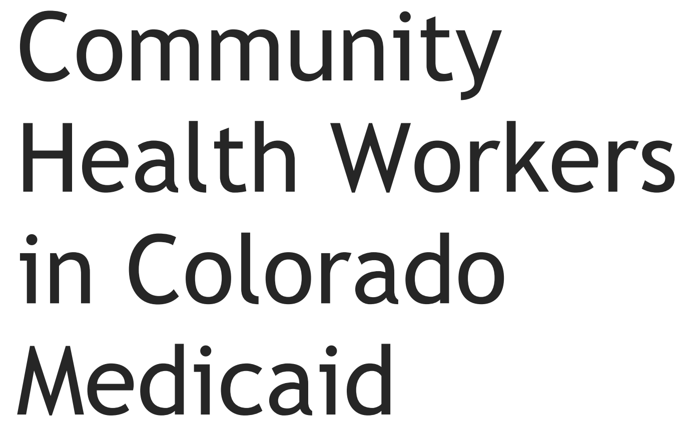

# Community Health Workers in Colorado Medicaid

## Stakeholder Findings Report

HCPF

COLORADO
Department of Health Care Policy & Financing

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# I. Executive Summary

Community health workers (CHWs are currently a covered service for Medicaid members in 24 states with three states in the process of implementation. Each state has a unique definition for these services and process for the credentialing of these workers for them to receive reimbursement. In Colorado, Senate Bill 23-002 was passed on May 10, 2023, and requires the Department of Health Care Policy and Financing (HCPF) to seek federal approval to reimburse for CHW services by July 1, 2024, and begin implementing coverage once approval is received from the Centers for Medicare and Medicaid (CMS). Before seeking federal approval HCPF must complete the following:

*Caption: HCPF executive Director Kim Bimestefer (left), Governor Jared Polis (middle), and Kyle Mullica (right), CHW bill sponsor, signing SB 23-002 at the Clinica Family Health Center in north Denver, CO*

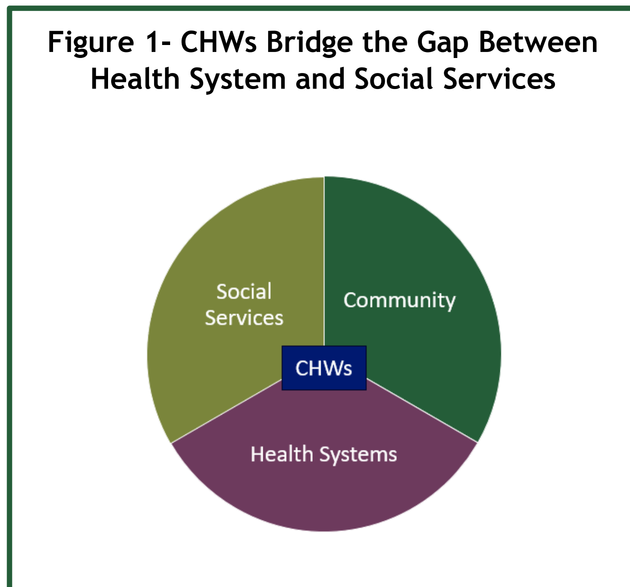
- Hold four public stakeholder meetings. Stakeholders should include community health workers, representatives from the Colorado Department of Public Health and Environment (CDPHE), consumer advocates, local public health agencies, CDPHE recognized training programs, health care providers, managed care entities (MCOs), and schools and school-based health clinics.
- Leverage the registry that is currently being operated by CDPHE.
- Launch the community health worker benefit for Medicaid reimbursement by July 1, 2025.
- Report in a SMART Act Hearing on the implementation progress by January 31, 2026.

This report will summarize the findings of the four public stakeholder meetings, including poll questions, results, and comments from attendees. This report will also provide a summary of barriers to engagement, lessons learned throughout engagement, as well as next steps for post-stakeholder engagement.

### What are Community Health Workers (CHWs) and What Role do They Play?

According to the American Public Health Association, a community health worker is defined as a frontline public health worker who is a trusted member of, and has a close understanding of, the community that worker serves. This trusting relationship enables the worker to serve as a liaison between health and social services and improve the quality and cultural competence of service delivery (seen in Figure 1). In Colorado, the title “community health worker” is meant to be an umbrella term for individuals who go by many names like health promoters, community outreach workers, promotoras de salud, health navigators, and patient navigators. Oftentimes, these roles have similar skill sets and provide similar services to patients and clients which allows them to work in a variety of settings and capacities. Examples of CHW services include outreach, community education, informal counseling, social support, advocacy, translation and interpreting, health care navigation, and tracking patient progress.

