Health Educator Perspectives on Seeking Medicaid Reimbursement in Indiana

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This is the author's manuscript of the article published in final edited form as:

Yazel-Smith, L., Hancher-Rauch, H. L., & Britt-Spells, A. (2019). Health Educator Perspectives on Seeking Medicaid Reimbursement in Indiana. Health Promotion Practice, 1524839919845670. https://doi.org/10.1177/1524839919845670

ABSTRACT

Health education is a growing field. However, there is confusion about the role delineation of health education specialists (HES) and other health education (HE) providers. Additionally, recent reimbursement opportunities allow employers to bill for HE services but offer confusing language regarding eligible service-providing professionals. This study surveyed health educators in Indiana to assess knowledge, attitudes, and perceived abilities to bill Medicaid and other insurers for HE services. Using a cross-sectional research design, an original 22-item Web-based questionnaire was developed and distributed to all Certified Health Education Specialist/Master Certified Health Education Specialist (CHES/MCHES) practitioners residing in Indiana. Additional respondents were recruited using a snowball technique, as original respondents asked to share the survey with colleagues. A final data set of 61 respondents was analyzed. All respondents' organizations provided HE services, with the majority indicating they do not charge and do not bill for HE services. Additionally, 60% of the respondents agreed that HES should be reimbursed for services, and the vast majority believed reimbursement to be important for the field. With recent reimbursement opportunities for HE and preventative health services, it is important that HES advocate for the profession and for potential reimbursement opportunities, such as Medicaid, to enhance the field and support HES jobs.

Keywords: health education, health education specialists, Medicaid reimbursement

INTRODUCTION

Over the past decade, much professional growth and change have occurred in the health education (HE) field, including program accreditation, certification opportunities, and better role delineation for the job responsibilities of health educators. According to the U.S. Bureau of Labor Statistics (BLS; 2018), there were 61,000 health educators employed in the United States in 2016, with projected growth to almost 70,000 by 2026. These health educators are employed in public health departments, universities, nonprofit organizations, private businesses, and health care facilities (BLS, 2018). In Indiana, it is estimated that there are between 680 and 1,510 health educators employed in these settings (BLS, 2018). The job prospects appear strong for health educators, but challenges exist, such as increased need for funding to support the field, individuals not academically trained as health education specialists (HES) being hired to fill HES roles, and confusion about the differences between community health workers (CHWs) and HES.

BACKGROUND

While the job outlook and progress in the profession have been strong, challenges exist for the HE field. One challenge is the confusion among hiring managers regarding who is qualified to fill HE jobs. One study surveyed those in hiring positions within organizations employing health educators and found that nearly one third believed others could fill roles of professionally trained health educators or they did not believe they needed to hire health educators for HE roles (Gambescia et al., 2009). The emphasis on cost control and quality improvement within the Affordable Care Act (ACA) led to significant opportunities for health educators (Strong, Hanson, Magnusson, & Neiger, 2016), but it also has resulted in confusion regarding the difference between health educators and CHWs. This may be due to the ACA specifically discussing various roles for CHWs within accountable care organizations and medical homes as part of interdisciplinary health care teams (Shah, Heisler, & Davis, 2014). It also makes specific recommendations for the Center for Medicaid and Medicare Innovation to study whether CHWs can effectively practice in innovative service delivery models.

Though the BLS and professional organizations representing HES delineate differences in training and skills of CHWs and health educators, there is still confusion among decision makers in governmental, public, and private organizations as to the differences between these professionals. In fact, the terms are sometimes used interchangeably, such as the case in a recent charter program through the Indiana Family and Social Services Administration Office of Medicaid Policy and Planning, which used the term community health workers to refer to anyone engaged in HE services (J. Walthall, personal communication, December 7, 2017). This pilot allows CHWs to receive reimbursement through Medicaid when supervised by a medical director. The confusion arises when organizations see the term community health worker and interpret the language literally, meaning defining the term consistent with the BLS (2018) definition of CHWs as those who "share information with health educators and healthcare providers so that health educators can create new programs or adjust existing programs or events to better suit the needs of the community" (para. 7).

