



2021 STATE LEGISLATIVE AGENDA

AB191 POLICY BRIEF

MEDICAID REIMBURSEMENT FOR COMMUNITY HEALTH WORKERS HILEY DOBBS, GRADUATE STUDENT, INTERN KELLY BUMGARNER, PHD, MPH, DIRECTOR OF HEALTH POLICY

Nevada's beautiful and expansive geography presents one of our greatest challenges in connecting Nevadans to healthcare: Of Nevada's 17 counties, 14 are rural or frontier regions, accounting for 87% of its land mass. Across the state, the ratio of primary care providers (PCPs) to the population is 37% below the national average, dropping to 43% below average in our frontier and rural counties (1). Especially during the pandemic, this limited access to care presents significant risks to our communities, families, and children. Without a PCP, Nevada's children often lack support to address social factors (social determinants of health) like geography, exposure to violence, access to food, and housing instability. Social determinants adversely impact health outcomes and are often additional barriers to accessing care for those who need it most (3,8). Effective delivery of healthcare and support services across our state are a crucial part of protecting children from preventable illness and injury.

Advocates, scholars, nonprofits, and governmental entities have explored various models to attract physicians, nurse practitioners, physician's assistants, and other licensed medical providers to rural and frontier areas. Loan forgiveness programs and other incentives are often used to draw providers to underserved communities (6). Erik Schoen, Executive Director of Community Chest, calls this method "import-a-professional". While this strategy does temporarily alleviate need, it is not sustainable, as providers do not have roots in the area and often return to their home communities once their obligations are fulfilled. Additionally, out of town providers who are not members of a community may struggle to understand or build trust with those they serve (2).

Community Health Workers (CHWs) are trusted, culturally competent, cost effective, trained, and certified professionals who work in a variety of settings under different titles; in schools as resource coordinators, in health centers as care coordinators, or in treatment centers, food banks, and tribal health centers (1). CHWs are certified to work under the supervision of licensed healthcare professionals (MD, DO, APRN, and PA) to provide what DuAne Young, Deputy Administrator of the Division of Health Care Financing and Policy, calls "non-glove" services (2). These services do not replace the work of licensed medical providers or community paramedics who provide "gloved" services like medication administration or wound dressing; rather, they support access to care by teaching health literacy, providing individualized health goal tracking, and creating connections between community resources and basic needs. Community Health Workers allow other professionals to work at the top of their scopes of practice (2,3).

Instead of importing professionals, CHWs are homegrown. In Nevada, most CHWs are residents of the communities they serve and are working to become healthcare or service providers with a higher scope of care. Ninety-two percent of CHWs report that they are interested in developing their skill sets and continuing their education to pursue careers in health/human services (7). In October 2019, there were 820 certified CHWs in Nevada. Twenty percent of Nevadan CHWs work in clinics already equipped for Medicaid billing (7). Currently, Nevada's CHW Program is grant funded through the Center for Disease Control and Prevention and other federal grants (5,9). However, to support and expand the work of CHWs, sustainable funding (like Medicaid reimbursement) is required.

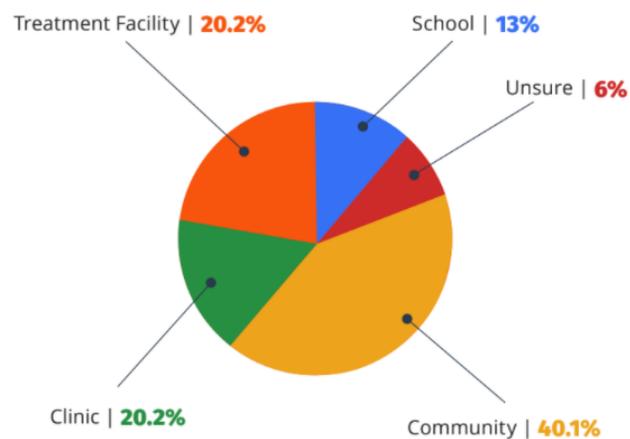
In public comment at the Legislative Committee on Health Care in 2019, Faith Barber of Carson City Health and Human Services testified to the importance of CHWs, not only for culturally competent care and a sustainable workforce, but also for cost savings. Barber shared the story of a woman who had visited the emergency room by ambulance over 30 times, costing the city over \$90,000. Once the woman was matched with a CHW who connected her to resources providing the medication she needed, the calls stopped (2). Utilization of CHW services reduces health spending by allowing clinicians to work at the top of their scope and ensuring costly emergency and speciality services are not overutilized. This model is 40% less expensive than other routes of healthcare capacity building, such as recruiting more expensive professionals (2). Multiple states have noted economic benefits and return on investments, estimating \$2-\$6 in savings for every dollar spent on CHWs (1,2,3). A Baltimore program that utilized Medicaid funds to match diabetic patients with CHWs demonstrated significant decreases in emergency room visits and hospitalizations (38% and 30%, respectively), equaling a 27% reduction in Medicaid costs (1).

Medicaid coverage of CHW services through existing billing codes would sustainably mitigate the provider shortage in our state. Health centers could bill Medicaid for CHW services, thus increasing the number of facilities able to hire CHWs, which would create more jobs during this sustained economic downturn. 60,000 Nevadan children do not have health insurance, and experts estimate at least half of them are eligible for Medicaid or the Children's Health Insurance Plan (CHIP) (10,11). The implementation of Medicaid funded CHW services would reach a significant number of children in our state to increase coverage and access to care while decreasing costs (4).

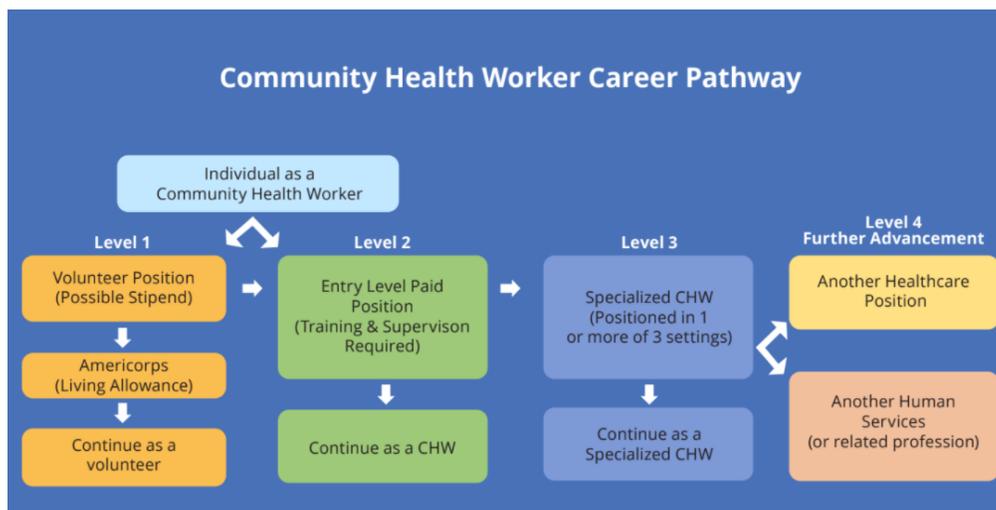
RECOMMENDATION FOR IMPROVEMENT:

-Allow Nevada Medicaid to reimburse services provided by Community Health Workers

Nevada Community Health Worker Association (2020)



The results represent 391 responses from CHWs to an ongoing survey conducted by the Nevada Community Health Worker Association between December 5, 2017 through October 28, 2019.



REFERENCES & FURTHER READING GUIDE

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