



U.S. Community Health Worker Landscape Overview

PIH United States
Updated January 2026

Photo by Scott McIntyre for PIH

Acknowledgement

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This product also draws on the work of numerous organizations and individuals deeply immersed in the work of defining and supporting Community Health Workers. Their contributions are gratefully acknowledged through references cited throughout this resource.

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Commonly Used Abbreviations

ACL	Administration of Community Living	FQHC	Federally Qualified Health Center
ACO	Accountable Care Organization	HRSN	Health-related Social Needs
APM	Alternative Payment Mechanism	MA	Medicare Advantage
CBO	Community-Based Organization	MCO	Managed Care Organization
CCH	Community Care Hub	PFS	Physician Fee Schedule
CHC	Community Health Center	PPS	Prospective Payment System
CHW	Community Health Worker	ROI	Return on Investment
CMS	Centers for Medicare & Medicaid Services	SDOH	Social Determinants of Health
D-SNP	Dual Eligible Special Needs Plan	SPA	State Plan Amendment
FFS	Fee-for-service	VBP	Value-based Payment

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Who is considered a community health worker (CHW)?

The American Public Health Association CHW Section has adopted the following definition of a CHW:

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.

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

CHWs are members of the community themselves, and as such, have unparalleled expertise in the health issues affecting their communities and geographies.



CHWs play a critical role in promoting health equity, yet are often under-recognized partners in the public health workforce

CHWs have been working for decades as educators, outreach workers, and trusted members of community who advise others on navigating health and support systems.

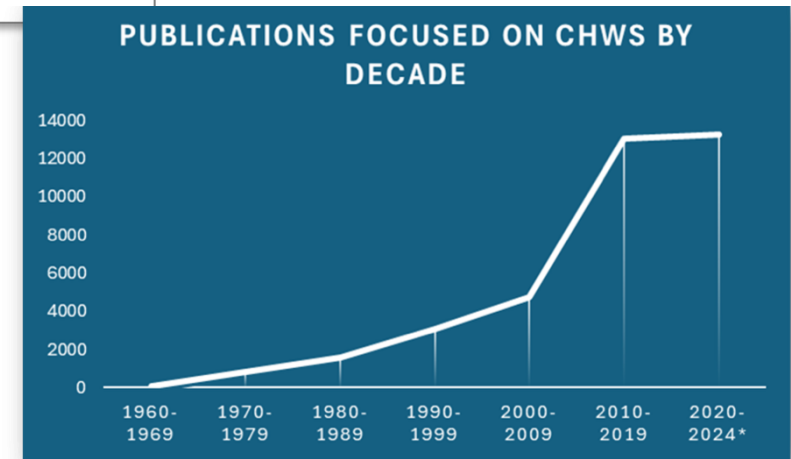
The COVID-19 pandemic brought attention to CHWs and their work. As health departments battled mistrust and disinformation, CHWs proved to be an important partner in educating people, spreading awareness, helping others with testing and vaccination, while also connecting people to supportive resources.

Over the last four years (2020-2024) publications about CHWs have equaled those of the prior decade, indicating the increasing interest in this workforce and its return on investment.



The screenshot shows a perspective article from the American Medical Association (AMA). The title is "How community health workers can help improve outcomes, cut costs" by Tanya Albert Henry, Contributing News Writer, dated January 6, 2020. The article is part of a "Perspective" series from the New England Journal of Medicine, dated November 5, 2020. The full title of the article is "Community Health Workers and Covid-19 — Addressing Social Determinants of Health in Times of Crisis and Beyond" by Patricia J. Peretz, M.P.H., Nadia Islam, Ph.D., and Luz Adriana Matiz, M.D.

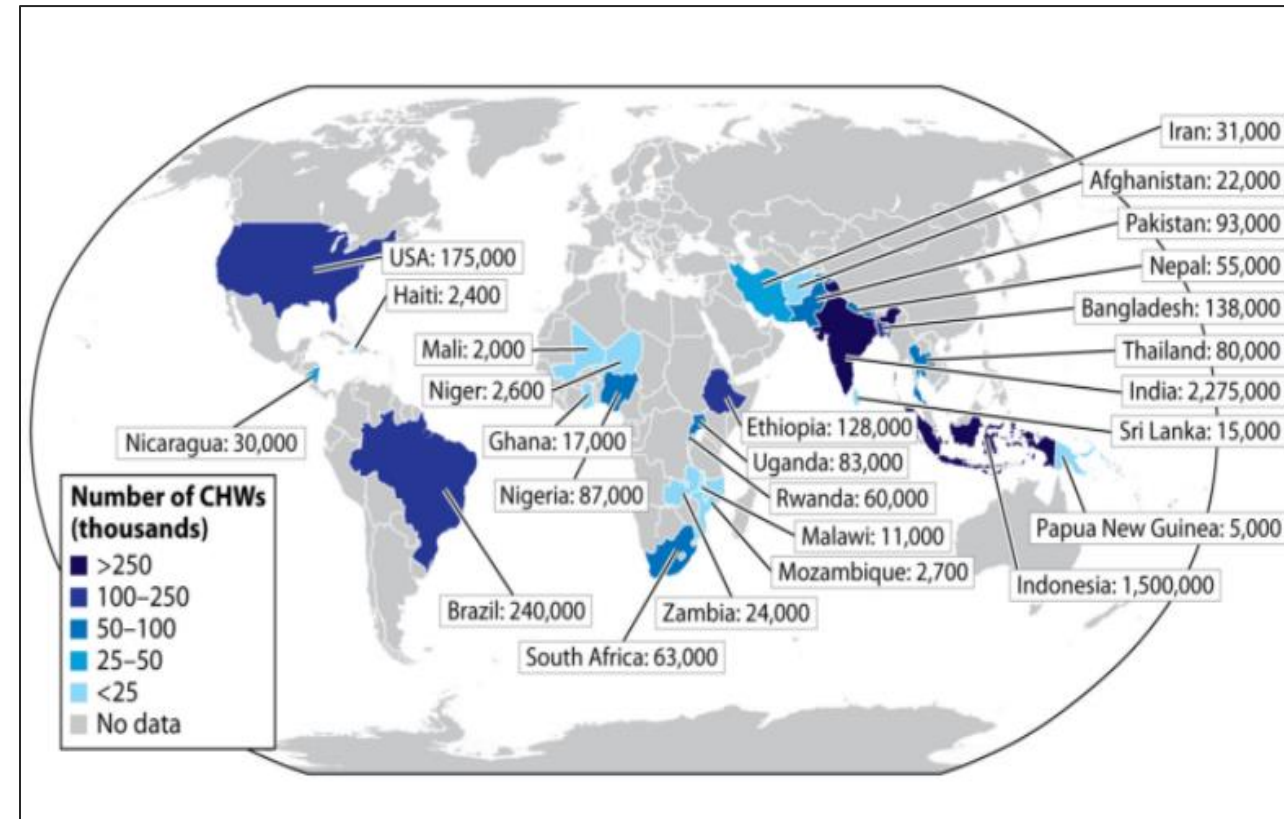
Source: Peretz, P. J., Islam, N., & Matiz, L. A. (2020). Community health workers and COVID-19—Addressing social determinants of health in times of crisis and beyond. *New England Journal of Medicine*, 383(19), e108. [Link](#)



Source: Cargill, V., & Totten, A. (2024, October 24). *Community health workers: An effective, underutilized health intervention*. Milken Institute. [Link](#)

CHWs significantly impact low-resource communities across the world

- Contribute to **reduction of undernutrition** by promoting of exclusive breastfeeding care (Black et al. 2008).
- Effective in **reducing mortality in children** under 5 years of age (Inst. Int. Health Progr. 2012).
- Provide **community case management** of serious childhood illness (Black et al, 2010).
- Provide interventions to **reduce neonatal mortality** (Lassi et al., 2010).
- **Reduce maternal mortality** and expand access to **family planning services** (Prost et al, 2013).
- **Prevent and reduce the spread of HIV/AIDS** (UNAIDS, 2012).
- **Prevent malaria and TB** (WHO, 2012).
- **Improve hypertension, reduce cardiovascular risk factors, increase knowledge, improvements in physiological measures and positive changes in lifestyle and self-care** were noted for diabetes, and **improve mammography screenings** (Inst. Med. 2010, Norris et al., (2006), Wells et al., (2011)).



