United Methodist HealthMinistryFund

To: Sarah Fertig, Medicaid Director, Kansas Department of Health and Environment

From: David Jordan, President and CEO, United Methodist Health Ministry Fund

Date: April 17, 2023

RE: Proposed Community Health Worker State Plan Amendment

Thank you for the opportunity to provide comments regarding the Kansas Department of Health and Environment's (KDHE) proposed Community Health Worker (CHW) State Plan Amendment (SPA). I would also like to thank the department for their partnership and ongoing commitment to working to advance and sustain the CHW profession in Kansas.

While I appreciate the spirit of the state's proposed SPA and its leadership on CHWs, I have several technical comments as well as comments focused on implementation, including:

- **Recommended technical changes:**
  - **Broaden the list of supervising practitioners** to include community-based organizations and dentists.
  - Revise the certification language to **recognize the existing certification** established by the Kansas CHW Coalition in partnership with the KDHE.
  - Recognize the **various job titles** for CHWs.
  - Authorize **services to be provided remotely**.

- **Recommendations for implementation:**
  - Include key stakeholders in developing **implementation guidance**.
  - Utilize payment codes that reflect CHWs' scope of practice and covered services included in the SPA.
  - Ensure adequate payment rates to **support employers' utilization of CHWs and ability to provide a living wage** to CHWs.
  - Work with key stakeholders over time to **evaluate the implementation of the SPA** and make adjustments to guidance, as needed, to encourage broad uptake across Kansas.

Our comments are driven by the distinct and valuable role CHWs can and do play in helping patients, especially KanCare enrollees, achieve improved health and better access to services. As you know, CHWs are community members trained to work with the local health care and social services systems to bridge the gap between these systems and their clients. CHWs are also referred to as: health navigator, promotor(a), advocate, and educator.

Their work ensures clients receive access to needed health, social and community services. Unlike many members of the health care team, CHWs are often seen beyond the walls of health care facilities, working in the community, and even making house calls. CHWs can serve as the eyes and ears of the health care team.

CHWs are predominately female and persons of color, who share ethnicity, diagnosis, socio-economic status and geography with the marginalized communities they serve. CHWs are disproportionately affected by inequities, often experiencing many of the same barriers to health and healthcare. As a result, CHWs are unique stakeholders where evidence of effectiveness in improving health outcomes has been demonstrated nationally. Additionally, CHWs address structural racism and effectiveness in health services delivery and represent both provider and patient/community members' voices.

As culturally competent providers, CHWs play a critical role in helping underserved patients, including those enrolled in KanCare, navigate our fragmented health care delivery system. The role and work of CHWs is foundational to helping underserved Kansans improve their health**. It is an important role that needs to be sustained, which is why it is critical for KDHE to have a strong payment policy to finance and sustain these services for KanCare patients.**

In particular, it is critical to provide adequate reimbursement to CHWs to ensure that it is financially viable to employ CHWs and to adequately compensate CHWs, who as noted are affected by the same inequities as the population they serve.

A strong payment policy, informed by other states' approaches, could help improve the health of KanCare enrollees and should be seen as an opportunity to build the health care workforce of the future. With that in mind, please find comments on the SPA below.

Recommended Technical Changes:

1. **Supervision.** Many CHWs are supervised by provider types not listed in the SPA, including community-based organizations (CBOs) or dental providers. Without explicitly allowing supervision of other provider types and encouraging partnership with CBOs, Kansas is excluding a significant portion of the CHW workforce from serving Kansas Medicaid clients.

Recommendation: Include CBOs and dental providers in partnership with licensed practitioners as supervising provider types.

2. **Certification.** The language in the draft SPA is "A community health worker (CHW) is an individual certified in the State of Kansas to provide services within the scope of the certification program." The language, as crafted, is problematic as it could imply a state-run certification rather than the state recognized certification program that is managed by the Kansas Community Health Worker Coalition.

Recommendation: Modify language regarding certification to read "To provide services in Kansas Medicaid, a CHW must maintain a certification through the Kansas Community Health Worker Coalition. A CHW may perform duties under a variety of titles including promotores or community health representative."

3. **Coverage for different job titles used for CHWs.** As previously noted, CHWs have a variety of titles such as promotores or community health representatives. The KCHWC certification is open to the variety of job titles, which should be the basis for certification in Kansas Medicaid.

Recommendation: Adopt the language in number 3 to ensure the CHWs operating under a variety of titles can participate in Kansas Medicaid.

4. **Services provided via telehealth and telephone.** The SPA states that services may be provided "in the community, in a clinic setting, individually or in a group." While KDHE deserves credit for authorizing services to be provided in the community, I also recommend CHWs be authorized to provide services under general supervision and remotely through tele-health or via telephone.

