Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

January 6. 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peña-Melnyk
Chair, House Health & Government Operations Committee
Rm 241, House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 290 - Public Health – Dental Services – *Access* (Chapter 377 of the Acts of 2023), Study on Providing Reimbursement for Services Provided by a Certified Community Health Worker (MSAR# 14986)

Dear Chairs Beidle and Peña-Melnyk:

Pursuant to the requirements of House Bill (HB) 290, *Public Health – Dental Services – Access* (Chapter 377 of the Acts of 2023), the Maryland Department of Health (the Department) respectfully submits this study related to providing reimbursement for services provided to a Maryland Medical Assistance Program (Medical Assistance) participant by a community health worker (CHW) certified under § 13–3706 of the Health – General Article.

If further information is needed please contact Sarah Case-Herron, Director, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

Enclosure

cc: Erin McMullen, Chief of Staff
Ryan Moran, Deputy Secretary, Health Care Financing & Medicaid Director
Tricia Roddy, Deputy Medicaid Director
Alyssa Brown, Director of Innovation, Research, and Development
Sandra Kick, Director of Medical Benefits Management
Sarah Case-Herron, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Study on Providing Reimbursement for Services Provided by a Certified Community Health Worker

Pursuant to House Bill 290/Ch. 377 of the Acts of 2023

December 2024

Introduction

House Bill (HB) 290, *Public Health – Dental Services – Access* (Chapter 377 of the Acts of 2023), required the Maryland Department of Health (the Department) to conduct a study related to providing reimbursement for services provided to Maryland Medical Assistance Program (Medical Assistance) participants by a community health worker (CHW) certified under § 13–3706 of the Health-General Article. The bill specifically requires assessing reimbursement associated with assisting Medical Assistance participants in accessing dental services. However, the value and scope of CHW services extend beyond their ability to connect individuals to needed dental services. In addition, based on a review of CHW reimbursement in other states, the Department found that most states do not limit reimbursement for CHWs to referrals for one category of services. As such, this report analyzes the impact of reimbursing CHWs for their entire scope of services as they relate to the Medical Assistance program.

A CHW is a trusted member of the community who can serve as a liaison to, link to, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self‑sufficiency through a range of activities such as outreach, community education, the provision of information to support individuals in the community, social support, and advocacy. CHWs aim to improve person-level health by augmenting traditional medical care through these various linkages and care management. Given their close ties in the community and knowledge of a wide breadth of resources, CHWs may directly impact social determinants of health (SDOH). By connecting people to social supports such as tenancy assistance, nutritious meals, and transportation assistance, CHWs enable the improvement of many aspects of whole person health. While the term CHW is sometimes applied to other specially trained non-traditional health practitioners such as doulas or peer recovery specialists, this report is specifically focused on Certified Community Health Workers as defined in Maryland Code Health-General Article § 13-3701.[1]

The Department's study concludes that reimbursing certified CHWs as providers would have both operational and fiscal impacts totaling an estimated $53.0 million ($32.2 million federal funds, $20.8 million state general funds) annually for the Medical Assistance program.

Existing Care Coordination in the Maryland Medical Assistance Program

Maryland Medical Assistance and its partners, including the HealthChoice managed care organizations (MCOs), the behavioral health administrative services organization (ASO), the dental ASO, and home- and community-based (HCBS) waiver programs offer case management or care coordination for participants in various capacities.

A core purpose of the Medical Assistance HCBS waiver programs is to provide services to support older adults, individuals with disabilities, or children with chronic illnesses to live in

[1] Maryland Code, Health-General Article § 13-3701: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=13-3701&enactments=false

their communities rather than institutional settings. These programs enable case management to be consistent and tailored to the individual needs of a participant.

All MCOs are required to designate a special needs coordinator to oversee services provided to participants in the special needs populations. Case management for these populations includes assigning case managers, performing home visits, collaborating with providers, documenting plans of care, and being knowledgeable of social supports in the community that may be useful to a participant. Special needs populations are as follows:

- Children with special health care needs;
- Individuals with a physical disability;
- Individuals with a developmental disability;
- Pregnant and postpartum women;
- Individuals who are homeless;
- Individuals with HIV/AIDS; and
- Children in State-supervised care.

