

BLOG / 08-05-24

Updates and FAQs: Developing and Implementing a Medicaid State Plan Amendment to Authorize Community Health Worker Reimbursement

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Most states have used COVID-19 pandemic-related [federal grant funding \(https://www.cdc.gov/covid-community-health-workers/php/about/index.html\)](https://www.cdc.gov/covid-community-health-workers/php/about/index.html) to build or strengthen community health worker (CHW) programs, recognizing this workforce's critical role in community-led linkages with the health and social services ecosystem. CHWs are key to engagement, care coordination, and increasing access to clinical and support services for Medicaid enrollees from their communities. As such, states increasingly are pursuing Medicaid reimbursement options as part of a comprehensive CHW service financing approach, which is currently reliant on expiring grant programs.

Several states have received approval from the Centers for Medicare and Medicaid Services (CMS) of Medicaid State Plan Amendments (SPAs) that authorize reimbursement for CHW services. Other states are in the process of SPA development. NASHP's CHW Learning Collaborative SPA workshop series provides opportunities for states to share best practices, implementation opportunities, and insights. This blog post summarizes those insights in a Frequently Asked Questions (FAQ) resource. The FAQ follows an update to NASHP's [2022 summary of the SPA landscape \(https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/\)](https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/) (including updated information from five states).



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Recent Developments Related to CHW SPAs

Currently, SPAs are in effect in 15 states (<https://nashp.org/state-tracker/state-community-health-worker-policies/>), with five SPAs (Arizona, Kansas, Kentucky, Michigan, and New York) approved in 2023 and one SPA (New Mexico) approved in 2024 by CMS. See Table 1 for additional information on each of these SPAs. NASHP's [previous issue brief \(https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/\)](https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/) provides details for the other 10 approved SPAs in states across the country.

Table 1: Community Health Workers Medicaid State Plan Amendments Approved in 2023 and 2024

Note: Language used in the table is drawn from each state's Medicaid SPA and adapted to fit the format of the table. Authority refers to the section of Medicaid regulations that the state used for the SPA. All six SPAs include language requiring that CHWs complete state-sponsored certification or standardized core skills training.

State and Authority	Covered Services	
<p>Arizona https://www.medicaid.gov/sites/default/files/2023-02/AZ-22-0029.pdf (2023) 42 CFR 440.60</p>	<p>Services must be documented in the Medicaid beneficiary's medical record and may include:</p> <ul style="list-style-type: none"> • Health system navigation and resource coordination. • Health education and training to increase the member's awareness of methods to avoid illness and/or lessen its effects. The content of the education must be consistent with established or recognized health care standards. • Health promotion and coaching to provide information and training to members that enables them to make positive contributions to their health status. 	<p>Arizona individu docum The Ar lead to</p>
<p>Kansas https://www.medicaid.gov/sites/default/files/2023-07/KS-23-0024.pdf (2023) 42 CFR 447</p>	<ul style="list-style-type: none"> • Screening and assessment to identify health-related social needs and barriers to accessing health care 	<p>To rece license certifie</p>

Frequently Asked Questions (FAQs) about CHW SPA Development

NASHP hosted a series of workshops in 2023 for states that are embarking on CHW SPA development or implementation. Below are answers to frequently asked questions from participating states across several categories along with illustrative examples from leading states. For the latest information, or answers to specific questions, email [Megan D'Alessandro \(mailto:mdalessandro@nashp.org\)](mailto:mdalessandro@nashp.org).

Logistics of CHW SPA Development

How do states begin the CHW Medicaid SPA development process?

- In some states, legislation has directed state Medicaid offices to develop a SPA and add a CHW benefit to the Medicaid program. In other states, state Medicaid agencies took the lead in seeking federal approval to cover CHW services under Medicaid, often as part of cross-sector approach toward improving outcomes in underserved communities.