Perry et al. (2014) estimated the numbers and locations of CHWs from selected countries with the largest CHW programs globally.

Source: Perry HB, Zulliger R, Rogers MM. Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness. Johns Hopkins Bloomberg School of Public Health; 2014. [Link](#)

Click [here](#) to learn more about the need for CHWs around the world through Community Health Impact Coalition (CHIC)

CHWs play an important part in healthcare in high-income nations

- CHWs play a significant role in **increasing patient's use of preventive services** such as breast and cervical cancer screening among low-income and immigrant populations (Mock et al., 2007; Junghans et al., 2023).
- CHWs are effective in the **provision of culturally appropriate care**, health education and advocacy (Pérez & Martinez, 2008).
- CHWs have shown to have **positive effects in chronic disease management** including significant impacts on diabetes care, hypertension, cardiovascular diseases, and their clinical outcomes (Gary et al., 2003).
- CHWs have **increased access and utilization of primary health care services** reducing hospital admissions and improving post-hospital care (McCollum et al., 2014).
- CHWs intervention can **reduce need for inpatient care, refocusing on less costly primary care services**, with a return on investment of \$2.28 per \$1 spent on CHW intervention (Javanparast et al., 2018).
- CHW programs can **contribute to addressing community needs**, improving social inclusion and community empowerment (Whitley et al., 2006).
- CHWs can play a significant role in **pre-natal health promotion outreach, community development, and addressing social determinants of health** among migrant and refugee groups (Torres et al., 2014).

Benefits of engaging CHWs in healthcare

➤ CHWs are a vital part of the US healthcare system. In addition to helping to reduce healthcare costs, they play a critical role in improving population health and individual patient outcomes through health education and other services.

Local CHW Case Studies

Baltimore | Among Medicaid patients with diabetes who engaged with CHWs, there was an average **annual savings of \$2,245 per patient per year**

Denver | Among health safety net users who engaged with CHWs, there was a **2.28:1 return on investment** from reduced use of urgent, inpatient care

Hawaii | A CHW program **reduced asthma-related per capita charges by 75%** mainly from decline in ER visits

National CDC CHW Case Studies

Improved hypertension control with teams including CHWs

Improved cancer screening knowledge and cervical and mammography **screening outcomes**

Improved **appointment keeping, compliance**, risk reduction, BP control, and related **mortality**

Better diabetes clinical measures when cared for by a CHW and nurse case-manager group compared to CHW or nurse alone

CHWs have a significant impact on preventive care, as recognized by the Community Preventive Services Task Force (CPSTF)

The Community Preventive Services Task Force (CPSTF) is an independent, nonfederal panel of 15 CDC-appointed experts in public health and prevention, and is the complement the [U.S. Preventive Services Task Force \(USPSTF\)](#).

Physicians commonly rely on USPSTF guidelines for clinical preventive service recommendations, and CPSTF recommendations are held in equally high regard for guiding community-level prevention efforts. A full list of CPSTF recommendations can be found [here](#).

The CPSTF has made strong recommendations for engaging the community health workforce in interventions for cervical screening, colon cancer screening, breast cancer screening, as well as heart disease and stroke prevention.



CHW roles in the COVID-19 response

CHWs have played important roles across all aspects of COVID-19 response - as vaccine outreach workers, navigating difficult conversations, care resource coordinators, and more - prioritizing social supports and bringing a strong understanding of community-specific healthcare challenges/barriers to their work. CHWs have:



Shared accurate and culturally relevant information on COVID-19 prevention. Distributed PPE, cleaning supplies, and other resources to prevent spread of disease.



Improved access to and uptake of COVID-19 testing - hosting testing events, providing at-home kits and education, and connecting people to testing sites.



Carried out contact tracing and case investigation to slow transmission and connect individuals to resources.



Coordinated provision of resources and services to enable safe isolation and quarantine, particularly in underserved areas or in specific communities.



Increased vaccine uptake by providing culturally-relevant COVID-19 education, supporting vaccination events, and acting as a trusted messenger to navigate challenging conversations with community members.

CHW roles in the COVID-19 response: the RADx-UP consortium

RADx[®] Underserved Populations (RADx-UP) is a consortium of 144 research projects studying COVID-19 testing patterns in communities across the United States, territories, and Tribal Nations. Many of the 137 RADx-UP projects embedded CHWs as key partners in their programmatic infrastructure to reduce inequities in COVID-19 testing. Through publications, the initiative was able to identify a number of ways in which CHWs were integral to Covid-19 immunization campaigns.