**Figure 1- CHWs Bridge the Gap Between Health System and Social Services**

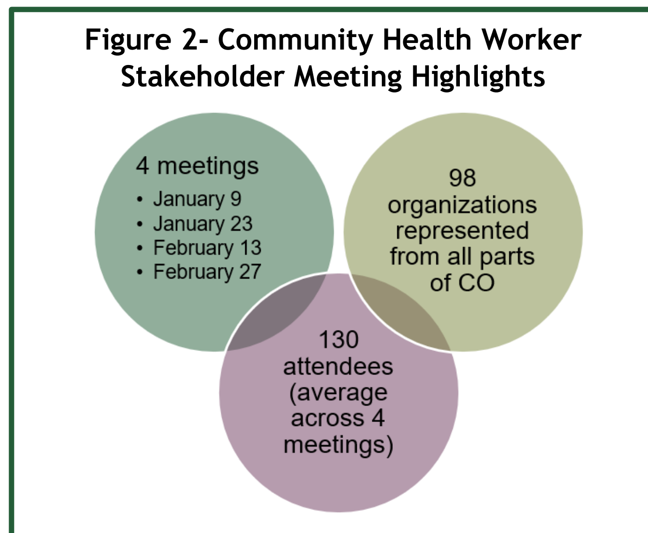



## II. Methods

### Stakeholder Engagement Overview

The four public stakeholder meetings took place on January 9, January 23, February 13, and February 27, 2024. All meetings were from 10 am to 12 pm and took place via Zoom. Outreach and communication of the meetings happened via HCPF newsletters (Accountable Care Collaborative (ACC) newsletter, Office of Community Living (OCL) newsletter, and the HCPF Provider Bulletin) as well as direct email communication with organizations and individuals that contacted HCPF about the benefit. Across the four meetings, we had an average of 130 attendees and 98 organizations represented. Figure 2 summarizes the stakeholder meetings.

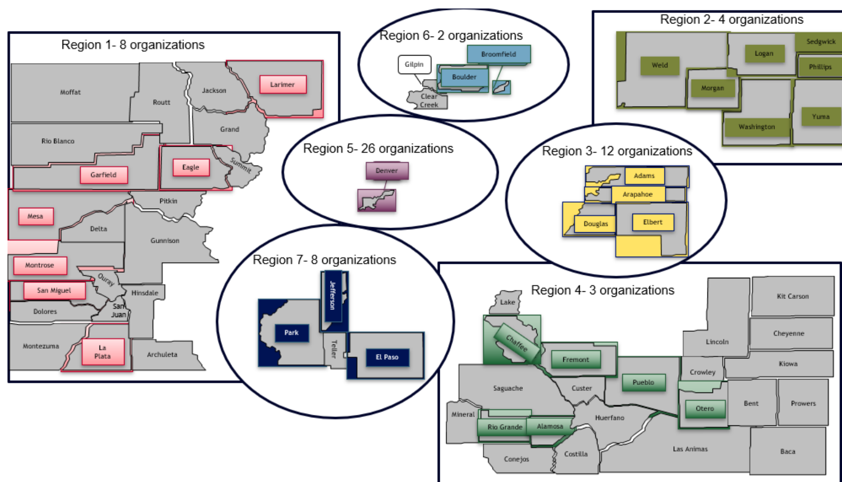
**Figure 2- Community Health Worker Stakeholder Meeting Highlights**




Geographic locations of the organizations are based on the Regional Accountable Entity (RAE) regions. The types of organizations represented during the stakeholder meetings include non-profits and institutions, health care providers, other state agencies (CDPHE), CHW training agencies, school-based health centers, federally qualified health centers (FQHCs), managed care entities, local public health agencies, advocates, and current CHWs.

By hosting the stakeholder engagement sessions virtually, HCPF was able to reach organizations in every RAE region in the state and have representation in urban, rural, and frontier counties during our engagement period. Geographic location of the organizations can be seen in Figure 3.

**Figure 3- Geographic location of Organizations**




Throughout the four webinars, HCPF focused on several topics. Topics that were discussed during the stakeholder meetings can be seen in Figure 4. Because this stakeholder group has not interacted with HCPF and the Medicaid system previously, it was important for the first two meetings to focus on high level information about HCPF and Health First Colorado (Colorado's Medical Assistance Program). Stakeholders had a lot of interest in the Colorado Department of Public Health and Environment (CDPHE) CHW registry, training, and enrollment requirements as this will require some current CHWs to go through a training and certification process to be eligible for reimbursement through Health First Colorado. In addition to the CDPHE CHW registry, stakeholders also were interested in the supervision requirements that are currently outlined in the Code of Colorado Regulations 10 C.C.R. 2505-10 8.200.1.A. Lastly, stakeholders had a great amount of interest in a new provider type enrollment for CHW Agencies. This new provider type will allow a community-based organization to submit billing claims on behalf of one or more CHWs enrolled as an individual within a group. An example of this would be a community-based organization who does food security work and who also employs CHWs.

**Figure 4- Overview of Topics Covered During CHW Stakeholder Meetings**

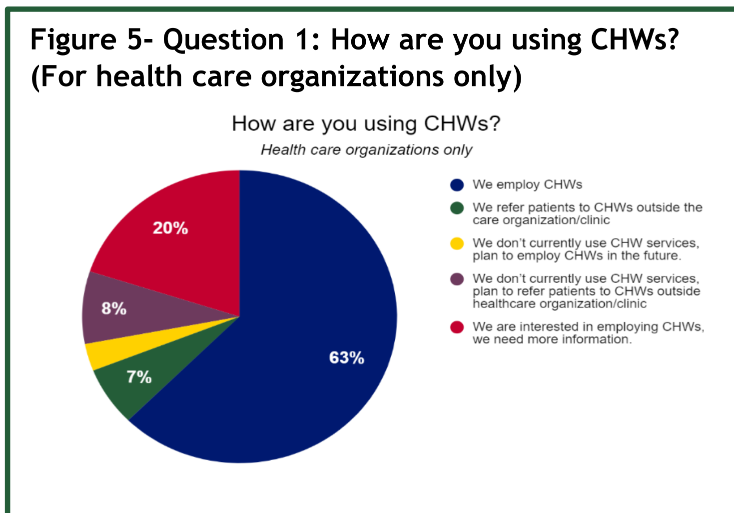
| Stakeholder Meeting #1 (January 9) | Stakeholder Meeting #2 (January 23) | Stakeholder Meeting #3 (February 13) | Stakeholder Meeting #4 (February 27) |
|---|---|---|---|
| 1. Who is HCPF?<br>2. What is Medicaid/Health First Colorado?<br>3. SB 23-002 Overview and Timeline<br>4. Federal Authority Options<br>5. CHW Registry, Training, and Enrollment | 1. Topics 1-5 from Stakeholder Meeting #1<br>2. Patterns in CMS Coverage<br>3. Self-Management Education Codes<br>4. The Spectrum of CHW Services | 1. Results from January Meetings<br>2. Federal Authority Decision<br>3. Preventative Services<br>4. Medical Necessity<br>5. Definition of CHW Services<br>6. Supervision of CHWs<br>7. Limitations and Rates | 1. Billing Guidance & Requirements<br>2. Complaints<br>3. CHW Agency Enrollment & Reimbursement<br>4. Helpful Resources |

