National Center for
HEALTHY HOUSING

Milken Institute School
of Public Health
THE GEORGE WASHINGTON UNIVERSITY

Advancing the Role of Community Health Workers:
Engaging State Medicaid Offices to Develop State Plan Amendments Regarding the Preventive Services Rule Change

INTRODUCTION

Community health workers (CHWs)[1] provide services that address the social and environmental determinants of health, including preventive home- and community-based health services (HCBS). Often as members of medical teams, CHWs are a vital part of the healthcare workforce in the vast majority of states, yet few state Medicaid programs reimburse even a portion of this work.[2, 3, a] Despite their rhetorical popularity, most CHWs continue to rely upon unpredictable and often insufficient financial support.

A new pathway of reimbursement for CHW services through Medicaid emerged in 2014. Before the Centers for Medicare and Medicaid Services (CMS) updated the regulatory definition of preventive services, preventive services could only be provided by physicians or other licensed practitioners (e.g., chiropractors or registered nurses). This "preventive services rule change" gave states the option to reimburse nonlicensed practitioners, including CHWs, for preventive services *recommended* by a licensed practitioner. In effect, the preventive services rule change enables states to include CHWs, as defined by the state's requirements for education, training, or credentialing, as qualified providers of certain preventive services under Medicaid.

To invoke the preventive services rule change, states must use a mechanism called a Medicaid state plan amendment (SPA). States use SPAs to notify or seek permission from CMS for any change to eligibility, coverage, or reimbursement. For example, a state may submit a SPA in order to extend coverage for home-based asthma services and explicitly include CHWs as qualified providers of those services. A state may also update an existing provision that defines the qualified providers of a preventive service to include CHWs. In doing so, states can bolster their healthcare workforce where needed.

[a] A 2017 survey funded by the National Center for Healthy Housing and the W.K. Kellogg Foundation found that several states are in the process of pursuing mechanisms like SPAs to incentivize the use of CHWs in home-based primary prevention services.

Missouri submitted a SPA that, in part, leverages the preventive services rule change for asthma prevention.[4] The state plan amendment states:

> *"Asthma preventive education and counseling and in-home assessments for asthma triggers require a referral and/or a prescribed service in the participant's plan of care by a physician and may be provided by practitioners other than physicians or other licensed practitioners."*

The state specifies training and certification requirements for asthma educators and environmental assessors to provide these services.

Delaware, New Jersey, Wisconsin, and other states also report ongoing discussions about potential preventive services, SPA development, and submission.[5]

Unfortunately, few states have taken advantage of this opportunity, and the majority of the CHW workforce continues to be limited by unstable funding. Some states have taken or are pursuing steps to reimburse CHWs through a variety of other mechanisms, often tying CHW reimbursement to specific services or provider networks (see text box on page 4: *Other Pathways to Medicaid Funding for CHWs*).

This brief is intended to aid stakeholders working with states to write and submit SPAs that will allow for Medicaid reimbursement of preventive services provided by CHWs. It explains the SPA process, describes how a SPA can be used to adopt CMS' preventive services rule change, and concludes with key lessons for stakeholders, including alternative opportunities to fund this work.

MEDICAID PLANS AND STATE PLAN AMENDMENTS

A Medicaid state plan is an agreement between the state and the federal government. It describes how the state will administer its Medicaid program. The state plan defines member eligibility, scope of services provided, and provider reimbursement methods. To make changes in these areas, states must submit SPAs to CMS. Once approved, a SPA can only be ended or changed through a subsequent SPA.

States can use a SPA to change virtually any provision of Medicaid, as long as the proposal complies with Medicaid statute and regulations. In general, SPAs must propose changes that are:

- Statewide – The changes must apply to Medicaid enrollees throughout the state, not just in certain areas;
- Comparable – All people eligible for Medicaid must be offered similar services, regardless of their eligibility category. A state cannot change services for just one group of Medicaid enrollees; and
- Offer a Choice of Providers – Medicaid enrollees must be free to choose among healthcare providers.

SPA SUBMISSION PROCESS

The agency that houses the state Medicaid program, which may or may not be a state health department, must first submit a proposed SPA to the governor or his/her designee for review before filing it with the state's CMS regional office. The governor must be given a specific amount of time to review the plan, and his or her comments must be submitted alongside the SPA. The only exception to this rule is if the governor's designee is the head of the state's Medicaid office.[6]

Public notice of any changes to payment methodologies or processes related to access to care, including the preventive services rule change, must be issued online, in newspapers, and/or in state registers at least one day prior to the effective date of the state's proposed change.[7] This notice must identify the changes, notably including which services or benefits are affected, a rationale for these changes, and times, dates, and locations at which the public can submit a comment. The state must analyze and consider the public input and submit that analysis along with the SPA submission.

