Medicaid Reimbursement for Community Health Worker Services: Model State Plan Amendment & Other Guidance

BY ANNIE CLOKE, MARGARITA HART, JANÉE TYUS, DAWN ALLEY, AND SHREYA KANGOVI

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Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org

OVERVIEW

Community health workers, *promotores*, and community health representatives (CHW/P/CHR) address health-related social needs through resource navigation, peer social support, health coaching, and advocacy. A large body of research suggests that well-designed CHW/P/CHR programs improve chronic disease control and mental health, promote healthy behaviors, reduce hospitalizations, and increase participation in primary care. CHW/P/CHR programs have historically relied on a patchwork of grants for funding, but more than half of state Medicaid programs have now implemented some form of CHW/P/CHR coverage and payment policy. This toolkit provides model language for state Medicaid leaders and CHW/P/CHR advocates to use as they develop State Plan Amendments and accompanying guidance documents to establish coverage and payment for CHW/P/CHR services.

BACKGROUND

New National Health Expenditure projections suggest that by 2032, US health care spending will reach $7.7 trillion, roughly 20% of the gross domestic product (GDP).[1] Yet, the health status of Americans — particularly those insured by Medicaid — is deteriorating.[2]

The way that we in the United States spend money on health care is inversely related to the value of our dollar. The majority of US health care spending goes to clinicians who deliver the most costly medical care rather than to lower-cost preventive care and social services. Yet the effect of medical care on health outcomes is dwarfed by the impact of adverse social determinants of health (SDOH).[3]

The evidence is clear that community health workers, *promotores*, and community health representatives (CHW/P/CHRs) and their flexible, person-centered approach to addressing health-related social needs can produce remarkable outcomes.[4] A large body of research suggests that well-designed CHW/P/CHR programs improve chronic disease control[5] and mental health,[6] promote healthy behaviors,[7] reduce hospitalizations,[8] and increase participation in primary care.[9] Their effect on health translates into cost savings. Randomized controlled trials have shown that CHW/P/CHRs working with Medicaid beneficiaries with chronic diseases prevent costly hospitalizations and save $2,500 per enrollee annually.[10]

Over their 80-year history in the United States, CHW/P/CHR programs have mostly relied on a patchwork of grants for funding. Recognizing these public health workers can improve health and reduce cost of care, Medicare and state Medicaid programs are beginning to pay for their services. In its 2024 Physician Fee Schedule, Medicare introduced the first billing code for CHW services.[11] Medicaid programs are following suit: as of January 2024, just over half of state Medicaid programs covered CHW services.[12] While some states include reimbursement for CHW/P/CHR services under Medicaid managed care organization (MCO) contracts, most states are implementing CHW coverage through State Plan Amendments (SPAs). The National Academy for State Health Policy recently published an excellent review of the process of CHW SPA development, including best practices for engaging CHW/P/CHRs in the process.[13] We build on this work and offer model language that states may use in their SPAs.

INTRODUCTION

Community health workers,[14] promotores, and community health representatives[15] (CHW/P/CHR) are a Department of Labor–classified workforce[16] that addresses people's health-related social needs. CHW/P/CHRs are trustworthy individuals who share life experiences with the people they serve and have firsthand knowledge of the causes and impacts of poor health. In best practice models, authentic CHW/P/CHRs find and meet people where they are, get to know their life stories, and work together on goals that will improve clients' lives and health. They provide social support, health coaching, navigation, and advocacy for community members.

This toolkit provides model language for state Medicaid leaders and CHW/P/CHR advocates to use as they develop SPAs and accompanying guidance documents to establish coverage and payment for CHW/P/CHRs services. This toolkit also includes considerations for payment rates.

The development of this toolkit was guided by a set of key principles:

- **Inclusion**. "Nothing about us without us" is a philosophy that emphasizes the inclusion of the individuals who will be impacted by policies in their development.[17] As policies are developed or refined, it is critical that CHW/P/CHRs are at the table.
- **Empowerment.** There is power in the lived experiences and perspectives of CHW/P/CHRs. This power should be recognized and uplifted by policymakers in the development of policies that govern this workforce.
- **Evidence.** CHW/P/CHRs serve people who have significant needs and have historically been underserved by health and social services systems, making it even more critical that CHW/P/CHR programs draw on good data to ensure they effectively improve clients' health and well-being.

