Mechanisms for Sustainably Financing Community Health Worker Based Interventions to Address Social Determinants of Health

An analysis of state and federal policies and best practices to support long-term financing and integration of Community Health Workers (CHWs) into the healthcare-to-community continuum. Conducted as part of PolicyLab at Children's Hospital of Philadelphia's evaluation of the Alliance for the Determinants of Health, in partnership with the Kem C. Gardner Policy Institute.

The Alliance for the Determinants of Health's demonstration project seeks to address social needs, improve health outcomes, and reduce healthcare costs for SelectHealth Community Care Medicaid members. To sustain these efforts, Intermountain Healthcare engaged PolicyLab at Children's Hospital of Philadelphia and the Kem C. Gardner Policy Institute at the University of Utah to complete key informant interviews and a state and national policy scan to inform efforts to sustainably finance and integrate social need interventions in healthcare settings.

To identify the priority areas for this work, PolicyLab and the Gardner Institute first met with stakeholders from Intermountain Healthcare, including leaders of the Alliance for the Determinants of Health. These meetings identified four priority areas to achieve the Alliance's goals for sustainability:

- Community Health Worker reimbursement
- Community Health Worker certification
- Reimbursement of screening for social needs in the healthcare setting
- Standardized digital platforms with a closed feedback loop between community organizations and health systems

A June 2021 report provided to the Alliance presented a landscape review of Medicaid financing levers to support these priority areas. In continued evaluation of the Alliance's work, changes within Utah's policy landscape, and subsequent conversations with Alliance leaders and stakeholders, it was determined that a near-term policy priority for the Alliance is Community Health Worker (CHW) reimbursement, with a particular interest in financing CHWs within a value-based payment framework. To address this near-term priority, this analysis focuses exclusively on options for CHW reimbursement through Medicaid and provides some ideas about how best to achieve a value-based payment framework to support CHWs in Medicaid. It should be noted, however, that a review of available public resources to prepare this analysis highlights that efforts to integrate value-based payments in Medicaid are still somewhat in their infancy.

More information on the other three priority areas, and detailed information on all four priority areas, is available in the June 2021 report. For further information about this report and PolicyLab's evaluation of the Alliance for the Determinants of Health, please contact Rebecka Rosenquist (ROSENQUISR@chop.edu), Doug Strane (straned@chop.edu), or Laura Summers (Laura.Summers@utah.edu).

Community Health Worker Reimbursement Options

CHWs, also known as *promotoras* or patient navigators in Utah, are demographic mirrors of the communities they serve. They provide a link between patients, communities, and health and social services, facilitating access to services and improving the quality and cultural competence of care delivery. CHWs support providers and payers in the provision of social care, playing an important role for organizations hoping to achieve the triple aim of improving experience of care and outcomes while reducing per-capita costs. CHWs help expand access to care among underserved populations and are recognized as significant contributors in helping to reduce racial and ethnic disparities in healthcare.

Three primary policy levers can be used for establishing and sustaining CHW reimbursement in Medicaid:

1. States can submit a State Plan Amendment (SPA) to CMS to add reimbursable services to their Medicaid program.

2. States can use Medicaid managed care contracts to promote the utilization and uptake of CHW services.

3. States can submit Medicaid Section 1115 waivers to the Centers for Medicare & Medicaid Services (CMS) to make changes to their Medicaid program and test different models for delivering care.

Policy Point: A SPA may be the most straightforward policy lever for securing Medicaid reimbursement of CHWs based on recent changes to policies governing CHW practices in Utah. Managed care contracting is another feasible option given Utah's Medicaid Accountable Care Organization (ACO) contracts are renewed every fiscal year, presenting an opportunity to structure CHW reimbursement in a more flexible way.

While seeking reimbursement through a Medicaid 1115 waiver may be the most administratively difficult path, it also provides the greatest flexibility to finance services not traditionally reimbursed by Medicaid. It would also establish opportunities to reimburse CHWs as part of a broad system redesign focused on addressing the social determinants of health (SDOH). For example, recent state reforms have leveraged the 'in lieu of services' mechanism in combination with an 1115 waiver to pay for non-medical interventions and services. More information on these points is provided in the "Leveraging 1115 Waivers for Larger Scale System and Payment Reform" section below.

Current state of CHW Reimbursement in Utah

As of June 2022, CHWs were not an approved provider type reimbursable by Medicaid in Utah, meaning CHW-provided services are funded primarily through grants, by health systems, or by Medicaid ACOs using an administrative expense classification. While the Utah Department of Health has reportedly been exploring possible pathways for Medicaid reimbursement of CHWs for several years, potentially through Z and T codes with particular attention toward reimbursing non-clinical work, the lack of

provider certification is a primary reason why CHWs are not yet a reimbursable Medicaid provider type in Utah.

Legislation passed in the Utah legislature in 2022 (SB 104) establishes a state certification for CHWs and requires the Department of Health to administer the certification. Certification of CHWs is necessary under the SPA option and potentially under the managed care contracting option, given that Medicaid cannot designate CHWs as a Medicaid-enrolled provider type without state-approved certification. This recent legislation creates a pathway for Medicaid reimbursement of CHW-provided services.

