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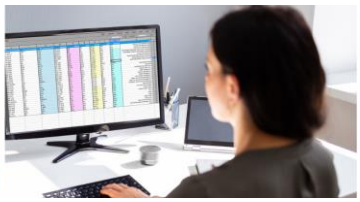


WORKFORCE EXPANSION

POLICY BRIEF

Minnesota Community Health Workers – Defining Care Coordination

This policy brief focuses on the definition of care coordination services provided by Community Health Workers (CHWs) in the state of Minnesota and was written in response to a request for research on how other state statutes and regulations define care coordination services. Minnesota is investigating the potential to expand CHW service coverage to ensure the sustainability of CHWs in the state. The state is looking into ways to define care coordination that allows the service to be covered. The Minnesota Department of Human Services defines a CHW as "a trained health educator who works with Minnesota Health Care Programs (MHCP) members who may have difficulty understanding providers due to cultural or language barriers."[1] Despite Minnesota law stating that "[m]edical assistance covers the care coordination and patient education services provided by a community health worker…", the only billable services provided by CHWs are supervised diagnosis-related patient education services.[2] When the original state plan amendment (SPA) was implemented that approved coverage for these services, Minnesota Medical Assistance (the state Medicaid agency) sought federal approval for diagnosis-related health education services only and postponed care coordination payment for further study and definition.[3] However, despite recent efforts by organizations like the National Quality Forum (NQF) and the Community Health Worker Core Consensus (C3) Project, there does not appear to be a standard definition for care coordination.[4]

Introduction

A CHW is defined by the Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) as "a frontline public health worker who is a trusted member or has a particularly good understanding of the community served."[5] A CHW serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery."[6] CHWs facilitate access to services for community members by providing education and care coordination[7]. Care coordination can encompass a range of services, such as referrals for health services, community services, and social services. Consistent funding is critical for the sustainability of all CHW services, including care coordination. Funding may be obtained through several sources, including state Medicaid programs, specialized state and Centers for Medicare & Medicaid Innovation (CMMI) models and programs, as well as federal grant programs.[8]

In 2006, the NQF, a nationally recognized non-profit organization contracted by the U.S. Department of Health and Human Services, defined care coordination as a "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time to achieve improved outcomes."[9] The NQF identified five key domains to examine and understand care coordination: (1) Healthcare "Home"; (2) Proactive

Plan of Care and Follow-up; (3) Communication; (4) Information Systems; and (5) Transitions or Handoffs.[10] In 2010, the NQF also endorsed 25 care coordination practices and 10 performance measures.[11]

In 2016, the C3 Project conducted a study to determine the core roles, skills and qualities of CHWs.[12] One of the CHW roles was termed "Care Coordination, Case Management, and System Navigation" with the following sub-roles: (a) participating in care coordination and/or case management; (b) making referrals and providing follow-up; (c) facilitating transportation to services and helping to address other barriers to services; (d) documenting and tracking individual and population level date; and (e) informing people and systems about community asset and challenges.[13]

Efforts to Define Care Coordination Services in Minnesota

Some laws and regulations in Minnesota provide context for terms including or related to care coordination in specific settings. Minnesota law defines "in-reach community based service coordination" performed through a hospital emergency department for a frequent user to include "navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization."[14] Moreover, "in-reach community based service coordination" is defined as "the practice of a community-based worker with training, knowledge, skills and abilities to access a continuum of services", which include housing, transportation, and peer support services.[15] Minnesota law also defines "officer-involved community based care coordination" to mean "navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination."[16]

In Minnesota, a health care home and county are obligated to provide care coordination to patients with complex medical needs or a disability who need and are eligible for additional local services.[17] Those services include but are not limited to "waivered services, mental health services, social services, public health services, transportation, and housing."[18] Under Minnesota Administrative Rules for Health Care Homes, a "care coordinator" is defined as "a person who has primary responsibility to organize and coordinate care with the participant in a health care home."[19] In these same rules, "care coordination" is defined as "a team approach that engages the patient, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the patients' well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust."[20]

Other State Laws

Definitions for care coordination or for CHW services that address care coordination (or comparable services) may be found in the statutes or regulations of at least nine states.