One reason health educators may be concerned with clear role delineation between themselves and CHWs is payment for services. Because HES must have at least a bachelor's degree relevant to the field of HE, while CHWs require a high school diploma and skills training (Society for Public Health Education [SOPHE], n.d.), there is a significant difference in the estimated annual salary of each. According to the BLS (2018), there is an approximate $15,000 annual salary difference between the two professions, with health educators making an average of $53,940 in 2017. Because only about 3% of the U.S. national spending on health is allocated to public health (Institute of Medicine, 2012), organizations seeking to provide public and community health services often are left to fight for grant funding to survive. In order to save money, agencies may seek to employ CHWs instead of health educators, though supporting data could not be located. This concern among health educators is exacerbated by the fact that recent state and federal policies specifically referred to reimbursement of services for CHWs (Malcarney, Pittman, Quigley, Horton, & Seiler, 2017), while not necessarily mentioning health educators by name. However, there are options within the ACA and some state Medicaid programs to provide reimbursement for HE services as well (SOPHE, 2015).

As part of the prevention strategies associated with the ACA, the Centers for Medicaid and Medicare Services enacted a federal rule allowing state Medicaid programs to offer reimbursement for community-based prevention services provided by nonlicensed providers such as HES (SOPHE, 2015). In order to qualify for reimbursement, patients would need the preventive service to be recommended by a licensed health care provider, and states would need to write the new reimbursement policy into their state Medicaid plans (SOPHE, 2015). As a result of this, multiple professionals have encouraged health educators to consider new roles they may play in the provision of health care in the United States (SOPHE, 2015; Strong et al., 2016). However, it appears that many in the field have little understanding regarding the reimbursement provisions of the ACA (Strong et al., 2016). To that end, the current study set out to assess the knowledge and attitudes of those who provide HE services in Indiana regarding Indiana Medicaid in general, as well as their perceived abilities to bill Indiana Medicaid for services rendered.

METHODS

PARTICIPANTS

Study participants consisted of Certified Health Education Specialist/Master Certified Health Education Specialist (CHES/MCHES) certified practitioners who resided in Indiana during the study time frame. Additionally, snowball sampling was employed to capture participants who conducted HE services or worked for an employer that conducted HE services. This was done by asking HES to forward the e-mail with the survey link to their colleagues who provide HE services. For those captured in snowball sampling, some may have been academically trained health educators, while others may have had on-the-job experiential training.

STUDY DESIGN

A cross-sectional study design allowed for data collection in a quick time frame and prior to the implementation of the Community Health Worker Charter Program through the Indiana Family and Social Services Administration Office of Medicaid Policy and Planning. This study was approved by the Indiana University Institutional Review Board. The process began by requesting a list of e-mail contact information for all CHES/MCHES

certified practitioners in Indiana from the National Commission for Health Education Credentialing, Inc. (NCHEC). After complying with NCHEC policies, the list of CHES/MCHES practitioners in Indiana was sent to the researchers via e-mail correspondence.

Data were then collected via a 22-item original Web-based questionnaire and reviewed by the NCHEC Board of Commissioners. The questionnaire, which was tested for usability and face validity by the research team and peer experts, captured basic Indiana Medicaid knowledge and attitude data from participants. The questionnaire was tested for usability by researchers and student interns for 2 weeks during early 2018, with revisions made to accommodate typographical errors and formatting issues.

In April 2018, an e-mail invitation was sent to all CHES/MCHES certified practitioners in Indiana listed in the NCHEC file, inviting them to participate in the research study. The e-mail invitation (a) provided recipients an overview of the study and research objectives, (b) notified recipients that their participation in the study was voluntary, (c) stated their participation in the study was an acknowledgment of consent, (d) provided instructions for completing the questionnaire, (e) included the link to the online questionnaire for completion, and (f) asked recipients to forward the invitation to colleagues.

