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Affordable Care Act Opportunities for Community Health Workers

How Medicaid Preventive Services, Medicaid Health Homes, and State Innovation Models are Including Community Health Workers

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Affordable Care Act Provisions Create New Opportunities for Community Health Workers

The Affordable Care Act (ACA) included a range of provisions that may help enhance the role of community health workers (CHWs) in the U.S. healthcare system. Notably, section 5313 of the ACA authorized the Centers for Disease Control and Prevention to issue grants to organizations to improve health in underserved areas through the use of CHWs. While unfortunately Congress did not appropriate funds for these grants, the ACA has nevertheless generated health system changes that have already increased the role of CHWs.

Here, we review three ways that the ACA opened doors for CHWs and how states are implementing each. First, the ACA has increased access to preventive health services under Medicaid, and implementing regulations have clarified that states may designate non-licensed providers (i.e., CHWs) to provide preventive services. Second, the ACA offers state Medicaid programs the opportunity to create "Health Homes" for beneficiaries living with chronic illness, and several states have taken the opportunity to design plans that explicitly include or refer to CHWs. Third, the ACA creates funding for State Innovation Models, which are intended to help states improve health outcomes and quality of care while slowing growth in health costs. Of six states currently implementing their Model designs, four have included CHWs in their plans.

The ACA has created significant incentives and opportunities to increase the role of CHWs in state Medicaid programs. In order to fully benefit from these opportunities, CHWs and CHW professional associations should collaborate with states to define the CHW role in the state and identify CHW workforce supports. To the extent that some opportunities require states to define CHW skill and training requirements, CHWs must be at the table to participate in these decisions.

BACKGROUND ON MEDICAID

Medicaid is a health insurance program funded jointly by the federal and state governments. The amount of federal funding varies by state, eligibility category, and type of service. Federal law forms the backbone of the Medicaid program in all states. States participating in the Medicaid program must write State Plans describing their programs, and the federal Centers for Medicare and Medicaid Services (CMS) must approve these plans, ensuring that they comply with federal Medicaid rules.[1] When states wish to change their Medicaid programs, they generally must file a State Plan Amendment with CMS, which must approve any changes.

Federal law identifies a set of "mandatory services" that states must cover for the traditional Medicaid population.[2] Most Medicaid beneficiaries are entitled to receive these mandatory services subject to a determination of medical necessity by the state Medicaid program or a managed care plan under contract with the state.[3] The required services include:

- Physician services;
- Hospital services (inpatient and outpatient);
- Laboratory and x-ray services;
- Early and periodic screening, diagnostic, and treatment services for individuals under age twenty-one;
- Federally-qualified health center (FQHC) and rural health clinic services;
- Family planning services and supplies;
- Pediatric and family nurse practitioner services;
- Nurse midwife services;
- Nursing facility services for individuals twenty-one and over;
- Home health care for persons eligible for nursing facility services; and
- Transportation services.[4]

States have flexibility to cover additional services that federal law designates as "optional."[5] Examples include prescription drugs—which all states cover—personal care services, rehabilitation services, and habilitation services.[6] Other optional services include: clinic services, dental services, prosthetic devices, eyeglasses, rehabilitation, case management, home and community-based services, personal care services, and hospice services.[7] Note that the category of benefits called "other diagnostic, screening, preventive, and rehabilitative services" is also optional.[8]

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[1] KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID A PRIMER (2013), http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.
[2] KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID A PRIMER 13 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.
[3] Id.
[4] Id.
[5] Id.
[6] Id.
[7] Id.
[8] MEDICAID.GOV, *Medicaid Benefits*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

Federal law also defines mandatory and optional eligibility categories. For example, states are required to provide Medicaid coverage to families with dependent children receiving cash assistance through the Temporary Aid to Needy Families program, and have had the option to cover pregnant women with income between 150% and 180% of the federal poverty level. [9] Under the ACA, states have the option to add most adults with income below 138% of the federal poverty level.[10] As of March 2014, 27 states are working to implement the coverage expansion,[11] and the newly covered group is called the "expansion population."

[9] MEDICAID.GOV, *List of Medicaid Eligibility Groups*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf.
[10] MEDICAID.GOV, *Eligibility*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html.
[11] *Where the States Stand on Medicaid Expansion*, THE ADVISORY BOARD COMPANY (Mar. 28, 2014), http://www.advisory.com/daily-briefing/resources/primers/medicaidmap.

