CHW Toolkit

SUMMARY OF REGULATORY AND PAYMENT PROCESSES

MDH Minnesota Department *of* Health
OFFICE OF RURAL HEALTH AND PRIMARY CARE
EMERGING PROFESSIONS PROGRAM

health reform MINNESOTA
A Better State of Health

Minnesota Department of Human Services

CHW Toolkit: Summary of Payment and Regulatory Processes

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Background

This report summarizes the payment and regulatory processes for Community Health Workers (CHWs). A key goal of this report is to provide practical, step-by-step guidance on navigating the payment processes for Medicaid reimbursement. Therefore, while there are numerous funding sources to support CHW payment, this report details the reimbursement process for CHWs working under Minnesota Health Care Programs administered by the Minnesota Department of Human Services.

While the primary focus is on Minnesota State laws, regulations, and administrative policies, some information is provided about relevant federal law, including changes enacted through the Affordable Care Act.

For Minnesota payment and regulatory purposes, the following definitions are helpful in understanding who is a CHW in Minnesota.

Minnesota Department of Human Services

A community health worker (CHW) is a trained health educator who works with MHCP [Minnesota Health Care Programs] *recipients who may have difficulty understanding providers due to cultural or language barriers. CHWs extend the reach of providers into underserved communities, reducing health disparities, enhancing provider communication, and improving health outcomes and overall quality measures. Working in conjunction with primary care providers, CHWs can bridge gaps in communication and instill lasting health knowledge.*[1]

U.S. Bureau of Labor Statistics

Community Health Workers (BLS Job Code 21-1094) *assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.*[2]

Methods

Information on current laws, regulations and policies was collected primarily from the Minnesota State legislature and the Minnesota Department of Human Services. Definitions of legal terms used in this report are found in **Appendix 1**.

Following compilation, the report was reviewed by experienced practitioners for clarity.

Legal Framework

The Healthcare Education-Industry Partnership (now HealthForce Minnesota) was funded by the Minnesota Legislature in 1998 under the Minnesota State Colleges and Universities (MnSCU) system. In the early 2000's, as a proposed means to address health disparities, HEIP began to examine the role of CHWs through a Minnesota Community Health Worker Project (MCHWP). MCHWP brought together 21 healthcare industry, university, and non-profit organizations to examine processes for developing a sustainable CHW profession.[3] Based on outcomes from this project:

- In 2005, Minnesota became the first state to implement a standardized CHW curriculum through MnSCU and private higher education institutions; and,
- In 2007, the Minnesota Legislature approved the direct Medicaid reimbursement of specific CHW services.

The provisions of the bill (HF 1078, Subdivision 49) are codified under the following statutes:

> Minnesota Statutes 256B.0625, subd. 49 (Community health worker)
> Minnesota Statutes 245.462, subd. 18 (Mental health professional)
> Minnesota Statutes 245.4871, subd. 27 (Mental health professional)

In summary, the statutes provide for medical assistance reimbursement of "care coordination and patient education services provided by a CHW" when the following conditions are met:

- The CHW has completed a qualified certificate program using the MnSCU-approved CHW curriculum.
- The CHW is working under the supervision of a qualified health provider

At the time of the legislation, CHWs who had at least five years of experience as a CHW working under a qualified health provider were "grandfathered" in and could be eligible for reimbursement if they completed the certificate program by January 1, 2010. This provision is no longer applicable.

In 2010, Minnesota received approval from the Centers for Medicaid and Medicare Services for a State Plan Amendment proposing coverage of diagnostic-related patient education services delivered by CHW certificate holders. The SPA does not include approval for CHW provision of care coordination.

Medical Assistance/MinnesotaCare Reimbursement

This section lays out the key requirements and processes for CHW reimbursement under Medical Assistance (Medicaid) and MinnesotaCare. Most Medical Assistance and all new MinnesotaCare recipients must enroll for coverage through managed care organizations (MCO). MCOs are required to provide the same benefits or better as the fee-for-service Medical

Assistance/MinnesotaCare; PMAP are required to pay for CHW services. This section focuses on CHW reimbursement via the fee-for-service (FFS) mechanism through DHS.

Please note that requirements are subject to change. Full and updated information on these FFS requirements for CHWs can be found in the ***MHCP Provider Manual for Community Health Workers*** on the DHS website[4] at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140357.