A reminder e-mail was sent to the listing of CHES/MCHES certified practitioners 3 weeks after the initial e-mail and final reminder e-mail 2 months after the initial e-mail. Additionally, snowball sampling was employed to capture professionals who either provide HE services to patients/clients or work for organizations that provide HE services to patients/clients but were not on the original list from NCHEC. The link took participants to the data collection tool in Research Electronic Data Capture, a Web-based data management system (Harris et al., 2009).

All analyses were conducted using STATA 15.1. Descriptive statistics included frequencies and percentages. Chi-square and Fisher's exact test analyses examined differences between (a) certified and noncertified practitioners, (b) practitioners at varying types of organizations, and (c) practitioners with varying levels of training. Responses that were missing or unsure were excluded from the bivariate analyses.

RESULTS

The listing of CHES/MCHES certified practitioners in Indiana consisted of 253 individuals, and all were eligible to participate in the research study. The initial e-mail invitation and both follow-up e-mails were sent to all 253 individuals. Eight (3.0%) e-mail addresses "bounced back" as no longer valid. Researchers did not track snowball recruitment. However, 43 respondents indicated they were CHES/MCHES, leaving 18 respondents indicating they were not, suggesting they were invited by colleagues. Between April and June 2018, 76 individuals completed the questionnaire, but 15 were eliminated due to multiple missing variables, blank entries, or repeat respondents, therefore reducing the final data set to 61.

Descriptive statistics are found in Table 1. The majority of survey participants were female (85.25%), were CHES/MCHES certified (70.49%), and had a graduate degree (65.57%). Participants worked in a variety of settings, including academic (32.79%), community (24.59%), and government/state (27.87%). Over one third (37.70%) reported having 10 years or more field experience, and the majority of those (44.26%) reported having 5 years or less.

Table 1 Descriptive Statistics of Participant Personal Demographics, Work Setting, Organization Functions, and Attitudes (N = 61)

TABLE 1
Descriptive Statistics of Participant Personal Demographics, Work Setting, Organization Functions, and Attitudes (N = 61)

Variables	*Frequency (%)*
Gender	
Male	9 (14.75)
Female	52 (85.25)
Education	
Bachelor's degree	21 (34.43)
Graduate degree	40 (65.57)
Work setting	
University/K-12	20 (32.79)
State/county/government	17 (27.87)
Health care/hospital services	9 (14.75)
Community/other/gym	15 (24.59)
CHES or MCHES certified	
Yes	43 (70.49)
No	18 (29.51)
How long worked in field?	
0-5 years	27 (44.26)
6-10 years	11 (18.03)
10+ years	23 (37.70)
Intent of non-CHES/MCHES to complete exam (n = 18)	
Will take exam	3 (16.67)
Will not take exam	4 (22.22)
Unsure	7 (38.89)
Ineligible	4 (22.22)
Work setting of non-CHES/MCHES to complete exam (n = 18)	
University/K-12	3 (16.67)
State/county/government	10 (55.56)
Health care/hospital services	1 (5.56)
Community/other/gym	4 (22.22)
Organization charges for health education services	
Yes	15 (24.59)
No	38 (62.30)
Unsure	8 (13.11)
Employer can bill services provided	
Yes	19 (31.15)
No	31 (50.82)
Unsure	11 (18.03)
Organization currently bills Medicaid	
Yes	13 (21.31)
No	3 (4.92)
Unsure	3 (4.92)
Missing	42 (68.85)
How position is supported	
Fully funded by grants or funding from outside your organization	27 (44.26)
Partially funded by grants or funding from outside your organization	11 (18.03)
Not funded by grants or funding from outside your organization	18 (29.51)
Vary depending on available funds	5 (8.20)
Ability to bill will sustain your position	
Yes	25 (40.98)
No	13 (21.31)
Unsure	22 (36.07)
Missing	1 (1.64)
If billed, does the organization have resources	
Yes	23 (37.70)
No	10 (16.39)
Unsure	28 (45.90)
Familiarity with services Medicaid covers	
Familiar	42 (68.85)
Unfamiliar	19 (31.15)
Familiarity with how to bill Medicaid	
Familiar	14 (22.95)
Unfamiliar	47 (77.05)
Agree health education services specialists should be reimbursed by insurance	
Strongly agree	38 (62.30)
Somewhat disagree or disagree	23 (37.70)

NOTE: MCHES = Masters Certified Health Education Specialist; CHES = Certified Health Education Specialist.