Resource Allocation

- Liaisons
- Identifying Resource Needs
- Community Advisory Boards



Payment

- Identifying assets



Access

- Resource Navigation
- Direct resource delivery



Communication

- Community outreach



Data

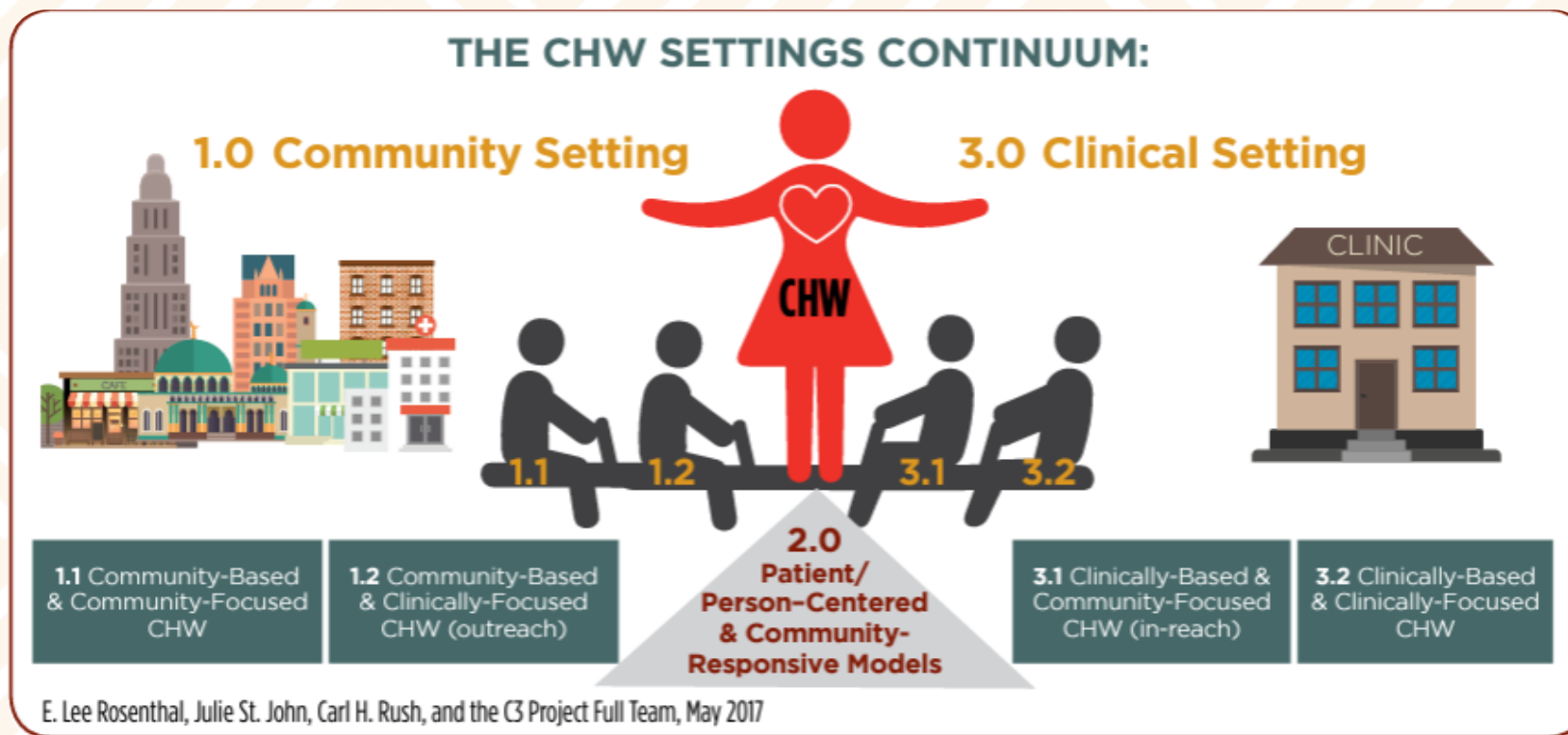
- Data collection
- Community-based participatory research

CHW titles may vary, however their function as trusted messengers and connectors define their role as a community health worker

Partial list of titles for CHWs

- **Community Health Worker (CHW)**
- Promotor(a) de Salud
- Aunties (Hawaii)
- Birth Assistant (Doula)
- Birthing Family Support Worker
- Care Coordinator
- Community Advocate
- Community Aide
- Community Care Specialist
- Community Care Worker
- Community Coordinator
- Community Dental Health Coordinators
- Community Health Associate
- Community Follow-Up Worker
- Community Health Advocate
- Community Health Aide
- Community Health Coach
- Community Health Coordinator
- Community Health Educator (CHE)
- Community Health Navigators
- Community Health Organizer
- Community Health Outreach Worker
- Community Health Partners
- Community Health Representative (CHR)
- Community Health Specialist
- Community Liaison
- Community Navigator
- Community Organizer
- Community Outreach Navigator
- Community Outreach Worker
- Community Promoter
- Community Social Worker
- Cultural Case Manager
- Cultural Interpreter
- Cultural Mediator
- Diabetes Education Associate
- Diabetes Self-Management Support Associate
- Diabetes Educator
- Diabetes Family Support Worker
- Diabetes Navigator
- Family Advocate
- Family Planning Counselor
- Family Support Worker
- Family Advocate
- Family Health Advocate
- Family Health Promoter
- Family Outreach Worker (FOW)
- Family Support Specialist
- Family Support Worker
- Health Ambassadors
- Health Communicator
- Health Extension Workers
- Health/Nutrition Support Worker
- Health Promoter
- Health Liaison
- Health Specialist
- Health Workers
- HIV/AIDS Educator
- HIV/AIDS Family Support Worker
- HIV Peer Advocate
- Homeless Advocate
- Lay Health Advocate
- Lay Health Worker (LHW)
- Mental Health Worker
- Men's Health Specialist
- Men's Health Worker
- Navigator
- Neighborhood Health Advocate
- New Professionals
- Outreach Advocate
- Outreach Coordinator
- Outreach Educator
- Outreach Specialist
- Outreach Worker
- Patient Experts
- Patient Navigator
- Peer Advocate
- Peer Counselor
- Peer Educator
- Peer Health Educator
- Peer Support Specialist
- Peer Wellness Specialist
- Physical Activity Specialist
- Social Determinants of Health Specialists
- Street Outreach Worker
- Wellness Ambassadors
- Wellness Guide
- Women's Health Specialist
- Youth Development Specialist
- Youth Peer Counselor
- Youth Worker

CHW work settings can range from community-based environments to roles within the formal health care system



1.1

This CHW represents and brings forward community voices on community matters.

1.2

This CHW is in the community but brings in the clinical viewpoint to the community through outreach.

2.0

Represents a CHW at the balance point—representing innovative models looking to deliver patient-centered and community-centered programs and services.

3.1

This CHW facilitates the medical care system and health education access.

3.2

CHWs carrying out community in-reach—bringing the community voice into the clinical setting.

Challenges in the field

Access to transportation: CHWs often travel to rural communities to provide services or conduct outreach because the populations they work with often have limited access to transportation. CHWs should be reimbursed for traveling costs.

Safety Issues: CHWs often deal with challenging interpersonal situations in communities and home visits, ranging from conflict management to interpersonal violence. Programs must ensure the safety of CHWs and should provide safety training to CHWs.

Program resources: CHWs need access to technology including mobile technology to help them accomplish their job on-the-go and in rural settings. Programs should provide resources such as wireless internet access cards, tablets, and other tools necessary to complete their tasks.

Cultural barriers: CHWs are often able to bridge cultural and linguistic barriers that impede positive health outcomes. All program materials should be culturally appropriate, communicating information in a way that considers the local customs, beliefs, values, and traditions of the community.

Patient referral challenges: CHWs often have difficulties in referring patients to healthcare providers and coordinating services with outside providers due to lack of system coordination. Steps should be taken to improve systems for coordination of care between agencies.



Photo by Scott McIntyre for PIH

Challenges as a field

Lack of integration with other partners: CHW's in the community are often not connected to the rest of the public health system, including public health departments, primary care, and other less traditional health system players including social service providers.