Policy Point: Once the certification outlined in SB 104 is developed and in place, a SPA may be the most straightforward policy lever for establishing Medicaid reimbursement for CHWs in Utah. This is based on previous discussions with the state as well as the relatively low administrative barriers to implementation associated with this option. As such, it is important to understand the potential benefits and limitations to this approach. These are highlighted below, and more detailed information is available in the June 2021 report.

Reimbursing CHW Services through a Medicaid State Plan Amendment

A Medicaid state plan is an agreement between a state and CMS that outlines how the state will administer its Medicaid program, including information on what services are covered and how providers will be reimbursed. When states add services or change Medicaid benefits, they submit a State Plan Amendment (SPA) to CMS for approval. If the activities in the SPA comply with federal statutory and regulatory requirements, states can claim federal matching funds for those services, based on the state's Federal Medical Assistance Percentage (FMAP).

Current federal regulation allows states to reimburse CHWs for preventive services if the CHW is certified and if the services provided are recommended by a physician or another licensed practitioner. The services, which can include counseling, health education, or investigating the potential cause of a condition, must involve direct patient care and must directly address the physical or mental health of the patient.

Amending Utah's Medicaid state plan to reimburse for CHW services requires legislative oversight (particularly if the estimated cost of CHW services will significantly impact the state budget and necessitate an appropriation request), the creation of CHW certification (as noted above), and a clear definition and scope for CHW services. Ensuring the determined scope of service aligns with and supports the services provided by CHWs in the Alliance demonstration project will help guarantee outcomes achieved through this work can be sustained. The following subsections dive deeper into this point and other considerations of pursuing a SPA to pay for CHWs.

Aligning CHWs' Scope of Services with Alliance Needs

Alliance and other Utah healthcare stakeholders interviewed for this project by PolicyLab and the Gardner Institute noted that a Medicaid CHW scope of service should balance the state's need to control spending and utilization with the goal of CHW services being broad enough to effectively address

social needs. For example, the scope of service could include language that would allow CHWs to address needs related to social, behavioral, and health services through a connection to care management, but with a clear delineation from care management to avoid duplication of services.

Local stakeholders suggested that the CHW scope of service could mirror the state's current peer support model. Utah's Medicaid peer support specialists assist clients with substance use disorder to develop skills such as creating recovery goals, independently obtaining food, clothing, housing, and medical care, socialization, and securing and maintaining employment. The state's Division of Substance Abuse and Mental Health provides training and certification for peer support specialists.[1]

SB 104 (2022) defines a CHW as an "individual who works to improve a social determinant of health; acts as an intermediary between a community and health services or social services to facilitate access to services or improve the quality and cultural competence of service delivery; and increases health knowledge and self-sufficiency of an individual or a community through outreach, capacity building, community education, informal counseling, social support, and other similar activities."

In the Alliance demonstration, CHWs are community resource specialists who assist patients with a diversity of social needs. They importantly also have access to discretionary funds to pay for incidental costs not covered by Medicaid or other community resources. Key components of their scope of service within the demonstration include: (1) screening patients for needs related to the social determinants of health; (2) coordinating, managing, and following up on referrals sent through the Unite Us platform or the Connect Us Coordination Center from Intermountain clinics and care managers, SelectHealth and Castell care managers and care coordinators, and community-based clinics and organizations; and (3) connecting patients to appropriate community resources and leveraging discretionary funds for goods and services to assist the patient with overcoming barriers to managing their health.

If Utah moves forward with a SPA to reimburse for CHW services, the Medicaid defined scope of services should reflect these and any other services provided by Alliance CHWs that the evaluation determine to be effective and necessary. For example, California's SPA language (highlighted below) may most closely reflect the broad scope of services CHWs provide through the Alliance demonstration.

Not all services may be reimbursable through a SPA though. Leveraging discretionary funds, for example, would require a separate private or public funding stream or could be wrapped into an 1115 waiver. More information on this point is provided in the 1115 waiver section.

Policy Point: One lesson learned from Policy Lab and Gardner Institute's key informant interviews and national policy scan is to avoid a narrow definition of reimbursable CHW services, as differing patient needs necessitate flexibility in CHWs' roles. The Alliance may want to consider leveraging its state partnerships as well as relationships with CHWs and the Utah Public Health Association[2] to provide appropriate input on the scope of services as it is developed by the state's Medicaid agency. A formal public notice and comment period would likely not be necessary for a SPA regarding CHW services. That said, there would be opportunities to provide public input during the state's Medicaid Medicare Care Advisory Committees (MCAC), which has a standing agenda item to review all proposed SPAs. There may

also be an opportunity to submit public comment when the Utah State Bulletin is released. The Bulletin provides information on new Medicaid rules and policies or changes to existing rules and policies.

Intermountain could consider a similar process in Idaho where it appears CHWs are not yet a Medicaid-enrolled provider.[3] The state does reimburse home delivered meal providers as well as home modification contractors, indicating some precedence for reimbursing non-medical services. There may also be an opportunity to reimburse CHWs through the state's primary care case management program, Healthy Connections, although it is unclear if CHWs are used in this model and how CHWs would be reimbursed (e.g., directly drawing down reimbursement or funded indirectly through the enhanced care management fee).