Minnesota medical programs that are eligible for CHW services currently include:

- Medical Assistance
- Minnesota Care

The key steps in the reimbursement process are:

- EDUCATION – CHW completes certificate program
- EMPLOYMENT – CHW employed by MHCP-eligible provider
- ENROLLMENT – CHW becomes an MHCP-enrolled provider with DHS
- SUPERVISION – CHW supervision is done by an MHCP-enrolled provider
- SERVICE PROVISION – A MHCP-enrolled provider (or registered nurse working under an enrolled provider) orders approved CHW services for patient/client, the CHW provides them as prescribed
- DOCUMENTATION – CHW services rendered are documented per DHS requirements
- CLAIM - Reimbursement claims submitted to DHS or health plan

The sections below provide specific policies and procedures for these processes.

Education Requirements for CHW

Originally developed in 2005, completion of the MnSCU-approved Minnesota CHW certificate program is required for CHWs to be reimbursed by Medicaid through the Minnesota Department of Human Services (Minnesota Statute 256B.0625 Subdivision 49). Minnesota is currently the only state that offers a standardized CHW certificate program through accredited post-secondary educational institutions.

During 2015/2016, the curriculum has been undergoing some revisions to reflect a stronger focus on pre-diabetes, pre-hypertension and behavioral health information as well as strengthening existing materials. Currently, the program requires completion of 14 credits covering the following content:[5]

- CHW Role, Advocacy and Outreach (2 credits)
- Organization and Resources (1 credit)
- Teaching and Capacity Building (2 credits)
- Legal and Ethical Responsibilities (1 credit)
- Coordination, Documenting and Reporting (1 credit)
- Communication and Cultural Competence (2 credits)

- Health Promotion Competencies (3 credits; includes healthy lifestyles, heart disease and stroke, maternal/child/teen health, diabetes, cancer, oral health, mental health)
- Internship (2 credits; 72-80 hours supervised practical experience)

Institutions offering the program typically require 16-17 credits, with additional course offerings in areas such as public speaking, medical terminology, and others. In part, the additional credits allow students to reach the financial aid threshold. Most programs can be completed over two semesters. Table 1 provides an overview of the institutions currently offering the course.

TABLE 1. POST-SECONDARY INSTITUTIONS OFFERING CHW CERTIFICATE COURSE

Institution / Website	Location (in MN)	Program Duration	Mode of Instruction
Minneapolis Community & Technical College (MCTC)	Minneapolis	17 credits (Fall or Spring/ Summer semesters)	In-person
Minnesota West Waiting for approval from MnSCU, possibly Summer 2016	Marshall	16 credits	Online or hybrid
Normandale Community College	Bloomington	16 credits / 2 semesters	In-person, Online in future
Northwest Technical College	Bemidji	17 credits / 2 semesters (Fall or Spring start)	Online, offsite (virtual meetings)
Rochester Community & Technical College (RCTC)	Rochester	16-17 credits/ 1 semester	In-person, customized contract only
Summit Academy OIC	St. Paul	20 weeks	In-person
St. Catherine University	St. Paul	17 credits (2 semesters)	In-person or hybrid evening/ weekend

*Financial aid is available for qualifying students at all institutions.

Enrollment of CHW with DHS

Once a CHW has completed the certificate course and is employed by a MHCP-eligible provider, they can be enrolled as a provider with DHS. (Note: MCOs also require that CHWs are enrolled with DHS for claims submitted to health plans. Further clarification around any additional credentialing requirements can be obtained from each health plan.) The process for enrolling a CHW is slated to take 30 days, but can take up to 6 months. It is helpful to follow up with DHS if approval is not received after 30 days. For assistance, contact the MHCP Provider Call Center and select option 3 for "CHW Technical Assistance." (Note: this is not the same as the MHCP Member Help Desk.)

Along with a copy of the CHW certificate, the CHW must complete and submit the following forms via fax (#651-431-7462) to enroll with DHS:

- MHCP Provider Agreement – DHS 4138

- MHCP Enrollment Application – DHS 4016
- MHCP Applicant Assurance Statement – DHS 5308

If a CHW is enrolled already, but needs to submit any change of address or change/add an employer/affiliation (e.g. contracted agency, dentist, APRN, PHN, mental health professional), they must submit the form below:

- Individual Practitioner MHCP Provider Information Change Form – DHS 3535

Note that the NPI (National Provider Identification) number is issued to healthcare providers by the Centers for Medicare and Medicaid Services (CMS). The UMPI (Unique Minnesota Provider Identifier) number is issued by MHCP to providers who do not qualify for a NPI (e.g. CHWs). When DHS approves first-time enrollment for the CHW, they will return a UMPI with the approval notice.