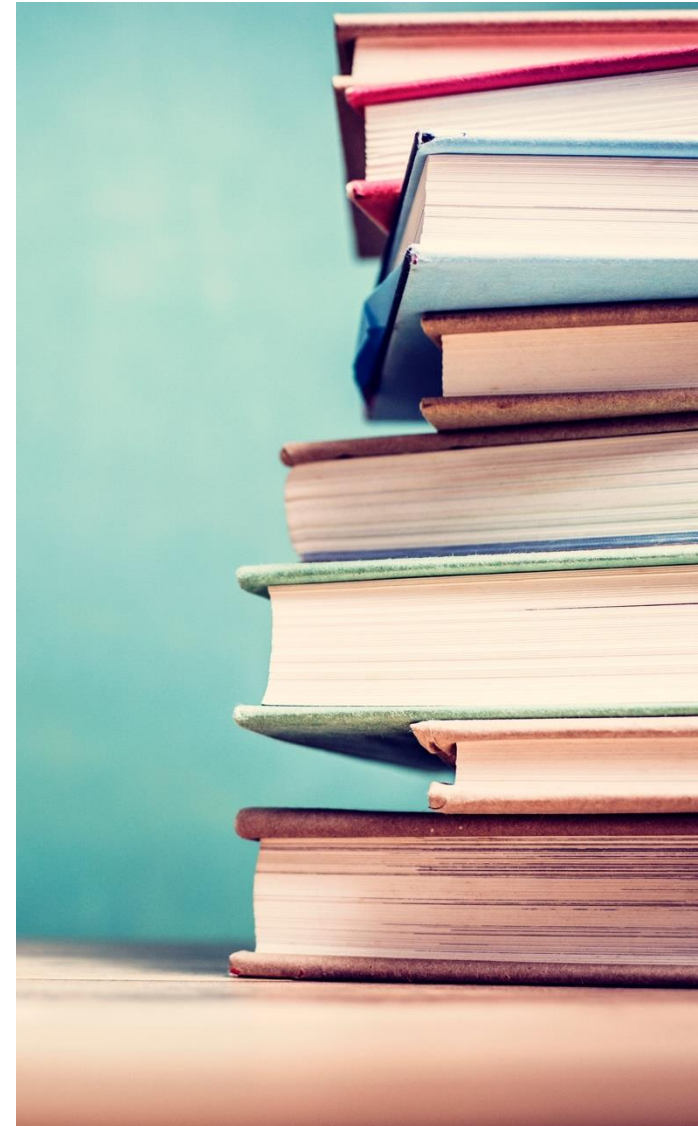
Variable compensation (often low or none): The compensation mechanisms for CHWs are fragmented and these positions are often time-limited, which contributes to reduced draw for new professionals and to retention challenges.

Perceived lack of standardization: Approaches to programming, training, and certification vary among CHWs – and while this offers flexibility for different contexts, it poses challenges for unified advocacy and public awareness.

Unclear career advancement pathways: "Advancement" often moves CHWs out of their role rather than into leadership positions that inform community health work, contributing to low workforce retention and a significant resources diverted to re-hiring and training.

Funding challenges: CHW programming is often funded by multiple grants of varying terms; funding is many times inflexible and short-term, restricting programmatic activities and staff development.

Common threads running through these challenges include lack of awareness and value for the CHW role, as well as insufficient or inconsistent coordination with other players in the health ecosystem.



An emerging challenge: CHW burnout post-pandemic

➤ US healthcare workers were already [experiencing concerning levels](#) of burnout prior to the pandemic. Now, the post-pandemic world has left nearly [76% of all frontline healthcare workers](#), CHWs included, exhausted and burned out.

The US Surgeon General Advisory has [sounded the alarm](#) on health worker burnout and resignation, as more than half of all US health workers suffer from at least one mental health condition.

CHWs, as they work diligently to support their clients, may struggle to support themselves. According to a 2021 self-care survey:

- Only 35% of CHWs stated can identify their *own* issues of trauma, stress, and grief and loss.
- 13% of participants rarely practice self-care and 50% practice only as needed.

An important note on burnout

Many aspects of burnout depend on the social and political, biological, psychological, and medical factors that cannot be fixed with self—care methods and require organizations to work across the system to create solutions. This fact is often obscured in the discourse around burnout, which puts much of the burden on the individual to use self-care for prevention. See [this article](#) for more on this perspective.

Resources:

- [Surgeon General’s Advisory Addressing Health Worker Burnout](#)
- [NRC-RIM CHW Self-Care Training](#)
- [Self-Care for CHWs Curriculum](#)
- [Self-Care Action Plan](#)

Given the diversity in CHW roles, survey data is critical to understanding the CHW workforce and CHW employers within the local context.

- > Identifying the titles and classifications of CHWs within the region **facilitates an accurate estimation of workforce size.**
- > Conducting surveys helps identify the primary roles and responsibilities CHWs fulfill across various parts of the catchment area. **Understanding roles provides insight into existing capabilities and needs** within the community's CHW workforce.
- > Understanding the geographic distribution of CHWs can **inform strategic decisions** regarding funding allocation, employment opportunities, and employer training needs.

Guiding Questions for a CHW Survey

- What are the **demographics** of CHWs in the area?
- What are CHWs' roles?
- **Where** do CHWs work?
- What does **integration** look like?

Who is represented in the CHW landscape?

What are the needs of CHWs and employers in the area?

- What are CHWs' KAPs around their work?
- What is the average **pay**?
- What are **barriers** to employment?

States, Territories, and Freely Associated States (ST/T/FAS) with CHW Surveys

ST/T/FAS	SURVEYS	ST/T/FAS	SURVEYS	ST/T/FAS	SURVEYS	ST/T/FAS	SURVEYS
AL		IL	2022 ES	NV		RMI	
AK		IN	2022 WS	NH	2024 WS	SC	2022 WS
AZ	2022 WS	IA	2025 ES/WS	NJ	ES in development	SD	
AR	2021 ES	KS	2021 WS	NM	WS in development	TN	2018 WS
AS		KY		NY		TX	2021 ES ; 2024WS
CA	2023 ES	LA	2020 WS	NC	2017 WS	UT	2016 WS
CO		ME				VT	2022 WS
CT	2022 WS	MD	2022 ES	ND		VA	
DE		MA	2016 WS ;	MP		VI	
DC		MH		OH	2018 WS/ES ;	WA	WS in development
FL		MI	2023 WS ; 2024 ES	OK		WV	
FM		MN	2015 WS	OR	2018 WS	WI	
GA		MS		PA	2013 ES ; 2024 WS	WY	
GU		MO	2022 WS	PR			
HI		MT	2017 WS	PW			
ID		NE	2019 WS	RI	2018 WS , 2021 WS		

A blank cell indicates that the survey has either not yet been developed or is not publicly accessible at this time.

If you are aware of a CHW survey that should be included, please contact us to request its addition to the list.

Abbreviations

ES= Employer Survey
WS = Workforce Survey

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Education and training for CHWs

➤ **Training is a part of any effective CHW program, regardless of whether certification is the end goal.** Training should be a continuous process that provides opportunities for updated knowledge and further skills development

- Training may be managed in house by the employer or through collaboration with external partners.
 - CHW certification bodies may partner with an outside organization to develop and administer a formal, standardized training curriculum for initial training (pre-service).
 - External organizations may include CHW associations, nonprofits, training centers, and/or institutional health education centers like community colleges.
- Some programs require a certain number of continuing education (CE) credits over a given time or offer CE for specialized care (specific conditions or advanced skills)
- **There are potential shortcomings of standardized curricula:** statewide standardization may not align with employer-specific training or lower resourced organizations may struggle to provide ongoing training or continuing education.



Photo by Zack DeClerck / PIH Malawi

A wide variety of topics may be included in training curricula

Topics covered by CHW training programs may differ from program to program and community to community.

Topics may include:

- Accessing healthcare and social services systems
- Practicing cultural competency
- The pathophysiology (disease processes) of different diseases
- Social determinants of health
- Translating, interpreting, and facilitating client-provider communications
- Gathering information for medical providers
- Working with clinicians
- Supporting family members and caregivers
- Delivering services as part of a medical home team
- Educating social services providers on community and population needs
- Teaching concepts of disease prevention and health promotion to patients
- Understanding how work aligns with health system goals
- Managing chronic conditions, including training on lifestyle strategies, risk factors, self-monitoring and medications
- Engaging in health prevention and promotion activities
- Home visiting
- Liability, legal, and ethical issues
- Trauma-informed care
- Stigma and community prejudices
- HIPAA and patient privacy
- Safety
- Mental health
- Motivational interviewing and public speaking
- Utilizing technology, including mobile applications and electronic health records
- Evaluation and research

Training curricula should focus on building core skills and competencies

In light of the considerable variation in training topics, the C3 Project has set out to promote alignment around core skills and competencies. **Many states align their training programs to the C3 standard to ensure CHWs have a well-rounded set of competencies and skills** that are applicable in a range of community health worker roles.

