STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0115

Assembly
California Legislature

Joint Informational Hearing

Assembly Health Committee and Budget Sub No. 1

Assemblymembers Bonta and Dr. Weber, Chairs

Bright Spots and Remaining Barriers to Realizing the Potential of Community Health Workers, Promotoras, and Representatives to Improve Health in California

Tuesday, March 12, 2024 – 1:30 PM
1021 O Street, Room 1100

BACKGROUND

Summary

Building the community health workers, promotoras, and representatives (CHW/P/R) workforce and financing CHW/P/R services are promising strategies to promote health equity and person-centered, culturally competent care. By leveraging their deep understanding of and connection to their communities, CHW/P/Rs can help people navigate the health care system and access resources; provide salient and understandable health information; support and advocate for someone as they grapple with a health condition; and, much more. Evidence demonstrates that CHW/P/Rs can improve health outcomes and health equity in a variety of settings, with differing populations, and with specific diseases and conditions.

In recent years, the state has enacted two major initiatives related to CHW/P/Rs: First, the Department of Health Care Services (DHCS) added CHW services as a Medi-Cal benefit starting in July 1, 2022, and has leveraged CHW/P/Rs in specific roles under the Medi-Cal transformation project called California Advancing and Innovating Medi-Cal (CalAIM). Second, the 2022 Budget Act included $281.4 million over three years to support a new program administered by the Department of Health Access and Information (HCAI) to recruit, train, and certify 25,000 new CHW/P/Rs by 2025.

Both initiatives are still in the early stages of implementation, and although there is significant excitement about these investments and the potential of both initiatives, and a number of promising developments, a diverse array of stakeholders have also noted various barriers to

implementing these efforts and to expanding CHW/P/R workforce and services generically. This hearing aims to provide background on CHW/P/Rs and recent state efforts, document and discuss both bright spots and challenges in implementation of the state initiatives and broader deployment of CHWs, and challenge all involved stakeholders to think deeply about what more can be done, as well as what each stakeholder can do within their unique role, to help the state realize the transformative potential of CHW/P/Rs to improve health and health equity in California.

Background

Who are CHW/P/Rs?

According to the National Association of Community Health Workers, "CHW" is used as an umbrella term to describe community health representatives, promotores de salud or promotoras, outreach workers, and many other different work titles.[1] CHWs share life experience with the people they serve and have firsthand knowledge of the causes and impacts of health inequity. In the United States (US), the majority of CHWs serve communities that have experienced structural oppression and who are marginalized by traditional health care systems, including Black, Latinx, American Indian/Alaska Native, and Asian/Pacific Islander communities, as well as rural and low-income communities. [2] According to the American Public Health Association (APHA), CHWs can assist in addressing health issues from a community-centered approach; however, their presence in the US health system is fragmented, and their potential contributions are poorly understood by many.[3]

APHA defines CHWs as frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. APHA's definition is commonly cited by other organizations. California's Welfare and Institutions Code Section 18998 contains a similar definition, and emphasizes that a CHW's lived experience aligns with and provides a connection to the community being served.

Although CHW is commonly used as an umbrella term, promotores and Community Health Representatives (CHRs) have distinct histories and footprints in California.

- **Promotores**. Promotores de salud, or promotores, are lay health workers who most often provide culturally congruent services informed by their lived experiences to Spanish-speaking communities. Characterized by servicio de corazon (service from the heart), promotores are skilled relationship builders who share lived experiences with other

[1] (National Association of Community Health Workers, 2024)
[2] (Knowles M, 2023)
[3] (American Public Health Association, 2009)

community members and are agents of change in immigrant communities, low-income communities, and communities of color.[4]

- **CHRs**. According to the federal Indian Health Service (IHS), a CHR is a tribal or Native community-based, well-trained, medically-guided, health care provider, who provides health promotion and disease prevention services in their communities and may include traditional Native concepts in their work. CHRs serve as a link between the clinical setting and the community to facilitate access to services and improve the quality and cultural competence of service delivery. IHS established a grant program to fund CHRs in 1968 in response to the expressed needs of American Indian and Alaska Native governments for a health care program which would provide an outreach component to meet specific tribal health care needs.[5]

What Do CHW/P/Rs Do?

CHWs work to improve overall health in under-resourced communities by providing social support, care coordination, navigation, coaching, and advocacy. CHWs also provide culturally appropriate health promotion and education.[6] During the COVID-19 pandemic, CHWs played an important role in trying to mitigate the spread of the virus.

CHW/P roles and contributions can vary significantly. Some CHW/Ps focus on health education for specific health conditions, such as asthma or diabetes; others employ strategies to address the social determinants of health, such as housing access or workplace safety.[7]

There is currently no national consensus on CHW "scope" and qualifications; however, the Community Health Worker Core Consensus Project (C3 Project), coordinated by University of Texas – Houston School of Public Health, has synthesized a single set of CHW roles and competencies, which is commonly used by those both inside and outside the field (below).[8]

C3 Project Core CHW Roles

1) Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems;
2) Providing Culturally Appropriate Health Education and Information;
3) Care Coordination, Case Management, and System Navigation;
4) Providing Coaching and Social Support;
5) Advocating for Individuals and Communities;
6) Building Individual and Community Capacity;
7) Providing Direct Service;
8) Implementing Individual and Community Assessments;
9) Conducting Outreach; and,

[4] (Visión y Compromiso , 2024)
[5] (US Indian Health Service, 2024)
[6] (Haldar & Hinton, 2023)
[7] (California Health Workforce Alliance, 2015)
[8] (Community Health Worker Core Consensus Project, 2014-2022)

10) Participating in Evaluation and Research.

C3 Project Core CHW Competencies

1) Communication Skills;
2) Interpersonal and Relationship-Building Skills;
3) Service Coordination and Navigation Skills;
4) Capacity Building Skills;
5) Advocacy Skills;
6) Education and Facilitation Skills;
7) Individual and Community Assessment Skills;
8) Outreach Skills;
9) Professional Skills and Conduct;
10) Evaluation and Research Skills; and,
11) Knowledge Base.

CHWs can work across a wide range of health conditions and settings, as well as with diverse population groups, including children and adults. The federal Centers for Disease Control and Prevention (CDC) provides examples of CHW programs across a range of chronic conditions and infectious disease, injury prevention, and general health and wellness. Medi-Cal's CHW benefit, which is further detailed below, similarly allows CHWs to address a wide range of health issues.

CHW/P/Rs in California

As of May 2022, the federal Bureau of Labor Statistics (BLS) estimated about 67,200 CHWs working in the US, with 8,940 working in California.[9] However, this is likely an underestimate, given the various titles and roles that may be similar to CHWs. A 2007 study by the federal Health Resources and Services Administration more specific to the CHW workforce estimated there were about 86,000 CHWs in the US in 2000.[10] The BLS projects a growth rate for CHWs of 14% over the next ten years, which is much faster than average for all occupations. If the state's workforce goals of training 25,000 CHWs are met in the coming years, the growth rate would be significantly higher.