Enhanced case management and care coordination are also primary tenets of the MOM program, which supports pregnant and postpartum Medicaid participants who have opioid use disorder. MCOs are paid a per member per month rate to offer these services to participants. In addition, MCOs are required to provide "coordinated and continuous case management…involving the enrollee and, as appropriate, the enrollee's family, guardian, or caregiver" for defined special needs populations.[2]

Medical Assistance's Home Visiting Services (HVS) facilitate screening and care coordination needed to support healthy outcomes through pregnancy and up to a child's second or third birthday.[3] Enrolled HVS programs are paid for each home visit that is delivered to a participant. HVS in Maryland currently uses two evidence-based home visiting programs, Healthy Families America and Nurse Family Partnership. Both programs provide prenatal, postpartum, and infant home visits. Services during visits range from pregnancy and parenting education, screening for substance use disorders, establishing primary care connections and access to resources.

Medical Assistance's behavioral health ASO, in conjunction with the MCOs, provides care coordination to individuals to reduce avoidable utilization of high-intensity services, coordinate referrals, and promote participant understanding of the care they receive. Care coordination supports high-risk pregnancy populations, those who are court-ordered from State facilities, and individuals with long-term service and support needs. Through this coordination, the behavioral health ASO and MCOs establish critical communication with other partners and are able to evaluate treatment effectiveness.

Medical Assistance's dental ASO also provides outreach coordination for participants, which includes help making an appointment, explaining any questions about benefits, help navigating

[2] COMAR 10.76.04.04: https://dsd.maryland.gov/regulations/Pages/10.67.04.04.aspx
[3]Medicaid Home Visiting Services Program Manual
https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/HVS/Medicaid%20Home%20Visiting%20Services%20Program%20Manual_8.2.24.pdf

the HealthySmiles website, and help with other special needs.[4] Other Medicaid programs such as Assistance in Community Integration Services (ACIS) connect participants with social services, such as housing. ACIS provides housing and tenancy-based case management services to qualifying Medicaid participants who are at risk for, or are currently experiencing, homelessness. The goal is to reduce unnecessary health services use, increase housing stability, and improve health outcomes for Medicaid participants at risk of institutional placement or homelessness.

Care management is also a feature of new initiatives being planned by the Department to improve transitions back to the community for justice-involved individuals. The Consolidated Appropriations Act of 2023, § 5121, requires 30 days each of pre-and post-release case management for post-adjudication Medicaid "eligible juveniles" beginning January 1, 2025.[5] The Department also has an open application to CMS to amend its §1115 HealthChoice Demonstration to include, among other services, case management services to sentenced individuals with substance use disorder, severe mental illness, or both, who are within 90 days of their release date.[6]

CHWs are also part of the core staff for the Department's CHIP Health Services Initiative, Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program. This program delivers environmental assessment and in-home education programs for children enrolled in, or are eligible for, Medicaid/MCHP who have exposure to lead or moderate to severe asthma, and provides three asthma home visits to test for indoor air quality, pests, and secondhand smoke, provide individualized referrals and case management; and conduct sustainable environmental risk reduction including integrated pest management (IPM) practices. The asthma home visits are conducted by environmental case managers and CHWs seated in eleven Local Health Departments (LHDs).[7] Services provided include asthma home visits and assessments that 1) identify asthma triggers and conditions that could contribute to lead poisoning in the homes of eligible children with asthma and/or an elevated blood lead levels, and 2) provide educational home visits to help the family address medication adherence, nutrition, and safe cleaning techniques. This program aims to reduce exposures to lead and asthma triggers within the homes of Medicaid/MCHP enrolled or eligible children.

The Department notes that CHWs may broaden case management efforts by assisting with encouraging referrals to case management and care coordination, and thereby increase access to such services for participants who may not receive it through another avenue. In fact, the Final Report from the Workgroup on Workforce Development for Community Health Workers (2015) attests that "CHWs cannot work in isolation. They operate by building connections with community, state, and charitable resources which complement health interventions, but also in

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[4] For more information, please see the HealthySmiles Member Handbook.

[5] "An eligible juvenile is an individual who is under 21 years of age who was determined eligible for any Medicaid eligibility group, or an individual determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution." https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

[6] https://health.maryland.gov/mmcp/Documents/1115%20Waiver%20Medicaid/Maryland_Reentry%201115%20Amendment%20Application%202024.pdf

[7] The following jurisdictions participate in the lead and asthma home visiting program: Anne Arundel County, Baltimore City, Baltimore County, Charles County, Dorchester County, Frederick County, Harford County, Montgomery Counties, Prince George's County, St. Mary's County, and Wicomico County.

many cases by building strong connections with healthcare systems to accomplish direct health goals for the patient."[8]

Brief History of Community Health Worker Legislation in Maryland

House Bill (HB) 856/Senate Bill (SB) 592, *Workgroup on Workforce Development for Community Health Workers* (Chapters 181 and 259 of the Acts of 2014), required the establishment of a workgroup including both the Department and the Maryland Insurance Administration (MIA).[9] In 2015, the Workgroup submitted a report with recommendations to the General Assembly used to advise Maryland's CHW certification process, including roles and core competencies.[10] The recommendations greatly informed the State's definition of a CHW, core competencies, and the establishment of the State CHW Advisory Committee. The Workgroup also provided recommendations regarding training requirements and exemptions to those requirements. At that time, the Workgroup determined recommendations pursuant to the reimbursement of CHWs would be premature prior to establishing a framework for certification.