Our process for developing this document was grounded in these principles. CHW/P/CHRs were coauthors who substantially contributed to the content, and we incorporated feedback from several leaders of CHW associations. We also used our principles to guide our selection of model SPA text. We chose model text that was recommended by or empowering to CHW/P/CHRs, and/or was supported by the best available evidence. In select cases, we included model text that did not align with our principles because that text is already widely in use. In these cases, we are careful to explain that while the text has precedent, it also carries risks.

The toolkit is organized into the following sections:

- **CHW State Plan Amendment Model Text.** Model text for SPAs or guidance that is organized by section (e.g., eligible population, services covered). In some sections we provide more than one option for model text and list the benefit of each option.
    - **CHW Model Text Rationale.** Our rationale for selecting model text, including references to existing precedent or supporting research, pros and cons of using the model text, and recommendations for where exactly the model goes (e.g., SPA, rule, guidance).

- **Principles for CHW Reimbursement Rates.** Guiding principles for states developing or refining payment rates for CHW/P/CHR services.
- **Glossary.** Definitions of key features of CHW/P/CHR policy.

CHW STATE PLAN AMENDMENT MODEL TEXT

1. (Definition)

A community health worker, promotore, and community health representative (CHW/P/CHR) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

2. (Population Eligible for CHW Services)

(*Option 2a. Prioritizes Access*) CHW/P/CHR services are available to all Medicaid beneficiaries.

(*Option 2b. Prioritizes Rising Risk Population*) CHW/P/CHR services are available to beneficiaries with at least two chronic conditions or at least one chronic condition and one identified health-related social need.

3. (Service Covered)

(*Option 3a. Prioritizes Comprehensive Evidence-Based Services*) The following services are covered when performed by CHW/P/CHRs:

- Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.
- Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.
    - Conducting a person-centered assessment to understand a patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs.
    - Facilitating patient-driven goal setting and establishing an action plan.
    - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjusting daily routines to better meet diagnosis and treatment goals.
- Building patient self-advocacy skills so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s) in ways that are more likely to promote personalized and effective diagnosis or treatment.

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Practitioner, Home-, and Community-Based Care Coordination
  - Coordinating receipt of needed services from health care practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregivers (if applicable).
  - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).
- Health education — helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.
- Healthcare access/health system navigation — helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.

(*Option 3b. Prioritizes Defined Service Package*) Covered CHW/P/CHR services include system navigation, health promotion, and clinical support. These services include but are not limited to:

- Addressing basic needs such as food and shelter
- Navigating health and social systems
- Assisting with enrollment in health programs and services
- Coaching on problem-solving, self-care, and self-management,
- Promoting understanding of health information and health education materials
- Leading educational and support groups

- Conducting home safety assessments
- Measuring and responding to vital signs
- Providing feedback to medical providers

4. (Requirements for Billing Entity)

(*Option 4a. Prioritizes Evidence and CHW/P/CHR Work Environment*) CHW/P/CHR program must meet state-approved accreditation standards that consider, at a minimum:

- Hiring of authentic CHWs
- CHW wage transparency
- Use of person-centered work practices
- Manageable caseloads
- Adequate training, support, and supervision for CHWs
- CHW career ladders

(*Option 4b. Prioritizes Ease of Requirements*) CHW/P/CHR program must employ individuals who have been trained on CHW core competencies, including relationship building and system navigation.

5. (Service Initiation & Supervision)

(*Option 5a. Prioritizes Access & Flexibility*) This standing order authorizes CHW/P/CHRs and agencies that provide CHW/P/CHR services to provide covered CHW/P/CHR services to eligible individuals.

(*Option 5b. Prioritizes Access & Provider Relationships*) A Medicaid-enrolled provider may establish a standing order with a contracted community-based organization that allows CHW/P/CHRs to provide covered CHW/P/CHR services to eligible individuals.

(*Option 5c. Prioritizes Role of the Provider*) CHW/P/CHRs must deliver services under the general supervision of a Medicaid-enrolled, licensed provider who orders CHW/P/CHR services for eligible individuals. The CHW/P/CHR may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization.

6. (Delivery Location & Mechanism)

(*Option 6a. Prioritizes Access*) Services may be delivered in person in the clinic, in person in the home or community, telephonically, or via telehealth. Service time billed must be for either direct contact (in person, telephonically, or via telehealth) with a beneficiary or for services performed as part of an individual's care plan even if the individual is not present.

There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

(*Option 6b. Prioritizes Access, Favors in Person*) Services may be delivered in person in the clinic, in person in the home or community, telephonically, or via telehealth. Service time billed must be for either direct contact (in person, telephonically, or via telehealth) with a beneficiary or for services performed as part of an individual's care plan even if the individual is not present.