- **Minnesota** was the first state in the nation to introduce a SPA for CHW reimbursement, which received CMS approval in 2008 (<https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/>). Key legislation (<https://www.revisor.mn.gov/statutes/cite/256B.0625>) gained support through estimates of net savings and outlined coverage and supervision requirements for CHWs.
- **Michigan's fiscal year 2023 omnibus bill** (<https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Final-Signed-Budget-Bills/FY23-General-Omnibus-Budget--PA-166-of-2022.pdf?rev=bd8046f52ca34add82153b25098d7b1f&hash=834779B0701389EACB946DD740496D2C>) required the state to seek federal approval to formally enroll and recognize CHWs as Medicaid providers who can receive Medicaid reimbursement for defined services.
- Building strong cross-sector partnerships across state government, especially between state departments of health and Medicaid programs, can result in collaborative efforts that augment capacity building and support resource alignment.
 - Collaboration between **South Dakota's** Department of Health and Department of Social Services was key to supporting CHW workforce development alongside the development of a Medicaid SPA. This allowed for the state to develop certification and scope of practice along with CHWs.
- States can also take inventory of CHW programs and funding streams across state agencies and departments, academic institutions, health care systems, and community-based organizations to better align funding, training programs, and partnership approaches for a whole-of-government strategy. This coordination supports deeper understanding across state government of how a Medicaid reimbursement approach fits into a long-term sustainability strategy for the CHW workforce.

What are key strategies for communicating with leadership and key partners about developing and successfully implementing a Medicaid SPA?

- A key starting point for discussions about CHW policy is to ensure a shared understanding of who CHWs are and the work they do. This involves a shared definition of the workforce and Medicaid-eligible services they offer. Drawing from existing state definitions or the American Public Health Association definition of CHWs (<https://www.apha.org/apha-communities/member-sections/community-health-workers>) can support deeper understanding among state leaders. Engagement with the CHW workforce routinely is also critical to understand how they work with communities, unique roles they play, and specific barriers and opportunities needed to sustain their efforts toward reducing health disparities (such as during the COVID-19 pandemic).
- **South Dakota** has developed a resource (<https://chwsd.org/chw-career-comparisons/>) to promote understanding of the CHW profession and how it differs from comparable roles. The state also has a series of success stories (<https://chwsd.org/success-stories/>) that illustrate the return on investments from a CHW workforce. These resources can be used with state leadership, legislators, and other partners. Additionally, the state also developed partner workgroups. A billing and provider manual outlining covered services was essential in guiding decision-making.

- **Rhode Island** benefitted from strong support within the state health department and credibility of its [state CHW association \(https://chwari.org/\)](https://chwari.org/) following development of an [independent certification program \(https://chwari.org/certification/\)](https://chwari.org/certification/), as well as a history of successful CHW initiatives through its state health improvement plan.

What are some best practices for CHWs and community engagement when designing and implementing a CHW SPA?

- [Engaging CHWs \(https://nashp.org/lessons-for-advancing-and-sustaining-state-community-health-worker-partnerships/\)](https://nashp.org/lessons-for-advancing-and-sustaining-state-community-health-worker-partnerships/) in design and implementation consideration is key to developing a SPA and building trust between CHWs and state officials. Working with [national \(https://nachw.org/\)](https://nachw.org/) and [state CHW associations \(https://nashp.org/developing-meaningful-and-effective-partnerships-between-state-leaders-and-community-health-worker-associations/\)](https://nashp.org/developing-meaningful-and-effective-partnerships-between-state-leaders-and-community-health-worker-associations/), coalitions, and training entities and holding listening sessions and opportunities for workforce feedback on proposed benefits [are all strategies states have used \(https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/\)](https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/) when developing a SPA.
 - **Michigan**, for example, [developed a primer series \(https://www.youtube.com/playlist?list=PL7n_k_3drTUueyZbh3AisBOIYHNjCNGAC\)](https://www.youtube.com/playlist?list=PL7n_k_3drTUueyZbh3AisBOIYHNjCNGAC) that was aimed at enhancing meaningful engagement and providing interactive feedback through its design. Comprising four concise recorded updates on policy initiatives, the primer series served as a precursor to shaping policy direction before the official public comment period. Each video included a topic-specific survey, enabling collaborators to offer real-time feedback directly to the policy development team.
 - **California** led a series of community dialogue sessions with CHWs, promotores, community health representatives, navigators, other non-licensed public health workers, and interested partners to communicate the state's vision for supporting and scaling CHW/P/R services in the state and to engage community partners on how to achieve that vision. The state has also introduced an ad-hoc CHW/P/R partner group to help inform the community dialogue sessions and provide additional input from the CHW/P/R workforce. The goal is to formalize this workgroup in the future to have a longer-term opportunity for CHW/P/R collaborators to provide input on CHW/P/R workforce development.
 - Outside of the SPA context, **Massachusetts** met with CHW interested parties to better understand how to support CHWs (which could be supported with Delivery System Reform Incentive Payment Program funding paid to accountable care organizations authorized through the state's previous 1115 Demonstration Waiver, rather than a SPA).
- Deliberate efforts are necessary if community-based organizations (CBOs) are to be included. CBOs typically employ a large percentage of the CHWs in any given state. **Rhode Island** engaged with a statewide nonprofit to organize and educate CHW employers, especially CBOs, in processes for enrolling with Medicaid and submitting claims. For more information, read the [Medicaid CHW manual \(https://eohhs.ri.gov/providers-partners/provider-manuals-guidelines/medicaid-provider-manual/community-health-worker\)](https://eohhs.ri.gov/providers-partners/provider-manuals-guidelines/medicaid-provider-manual/community-health-worker).