## III. Input Collected

### Poll Results

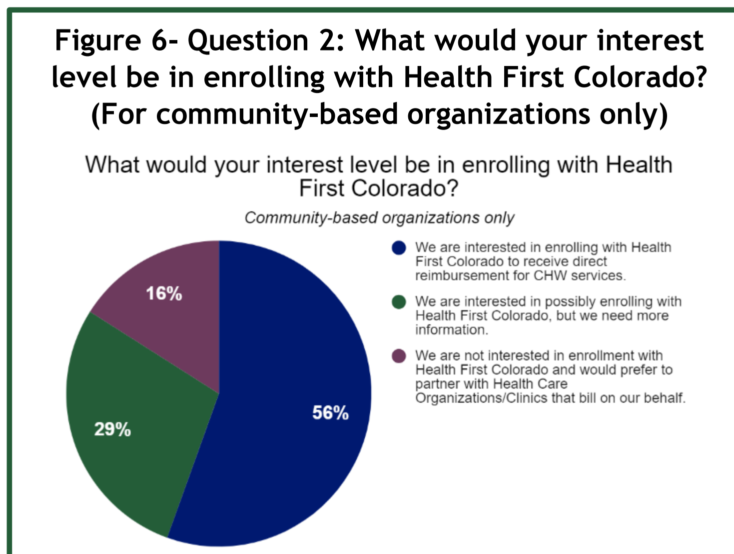
Zoom polls were utilized to collect feedback and insight in the January 9th, January 23rd, and February 13th meetings. During the January meetings, HCPF wanted to better understand how CHWs are being used in health care organizations, the interest level among CHW agencies in enrolling with Health First Colorado to receive reimbursement, the federal authority option preference, and the familiarity of Medicaid billing and structure among attendees. These results were also shared with stakeholders during the February 13th webinar. In the first question or figure 5, HCPF asked attendees who were representing health care organizations how they were using CHWs in their organizations. The most common response was "we employ CHWs".

**Figure 5- Question 1: How are you using CHWs? (For health care organizations only)**




It was important to HCPF to understand the interest level among community-based organizations in enrolling with Health First Colorado as a provider to receive direct reimbursement or if they would rather partner with health care organizations or clinics and have them bill on their behalf. At the two meetings, 56% of attendees were interested in enrolling with Health First Colorado as a provider and 29% of attendees were interested in possibly enrolling with Health First Colorado but would need more information. Figure 6 depicts the answers from question 2.

**Figure 6- Question 2: What would your interest level be in enrolling with Health First Colorado? (For community-based organizations only)**




Due to most CHW stakeholders being new to Health First Colorado, it was important for HCPF to present details on the federal authority options for covering the CHW benefit. Different federal authority options have different impacts on the implementation timeline, evaluation requirements, flexibility in funding amounts, services covered, and length of federal approval. Section 1115 Demonstration Waivers have the most flexibility regarding services covered and reimbursement amounts. However, Section 1115 Demonstration Waivers have the longest timelines for federal approval, more requirements for evaluation, and are only temporary in their authority. Over the past few years, CMS has been encouraging State Medicaid Agencies to pursue State Plan authority instead of Section 1115 Demonstration Waiver authority. Health First Colorado is mostly a fee for service (FFS) physical health state, but another option includes using the Regional Accountable Entities (RAEs), which are Primary

Care Case Management (PCCM) entities, which is a form of managed care. HCPF sends Per Member Per Month (PMPM) administrative payments to the RAEs for care coordination related activities.

HCPF presented both options to stakeholders to collect their feedback and preference. Option one is for the CHW benefit to be delivered through Fee for Service using State Plan authority. HCPF would open price procedure codes for CHW providers to bill for direct reimbursement. Fee for Service means that the reimbursement would be consistent since it’s based on the published fee schedule amount for the codes. Fee schedule reimbursement also means that eligible claims receive 100 percent of the fee schedule reimbursement amount. When a state proposes an amendment to its state plan, it sends CMS the revised page(s) with an official transmittal form. Once a SPA is submitted, CMS has 90 days to decide, otherwise the proposed change automatically goes into effect. Once a SPA is approved it does not expire. This streamlined SPA review process ensures a July 2025 start date.