C3 Core Skills

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

Beyond simple lecture, the following approaches/delivery methods are highly encouraged in training:

- Popular education methods (see next slide)
- Practice time for new skills learned
- Role-play prior to interacting with patients
- Team-based exercises
- Retention and reference to training materials, such as pamphlets or manuals, 1-pagers, review cards
- Shadowing CHWs in the field
- Supervised home visits early on in training

State CHW associations will be helpful in supporting comprehensive and ongoing training.

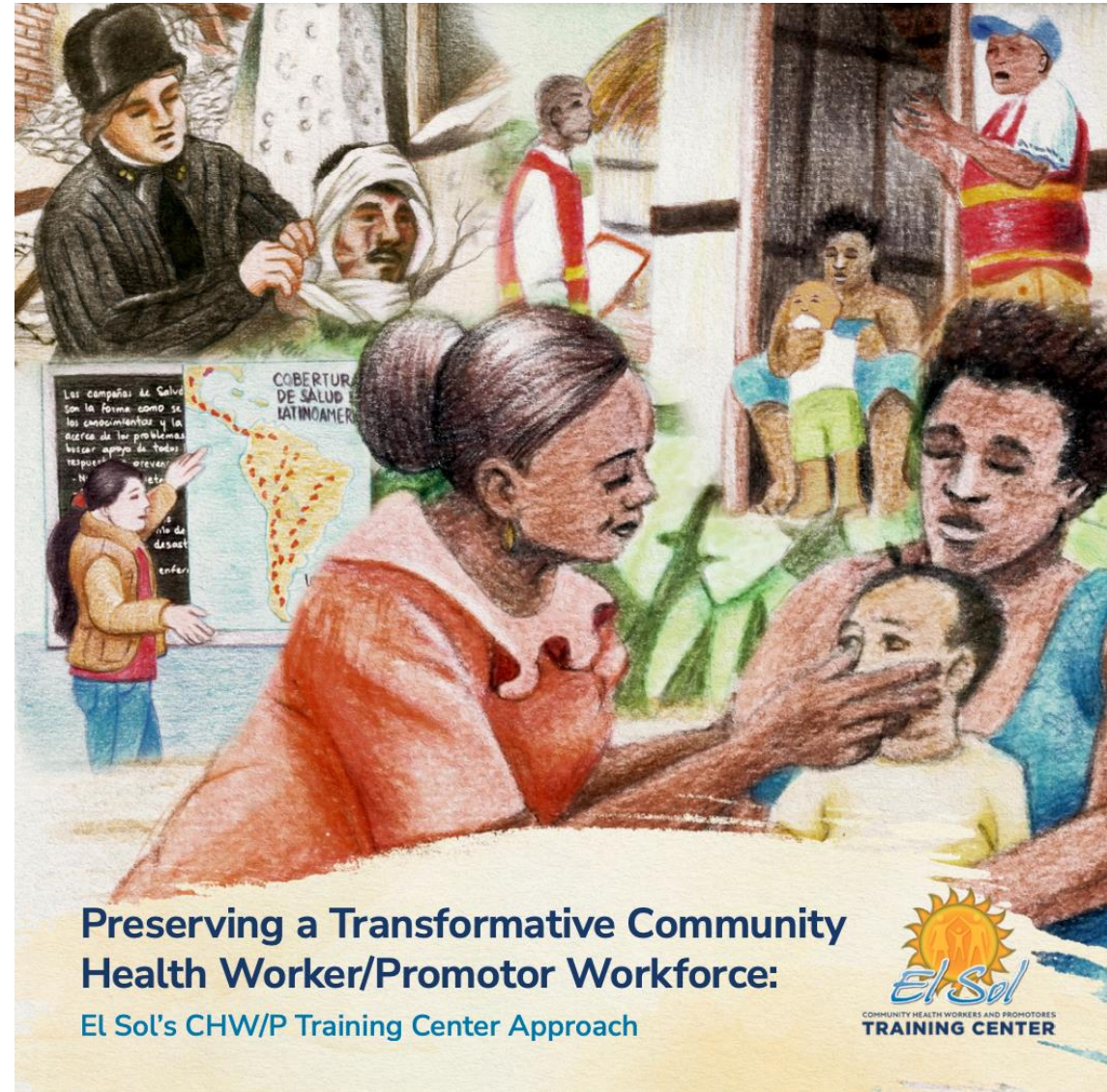
The popular education method for training

Best practices in CHW training follow [popular education methods](#).

Popular education is a learning style that encourages participation, cooperative study, and action. It is characterized by the belief that all people have a right to knowledge, and that education can be a collective process where students can teach and teachers facilitate exchange of information.

Popular education allows for bidirectional learning between the trainers and the students and acknowledges the role of both theory and lived experiences in learning.

[Read more](#) about one organization's approach to training CHWs using popular education methods (El Sol)



CHW certification



Certification mechanisms, standards, and benefits vary greatly. Below are the main principles of CHW certification.



Certification Body: Certification can be operated by a certifying body in a **government agency** that is mandated through legislation **or privately operated** by a CHW association or medical board.



Requirement: Certification may be **voluntary or mandatory**. Even if it is not mandated by the government, certain employers and organizations may make it a mandatory requirement in order to be hired by their organization. It may also be a requirement for reimbursement (e.g., some [Medicaid](#) plans (see page 9))



Eligibility: Certification may require a combination of **formalized training** and practical experience. Equitable and responsive certification programs may also offer a legacy or “grandparenting” track to give an alternative option to training requirements for people who have been working as CHWs for many years before certification was introduced

Not all jurisdictions pursue certification, and there are risks and benefits to certifying CHWs (see next slide). The decision and process to develop certification pathways **should be made with CHWs** and consider both environment and context.

Definitions of certification and accreditation

Certification

Certification commonly refers to certifying individuals who have proven a level of mastery and met certain criteria in community health work. Some institutions use credentialing and certification interchangeably, but credentialing may include licensure, registration, and permit issuance – none of which are typically required of CHWs.

Accreditation

Accreditation is sometimes used in place of the word certification; however, it is more often applied to institutions and organizations that have proven to meet certain criteria in supporting their community health workforce.

Examples of Criteria for Certification and Accreditation

Certification for Individuals	Accreditation for Organizations
<ul style="list-style-type: none">• Completion of a recognized training program or known lived experience• Certain number of hours already completed in the field• Completed continuing education requirements	<ul style="list-style-type: none">• Representation of the communities served in the hired workforce• Clear support resources for CHWs• Fair compensation and benefits for CHWs• Appropriate scopes of work for CHWs

Not all states have an official certification process. There are benefits as well as drawbacks of requiring certification for both CHWs and employers/payers

	CHWs	Payers and Employers
Anticipated Benefits	<ul style="list-style-type: none">• Higher wages.• Improved working conditions.• Increased respect from other professions.• Wider career opportunities.• Stable employment.• Sustainable funding.• Progress in building professional identity.• Increased understanding of the field.• Consistent standards for the field.	<ul style="list-style-type: none">• Clear scope of practice boundaries.• Consistent, reliable qualifications among CHWs.• Simplified recruitment and selection, and a more fluid job market.• Reduced on-the-job training costs.• A clearer rationale for integrating CHWs into care teams.• Reduced dependence on short-term funding.
Assumed Negative Impact	<ul style="list-style-type: none">• New barriers to entry.• Creation of a “class” system among CHWs.• Making CHW practice more clinical and less connected to the community.• Regulations, restrictions, or changes to what CHWs are allowed to do.• Employing people without strong connections to the community.• Further marginalization of volunteer CHWs.	<ul style="list-style-type: none">• Pressure to increase wages.• New regulations and restrictions on their organizations.• Increased overall training costs.• CHWs losing touch with the community, thereby becoming less effective overall.