CHWs are state plan approved Medicaid providers in Nevada but their scope of service is limited to health education. To better align reimbursable CHW services with the type of services that are provided through the Alliance demonstration, Intermountain may consider discussing opportunities to expand the scope of CHW services with the state's Medicaid agency.

Lessons Learned from Other States

Minnesota: Minnesota's Medicaid state plan limits CHW reimbursement to health education and self-management services, explicitly excluding social services and care coordination services. In addition, the state required services to be provided under the supervision of a Medicaid provider in its SPA, rather than under a Medicaid provider's referral, which can make it more difficult for CHWs to provide and be reimbursed for services. Lastly, the state did not create a standardized payment structure for its Medicaid managed care organizations (MCOs) to reimburse providers. As a result, many Minnesota MCOs initially opted-out of reimbursing for CHW services and providers were less likely to hire or contract CHWs given unreliable reimbursement.

Nevada: Nevada also excludes care coordination from CHW state plan covered services. CHWs are essentially "trained public health educators."[4] The state's managed care plans can elect to partner with CHWs for care coordination purposes, but those services are funded through the administrative portion of the managed care plans' capitation rate.

California: California added CHW services as a state plan benefit starting July 1, 2022. CHW services must be recommended by a Medicaid-enrolled physician or other licensed practitioner who develops a written plan of care describing the supports and services a CHW will provide. CHWs can be reimbursed for providing (1) health education services, (2) health navigation services (including connecting beneficiaries to community resources and serving as a cultural liaison on the health care team), (3) screening and assessment, and (4) individual support or advocacy related to assisting a beneficiary prevent the onset or exacerbation of a health condition or preventing injury or violence.[5] There are multiple pathways for a CHW to become a Medicaid-enrolled provider, including both certification and work experience.

Addressing State Spending and Utilization Concerns

One concern with using a SPA to support reimbursement of CHWs that was raised by stakeholders interviewed for this project is a lack of state control over spending and utilization of CHW services. To overcome this limitation, several states have leveraged SPAs to deliver CHW services to discrete populations. For instance, Maine, New York, Oregon, and Washington are among states that have used SPAs to design Medicaid Health Home programs that engage CHWs and target specific populations.

Another way to mitigate concerns with spending and utilization is through a value-based payment approach. Value-based payments can be difficult to achieve through state plan defined services (which are typically reimbursed on a fee-for-service basis); as such they are more often achieved in Medicaid through managed care contracts and 1115 waivers.

The use of value-based payments in Medicaid, however, is still relatively new. The most commonly used approaches include: (1) capitated payments, where the MCO or provider receives a per-member, per-month payment for services; (2) pay-for-performance or pay for success, where the MCO or provider is rewarded for providing a set of pre-determined services or achieving pre-determined outcomes; (3) shared savings, where the MCO or provider is rewarded for achieving cost savings for the patient population served; and (4) bundled or episode-of-care payments, where the MCO or provider receives a lump-sum payment for all services delivered to a member for a particular episode (e.g., illness, procedure, or condition).[6]

Most states leverage the first three approaches in their value-based payment designs, particularly when used in managed care contracts. However, an increasing number of states are leveraging 1115 waivers in order to achieve more flexibility in their ability to pay for health-related social needs.

Reimbursing CHWs through Managed Care Contracts

States can use managed care contracting processes to explicitly promote the utilization and uptake of CHW services in their Medicaid programs by defining minimum CHW to patient ratio requirements in their managed care contracts or establishing a minimum list of services that CHWs must provide. Often states incentivize their managed care plans to make these types of investments by covering certain social need interventions in the Medicaid state plan and building these costs into managed care capitated rates.

Lessons Learned from Other States

Michigan: Michigan requires its Medicaid MCOs to engage a certain number of CHWs per covered patient. Originally, Michigan required one CHW per 20,000 covered patients. Over time, the state has lowered the CHW to patient ratio to one CHW per 5,000 covered patients, and advocates hope to lower the ratio to one CHW for every 300 patients. To overcome limitations around duplication of efforts between MCOs and providers, Michigan created a bonus structure to reward MCOs who deploy CHWs to community providers and CBOs. These deployments count towards the MCO's CHW to patient ratio and include a multiplier, effectively lowering the number of CHWs an MCO must engage. Michigan

designed the MCO contracting arrangement to exclude outreach and education from the set of reimbursable CHW services. To supplement this gap in services, Michigan leverages a Medicaid outreach fund that is financed with MCO dollars and a state match to reimburse CHWs engaged in outreach and service coordination.

Maine: Maine provides a capitated rate for CHW services of $6.40 per-member, per-month. In setting the rate, it assumes that 5% of MaineCare members will utilize CHW services at about 40 minutes per week per member. The goal of this capitated payment is to help build a sustainable CHW workforce that effectively partners with community-based organizations. The capitated payment is based off CHWs being paid $24.53 per hour, plus benefits.