Following state-level approval, a state submits its SPA alongside an official transmittal form[8] and its analysis of public input through the Medicaid and CHIP Program (MACPro) electronic submission portal.[9] In addition to serving as a submissions portal, MACPro also provides SPA templates (though not for the preventive services rule), automated workflows, and allows states to check the status of their submission.

CMS has 90 days from the receipt of the completed SPA to negotiate any requested changes and to make a decision, otherwise the proposed changes automatically go into effect. Once submitted, CMS must approve or deny the application, or else "stop

the clock" by requesting additional information from the state. CMS may only stop the clock once per submission. As long as the SPA does not violate federal rules, CMS is likely to approve it.

Approved SPAs can be implemented immediately and take effect retroactively to the first day of the quarter in which the SPA was submitted (e.g., if a state submitted a SPA on May 1 of a quarter that began April 1, the approved changes could apply as far back as April 1). Although they may be evaluated as part of Medicaid operations reviews, these SPAs will not expire and can only be changed through a subsequent SPA.[10]

KEY TAKEAWAYS FOR STAKEHOLDERS

Understanding the federal requirements and limitations of the preventive services rule change will be crucial to the development of the SPA. The SPA must clearly and comprehensively define the services, providers, and settings that are eligible for Medicaid reimbursement.

- The Rule Change Affects *Who Provides Services* but Not *the Scope of Services*: The preventive services rule change altered who can provide preventive services, but not *which* preventive services may be provided. If the preventive benefits defined in the state's existing state plan is not inclusive of the full scope of services a CHW may provide and that the state wishes to reimburse, the state must amend their list of covered benefits. A single SPA may implement both changes. For example, to include CHW-provided home-based asthma care as part of its Medicaid benefits package, the state could submit a SPA that both adds these services to its list of covered benefits and includes CHWs as qualified providers of these services.[11]

  Under current federal law, Medicaid defines *preventive care* as services that prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.[12] Coverage of preventive services is mandatory for beneficiaries under age 21, but states can decide on the scope of coverage for adults (other than the ACA "expansion population," who are entitled to a broad set of preventive services recommended by the U.S. Preventive Services Task Force). To find out what is covered under their state's Medicaid definition of preventive services, stakeholders may contact their state Medicaid office.

- State-Specific Processes: Beyond the specific regulatory requirement for a governor's review, states have different internal processes for writing and submitting SPAs. Some require legislative approval, while others do not. The governor may hold a great deal of authority over the Medicaid program, or the Medicaid agency may have significant authority. Stakeholders should develop a clear understanding of their state's SPA process.

- Other Reimbursement Pathways for CHWs: While this brief focuses on the preventive services rule change, states have multiple options available to them to provide reimbursement for CHWs through Medicaid and expand the scope of coverage as necessary to support this workforce. Other approaches, including Section 1115 waivers, Medicaid health homes, and Medicaid managed care contract requirements, can be used to support funding for CHWs; each has its own advantages and limitations. Medicaid managed care organization (MCO) program costs can also be classified as a medical service or administrative expense.[13]

  The State Community Health Worker Models project from the National Academy for State Health Policy (NASHP) offers information on every state's approach to CHWs, including information about financing, education and training, certification, state legislation, organization, CHW roles, and the relevant state agencies.[15] Additionally, a series of case studies from the National Center for Healthy Housing (NCHH) describes state strategies to fund home-based asthma services provided by CHWs.[16]

- Training and Certification: States must include in their SPA any certification or training standards required for CHWs to be eligible for reimbursement. These qualifications are not standardized at the federal level. While some advocates call for strict curricula and training programs, others are concerned that standardization could undervalue

A useful flow chart for determining when a SPA or other funding mechanism will be needed can be found in NCHH's