Payment rates may differ based on modality of delivery.

There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

7. (Provider Billing)

(Option 7a. Prioritizes Empowering CHWs) CHW/P/CHRs or Community-Based Organizations (CBOs) may enroll as a CHW/P/CHR provider to be able to provide and bill for services for Medicaid beneficiaries.

(Option 7b. Prioritizes Role of the Provider) CHW/P/CHR services are reimbursed incident to the Medicaid-enrolled, licensed provider providing general supervision to the CHW/P/CHR.

The CHW/P/CHR may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization.

8. (Duration of Services/Frequency Limits)

(Option 8a. Prioritizes Access and Cost Containment) Covered CHW/P/CHR services are limited to 4 units (or 2 hours) per day, per beneficiary. Covered CHW/P/CHR services are limited to 24 units (or 12 hours) per month, per beneficiary.

(Option 8b. Prioritizes Access) There is no monthly or annual limit to the number of allowed CHW/P/CHR visits/hours per beneficiary.

9. (Documentation)

CHW/P/CHRs are required to document the amount of time spent with the patient and the nature of the activities.

CHW MODEL TEXT RATIONALE

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
1. Definition	**N/A**	American Public Health Association definition for CHWs: "A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." [1]	**Pro:** Adopts broadly used definition.	SPA Legislation Regulation
2. Population Eligible for CHW Services	**2a.** *Prioritizes Access*	New York has close to universal CHW coverage for all Medicaid beneficiaries. It "covers CHW services for the following NYS Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) members: A. children under 21 years of age; B. pregnant and postpartum individuals during pregnancy, and up to 12 months after pregnancy ends, regardless of the pregnancy outcome; C. adults with chronic conditions; D. individuals with justice system involvement within the past 12 months;	**Pro:** Broad population eligibility improves health for a large portion of the state's Medicaid enrollees. **Con:** Not all beneficiaries have baseline health spending high enough to drive a return on investment with a CHW/P/CHR program.	SPA Guidance (e.g., policy manual)

[1] American Public Health Association, "Community Health Workers", Accessed November 21, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
2. Population Eligible for CHW Services	**2a.** *Prioritizes Access*	E. individuals with an unmet health-related social need in the domains of housing, nutrition, transportation, or interpersonal safety, which have been identified through screening using the Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Health-Related Social Needs Screening Tool; and F. individuals who have been exposed to community violence or have a personal history of injury sustained as a result of an act of community violence, or who are at an elevated risk of violent injury or retaliation resulting from another act of community violence."[2]		
	2b. *Prioritizes Rising Risk Population*	Research has shown that evidence-based CHW programs serving the adult population with two or more chronic conditions can reduce readmissions, decrease hospital days, improve engagement,[3] and result in Medicaid return on[4] investment. In South Dakota, CHW services are a "preventive health service to prevent disease, disability, and other health conditions or their progression" available to "individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for individuals with a documented barrier that is affecting the individual's health."[5]	**Pro:** Strong evidence of impact of CHW/P/CHR services on populations with rising health risks (e.g., individuals with chronic conditions and/or health-related social needs).	SPA Guidance (e.g., policy manual)

[2] New York, Community Health Worker Services Policy Manual, eMedNY New York State Medicaid Provider Policy Manual. October 2024.

[3] Kangovi S, Mitra N, Norton L, et al. Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial. *JAMA Intern Med.* 2018;178(12):1635–1643. doi:10.1001/jamainternmed.2018.4630

[4] Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Affairs 2020;39(2):207–213.

[5] South Dakota, State Plan Amendment (SPA) #: 22-0007, Approved August 29, 2022.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
3. Services Covered	**3a.** *Prioritizes Comprehensive Evidence-Based Services*	Medicare's Community Health Integration services include (but are not limited to) providing socioemotional support, building self-advocacy skills, and facilitating access to community-based resources, care coordination, and health system access/navigation.[6]	**Pro:** Reimbursement for a comprehensive set of evidence-based CHW/P/CHR services.	SPA Guidance (e.g., policy manual, toolkit)
	3b. *Prioritizes Defined Service Package*	In New Mexico, "CHWs are able to provide system navigation, health promotion, and clinical support. These services include but are not limited to: • Addressing basic needs such as food and shelter, • Navigating health and social systems, • Assisting with enrollment in health programs and services, • Coaching on problem solving, self-care, and self-management, • Promote understanding or health information and health education materials, • Lead educational and support groups, • Conduct home safety assessments, • Measure and respond to vital signs, and • Provide feedback to medical providers."[7] In South Dakota, covered CHW services include: • Health system navigation and resource coordination. These services help individuals access needed health system and community resources. This includes, but is not limited to, helping individuals find and select a Medicaid provider, make an appointment, arrange transportation to a Medicaid covered medical appointment, and attend an appointment for a covered medical service. • Health promotion and coaching. These services may include topics such as cessation of tobacco use, reduction in the misuse of alcohol or drugs, improvement in nutrition, Improvement of physical fitness, and family planning.	**Con:** Narrower coverage omits services like socioemotional support, which has been proven to be a key driver of effectiveness.	SPA Guidance (e.g., policy manual, toolkit)