New Mexico: New Mexico uses Medicaid managed care contracts to support the use of CHWs.[7] CHW salaries, training, and service costs are embedded in capitated rates paid to Medicaid managed care organizations. These costs are considered MCO administrative costs and funded through the administrative portion of the managed care plans' rates.[8] The state's managed care contracts require plans to provide CHW services to at least 3% of their members.[9]

A less direct means of promoting CHW services through managed care contracts is tying CHW services to quality improvement and care coordination services, which are included in the numerator of the medical loss ratio (MLR). The MLR is the proportion of premium funds insurance companies spend on medical care compared to administrative costs and it must be at least 85%, per rules put in place by the Affordable Care Act. Including expenditures related to CHW services in the numerator of the MLR create a greater incentive for managed care plans to spend on social need interventions as doing so does not count against their MLR. That said, some stakeholders noted that there might be limitations on how many dollars can be counted under the quality improvement component of the MLR. This would limit the amount of dollars Utah ACOs can spend on CHW services and count in the numerator of their MLR if other expenditures are currently being counted there.

This limitation could also impact a managed care plan's decision to employ CHWs vs. contracting with them (or contracting with an organization that employs them). As noted in the state examples throughout this paper, CHWs seem to be most commonly funded through the administrative portion of managed care capitation rates. While counting CHW expenses in the administrative portion may allow for more dollars to be spent on CHW services than if funded through the quality improvement portion, it could also negatively impact a managed care plan's MLR. CHW service costs would also not be reflected in future rate adjustments.[10]

As a result, there are limitations to funding CHWs through managed care contracts, particularly if an organization is looking to cover the full cost of a CHW's salary and benefits. Managed care contracts and capitated rates, however, do provide more flexibility than what would be available under a Medicaid state plan and fee-for-service approach. Alternatively, an 1115 waiver could provide more funding support and flexibility (see the 1115 section below).

Lessons Learned from Other States

Oregon: Oregon's 1115 waiver established regional managed care plans, or Coordinated Care Organizations (CCOs), which are responsible for providing all medical, dental, and behavioral health services for Medicaid members in their coverage area. As part of their contracts, CCOs are required to provide access to Traditional Health Workers (THW), including CHWs. Oregon's CCOs use a variety of ways to integrate CHWs into their care models, including direct employment, subcontracting with provider groups to hire CHWs, and working with a central organizing agency to manage contracts and services with partners, including CHWs.[11]

CCOs that use the direct employment approach are typically smaller health plans and employ a small number of CHWs (less than five). The CHWs are based within the CCOs' administrative offices and work with care coordination teams throughout the larger health care system. Most of the CCOs that use this approach report CHW-related expenses as administrative costs.

CCOs that subcontract with provider groups to hire CHWs are typically larger health plans with wider geographic coverage areas. CCOs use a mix of alternative payment models (APM), sub-capitated payments, and fee-for-service in their subcontracts. As such, funding for CHW services is counted in the medical portion of their expenses.

For more information on Oregon's model see: George R, Gunn R, Wiggins N, et al. Early Lessons and Strategies from Statewide Efforts to Integrate Community Health Workers into Medicaid. J Health Care Poor Underserved. 2020; 31(2):845-858. doi:10.1353/hpu.2020.0064

Policy Point: As highlighted in the example above, different approaches are available for integrating CHWs into managed care and health system care models (e.g., direct employment, subcontracting with provider groups to hire CHWs, working with a central organizing agency to manage CHW contracts and services, etc.). There are also many factors to consider when determining which approach to use, including, but not limited to, the services being provided, the desired scope of CHW services, the size and needs of the target populations, the number of CHWs needed to serve the target populations, and broader partnerships with community-based organizations, among others.

Regardless of which model is selected, it is important to consider what community or operational infrastructure will best support, sustain, and integrate CHWs into the broader health care system for the model to be successful. This includes considering what type of referral systems are needed, which part of the health system will manage, utilize, and intersect with CHW workflows, and how CHWs will operate among and between health system and social service agencies. If possible, the selected policy lever should reflect and support the desired infrastructure.

The primary benefits of the managed care contracting approach to pay for CHWs include lower administrative and legislative barriers, and greater flexibility to cover services not traditionally covered under Medicaid. Unlike both the SPA and 1115 waiver options, legislative approval would likely not be required for including CHW provisions in managed care contracts, but this will depend on the specifics of

the contract arrangement. The flexibility provided through the managed care contracting model also allows for social need interventions to be delivered to targeted populations.

Some of the limitations of the managed care contracting approach include a potential duplication of effort with providers that have pre-existing relationships with patients and are already addressing their social needs. Additionally, managed care plans may be incentivized to target social need interventions toward patients with higher levels of healthcare utilization, who are most likely to realize a return on investment from addressing social needs. This can help further the triple aim of improved care and outcomes for lower cost—but it may also mean that populations who could realize long-term benefits from social need interventions, such as children without medical complexity, do not benefit from CHW services. As noted above, there may also be limits to using value-based payment arrangements to support CHWs, unless the managed care contracts are coupled with additional delivery system reforms achieved through 1115 waivers.

Policy Point: ACO contracting may be an option for Utah to reimburse CHW services given the relatively low administrative and legislative barriers, and Utah's existing shared-risk ACO contracts. Utah's ACO contracts are renewed every fiscal year, offering an opportunity to re-engineer the contracts to better address social needs through value-based payment approaches.