Option two is for the benefit to be delivered through the RAEs as part of the Behavioral Health managed care system through the Per Member Per Month administrative payments under a 1915(b)3 waiver. Similar to Option 1, the CMS approval process for 1915(b) waivers is 90 days. However, CMS approval of 1915(b) waivers is effective for 5 years, meaning HCPF would need to see continued approval every 5 years for Option 2. Under Managed Care, CHWs and providers would bill and receive reimbursement from the RAEs. RAE contracts must be procured every 7 years which means that CHWs could potentially need to reestablish RAE contracts and relations any time a new RAE contract was procured. A key consideration for the Managed Care option is that reimbursement could include care coordination, but every RAE would have its own reimbursement process. Figure 7 depicts the reimbursement options slide that was presented to stakeholders during the January 23rd meeting.

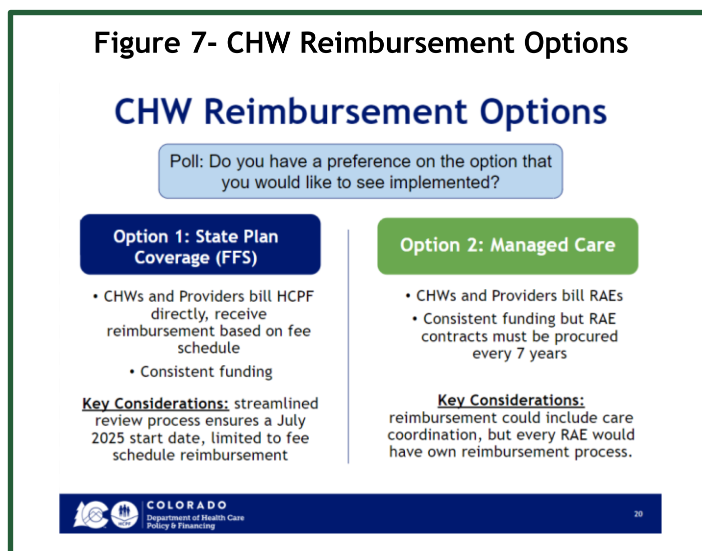
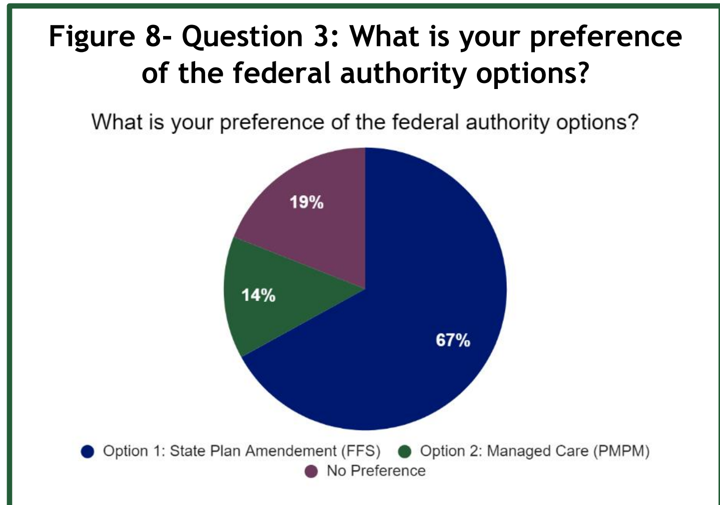


**Figure 7- CHW Reimbursement Options**

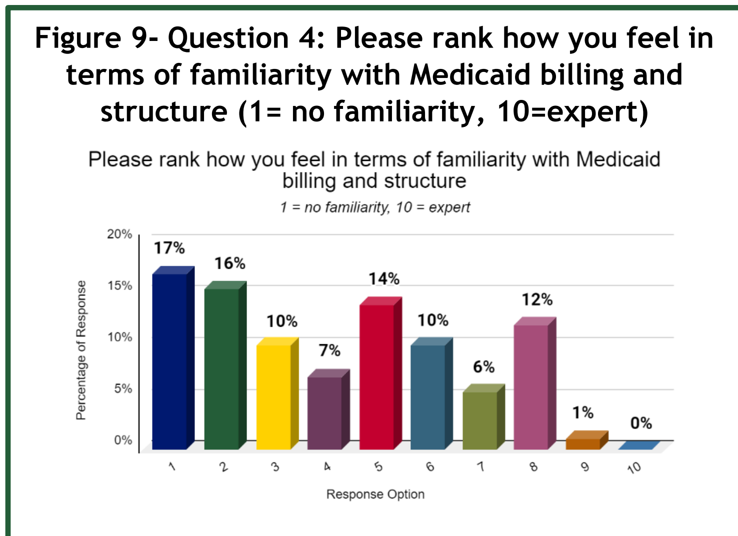
Question 3 regarding the federal authority option was launched after we presented the pros and cons between a State Plan Amendment (Fee for Service) or Managed Care (Per Member Per Month). HCPF staff also included an option for those that might not have a preference in the federal authority option. During the meeting, some attendees shared that they did not know which option they would prefer, but the Department did not have that as an option for attendees to respond to. Most respondents (67%) indicated that Option 1: State Plan Fee for Service was their preferred federal authority option. Results from question 3 can be found in Figure 8.