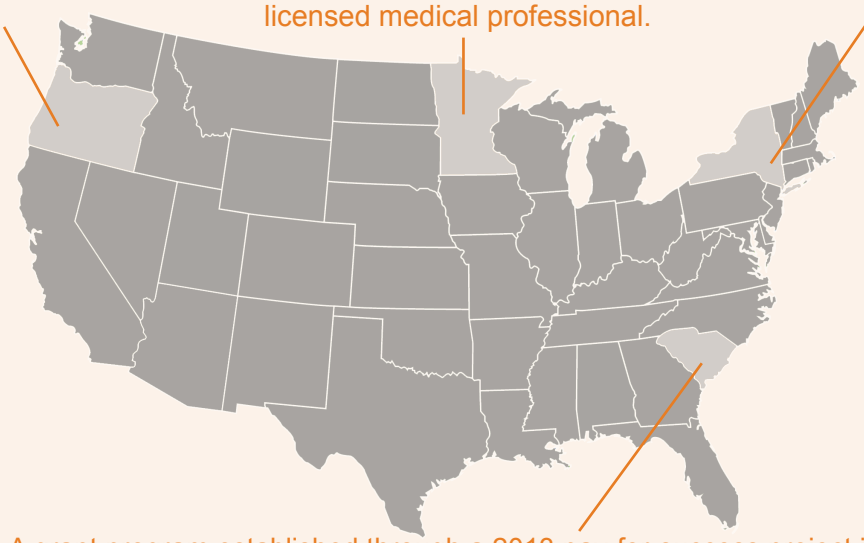
Pathways to Reimbursement: Understanding and Expanding Medicaid Services in Your State

OTHER PATHWAYS TO MEDICAID FUNDING FOR CHWS

While the preventive services rule change is one route to CHW coverage, states have used other approaches to reimburse for CHWs providing asthma services through Medicaid.

Oregon reimburses CHWs as part of coordinated care organizations (CCOs), which were established through an 1115 waiver. In addition, a **2012 SPA** defined CHWs as qualified providers of home-based asthma and other chronic disease care as part of patient-centered medical homes.

In **Minnesota**, Medicaid will reimburse CHWs who provide diagnosis-related health education under the supervision of a licensed medical professional.



New York State, through a **Section 1115 Medicaid waiver**, has reinvested savings generated by healthcare reform into a Delivery System Reform Incentive Payment (DSRIP) program. One asthma-specific project under DSRIP trains CHWs to perform home environmental assessments.

A grant program established through a 2013 pay-for-success project in **South Carolina** allowed primary care practices to hire CHWs and bill Medicaid for their services. Those that hired a CHW received a $6,000 grant from the South Carolina Department of Health and Human Services to cover the CHW's training and administrative costs. Primary care practices were also authorized to bill Medicaid for the CHW's work on a fee-for-service basis.

CHWs' close community ties. Determining the qualification and training of CHWs that suits the needs and values of the state will be essential to submitting a SPA. This process may vary from state to state, and involve multiple stakeholders (e.g., departments of education or health, boards of nursing, or other licensing organizations). These discussions may include the scope of practice, the role of supervisors, and other factors.

NASHP maintains a list of current state certification programs, which illustrates the variety of approaches implemented throughout the country.[17] States may develop their own CHW curricula and certification standards or, as numerous states have already done, adopt others', such as:

- Certification Guidelines: Credential Standards and Requirements Table – Certified Community Health Worker (CCHW) – Florida Certification Board[18]
- Community Health Worker (CHW) – Minnesota Department of Health[19]

Stakeholders should be ready to assist their state in developing the CHW certification process.

Even after CHW core competency certification, additional training will be required before CHWs are prepared to undertake home visiting activities related to healthy homes. Some of these training options include:

- Healthy Homes for Community Health Workers and Healthy Homes Assessment for Community Health Workers – National Healthy Homes Training Center at Healthy Housing Solutions, Inc.[20]
- Reducing Environmental Triggers of Asthma in the Home – Minnesota Department of Health[21]
- Community Health Worker Training Programs (database) – Asthma Community Network[22]

Additionally, if the state lacks CHW capacity, the SPA should include provisions to build that CHW workforce. CHWs themselves may need incentives to undertake the additional training needed to

provide home visiting services related to healthy homes issues. For more information about how to assemble a qualified workforce that includes CHWs as part of the care team, see:

  - "Assembling a Qualified Workforce," in Building Systems to Sustain Home-Based Asthma Services – NCHH[23]

- Data Collection and Analysis: A state-wide database or registry of CHWs can assist states in workforce development, tracking and analysis, and hiring but may need to be established. For example, the Texas Department of State Health Services tracks CHW networks and associations throughout the state, as well as their approximate number of CHW employees, regions served, and meetings scheduled.[24] The American Public Health Association also tracks CHWs according to their Standard Occupational Classification (SOC),[25] which may help states understand the size and scope of their CHW workforce. This knowledge is necessary to craft a SPA that is sensitive to the needs of the state.
- Anticipate Challenges in Implementation: Once a preventive services rule change SPA is implemented, stakeholders should anticipate challenges to building an effective system for service delivery. CHWs will continue to require the recommendations of licensed providers to drive their work. Therefore, it is important to foster working relationships between CHWs and licensed providers. Similarly, CHWs may require more plentiful and robust training to provide the full scope of services that may be allowable. Broadly speaking, stakeholders should be aware of the potential challenges that may inhibit the growth of the CHW workforce even after implementation of a SPA and work with states to preempt or mitigate these problems.