COMMUNITY HEALTH WORKERS CAN PROVIDE MEDICAID PREVENTIVE HEALTH SERVICES

As part of a regulation implementing ACA requirements regarding health benefits in both private and Medicaid plans, CMS made an important change to its previous regulations defining preventive healthcare services in Medicaid. The Social Security Act, the federal statute authorizing and defining Medicaid, had always defined preventive services as those "recommended by a physician or other licensed practitioner…" yet the CMS regulation had defined these services as those "*provided by* a physician or other licensed provider…" (emphasis added). In a regulation effective January 1, 2014, CMS amended the regulation to match the statute, so that preventive services recommended by a physician or licensed provider – but possibly provided by a non-licensed provider like a CHW – could be reimbursed.[12]

In order to take advantage of this change, states must file a State Plan Amendment that describes what services will be covered; who will provide them and "any required education, training, experience, credentialing or registration" of these providers; the state's process for qualifying providers; and the reimbursement methodology.[13]

A policy brief produced jointly by the Trust for America's Healthy and Nemours identified a wide range of preventive services that states can now allow non-licensed providers to provide. The list includes the YMCA Diabetes Prevention Program, home visiting, group health education, care coordination, and CHW services generally.[14]

As of this writing, no state has yet filed a State Plan Amendment, but this rule change is an exciting opportunity for CHWs to engage with Medicaid offices to develop these state plans. Nemours developed a questionnaire to assist CHWs and others in such planning efforts. The questionnaire includes topics such as:

- Requirements for non-licensed providers;
- Covered services;
- Eligible Medicaid members; and
- The overall rationale and purpose for use of the provider.[15]

CHW organizations can use this questionnaire to work with state Medicaid offices and develop State Plan Amendments that meet CHW needs.

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[12] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Update on Preventive Services Initiatives*, Nov. 27, 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf.

[13] Id.; TRUST FOR AMERICA'S HEALTH & NEMOURS, *Medicaid Reimbursement for Community-Based Prevention*, available at http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/.

[14] TRUST FOR AMERICA'S HEALTH & NEMOURS, *Medicaid Reimbursement for Community-Based Prevention*, available at http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/.

[15] Nemours, *Medicaid Provision of Preventive Services Regulation Questionnaire*, Dec. 2013, available at http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/.

United States Preventive Services Task Force Recommended Services:

The ACA creates new insurance coverage requirements affecting Medicare, Medicaid, and the private insurance market. One of these requirements pertains to preventive healthcare services, requiring that Medicare and non-grandfathered individual and small group insurance plans cover, without cost-sharing, all preventive services recommended with an "A" or "B" grade by The United States Preventive Services Task Force (USPSTF). Within Medicaid, plans designed for the expansion populations must also cover these services without cost-sharing, while for traditional Medicaid populations, states can choose to cover these services without cost-sharing. If states do cover these services without cost-sharing, the federal government will pay for an additional one percent of the cost.[16]

The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve health by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. The Agency for Healthcare Research and Quality (AHRQ) within the Department of Health and Human Services is charged with supporting and funding the USPSTF. The preventative services that the Task Force focuses on are screening tests, counseling interventions, immunizations, and chemoprevention delivered to persons without recognized symptoms or signs of the target condition.[17] The Task Force does not typically make recommendations aimed at preventing complications from a disease, while it does make recommendations for preventing morbidity or mortality from a second condition among those who have a different established disease. See the appendix for a list of USPSTF recommendations with an A or B grade.

In a 2013 study covering June to November 2012, researchers at George Washington University investigated the degree to which state Medicaid programs covered twenty-four of these recommended services. They found that while many states covered some services (for example, thirty-four states cover well-adult visits in both managed care and fee-for-service Medicaid and all but three states appeared to cover mammograms) most states did not cover all recommended services. Further, the coverage rules were often written in a confusing manner, so that it was not clear which services would be available to which beneficiaries.[18] This finding suggests that many states will need to make significant changes to their coverage plans in order to cover all A and B graded preventive services.

The ACA has given states the opportunity to receive an extra one percent in federal funding for these services if they agree to provide all of them free of cost-sharing to beneficiaries in

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[16] *Health Policy Brief: Preventive Services Without Cost Sharing*, HEALTH AFFAIRS, Dec. 28, 2010, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=37; CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Update on Preventive Services Initiatives* at footnote 1, Nov. 27, 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf.