Leveraging 1115 Waivers for Larger Scale System and Payment Reform

States can submit Medicaid Section 1115 waivers to CMS to make changes to their Medicaid program and test different models for delivering care. If approved, they can be used to finance services not traditionally reimbursed by Medicaid. The downside is that Medicaid 1115 waivers are time-limited, require extensive discussions with CMS and legislative approval, and must be budget-neutral in terms of federal spending.[12]

In the last decade, an increasing number of large, delivery system reform 1115 waivers have been sought and approved by CMS that address SDOHs and health-related social needs by establishing or strengthening the state's social care network. Many of these waivers include a CHW component.

Lessons Learned from Other States

Texas: Texas' Delivery System Reform Incentive Payment (DSRIP) program 1115 waiver demonstration allocates additional funding to providers to spend on social need-related projects. The funding is tied to performance metrics, including social need metrics. The DSRIP demonstration gives providers, clinics, and hospitals the flexibility and funding to hire or engage CHWs and partner with community-based organizations (CBOs) as needed to offer a localized approach to addressing social needs.

While Texas's Medicaid 1115 waiver provided the state with flexibility to reimburse for CHW services at the local level, the Texas Medicaid officials interviewed cited several limitations of the waiver, including: (1) its time-limited nature; (2) the fact that smaller providers such as Federally Qualified Health Centers (FQHCs) struggled to participate given the need to contribute some matching funds; and (3) the administrative complexity of only being able to bill for CHW services provided under clinical supervision.

In addition to Texas, several other states have approved 1115 waivers that address health-related social needs through delivery system and payment reform. The following subsection provides information on opportunities that larger 1115 waiver demonstrations may offer related to the Alliance's interest in discretionary funds and payment reform.

Discretionary Funds

Policy Point: Utah could leverage a large system and payment reform demonstration to elevate CHWs' ability to leverage discretionary funds for goods and services to meet the patient's social needs. The use of these discretionary funds was frequently cited as one of the most successful components of the demonstration during evaluation interviews and input sessions with Alliance stakeholders.

Discretionary funds for the demonstration project currently come from Alliance funding approved by local steering committees and the Financial Distribution Committee. CHWs use these funds as "payer of last resort" to assist members with needs that are not covered by Medicaid or another community resource.[13] Examples include childcare, winter coats, personal hygiene supplies, mattresses, phone chargers, blood pressure monitors, bus tokens, and portable heater/air conditioners. A large portion of the funding has been used to assist with housing needs such as application fees, house payments, rent, or temporary housing.

As noted earlier, funding for these types of services could not be covered through a Medicaid state plan under current rules and regulations. Medicaid managed care rules also restrict the amount of non-medical spending by managed care plans and federal anti-kickback statutes create further implications for managed care plans providing enhanced or non-medical benefits. These rules limit the ability to use Medicaid managed care contracts as a lever for flexible discretionary spending.

Some states have, however, secured funding for similar non-medical services through 1115 waivers (examples are provided below). That said, it is important to note that there is limited flexibility around the types of non-medical services that can be provided, even with using an 1115 waiver. Both North Carolina and California worked with CMS to develop lists of pre-approved non-medical services. Oregon's model offers the most flexibility, but reimbursement for non-medical services is only provided if specific guidelines are met.

Lessons Learned from Other States

North Carolina: North Carolina recently launched its Healthy Opportunity Pilots program, which is part of its 1115 waiver. These pilots leverage Medicaid funding to pay for 29 non-medical interventions that address health-related social needs including housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress. These interventions are outlined in the pilot service fee schedule and the state uses three types of reimbursement for pilot services: fee-for-service, per-member-per-month payments, and cost-based reimbursement up to a cap.[14] Prepaid Health Plans (PHPs) receive a capped allocation of funding to spend on pilot services and pay for non-traditional

providers, and are responsible for implementing the pilots in three areas of the state in collaboration with state's care management entities.[15]

The Healthy Opportunities Pilots Fee Schedule does not specify the types of non-traditional providers that are approved to provide the 29 services. Instead, PHPs work with Network Leads (organizations selected through a competitive bid process) to establish a network of Human Service Organizations (community-based organizations and social services agencies) to cover and provide non-medical services to enrolled members in their region.

California: California's 1115 waiver-enabled Whole Person Care Pilot program leverages Medicaid funding to provide Community Supports to "address social drivers of health." Community Supports include 14 defined services delivered through community providers. Examples include housing navigation services, medical respite, environmental accessibility adaptations, medically tailored meals, and sobering centers.[16] Using the 'in lieu of services' (ILOS) mechanism (through Section 1915(b) waiver authority), managed care plans can substitute these services for certain Medicaid-covered medical services (e.g., emergency department visits, inpatient hospital care, nursing facility services, etc.). ILOS-associated costs are factored into managed care rates and may be included in the numerator of the MLR.[17] It is important to note that ILOS must be medically appropriate and cost-effective substitutes for other medical care, although CMS has adopted a broader approach to how these terms are defined in approving California's waiver. The state must demonstrate that the substituted services are cost-effective (on an aggregate basis) to meet CMS' regulatory requirements.[18]