CONCLUSION

Community health workers contribute vital work by providing services that address the social and environmental determinants of health. The preventive services rule change presents one opportunity for states to broaden and strengthen their health care systems significantly by allowing for Medicaid reimbursement of certain preventive services provided by CHWs in the community setting.

National Center for HEALTHY HOUSING

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

We gratefully acknowledge the following individuals at the George Washington University Milken School of Public Health in the preparation of this case study:

Katie Horton, JD, MPH, RN
Anya Vanecek
Naomi K. Seiler, JD

This case study was made possible through a contract between the W.K. Kellogg Foundation and the National Center for Healthy Housing. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the W.K. Kellogg Foundation.

September 2018

ACRONYMS

ACA	***Affordable Care Act***
CHW	***Community Health Worker***
CMS	***Centers for Medicare and Medicaid Services***
HCBS	***Home- and Community-Based Health Services***
MACPro	***Medicaid and CHIP Program Poral***
MCO	***Managed Care Organization***
NASHP	***National Academy for State Health Policy***
NCHH	***National Center for Healthy Housing***
SOC	***Standard Occupational Classification***
SPA	***State Plan Amendment***

DEFINITIONS

Administrative expense
The National Center for Healthy Housing found that "Medicaid MCO program costs can be classified as a medical service or an administrative expense. Medical services are reimbursable by Medicaid and include the various clinical services offered by physicians and other practitioners in health centers, laboratories, and in inpatient/outpatient hospital settings. Administrative expenses cover nonmedical activities important for MCO operations, such as enrollment, advertising, claims processing/billing, and patient grievances/appeals. These types of services are paid for from plan revenue. Administrative expenses also include medical management services and quality improvement activities, such as coordinating and monitoring services for Medicaid recipients. Home-based asthma interventions often fit this category of plan spending. An MCO may be motivated to cover certain medical management services and quality improvement activities under their administrative budget (in other words, investing what would otherwise be profit back into patient care) if these services save them significant dollars elsewhere, such as by reducing urgent care costs." For more information, visit
http://nchh.org/resource-library/Case-Study_Asthma_DE_Final.pdf

Community health worker (CHW)
The American Public Health Association defines a CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." For the full definition, visit
https://www.apha.org/apha-communities/member-sections/community-health-workers

Home-based asthma services
This case study uses the *Community Guide to Preventive Services* definition of home-based, multi-trigger, multicomponent asthma interventions. These interventions typically involve trained personnel making one or more home visits, and include a focus on reducing exposures to a range of asthma triggers (allergens and irritants) through environmental assessment, education, and/or remediation. For the full definition, visit
https://www.thecommunityguide.org/sites/default/files/assets/Asthma-Home-Based-Children.pdf

REFERENCES

[1] American Public Health Association. (n.d.). Community health workers. Retrieved May 15, 2018, from https://www.apha.org/apha-communities/member-sections/community-health-workers

[2] National Academy for State Health Policy. (2017, August). State community health worker models. Retrieved May 15, 2018, from https://nashp.org/state-community-health-worker-models/

[3] National Academy for State Health Policy & National Center for Healthy Housing. (2018, March 2). Responses to a 2017 survey on state policies regarding community health workers: Home visiting to improve the home environment. Retrieved May 15, 2018, from https://nashp.org/wp-content/uploads/2015/05/Home-visiting-PDF-final-approval-NCHH-3.2.18.pdf

[4] Missouri state plan amendment 16-0004. (2016). Retrieved May 15, 2018, from the Medicaid website: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MO/MO-16-04.pdf

[5] National Academy for State Health Policy & National Center for Healthy Housing. (2018, March 2). Responses to a 2017 survey on state policies regarding community health workers: Home visiting to improve the home environment. Retrieved May 15, 2018, from https://nashp.org/wp-content/uploads/2015/05/Home-visiting-PDF-final-approval-NCHH-3.2.18.pdf

[6] Grants to States for Assistance to Programs, 42 C.F.R. § 430.12 – Submittal of state plans and plan amendments (2017). Retrieved May 15, 2018, from https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/xml/CFR-2017-title42-vol4-part430.xml