Between October 2021 and January 2022, researchers affiliated with the Philip R. Lee Institute for Health Policy Studies and Healthforce Center at UCSF conducted a survey of California CHW/Ps working in a paid CHW/P position.[11] Among these respondents, key findings included:

- Nearly 60% reported employment with a community-based organization, while close to 20% indicated they were employed by a Federally Qualified Health Center (FQHC).

[9] (US Bureau of Labor Statistics, 2022)
[10] (US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, 2007)
[11] (Chapman, Bates, & Miller, 2022)

- Most respondents had completed relatively short CHW/P training (40 hours or less). Nearly 70% of survey respondents had completed CHW/P training. For most of these respondents, training was required and paid for by their employer.
- The type of work that respondents most often reported performing included identifying/ referring people to community resources and case management/coordination/navigation.
- The work of a plurality of respondents did not focus on specific health conditions. Among respondents whose work did focus on particular health conditions, chronic health conditions like diabetes and complex health or social needs were most often reported.
- A majority of respondents were women (79%) and Latinos/x (65%).
- A majority of respondents were employed in the Bay Area.
- Nearly two-thirds of respondents' employers required a high school diploma or less.
- Almost 70% reported they spoke more than one language, and among this group, 84% indicated they spoke both English and Spanish.

For individuals, working as a CHW also provides an entry-level position in the health care system with relatively low formal educational and training requirements. Nearly half of respondents to the survey above were paid $20 to $25 per hour. The BLS estimates annual mean wages of around $51,200 in the greater Los Angeles area and $67,600 in the San Francisco Bay Area for these workers.

Financing CHW/P/R Services

Most CHW/P/R services rely on the availability of public or private grant funding, which have historically been the primary sources of financing for CHW services and salaries[12]. Some health care payers and providers have also opted to internally finance CHW programs. The APHA points out relying on grant funding for CHW services can create persistently low wages, high turnover, and low job security.[13]

This dynamic of grant-based funding has the potential to change with the introduction of CHW services as a Medi-Cal benefit. However, it should be noted Medi-Cal will not cover all the different types of activities that are in a CHW/P/R's scope. Similar to traditional health care providers, CHWs can provide services directly to individuals, but they also commonly provide services for and on behalf of communities. Although a single CHW may fluidly move between these different types of activities, this distinction becomes important in the context of financing CHW services, since only services directly provided to individuals (or defined groups, such as participants in a health education class) are considered reimbursable health care benefits. Other community-based public health services may not be billable to Medi-Cal.

Evidence for CHW/P/Rs

Evidence demonstrates CHWs can have an impact on health outcomes in a variety of settings, with differing populations, and with specific diseases and conditions. Studies highlight positive outcomes for HIV, heart failure, stroke prevention, childhood asthma, and type 2 diabetes,

[12] (Rush, 2020)
[13] (American Public Health Association, 2009)

among others.[14] Studies clearly demonstrate that CHWs contribute significantly to improvements in members' access to and continuity of care, screening and other prevention activities, and adherence to treatment. Research also confirms the effectiveness of CHWs in reducing health care costs and advancing health equity.[15] As explained above in "Who are CHW/P/Rs?," CHW/P/Rs achieve these results because of their deep understanding of their communities, as well as the knowledge and skills to be the bridge between their communities and health care system. They can use their understanding of the socioeconomic and cultural context to communicate effectively and develop tailored approaches that are more likely to succeed.[16]

In 2019, the California Future Health Workforce Commission recommended scaling the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement.[17] The Commission's final report indicated such providers can help meet increasing demand for team-based integrated primary and behavioral health care, drawing on lived experience and experiential knowledge to support better health outcomes for all and to promote recovery and self-sufficiency for people with mental illness and substance use disorder.

State Efforts

Expanding CHW/P/R Services and Workforce Aligns with State Goals and Goals of Many Advocacy and Health Care Organizations

Through legislation, resolutions, hearings, and budget actions, the California Legislature has highlighted the importance of addressing social determinants of health, health-related social needs, and workforce diversity and cultural competence in health care delivery. Similarly, California state health agencies including the California Health And Human Services Agency (CalHHS), DHCS, and HCAI have explicitly embraced person-centered, culturally competent care and health equity as part of their core strategic priorities. Many health care organizations representing professionals and facilities, as well as advocates for ethnically and racially diverse low-income children, individuals, and families, have similarly recognized and embraced health equity, addressing stubborn health disparities, and empowering patients to manage and improve their health as key strategic priorities.

Given the evidence cited above of CHW/P/Rs effectiveness at addressing these goals, building the CHW/P/R workforce and financing the services they provide to diverse communities throughout California is squarely aligned with these strategic priorities.

[14] (Kim, 2016)
[15] (Center for Health Care Strategies, 2021)
[16] (ibid.)
[17] (California Future Health Workforce Commission, 2019)

CHWs in Medi-Cal

CHW Services

As of July 1, 2022, over half of states (29 of 48) reported allowing Medicaid payment for services provided by CHWs.[18] DHCS engaged with stakeholders and experts on Medicaid coverage of CHW services in other states to inform policy and implementation of the CHW benefit. DHCS added CHW services, including violence prevention services, as a Medi-Cal benefit starting July 1, 2022. The benefit was codified through AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022. CHW services are defined to include those delivered by promotores, CHRs, navigators, and other non-licensed public health workers.

General Rules. CHW services are defined in Medi-Cal under federal regulations on "preventive services," and must therefore be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. In addition to physicians, a range of non-physician medical practitioners and behavioral health professionals can recommend CHW services. The recommending provider does not need to be enrolled in Medi-Cal or be a network provider for the Medi-Cal member's managed care plan. Medical necessity for services is defined fairly broadly—individuals are eligible for services if they have one or more chronic conditions, have a behavioral health diagnosis or suspected behavioral health condition, have visited a hospital emergency department or had an inpatient stay within the prior six months, express need for support in health system navigation or resource coordination, or meet at least one of a number of other criteria. To provide more than 12 units (six hours) of CHW services for an individual, the services must be provided pursuant to a written plan of care.

Services can be provided in an individual or group setting, and can be provided virtually. There are no restrictions as to where services can be delivered.

The federally approved State Plan Amendment[19] for CHW services describes the services and qualifications, and the Medi-Cal Provider Manual for CHW services[20] further describes billing procedures, policies, and supervision of CHWs. The supervising provider, who submits claims for services, is an enrolled Medi-Cal provider who oversees the services provided and ensures a CHW meets the defined qualifications. The supervising provider can be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO). CHWs may be supervised by a CBO or LHJ that does not have a licensed provider on staff.