[6] Centers for Medicare and Medicaid, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, MLN Booklet, MLN9201074 January 2024.

[7] New Mexico Health Care Authority, New Mexico Medicaid Community Health Workers (CHWs) & Community Health Representatives (CHRs), July 1, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
		• Health education. Covered services include teaching or promoting methods and measures that have been proven effective in avoiding illness and/or lessening its effects. Topics may include immunizations, preventative services, control of high blood pressure or diabetes, and appropriate utilization of health care facilities.[8]		
4. Requirements for Billing Entity	**4a**. *Prioritizes Evidence and CHW/P/CHR Work Environment*	The Utilization Review Accreditation Commission's (URAC) Community Health Worker Program Accreditation is a national accreditation program for organizations that employ or contract directly with CHWs.[9] The Tennessee Community Health Worker Association (TNCHWA), Tennessee Medicaid (TennCare), and the National Committee for Quality Assurance developed Tennessee Community Health Worker (CHW) Program Accreditation Standards for agencies employing CHWs.[10] These standards are based on CHW/P/CHR input and implementation science.	**Pro:** Evidence-informed accreditation standards for CHW/P/CHR programs are associated with high-quality outcomes and a positive CHW/P/CHR work environment.	SPA Guidance (e.g., accreditation standards)
	4b. *Prioritizes Ease of Requirement*	CHWs delivering Medicare Community Health Integration (CHI) services must meet applicable state requirements. "In states with no applicable requirements, auxiliary personnel must be certified and trained in the following competencies: • Patient and family communication • Interpersonal and relationship-building skills • Patient and family capacity building • Service coordination and systems navigation • Patient advocacy, facilitation, individual and community assessment • Professionalism and ethical conduct	**Pro:** Strong precedent for individual certification requirements and consensus-based core CHW/P/CHR competencies. **Con:** Individual CHW/P/CHR certification/training has not been associated with improvements in quality.	SPA Guidance (e.g., policy manual)

[8] South Dakota Medicaid Billing and Policy Manual, Community Health Worker Services. Community Health Workers Services – Eligible Providers. Updated, October 2024

[9] Utilization Review Accreditation Commission's (URAC), Community Health Worker Program Accreditation. Accessed November 21, 2024.

[10] Tennessee Community Health Worker Program Accreditation Standard, Updated January 16, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
		• Development of an appropriate knowledge base, including local community-based resources."[11]	**Con:** Certification can be a barrier to entry for otherwise qualified CHW/P/CHRs. **Con:** Allows individuals who have completed a training but may not share lived experience with the communities they serve to enter the CHW/P/CHR workforce.	
		In New York, "CHW services are covered when the following training or work experience requirements have been met by the CHW providing the direct service: • 20-hour minimum training that includes the CDC-endorsed CHW Core Consensus Competencies (C3) OR 1400 hours of experience working as a CHW in formal paid or volunteer roles within the past three years. • Basic HIPAA training. • For CHWs providing community violence prevention services, the training and work experience requirements detailed in Sections 11 and 11.2 apply."[12]		

[11] Centers for Medicare and Medicaid, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, MLN Booklet, MLN9201074 January 2024.