Some states and jurisdictions, (e.g., [Louisiana](#) and [Wisconsin](#)), in consultation with CHWs, have chosen not to create certification programs and instead invested in robust training programs that build core competencies. Others have pursued certification with attention to the considerations above. The **US Virgin Islands** launched its certification program in 2023 and intends to introduce additional tiers in the future.

CHW certification approaches vary by state

States may have different approaches to certification in terms of how, and under what authority and regulating body, to finance, train, certify, and regulate the workforce.

State- Operated

AR	MN
AZ	MO
CA	MS
CO	ND*
CT	NH
IL*	NM
KY	OH
MA	OR
MD	TX
MI	UT

Privately- Operated

IN	FL
KS	NV
ME*	PA
NC	RI
SC	VA
SD	
TN	

**In development*

Certification may occur through a **state-operated certification process** (e.g., through a state health department), or a **privately operated certification process** (e.g., through a private certifying board).

Some efforts are guided by state legislative authority. These bodies may establish a board or workgroup of stakeholders to make recommendations around CHW certification and training.

There is a broad range of activity around CHW certification in the US

State-Operated Program, Certification Required

Texas

- The Texas Department of State Health Services (DSHS) established the CHW program, in accordance with Health and Safety Code Chapter 48, to operate a program designed to train and educate persons who act as promotores or CHWs.
- Certification is required for any promotora or CHW receiving compensation for providing services.

State-Operated Program, Certification Voluntary

Massachusetts

- The Board of Certification of CHWs has the authority to grant voluntary certification to individual CHWs and to approve CHW Core Competency Training Programs.
- Certification regulations also require approved training programs to include a CHW co-trainer or trainer in at least 40% of instructional hours, which provides an advancement opportunity for CHWs.

Privately Operated Program, Certification Voluntary

Florida

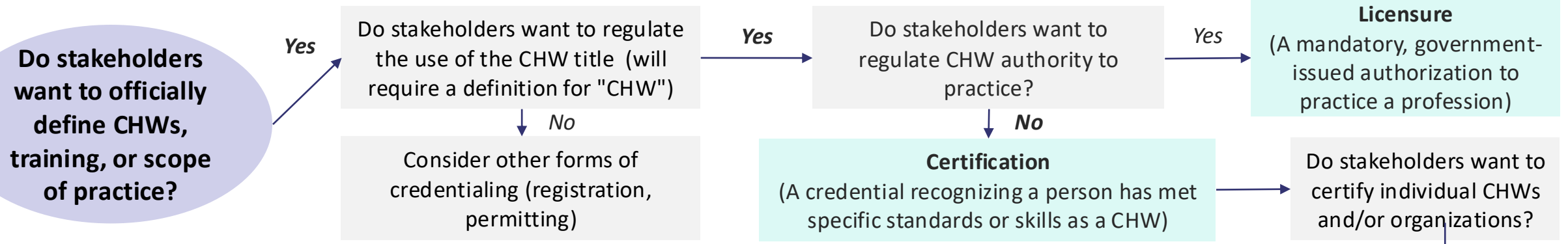
- Certification is recommended, but not required. Recommendation varies from payer to payer - certification is voluntary in Florida.
- The state currently has no policy on supervision.
- Florida is examining stackable credentials that will allow CHWs to progress on a career path and to enhance the prospect of sustainability and provide them with opportunities for livable wages.

No Certification Programs; Training Options

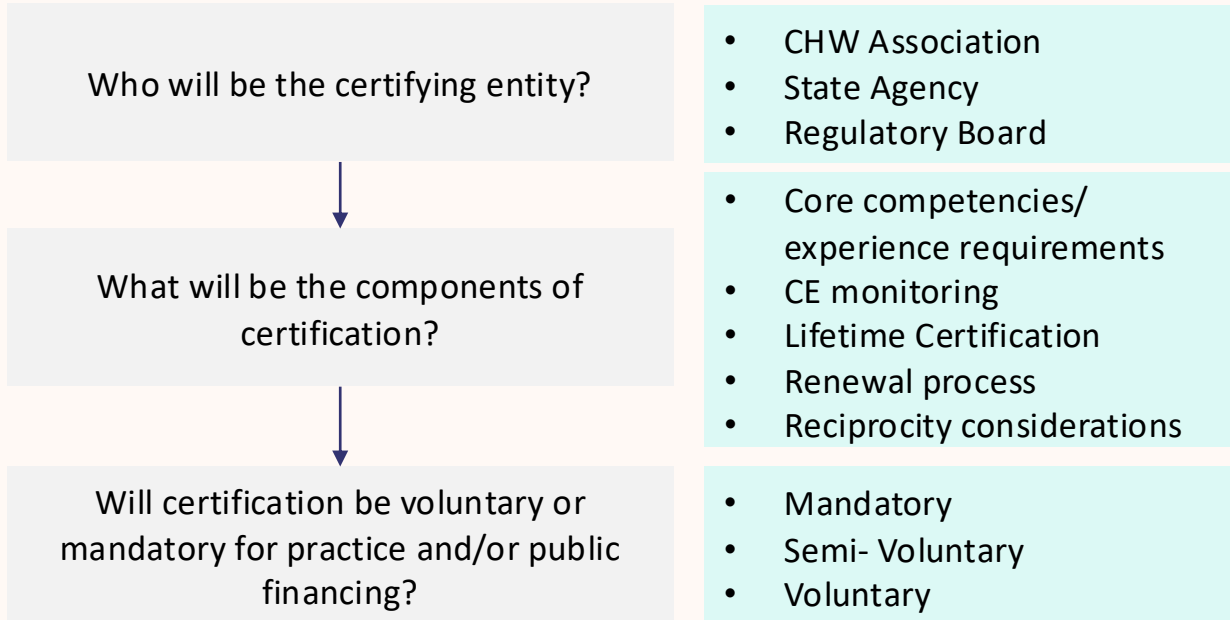
New York

- New York State currently does not have certification for CHWs, but there are training programs available which provide a certificate of completion.
- The New York State Department of Labor supports CHWs entering the workforce through an [apprenticeship](#) program.
- Many employers require a training certificate before or during the initial 6 months of employment.