Approximately how long did SPA development take other states?

- SPA development and approval timelines vary, depending on factors such as engagement, legislation, and the strength of cross-sector partnerships. **Michigan** developed a [Project Fact Sheet detailing CHW Medicaid incorporation \(https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Medicaid-Provider-Assets/Provider-Training-Assets/CHW-Project-Fact-Sheet.pdf?rev=6a542182649c4d3eabb9d3a0ee925c53&hash=FBFF5BDDA35379E25BAF0AAC29C45244\)](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Medicaid-Provider-Assets/Provider-Training-Assets/CHW-Project-Fact-Sheet.pdf?rev=6a542182649c4d3eabb9d3a0ee925c53&hash=FBFF5BDDA35379E25BAF0AAC29C45244). It includes information on the project planning period, objectives, background, and community engagement. While timelines vary across states, it is worth factoring in opportunities to engage with the workforce and understand opportunities to support benefit uptake as the SPA is being developed.
 - Before developing a SPA, **South Dakota's** Department of Health and Department of Social Services took several years researching the current CHW workforce. After approval, it took the state several years of providing technical assistance on Medicaid billing and building up the state's CHW/R workforce before providers were able to submit claims for services provided.
- Some states have opted to model new SPAs off existing approaches in other states to support a smoother approval process with CMS. **Indiana** (<https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-18-005.pdf>) and **California** (<https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf>) offer two good examples for SPA development, and many states have included very similar scope of covered services for their CHW benefits.

Details of the CHW SPA Design

What are key considerations for designing Medicaid reimbursement for CHW services?

- **Authority:** Most states that reimburse for CHW services use SPAs that authorize payments either through the “other practitioner services” or “preventive services” regulatory authority. Some states, such as California, Maine, Michigan, Washington, and West Virginia [allow CHWs to be included in home health program care teams \(https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf\)](https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf).
- **Scope of Services and Billing:** To be reimbursed for services via a SPA, CHW services must be recommended by a licensed clinician (such as a physician). States typically bill CHW services through health education, health promotion and coaching, and health system navigation/resource coordination services (See Table 1 for examples). Many states use CPT codes 9896x and bill in 15- or 30-minute increments. For a more comprehensive overview of state SPAs, including authority, covered services, and billing codes, please review “[State Approaches to Community Health Worker Financing through Medicaid State Plan Amendments \(https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/\)](https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/).”
 - **Minnesota** was the first state to use CPT codes 98960, 98961, and 98962. Some states, such as Indiana, Louisiana, Nevada, and South Dakota, have modeled SPAs authorizing CHW reimbursement using Minnesota's scope of services and CPT codes.

- Note: There are limited data available on the CHW workforce, which poses some challenges for states determining reimbursement rates and estimating utilization. Therefore, almost all states have opted for a fee-for-service billing approach as they gather data to determine the best payment strategy and rate structure. Some states, such as **South Dakota**, have chosen to [model rates after those for other nonclinical health care providers](https://dss.sd.gov/docs/medicaid/providers/feeschedules/Other_Services/Community_Health_Worker_Agencies_SF24.pdf) (https://dss.sd.gov/docs/medicaid/providers/feeschedules/Other_Services/Community_Health_Worker_Agencies_SF24.pdf) and have factored in non-billable time when setting rates. **Maine** has hired a third-party vendor to help coordinate work and set rates for CHWs through [an alternative payment model](https://nashp.org/qa-using-an-alternative-payment-model-to-support-community-health-worker-sustainability-in-maines-primary-care-plus-program/) (<https://nashp.org/qa-using-an-alternative-payment-model-to-support-community-health-worker-sustainability-in-maines-primary-care-plus-program/>). Some other states are considering contracting for actuarial studies.

Are there any examples of states that have taken an alternative payment approach rather than a fee-for-service billing approach for CHW services?