[12] New York, Community Health Worker Services Policy Manual, eMedNY New York State Medicaid Provider Policy Manual. October 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
		• Despite this precedent, an Agency for Healthcare Research and Quality (AHRQ) review found that individual CHW training-based certification had no effect on quality of CHW programs and "weeded out" many qualified CHW/P/CHRs.[13] Another study of the effects of state certification policies found that they may entrench pay inequities, raising wages for white male CHWs while resulting in no significant effect on wages for CHWs of color and women, who make up the majority of the workforce. The study found that while pay overall increased for CHWs in states with certification, inequities in wages among CHWs widened.[14]		
5.Service Initiation & Supervision	**5a.** *Prioritizes Access & Flexibility*	New Mexico's chief medical officer of the Medical Assistance Division (Medicaid) issued a standing order that "authorizes any New Mexico Community Health Workers (CHW) and Community Health Representatives (CHR), for system navigation, health promotion and health coaching, and clinical support services. ... This standing order may be used by a CHW, CHR & agencies that provide CHW/CHR services for New Mexico Medicaid eligible recipients as a valid order."[15]	**Pro:** Standing order allows members of the care team (CHW/P/CHRs) to provide specific services for eligible individuals without individual provider order. **Pro:** Allows services to reach the large numbers of beneficiaries that face barriers getting an order from a clinical provider.	Guidance (e.g., statewide order)

[13] Ibe CA, Wilson LM, Brodine J, et al. Impact of Community Health Worker Certification on Workforce and Service Delivery for Asthma and Other Selected Chronic Diseases [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Mar. (AHRQ Comparative Effectiveness Technical Briefs, No. 34.)

[14] Jones TM, Jeung C, Schulte A, Lewis CM, Maddox PJ. Hourly Wages and Turnover of Community Health Workers According to US State Certification Policy and Medicaid Reimbursement, 2010-2021. Am J Public Health. 2022 Oct;112(10):1480-1488. doi: 10.2105/AJPH.2022.306965. Epub 2022 Aug 11. PMID: 35952329; PMCID: PMC9480469.

[15] New Mexico Health Care Authority, New Mexico Statewide Standing Order & Form for Community Health Workers (CHW) and Community Health Representatives (CHR) services in an outpatient setting Starting July 1, 2023. MAD 872, Issued July 1, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
			Con: A state's Medicaid agency would need to identify a provider (e.g., state Medicaid program's chief medical officer) to issue and sign the standing order. **Con:** States should also consider quality guardrails (e.g., accreditation, program requirements, quality measurement) to guard against low-quality or misuse of services.	
	5b. *Prioritizes Access & Provider Relationships*	Rhode Island's CHW Coverage Policy states that "as a preventive health service, CHW services must be recommended for a patient by a licensed practitioner of the healing arts ... A licensed practitioner of the healing arts may establish a standing order or protocol as their mechanism to implement the recommendation."[16]	**Pro:** Standing order between provider and community-based organization allows employed CHW/P/CHRs to provide services to eligible individuals without an order for a specific beneficiary.	Guidance (e.g., policy manual)

[16] Rhode Island Executive Office of Health and Human Services Medicaid Program, RI Medicaid, Community Health Workers. October 2023. Version 2.2.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
		In Minnesota, "some CHW employers have developed and implemented CHW standing orders or similar vehicles." The orders may be used "to provide authorization by the Medicaid-enrolled ordering provider for the CHW certificate-holder employed by the partnering agency to provide patient education and self-management services to MHCP [Minnesota Health Care Programs] enrollees that are included in the approved benefit set."[17]	**Pro:** Addresses barriers to access and reduces CHW/P/CHR and provider documentation burden.	
	5c. *Prioritizes Role of the Provider*	Medicare Community Health Integration (CHI) services may be performed by an auxiliary personnel, including CHWs, "incidental to the professional services of a physician or other billing practitioner, under general supervision... The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel, if they meet all 'incident to' requirements and conditions for payment of CHI services."[18]	**Pro:** CHW/P/CHRs provide services under the direction of the provider, but provider does not need to be present. Creates flexibility in site of CHW/P/CHR service delivery. **Con:** Provider order, referral, and general supervision requires clinical providers to be involved in identifying need, referring patients to CHW/P/CHRs, and ongoing care management. This severely limits access to CHW/P/CHR services.	SPA Guidance (e.g., policy manual)

[17] Minnesota Community Health Worker Alliance, Fact Sheet Community Health Worker Standing Orders, June 2017.

