



# Innovative Community Health Worker Strategies: Medicaid Payment Models for Community Health Worker Home Visits

Tina Kartika



Due to mounting evidence that community health workers (CHWs) can improve health outcomes, increase access to health care, and control medical costs,<sup>1</sup> states are increasingly engaging their CHW workforce to replicate those successes at the state level. However, the policies and programs that regulate and pay for CHWs differ dramatically across states,<sup>2</sup> and states facing difficulties advancing CHW initiatives can gain insights from the experiences of other programs across the country.

The National Academy for State Health Policy (NASHP) recently updated its [State Community Health Worker Models Map](#), and is currently identifying innovative state strategies that have helped CHW initiatives meet their goals. This case study, which explores payment models for CHWs conducting home visits in Minnesota, New York, Utah, and Washington State, is the second in a series of products that highlight those CHW program strategies.

## Community Health Workers and Home Visits

Health outcomes are influenced by many factors, one of which is physical environment. Living in an unhealthy home environment can cause or exacerbate health issues. For example, exposure to lead in the home from lead paint or contaminated drinking water, “affects the brain’s ability to control impulses and process information,” which can lead to children’s underperformance in school and later in the workplace.<sup>3</sup> Exposure to dust mites, mold, and cockroaches can trigger asthma attacks.<sup>4</sup>

In addition to improving health outcomes and quality of life, addressing health hazards in the home environment can yield positive economic results. Remediating lead paint hazard in homes built before 1960 is estimated to generate \$3.5 billion of earnings, health and education savings, and quality-adjusted life year benefits for 311,000 low-income children.<sup>5</sup> Home visiting services targeting asthma are estimated to generate \$1.39 to \$5 of savings for every dollar invested.<sup>6</sup> Assessing the home environment is a critical first step to reduce these hazards, and CHWs can be trained to conduct healthy home assessments,<sup>7</sup> educate, and connect patients to resources during home visits.<sup>8</sup>

## Payment Models

Low-income households are more likely to live in unhealthy homes with significant lead-based paint hazards and indoor allergens.<sup>9</sup> Although Medicaid covers many low-income children and adults,<sup>10</sup> few state Medicaid programs directly reimburse CHWs to provide in-home services that address healthy home environments. The following are examples of payment models used by several states to finance home-based preventive services provided by CHWs:

- **Medical expenditure:** In **Minnesota**, home-based preventive services provided by CHWs can be [reimbursed](#) under Medicaid as long as the services qualify as diagnostic-related patient education and the CHWs work under the supervision of a licensed medical professional. Beneficiaries can receive up to 12 hours of these services each month.
- **Administrative expenditure:** Some accountable care organizations (ACOs) in **Utah** are covering the costs of home-based preventive services through administrative payments.<sup>11</sup> According to a [National Center for Healthy Housing case study](#), Medicaid managed care organizations (MCOs) in **New York** can also choose to provide home-based asthma services and bill the services as administrative expenses.
- **Incentive payment:** Under the authority of [1115 waivers](#), 12 states have implemented [Delivery System Reform Incentive Payment](#) (DSRIP) programs that “restructure Medicaid funding into a pay-for-performance arrangement in which providers earn incentive payments outside of capitation rates for meeting certain metrics or milestones based on state-specific needs and goals.”<sup>12</sup> [New York’s](#) and [Washington’s](#) DSRIP programs in particular include projects that incentivize participating provider entities to provide CHW home visits to their members.
  - In **New York**, 8 out of 25 participating [Performing Provider Systems](#) (PPSs) have implemented a project that expands asthma home-based self-management programs and includes home environment assessment, remediation, and education. During a meeting in February 2017, five of those eight PPSs [reported](#) engaging CHWs to meet the goals of the project.<sup>13</sup>
  - Similarly, **Washington’s** [Accountable Communities of Health](#) (ACHs) can choose to implement a DSRIP project on chronic disease prevention and control and pay CHWs to conduct home visits for asthma services using DSRIP funding.

## Takeaways

Minnesota, New York, Utah, and Washington provide examples of using Medicaid dollars to finance CHW home-based services. States can enable providers to bill certain CHW home visits as medical expenses, encourage MCOs to cover these services as administrative expenses, and use incentive payments to fund these services. States seeking sustainable CHW programs can explore these models to determine what fits their needs and goals.