[17] UNITED STATES PREVENTIVE SERVICES TASK FORCE, *About the USPSTF*, http://www.uspreventiveservicestaskforce.org/about.htm.

[18] Sara E. Wilensky & Elizabeth A. Gray, *Existing Medicaid Beneficiaries Left off the Affordable Care Act's Preventive Services Bandwagon*, HEALTH AFFAIRS, July 2013, available at http://content.healthaffairs.org/content/32/7/1188.abstract.

traditional Medicaid. As of this writing, seven states have filed State Plan Amendments to provide these services and receive the additional federal funding:[19]

- California
- Hawaii
- Nevada
- New Hampshire
- New Jersey
- New York
- Washington

As mentioned above, the ACA required states to include these services in Medicaid plans designed for "expansion populations." This means that each state that expanded Medicaid will cover these recommended services without cost-sharing for the expansion population. As of March 2014, the following states have expanded Medicaid: [20]

- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Hawaii
- Illinois
- Iowa
- Kentucky
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Dakota
- Ohio
- Oregon
- Rhode Island

[19] MEDICAID.GOV, *Medicaid State Plan Amendments*, http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html.
[20] *Where the States Stand on Medicaid Expansion*, THE ADVISORY BOARD COMPANY (Mar. 28, 2014), http://www.advisory.com/daily-briefing/resources/primers/medicaidmap.

- Vermont
- Washington
- West Virginia

CHWs may be well-suited to provide some of these recommended services. In conjunction with a State Plan Amendment adding CHWs as authorized Medicaid providers for certain preventive services, the addition of more preventive services to Medicaid plans can greatly enhance the role of CHWs.

However, no state can take advantage of this ACA provision to increase the role of CHWs until it submits and receives approval for a State Plan Amendment. Therefore, the next step in all states will be for CHW organizations to collaborate with state Medicaid offices to design State Plan Amendments adding CHWs to the list of Medicaid providers in the manner that will best suit the states' needs. It will make sense to identify which recommended preventive services can be provided by CHWs, and include that information in the State Plan Amendment adding CHWs to the list of Medicaid providers.

MEDICAID HEALTH HOMES

The Medicaid Health Home is a major opportunity to integrate CHWs into whole-person care teams under the ACA. States have the option to establish "health homes" to coordinate care for Medicaid beneficiaries living with chronic conditions. Medicaid Health Homes must provide six core services, including: comprehensive case management; care coordination; health promotion; comprehensive transitional care and follow-up; patient and family support; and referrals to community and social support services. For the first 8 quarters the program is effective, the federal government will pay for 90% of the cost of the six core services provided through the program.

Just as states must file State Plan Amendments to change their Medicaid programs to add CHWs as providers of preventive services, they must also file State Plan Amendments to add the Medicaid Health Home to their Medicaid program. The following states have filed and received approval for Medicaid Health Home State Plan Amendments:[21]

- Alabama
- Idaho
- Iowa
- Maryland
- Maine
- Missouri
- New York
- North Carolina
- Ohio
- Oregon
- Rhode Island
- South Dakota
- Vermont
- Washington
- Wisconsin

CHWs are particularly well-positioned to provide four of the six core Health Home services: health promotion; comprehensive transitional care and follow-up; patient and family support; and referrals to community and social support services. For this reason, Maine, New York, Oregon, South Dakota, Washington, and Wisconsin have designed programs that explicitly include or reference CHWs.

Maine:

Maine's Health Home program is available statewide, to Medicaid beneficiaries with two chronic conditions and those with one chronic condition who are at risk of developing another.

[21] MEDICAID.GOV, *Approved Health Home State Plan Amendments*, http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html.

Eligible conditions include mental health conditions; substance abuse disorders; asthma; diabetes; heart disease; BMI over 25; and other chronic conditions (tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities).[22]

Maine requires Health Home practices to contract with a Community Care Team, which is intended to complement the care management provided by primary care providers and their care teams.[23] The Community Care Teams employ care managers, who visit patient homes and work with the Health Home practice to plan and coordinate referrals for community and social supports and to assist with referrals. Maine has identified the following organizations as eligible to serve as Community Care Teams: hospitals, health systems, home health agencies, Federally-Qualified Health Centers, Rural Health Centers, primary care practices or groups of primary care practices, behavioral health organizations, social service organizations, and/or other community-based entities.[24]

Community Care Teams must have a multidisciplinary staff, and the State Plan Amendment notes that most Teams employ "a mix of care managers who are nurses and social workers, including behavioral health social workers with master's degrees," and that staff may also include "a care coordinator; nutritionist; case manager; pharmacist; chronic care assistant, *community health worker; care navigator; health coach*; and/or other staff approved by the state," (emphasis added).[25]

Through this State Plan Amendment, Maine has created space for Community Care Teams to employ CHWs and pay for their services with Medicaid Health Home reimbursement.