SB 163, Chapter 441 of the Acts of 2018, *Public Health – Community Health Workers – Advisory Committee and Certification*, established the State Community Health Worker Advisory Committee. The Committee's role is to advise the Department on CHW certification and training and related regulations.[11] The Committee still operates today and meetings are open to the public.

Regulations on CHW certification as well as regulations governing the accreditation of training programs were promulgated in 2019.[12] While other legislation related to reimbursement for CHWs has been proposed over the years, it has not passed.

Community Health Worker Certification and Training Program Accreditation Standards

The certification and accreditation process of CHWs in Maryland is overseen by the Department's Office of Population Health Improvement (OPHI). To be a certified CHW, an individual must successfully complete a CHW certification training program accredited by the Department and submit an application to the Department. Individuals must be certified by the Department prior to representing themselves as a certified CHW in public. Certifications are effective for two years from the issue date.

Organizations with CHW training programs must be accredited by the Department prior to offering a CHW certification training program. Programs must renew accreditation every 3 years. Accredited training programs must provide at least 100 hours of instruction, verify

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[8] https://health.maryland.gov/mmcp/Documents/communityhealthworkersJCRfinal6-15.pdf

[9] Please note, an earlier draft of SB 592 required Medicaid to reimburse for CHWs. Medicaid determined doing so would have a substantial financial impact on the Program.

[10] https://health.maryland.gov/mhhd/Documents/workgroup-on-workforce-development-for-community-health-workers-dhmh-and-mia-june-2015.pdf

[11] https://health.maryland.gov/pophealth/Community-Health-Workers/Pages/Advisory-Committee.aspx

[12] COMAR 10.68.01, Certification of Community Health Workers, through 10.68.02, Community Health Worker Certification Training Programs.

completion of an additional 40-hour supervised practicum by a student, and include the following core competencies in the curriculum:

a. Advocacy and community capacity building skills;
b. Effective oral and written communication skills;
c. Cultural competency;
d. Understanding of ethics and confidentiality issues;
e. Knowledge of local resources and system navigation;
f. Care coordination support skills;
g. Teaching skills to promote healthy behavior change;
h. Outreach methods and strategies; and
i. Understanding of public health concepts and health literacy.

As of the drafting of this report, 20 CHW training programs are accredited and 1,044 CHWs are certified by the Department through the OPHI.[13] The U.S. Bureau of Labor Statistics (U.S. Department of Labor) estimates there are 2,440 CHWs in Maryland as of May 2023.[14]

Environmental Scan on Community Health Workers

According to a January 2024 environmental scan on CHWs commissioned by the Connecticut Health Foundation, 24 state Medicaid programs currently reimburse for CHW services and three additional states are working to implement reimbursement for CHW services.[15] Neighboring states including Delaware, Virginia, and the District of Columbia do not reimburse for CHW services. West Virginia reimburses CHW services for pregnant people with opioid use disorder (OUD) only. While Pennsylvania does not directly reimburse for CHW services, the state requires its MCOs to offer community-based care management (CBCM) programs, which may include CHWs as part of the delivery model.

Overall, the majority of states reimbursing for CHW services use State Plan authority to cover CHW services through a State Plan Amendment (SPA), although a few use § 1115 demonstration waivers. While states vary in terms of how the use of CHWs is targeted, for example focusing on certain special populations or individuals with certain health conditions, no state has limited CHWs to connecting beneficiaries to one type of health care service, such as dental services.

The majority of states have adopted the following Current Procedural Terminology (CPT) codes when reimbursing for CHW services:

- 98960: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

[13] As of April 17, 2024.
[14] https://www.bls.gov/oes/current/oes211094.htm
[15] https://www.cthealth.org/wp-content/uploads/2024/01/CHW-Medicaid-Policies-and-Reimbursement-Approaches-by-State.pdf

- 98961: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
- 98962: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients

In lieu of directly reimbursing CHWs, some states, including Oregon and Washington, enable MCOs to embed CHWs in their organization and reimburse for these costs through an enhanced capitation rate. Other states, such as Maine, incentivize primary care practices to integrate CHWs into primary care and case management. Practices that do so and meet certain other criteria receive an enhanced per member per month (PMPM) rate from the Medicaid program. The Department notes that New Mexico released guidance on May 31, 2024 (applying retroactively effective July 1, 2023) establishing CHWs as their own provider type, sunsetting the previous payment model where CHW services had been reimbursed through enhanced MCO PMPM payments.[16]

Medicare reimburses for CHW services as care management and behavioral health integration services. Qualifying practitioners and providers can bill Medicare Part B for these services, as well as other potentially team-based services, such as diabetes self-management training and medical nutrition therapy services, if certain rules are met.[17]

There have been several federal grant opportunities to support CHW training and infrastructure including the Health Resources and Services Administration's (HRSA) Community Health Worker Training Program (CHWTP), the Centers for Disease Control and Prevention's (CDC) Community Health Workers for COVID Response and Resilient Communities (CCR) grant. Other grants, such as the CDC's Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke, aim to embed CHWs in care models to lead to sustainability. The CDC's National Breast and Cervical Cancer Early Detection Program has an equity focus and funding may be used to pay CHW salaries with trusted community relationships.[18]

Commercial Utilization of Community Health Worker Services in Maryland

The Maryland Health Care Commission (MHCC) provided Maryland commercial utilization data from the All-Payer Claims Database, known as the Medical Care Data Base (MCDB), on three codes associated with CHW services: 98960, 98961, and 98962 for calendar years 2020 through 2023. The Department notes that the Medicare Advantage population is excluded from this data. In addition, self-funded Employee Retirement Income Security Act (ERISA) plan data is not included in the MCDB. Therefore, the MCDB only accounts for 25 to 30 percent of the self-insured market.[19]

[16] https://www.hsd.state.nm.us/wp-content/uploads/Final-24-08-Supplement-CHW-CHR-LR_TDG5.20.24-003-1.pdf
[17] https://www.cms.gov/files/document/community-health-worker.pdf
[18] https://www.astho.org/globalassets/report/advancing-sustainable-financing-of-community-health-workers.pdf
[19] https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_mcdb.aspx

The majority of services have been accessed by individuals under the age of 65. In addition, claims for services have increased greatly over the past four years, from 7,043 claims for CHW services in 2020 (under age 65) to 8,599 services in 2023 (under age 65). Most of these claims were for individual patients versus group services. The Department notes that given the low utilization indicated by this data, the number of commercial plans reimbursing CHWs as a standalone service provider may be limited at this time. Table 1, below, depicts this data.

Table 1. Commercial Utilization of CHW Services*

CPT Code	Year			
	2020	2021	2022	2023
< Age 65				
98960	6,658	6,370	6,295	6,437
98961	216	174	642	1,763
98962	169	82	97	399
Total	7,043	6,626	7,034	8,599
≥ Age 65				
98960	*	375	365	528
98961	*	*	*	16
98962	0	*	*	0
Total	330	393	394	544
Grand Total	**7,373**	**7,019**	**7,428**	**9,143**

**This data excludes the Medicare Advantage population.*

Fiscal Estimate

Reimbursement of Services

The Department currently reimburses for services provided by certified peer recovery specialists (CPRS) with lived experience to individuals with a substance use disorder. Similar to a CHW, a CPRS is a trusted community resource for participants. Services covered by Maryland Medical Assistance through the CPRS benefit include: supporting a participant's goals, facilitating support groups, providing referrals to community-based supports, and providing culturally competent care.[20]

[20] https://health.maryland.gov/mmcp/provider/Documents/Transmittals_FY2023/PT%2059-23%20Medicaid%20Coverage%20of%20Peer%20Recovery%20Support%20Services%20in%20Licensed%20Community-Based%20Substance%20Use%20Disorder%20Programs%20sk%20signed%206.12.23.pdf

Due to the similarities between services provided by CPRSs and CHWs, for the purpose of this fiscal analysis the Department assumes that the reimbursement for CHWs would be aligned with that for CPRSs. As of July 1, 2024, CPRS services are reimbursed at a rate of $18.77 per 15 minutes of individual services (procedural code H0038) and $5.22 per 15 minutes of group services (procedural code H0024).

As of September 2024, roughly 1.6 million individuals were enrolled in Maryland Medical Assistance and thus eligible to receive CHW services. As of April 2024, there were 1,044 certified CHWs who could enroll as providers in the Medical Assistance program. The Department assumes a productivity estimate of 1,056 hours per year per CHW. This assumption accounts for time and activities that are not billable, such as administrative time and activities, potential leave, and travel time. The Department also assumes utilization limits in line with those imposed by New Mexico Medicaid, where CHW services are covered for participants on an outpatient basis.[21] Participants may receive 8 hours of CHW services per 30-day period, or 96 hours per year. The Department assumes 50 percent of the costs are associated with individual services and 50 percent of the costs are associated with group services (48 hours of individual services, 48 hours of group services).