- **Maine's** Primary Care Plus Initiative (PCPlus) is an alternative payment model (APM) through MaineCare, Maine's Medicaid program, that provides a higher per-member per-month (PMPM) rate for a [whole-person care approach](https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know) (<https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know>) that includes care delivery requirements such as care coordination, health and oral screenings, and care transition. Eligible primary care practices must engage CHWs starting in 2024. Read [NASHP's blog post to learn more](https://nashp.org/qa-using-an-alternative-payment-model-to-support-community-health-worker-sustainability-in-maines-primary-care-plus-program/) (<https://nashp.org/qa-using-an-alternative-payment-model-to-support-community-health-worker-sustainability-in-maines-primary-care-plus-program/>) about how Maine is using an APM to reimburse for CHW services.
- **Oregon** incorporated CHW investment into contracts for their accountable care organizations, or coordinated care organizations (CCOs), through the state's [Traditional Health Worker program](https://www.oregon.gov/oha/ei/pages/about-traditional-health-workers.aspx) (<https://www.oregon.gov/oha/ei/pages/about-traditional-health-workers.aspx>). The areas all CCOs are [required to address](https://www.oregon.gov/oha/ei/pages/cco-traditional-health-worker-deliverables.aspx) (<https://www.oregon.gov/oha/ei/pages/cco-traditional-health-worker-deliverables.aspx>) include implementing a Traditional Health Worker (THW) Integration and Utilization Plan, developing a THW Payment Model Grid, and submitting a THW Integration Utilization Report.
- The **Massachusetts** primary care sub-capitation model was launched in 2023 by MassHealth (Medicaid) as part of its broader ACO system. It is a primary care population-based payment (PBP) model. The MassHealth ACO model itself is a total-cost-of-care (TCOC) model that is paid as a capitation, and the primary care sub-capitation model is designed to ensure that primary care practices are also paid through a PBP such that funds can be more easily leveraged to hire expanded care team staff such as CHWs.

How are federally qualified health centers (FQHCs) impacted by CHW SPAs?

- States have varied methods for handling CHW funding for FQHCs. The typical prospective payment system (PPS) for FQHCs in most states does not allow treating a separate contact between a CHW and a patient as a "medical (i.e., billable) encounter." Several states, such as **Louisiana, Rhode Island,** and **Michigan**, allow FQHCs to submit Medicaid claims for CHW services outside the PPS billing process. In **Nevada**, the definition of a "medical encounter" includes an encounter with a CHW as long as no other billable encounter takes place on

the same day. However, Nevada's FQHCs are able to bill medical, behavioral health, and dental encounters on the same day (when applicable).

- **California** is planning to implement a voluntary alternative payment methodology (APM) for FQHCs to be paid under a sub-capitation system and thereby have increased flexibility to pay for CHWs. Note: The APM does not provide direct reimbursement for CHWs; however, it allows FQHCs flexibility in utilizing non-PPS providers.

What qualifications must CHWs meet to be reimbursed through Medicaid?

- There is currently no national qualification or credential for CHWs. CMS requires that states have a method of determining qualifications for Medicaid reimbursement (<https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf>) under a SPA. However, CMS does not require that states use certification to determine CHW qualification.
- Some states do require CHWs to be certified to be eligible for Medicaid reimbursement. In states with CHW certification, there are typically two pathways for becoming certified: CHWs must either meet a set number of training hours by an approved entity or be granted certification through a work experience pathway if they have been a practicing CHW for a certain number of years and can demonstrate proficiency and experience. In states that do not utilize certification as a qualification for Medicaid reimbursement, qualifications may be determined through a recognized training program. See NASHP's 50 state tracker (<https://nashp.org/state-tracker/state-community-health-worker-policies/>) for examples of CHW certification programs.
 - Instead of certification, **Louisiana** offers a standardized training for CHWs (<https://www.astho.org/communications/blog/why-louisiana-doesnt-certify-community-health-workers/>). The Louisiana CHW Workforce Coalition created criteria and a review process for CHW training programs in the state.
 - **Kentucky** has a permanent experience pathway (<https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/CHW%20Program/CHWManual.pdf>) for certification. Those who have done CHW work within three years of applying can include documentation verifying experience for certification.
 - **California** adopted its SPA requiring CHWs to possess a certificate of completion, which can include any certificate issued by the State of California, such as the Department of Health Care Access and Information or another certificate by other organizations that meets certain core competencies as outlined in the California State Plan and policy guidance. CHWs may also meet qualifications with demonstrated work experience, although they would need to earn a CHW certificate within 18 months of providing services to Medi-Cal members.
- CHW leaders and states recognize the importance of making CHW certification voluntary, even if it is required for Medicaid reimbursement. In many states, there is an emphasis on reducing barriers, such as fees and background checks, that may prevent CHWs from becoming certified.
 - While CMS does not require background checks (<https://www.networkforphl.org/wp-content/uploads/2023/08/Addressing-Legal-Obstacles-to-Hiring-Formerly-Incarcerated-Individuals-as-Community-Health-Workers-1.pdf>) to approve a SPA, background checks are often up to