[18] Centers for Medicare and Medicaid, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, MLN Booklet, MLN9201074 January 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
			Con: Requiring CHW/P/CHRs to be under general supervision of clinical providers risks over-medicalization of CHW/P/CHR services and can exclude community-based organizations that have been delivering CHW/P/CHR services for decades.	
6. Delivery Location & Mechanism	**6a.** *Prioritizes Access*	Medicare Community Health Integration (CHI) services may be performed "using a combination of in-person and virtual via audio-video or via two-way audio since evidence shows that there should be some in-person interaction."[19] Under Louisiana's Medicaid policy, "there is no restriction as to the site of service, which may include, but is not limited to: a health care facility, clinic setting, community setting or the beneficiary's home. Delivery of the service through a synchronous audio/video telehealth modality is also permissible."[20]	**Pro:** Allows services to be delivered in the most appropriate and low-cost setting (e.g., health care or community setting; in person, telephonically, or via telehealth).	SPA Guidance (e.g., policy manual)

[19] Centers for Medicare and Medicaid, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, MLN Booklet, MLN9201074 January 2024.

[20] Louisiana Department of Health, Professional Services, Chapter Five of the Medicaid Services Manual, Section 5.1: Covered Services, "Community Health Workers." Issued August 12, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
		In Rhode Island, "service time billed must be for either direct contact with a beneficiary (in-person or through telehealth) or for collateral services on an individual basis. Collateral services are those delivered on behalf of an individual beneficiary but that are not delivered in that beneficiary's presence/directly to the beneficiary. The collateral service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service."[21]	**Con:** Creates incentives for organizations to skimp on in-person CHW/P/CHR services in favor of less costly remote services. The evidence for CHW/P/CHR effectiveness is primarily based on in-person services and there is less conclusive supportive evidence for remote CHW/P/CHR services.	
	6b. *Prioritizes Access, Favors in Person*	States have the option to reimburse differently for covered services delivered via telehealth vs. face-to-face.[22] (A SPA is needed if a state plans to cover or pay for services delivered via telehealth differently than they do for services delivered face-to-face).	**Pro:** Enables services to be delivered in person or virtually but allows state to vary payment levels based on modality to reward in-person care.	

[21] Rhode Island, State Plan Amendment (SPA) #: 21-0012, Approved May 23, 2022.

[22] CMS, State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth COVID-19 Version. Accessed November 21, 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
7. Provider Billing	**7a.** *Prioritizes Empowering CHWs*	In New Mexico, CHWs and CHRs can bill Medicaid if they: • "Enroll with New Mexico Medicaid as a provider and complete a Provider Participation Agreement, • Verify a member's Medicaid eligibility using the New Mexico Medicaid portal, • Complete a standing order form for each date of service, and • Follow all claims submissions requirements."[23] Rhode Island permits certified CHWs to enroll and bill as a "Atypical" provider type.[24] In California, a CBO can enroll as a Medicaid provider and submit claims for services provided by CHWs.[25]	**Pro:** Allows CHW/P/CHRs to enroll as a provider type and bill directly, streamlining the billing process and claims submission. **Con:** Many CHW/P/CHRs may lack the capability and systems to bill. States should also consider support for infrastructure and/or technical assistance for billing.	Guidance
	7b. *Prioritizes Role of the Provider*	Louisiana Medicaid will reimburse CHW services "'incident to' the supervising physician, APRN, or PA."[26] Medicare Community Health Integration (CHI) services may be performed by CHWs "incidental to the professional services of a physician or other billing practitioner, under general supervision."[27]	**Con:** "Incident to" may place additional administrative burden on providers due to supervision requirements. **Con:** Limits ability for CHW/P/CHRs to use their professional judgment to provide most appropriate covered services to patients. **Con:** Approach creates challenges for individuals without a usual source of care.	Guidance (e.g., policy manual)

[23] New Mexico Health Care Authority, New Mexico Medicaid Community Health Workers (CHWs) & Community Health Representatives (CHRs), July 1, 2024.

[24] Rhode Island Executive Office of Health and Human Services Medicaid Program, RI Medicaid, Community Health Workers. October 2023. Version 2.2.

[25] California Medi-Cal. Community Health Worker (CHW) Preventive Services, Part 2 – Community Health Worker (CHW) Preventive Services, Updated November 2024.

[26] Louisiana Medicaid Program, Chapter 5: Professional Services. Section 5.1: Covered Services, "Community Health Workers." Issued June 20, 2022.

[27] Centers for Medicare and Medicaid, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, MLN Booklet, MLN9201074 January 2024.

Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
8. Duration of Services/ Frequency Limits	**8a.** *Prioritizes Access and Cost Containment*	Indiana coverage of CHW services is "limited to 4 units (or 2 hours) per day, per member" and "24 units (or 12 hours) per month, per member." [28] In Nevada, "services provided by a CHW are limited to four units (30 minutes per unit) in a 24-hour period, not to exceed 24 units per calendar month per recipient." [29] CHW programs with the strongest evidence deliver an average of 90 minutes per week for a 6-month period, building trust by achieving regular progress on the issues most important to the patient over a specific program duration.[30]	**Pro:** Allows a state to set reasonable limits on frequency of CHW/P/CHR services.	Guidance (e.g., provider bulletin)
	8b. *Prioritizes Access*	In Rhode Island, "there is no limit to the number of visits/hours allowed per member." [31] Providers can bill for Medicare Community Health Integration services as medically reasonable and necessary.[32]	Pro: No limits on the number of CHW/P/CHR services allows services to be delivered at a frequency most appropriate for meeting a patient's care needs and person-centered goal(s).	Guidance (e.g., policy manual)

[28] Indiana Health Coverage Programs (IHCP) Bulletin Indiana Health Coverage Programs, BT201826, "IHCP Adds Coverage Of Community Health Worker Services." May 31, 2018.

[29] Nevada, Division Of Health Care Financing And Policy, Medicaid Services Manual Transmittal Letter, Medicaid Services Manual Changes Chapter 600 Physician Services, Section 605, January 31, 2023.

[30] Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community Health Worker Support for Disadvantaged Patients with Multiple Chronic Diseases: A Randomized Clinical Trial. Am J Public Health. 2017 Oct;107(10):1660-1667. doi: 10.2105/AJPH.2017.303985. Epub 2017 Aug 17. PMID: 28817334; PMCID: PMC5607679.

[31] Rhode Island Executive Office of Health and Human Services Medicaid Program, RI Medicaid, Community Health Workers. October 2023. Version 2.2.

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Model Text	Option	Source of Text / Supporting Research	Pros and Cons	Policy Vehicle for Text
9. Documentation Requirements	*N/A*	Rhode Island requires CHW providers "to maintain notes reflecting the dates and time/duration of services provided to beneficiaries. The notes should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. The notes may also need to document how a patient meets criteria in a standing order or protocol to be recommended for CHW services."[33]	**Pro:** Supports integration of CHW/P/CHR services into the patient record through minimal documentation requirements. **Pro:** Aligns with Medicare Community Health Integration documentation requirements, reducing burden for providers submitting claims to both Medicare and Medicaid.	Guidance (e.g., policy manual)

[33] Rhode Island Executive Office of Health and Human Services Medicaid Program, RI Medicaid, Community Health Workers. October 2023. Version 2.2.

Principles for CHW Reimbursement Rates

Developing Sufficient Rates. As of January 2024, there was significant variation in Medicaid payment rates for CHW/P/CHR services covered by state fee-for-service (FFS) programs, ranging from just under $10 to $35 per 30 minutes.[18] For comparison, the average national rate for 30 minutes of Medicare Community Health Integration services provided by a CHW is $50.26.[19]

States with SPAs authorizing CHW/P/CHR reimbursement have largely established FFS payment rates. Some states have included requirements for integration of CHW/P/CHR services into managed care contracts.

An analysis of state Medicaid FFS and managed care reimbursement for CHW/P/CHR services found that payment rates need to be higher to support the financial viability of CHW/P/CHR programs. The study recommended a minimum FFS rate of $53.24.[20]

Regardless of how CHW/P/CHR services are paid (e.g., FFS or MCO), the following principles should guide rate development. Rates must:

- Ensure delivery of high-quality services (e.g., in-person services provided at least once a month)
- Support access to services (e.g., payments that cover both direct and indirect costs, enabling sustainable operation of a CHW/P/CHR program)
- Ensure livable wages for CHW/P/CHRs and promote opportunities for CHW/P/CHR career advancement

Considerations for federally qualified health centers (FQHCs). FQHCs are a large employer of CHW/P/CHRs in many states and a critical access point for many Medicaid beneficiaries. As states develop CHW/P/CHR reimbursement rates, CHW/P/CHR services provided by FQHCs must be accounted for either in the state's FQHC prospective payment system (PPS), through billing codes outside of the PPS rate, or through an alternative approach (e.g., an alternative payment model).

Glossary

Delivery location and mechanism: Where and through what mechanism covered CHW/P/CHR services can be delivered (e.g., clinic-based, home- or community-based, face-to-face, telephonically, via telehealth).

Documentation requirements: What information CHW/P/CHRs need to document for reimbursement purposes when providing covered CHW/P/CHR services.

Duration of services/frequency limits: Frequency of covered CHW/P/CHRs services (daily, monthly, annually).