Types of Health Conditions. CHWs can address issues that include but are not limited to:

- Control and prevention of chronic conditions or infectious diseases;
- Mental health conditions and substance use disorders;
- Perinatal health conditions;

---

[18] (Haldar & Hinton, 2023)

[19] (Department of Health Care Services, California State Plan Amendment (SPA) 22-0001, 2022)
[20] (Department of Health Care Services, CHW Preventive Services Manual, 2024)

- Sexual and reproductive health;
- Environmental and climate-sensitive health issues;
- Child health and development;
- Oral health;
- Aging;
- Injury;
- Domestic violence; and,
- Violence prevention.

Specific Activities. Medi-Cal defines CHW services as including:

- Health education;
- Navigation to health care and other community resources that address health-related social needs;
- Screening and assessment to identify the need for services; and,
- Individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence.

CHW Qualifications

Unlike most health care professionals, there are no required qualifications for CHWs at the state level, such as a license or certificate. Therefore, minimum qualifications for CHWs were defined through the Medi-Cal State Plan Amendment that added the service. CHWs must demonstrate minimum qualifications through either: 1) earning a certificate of completion that attests to skills and/or training in the "C3 Core CHW Competencies" listed above; or, 2) an experience pathway, whereby an experienced individual can provide services for a maximum of 18 months without a certificate of completion. A Violence Prevention Certificate allows individuals to provide CHW violence prevention services. CHWs must also have lived experience that aligns with and provides a connection between the CHW and the community being served.

These qualifications only apply to CHWs for purposes of Medi-Cal billing; there are no minimum qualifications one must meet to work as a CHW **outside** of Medi-Cal.

CHWs in CalAIM

CHW/P/Rs also deliver case management and navigation services within programs under the umbrella of the CalAIM initiative. DHCS describes CHW services as an integral part of Enhanced Care Management (ECM) and Community Supports offered by Medi-Cal managed care plans (MCPs) through CalAIM. DHCS indicates it engaged considerably with stakeholders relative to Enhanced Care Management and Community Supports offered by MCPs as part of CalAIM.

ECM addresses the clinical and non-clinical needs of the highest-need Medi-Cal members by building trusting relationships with members and providing intensive coordination of health and health-related services. Given the lived experience and skill set of CHWs, they are well-suited to this work and are currently engaged across the state in providing ECM services.

Community Supports are services provided by MCPs to address Medi-Cal members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. Some Community Supports can be provided by CHWs directly, such as housing transition navigation services. For others, such as the medically supportive food benefit, CHWs can help educate members about and connect them to the services.

DHCS has put rules in place to prevent double-billing for services like navigation that may be provided as part of ECM or Community Supports as well as under the CHW benefit.

CHW Benefit Utilization and Expenditure Data

As of July 1, 2022, CHW services have been a covered benefit in Medi-Cal Fee-for-Service (FFS) and managed care. The 2023 Budget and the 2024-25 Governor's Budget each assume total annual Medi-Cal expenditures of $91.9 million for the CHW benefit ($82.7 million in managed care and $9.2 million in FFS). Costs associated with CHW services are reflected in managed care rates as of January 1, 2023.

Actual data on CHW visits billed to Medi-Cal through FFS and managed care through January 25, 2024, are shown in the chart below. These data only include CHW services that were individually billed through the CHW benefit. CHW services are also billed in other ways, so these data do not include important avenues through which CHW services may be delivered in Medi-Cal. Specifically, CHW visits provided by FQHCs, and ECM and Community Supports services provided by CHWs, are not included in the data.

Delivery System	Total Unique Members Served*	Total Visits*	Total Reimbursements*
Fee for Service	106	129	$3,413
Managed Care	5,376	8,765	Exact amount is unknown; Less than $1 million

* Numbers do not include CHW visits provided by FQHCs nor Enhanced Care Management and Community Supports services provided by CHWs.

Budget estimates for new benefits, particularly when provided by non-traditional providers, are often uncertain and a ramp-up period is expected. Although the data show thousands of Medi-Cal members have received CHW services through the CHW benefit, given the size of the Medi-Cal population and the potential to deploy CHWs in many different areas to meet health and health-related social needs, it is apparent that the rollout of the CHW benefit has been slower than anticipated.

Implementation Efforts

DHCS has taken a number of actions to describe expectations for coverage and provision of the CHW benefit, as well as planned monitoring. These actions include:

1) **Guidance to Managed Care Plans**. Most Medi-Cal members are now enrolled in and receive services from MCPs. DHCS issued an all-plan letter (APL) to describe how MCPs must deliver the CHW Medi-Cal benefit. APL 22-016[21], originally issued in 2022 and updated in September 2023, includes the following guidance:

   - **Use of Data to Target Services**. Plans must use data to determine and understand priority populations eligible for CHW services, including specific processes specified by DHCS to help with identification and assessment of priority populations. Plans should use this data to identify members who qualify for CHW services and attempt outreach to qualifying members and their providers to encourage utilization of CHW services. MCPs should prioritize usage of CHW services for priority populations.

   - **Education about Benefit**. Plans should encourage providers to communicate with members about the availability of CHW services.

   - **Adequacy of Providers**. As part of their network, MCPs must ensure and monitor sufficient provider networks within their service areas, including for CHW services. DHCS strongly encourages MCPs to contract with existing CHW networks serving Medi-Cal populations, especially those in local public health departments.

   - **Integration Plan**. The APL requires MCPs to submit to DHCS, for review and approval, a CHW Integration Plan that describes the MCP's strategies for supporting CHW integration and approach for building sustainable infrastructure and supports. The Integration Plan must address how the plan will integrate CHWs into care delivery, build CHW capacity in provider networks, communicate to members and providers about the scope, benefits, and availability of CHW services, and how the plan will monitor utilization and evaluate the impact of CHWs. DHCS encourages plans to focus their initial CHW integration plan to align with DHCS' Bold Goals Initiative, as outlined in the 2022 DHCS Comprehensive Quality Strategy. These priority areas include improving behavioral health integration into primary care, children's preventive services, and birth outcomes—meaning plans are advised to first develop CHW capacity in these areas.

     In the APL, DHCS indicates it will monitor MCPs' implementation of the requirements through existing data reporting mechanisms such as encounter data and grievances and appeals, as well as reviewing the Integration Plan to determine the number of CHWs within each network. DHCS indicates any failure to meet the requirements of the APL may result in a corrective action plan and subsequent sanctions. The APL does not articulate specific utilization benchmarks plans are expected to meet, specify how quickly plans are expected to ramp up services, define what constitutes a sufficient provider network, nor whether specific actions will be taken if plans do not meet expectations.