A variety of community providers can be used to deliver Community Supports. Community Supports providers are required to enroll as a Medicaid provider if there is a state-level enrollment pathway for them (see the California example in the state plan section above for the CHWs enrollment pathway). Providers that don't have a corresponding Medicaid enrollment pathway are not required to enroll in Medicaid but are vetted by the managed care plan.[19]

Oregon: Oregon's 1115 waiver created a "health-related services" budget category for its managed care plans, or CCOs. This category is part of the CCOs global budget but separate from its medical and administrative expenses and can be used to address individual health-related needs (not covered by Medicaid) or for making SDOH-related community-level investments.[20] Health-related services spending is considered quality improvement and included in the numerator of the MLR. CCOs spend these health-related services dollars on health information technology, housing, prevention services not covered by Medicaid, education, family resources, and personal items.[21]

To be considered a health-related service a service must "meet the requirements for: a) activities that improve health care quality (as defined in 45 CFR 158.150) or b) expenditures related to health information technology and meaningful use requirements to improve health care quality (as defined in 45 CFR 158.151)." Activities that improve health care quality must meet specific criteria, including: "(1) be designed to improve health quality; (2) increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements; (3) be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-enrollees; and (4) be grounded in

evidence-based medicine, widely accepted best clinical practice, or criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations." The state also outlines the types of services that are excluded from health-related services.[22]

Policy Point: If the Alliance is interested in including CHW services in a larger 1115 waiver that addresses health-related social needs through delivery system and payment reform, it may want to work with the Utah Department of Health and Human Services in developing a broader system-focused 1115 waiver. The flexibility offered through Medicaid 1115 waivers could allow Utah to address SDOH by incorporating CHW reimbursement, discretionary funds, value-based payments, social need screenings and referrals, and other SDOH-related reforms into one waiver or waiver amendment.

Despite the considerable strengths of the Medicaid 1115 Waiver option, there are administrative barriers to having a waiver approved. For example, 1115 waivers are technically time-limited, although they are often renewed for extended periods of time. While the time limit is a drawback in terms of being a sustainable funding source for addressing SDOH, the "demonstration" aspect of waivers may be appealing to Utah's legislature. In addition, Medicaid 1115 waivers allow states to set a cap on services, making it more possible to control costs.

Utah recently secured CMS approval for a five-year renewal of its Medicaid 1115 waiver, which expired June 30, 2022. The newly approved waiver will be in place from July 1, 2022, through June 30, 2027. In its waiver, the state has approval to provide housing-related supports and services to targeted Medicaid populations (i.e., the Targeted Adult Medicaid (TAM) population), which includes individuals with acute and chronic medical and behavioral health conditions, criminal justice system involvement, and extended periods of unemployment and poverty who are experiencing homelessness, housing, food or transportation insecurity, interpersonal violence, or trauma. Services and supports include tenancy support services, community transition services, and supportive living and housing services.[23] Leveraging these services for the TAM population could reduce the Alliance's spending of discretionary funds on similar services, creating opportunity to use the discretionary funds for other needs.

Approval of these services may help set precedence for including other SDOH-related services in future waivers or waiver amendments. Moving forward, the state can continue to seek amendments to its existing 1115 waiver or a new 1115 waiver, both of which would require legislative approval. A CHW-related provision, as well as provisions related to other SDOH interventions, could be included in a waiver amendment or a new waiver.

Key Takeaways

Legislation passed in Utah in 2022 establishes a state certification for CHWs. This creates a pathway for Medicaid reimbursement of CHW-provided services. Once the certification is developed and in place, a SPA may be the most straightforward policy lever for establishing Medicaid reimbursement for CHWs in Utah. This is based on previous discussions with the state as well as the relatively low administrative barriers to implementation. As part of amending Utah's Medicaid state plan to reimburse for CHW services, the state will need to develop a clear definition and scope for CHW services.

Ensuring the determined scope of service aligns with and supports the services provided by CHWs in the Alliance's demonstration project will help guarantee outcomes achieved through the Alliance can be sustained. One lesson learned from other states is the importance of avoiding a narrow definition of reimbursable CHW services. The Alliance may want to consider leveraging its state partnerships to provide appropriate input on the scope of services as it is developed by the Medicaid agency.

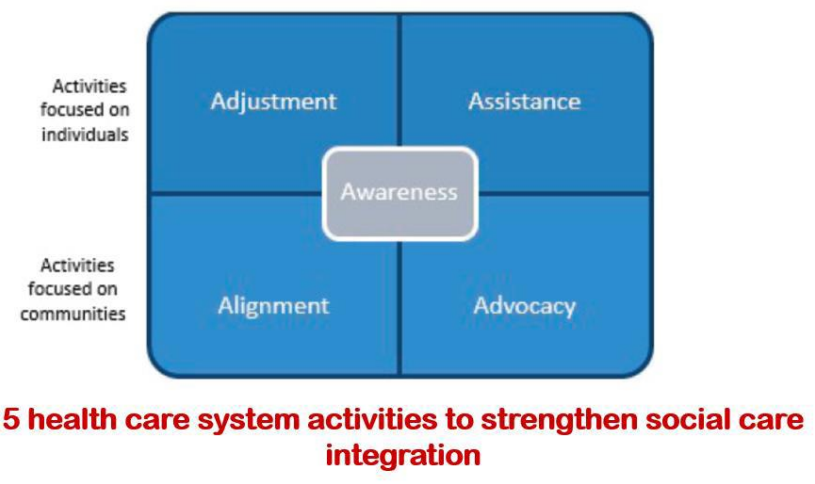
One downside to state plan defined services is that they are typically reimbursed on a fee-for-service basis. Leveraging ACO contracts to support and expand CHW services may be another option for Utah to pursue given the relatively low administrative and legislative barriers and Utah's existing shared-risk contracts.