Considerations for state CHW certification

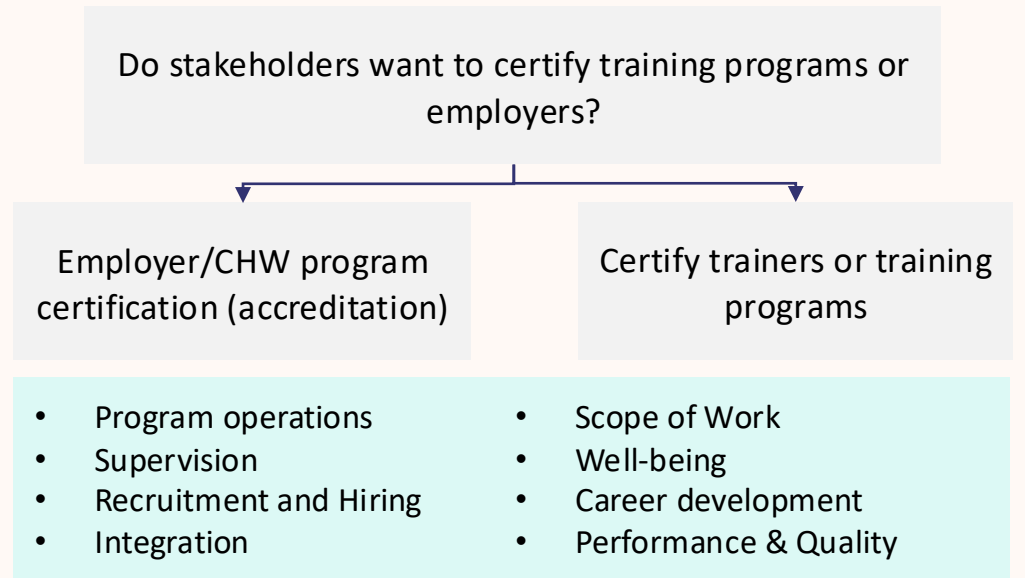


Individual certification



- CHW Association
- State Agency
- Regulatory Board
- Core competencies/ experience requirements
- CE monitoring
- Lifetime Certification
- Renewal process
- Reciprocity considerations
- Mandatory
- Semi- Voluntary
- Voluntary

Organizational/Program Certification



- Program operations
- Supervision
- Recruitment and Hiring
- Integration
- Scope of Work
- Well-being
- Career development
- Performance & Quality

Best Practices in CHW Certification

A certification process that is both responsive and equitable:

- **Involves CHWs in decision-making roles** from the beginning of design
- **Involves multiple stakeholders** (CHWs, employers, hospital associations, community health centers, insurance plans, territorial Medicaid, medical providers, and community-based organizations) during development to help legitimize the certification
- **Is steered by an advisory body or certification council/board** that creates + monitors processes, reviews applications, lays out requirements for recertification and advancement; includes substantial representation of the CHW workforce
- **Allows for multiple pathways to entry**, such as a legacy/grandparenting process
- Can have **tiers for advanced practice levels**
- **Is accessed through a user-friendly application process without large fees**
- **Does not impose strict pre-requirements** around educational attainment, language, citizenship, criminal background
- Requires **trainings that are accessible** (in terms of geography, \$, language, etc.) and includes standards for trainers

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[CHWs and the Aging Population](#)

[State by State Comparison](#)

[Appendix \(Evidence Deep Dive\)](#)

Financing CHW programs and services

The funding landscape for CHWs in the US reflects the fragmented approach to healthcare in the country.

Most states use a combination of sources to pay for CHW programs, with CHW services paid for by the government or public funding streams, individual payment, or via grant funding to employers.

Funding is often...

...**short-term**

...**subject to funder-led decisions**

...**targeted to very specific goals or issues.**

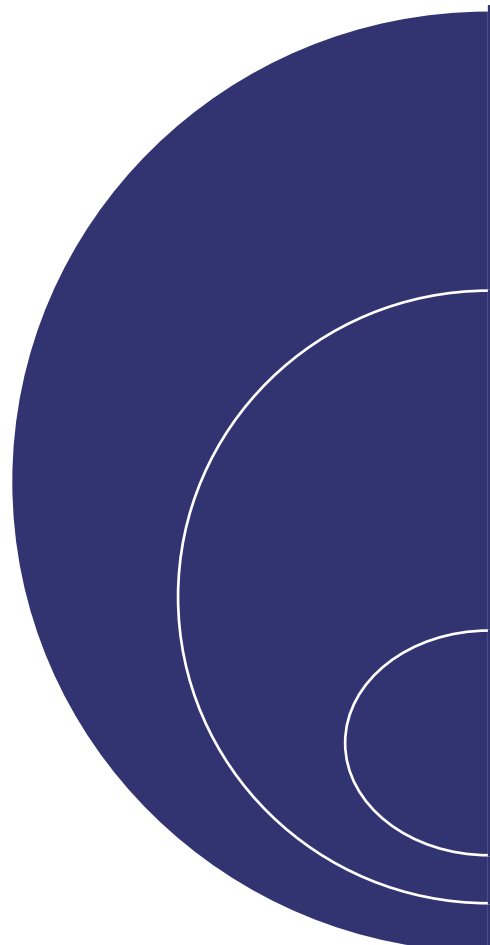
This reality keeps CHWs in siloes and limits incentives for policy change. Loss of project funding → lay-offs or disinvestment in community programming → continual need for reinvestment in the workforce.

As noted by the National Association of Community Health Workers, sustainable approaches to funding are *not* through project-specific grants and contracts, but via “ongoing revenue streams that explicitly provide for or ‘cover’ CHW services” or by “incorporating CHWs into ongoing budgeting within the employer’s overall revenue picture.” [NACHW 2020](#)

This section will review key financing mechanisms for consideration by program stakeholders seeking to establish a long-term financing strategy.

A snapshot of the complexity: sources of funding for CHW positions

Even with positive returns, there is no one funding stream that comprehensively covers CHWs. Below is a non-exhaustive list of funding sources that could be explored for CHW financing

