medicaid reimburses CHW services through the state plan. South Dakota Medicaid is working closely with the South Dakota CHW Collaborative to develop a robust CHW workforce that can support communities in the rural and frontier areas of the state.

Conclusion

Many state leaders see a robust community-based workforce as one of the keys to modernizing their public health systems and to meaningfully incorporating community-identified health and health-determining needs in an equitable way. CHWs offer an opportunity to boost workforce capacity and to provide more direct connection to community voices and needs. States that have incorporated CHWs into public health and Medicaid programs recognize the crucial role they plan in creating connections with communities during the pandemic and providing unique supports to the entire public health response (e.g., contact tracing, providing basic needs resources and supports, and vaccination efforts). As state leaders look towards pandemic recovery and the future of public health, there are opportunities to bolster state partnerships with CHWs, ensure culturally competent care, and bring community voices into the policymaking process.

NASHP will continue to support state officials in building on the current momentum to effectively partner with CHWs, and facilitate state-to-state exchange of innovative approaches on the key priorities surfaced, including:

- Engaging CHWs in policymaking via state or regional associations and/or provider networks of CHWs and other community-based stakeholders to inform the development of CHW programs and elevate community-specific strategies to address health equity.
- Advancing innovative partnerships with CHWs established during COVID-19 that may be vital to workforce strategies and health system transformation which include assessing key roles and contributions made, determining ongoing need, and building sustainable supports and financing around effective efforts.
- Investing sustainably in core CHW roles, including through reimbursement of services, braided financing approaches across health and health-related systems, as well as building career paths for a resilient and sustained workforce.

Please email Elinor Higgins (ehiggins@nashp.org) if you are interested in learning more about NASHP's work on CHWs or if you are interested in engaging with other states on this topic.

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