If the Alliance is interested in including CHW services in a larger 1115 waiver that addresses health-related social needs through delivery system and payment reform, it may want to work with the Utah Department of Health and Human Services in developing a broader system-focused 1115 waiver. The flexibility offered through Medicaid 1115 waivers could allow Utah to address SDOH by incorporating CHW reimbursement, discretionary funds, value-based payments, social need screenings and referrals, and other SDOH-related reforms into one waiver or waiver amendment.

Addendum 1: Screening and payment levers for social needs in healthcare settings

Standardized screening for social needs is another important piece of addressing SDOH in healthcare settings. Screening is a key component of CHWs' scope of service within the Alliance demonstration and is an important means for providers to gain awareness of patient and population social risks and assets. The National Academies of Science, Engineering, and Medicine[24] conceptualized healthcare system activities to strengthen social care integration, as shown in the graphic below, which situates awareness at the center to inform all other activities.

Figure 1: Awareness is the Key to Addressing Social Determinants of Health



That said, screening itself is not an intervention, and it is essential to ensure that screening is patient-centered and effective. In separate work, PolicyLab elaborates on considerations in this regard specific to serving a pediatric population, and the SIREN Network recently reviewed the evidence on social needs screening, which may be useful to the Alliance.

It was noted during the interviews PolicyLab and the Gardner Institute conducted in 2021 that Utah's Medicaid program reimburses social need screening as part of an Evaluation and Management service on a fee-for-service basis, with a relatively low reimbursement rate. Stakeholders noted that the amount does not fully compensate for the time needed to screen and document social needs and assist patients interested in accessing follow-up interviews or referrals. In separate work, PolicyLab further explores opportunities for state Medicaid programs seeking to address unmet social needs in health care settings, and how challenges in doing so could be addressed in state-level policy design.

Several states use managed care contracts as a way to advance social need screening and referral processes. In **California**, MCOs must ensure that newly enrolled Medicaid members are screened and referrals are made to follow-up services. As part of the California Advancing & Innovating Medi-Cal (CalAIM) initiative, the state is planning to require MCOs to create a plan to identify and assess social risks and needs on an ongoing basis by July 2023. Additionally, social need screening is built into the state's Medicaid 1115 waiver-enabled Whole Person Care Pilot program, designed to integrate the care of high-utilizing Medicaid beneficiaries. There is variation in how Whole Person Care Pilot entities (which include MCOs) are reimbursed for screening, with some being reimbursed through bundled payments and others reimbursed through fee-for-service payments. Bundled payments must be approved by the Medicaid agency as part of the entities' total proposed budget request.[25]

Other states leverage large system and payment reform demonstrations to advance social need screening. For example, **Massachusetts'** Medicaid 1115 waiver created an ACO-based model for delivering care, where ACOs are required to screen for social need using a standardized screening tool. Screening is a value-based payment metric; however, as currently constructed, there are few incentives for directly assisting patients with accessing services that can address their unmet social needs. This raises the potential of unintended consequences of screening without appropriate connection to care that the PolicyLab resources shared earlier further delineate. Massachusetts' 1115 waiver is set to expire in July 2023, and, in its amended waiver, the state is exploring adjusting capitated rates upwards for patients living in communities with higher levels of unmet social need.

Addendum 2: Pathways for addressing SDOH in Medicare

CMS recently expanded opportunities for Medicare Advantage Plans to address SDOHs through supplemental benefits. This includes establishing Special Supplemental Benefits for the Chronically Ill (SSBCI), broadening the definition of Health Related Supplemental Benefits, and testing of the Value-Based Insurance Design (VBID) model. Brief information on these opportunities and resources for

more information are provided below. Intermountain could consider these benefits and models as possible ideas to leverage when examining different Utah-specific approaches to addressing SDOHs.

Special Supplemental Benefits for the Chronically Ill (SSBCI): **"**SSBCI includes supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees. In general, Medicare Advantage organizations have broad discretion in developing items and services they may offer as SSBCI, provided that the item or service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." Costs associated with SSBCI count towards patient care in calculating the MLR if Medicare Advantage plans incur a non-zero, non-administrative cost in providing the benefit. For more information see: Implementing Supplemental Benefits for Chronically Ill Enrollees.