Based on these assumptions, the Department estimates the fiscal impact of the reimbursement of CHW services to be $52.9 million total funds, subject to Federal Medical Assistance Percentage (FMAP) ($32.1 million federal funds, $20.8 million state general funds) or $4,606.08 per participant annually. To the extent that the availability of separate reimbursement encourages additional individuals to be certified as CHWs, these costs would increase. In addition, actual participants served may be higher if individual participants utilize fewer services each thus enabling CHWs to serve a higher number of people, potentially increasing costs. Costs may increase if more participants receive individual services rather than group services.

Systems Impact
In order to reimburse for CHW services, Maryland would need to add a provider type to MDH's provider enrollment system, Electronic Provider Revalidation and Enrollment Portal (ePREP), resulting in additional fiscal impact. The Department pays a $8.32 per member per month (PMPM) fee for each enrolled provider. Assuming all certified CHWs (1,044) enroll in Maryland Medical Assistance, the system cost for enrolling CHWs amounts to $104,233, subject to FMAP ($78,175 federal funds, $26,058 state general funds).

To the extent that the availability of separate reimbursement incentivises additional individuals to be certified as CHWs, these costs would increase.

Overall Fiscal Impact
Taking into account both the cost of services and necessary system changes, the Department estimates a total annual fiscal impact of $53.0 million ($32.2 million federal funds, $20.8 million

[21] See https://www.hsd.state.nm.us/wp-content/uploads/Final-24-08-Supplement-CHW-CHR-LR_TDG5.20.24-003-1.pdf for additional information on covered services and limitations in New Mexico.

state general funds). To the extent that the scope of practice for CHWs increases and additional CPT codes would need to be opened for reimbursement, the fiscal impact would increase.

Operational Considerations

In order to reimburse for CHW services, the Department would need to consider which federal authority to apply for through the Centers for Medicare and Medicaid Services. A SPA will enable CHW services to be reimbursed for populations statewide, while an 1115 waiver may allow the Department to target the use of CHWs and focus on certain special populations or individuals with certain health conditions.

In addition, as CHWs are not currently enrolled as providers for the Maryland Medical Assistance Program, Medical Assistance would need to implement system changes and establish a new provider type specific to CHWs. This process may take months as system changes are implemented. Once the provider type has been created, the Department would need to ensure that stakeholders are aware of the steps needed to enroll as a Medical Assistance provider. Because a statewide certification process is in place already today, this process will be simplified. Based on past experience, the Department would work hand-in-hand with stakeholders to assist with this transition, as well as MCOs to encourage contracting between CHWs and MCOs. Reimbursement for services also requires system changes to add the new CHW provider type. The Department would need to decide upon and open CPT codes in the system for billing purposes.

The Department also notes that consideration would need to be given to both MCO capitation rates and fee-for-service (FFS) costs. For any somatic care and primary behavioral health services, CHWs would need to be included in MCO capitation rates. For any populations or services carved out of the MCO package, such as dental and specialty behavioral health, CHW services would need to have billing codes implemented with the respective ASOs and FFS program. Medical necessity criteria would need to be considered and defined.

Further, there could be an increase in the CHW workforce should Medical Assistance begin reimbursing for CHW services. This may also increase the fiscal impact. MDH notes that take up may be slower in the beginning years before the workforce grows due to the incentive of reimbursement. According to the U.S. Bureau of Labor Statistics, there were an estimated 2,440 CHWs in Maryland as of May 2023.[22] In May 2021, the Bureau estimated that Maryland had 1,470 CHWs, illustrating that there is precedent of the workforce growing. In addition, the number of accredited CHW training programs has increased after OPHI released a request for applications (RFA) for the expansion of CHW certification training programs in July 2023. This could also result in an increase of certified CHWs who enroll with the Maryland Medical Assistance Program.

To the extent that reimbursement for CHWs improves health outcomes, savings may eventually be realized in the long term. However, savings cannot be quantified in the near term and may not be realized directly by the Department due to churn out of Medical Assistance as individuals shift to other health care coverage, for example to a commercial payor or Medicare.

[22] https://www.bls.gov/oes/current/oes211094.htm

Conclusion

The Department will continue to monitor other state Medicaid trends as it comes to CHW reimbursement. The Department will also continue to collaborate with the Legislature as well as other stakeholders to explore pathways forward to ensure equitable access to care for all Medical Assistance participants.