Arizona

Under Arizona law, a CHW is defined as a "nonmedical health worker who serves as a liaison for health and community service providers and enrollees to facilitate access to services and improve the quality of service delivery, including the coordination of services to improve medical and behavioral health outcomes."[21]

Indiana

Under Indiana Administrative Code, "behavioral and primary health care coordination services" means the "coordination of health care services to manage the health care needs of the [person receiving BPHC services] including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services."[22] CHWs are included in the list of service provider staff for behavioral and primary health care coordination services.[23]

Iowa

Under Iowa Administrative Code, Maternal and Child Health Program, care coordination is defined as follows:

"Care/service coordination" or "care coordination" means a comprehensive, family-centered approach that proactively engages and links clients and families to needed health care services, including medical, dental, emotional, behavioral, and health education services. Care coordination encompasses a specific set of activities that promote a client's potential for optimal health and facilitate quality outcomes. By working with the client, family, and other involved disciplines, a care coordinator can promote seamless access and a holistic approach to service provision.o-0 Care coordination incorporates the following:

1. Meaningful assessment of needs and concerns.
2. Shared development of care plans.
3. Mobilization of agency and community resources.
4. Continued monitoring and follow-up.
5. Clear and transparent communication.
6. Complete documentation.[24]

Michigan

Currently, under Michigan's Mental Health Code "Assisted outpatient treatment…may include a case management plan and case management services to provide care coordination under the supervision of a psychiatrist and developed in accordance with person-centered planning under section 712."[25] The relevant portion of section 712 states:

> *The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.*[26]

In 2017, the Michigan Primary Care Consortium held the Coordinating the Care Coordinators workshop series, the findings from which were reported in 2018.[27] The prime result of the workshop series was the development of a definition of "Coordination of Care" to be presented to the State of Michigan and Michigan's Health Information Technology Commission.[28] Coordination of Care was defined as follows:

1. Monitoring a person's goals, needs, and preferences.
2. Acting as the communication link between two or more participants concerned with a person's health and wellness.
3. Organizing and facilitating care activities and promoting self-management by advocating for, empowering and educating a person.
4. Ensuring safe, appropriate, non-duplicative, and effective integrated care."[29]

New Mexico

Under New Mexico law, a medical home model may include "mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost care or social support needs, including attendant care and other services needed to remain in the community."[30] A medical home model may also include "implementation of a comprehensive, community-based initiative to educate recipient about effective use of the health care delivery system, including the use of community health workers."[31] In addition, the Medical Assistance Division of the New Mexico Human Services Department's Managed Care Policy manual mandates that an "MCO or its delegate will make reasonable efforts to contact members to conduct an HRA and provide information about care coordination. Such efforts shall include, but not be limited to, engaging community supports such as [CHWs]…"[32] Care coordination functions are listed in detail by the Managed Care Policy and include conducting a comprehensive needs assessment, semi-annual or quarterly in-person visits with the member, telephone contact, and developing a comprehensive care plan, among other functions.[33]

Under New Mexico Administrative Code regulating the Managed Care Program, care coordination is defined as involving, but not limited to:

> *[P]lanning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning.* [34]

In addition, "[i]f a native American member requests assignment to a native American care coordinator, the MCO or MCO Delegate must employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator."[35]

Ohio

Under Ohio law, CHWs are recognized as:

> *[I]ndividuals who, as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of such services as education, role modeling, outreach, home visits, and referrals, any of which may be targeted toward an individual, family, or entire community. The certification program also shall reflect the board's recognition of the individuals as members of the community with a unique perspective of community needs that enables them to develop culturally appropriate solutions to problems and translate the solutions into practice.*[36]

Ohio's definition of CHW Services or Services Provided by a Public Health Nurse includes the term "qualified community hub", which refers to a "central clearinghouse for a network of community care coordination agencies" that meets specific criteria, including use of "certified community health workers or public health nurses to connect at-risk individuals to health, housing, transportation, employment, education, and other social services…"[37] Further, each Medicaid managed care organization must provide enrollees with other services provided by a CHW or public health nurse "that are not community health worker services or services provided by a public health nurse but are performed for the purpose of ensuring that the enrollee is linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services."[38]

Oregon

Under Oregon's Human services, juvenile code, and corrections statutes, "integrated health care" means care that includes care team members (who may be CHWs) addressing not only mental illness and substance use disorders but also health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization. [39]

Under the Oregon Administrative Rules for Outpatient Behavioral Health Services, care coordination is defined as "a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs."[40] The definition further includes:

> *[F]acilitating communication between a person or family served, the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.*[41]

In this same regulation, "case management" is defined as "services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to desired medical, social, education, entitlement, and other applicable services."[42] CHW is also defined in part, as "[t]raditional health workers utilized by coordinated care organizations."[43]

The Oregon Administrative Rules for Medical Assistance Programs define "case management services" to include services that ensure "members obtain health services necessary to maintain physical, mental, and emotional development and oral health" and includes "the development and implementation of a plan to obtain or make referrals for needed medical, mental,

chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies."[44] The term "targeted case management" (TCM) is also defined, and includes assisting a client in a target group to gain access to medical, social, educational, and other services needed as well as "locating, coordinating, and monitoring necessary and appropriate services."[45] Under TCM provider requirements, Asthma/Healthy Homes Program case managers may be CHWs.[46] CHWs may also be case managers for Public Health Nurse Home Visiting, Babies FIRST!, CaCoon, Family Connects, and the Nurse-Family Partnership program if working under a licensed registered nurse.[47] Lastly, "Maternity Case Management" refers to non-medical prenatal services that address social, economic, and nutritional factors.[48]

Rhode Island

Under its Commission for Health Advocacy and Equity laws, the State of Rhode Island defines a CHW as "an individual who assists and coordinates services between providers of health services, community services, social agencies for vulnerable populations."[49] Additionally, CHWs "may facilitate improved individual and community well-being" including but not limited to:

1. Linking with services for legal challenges to unsafe housing conditions;
2. Advocating with various state and local agencies to ensure that the individual/family receives appropriate benefits/services;
3. Advocating for the individual/family within the health care system. This could be done in multiple settings (community-based organization, health care setting, legal service setting);
4. Connecting the individual or family with the appropriate services/advocacy support to address those issues such as:
    i. Assisting in the application for public benefits to increase income and access to food and services;
    ii. Working with community-based health agencies and organizations in assisting individuals who are at-risk for or who have chronic diseases to receive better access to high-quality health care services;
    iii. Anticipating, identifying and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding; and
    iv. Coordinating with the relevant health programs to provide information to individuals about health coverage, including RItecare[50] and other sources of health coverage;
5. Assisting the department of health, other agencies, health clinics, healthcare organizations, community clinics and their providers to implement and promote culturally competent care, effective language access policies, practices and disseminate best practices to state agencies;
6. Training of health care providers to help patients/families access appropriate services, including social services, legal services and educational services.
7. Advocating for solutions to the challenges and barriers to health that a community may face.[51]

Washington

Washington Administrative Code defines care coordination for maternity support services as "[p]rofessional collaboration and communication between the client's [maternity support services] provider and other medical and/or health and social service providers to address the individual's client's needs as identified in the care plan."[52] A "care plan" is defined as a "written statement developed for a person that continues throughout the eligibility period and outlines any medical, social, environmental or other interventions to achieve an improved quality of life, including health and social outcomes."[53] Community health workers are also identified as part of the maternity support services interdisciplinary team.[54]

State Plan Amendments Relating to Care Coordination

A Medicaid state plan amendment (SPA) is an agreement between a state and the Federal government that describes how a state administers its Medicaid and Children's Health Insurance Program (CHIP) programs.[55] Several SPAs provide some framework for care coordination services to be covered, though the terms used to reference these services vary.

Arizona

A 2023 Arizona SPA includes health system navigation and resource coordination under CHW services, however those terms are not further defined.[56]

California

A 2022 California SPA defines CHW services as preventative. [57] Though the state plan does not cover "care management that requires a license, personal care/homemaker services, transportation" and other services, it does cover health navigation for CHWs to assist with connecting to community resources. [58] It also broadly covers "[i]ndividual support or advocacy that assists a beneficiary in preventing a health condition, injury, or violence."[59] However, among the CHW services specifically excluded from coverage, CHWs may not help "a recipient enroll in government programs or insurance that is not related to improving their health as part of a care plan."[60]

Louisiana

A 2022 Louisiana SPA includes health system navigation and resource coordination, "including helping to engage, re-engage, or ensure follow-up in primary care/routine preventative care, adherence to treatment plans and self-management of chronic conditions."[61] It does not cover insurance enrollment and navigation assistance, case management or care coordination, or transportation to and from services.[62]