Of the 18 participants who reported non-CHES/MCHES certified, approximately 17% reported they intended to seek the credential in the future, while 61.11% were uncertain about taking the exam or were ineligible. Non-CHES/MCHES certified individuals were most likely to work in the state/county/government setting (55.56%) followed by the community setting (22.22%). All participants who indicated they were not CHES/MCHES certified also reported that their work did not include any of the Seven Areas of Responsibilities and Competencies for HES (Seven Areas; NCHEC, 2015).

All participants in the study reported that their organization provided HE services to patients, clients, employees, and/or community members. However, a majority indicated that their organization does not charge for HE services (62.30%) and is not a rendering provider that can bill insurance for services provided (50.82%). Many (44.26%) study participants' positions were fully supported by grants or outside funding. Regarding billing for services, 68.85% of participants endorsed being familiar with the services covered by Indiana Medicaid, but only 22.95% reported they were familiar with billing procedures. Over 60% of participants indicated they strongly agreed that HE services should be reimbursed by insurance. Furthermore, 41% believed that the ability for their employer to bill Medicaid for HE services reimbursement would sustain their position. Most respondents (45.90%) were unsure whether their organization would have the resources to bill Indiana Medicaid for HE services; however, over 30% believed their organization would be able to provide the necessary resources for billing. Further details concerning attitudes and organization function may be found in Table 1.

Table 2 details in which of the Seven Areas partici-pants reported working. Only MCHES/CHES certified participants reported working in one of the Seven Areas. Among those who worked in each of these areas, over 60% reported being familiar with Medicaid-covered services and strongly agreed that HE services should be reimbursed by Medicaid. Across all Seven Areas, over 75% of respondents reported not being familiar with how to bill services.

Table 2 MCHES/CHES Certified Participants (N = 43)

TABLE 2
MCHES/CHES Certified Participants (*N* = 43)

Area	*MCHES/CHES Who Work in Area,* n *(%)*	*Familiar With Medicaid-Covered Services,* n *(%)*	*Familiar With Medicaid Billing,* n *(%)*	*Strongly Agree HES Specialist Should Be Reimbursed,* n *(%)*
Area I	39 (90.70)	27 (69.23)	8 (20.51)	27 (69.23)
Area II	40 (93.02)	27 (67.50)	8 (20.00)	28 (70.00)
Area III	42 (97.97)	29 (69.05)	8 (19.05)	29 (69.05)
Area IV	35 (81.40)	24 (68.57)	7 (20.00)	25 (71.43)
Area V	39 (90.70)	26 (66.67)	7 (17.95)	28 (71.79)
Area VI	40 (93.02)	27 (67.5)	8 (20.00)	28 (70.00)
Area VII	36 (83.72)	24 (66.67)	8 (22.22)	26 (72.22)

NOTE: MCHES = Masters Certified Health Education Specialist; CHES = Certified Health Education Specialist; HES = health education specialists.

Bivariate analyses using chi-square and Fisher's exact test were conducted on variables from Table 1. Relevant results have been reported in Table 3. Among the Seven Areas, a statistically significant interaction ($p = .042$) was found when comparing attitude about HE services reimbursement among those who worked or did not work in Area V (Administer and Manage Health Education). A marginally statistically significant interaction ($p = .055$) was found when comparing attitude about HE services reimbursement among those who worked or did not work in Area VII (Communicate, Promote, and Advocate for Health and Health Education). Statistically significant interactions ($p < .001$) were found when comparing respondents' work settings and whether their organization could bill insurance services. Last, a statistically significant interaction was found when comparing how respondents' positions were funded and their familiarity with Medicaid-covered services. No other statistically significant interactions were found.