Health Related Supplemental Benefits: CMS defines "a supplemental health care benefit in the Medicare Managed Care Manual (section 30.1) as an item or service (1) not covered by Original Medicare, (2) that is primarily health related, and (3) for which the MA plan must incur a non-zero direct medical cost." A few years ago, CMS announced that it was broadening the definition of "primarily health related" to include benefits that "(1) diagnose, prevent, or treat an illness or injury, (2) compensate for physical impairments, (3) act to ameliorate the functional/psychological impact of injuries or health conditions, or (4) reduce avoidable emergency and healthcare utilization." Supplemental benefits under this broader interpretation must be medically appropriate and recommended by a licensed provider as part of a care plan if not directly provided by one. "Supplemental benefits do not include items or services solely to induce enrollment." For more information see: Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (p. 207–209).

Value-Based Insurance Design (VBID): CMS is "testing a broad array of complementary MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, and improve the coordination and efficiency of health care service delivery" through the VBID Model. The VBID Model allows participating plans to further target benefit design to enrollees based on chronic condition and/or socioeconomic characteristics, and to engage their enrollees through wellness and health care planning. For more information see: Medicare Advantage Value-Based Insurance Design Model.

End Notes

[1] The State of Utah is currently in the process of consolidating the Utah Department of Health and the Department of Human Services. The consolidation process is ongoing and many of the details, such as restructuring specific divisions and responsibilities within and across the departments, are yet to be determined. As such, the entities that are currently overseeing this training and certification may change.

[2] Other key groups include but are not limited to the Association of Utah Community Health, the Utah Community Health Worker Coalition, Utah Public Health Association Community Health Worker Section, and the Utah Department of Health Office of Health Disparities.

[3] A key partner could include the Idaho Community Health Workers Association. It also appears there is a CHW certificate and training available through Idaho State University.

[4] CHWs provide recipients culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options. For more information see https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT89.pdf

[5] For more information on Medi-Cal Community Health Worker (CHW) Preventive Services see https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf

[6] McGinnis T, Crumley D, Chang D. (2018). Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value Based Purchasing. Supported by Academy Health, Robert Wood Johnson Foundation, and Nemours Children's Health System.
Phelps A, Cischke E. (2017). Alternative payment models in Medicaid: Could MACRA be a catalyst for states' value-based care efforts? Health Policy Brief. Deloitte.

[7] This work is supported by New Mexico's Medicaid 1115 Waiver, Centennial Care.

[8] State Community Health Worker Models. (Updated 2021 Dec. 10). NASHP. Available from https://www.nashp.org/state-community-health-worker-models/#tab-id-2

[9] Medicaid Coverage of Community Health Worker Services. (2022 April). MACPAC Issue Brief.

[10] George R, Gunn R, Wiggins N, et al. Early Lessons and Strategies from Statewide Efforts to Integrate Community Health Workers into Medicaid. (2020). *J Health Care Poor Underserved*. 31(2):845-858. doi:10.1353/hpu.2020.0064

[11] Ibid.

[12] The Biden Administration has reportedly expressed interest in revising the budget neutrality provision to better address health equity. Mann C, O'Hagen Karl A, Howard H. (2022 June 13). Rethinking The Budget Neutrality Requirement for Medicaid 1115 Demonstrations. Health Affairs Forefront.

[13] Alliance for the Determinants of Health. Update 2021.

[14] For more information on North Carolina's Healthy Opportunities Pilots see "Frequently Asked Questions." Available from https://www.ncdhhs.gov/media/12642/download?attachment

[15] For more information on North Carolina's Healthy Opportunities Pilots see "Fact Sheet: Healthy Opportunities Pilots." Available from https://www.ncdhhs.gov/media/14772/download?attachment

[16] For more information on California's Community Supports or In Lieu of Services (ILOS) see "Policy Guide." Available from https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

[17] Tong M, Hinton E. (2022 March 17). California Efforts to Address Behavioral Health and SDOH: A Look at Whole Person Care Pilots. Kaiser Family Foundation (KFF).

[18] Mann C, Reyneri D. (2022 April 19). New Policy Opens the Door for States to Address Drivers of Health in Medicaid. The Commonwealth Fund.

[19] For more information on California's Community Supports or In Lieu of Services (ILOS) see "Policy Guide." Available from https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

[20] CCOs must report their HRS expenditures annually, providing service categories, member IDs where relevant, and anticipated horizon of resulting cost savings. Oregon leverages Medicaid to address social determinants of health and health equity. (2021). Center for Health Systems Effectiveness, Oregon Health & Science University.

[21] Health-Related Services Summary: 2020 CCO Health-Related Services Spending. (2021 Nov). Oregon Health Authority.

[22] For more information see Health-Related Services Brief. (2022 Nov). Oregon Health Authority. Available from https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf

[23] For more information on available services see Utah's Medicaid Reform 1115 Demonstration CMS approval letter, expenditure authorities, and Special Terms and Conditions (STCs). Available from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-pcn-appvl-06302022.pdf

[24] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019 Sep 25). Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington (DC): National Academies Press (US). PMID: 31940159.

[25] For more information on California's Medi-Cal 2020 Waiver – Whole Person Care (WPC) Pilots see "Frequently Asked Questions and Answers." Available from https://www.dhcs.ca.gov/services/Documents/RevisedDHCSWPCFAQ6-2-16.pdf