Michigan

A 2016 SPA for Michigan's Medicaid Health Homes program requires the inclusion of CHWs on a health care team.[63] CHW services under the MI 2016 SPA include coordination and providing access to individual and family supports, meeting with the recipient's care team regularly, identifying community resources, referral tracking, coordinating and providing access to chronic disease management, implementing wellness and prevention initiatives, and providing services relating to health education.[64]

A more recent 2020 Michigan SPA under the Health Homes program defines care coordination as follows:

> *Care coordination is the organization of activities between participants responsible for different aspects of a patient's care designed to facilitate delivery of appropriate services across all elements of the broader health care system. It includes management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goals of holistic, high quality, cost-effective care and improved patient outcomes. Components of care coordination include knowledge of and respect for the patient's needs and preferences, information sharing/communication between providers, patient, and family members, resource management and advocacy.*[65]

The 2020 Michigan SPA specifically includes CHWs as key support roles for care coordination.[66]

Rhode Island

A 2021 Rhode Island SPA lists health system navigation and resource coordination under covered CHW services which includes helping to "engage, reengage, or ensure patient-led follow-up" for care, medication, and adherence to treatment plans "and/or self-management of chronic conditions including by assisting beneficiaries to access covered services and other relevant community resources."[67] Care planning with an interdisciplinary care team is also covered.[68]

South Dakota

A 2019 South Dakota SPA states that CHW services may include "[h]ealth system navigation and resource coordination" which could involve helping a recipient, in connection to a covered service, find Medicaid providers, make appointments, arrange transportation, attend an appointment, and find other community resources such as support groups.[69]

STATE LAWS, REGULATIONS, AND SPAS DEFINING CARE COORDINATION OR SIMILAR SERVICES

STATE	SOURCE	LANGUAGE	CITATION
ARIZONA	**Public Health and Safety Statute**	[A] nonmedical health worker who serves as a liaison for health and community service providers and enrollees to facilitate access to services and improve the quality of service delivery, including the coordination of services to improve medical and behavioral health outcomes.	Ariz. Rev. Stat. §36-765
	2023 SPA	CHW Services: [M]ust be documented in the member's medical record and may include [h]ealth system navigation and resource coordination.	AZ SPA 22-0029
CALIFORNIA	**2022 SPA**	CHW services may include: Health navigation to provide information, training, referrals, or support to assist beneficiaries to: Access health care, understand the health care system, or engage in their own care; Connect to community resources necessary to promote a beneficiary's health, address health care barriers, or address health-related social needs. Screening and assessment to identify the need for services. Individual support or advocacy that assists a beneficiary in preventing a health condition, injury, or violence. CHW services, including violence prevention services, do not include the following: Clinical case management/care management that requires a license; Child care; Chore services including shopping and cooking. Companion services; Employment services; Helping a recipient enroll in government programs or insurance that is not related to improving their health as part of a care plan; Delivery of medication, medical equipment, or medical supply; Personal Care services/homemaker services; Respite care; Services that duplicate another covered Medi-Cal service; Socialization x Transportation	CA SPA 22-001
INDIANA	**Behavioral and Primary Health Coordination Services Administrative Code**	[C]oordination of health care services to manage the health care needs of the member including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services. [P]rovider staff delivering services under this section must be one of the following... (5) An office-certified community health worker.	405 Ind. Admin. Code 405 IAC 5-21.8-2 (c) 405 Ind. Admin. Code 405 IAC 5-21.8-8(e)(5)
IOWA	**Public Health Department Administrative Code**	[A] comprehensive, family-centered approach that proactively engages and links clients and families to needed health care services, including medical, dental, emotional, behavioral, and health education services. Care coordination encompasses a specific set of activities that promote a client's potential for optimal health and facilitate quality	Iowa Admin. Code R.641 §76.4(135)

		outcomes. By working with the client, family, and other involved disciplines, a care coordinator can promote seamless access and a holistic approach to service provision. Care coordination incorporates the following: (1) Meaningful assessment of needs and concerns; (2) Shared development of care plans; (3) Mobilization of agency and community resources; (4) Continued monitoring and follow-up; (5)Clear and transparent communication; (6) Complete documentation.	
LOUISIANA	**2022 SPA**	Community Health Worker Services – B. Covered Services: 3. Health system navigation and resource coordination services, including helping to engage, re-engage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions. The following services are not covered: (1) Insurance enrollment and insurance navigator assistance; (2) Case management; and (3) Directly providing transportation for a beneficiary to and from services.	LA SPA 22-0003
MINNESOTA	**Public Welfare and Related Activities Statute**	Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization. For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance. “[N]avigating services to address a client’s mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.	Minn. Stat. § 256B.0625 Subd.56(a)(1) and (c)(1) Minn. Stat. 256B.0625 Subd.56a(b)