[21] (Department of Health Care Services, All-Plan Letter 22-016 (Revised), 2022-2023)

However, DHCS notes the following as it relates to efforts to hold plans accountable to provide and support CHW services:

- DHCS continues to work with MCPs to understand barriers and encourage them to grow their network. As DHCS receives data from MCPs, DHCS will have a better understanding of how MCPs are utilizing CHWs in their network and the barriers to increasing provider participation, whether actual or perceived.
- DHCS will continue to identify ways to provide further guidance to MCPs to leverage the CHW benefit.
- DHCS has several enforcement levers in the event that the MCP fails to meet the requirements of the contract, such as providing access to CHW services. These include administrative and financial enforcement actions such as corrective action plans and monetary penalties. The authorizing statute for sanctions considers good cause as a basis for imposing sanctions.

2) **New Enrollment Pathway for Community-Based Providers**. CBOs and LHJs have traditionally been major employers of CHWs. Effective January 8, 2024, LHJs and CBOs providing community health worker and/or asthma preventive services are able to enroll as Medi-Cal providers and submit their applications through Medi-Cal's Provider Application and Validation for Enrollment (PAVE) online enrollment portal. Although MCPs were not prohibited with contracting from these providers prior to the availability of the PAVE enrollment pathway, the pathway allows these entities to establish they meet Medi-Cal provider requirements on a statewide basis and is anticipated to help streamline the credentialing and contracting process between these entities and MCPs.

3) **Incentive Payments.** DHCS's CalAIM Incentive Payment Program (IPP) supports the implementation of new initiatives by providing incentives to MCPs. To incentivize CHW services, the IPP contains a measure that tracks the number of members using CHW services and total CHW encounters, and directly incentivizes MCPs to offer CHW services. Although plans reported little utilization in the period covering January 2023 through June 2023, DHCS expects utilization to increase for July through December 2023, for which data will be reported in March 2024. Increasing CHW utilization will allow plans to earn incentive payments**.**

4) **Dental State Plan Amendment.** Although the CHW benefit already includes oral health, there is not currently a pathway for billing within the Medi-Cal Dental program. Dental providers use a specific set of billing codes separate from those used by medical professionals. DHCS is submitting a State Plan Amendment for federal approval necessary to establish these codes, which will allow for billing within the Medi-Cal Dental program for oral health-related CHW services.

5) **Population Health Management (PHM) Monitoring**. In addition to requiring CHW Integration Plans through the APL mentioned above, DHCS intends to monitor the provision

of CHW services through another CalAIM initiative called PHM.[22] PHM is designed to ensure that all members' needs are assessed and they are provided appropriate services based on their needs. All MCP members, regardless of need, receive Basic PHM, which DHCS defines to include a range of primary and preventive care and care coordination services, including services provided by CHWs under the new CHW benefit. Through Basic PHM monitoring, MCPs will report on and DHCS will monitor the percentage of members who receive CHW benefit services.

HCAI Workforce Funding

The 2022 Budget Act included approximately $281.4 million over three years to support a new program to recruit, train, and certify 25,000 new community health workers by 2025, including those with specialized training to work with specific populations or on specific issues. According to HCAI, the training requirements would align with Medi-Cal requirements for reimbursement.

1) **Funding Delays**. In 2023, the Governor proposed to delay all funding for this project for one year, but the final 2023 Budget Act retained $15 million in the HCAI budget for CHWs for fiscal year 2023-24. The 2023 Budget Act assumed the balance of the $281.4 million funding would be spread over the following two budget years. The 2024 Governor's Budget maintains the same funding level that was approved in 2023 for this initiative. The chart below shows the original 2022 Budget Act numbers and the revised numbers which incorporate the delay.

   (In millions)

	2022-23	2023-24	2024-25	2025-26
2022 Budget Act	$20	$130	$131.4	$0
2023 Budget Act (same as Governor's Proposed 2024-25 Budget)	$20	$15	$188.9	$57.5

2) **HCAI Statutory Requirements.** SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, the 2022 Health Trailer Bill, described the initiative. It required HCAI to develop statewide requirements for CHW certificate programs in consultation with stakeholders. Specifically, it required HCAI to do the following:
   - Consult evidenced-based and community-defined materials.
   - Determine necessary curriculum to meet certificate program objectives.
   - Determine criteria for specialty certificate programs and specialized training requirements that build on the lived experience of community health workers.
   - Determine a structure of statewide oversight that reduces barriers to training.
   - Determine how past experience as a community health worker may provide a pathway to certification, and how to verify past experience.
   - Approve statewide requirements for the development of certificate programs for CHWs, approve the curriculum for such programs, and review, approve, or renew evidence-based

[22] (Department of Health Care Services, CalAIM: Population Health Management (PHM) Policy Guide, 2024)

curricula and community-defined curricula for core competencies, specialized programs, and training. The statute allows organizations to submit an application for HCAI approval of a CHW certificate program.

3) **Implementation Work**. In July 2023, following a series of stakeholder consultation sessions, HCAI issued a guidance letter implementing the requirements described above. However, the guidance letter has since been "paused," as explained further below. The July 2023 letter outlined:
   - Core competencies and roles aligned with the C3 project, discussed above;
   - Multiple pathways to obtain a state-issued CHW/P/R certificate, including training pathways and an experience pathway that would allow a CHW/P/R to be "grandfathered" in based on documented hours, attestation of lived experience, and verification of a supervisor;
   - Reciprocity with other states and countries;
   - Renewal on a two-year cycle; and,
   - General requirements for specialty certificate training programs.

   The letter discussed the CHW requirements for Medi-Cal, and indicated that HCAI is working closely with DHCS to align pathways and eventually consolidate into one state certificate process for CHW/P/Rs.

4) **Stakeholder Engagement and Work Going Forward**. HCAI has paused implementation of its July 2023 guidance letter and funding in order to conduct a more robust and responsive stakeholder engagement process. HCAI's stakeholder work is described below:

   - **Initial Stakeholder Work**: To inform the development of the July 2023 guidance letter, HCAI conducted 43 stakeholder sessions with a total attendance of 1,573 across all sessions. HCAI developed the certificate model through three iterative models in response to stakeholder feedback. HCAI shared each certificate model iteration in draft form during information sessions and solicited suggestions for improvement. HCAI conducted sessions in Spanish and offered Spanish language translation services during English sessions. Written feedback from stakeholders was also encouraged, and HCAI received written comments in both English and Spanish. HCAI offered to provide translation and interpretation services in other languages upon request.