**Figure 8- Question 3: What is your preference of the federal authority options?**



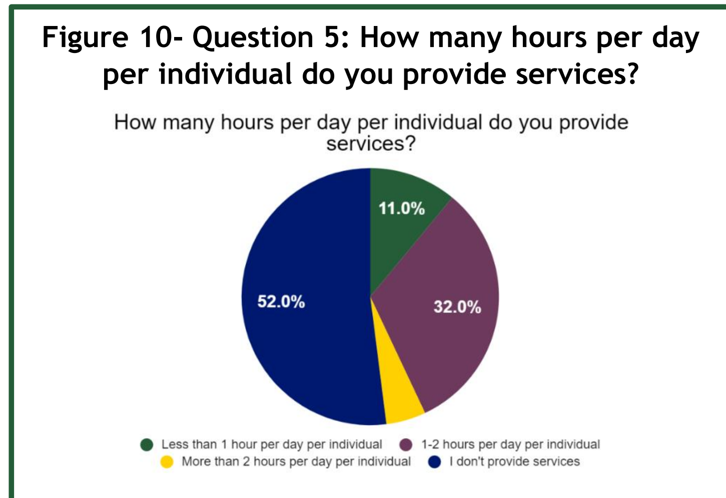

Question 4 asked stakeholders to rank their familiarity with Medicaid billing and structure on a scale of 1 to 10, 1 being no familiarity and 10 being an expert. Results from this poll can be found in Figure 9. The purpose of this question was to better inform future stakeholder meeting topics include billing information, documentation requirements, and referral requirements. During the January meetings, 64% of respondents responded on the lower end (1-5) of the ranking system. Based on the results, stakeholders are new to Medicaid billing and would need additional information and training. With that in mind, HCPF staff decided to include referral and documentation requirements in the February webinars to ensure that stakeholders were aware of the requirements.

**Figure 9- Question 4: Please rank how you feel in terms of familiarity with Medicaid billing and structure (1= no familiarity, 10=expert)**



During the February 13th meeting, information on benefit limitations was presented to stakeholders. This section of the presentation included examples from other states and then a poll was launched to ask attendees how many hours per day per individual do you provide services? Attendees had 4 response options: less than 1 hour per day per individual, 1-2 hours per day per individual, more than 2 hours per day per individual, or I don't provide services. Most respondents said that they do not provide services while the next common answer was 1-2 hours per day per individual. Figure 10 depicts the results from the poll. In the chat, some attendees said that the first visit with a member usually lasts longer than 2 hours but then the subsequent appointments last between 1-2 hours.

**Figure 10- Question 5: How many hours per day per individual do you provide services?**




## Stakeholder Thoughts and Comments

During all 4 webinars, stakeholders had the opportunity to place comments and questions using the chat function or the Q & A function on Zoom. Questions from the stakeholder engagement webinars will be compiled and an FAQ document will be released in the Spring of 2024. The comments were also collected and some of the most impactful ones can be seen in Figure 11.

**Figure 11- Impactful Comments from Stakeholders**

*"Please let us lead. I often feel these conversations are had by everyone but the navigators."*

*"Community-based organizations should be able to access this benefit. They connect to the system in powerful ways."*

*"I believe that people talk to me because they see me as somewhat outside of the typical healthcare hierarchy. We're non-clinical, and don't have some of the weighty context and history that social work has."*

The January 9th meeting kicked off our stakeholder engagement period. At the end of the webinar, HCPF asked attendees the following questions:

1. How should CHW services be defined?
2. Which specific CHW activities should be reimbursed?
3. What services are CHWs currently providing? What services do CHWs want to provide that they currently do not?
4. Other related concerns?

Attendees were invited to come off mute and share their answers or place their responses in the chat. HCPF also created a Google Form to collect responses to these questions, allowing attendees time to consider their responses as well as share the link with additional individuals that might not be able to attend the stakeholder meetings.

In the beginning of the webinar, HCPF staff presented information on the definition of CHWs. For the Medicaid reimbursement of CHWs, HCPF is using the American Public Health Association's (APHA) definition. The APHA defines a community health worker as a frontline public health worker who is a trusted member of, and has a close understanding of, the community that worker serves. This trusting relationship enables the worker to serve as a liaison between health and social services and improve the quality and cultural competence of service delivery. In Colorado, there is also an adaptation for the community health worker term that is used. Previously, the term "health navigators" was being used to define workers that are working in a capacity similar to promotoras, patient navigators, or resource navigators. With that definition in mind, Question 1 of the Google Form asks stakeholders how they would define CHW services and responses can be seen in Figure 12. It should be noted that many attendees agreed with the APHA definition and did not have additional suggestions for the definition.

**Figure 12- How should CHW services be defined?**

*"A person from the community who works with people to address and improve risk factors of social determinants of health."*

*"A community health worker who also builds individual and community capacity by increasing health knowledge and self-sufficiency though a range of activities such as outreach, social support, and advocacy."*

*"CHWs bridge the gap between clinical staff members and patients understanding of their plan of care and evaluating their sense of urgency to enact change. A CHW looks at socioeconomic determinants of health as well as cultural influences to increase a patient's power to advocate for themselves in a way that achieves a common goal."*

The next question that attendees were asked to consider was regarding the specific activities that should be eligible for reimbursement. During the January 23rd webinar, HCPF staff presented patterns that we have seen other states use to define the services that CHWs can provide. The proposed definitions can be seen in Table 1.