	Insurance Statute	The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and the health care home.	Minn. Stat, 62U.03 §9
	Health Department Administrative Rules	"Care coordination" means a team approach that engages the participant, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the participant's well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust. "Care coordinator" means a person who has primary responsibility to organize and coordinate care with the participant in a health care home.	Minn. R. 4764.0020, Subd. 3 and 5
MICHIGAN	**Mental Health Code**	"Assisted outpatient treatment" …may include a case management plan and case management services to provide care coordination under the supervision of a psychiatrist and developed in accordance with person-centered planning under section 712. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.	MCL 330.1100a(8) MCL 330.1712 (1)
	2016 SPA	At a minimum, each FQHC and THC must provide the following on-site care team members who are qualified to perform functions including but not limited to...Community Health Worker. • Coordinate and provide access to individual and family supports, including referral to community supports; • Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic; • Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness; referral tracking; • Coordinate and provide access to chronic disease management including self-management support; • Implement wellness and prevention initiatives; • Facilitate health education groups; • Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.	MI SPA 15-2000
	2020 SPA	Care coordination is the organization of activities between participants responsible for different aspects of a patient's care designed to facilitate delivery of appropriate services across all elements of the broader health care system. It includes management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goals of holistic, high quality, cost-effective care and improved patient outcomes. Components of care coordination include knowledge of and respect for the patient's needs and preferences, information	MI SPA 20-1500

		sharing/communication between providers, patient, and family members, resource management and advocacy Key support roles include the Peer Support Specialist, Community Health Worker (CHWs), and Medical Assistants (MAs). Peer Support Specialist services are provided by an individual with a lived experience and journey in receiving public mental health services and supports.	
NEW MEXICO	**Public Assistance Act**	Components of the medical home model may include: (8) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community; (9) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras;	NM Stat. 27-2-12.15(A)(8) and (9)
	Managed Care Program Administrative Code	**(1)** Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning. Managed care organizations (MCOs) may delegate care coordination functions through a full delegation model or a shared functions model, while retaining oversight of all care coordination activities. **(3)** If a native American member requests assignment to a native American care coordinator, the MCO or MCO delegate must employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator.	N.M. Admin. Code. § 8.308.10.9(1) and (3)
OHIO	**Occupations-Professions Code**	The board of nursing shall develop and implement a program for the certification of community health workers. The board shall begin issuing community health worker certificates under section 4723.85 of the Revised Code not later than February 1, 2005. The certification program shall reflect the board's recognition of individuals who, as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of such services as education, role modeling, outreach, home visits, and referrals, any of which may be targeted toward an individual, family, or entire community. The certification program also shall reflect the board's recognition of the individuals as members of the community with a unique perspective of community needs that enables them to develop culturally appropriate solutions to problems and translate the solutions into practice.	Ohio Rev. Code § 4723.81

		The certification program does not require an individual to obtain a community health worker certificate as a means of authorizing the individual to perform any of the activities that may be performed by an individual who holds a community health worker certificate.	
	Public Welfare Code	(A) As used in section: (5) "Qualified community hub" means a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria: (a) Demonstrates to the director of health that it uses an evidenced-based, pay-for-performance community care coordination model (endorsed by the federal agency for healthcare research and quality, the national institutes of health, and the centers for medicare and medicaid services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to health, housing, transportation, employment, education, and other social services; (B) Each medicaid managed care organization shall provide to an enrollee who meets the criteria in division (C) of this section, or arrange for the enrollee to receive, both of the following services provided by a certified community health worker or public health nurse, as applicable, who is employed by, or works under a contract with, a qualified community hub: (1) Community health worker services or services provided by a public health nurse;	Ohio Rev. Code § 5167.173(A)(5)(a) and (B)(1)
OREGON	**Human Services; Juvenile Code; Corrections**	(7) “Community health worker” means an individual who meets qualification criteria adopted by the authority under ORS 414.665 (Traditional health workers utilized by coordinated care organizations) and who: (a) Has expertise or experience in public health; (b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system; (c) to the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves; (d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; (e) Provides health education and information that is culturally appropriate to the individuals being served; (f) Assists community residents in receiving the care they need; (g) May give peer counseling and guidance on health behaviors; and (h) May provide direct services such as first aid or blood pressure screening. (15) (a) “Integrated health care” means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: (A) Mental illness; (B) Substance use disorders; (C) Health behaviors that contribute to chronic illness; (D) Life stressors and crises; (E) Developmental risks and conditions;	Or. Rev. Stat. Ann. § 414.025(7) and (15a)