New York:

New York's Health Home program is now available statewide, although it was rolled out across the state in several phases.[26] New York's program is available to beneficiaries with two chronic conditions; those with one chronic condition (HIV/AIDS) who are at risk of developing another; and those with a serious mental illness. Eligible chronic conditions include mental health conditions; substance abuse disorders; asthma; diabetes; heart disease; BMI over 25; and other chronic conditions (including respiratory disease and HIV/AIDS).[27]

New York designates eligible providers, which include managed care plans; hospitals; mental and chemical dependency treatment clinics; primary care practitioner practices; patient-centered medical homes; Federally-Qualified Health Centers; Targeted Case Management providers;

[22] Maine Health Home State Plan Amendment at 1-2, available at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Maine-SPA-4.pdf.
[23] Id. at 3.
[24] Id. at 4.
[25] Id.
[26] New York Health Home State Plan Amendment at 2, available at http://www.chcs.org/usr_doc/2012-12-11_spa_approval_plan_pgs_(phase_III).pdf.
[27] Id. at 2-4.

certified home health care agencies; and any other Medicaid-enrolled provider that meets Health Home standards.[28]

All Health Homes are required to use "multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses, and other care providers led by a dedicated case manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care."[29] The State Plan Amendment goes on to explain that "optional team members may include nutritionists/dieticians, pharmacists, *outreach workers including peer specialists* and other representatives as appropriate to meet the enrollee needs," (emphasis added).[30]

As in Maine, New York's State Plan Amendment has created an opening for Health Home providers to employ CHWs as part of their multidisciplinary teams.

Oregon:

Oregon's Health Home program is available statewide, to beneficiaries with two chronic conditions; those with one chronic condition who are at risk of developing another; and those with one serious mental illness. Eligible chronic conditions include mental health conditions; substance abuse disorders; asthma; diabetes; heart disease; BMI over 25; and other chronic conditions (Hepatitis C, HIV/AIDS, chronic kidney disease, or cancer).[31]

Oregon refers to Health Homes as Patient-Centered Primary Care Homes (PCPCH).[32] Providers eligible to enroll as a PCPCH include physicians (including pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners, and Physician Assistants); clinical practices or clinical group practices; Federally-Qualified Health Centers; Rural Health Clinics; Tribal Clinics; community health centers; community mental health programs; and drug and alcohol treatment programs with integrated primary care providers. [33]

In its State Plan Amendment, Oregon describes how it will provide the six core Health Home services, including notes on the type of provider involved in each service. The Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Support Services descriptions each note that the services will "occur under the direction of licensed health professionals, physicians, physician assistants, nurse

[28] Id. at 5.
[29] Id.
[30] Id.
[31] Oregon Health Home State Plan Amendment at 1, available at http://www.chcs.org/usr_doc/OR11-011_Approval_Package_(3_13_12).pdf.
[32] Letter from Carol J.C. Peverly, Associate Regional Administrator for the United States Department of Health and Human Services Division of Medicaid and Children's Health Operations to Bruce Goldberg, Director of the Oregon Health Authority, Mar. 13, 2012, available at http://www.chcs.org/usr_doc/OR11-011_Approval_Package_(3_13_12).pdf.
[33] Oregon Health Home State Plan Amendment at 2, available at http://www.chcs.org/usr_doc/OR11-011_Approval_Package_(3_13_12).pdf.

practitioners, nurses, social workers, or professional counselors, *community health workers, personal health navigators, or peer wellness specialists,*" (emphasis added).[34]

The State Plan Amendment goes on to explain that "Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized."[35] This indicates that only certified CHWs can participate as official members of the PCPCH care teams.

Oregon has strongly emphasized the role of CHWs in accomplishing major portions of its Health Home program. This will likely encourage PCPCH providers to employ CHWs as part of their care teams.