**Table 1- CHW Proposed Service Definitions**

| Health Promotion and Coaching | Health Education and Training | Health System Navigation and Resource Coordination |
|---|---|---|
| The purpose of this service is to provide information and training to members that enables them to make positive contributions to their health status. Health Promotion and Coaching includes screening for health-related social needs, setting goals and creating | The purpose of this service is to train and/or increase the member's awareness of methods and measures that have been proven effective in avoiding illness and/or lessening its effects. The content of the education must be consistent with | Health system navigation and resource coordination services include helping engage, re-engage, or ensure member-led follow-up in primary care, routine preventative care, adherence to treatment plans and/or self-management of chronic conditions including |

| action plan, and providing information and/or coaching | established or recognized health care standards. | assisting beneficiaries to access covered services and other relevant community resources. |
|---|---|---|

During the meeting, no stakeholder disagreed with the proposed CHW service definitions. With those definitions in mind, attendees were asked to share what services they would like to see become reimbursable services. Common themes stakeholders suggested included expanded health education opportunities, screenings, referrals, outreach to community members, and connection to resources.

Because the types of services CHWs provide are broad and vary between settings, HCPF staff wanted to understand the services that CHWs currently provide. According to stakeholders, some of the services that they are providing to members include health education, connection to primary and mental health services, case management, advocacy, and assistance with barriers (i.e. food, housing, or utility assistance).

In addition to understanding the services currently being provided by CHWs, stakeholders were asked what services they want to provide but currently do not. Stakeholder responses can be seen in Figure 13. It should be noted that some respondents did not know what additional services they would like to provide or were unfamiliar with their CHW programs to make a comment.

**Figure 13- What services do CHWs want to provide that they currently do not?**

*"Our CHWs would like to spend more time with families who are challenged by health literacy. We are seeing an increased number of immigrants and refugees with various languages spoken other than English and Spanish, and we seek to coordinate translation and interpretation resources as well as provide education materials suitable for their language."*

*"Non face to face CHW work (ex. researching rental assistance, telephone calls, telemedicine, etc.)."*

The fourth question stakeholders were asked was in relation to other concerns or ideas for the CHW benefit implementation. Figure 14 depicts concerns and comments from stakeholders.

**Figure 14- Are there any other concerns or things that CHWs would like to see implemented in the new benefit?**

*"I appreciate the discussion. I think the current definition for CHW outlined in this presentation is adequate. We do a lot of care management services and are excited for this work collaboratively to improve our patients care. I am excited to see this work being done out of the RAE setting and being done in the clinical setting. I think it will have more impact. I would like RHCs and FQHCs to be fully considered for reimbursement. A model for care management like CMS is a sustainable model. We have two population nurses that do a lot of community health work but want to hire a Spanish speaking community health worker that is not clinic to connect to SDOH. Thank you for a great presentation!"*

The next section of the Google Form addresses the idea of creating a CHW Resource Center. Questions include how CHWs are contacted for services, how health care providers are reaching out, how providers and community members hear about CHW services, and what additional resources would be helpful to providers. Figure 15 depicts answers related to how CHWs are currently being contacted for CHW services.

**Figure 15- How are CHWs currently contacted for services?**

*"In our clinics, CHNs are contacted when there is a positive SDOH screener (the patient/caregiver notes 'yes' on the screener); direct referrals from our multidisciplinary teams that are not tied to screeners; direct referrals from patients/caregivers who have previously worked with our CHN teams."*

*"CHWs are currently contacted for services by school nurses in elementary schools (K-5 or K-8) who identify children with uncontrolled asthma based on the results of the asthma intake form at/after school registration."*

*"Screening during communicable disease investigation, during WIC appointments, street or CBO outreach from harm reduction, any intervention with the public, referrals from home visitation from providers or DHS."*

HCPF asked stakeholders how they are working with other healthcare providers. Figures 16 and 17 depicts answers related to how providers and community members are hearing about CHW services.

**Figure 16- How are health care providers reaching out?**

*"We have created a referral pathway with our FQHC to facilitate our home visits. Other OB/GYNs, hospitals, etc. refer via our website, phone calls or giving our information to patients."*

*"Across our programs, health care providers are not reaching out to us proactively. In fact, many of the students we serve do not initially have a routine source of healthcare, and our program is helping them obtain that. The participating health care provided by our CHWs, particularly our care coordination with them for requests such as considering additional preventative treatment, or an additional inhaler to have on-hand at school as well as home, or to sign off on the Colorado Asthma Care plan for schools so students have access to their asthma medications while in school."*

*"Primarily by phone, email, or our medical record system."*

**Figure 17- How do providers and community members hear about your CHW services?**

*"We collaborate and communicate regularly with providers who refer to us."*

*“Word of mouth, social media, existing relationships with community partners. We do not have a set list of CHW services that the community is trying to connect directly to. We have staff and CHWs do a lot of supportive work for community members as needs arise while we are engaging with the community member in other ways (i.e. during a WIC visit other needs arise and work is completed to connect the individual to other supportive services as time/capacity allows.”*

*“The health care providers and local school/community members hear about our program through direct communication from the schools via the school nurses and the asthma navigators.”*

It was important for HCPF staff to dedicate time during the February 27th meeting to ask stakeholders what resources they would like to see HCPF create as the new CHW benefit launches. A question was also added to the Google Form to collect feedback after the stakeholder engagement webinars were completed. HCPF staff made stakeholders aware that there would be a fact sheet and a FAQ document created and released in the spring of 2024. Figure 18 depicts answers from the February 27th stakeholder meeting as well as answers that were submitted by stakeholders to our feedback form.