   - **Current Work:** The state team comprised of CalHHS, DHCS, and HCAI has been working since late 2023 to design a further stakeholder engagement process, which launched in February. This work is planned to conclude in June 2024. In late February, the agencies convened an ad hoc advisory group comprised of a number of key organizations and thought leaders in the CHW/P/R space. This group advised on the dialogue guide, process, and site selection for stakeholder input and will continue to advise to ensure the process is comprehensive, relevant, and appropriate. The goal is to get stakeholder feedback on the following questions:

a) The state's vision is to expand and support the CHW/P/R workforce in California in order to improve access to and utilization of health care services, specifically for traditionally undeserved communities. What is working well in service of this vision and what are the biggest barriers?

b) How can HCAI best use its funds for recruiting, training, and certifying CHW/P/Rs?

c) What value would a statewide certificate add and for whom? What are the risks or unintended consequences of a statewide certificate, and for whom? Should the certificate be linked exclusively to billing for Medi-Cal?

HCAI indicates the intent is to conduct approximately 20 stakeholder dialogues from February to June 2024, with dialogues appropriately distributed by geography and also covering the wide range of populations that CHW/P/Rs serve. Once the stakeholder process has concluded, HCAI plans to finalize funding priorities with input from the ad hoc advisory group, with the aim of launching grants and contracts reflecting these priorities in early 2025. The first dialogue was held on February 24th, 2024, at La Clinica de la Raza in Oakland. Subsequent sessions are being scheduled with a list of host sites selected to maximize geographic distribution and population representation.

Bright Spots and Challenges

Bright Spots

As described, since 2022, California has taken on a leadership role in promoting the CHW/P/R workforce and services. The last several years has also seen a renewed interest in the importance of CHW/P/Rs based on their health promotion activities during the COVID-19 pandemic, sustained federal attention and investment, and increased effort and investment from private entities in California. Below, some of these promising signs are highlighted.

1) **"Policy Infrastructure" for Medi-Cal Financing of CHW Services.** Although there is significant work that must be undertaken by state agencies, health plans, health care providers, and CBOs to realize the full potential of the CHW benefit and CHW services in Medi-Cal, the policy framework of the CHW benefit, ECM and Community Supports being provided by CHWs, and the role of CHW/P/Rs in Population Health Management are in place. Similar to building a home, which must be framed up before electrical, plumbing, and the rest are built out, this policy infrastructure that is now built should allow for more rapid ramp-up for providers and plans to do program planning and implementation, contracting, hiring, training, and ultimately service delivery.

2) **Responsiveness to Stakeholder Input**. As it pertains to decisions affecting CHW/P/Rs and, by extension, their communities, CHW/P/Rs express an ethos of, "Nothing about us, without us." State departments have been intentional about seeking stakeholder input and this input has informed policy. HCAI's "pause" and reconfiguration of the policy process is intended to ensure a more thorough and robust stakeholder input. However, it should be recognized that

because CHW/P/R policy involves a wide range of stakeholders who have different interests, visions, and perspectives, and policy is constrained by various factors such as statutory and budgetary authority and federal rules, it is likely that decisions ultimately cannot satisfy all stakeholder interests simultaneously.

3) **Availability of CHW Training Programs**. According to the California Association of Community Health Workers, an organization working to promote a "CHW community of practice," at least eighteen California community college programs train CHWs in California.[23] A number CBOs and local agencies also have significant experience in provision of CHW training. In addition, for an established program, formal training on core competencies can be done fairly quickly compared to clinical training for health professionals that takes years. Additionally, although CHW training programs have capacity constraints, they are potentially easier to address than the same constraints in the clinical field such as medical or nursing school capacity or residency slots. CHW training infrastructure exists throughout California despite little direct and systematic state leadership in this space. The existence and experience of these programs is an asset that can hopefully be leveraged to quickly expand the number of CHWs with additional state investment.

4) **Statewide and Regional Collaboratives to Promote CHWs**. In June 2022, the California Health Care Foundation (CHCF), in partnership with Health Leads, launched the CHW/P Workforce Capacity Building Collaborative (CBC). The CBC supports four regional teams across the state. Each team is led by a local organization and includes community partners, such as safety-net health care providers, MCPs, county representatives, CBOs, local workforce investment boards, and more. Collaboratives are in Alameda County and San Diego County, as well as the Central Coast region (Santa Barbara and San Luis Obispo) and southern California (Orange, Riverside, and San Bernardino Counties). These collaboratives have been active in convening interested parties around shared goals and offering opportunities to learn together, and provide technical assistance on scaling CHW programs in a financially sustainable way, including billing and contracting. The San Diego Wellness Collaborative, for instance, has developed a contracting model for ECM whereby CBOs can contract through a central hub. CHCF indicates they hope to expand this work in the coming year.

   In addition, the California Pan-Ethnic Health Network convenes a statewide policy coalition. The CHW/P/R Coalition is a statewide grassroots coalition comprised of CHW/P/R individuals and community-based organizations that serve diverse communities including Black, indigenous, and people of color; immigrant; refugee; LGBTQ+ and persons with disabilities, and other interested stakeholders from across the state. The coalition is dedicated to ensuring that the needs of California's diverse CHW/P/R workforce are addressed and members are able to participate actively in policymaking processes related to the future of their workforce.

[23] (California Association of Community Health Workers, 2024)

5) **Capacity-Building Investments**. DHCS has awarded capacity-building dollars to build up infrastructure for certain providers through a CalAIM initiative called Providing Access and Transforming Health (PATH). PATH is allocating $1.85 billion over five years to build up the capacity and infrastructure of on-the-ground providers, such as CBOs, public hospitals, county agencies, Medi-Cal Tribal and designees of Indian Health Programs, and others, to successfully participate in the Medi-Cal delivery system as California implements CalAIM. PATH was designed to fund items like additional staff, billing systems, and data exchange capabilities that community providers will need to successfully contract with MCPs. However, anecdotally, smaller organizations that may lack readiness to engage in CalAIM initiatives also may not have been able to take advantage of this capacity-building funding. In addition, this funding focused on specific CalAIM initiatives like ECM and Community Supports, not on building capacity to deliver the CHW benefit. Despite these limitations, PATH funding has enhanced the ability of some organizations to integrate CHWs. In addition, some MCPs have also independently funded CHW activities, such as training.

6) **Federal Funding and Attention**.
   - The 2024 Medicare Physician Fee Schedule final rule[24,25] created a new Healthcare Common Procedure Coding System (HCPCS) code and Medicare payment for "community health integration services," which include person-centered planning, health system coordination, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs that interfere with a practitioner's diagnosis and treatment of the patient. According to the federal Centers for Medicare and Medicaid Services (CMS), these are the first Physician Fee Schedule services designed to specifically include care involving CHWs.
   - In 2022, the Health Resources and Services Administration (HRSA) awarded $16.1 million (of a national total of $225.5 million) to six California CHW training agencies through the Community Health Worker Training Program.[26]
   - CDC's Community Health Workers for COVID Response and Resilient Communities[27] initiative, launched in 2021, provided financial support and technical assistance to states, localities, and tribes to put more trained CHWs in the communities that had been hit hardest by COVID-19. According to CDC, this effort trained over 2,000 CHWs in COVID-19 response efforts, integrated CHWs into nearly 2,000 organizations and developed over 500 new partnerships to enhance CHW efforts.