	(F) Stress-related physical symptoms; (G) Preventative care; (H) Ineffective patterns of health care utilization. (b) As used in this subsection, "other care team Members" includes but is not limited to …(D) Community health workers who have completed a state-certified training program.	
Health Systems Division Administrative Rules	(17) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between person or family served, the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services. (18) "Case Management" or "Targeted Case Management" means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to desired medical, social, educational, entitlement, and other applicable services. (26) "Community Health Worker (CHW)" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 (Traditional health workers utilized by coordinated care organizations)	Or. Admin. Rule. 309-019-0105(17), (18), and (26)
	(18) "THW Applicant" means an individual who applies to the Authority for traditional health worker certification.	Or. Admin. Rule. 410-180-0305(18)
	(39) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies. (140) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules. (242) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.	Or. Admin. Rule. 410-120-0000(39),(140) and (242)
	(10) TCM Asthma/Healthy Homes Program case managers shall possess the following additional qualifications: (a) A current active Oregon registered nurse (RN) license; or (b) A registered environmental health specialist; or (c) An asthma educator certified by the National Asthma education and Prevention Program; or (d) A community health worker certified by the Stanford chronic Disease Self-Management Program; or (e) A case manager working under the	Or. Admin. Rule. 410-138-0060(10) and (11)

		supervision of a licensed registered nurse or a registered environmental specialist. (11) The TCM case managers for the Public Health Nurse Home Visiting, Babies First!, CaCoon, Family Connects, and Nurse-Family Partnership program…(c) May be a community health worker, family advocate, or a promotora working under the plan developed by a licensed registered nurse…	
RHODE ISLAND	**Health and Safety Laws**	As used in this chapter, the following words and phrases have the following meanings: (4) "Community health worker" means any individual who assists and coordinates services between providers of health services, community services, social agencies for vulnerable populations. Community health workers provide support and assist in navigating the health and social services system.	R.I. Gen. Laws 1956, §§ 23-64.1-2(4)
		Community health workers are individuals who have direct knowledge of the communities they serve, and of the social determinants of health, and can assess the range of issues that may impact an individual's, a family's or a community's health and may facilitate improved individual and community well-being and should include, but not be limited to: (1) Linking with services for legal challenges to unsafe housing conditions; (2) Advocating with various state and local agencies to ensure that the individual/family receives appropriate benefits/services; (3) Advocating for the individual/family within the health care system. This could be done in multiple settings (community-based organization, health care setting, legal service setting); (4) Connecting the individual or family with the appropriate services/advocacy support to address those issues such as: (i) Assisting in the application for public benefits to increase income and access to food and services; (ii) Working with community-based health agencies and organizations in assisting individuals who are at-risk for or who have chronic diseases to receive better access to high-quality health care services; (iii) Anticipating, identifying and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding; and (iv) Coordinating with the relevant health programs to provide information to individuals about health coverage, including RItecare and other sources of health coverage; (5) Assisting the department of health, other agencies, health clinics, healthcare organizations, community clinics and their providers to implement and promote culturally competent care, effective language access policies, practices and disseminate best practices to state agencies;	R.I. Gen. Laws 1956, §§ 23-64.1-8