Supervision by Enrolled Provider

All CHW services must be ordered by MHCP-enrolled providers who practice in the following categories:

- Physician
- Dentist
- Advanced Practice Registered Nurse (APRN)
- Certified Public Health Nurse (PHN) – must operate under a city, county, tribe or school district
- Mental health professional

Additional categories of healthcare employees operating under enrolled providers are currently under consideration, but not yet approved.

A RN working for a MHCP-enrolled provider may supervise CHWs. The supervising RN's NPI would not appear on the billing documents (see Billing/Claims section below).

Current law around mental health supervising providers can be found under Minnesota Statutes section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5).

Eligible CHW Services

Broadly, CHW services that qualify for reimbursement must meet the following requirements:

- A MHCP enrolled provider (from the list above) must order the patient education services
- The MHCP enrolled provider must specify that the services are to be provided by a CHW
- The patients for whom the services are ordered must be MA or Minnesota Care recipients
- The services must be provided **in person** by the CHW

- The services must be provided to an individual or a group with no more than 8 persons. Currently DHS has approved group sizes up to 15 people if the following criteria are met: 1) the CHW is certified as a life coach, and/or, 2) the CHW is a certified provider of the Diabetes Prevention Program. Consult with DHS to obtain approval for other group education programs and to obtain the appropriate billing/service code for groups larger than 8 persons.
- The services must be provided in an "outpatient, home, clinic or other community setting"
- The "content of the patient education…is consistent with established or recognized health or dental health care standards. Modifications can be made for cultural, clinical and health literacy needs.
- The patient education involves some aspect of self-management in coordination with a health care team.

Reimbursement requires a diagnosis; however, DHS does not limit the diagnosis codes that can be used related to CHW services.

Eligible services encompass physical, oral and mental health.

Services that are specifically **not** approved for reimbursement include case management, advocacy and enrollment assistance.

Documentation of CHW Services

CHW services are reimbursed in increments of 30 minutes and therefore orders must follow a similar logic.

Service order documentation in the patient record must include:

- Signature of a MHCP-enrolled physician, APRN, dentist, mental health professional or non-enrolled registered nurse or public health nurse working for an enrolled organization.
- Number of units (30-minute increments)
- Individual or group services specification, to be provided by a CHW

Other items required in the patient record includes:

- Date of service
- Start and end time of service
- Number of patients present
- Session content (i.e. patient education plan or training program)
- CHW signature and printed name
- Documentation of periodic (at least monthly) assessment of the recipient's progress and need for ongoing CHW services

Billing/Claims

CHW reimbursement requests require submission through MN-ITS using 837P. MHCP's Billing Policy provides general guidance while the MHCP MN-ITS User Manual provides step-by-step instructions for submitting claims through MN-ITS. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), under their current global payment models, cannot bill MA fee-for-service separately for CHW services. However, FQHC/RHC can submit a Change in Scope application if CHW costs are not included in the base encounter rate and they have hired CHWs. Upon review, DHS could determine that there is a net *increase* or *decrease* in cost, so FQHC/RHC should determine in advance if a Change in Scope application would be beneficial to their bottom line.

For the purposes of reimbursement, the following definitions are helpful:[6]

- The CHW who provided the services is the **Rendering Provider**. Use the CHW UMPI as the rendering provider number.
- The MHCP enrolled provider who assigned the CHW to provide services is the **Ordering Provider**.
- The NPI number of the hospital, clinic, physician, APRN, PHN's organization or mental health professional should be used as the **Billing Provider**. (See full list of eligible billing providers below.)

Also note the following instructions:

- Bill separate lines for each day services are provided
- Include only one calendar month of service per claim
- Enter diagnosis
- Documentation must support the number of units billed. Instructions for Electronic Claim Attachments can be located here.

Billing questions can be referred to the MHCP Provider Call Center.

If the patient is covered under a managed care organization, please contact the MCO directly to determine requirements and procedures. Note that MCOs are required to cover CHW patient education services for their Medical Assistance and MinnesotaCare members, but have leeway to set parameters such as only contracting with selected providers and setting different payment rates.