Recommendation: Modify the language to "These services may be provided under general supervision, and in the community, in a clinic setting, individually or in a group. Services may also be provided face-to-face, via telemedicine, or via two-way audio-only when beneficiaries do not have access to audio/visual telemedicine technology."

Over the last four years, the Health Fund has worked with KDHE and other partners on CHW credentialing and payment policy. Our hope is that we can continue to partner with KDHE to ensure the benefits of CHWs are able to be fully realized because strong policy and training is developed to advance and sustain the profession in Kansas. With that in mind, below please find **recommendations for implementation and rollout of CHWs in Kansas.**

1. **Collaboratively develop CHW provider manual, guidance and training for providers.** Policies are always better implemented in partnership with those directly involved, which is why it is recommended that KDHE partner with CHWs, community-based organizations, provider/employers, and philanthropy to develop key implementation tools – provider manual, technical guidance for providers, and trainings for providers. CHWS are unique providers and a collaborative, comprehensive approach to implementation is needed to ensure CHWs can be effectively integrated into clinical settings and their role can support clinical care teams in meeting the Department of Health Care Finance's goal to identify and address social drivers of health and improve health outcomes broadly for Medicaid clients.

2. **Reimbursement for CHW Services.** The proposed SPA does not list CPT codes that will be used for reimbursement. CHWs' proven effectiveness is grounded in a scope of practice integral to addressing social drivers of health, filling gaps in the clinical care team, supporting upstream investments in health care delivery, and promoting improved health outcomes. The procedure codes authorized for CHWs can either honor or restrict the CHW scope of practice. When the CHW scope of practice is limited, as in the cases of Minnesota and Indiana Medicaid which limited to health education only (CPT codes 98960, 98961, 98962), experience tells us there is very little take-up among

Medicaid providers. This is likely because health education is only a small portion of the CHW Scope of Practice and clinical providers are not able to leverage their skillset adequately with limited allowable procedure codes billable to their time. Without broad take up, clinical care teams are unable to fill gaps in the care team to adequately identify and address social drivers of health and meet quality goals.

As the State develops the underlying guidance, we recommend Kansas Medicaid considers adopting procedure codes that allow CHWs to **deploy the broader scope of services proposed in the SPA.**

3. **Support Fair and Sustainable Payment Rates.** As previously noted, how employers/providers are reimbursed for CHW services is going to impact the ability of providers to utilize CHWs. The payment rates will also impact how much CHWs will earn. Recognizing that the workforce is made up of people who predominately reflect the populations they serve, it is critical that payment allows for fair compensation of CHWs so that this profession is not perpetuating the inequities the profession aims to address.

Without seeing Kansas' proposed reimbursement strategy, it is important to recognize that Medicaid is a critical sustainable funding stream for the CHW workforce. Without adequate Medicaid payment rates, it will be challenging for employers to fully integrate CHWs into clinical care teams and support a living wage for CHWs.

To help inform decision making on rates, below are examples of payment rates among states for services provided by CHWs:

i. Minnesota pays the following in 30-minute increments:
    1. $21.56: CPT code 98960
    2. $10.41: CPT code 98961
    3. $7.43: CPT Code 98962[1]
ii. South Dakota pays the following in 30-minute increments:
    1. $30.89: CPT code 98960
    2. $15.45: CPT code 98961
    3. $10.81: CPT code 98962[2]
iii. California pays the following in 30-minute increments:
    1. $26.66: CPT code 98960
    2. $12.66: CPT code 98961
    3. $9.46: COT code 98962[3]
iv. Rhode Island pays the following in 15-minute increments:
    1. $15.76 for new patient: HCPCS code T1016-US
    2. $12.12 for an established patient: HCPCS code T1016
    3. $4.44 in group setting: HCPCS T1016-HQ[4]

[1] https://mn.gov/dhs/assets/mhcp-fee-schedule_tcm1053-294225.pdf
[2] https://dss.sd.gov/docs/medicaid/providers/feeschedules/Other_Services/Community_Health_Worker_Agencies_latest.pdf
[3] https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31781_01.aspx
[4] https://providersearch.riproviderportal.org/ProviderSearchEOHHS/FFSFeeSchedule.aspx

4. **Ongoing evaluation.** As noted above, collaboration is key to successful implementation of any policy. To ensure the policy is being implemented properly, I would recommend that the state partner with philanthropy and stakeholders' development of an ongoing evaluation to better understand the impact of the policy and implementation plan, and, most importantly, to partner to address these challenges through policy fixes and updated guidance and training.

Again, many thanks for the opportunity to partner on the development of the CHW profession in Kansas and for the opportunity to submit comments today. I look forward to continuing to partner with you on improvements to the policy and on implementation.

Sincerely,

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