Table 3 Selected Bivariate Analysis Using Chi-Square and Fisher's Exact for Test Participants

TABLE 3
Selected Bivariate Analysis Using Chi-Square and Fisher's Exact for Test Participants

Selected Bivariate Analysis Using Chi-Square and Fisher's Exact Test				
Area I	Strongly agree ($N = 61$)	Does not work in Area I	Works in Area I	$\chi^2(1) = 2.21$, $p = .137$
	No	11	12	
	Yes	11	27	
Area II	Strongly agree ($N = 61$)	Does not work in Area II	Works in Area II	$\chi^2(1) = 2.94$, $p = .087$
	No	11	12	
	Yes	10	28	
Area III	Strongly agree ($N = 61$)	Does not work in Area III	Works in Area III	$\chi^2(1) = 2.62$, $p = .106$
	No	10	13	
	Yes	9	29	
Area IV	Strongly agree ($N = 61$)	Does not work in Area IV	Works in Area IV	$\chi^2(1) = 2.92$, $p = .088$
	No	13	10	
	Yes	13	25	
Area V	Strongly agree ($N = 61$)	Does not work in Area V	Works in Area V	$\chi^2(1) = 4.15$, $p = .042$
	No	12	11	
	Yes	10	28	
Area VI	Strongly agree ($N = 61$)	Does not work in Area VI	Works in Area VI	$\chi^2(1) = 2.94$, $p = .087$
	No	11	12	
	Yes	10	28	
Area VII	Strongly agree ($N = 61$)	Does not work in Area VII	Works in Area VII	$\chi^2(1) = 3.69$, $p = .055$
	No	13	10	
	Yes	12	26	

Selected Bivariate Analysis Using Fisher's Exact Test			
Work setting	Yes—employer can bill insurance for services	No—employer cannot bill insurance for service	$p < .001$
University/K-12	4	13	
State/county/government	6	5	
Health care/hospital services	8	1	
Community/other/gym	1	12	
Work setting	Yes—organization charges for HE services	No—organization does not charge for HE services	$p = .012$
University/K-12	4	13	
State/county/government	0	13	
Health care/hospital services	4	4	
Community/other/gym	7	8	
How position is supported	Familiar with Medicaid-covered services	Unfamiliar with Medicaid-covered services	$p = .034$
Fully funded by grants or funding from outside your organization	21	6	
Partially funded by grants or funding from outside your organization	10	1	
Not funded by grants or funding from outside your organization	9	9	
Vary depending on available funds	2	3	

NOTE: HE = health education.

DISCUSSION

The purpose of this study was to assess the knowledge and attitudes of those who provide HE services in Indiana regarding Indiana Medicaid in general, as well as their perceived abilities to bill Indiana Medicaid for HE services rendered. The majority of participants were female, held a graduate degree, worked in a university/K-12 setting, reported being CHES/MCHES, and have worked in the field for less than 5 years. Additionally, the majority of CHES/MCHES reported working in all Seven Areas.

When examining the significance of those CHES/MCHES working in Area V, and the belief that HE services should be reimbursed, it is important to remember that those working in this capacity may have administrative duties as part of their jobs. Area V focuses on administration and management of HE, with competencies that focus on fiscal resources, programmatic support, leadership and management, and partnership facilitation (NCHEC, 2015). Reimbursement is an important factor when considering financial planning for programmatic and staff support. While the ACA supports increased funding for prevention strategies, like the use of HES, and some state policies offer reimbursement models, it is still unclear for many HES how to engage with these strategies, as revealed by this study. For instance, there were multiple missing responses related to questions focused on billing Medicaid for services and billing processes, leading researchers to believe that respondents did not know enough to even guess at the answer to the question posed.

Additionally, those reporting working in Area VII also seemed more likely than those working in other areas to support reimbursement for HE services. CHES/MCHES working in Area VII focus on competencies related to communicating about the professional field, engaging in professional advocacy, influencing health promoting policies, and promoting the profession (NCHEC, 2015). It is therefore unsurprising that practitioners engaged in advocacy for the profession would be supportive of HES reimbursement for services.