Eligible billing providers

Eligible billing providers are those on the list below:

- Advance practice registered nurse (APRN)
- Clinic
- Community health clinic
- Critical access hospital
- Dentist
- Family planning agency

- Federally qualified health centers (FQHC)
- Hospital
- Indian health service (IHS) facility
- Mental health professionals
- Physician
- Public health nurse clinic
- Rural health clinics (RHC)
- Tribal health facility

Billing Units

CHW services can be billed in 30-minute units. Currently, restrictions on billing units include:

- Limit of 4 units per 24 hours (e.g. maximum 2 hours)
- No more than 24 units per calendar month per recipient (note that this is an increase from the previous 8 units per calendar month)

Billing Codes and Rates

The procedure codes in Table 2 should be used when submitting claims. (Note: revisions to this list are under consideration but not yet approved).

Rates are subject to change and the MHCP Enrolled Providers Fee Schedule includes the most recent rates. Look up the rates by Service Code.

TABLE 2. MHCP SERVICE CODES AND RATES FOR CHWS

Service Code	Purpose	Delivery Mode	Number of Patients	Rates per unit (as of 4/16)
98960	Self-management education & training	Face-to-face	1	$19.94
98961	Self-management education & training	Face-to-face	2-4	$9.59
98962	Self-management education & training	Face-to-face	5-8	$6.81

For service codes for patient groups larger than 8, please contact the MHCP Provider Call Center. (See *Eligible CHW Services* section for more information.)

Other Payment Options

Many institutions are interested in providing CHW services to individuals who are not on MHCP (e.g. commercially insured, uninsured). Similarly, organizations who serve MHCP clients but are not MHCP eligible providers must seek other payment methods. Alternative payment models include:

- **Government agency and charitable foundation grants and contracts:** This model is the most common form of compensation arrangement in the US. Under this model, government and charitable funds are allocated to CHW employers (e.g., community-

based organizations, community clinics) to pay CHW salaries or administer CHW programs. For example, this could include the CMS Statewide Innovation Model awards.

- **Private insurance:** Under this model, CHWs' positions are financed by an insurance program or company. Additionally, some managed care organizations are considering reimbursement for CHW services. As billing requirements vary, each MCO should be contacted individually about rates and procedures. One example is that Michigan requires its MCOs to have 1 CHW per 20,000 enrollees.[7]
- **State and local general funds:** Under this model, federal, state or local governments can employ or reimburse CHW services directly. Government general funds are often used to provide support for a variety of programs that may not be supported by other funding mechanisms. States may provide dedicated line item budgets for CHW programs that include CHW salaries or services.[3,8-9]
- **Private sector organizations:** Under this model, CHWs can be either directly employed by private organizations such as health plans and hospitals or indirectly through a contract with clinics or community-based organizations.[3] In Minnesota, health plans and larger health systems have used administrative funds to implement this model. Some hospitals are directing their community benefit funds to support CHW programs.

Other models where CHW services can be reimbursed include:

- **Patient-Centered Medical Homes/Health Care Home**. Under Health Care Homes (HCH) in Minnesota, CHWs can provide services to MHCP-enrolled patients as part of the care coordination team. Institutions must first be certified as Health Care Homes or Behavioral Health Care Homes by the Minnesota Department of Health and maintain a current list of eligible providers. (See the MDH Health Care Homes website for more information.) Under this model, institutions can obtain reimbursement for care coordination services provided to MHCP-enrolled patients on a per member per month basis, with provisions for complexity and mental health or language issues. In addition, CHW patient education services provided to MHCP fee-for-service patients can be billed for separately, under the mechanism described above. For more information on the HCH requirements and procedures, please see the MHCP Provider Manual for Health Care Homes.
- **Accountable Care Organizations**. In 2011, the U.S. Department of Health and Human Services created the structure for ACOs as part of new rules related to the Affordable Care Act (ACA). The goal was to improve the *triple aim*, especially for high-utilizer patients, through care coordination. ACOs can use traditional fee-for-service payment with both private and public insurers, but CMS rules also require shared savings agreements conditional on meeting specified quality measures. The ACO model creates an incentive for providers to efficiently and effectively manage the health of their patients regardless of where the patient received care. Innovation lies in the flexibility of their structure, payments and risk assumption. That structure is likely to include primary care providers, specialists, a hospital and other provider and community agreements/partnerships. When an ACO succeeds both at delivering high-quality care and spending dollars more wisely the ACO will share in the savings it achieves. In Minnesota, ACOs share in savings (starting their first year) and losses (starting their second year). Utilizing CHWs can improve health outcomes and reduce the cost of care per patient, which would allow the ACO to use some of the shared savings to pay for the CHW services.