Barriers and Challenges

As discussed, the launch of these new and promising initiatives have increased attention and effort across many players in the health care system to expand the CHW/P/R workforce and services. However, stakeholders have raised an array of challenges that they assert have slowed and constrained robust expansion. These list below, which is not exhaustive, represents a range

[24] (US Centers for Medicare & Medicaid Services, Medicare Physician Fee Schedule Final Rule, 2023)
[25] (US Centers for Medicare and Medicaid Services, Press Release, 2023)
[26] (US Health Resources & Services Administration, FY 2022 Community Health Worker Training Awards, 2024)
[27] (US Centers for Disease Control and Prevention, 2024)

of issues that threaten not only the success and speed of implementation of state initiatives, but also the broader deployment of CHWs across their range of skills, such as addressing health at a community level.

1) **Administrative Infrastructure**. Billing, documentation, enrollment and credentialing, contracting with MCPs, and other administrative issues may pose barriers to integrating the community-based CHW/P/R workforce within the health care system through the CHW benefit. This is particularly true for smaller CBOs who have relied on grant funding and have not developed administrative infrastructure for billing. These administrative issues have also posed a challenge for other potential providers of CHW services, such as many LHJs, and for other nonclinical community-based personnel such as doulas, whose services were also recently added as Medi-Cal benefits. Despite the availability of the PATH capacity-building funding initiative described above, stakeholders continue to raise administrative capacity as a key challenge for many traditional providers of CHW services.

   It is worth considering what more can be done to support the successful integration into Medi-Cal of such nontraditional providers who are embedded in communities across the state— ideally, in a way that is systematic and at scale.

2) **Workforce Adequacy**. Although the HCAI workforce funding is designed to address workforce supply by training more CHW/P/Rs, the overall undersupply of trained and experienced CHW/P/Rs at this time in California constrains the potential for expanding CHW/P/R services until there is a larger workforce. Some health plans, for instance, have cited challenges in finding enough providers and have, in the meantime before HCAI's workforce initiative is launched, trained CHW/P/Rs or arranged for such training.

3) **Ongoing Financial Sustainability**. Programs and services incorporating CHWs have typically been time-limited (vs. permanent) and require combining, or braiding, multiple private and public funding sources.[28] The Medi-Cal CHW benefit offers a more reliable base of permanent, ongoing financial support for CHW services provided to individuals. However, for FQHCs and others looking to build, expand, and sustain a CHW/P/R workforce, various finance-related challenges have surfaced, as described below:

   - **Adequacy of Medi-Cal Reimbursement Rates**. According to a wide range of stakeholders, the most prominent financial challenge is the adequacy of current rates to be able to independently financially support CHW/P/R programs or expansions. The Medi-Cal FFS rates are shown below.

Billing Code	Number of patients	Medi-Cal FFS Rate
98960	Individual patient	$26.66
98961	Group of 2-4 patients	$12.66
98962	Group of 5-8 patients	$9.46

[28] (Insure the Uninsured Project, 2024)

Plans and providers generally agree these rates are inadequate to sustain the cost of providing the services. Although MCPs may negotiate with providers for rates different than FFS rates, FFS rates are commonly used as a baseline. If reimbursement based on billing is inadequate to sustain CHW/P/R services, providers may be wary to provide or expand these services, because ongoing support will require an ongoing subsidy from another part of the organization. For instance, one analysis performed to determine the financial viability of sustaining a CHW/P/R program based on billing the CHW benefit on behalf of an LA-based non-FQHC clinic found that the total "fully loaded" cost of employing a CHW was close to $100,000 and that they could reasonably expect about 60% of this cost to be sustained through billing. A 2023 study examined financing thresholds for sustainability of CHW programs in Medicaid using a simulation model to estimate CHW salaries, equipment, transportation, space, and benefits costs across the US. It estimated the minimum Medicaid FFS payment rate for a 30-min CHW visit (Medicaid billing code 98960) would be a mean of $53.24 nationwide and $67.81 in California (as compared to the current Medi-Cal rate of $26.66).[29]

- **FQHC Reimbursement**. One of the key challenges constraining additional billing for the Medi-Cal CHW benefit and expansion of CHW/P/Rs in FQHCs is that FQHCs cannot bill directly for CHW services like other providers. FQHCs are paid using a federally required, clinic-specific payment methodology called Prospective Payment System (PPS). Clinics are paid a PPS rate for each "visit," where visit is defined as an encounter with a specified (non-CHW/P/R) provider type. The PPS is quite complicated in practice, but it can be considered a cost-based reimbursement structure where allowable costs are divided by number of "visits," as defined, such that the PPS rate represents an average cost per visit. An encounter with a CHW/P/R does not qualify as a visit, so FQHCs cannot receive a PPS rate for such an encounter. FQHCs also cannot bill outside of the PPS structure for Medi-Cal CHW services.

  Theoretically, FQHCs have a mechanism to request reimbursement for CHW services. They may apply to DHCS to undergo a "change in scope of services request." This process could potentially adjust the PPS rate for all visits to include the costs of CHW services. Even though FQHCs could not bill for visits with a CHW/P/R, theoretically, the PPS rate for all visits would slightly increase since the recalculated rate would recognize the additional costs of employing the CHW/P/Rs.

  Although this mechanism exists, in practice, it takes significant administrative work. It is also financially risky for the clinics to recalculate their rate, since they cannot request the rate to simply "add the costs" for CHW services. The new rate requires an exhaustive audit of all costs, and there is no guarantee a rate adjustment would financially benefit the clinic overall. In practical terms, these issues serve as

[29] (Basu, S., Patel, S.Y., Robinson, K. et al. , 2024)

significant disincentives for FQHCs to seek a recalculation of their PPS rate for the chance to add the cost of CHW services. This leads back to a status quo where FQHCs are simply not in a position to bill for CHW services through the CHW benefit and struggle to expand or, sometimes, to sustain CHW services.

According to the California Primary Care Association, Michigan, Kansas, and Rhode Island allow FQHCs to bill outside PPS (on a FFS basis) for CHW services. There is precedent for this in the Medi-Cal program—for instance, DHCS has allowed FQHCs to bill for CalAIM ECM and Community Supports services outside of the PPS rate.[30] Another model for expanding availability of CHW services for FQHC patients is a partnership whereby an FQHC refers to a partner CBO that can provide and bill for the benefit.