**Figure 18- What are additional resources that would be helpful to you as a provider?**

*“Perhaps a monthly newsletter on where you are in the direction would be helpful.”*

*“Once the benefit becomes active, actual training on billing codes and who is eligible to bill which codes, etc. The provider manuals don’t tend to give a lot of information.”*

*“A template for the required documentation for billing.”*

*“A template for the required information that must be shared from CHWs to health care providers- the who, what, where, when etc.”*

*“More information on working with the RAEs would be helpful.”*

*“Connection/alignment with other initiatives: HTP, SHIE, Family Connects, Lactation benefit.”*

During the webinars, stakeholders were very interested in the changes being made to the training and certification for CHWs. Once the benefit is live, providers who are wanting to receive reimbursement from Health First Colorado for their services will have to be on the CDPHE CHW registry. Stakeholders had questions about current training programs, accessibility for those that do not speak English as their first language, acknowledgement of past work experience, financial assistance for training and testing, and location availability for testing.

Throughout stakeholder engagement, stakeholders also had questions and concerns about the workforce development of CHWs. While workforce development is an important

piece of CHWs, stakeholders were vocal that they would like CHWs and their agencies to lead those efforts and for HCPF to be a partner agency in the development of CHWs as a career field. Figure 19 depicts a summary of the questions that stakeholders asked during the webinars. Additional information regarding the registry, training requirements, and the certification will be available in the coming months.

**Figure 19- Questions from Stakeholders about Registry, Training, and Certification Requirements**

"In terms of training, what training programs are considered currently? How can community-based organizations become certified?"

*"In the process taking into consideration: language spoken/read, the possibility that many CHWs may not have literacy (reading/writing) skills that allow them to take tests. How is language and language skill being taken into consideration?"*

*"Will the registry be able to acknowledge, and support lived experience of doing the job rather than a written test of some type?"*

*"Equity will be an important consideration if you require a certification from people who represent disadvantaged communities. Would a certification be expensive to achieve? Will it reflect the knowledge and experience they will be utilizing?"*

*"Are you all reviewing and considering existing CBO CHW training in Colorado? How can those training become certified for the registry?"*

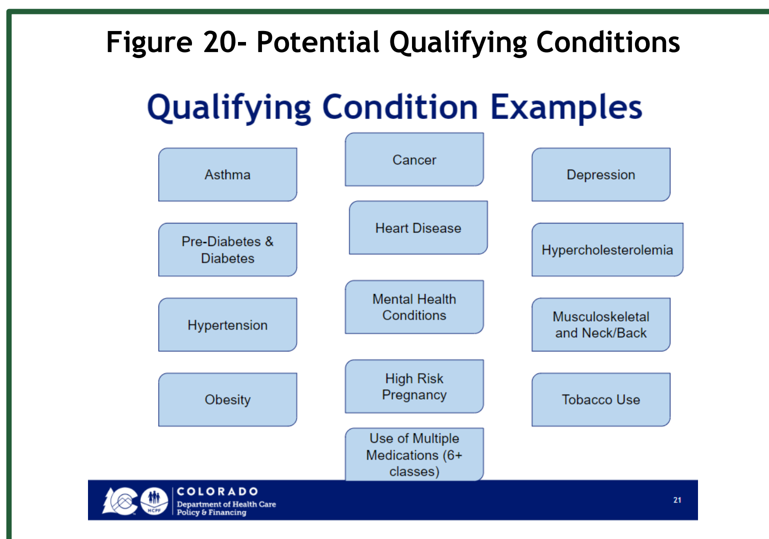
*"Can CDPHE offer scholarships for the certification?"*

"Is there any work underway to expand where people get the CHW certification?"

## Presentation Content Feedback

During the February 13th stakeholder meeting, information was presented on qualifying conditions. HCPF informed attendees that we don't anticipate needing to include a section about qualifying conditions in HCPF's SPA submission to CMS for federal authority, but we do anticipate having to add qualifying conditions to the Code of Colorado Regulations or in our billing guidance document. Figure 20 shows a depiction of the slide that was presented during the webinar.

**Figure 20- Potential Qualifying Conditions**



After presenting the examples of qualifying conditions, attendees were asked if there were any conditions that were missing from the list. In the chat, attendees offered suggestions for conditions for us to consider before finalizing the list. Responses from attendees can be depicted in Figure 21.

After presenting information on qualifying conditions, the presentation shifted towards supervising providers. Information on supervising providers included information on what providers will be required for ordering services and who would be able to be considered for supervising, why a supervising provider is necessary for CHW services, the types of supervision (ex. direct vs. general supervision), and information on supervision rules in the Code of Colorado Regulations. After that information was presented to attendees, attendees were asked if there were any questions, thoughts, and concerns. Many attendees had concerns about the constraints that supervision requirements put on CHWs to continue to operate in ways that make them important to bridging the gap between the health care system and social services. Attendees also listed other providers they believe could be a part of the supervising provider list. In listening to the feedback stakeholders provided, HCPF is committed to exploring other ways for CHWs to work without constricting supervision requirements. The list of missing supervising providers can be found in Figure 22.