		(6) Training of health care providers to help patients/families access appropriate services, including social services, legal services and educational services. (7) Advocating for solutions to the challenges and barriers to health that a community may face.	
	2021 SPA	The following component services are covered when performed by CHWs within the scope of their practice... Health system navigation and resource coordination services, including helping to engage, reengage, or ensure patient-led follow-up in primary care, routine preventive care, adherence to treatment plans, and/or self-management of chronic conditions including by assisting beneficiaries to access covered services and other relevant community resources. Care planning with a beneficiary's interdisciplinary care team as part of a team-based, person centered approach to prevent disease, disability, and other health conditions, prolong life, and/or promote physical and mental health and efficiency by meeting a beneficiary's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention for members with chronic condition management needs.	RI SPA 21-0012
SOUTH DAKOTA	**2019 SPA**	Community health worker services must be ordered by a physician, physician assistant, nurse practitioner, or certified nurse midwife and delivered according to a care plan. Services must be related to a medical intervention outlined in the individual' s care plan and may include the following: a. Health system navigation and resource coordination includes helping a recipient find Medicaid providers to receive a covered service, helping a recipient make an appointment for a Medicaid covered service, arranging transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, and helping a recipient find other relevant community resources such as support groups.	SD SPA 21-0012
WASHINGTON	**Health Care Authority Code**	"Care coordination" - Professional collaboration and communication between the client's MSS provider and other medical and/or health and social services providers to address the individual client's needs as identified in the care plan. "Care plan" - A written statement developed for a person that continues throughout the eligibility period and outlines any medical, social, environmental or other interventions to achieve an improved quality of life, including health and social outcomes. "Maternity support services (MSS) interdisciplinary team" - A provider's group of qualified staff consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist, and, at the discretion of the provider, a community health worker. Based upon individual client need, each team member provides maternity support services and consultation	Wash Admin. Code §182-533-0315

Conclusion

Minnesota law currently includes definitions of services that may be provided through "In-reach community based service coordination", "officer-involved community based care coordination", and "health care homes coordination with local services." These definitions, along with the examples cited from other states' statutes, administrative regulations, and SPAs, can be adapted to provide a framework for defining CHW care coordination services for purposes of Minnesota Medicaid coverage.

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[1] MINNESOTA DEPARTMENT OF HUMAN SERVICES, *Community Health Worker (CHW) Manuel* (July 29, 2020), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357.

[2] Minn. Stat. § 256B.0625, Subd. 49. Notably, the original state plan amendment which first integrated CHWs into Minnesota Medicaid cannot be located online. *See* CALIFORNIA HEALTH CARE FOUNDATION, *Summary of Medicaid State Plan Amendments for Community Health Workers* (August 2022), https://www.chcf.org/wp-content/uploads/2022/08/SummaryMedicaidStatePlanAmendmentsCHWs.pdf .

[3] Susan Wilger, *Community Health Worker Model for Care Coordination; A promising Practice for Frontier Communities,* NATIONAL CENTER FOR FRONTIER COMMUNITIES (August 2012), http://frontierus.org/wp-content/uploads/2019/10/FREP-Community_Health_Worker_Care_Coordination-2012.pdf.

[4] *Id.*

[5] CENTERS FOR DISEASE CONTROL AND PREVENTION'S NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION (NCCDPHP), *Community Health Worker Resources (*Last visited March 17, 2023), https://www.cdc.gov/chronicdisease/center/community-health-worker-resources.html.

[6] *Id.*

[7] Several other terms have been used to describe the types of services which could also be considered "care coordination", such as "coordination of care", "care management", "case management", and "service navigation."

[8] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Medical Assistance Division, On the Front Lines of Health Equity: Community Health Workers* (Last visited March 20, 2023), https://www.cms.gov/files/document/community-health-worker.pdf.

[9] NATIONAL QUALITY FORUM (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report* (2010),

https://www.qualityforum.org/publications/2010/10/preferred_practices_and_performance_measures_for_measuring_and_reporting_care_coordination.aspx.

[10] *Id.*

[11] *Id.*

[12] E. Lee Rosenthal, Carl H. Rush, and Caitlin G. Allen, *Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field,* THE COMMUNITY HEALTH WORKER (CHW) CORE CONSENSUS (C3) PROJECT (July 2016), https://www.c3project.org/_files/ugd/7ec423_fad3aaf52fc642e7984da849d50b10a7.pdf

[13] *Id.*

[14] Minn. Stat. § 256B.0625 Subd.56(a)(1).

[15] Minn. Stat. § 256B.0625 Subd.56(c)(1).

[16] Minn. Stat. 256B.0625 Subd.56a(b). Officer-involved community-based care coordination may only be provided by an employee of the county or an individual in contract with the county or is either an employee of or under contract with an Indian health service facility or one owned an operated by a tribe or a tribal organization. *See* Minn. Stat. 256B.0625 Subd.56a(c).

[17] Minn. Stat, 62U.03 §9.