- **Little Sustainable Financial Support for Public Health Efforts**. As noted above in "Financing CHW/P/R Services," there is a distinction between "direct health care" versus "public health" activities of CHW/P/Rs. The Medi-Cal benefit provides predictable financial support for direct services that CHW/P/Rs provide to individuals. Although some of the direct services provided by a CHW/P/R may have some degree of overlap with public health services, there are population-based public health activities of CHW/P/Rs that will not be eligible for Medi-Cal reimbursement. For instance, a common CHW/P/R activity like participating in a health fair to educate the broader community about the importance of vaccines or cancer screening is unlikely to be a "billable service," since the encounters are brief and less intensive, and a CHW is not verifying health insurance coverage status or Medi-Cal eligibility. These types of public health activities generally do not have any guaranteed funding and are largely reliant on the availability of time-limited public or private grants. Therefore, community-based public health services performed by CHW/P/Rs that do not fit into the "Medi-Cal box" are most often not supported by a permanent, sustainable funding stream.

4) **Disagreement about the Purpose and Value of Certification**. Certification can enhance professional credibility, promote integration into health care teams, standardize roles and competencies, and enhance professional development and career opportunities.[31] In a study of attitudes of CHW/Ps in California, participants concluded that certification would afford CHWs the opportunity to gain recognition from health care providers and enhance their legitimacy with the communities they serve. [32] Many participants also emphasized certification provides opportunities for establishing a career ladder and better pay. On the other hand, some have pointed out the standardization promoted by certification risks the over-professionalization of CHW roles, which could degrade the cultural ties and trust

[30] (Department of Health Care Services, CalAIM Enhanced Care Management and Community Supports Frequently Asked Questions (FAQ), 2022)
[31] (Coffinbargar, Damian, & Westfall, 2022)
[32] (Kissinger, 2020)

between CHWs and patients. Some participants in the survey described above note that a certification does not necessarily prove a CHW/P/R has relational skills essential for developing trusting relationships. Finally, some see certification requirements as excluding existing CHW/P/Rs or posing a barrier for CHW/P/Rs to find employment. [33] This concern could potentially be mitigated by establishing an "experience pathway" for certification, as DHCS has done and HCAI has proposed to do. A survey of employer perspectives also revealed similarly mixed opinions about certification. As noted above, HCAI intends to collect additional stakeholder feedback about the purpose and value of certification. Although certification has a number of potential benefits, it will be important in the course of designing the certification program for HCAI to think critically about its features and mitigate any potential downsides of such programs to the extent possible. HCAI's "pause" in the implementation of the certification program appears to be intended to foster such careful calibration.

5) **Ongoing Support for Promoting Best Practices.** CHW/P/Rs can be deployed and integrated in a number of different ways, and there are a variety of design choices inherent in such efforts. Many entities are looking to expand or to incorporate CHW/P/Rs in their workflow for the first time, and more are expected to join as the workforce expands. At the same time, there is a large and growing body of evidence available about effective models of CHW integration and services. Although CHCF has invested private funds into several regional collaboratives, there is currently no systematic statewide or state-led effort to support entities throughout the state to learn best practices and share information regarding building or expanding CHW programs in their organizations. However, DHCS indicates it plans to expand a series of technical assistance (TA) webinars, initially designed for MCPs, to other stakeholders in partnership with California Pan-Ethnic Health Network and other stakeholder groups. The TA series is intended to allow all stakeholders to share best practices, discuss barriers or issues they are facing, and to get connected with other stakeholders to open lines of communication.

6) **Training "Deserts."** Although a number of programs exist, the majority of programs are located in the San Francisco Bay Area and greater Los Angeles area, leaving training "deserts" throughout the state. For instance, there are no identified training California programs north of Sacramento.

7) **Contested Roles in Health Care And Community**. In 2014, Alan Weil, Editor-in-Chief of the journal *Health Affairs*, described the evolving role of CHWs in the era of health system reform, and the tension between two different models of delivery of CHW services. The first model is one with formalized training that is embedded into health care teams and that becomes part of the professional culture of health care. The second model hews closer to the roots of the CHW/P/R profession and is community-embedded, with roles defined through a process of engagement to serve the community's health needs, rather than the clinical or

[33] (Phillips, et al., 2023)

financial goals of the health care system or provider. Weil advocated for honoring "…the wisdom and experience of [CHW/P/Rs] as they define their future, rather than assuming that they will be absorbed into a health care system that is only beginning to learn how to support people in their communities."[34] Similar to Weil, Alex Fajardo of El Sol Neighborhood Educational Center, states, "Many institutions have seen the CalAIM ECM & Medi-Cal CHW/P/R benefit as just another funding stream, not as a transformational opportunity. [CHW/P/Rs] stand not only as navigators but as agents of change and community transformation. Institutions integrating [CHW/P/Rs] into their operations can become partners in preserving the community transformation and health equity roots […] by assuming more health equity and community transformation roles as an organization."

These issues may sound philosophical, but the way CHW roles are defined and the manner in which CHWs are deployed in a health care setting are bound to be heavily influenced by Medi-Cal billing rules and a health care organization's clinical and financial goals. This, in turn, may lead to tension and misalignment of expectations on-the-ground between traditional health care partners and CHW/P/Rs, if this core issue of the "two models" of CHW/P/R practice is ignored in CHW/P/R expansion and integration efforts. Ideally, organizations and CHW/P/Rs will be able to bridge these two models, leading to better two-way communication between the health care system and the patients and communities they serve, as well as preserving the credibility and identity of CHW/P/Rs as passionate, unapologetic advocates for their communities.

Conclusion

CHW/P/R services and workforce have been the subject of significant state effort, attention and investment in recent years. There is broad agreement between the Legislature, state agencies, and interested stakeholders across the state about the value of CHW/P/R services and the desire to expand and better integrate this diverse workforce that can address health-related social needs, improve the cultural competence of the health care system, and improve health equity and outcomes. The charge for all entities involved in these efforts is to ensure the CHW/P/R workforce and related services are expanded and integrated as quickly and as effectively as possible—and to ensure this is done while respecting the history, identity, and ethos of CHW/P/Rs as part of a larger movement for health equity and justice. This hearing offers all stakeholders an opportunity to pause and reflect on the successes so far, and grapple with the work still to be done to realize the transformational potential of CWH/P/Rs to improve health in California.

[34] (Weil, 2014)

Related Legislation (Recent)

1) AB 2250 (Weber) of 2024, requires a health plan contract or health insurance policy to include coverage for screenings for social determinants of health, and also requires a health plan or health insurer to provide primary care providers with adequate access to peer support specialists, lay health workers, social workers, or CHWs.

2) AB 2110 (Arambula) of 2024, allows CBOs and LHJs that provide health services through CHWs, as well as doulas, to provide and bill for Adverse Childhood Experiences (ACEs) trauma screenings through Medi-Cal.