Of the 61 participants, there were 18 respondents who indicated they were not currently CHES/MCHES. One interesting finding related to the 18 non-CHES/MCHES is that none related the work they do to any of the Seven Areas. One explanation for this is that those who are not CHES/MCHES have not been academically trained in the Seven Areas,

therefore not recognizing the responsibilities and how they relate to HE services. An additional reason may be that those who are not CHES/MCHES may not want to disclose their work being aligned with the Seven Areas due to not being a certified practitioner. However, those working in HE, regardless of their CHES/MCHES status or eligibility, are likely completing tasks associated with one or more of the Seven Areas. Having a systematic tracking system of this information could help delineate the roles of HES and others completing HE work, as well as help those hiring HE staff by offering directive job descriptions and allowing qualified HES to apply and obtain appropriate jobs.

When examining work settings of the respondents, there was no significance found between work setting and respondents' familiarity of services provided by Indiana Medicaid. However, significance was found between work setting and whether the organization has ever charged for HE services and whether the organization has the ability to bill for HE services. Therefore, the workplace setting does affect whether or not an organization charges and/or bills for HE services. This is specifically relevant for those practicing in Area VI, which provides direction for HES to act as a resource person, adding responsibility to HES to assist priority populations with appropriate health-related information (NCHEC, 2015), such as general Medicaid resources.

Two additional findings regarding workplaces are relevant to work settings and knowledge of Medicaid. First, many respondents working in health care and state/county/governmental settings reported that their organizations were qualified to bill for Medicaid services; however, very few indicated that billing for HE services actually takes place. Second, 69% of respondents indicated they were familiar with the services provided by Indiana Medicaid, but 77% were unfamiliar with the billing process. One explanation may be that these employers do not seek this revenue because they find reimbursement rates from Indiana Medicaid are not worthy of the additional staff and time resources needed for the billing process. An additional explanation may be that the employees simply are untrained in the billing process.

This study brings to light the challenges in the HE profession, including discrepancies among professional role delineation, lack of knowledge of Medicaid services and coordinating billing, and the need for targeted training in billable HE services. An

encouraging finding of this study is that HE services respondents who work in any of the Seven Areas strongly agree that HE services should be reimbursed for services provided, which provides advocacy momentum for the field. Additionally, it should be meaningful for employers offering HE services, as many face challenges in securing funding to fully support staff and HE needs. Finally, the study provides a starting point for HES in Indiana, and perhaps other states, to advocate for reimbursement regardless of the work setting.

LIMITATIONS

This study had limitations. First, the sample size was small and, therefore, not generalizable outside of the current setting. Additionally, the small sample comprised mainly early-career professionals. The outcomes of the study may have been different if more seasoned professionals had responded, though it is unclear why a high percentage of the participants were early in their careers. The small sample size may also be due to HES working in settings where reimbursement would not be possible, therefore leading to disinterest in the survey. Second, bias may be introduced as researchers specifically targeted HES and conducted snowball sampling to capture non-HE specialists. Third, the short time frame to develop, conduct, and gather data may have led to the omission of important constructs that could shed light on the knowledge and attitudes being measured. It is recommended that future researchers replicate the study utilizing a larger sample size with more controlled participant recruitment strategies in order to support or refute the current findings. However, it is believed that the current study provides a baseline for the levels of knowledge, attitudes, and perceived skills of HE regarding Medicaid reimbursement.

CONCLUSIONS

Though this was a relatively small sample of HE providers in only one state, there are a number of lessons that could be gleaned from this project. First, it is clear that the majority of surveyed HES strongly believed that HE services should be reimbursed through health care coverage organizations like traditional insurance, Medicare, or Medicaid. However, few HE providers appear to be familiar with the reimbursement process within their organizations. Therefore, professional and academic billing trainings may benefit HES. Continuing education opportunities for CHES/MCHES HES could also address this need.