[18] *Id.*

[19] Minn. R. 4764.0020, Subp. 5.

[20] Minn. R. 4764.0020, Subp. 3.

[21] Ariz. Rev. Stat. § 36-765.

[22] 405 Ind. Admin. Code 405 IAC 5-21.8-2 (c).

[23] 405 Ind. Admin. Code 405 IAC 5-21.8-8(e)(5).

[24] Iowa Admin. Code R.641 §76.4(135).

[25] MCL 330.1100a(8).

[26] MCL 330.1712 (1).

[27] MICHIGAN PRIMARY CARE CONSORTIUM, *Building Michigan's Coordination of Care Infrastructure* (January 30, 2018), https://mihin.org/wp-content/uploads/2018/09/Coordinating-the-Care-Coordinators-White-Paper-FINAL-1-31-18.pdf.

[28] *Id.* at 36.

[29] *Id.*

[30] NM Stat. 27-2-12.15(A)(8).

[31] NM Stat. 27-2-12.15(A)(9).

[32] NEW MEXICO HUMAN SERVICES DEPARTMENT, *Medical Assistance Division, Managed Care Policy Manual* (Last visited March 7, 2023), https://www.hsd.state.nm.us/wp-content/uploads/2020/12/Centennial-Care-Managed-Care-Policy-M.pdf.

[33] *Id.* at 37.

[34] N.M. Admin. Code. § 8.308.10.9(1).

[35] N.M. Admin. Code. § 8.308.10.9(3).

[36] Ohio Rev. Code § 4723.81.

[37] Ohio Rev. Code § 5167.173(A)(5)(a).

[38] Ohio Rev. Code § 5167.173(B).

[39] Or. Rev. Stat. Ann. § 414.025(7) and (15a).

[40] Or. Admin. Rule. 309-019-0105(17).

[41] *Id.*

[42] Or. Admin. Rule. 309-019-0105(18).

[43] Or. Admin. Rule. 309-019-0105(26); Or. Admin. Rule. 410-180-0305(18).

[44] Or. Admin. Rule. 410-120-0000(39).

[45] Or. Admin. Rule. 410-120-0000(242).

[46] Or. Admin. Rule. 410-138-0060(10).

[47] Or. Admin. Rule. 410-138-0060(11).

[48] Or. Admin. Rule. 410-120-0000(140).

[49] R.I. Gen. Laws 1956, §§ 23-64.1-2.

[50] "RIte Care is Rhode Island's Medicaid managed care program for families with children, pregnant women, and children under age 19." THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES- STATE OF RHODE ISLAND, *RIte Care* (Last visited March 9, 2023), https://eohhs.ri.gov/Consumer/FamilieswithChildren/RIteCare.aspx .

[51] R.I. Gen. Laws 1956, §§ 23-64.1-8.

[52] Wash Admin. Code §182-533-0315.

[53] *Id.*

[54] *Id.*

[55] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Medicaid State Plan Amendments* (Last visited March 20, 2023), https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

[56] ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, *Arizona State Plan Amendment (SPA) 22-0029* (April 1, 2023), https://www.medicaid.gov/medicaid/spa/downloads/AZ-22-0029.pdf.

[57]CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *California State Plan Amendment (SPA) 22-0001* (July 1, 2022), https://www.medicaid.gov/medicaid/spa/downloads/CA-22-0001.pdf.

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] STATE OF LOUISIANA DEPARTMENT OF HEALTH, *Louisiana State Plan Amendment (SPA) 22-0003* (February 1, 2022), https://www.medicaid.gov/medicaid/spa/downloads/LA-22-0003.pdf .

[62] *Id.*

[63] MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Michigan State Plan Amendment (SPA) 15-2000* (July 1, 2016), https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-15-2000.pdf.

[64] *Id.*

[65] MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Michigan State Plan Amendment (SPA) 20-1500* (October 1, 2020), https://www.medicaid.gov/medicaid/spa/downloads/MI-20-1500.pdf

[66] *Id.*

[67] HEALTH AND HUMAN SERVICES STATE OF RHODE ISLAND, *Rhode Island State Plan Amendment (SPA) 21-0012* (July 1, 2021), https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0012.pdf .

[68] *Id.*

[69]SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES, *South Dakota State Plan Amendment (SPA) 19-005* (April 1, 2019), https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SD/SD-19-005.pdf.