South Dakota:

South Dakota's Health Home program is available statewide, to beneficiaries with two chronic conditions; those with one chronic condition who are at risk of developing another; and those with one serious mental illness. Eligible chronic conditions include mental health conditions; substance abuse disorders; asthma; diabetes; heart disease; BMI over 25; and other chronic conditions (COPD, hypertension, and musculoskeletal and neck and back disorders).[36]

South Dakota's State Plan Amendment designates physicians, clinical practices or clinical group practices, rural clinics, community health center, community mental health centers, Federally-Qualified Health Centers, advanced practice nurses, and physician assistants as Health Home providers.[37]

South Dakota explains that the designated provider must lead a "team of health care professionals and support staff that may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, *a health coach/care coordinator,* chiropractor, pharmacist, support staff and other services as appropriate and available," (emphasis added).[38]

Like other states, South Dakota has not mandated the participation of CHWs in its Health Home program, but has specifically encouraged providers to hire a "health coach/care coordinator" to be part of the care team.

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[34] Id. at 6-9.
[35] Id.
[36] South Dakota Health Home State Plan Amendment: Health Homes Population Criteria and Enrollment at 1-2, available at http://www.chcs.org/usr_doc/SD-13-0008_Health_Home.pdf.
[37] South Dakota Health Home State Plan Amendment: Health Homes Providers at 1-2, available at http://www.chcs.org/usr_doc/SD-13-0008_Health_Home.pdf.
[38] Id. at 4.

Washington:

Washington's Health Home program is available in Pierce, Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima counties.[39] Medicaid beneficiaries are eligible if they have one chronic condition and are at risk of developing another. The eligible chronic conditions include mental health conditions, substance abuse disorder, asthma, diabetes, heart disease, and others, including cancer, renal failure, HIV/AIDS, and dementia or Alzheimer's disease.[40]

Washington's eligible providers include: clinical practices or clinical practice groups; Rural Health Clinics; community health centers; community mental health centers; home health agencies; case management agencies; Federally-Qualified Health Centers; hospitals; managed care organizations; participants in the Primary Care Case Management program; and substance use disorder treatment programs.[41]

The Washington Health Home is designed to have one of the above-listed organizations serve as a "Designated Provider/Lead Entity," which contracts with the state and is responsible for the service delivery model and program administration. The Designated Provider then also contracts with "Network Affiliated Care Coordination Organizations," which are responsible for staffing and oversight for the delivery of the six core Health Home services. Providers called "Care Coordinators" work under the direction of the Care Coordination Organizations, and interact directly with beneficiaries. The Care Coordinator, in turn, may receive administrative support from "*community health workers, peer counselors* or other non-clinical personnel," (emphasis added). This administrative support may include mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate in-person visits with the Care Coordinator.[42]

Washington has described the CHW role in the Health Home as administrative, and indeed the examples of CHW services given in the State Plan Amendment are somewhat limited compared with other state plans. Nevertheless, the presence of CHWs in the State Plan Amendment does create an opportunity to continue discussions with providers and the state to continue to enhance the CHW role.

Wisconsin:

Wisconsin's Health Home program is available in Brown, Kenosha, Milwaukee, and Dane counties. Beneficiaries living with HIV/AIDS who are either diagnosed with or at risk for another chronic condition are eligible to participate.[43]

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[39] Washington Health Home State Plan Amendment at 10-11, available at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/WA-Approved-HH-SPA-.pdf.
[40] Id. at 9-10.
[41] Id. at 12-19.
[42] Id. at 23.
[43] Wisconsin Health Home State Plan Amendment at 1, available at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Wisconsin-SPA.pdf.

The Wisconsin State Plan Amendment notes that only AIDS Service Organizations funded by the state Department of Health Services are eligible to serve as Health Homes under this program.[44]

In its discussion of the six core services, the State Plan Amendment explains that Individual and Family Support Services should include "peer-to-peer information sharing and support."[45]

Wisconsin seems to include the work of peer supporters in its State Plan Amendment, although the provider of "peer-to-peer information sharing and support" is not identified in the document.

[44] Id. at 2.
[45] Id. at 3-4.