[7] Wachino, V. (2016, June 24). Federal public notice and public process requirements for changes to Medicaid payment rates. CMCS Informational Bulletin. Retrieved May 15, 2018, from the Medicaid website: https://www.medicaid.gov/federal-policy-guidance/downloads/cib062416.pdf

[8] Department of Health and Human Services, Centers for Medicare and Medicaid Services. (1992, July). Transmittal and notice of approval of state plan material for: Centers for Medicare & Medicaid Services (Form CMS-179). Retrieved May 15, 2018, from https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS179.pdf

[9] Centers for Medicare and Medicaid Services. (n.d.). Medicaid and CHIP program (MACPro) portal. Retrieved May 15, 2018, from the Medicaid website: https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html

[10] Medicaid and CHIP Payment and Access Commission. (n.d.). State plan. Retrieved May 15, 2018, from https://www.macpac.gov/subtopic/state-plan/

[11] Bachrach, D., Guyer, J., & Levin, A. (2016, August 10). Medicaid coverage of social interventions: A roadmap for states. Retrieved May 15, 2018, from https://www.manatt.com/Insights/Newsletters/Medicaid-Update/Medicaid-Coverage-of-Social-Interventions-A-Roadm

[12] Services: General Provisions, 42 C.F.R. § 440.130(c) – Diagnostic, screening, preventive, and rehabilitative services (2013). Retrieved May 15, 2018, from https://www.gpo.gov/fdsys/granule/CFR-2013-title42-vol4/CFR-2013-title42-vol4-sec440-130

[13] National Center for Healthy Housing & George Washington University Milken School of Public Health. (2015, October). *Case studies in healthcare financing of healthy homes services: Medicaid reimbursement for home-based asthma services in Delaware*. Retrieved May 15, 2018, from http://nchh.org/resource-library/Case-Study_Asthma_DE_Final.pdf

[14] Oregon Health Authority. (2012, March 1). Application for amendment and renewal: Oregon health plan 1115 demonstration project – Medicaid and Children's Health Insurance Program. Retrieved May 15, 2018, from the Medicaid website: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/Health-Plan/or-health-plan2-amend-renewal-demo-app-03012012-4.pdf

[15] National Academy for State Health Policy. (2017, August). State community health worker models. Retrieved May 15, 2018, from https://nashp.org/state-community-health-worker-models/

[16] National Center for Healthy Housing. (n.d.). Healthcare financing of healthy homes services case studies. Retrieved May 15, 2018, from http://nchh.org/who-we-are/nchh-publications/case-studies/healthcare-financing-of-hh-services-case-studies/

[17] National Academy for State Health Policy. (2017, August). State community health worker models [Certification tab]. Retrieved May 15, 2018, from https://nashp.org/state-community-health-worker-models/

[18] Florida Certification Board. (2018, February). Certification guidelines: Credential standards and requirements table – Certified community health worker (CCHW). Retrieved May 15, 2018, from https://flcertificationboard.org/wp-content/uploads/CCHW-Standards-and-Requirements-Tables-February-2018.pdf

[19] Minnesota Department of Health. (2018). Community health worker (CHW). Retrieved May 15, 2018, from http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw

[20] Healthy Housing Solutions, Inc. (n.d.). Training courses [Healthy homes for community health workers & Healthy homes assessment for community health workers]. Retrieved May 15, 2018, from http://healthyhousingsolutions.com/hhtc/training-courses/

[21] Minnesota Department of Health. (2015, November 23). Home environment & asthma [with emphasis on Reducing environmental triggers of asthma in the home]. Retrieved May 15, 2018, from http://www.health.state.mn.us/asthma/homes.html

[22] Asthma Community Network. (n.d.). Community health worker training programs. Retrieved May 15, 2018, from http://www.asthmacommunitynetwork.org/chw_programs?province=All&tid=155&keys=&tid_1=All

[23] National Center for Healthy Housing. (n.d.). Building systems to sustain home-based asthma services. Retrieved May 15, 2018, from http://nchh.org/tools-and-data/financing-and-funding/building-systems-to-sustain-home-based-asthma-services/

[24] Texas Department of State Health Services. (2017, June). Texas promotor(a)/community health worker (CHW) [list of networks and associations]. Retrieved May 15, 2018, from http://www.dshs.texas.gov/chw/docs/NetworksAndAssociations-4-2018.pdf

[25] 2010 Standard Occupational Classification (SOC) – OMB's Final Decisions, 74 Fed. Reg. 12,3920 (Jan. 21, 2009). Retrieved May 15, 2018, from https://www.bls.gov/soc/soc2010final.pdf