3) AB 85 (Weber) of 2023, would have required a health plan contract or health insurance policy to include coverage for screenings for social determinants of health, and also would have required a health plan or health insurer to provide primary care providers with adequate access to CHWs. AB 85 was vetoed by Governor Newsom, who indicated support for the bill's goals but that the bill was duplicative of existing efforts and premature based on federal efforts to standardize screening tools.

4) SB 101 (Committee on Budget and Fiscal Review), Chapter 12, Statutes of 2023, delayed 2022 Budget Act funding of $230 million to 2024-25 and 2025-26 (split evenly between the two years) for the HCAI CHW initiative.

5) AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022, added CHW services as a covered benefit under Medi-Cal, required a Medi-Cal MCP to engage in outreach and education efforts to enrollees on the benefit, and required DHCS to inform stakeholders about, and accept input from stakeholders on, implementation of the benefit.

6) AB 1929 (Gabriel), Chapter 154, Statutes of 2022, added violence prevention services, as defined, as a covered benefit under Medi-Cal. AB 166 (Gabriel) of 2019, was similar and was vetoed by Governor Newsom, who stated the 2019 Budget Act provided $30 million in the General Fund for the California Violence Intervention and Prevention Program.

7) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, required HCAI to develop statewide requirements for CHW certificate programs in consultation with stakeholders.

8) SB 154 (Committee on Budget and Fiscal Review), Chapter 43, Statutes of 2022, included $281.4 million over three years to support a new program to recruit, train, and certify 25,000 new CHWs by 2025, with specialized training to work with certain populations including the justice-involved, the unhoused, older adults, or persons with disabilities.

9) A number of bills would have included CHWs in broader analyses of health care workforce, including SB 2804 (Waldron) of 2017, AB 3224 (Rodriguez) of 2020 and AB 240 (Rodriguez) of 2021, and SB 964 (Weiner) of 2022. None were chaptered.

Related Legislation (Prior to 2017)

1) ACR 75 (V. Mañuel Perez), Resolution Chapter 125, of 2009, recognizes the pioneering work of promotores and CHWs in delivering vital and cost-effective health care services in communities throughout California and declare October 2009 as California Promotores Month.

2) AB 2354 (V. Mañuel Perez) of 2010, which died on the Suspense File of the Senate Appropriations Committee, would have required the Department of Public Health to assess grant opportunities for promotores programs.

3) AB 361 (Mitchell), Chapter 642, Statutes of 2013, permits DHCS to establish a Health Home Program to provide health home services to Medi-Cal beneficiaries and Section 1115 waiver demonstration populations with chronic conditions, and allows CHWs to provide services under this program.

4) AB 898 (Saldaña) of 2007, which died on the Suspense File of the Assembly Appropriations Committee, would have created a Promotores de Salud School Health Center Nutrition Pilot Project.

5) AB 1736 (Levine) of 2005, would have allowed CHWs to provide chronic disease management in Medi-Cal. AB 1736 was vetoed.

Bibliography

American Public Health Association. (2009). *Policy Statement: Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities*. American Public Health Association.

Basu, S., Patel, S.Y., Robinson, K. et al. (2024). Financing Thresholds for Sustainability of Community Health Worker Programs for Patients Receiving Medicaid Across the United States. *J Community Health*.

California Association of Community Health Workers. (2024). Retrieved from Community Colleges.

California Health Workforce Alliance. (2015). *Community Health Workers In California: Sharpening Our Focus on Strategies to Expand Engagement*.

California Future Health Workforce Commission (2019). *Meeting the Demand of Health: Final Report of the California Future Health Workforce Commission*.

Center for Health Care Strategies. (2021). Advancing California's Community Health Worker & Promotor Workforce in Medi-Cal. California Health Care Foundation.

Chapman, S., Bates, T., & Miller, J. (2022). *Understanding California's Community Health Worker/Promotor Workforce: A Survey of CHW/Ps*. California Health Care Foundation.

Coffinbargar, M., Damian, A. J., & Westfall, J. M. (2022). Risks And Benefits To Community Health Worker Certification. *Health Affairs*.

Community Health Worker Core Consensus Project. (2014-2022).

Department of Health Care Services. (2022). State Plan Amendment 22-0001. (2022).

Department of Health Care Services. (2022). CalAIM Enhanced Care Management and Community Supports Frequently Asked Questions (FAQ).

Department of Health Care Services. (2022-2023). APL 22-016: CHW Benefit.

Department of Health Care Services. (2024). CalAIM: Population Health Management (PHM) Policy Guide.

Department of Health Care Services. (2024). Community Health Worker (CHW) Preventive Services Provider Manual.

Haldar, S., & Hinton, E. (2023). *State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services*. KFF.

Insure the Uninsured Project. (2024). *Fact Sheet: Community Health Workers and the Health Care Delivery System*.

Kim, K. e. (2016). Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. *Amer. Journal of Public Health*, 106, no. 4 (Apr. 1, 2016): e3–28.

Kissinger, A. (2020). *It's important for us to get recognized and be somebody: Community health worker attributes, attitudes towards certification, and certification options in California*. UC Berkeley.

Knowles M, C. A. (2023). Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States. *Annu Rev Public Health*, 44:363-381.

National Association of Community Health Workers. (2024, March 5). CHW Career Gateways, Requirements, Pathways, and Barriers.

Phillips, E., Kaalund, K., Farrar, B., Perreira, K., Taylor, M., Wellman, M., . . . Thoumi, A. (2023). *Advancing Community Health Worker Models In Health System Reforms: Policy Recommendations From The RADx-UP Initiative*. Health Affairs.

Rosenthal EL, M. P.-F. (2014-2022). *C3 Project Findings: Roles & Competencies*. The Community Health Worker Core Consensus (C3) Project Reports and Website.

Rush, C. (2020). *Sutainable Financing of Community Health Worker Employment*. National Association of Community Health Workers.

US Bureau of Labor Statistics. (2022, May). *Occupational Employment and Wage Statistics*. Occupational Employment and Wages, 21-1094 Community Health Workers.

US Centers for Disease Control and Prevention. (2024). *Community Health Workers for COVID Response and Resilient Communities (CCR)*.

US Centers for Medicare & Medicaid Services. (2023). 2024 Physician Fee Schedule.

US Centers for Medicare and Medicaid Services. (2023). CMS Finalizes Physician Payment Rule that Advances Health Equity.

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2007). *Community Health Worker National Workforce Study*.

US Health Resources & Services Administration. (2024). *FY 2022 Community Health Worker Training Awards | Bureau of Health Workforce*.

US Indian Health Service. (2024, March 5). Indian Health Manual. *Chapter 16 - Community Health Representatives Program*.

Visión y Compromiso. (2024, March 5)

Weil, A. (2014). What Is The Future For Community Health Workers? *Health Affairs*.

Table of Contents