STATE INNOVATION MODEL GRANTS

The ACA created a new department within the Centers for Medicare and Medicaid Services (CMS), the Center for Medicare and Medicaid Innovation (the Innovation Center). The Innovation Center administers seven categories of innovation models, including:

- Accountable care;
- Bundled payments for care improvement;
- Primary care transformation;
- Initiatives focused on the Medicaid/CHIP population;
- Initiatives focused on Medicare-Medicaid enrollees;
- Initiatives to speed adoption of best practices; and
- Initiatives to accelerate the development and testing of new payment and service delivery models. [46]

One of the projects funded by the Innovation Center is the State Innovation Models (SIM) Initiative. According to the Innovation Center, this initiative:

> *"is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP)."*[47]

The SIM grants are divided into three categories: Model Design Awards, for states to develop a Health Care Innovation Plan; Model Pre-Testing Awards, for states to continue work on their Innovation Plans; and Model Testing Awards, for states to implement their Innovation Plans.[48]

Of the six states that received Model Testing Awards, four explicitly mention or reference CHWs in their grant narratives. Below, we describe how these states include CHWs in their State Innovation Models.

Arkansas:

Arkansas's SIM is designed to help the state achieve the "Triple Aim" of improving health, increasing quality, and lowering healthcare costs. The plan is focused on both population-based and episode-based care.[49]

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[46] CENTER FOR MEDICARE AND MEDICAID INNOVATION, *Innovation Models*, http://innovation.cms.gov/initiatives/index.html#views=models.
[47] CENTER FOR MEDICARE AND MEDICAID INNOVATION, *State Innovation Models Initiative: General Information*, http://innovation.cms.gov/initiatives/state-innovations/.
[48] Id.
[49] ARKANSAS DEPARTMENT OF HUMAN SERVICES, STATE INNOVATION PLAN: ARKANSAS HEALTH SYSTEM TRANSFORMATION at 1 (Sept. 2012), available at http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=82.

A significant component of the population-based care improvement plan revolves around team-based care coordination. The SIM narrative explains that "[m]ulti-disciplinary teams, including primary care providers, care coordinators, and support services providers, will collaborate to improve care planning, diagnosis, treatment, patient coaching to ensure treatment adherence, and management through transitions of care."[50]

The narrative further expands on the role of the "care coordinators" throughout the document, and it appears that CHWs could very naturally fill these roles. In discussing patient-centered medical homes and health homes, the narrative discusses the need for these entities to provide patient education to "ensure understanding of their conditions, treatment plans, and how to navigate the health care system."[51] However, the narrative notes that physicians will need support to achieve this goal, and states that "the use of team-based care within medical homes will allow care coordinators to play this educator role along with physicians,"[52] and that "care coordinators will have an explicit role to invest time in consumer education as part of care management."[53] Consumer education is a common activity for CHWs, and the need for care coordinators to do this work creates an opportunity for CHW engagement in the state's plan.

In the Health Care Workforce section, the narrative notes that the state will "defin[e] requirements for care coordinators, including the number and geographic distribution, skills and training curricula."[54] This suggests that, as in other states, Arkansas is interested in pairing increased CHW involvement in the healthcare system with greater state engagement in CHW training. It will be important for CHWs to participate in any planning around skills and training curricula.

Maine:

The Maine SIM is also focused on achieving the Triple Aim, and to do so has identified four objectives:

1. "Reduce the total cost of care per person per year in Maine to the national average;
2. Improve the health of Maine's population in at least four categories of disease prevalence (including diabetes, mental health, obesity, and tobacco use);
3. Improve patient experience scores for targeted practices by 2% from the baseline 2012 survey;
4. Increase the number of practices reporting patient experience information from 50% to 66%."[55]

[50] Id. at 17.
[51] Id. at 29.
[52] Id.
[53] Id. at 30.
[54] Id. at 28.
[55] MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Maine State Innovation Model: SIM Goals*, http://www.maine.gov/dhhs/sim/strategies/sim-goals.shtml.

In order to achieve these objectives, the state will work to develop new payment models, strengthen primary care, integrate physical and behavioral health, develop new workforce models, centralize data and analysis, and engage people and communities.[56]

Maine's effort to develop new workforce models includes the creation of five new CHW pilot programs funded through the SIM grant. The pilots will:

- "Demonstrate the value of integrating CHWs into the health care team;
- Provide models for state-wide replication;
- Build a core group of experienced CHWs who can provide leadership for ongoing development of the system."[57]

The opportunity for these pilots to build a CHW leadership group is very exciting, and will help Maine CHWs to engage in future planning for any state CHW policies.