an employer's discretion. Some states, such as **Massachusetts** and **Oregon** (<https://www.oregon.gov/oha/EI/Documents/THW-Background-Check.pdf>), offer a formalized review requirement, meaning a flagged offense can be evaluated for whether it is serious and/or nonviolent.

- Certification is required for CHWs to bill Medicaid in **California** and **Rhode Island**. In **California**, as an alternative to the certificate pathway, an individual CHW can use the work experience pathway that allows CHWs to have 2,000 hours working in paid or volunteer positions within the past three years and have demonstrated skills/practical training in the core competencies outlined in the California State Plan and policy guidance and must earn a certification of completion within 18 months. However, non-certified CHWs in **Rhode Island** can continue to be paid through Medicaid if they have a plan to become certified within 18 months.

Can individual CHWs enroll directly as a Medicaid provider, or do they need to work under the supervision of a physician under another licensed provider?

- When provided as a preventive service, CMS does require CHW services to be recommended by a licensed provider. In some cases, services must be ordered, while others require general supervision by a licensed provider. This depends in large part on the regulatory authority on which the state relies in its [SPA application](#). Because CHWs do not provide clinical care, day-to-day supervision can generally be delegated to non-clinical staff and/or community-based organizations (CBOs) under contract. Some states are also pursuing standing orders to reduce paperwork.
 - CHWs' ability to enroll directly as a Medicaid provider varies across states. **Rhode Island** does not require CHWs to perform services under the supervision of a licensed provider, and individual CHWs may enroll with Medicaid and bill the state directly. However, CHWs are unable to bill for any services provided until recommended by a licensed provider and must document how the patient meets eligibility for services (or "medical necessity") requirements in clinical notes.

Implementing a CHW SPA

What are some key learnings from states as they navigate SPA implementation and uptake?

- Most states note that uptake of a new Medicaid CHW benefit is slow in the early stages. A state may need to build up the CHW workforce or increase training resources, and CHWs (or providers) may not be aware of the available benefit. CBOs typically do not have the administrative capacity, or agreements with other billing providers, required to bill Medicaid. Capacity building for those interested CBOs requires upfront investment to improve partnerships and benefit uptake. In addition, some CBOs and CHWs may not have interest in billing Medicaid or may consider billing rates too low. States may consider partnering with CHW associations and other networks to determine interest and barriers to benefit uptake and inform their Medicaid strategy as part of a comprehensive, braided/blended funding/financing approach. Many states have learned that gathering this information early has the dual benefit of informed policymaking and meaningful partnerships to tailor effective implementation approaches during the policy design process.

- **California** has continued to engage in feedback with CHWs regarding a new statewide certification program being designed to accompany the state's CHW Medicaid benefit. In January 2024, **California** added CBOs and local health jurisdictions (LHJs) as the newest CHW supervising provider types, and the state is actively working to enroll CBOs and LHJs as Medicaid providers so employed CHWs can be reimbursed through Medicaid
- **South Dakota** has been working to support and develop a CHW workforce that can meet the needs of the state's Medicaid enrollees. Following slow uptake of the benefit, the state raised reimbursement rates (equivalent to \$64.86 per hour) in response to CHW and employer feedback.
- **Maine** is developing a paid consultant group of CHWs to advise on implementation of the PCPlus model. The state also meets CHW leaders for continued partnership, planning, and communication. Together, they are developing a group charter, CHW definition, and sustainability levers like the PCPlus program.
- Currently, data on CHW work and participation are limited. Some states, such as **South Dakota** and **California**, are increasing data collection and reporting efforts to better understand the CHW landscape. Minnesota and South Dakota are among a small number of states now generating quarterly statistics on submitted and paid claims. Additionally, Rhode Island pulls monthly data on paid claims. Lack of data poses an ongoing challenge to CHW SPA implementation.

NASHP will continue to monitor state approaches to developing, financing, and sustaining the CHW workforce. State officials interested in learning more about NASHP's state learning collaborative on CHW policy should email [Megan D'Alessandro](mailto:mdalessandro@nashp.org) (<mailto:mdalessandro@nashp.org>).

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