Trainings on a larger scale could be offered through professional organizations like SOPHE for university faculty, focused on preparing them to train the next generation of HES to seek reimbursement for their services through private or public insurance. It is suggested that this type of training could be provided in the form of preconference workshops at annual meetings. Professional organizations could create messages for faculty members encouraging them to provide skill development within academic training programs. One thing to consider during these trainings is the complicated nature of seeking reimbursement for HE services. There is much to be learned from the structures set into place for reimbursement of services around the Diabetes Prevention Program (Diabetes Prevention Program Research Group, 2002). The collaborative partnerships being developed and implemented around this type of reimbursement likely help gain reimbursement for more general HES services as well. Working with organizational leaders of groups such as SOPHE's Advocacy and Resolutions committee could help move HE professional organizations forward with training initiatives.

Somewhat unsurprising was the finding that HES practicing in responsibility Areas V and VII were most likely to strongly believe in the need for the reimbursement. These are likely to be the individuals managing organizational resources, supervising other HES, and actively advocating for HE needs and resources. Continuing to provide training- and resources-related reimbursement for services for professionals practicing in these areas should be considered a priority for professional organizations. SOPHE has offered tool kits, trainings, and advocacy alerts on this topic previously (SOPHE, n.d.) and is encouraged to continue highlighting these resources. In providing future trainings, it is recommended that advocates be encouraged to fight for differing levels of reimbursement based on not only types of services provided but also service provider level of training. There is confusion among leadership in some states about the differences between HE providers such as CHWs and HES. This confusion, along with challenges associated with variable reimbursement structures, may result in a single level of reimbursement regardless of skill level of the service provider (J. Walthall, personal communication, December 7, 2017). Providing resources and guidelines for establishing variable reimbursement levels would be helpful tools as advocates fight for reimbursement in diverse states across the country.

Authors' Note:

The authors acknowledge the National Commission for Health Education Credentialing, Inc., for providing the listing of CHES/MCHES in Indiana, and Charity A. Bishop, MA, CHES, for assistance with development of the data collection instrument.

References

1. Group, T. D. P. P. (DPP) R. (2002). The Diabetes Prevention Program (DPP): Description of lifestyle intervention. *Diabetes Care*, *25*(12), 2165–2171. https://doi.org/10.2337/diacare.25.12.2165
2. Gambescia, S. F., Cottrell, R. R., Capwell, E., Auld, M. E., Conley, K. M., Lysoby, L., Goldsmith, M., & Smith, B. (2009). Marketing Health Educators to Employers: Survey Findings, Interpretations, and Considerations for the Profession: *Health Promotion Practice*. https://doi.org/10.1177/1524839909339583
3. Harris, P. A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009). Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, *42*(2), 377–381. https://doi.org/10.1016/j.jbi.2008.08.010
4. Medicine, I. of. (2012). *For the Public's Health: Investing in a Healthier Future*. https://doi.org/10.17226/13268
5. Malcarney, M.-B., Pittman, P., Quigley, L., Horton, K., & Seiler, N. (2017). The Changing Roles of Community Health Workers. *Health Services Research*, *52*(S1), 360–382. https://doi.org/10.1111/1475-6773.12657
6. *Responsibilities & Competencies | NCHEC*. (n.d.). Retrieved June 15, 2020, from https://www.nchec.org/responsibilities-and-competencies

7. Shah, M. K., Heisler, M., & Davis, M. M. (2014). Community Health Workers and the Patient Protection and Affordable Care Act: An Opportunity for a Research, Advocacy, and Policy Agenda. *Journal of Health Care for the Poor and Underserved*, *25*(1), 17–24. https://doi.org/10.1353/hpu.2014.0019
8. Society for Public Health Education . (2015). Advocating for health education reimbursement in Medicaid state plans. Retrieved from https://www.sophe.org/wp-content/uploads/2017/05/Medicaid-Toolkit-2.0.pdf
9. Society for Public Health Education . (n.d.). Complementary roles and training of health education specialists and community health workers. Retrieved from https://www.sophe.org/wp-content/uploads/2018/08/Complementary-Roles-of-HES-and-CHW.pdf
10. Strong, J., Hanson, C. L., Magnusson, B., & Neiger, B. (2015). Health Education Specialists' Knowledge, Attitudes, and Perceptions of the Patient Protection and Affordable Care Act: *Health Promotion Practice*. https://doi.org/10.1177/1524839915599360