Minnesota:

Minnesota plans to advance its efforts toward the Triple Aim by expanding the role of Accountable Care Organizations. As the SIM narrative explains, "ACOs will focus on the development of integrated community service delivery models and coordinated care models, building on Hennepin Health and Minnesota's Health Care Homes program, that bring together health care, behavioral health, long term supports and services, and community prevention services that are coordinated and centered around patient needs."[58]

During Phase 1 of the SIM, Minnesota plans to prepare nine ACO contracts, which are expected to cover about 25% of the state's Medicaid beneficiaries.[59] During Phase 2, the state will expand the number of providers operating as or partnering with ACOs, so that up to 50% of beneficiaries will be part of ACOs.[60]

During Phase 2, the state will provide infrastructure supports to the ACOs. These supports will focus on helping ACOs to perform a number of functions, including to "effectively use interprofessional teams in a coordinated care environment, (which may include emerging roles such as community health workers, community paramedics, dental therapists and other professionals)."[61]

The state's investment in ACOs' capacity to create interdisciplinary care teams that include CHWs is a great opportunity to further elevate the role of CHWs in the state. Minnesota already reimburses CHWs in its Medicaid program, but relatively few of the CHWs who have gone

[56] Id.
[57] MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Maine State Innovation Model: Develop New Workforce Models*, http://www.maine.gov/dhhs/sim/strategies/workforce-models.shtml.
[58] HEALTH REFORM MINNESOTA, *Minnesota Accountable Health Model Project Narrative* at 2, available at http://mn.gov/health-reform/images/SIM%20Grant%20-%20Project%20Narrative.pdf.
[59] Id. at 5-6.
[60] Id. at 7.
[61] Id.

through the certification program are currently participating in Medicaid.[62] This investment in care team development may help bring more CHWs into the system, increasing access to CHW services for Medicaid beneficiaries.

Oregon:

Oregon's SIM is designed to build on its Coordinated Care Organization model, discussed above. Oregon's CCOs are "community-based entities governed by a partnership of providers of care, community members and entities taking financial risk for the cost of health care," and the state has already used them to provide care within Medicaid.[63] The state will work to expand the model to those dually-eligible for Medicare and Medicaid, state employees, and people who buy insurance through the state Marketplace, and plans to use the SIM to test the model in order to support this expansion.[64]

One element of the CCO model to be evaluated is the goal to have a "redesigned, person-centered delivery system that reaches outside the four walls" of the healthcare setting.[65] Within this goal, Oregon includes a discussion of workforce development for non-traditional healthcare workers and interpreters. The SIM narrative explains that CHWs, peer specialists, and patient navigators are an "integral part" of the CCO team, and that CCOs are required to incorporate such non-traditional healthcare workers into their teams. To support this work, Oregon has committed to training 300 new CHWs by 2015.[66]

Oregon has a robust training and certification program for CHWs already in place, and through both its Health Home model and this SIM the state is demonstrating an ongoing commitment to further integration of CHWs into the healthcare system and to CHW workforce development.

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[62] Alice Burton, Debbie I. Chang & Daniella Gratatle, *Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models* at 9 NEMOURS (2013), available at http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf.

[63] OREGON HEALTH AUTHORITY, *Oregon State Innovation Models Testing Assistance Application: Project Narrative* at 2 available at http://www.oregon.gov/oha/OHPR/SIM/docs/Grant%20Narrative.pdf.

[64] Id. at 3.

[65] Id. at 7.

[66] Id. at 8-9.

CONCLUSION

The Affordable Care Act has greatly enhanced the role of community health workers in state Medicaid plans. This has primarily occurred as states have included CHWs in the care teams described in their Health Home and State Innovation Model plans. States have yet to take advantage of the new regulation allowing CHWs and other non-licensed providers to provide preventive health services in Medicaid, but with encouragement from state CHW organizations, it is likely that states will explore this new option.

Appendix

The following preventive services have been given A or B ratings from the USPSTF:[67]

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	February 2005
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA	B	December 2013

[67] *USPSTF A and B Recommendations*. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

	testing.		
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012
Chlamydial infection screening: nonpregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008

Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005

Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past	B	December 2013

	15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.		
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling:	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide	A	April 2009

pregnant women	augmented, pregnancy-tailored counseling to those who smoke.		
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011