Affordable Care Act

On June 29, 2005, the **Patient Navigator Outreach and Chronic Disease Prevention Act (PL 109-18)** was signed into law paving the way for the emerging profession of Community Health Worker. The measure provided $25 million for patient navigator services through community health centers over a period of 5 years (US Department of Health and Human Services, 2005). The law required that facilities receiving the grant agree to recruit, train, and employ patient navigators with direct knowledge of the communities they serve to provide healthcare services to individuals (PL 109-18, 2005).

The Patient Navigator Outreach and Chronic Disease Prevention Act was reauthorized under the Patient Protection and Affordable Care Act in 2010. **The Patient Protection and Affordable Care Act (ACA) of 2010** also contains elements that have provided more funding opportunities for community health centers and increased the number of CHWs and the number of people they serve in the US. (These laws coincided with creation of an occupation code for CHWs in 2009 and official recognition of the CHWs role via their own Standard Occupational Classification (SOC#21-1094) in 2010 by the Department of Labor, Bureau of Labor Statistics.)

According to Katzen & Morgan (2014),[10] three main ACA changes led to new community-based service options: 1) The ACA provides increased healthcare access through affordable health insurance. Recent Medicaid Essential Health Benefits rules clarify that state Medicaid programs may reimburse non-licensed providers (i.e., CHWs) for preventive services; 2) The ACA focuses on establishing a medical home for beneficiaries with chronic diseases, which gives states the flexibility in determining a range of eligible health home providers; and 3) The ACA establishes funding for the State Innovation Models (SIM) Initiative through the Center for Medicare & Medicaid Innovation (CMMI), which provides $275 million in funding for states to develop and test state-based models for multi-payer healthcare payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. The SIM design and test awards offer a significant opportunity to increase the use of CHWs and better integrate them into healthcare delivery system. According to CMMI's guidance, the focus of the SIM Initiative is improving population health outcomes and reducing the cost of Medicare, Medicaid and Children's Health Insurance Program (CHIP). Round One was awarded to 6 states (Oregon, Vermont, Massachusetts, Arkansas, Minnesota and Maine), of which 4 have included CHWs in their models (Oregon, Arkansas, Minnesota and Maine) (Katzen & Morgan, 2014, p.2; Centers for Medicare & Medicaid Services, 2015). Currently, 38 state awardees have some type of SIM award.

TABLE 3. FEDERAL LAWS RELATED TO CHWS

Law	Citation	Year	Summary
Patient Navigator Outreach and Chronic Disease Prevention Act	PL 109-18	2005	
The Patient Protection and Affordable Care Act (ACA)		2010	Reauthorized the Patient Navigator Outreach and Chronic Disease Prevention Act; Provided for changes

Law	Citation	Year	Summary
			to Medicaid Essential Health Benefit rules allowing reimbursement of non-licensed providers; supported use of CHWs through focus on medical homes and establishment of State Innovation Model funding
	Section 5313		Requires the Centers for Disease Control and Prevention to award grants to eligible entities to promote positive health outcomes for underserved populations through the use of CHWs.
	US Department of Health and Human Services, 2013, p.1	2013	Revisions to ACA to give more flexibility to states to recognize unlicensed providers in the delivery of preventive services.

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Appendix 1

Legal Terms

A number of legal terms are used in this report. A detailed summary of legal definitions is found on the Minnesota State Legislature's website. For purposes of clarity, some terms are summarized briefly below.

TABLE 1. LIST OF LEGAL TERMS AND DEFINITIONS

Term	Definition
Law	Broadly, the law is a system of regulations that govern conduct. In Minnesota, "a law is an idea, placed in bill form that has passed both the House of Representatives and the Senate and has not been vetoed by the Governor."
Act	In Minnesota, an act is "the official name for a bill that has been enrolled for presentation to the Governor." This statutory plan passed by a legislative body (i.e. Congress, state legislature) typically includes the statutory language along with the basis for the statute(s) and historical information.
Statute	Federal or state written law that is enacted/codified by a legal body (i.e. Congress, state legislature). In Minnesota, statutes are published every two years as "Minnesota Statutes" by the Revisor of Statutes Office. A supplement is printed every year.
Regulation / Rule	Regulations are the standards adopted as rules from legislative acts. As such, they are legally binding. The term regulation is often used interchangeably with rule. In Minnesota, the legislature gives authority to State offices/agencies to develop legally binding "operating principles or orders," otherwise known as "administrative rules"