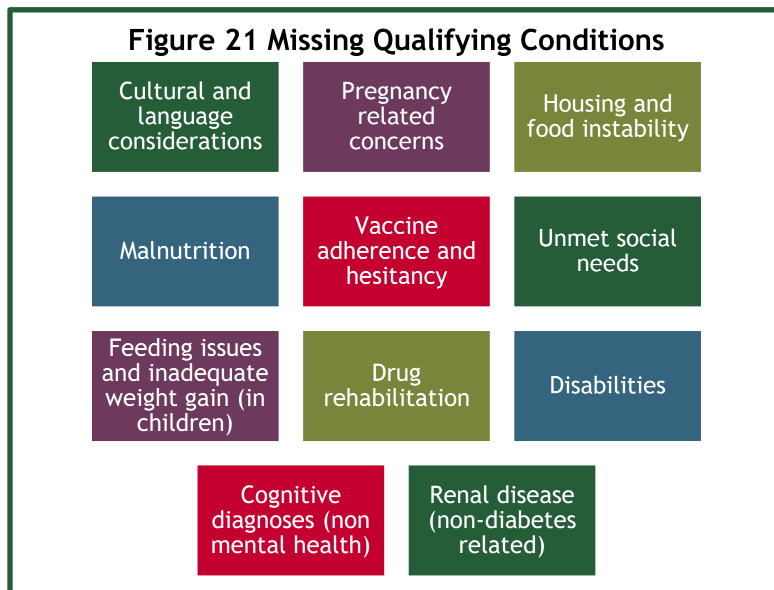


Figure 21 Missing Qualifying Conditions

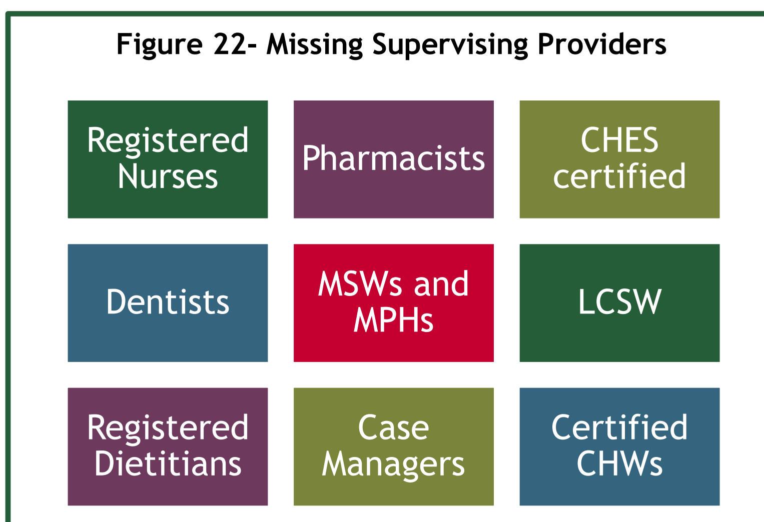



Figure 22- Missing Supervising Providers


## IV. Post-Stakeholder Engagement

The formal stakeholder process ended with the completion of our stakeholder webinars. With that, it is important to HCPF to maintain feedback avenues (ex. Google Form, written comments via email, and 1:1 meeting time with stakeholders) open as we begin to work with CMS and begin drafting the State Plan Amendment that will be sent to CMS for

approval in July. HCPF created a Google Form to collect contact information from those that wanted to receive email updates regarding the CHW benefit implementation and CHW email address (HCPF_CHW_Benefit@state.co.us) as well as informing stakeholders that we would continue to collect feedback until Wednesday, May 1, 2024. After the stakeholder webinars were completed, a thank you email was sent to everyone that attended any of the four meetings. Additionally, HCPF created a survey to receive feedback on the webinar series, the content that was presented, and the translation services that were provided to attendees. Figure 23 depicts the email that was sent to stakeholders who signed up for the mailing list.

**Figure 23- Thank You Email to Stakeholders**

Thank you for attending the 4-part webinar series on Medicaid Reimbursement for Community Health Workers! The stakeholder process is incredibly important and helps us shape this benefit in a way that is most meaningful to those that are actively working in the CHW space. During our webinar series, we had an average of 130 attendees and 98 organizations represented from all across Colorado. A couple of reminders regarding the CHW benefit:

- All slides from the webinars can be found on our HCPF CHW Webpage.
- Even though we have formally ended our stakeholder process, we are still collecting feedback from stakeholders. We will continue to collect feedback until **Wednesday, May 1, 2024**. We have two ways to provide feedback:
    - Feedback Form
    - Written comments are also welcome at HCPF_CHW_Benefit@state.co.us
- In addition, we have a contact form available for those that want to receive updates regarding the implementation of the CHW benefit. This is the best way to stay up to date with updates to the website.
- Lastly, we have created a survey regarding the webinar series, the content presented, and the translation services that were available. Please fill out this survey no later than **Friday, March 22nd.**

If you have any questions, please let me know. Thank you!

## V. Next Steps and Pending Guidance

Now that stakeholder results have been compiled into this report, HCPF is taking the following implementation steps.

- Preparing the State Plan Amendment that will be sent to CMS by July 1, 2024.
- Developing a CHW Frequently Asked Questions document that will be released by the end of June 2024 and will be continually maintained.
- Creating additional CHW resources for stakeholders and providers, such as billing manuals and fact sheets.
- Deploying additional stakeholder engagement webinars as necessary when the CHW benefit is implemented.

## VI. Conclusion

Community Health Workers are indispensable in bridging the gap between community members and essential social and healthcare services. The stakeholder engagement webinars conducted in January and February 2024, focusing on the new CHW benefit, were not only successful but also highly informative for all participants. These sessions featured a diverse array of representatives from various agencies and staunch advocates for CHW initiatives. Furthermore, the webinars served as a critical platform for stakeholders to voice questions, comments, and concerns to HCPF, particularly concerning various implementation details. HCPF remains dedicated to maintaining an open dialogue with stakeholders, ensuring ongoing communication and collaboration both prior to and following the implementation of the new CHW benefit.