## Endnotes

1. Sarah Redding et al., “Pathways Community Care Coordination in Low Birth Weight Prevention,” *Maternal and Child Health Journal* 19, no. 3 (2015): 643–650. <http://doi.org/10.1007/s10995-014-1554-4>; Shreya Kangovi et al., “Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial,” *JAMA Internal Medicine* 174, no. 4 (2014):535-543, <http://doi.org/10.1001/jamainternmed.2013.14327>; Donald Fedder et al., “The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension,” *Ethnicity & Disease* 13, no. 1 (2003):22-7, <http://doi.org/10.1089/heq.2017.0001>.
2. While many states adopt or modify the American Public Health Association’s definition of CHWs, some states use other definitions. For the purposes of this series, NASHP follows states’ definitions. Please visit <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities> for APHA’s definition.
3. Pew Charitable Trusts and Robert Wood Johnson Foundation, *Ten Policies to Prevent and Respond to Childhood Lead Exposure*, August 2017, [http://www.pewtrusts.org/~media/assets/2017/08/hip\\_childhood\\_lead\\_poisoning\\_report.pdf](http://www.pewtrusts.org/~media/assets/2017/08/hip_childhood_lead_poisoning_report.pdf); Aaron Reuben, Avshalom Caspi, and Daniel W. Belsky, “Association of Childhood Blood Lead Levels With Cognitive Function and Socioeconomic Status at Age 38 Years and With IQ Change and Socioeconomic Mobility Between Childhood and Adulthood,” *JAMA* 317, 12 (2017): 1244-1251, <https://doi.org/10.1001/jama.2017.1712>.
4. “Common Asthma Triggers,” Centers for Disease Control and Prevention, last updated August 20, 2012, accessed November 15, 2017, <https://www.cdc.gov/asthma/triggers.html>.
5. Pew and RWJF, *Ten Policies*.

6. Helen Lee and Colleen McCullough, *The Effectiveness of Interventions to Address Childhood Asthma*, MDRC, August 2016, [https://www.mdrc.org/sites/default/files/2016\\_The\\_Effectiveness\\_of\\_Interventions\\_to\\_Address\\_Childhood\\_Asthma.pdf](https://www.mdrc.org/sites/default/files/2016_The_Effectiveness_of_Interventions_to_Address_Childhood_Asthma.pdf); “Asthma Home Remediation: Program Overview,” Win-Win Project: UCLA Center for Health Advancement, accessed November 15, 2017, <https://insight.livestories.com/s/v2/asthma-home-remediation/b91e971b-eae2-4a45-986d-11233f9710ac/>.
7. An example is Healthy Housing Solutions’ training program: <http://healthyhousingsolutions.com/training-course/hha-for-chw/>.
8. “How Could a CHW Help You?” Success with CHWs: Asthma care for children, accessed November 15, 2017, <http://successwithchws.org/asthma/chws-help/>.
9. U.S. Department of Housing and Urban Development, Office of Healthy Homes and Lead Hazard Control, *American Healthy Homes Survey: Lead and Arsenic Findings*, April 2011, [https://portal.hud.gov/hudportal/documents/huddoc?id=AHHS\\_REPORT.pdf](https://portal.hud.gov/hudportal/documents/huddoc?id=AHHS_REPORT.pdf); Tyra Bryant-Stephens, “Asthma Disparities in Urban Environments,” *The Journal of Allergy and Clinical Immunology* 123, no. 6 (June 2009): 1199-1206, <http://dx.doi.org/10.1016/j.jaci.2009.04.030>.
10. Kaiser Family Foundation, *Medicaid Pocket Primer*, last updated June 2017, <http://files.kff.org/attachment/Fact-Sheet-Medicaid-Pocket-Primer>.
11. Personal communication with Anna Guymon, CHW Specialist at Utah Department of Health.
12. Tina Kartika and Jill Rosenthal, “Using DSRIP to Improve Population Health,” National Academy for State Health Policy, May 1, 2017, <http://www.nashp.org/using-dsrp-to-improve-population-health/>.
13. PPSs that reported using CHWs in their asthma projects: Alliance for Better Health Care, Suffolk Care Collaborative, OneCity, Bronx Health Access, and Bronx Partners for Healthy Communities. PPSs that did not report using CHWs in their asthma projects at the mid-point assessment meeting but indicated their intent to include CHWs in their project plans: Community Care of Brooklyn, NY Presbyterian-Queens, and Brooklyn Bridges (NYU Lutheran) PPS.

**Acknowledgement:**

The author thanks Anna Guymon, the New York State DSRIP Team, Jill Rosenthal, and Amy Clary for their helpful comments and contribution to this case study. This case study was made possible with funding from the National Center for Healthy Housing, supported through a grant from the W.K. Kellogg Foundation. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the National Center for Healthy Housing or the W.K. Kellogg Foundation.

**About the National Academy for State Health Policy:**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).