Eligible population: Population eligible to receive CHW/P/CHR services.

Provider billing: Which providers can bill/submit claims for CHW/P/CHR services.

Provider qualifications and requirements: Individual CHW/P/CHR certification or CHW/P/CHR program/employer accreditation requirements.

Services covered: CHW/P/CHR services the state Medicaid program reimburses for.

Service initiation: Which providers can initiate CHW/P/CHR services.

Supervision: Supervision requirements for CHW/P/CHRs delivering covered services.

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ABOUT THE AUTHORS

Annie Cloke is director of public partnerships at IMPaCT Care, where she works with state Medicaid agencies, providers, plans, and community-based organizations to improve health equity by strengthening and expanding access to the community health worker workforce. Before joining IMPaCT, Annie spent over 10 years as a health policy consultant focused on access and coverage to care and value-based care. Most recently, she was vice president at CapView Strategies, serving as an expert on Medicaid, state policy, and healthcare transformation. Annie holds a Bachelor of Arts degree from Georgetown University in Sociology with a concentration in Social Justice and a Master of Public Administration in Health Policy and Management from New York University. She currently serves on the board of Service Program for Older People, which provides behavioral health care and related services to adults ages 55 and older in New York City.

Margarita Hart, the executive director of Indiana Community Health Workers Association and Esperanza Ministries, has been a community health worker (CHW) for over 30 years both overseas and in the United States. Margarita is actively involved in crafting local, state, and national public health strategies, providing counsel and consulting services to community leaders. As a multilingual and certified medical interpreter, she facilitates culturally appropriate policy improvement and understanding in immigrant communities. Margarita's role as a board-certified chaplain specializing in end-of-life care is a testament to her dedication to serving the immigrants in central Indiana. Furthermore, as an ACC-accredited leadership coach, she provides consulting for project development and is a professional development coach, helping develop immigrant leaders and CHWs.

Janée A. Tyus, head of community mobilization at IMPaCT Care, is a life-long self-identified CHW. She holds a Bachelor of Science degree from the University of Michigan – Ann Arbor and a Master of Public Health from Drexel University's School of Public Health. Janée is the former executive director of the Michigan Community Health Worker Alliance and most recently served as the senior program director of the Mid-Michigan Community Health Access Program of the Greater Flint Health Coalition. She also serves as an adjunct lecturer at the University of Michigan-Flint. Janée was born and raised in Detroit, Michigan, and currently resides in Oakland County, Michigan.

Dawn Alley, PhD, is head of scale at IMPaCT Care, a public benefit corporation scaling evidence-based community health worker programs to improve health equity and drive health care value. She has 20 years of experience in leadership in population health research, health policy, and health care delivery in both the public and private sector. She has held federal leadership roles, including chief strategy officer at the Center for Medicare and Medicaid Innovation, senior advisor to the U.S. Surgeon General, and executive in residence at ARPA-H. She has also held executive roles as president of decision support at CareBridge Health, a Medicaid value-based provider, and head of healthcare innovation at Morgan Health, JPMorgan Chase's business unit focused on innovation in employer-sponsored insurance. Dr. Alley received her PhD from the University of Southern California and was a Robert Wood Johnson Foundation Health and Society Scholar at the University of Pennsylvania. She has published more than 50 peer-reviewed articles and is affiliate faculty at the George Washington University Milken Institute School of Public Health.

Shreya Kangovi, MD, MS, is a physician, scientist and the chief executive officer of IMPaCT Care a public benefit corporation that enables health organizations to build effective, sustainable community health workforces. Dr. Kangovi led the team that designed IMPaCT, the most widely used and evidence-based CHW model in the country. IMPaCT has been used by over 70 organizations across 20 different states.

Dr. Kangovi has led policy efforts along with a coalition of over 30 organizations, including NAACP, American Public Health Association, Society of General Internal Medicine, and the American Diabetes Association. She has worked with members of the US Senate and House of Representatives, and President Biden included her policy in his caregiving economy campaign platform.

Dr. Kangovi has authored numerous scientific publications and received over $30M in funding, including federal grants. She was named one of *Modern Healthcare's* Top 25 Innovators, is the recipient of the Academy Health Research Impact Award, the Robert Wood Johnson Foundation Health Equity Award, an elected member of the American College of Physicians, and a member of the National Academies of Sciences, Engineering, and Medicine's Roundtable on the Promotion of Health Equity. She is an adjunct professor at the University of Pennsylvania.

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