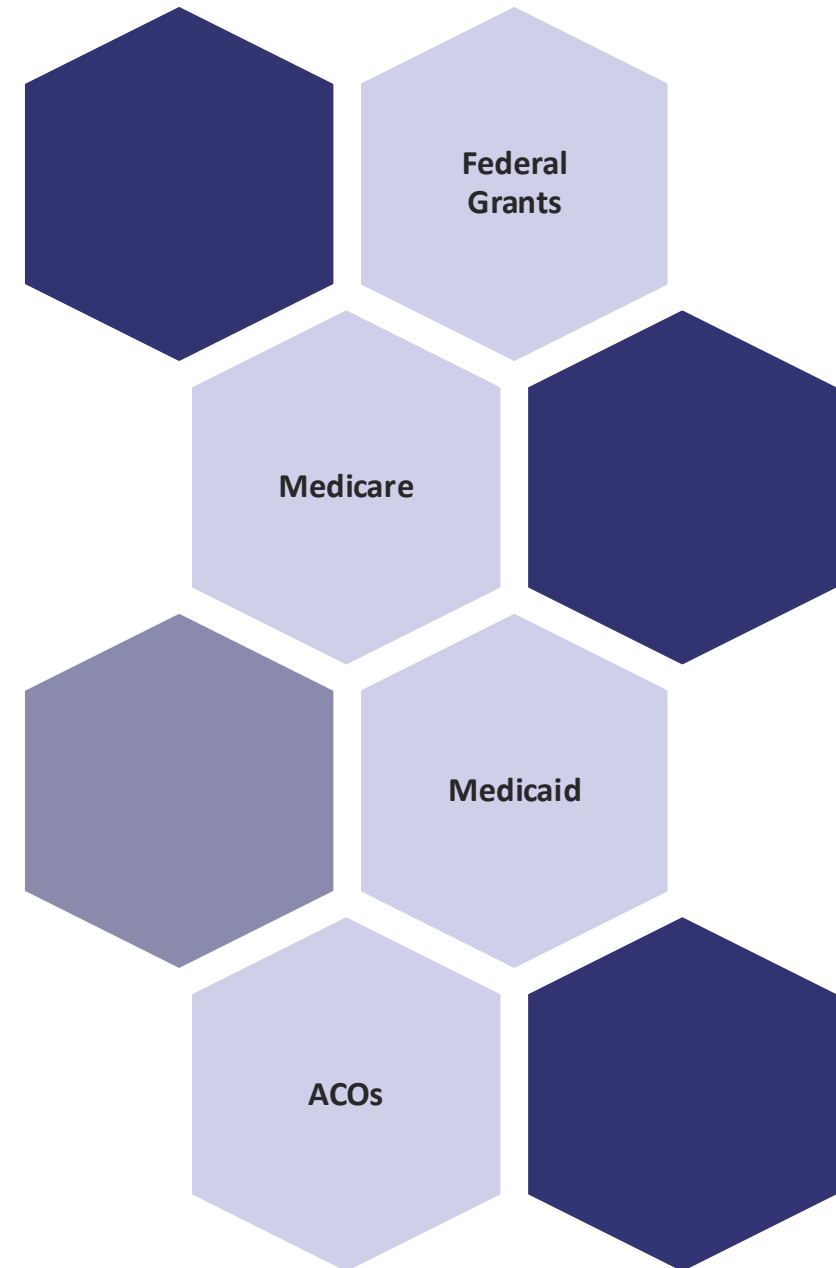


Federal Funding	<ul style="list-style-type: none"> • Medicare • Block grant programs (CDBG from HUD, CSBG, SSBG from ACF) • CHWs as a class of providers under major public insurance programs • Preparedness and disaster response
State Funding	<ul style="list-style-type: none"> • Medicaid, Children’s Health Insurance Program (CHIP) - <i>primarily state-run but joint federal & state program</i> • Mandates or incentives to state-funded provider • State mandates or incentives to include CHWs in major, ongoing categorical programs • Direct state appropriation
Local/Regional/ Private Funding	<ul style="list-style-type: none"> • Direct employment or contracting for CHW services by payers or intermediaries • Private commercial insurers • Philanthropy

Key concepts in CHW financing

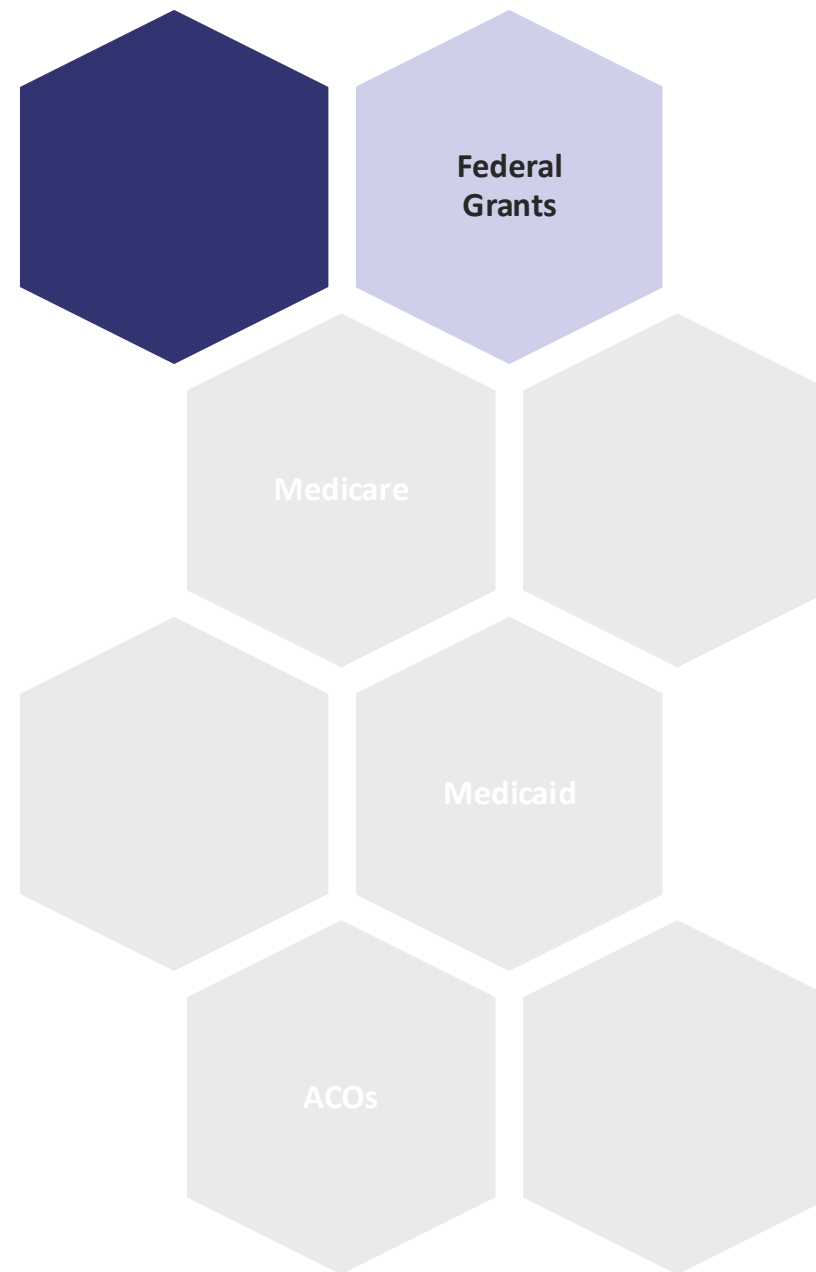
Each of the funding sources in the previous slide come with benefits, trade-offs, and complexities. It is critical to understand the basic processes and mechanisms behind each financing source in order to identify and create new opportunities for CHW financing

Given the recent spotlight on community health in state and federal programs, the following slides will give more details and resources related to **federal grants, Medicare and Medicaid financing mechanisms, and Medicare and Medicaid ACOs.**



Key concepts in CHW financing

Federal Grants



CMS Recommendation of Federal Block Grants That Can Include CHWs

Different organizations are eligible for a variety of federal grants to fund CHW programs. Below is a non-exhaustive list of discretionary grants that may be opportunities for CHW funding.

HRSA	CDC	OTHER
<ul style="list-style-type: none">• Black Lung Clinics Program• Community Health Center (CHC) Program (Section 330)• Behavioral Health Workforce Education and Training (BHWET) Program for Professionals Mental and Behavioral Health Education and Training Grants• National Organizations of State and Local Officials: Health Legislation and Governance• Rural Health Research and Policy Programs Centers• Ryan White HIV/AIDS Program• Special Projects of National Significance (SPNS) Program• Telehealth Programs• Title V Maternal & Child Health Services	<ul style="list-style-type: none">• Supported Activities: Prioritizing High Impact HIV Prevention• Colorectal Cancer Control Program (CRCCP) Organized Approaches to Increase• Viral Hepatitis Networking, Capacity Building, and Training Prevention and Control	<ul style="list-style-type: none">• Community Programs to Improve Minority Health Grant Program <i>OMH</i>• Community Services Block Grant (CSBG) <i>ACF</i>• National Institute of Nursing Research (NINR) <i>NIH</i>• Opioid Affected Youth Initiative <i>OJP</i>• Opioid STR (State Targeted Response to the Opioid Crisis) <i>SAMHSA</i>• Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHC) <i>SAMHSA</i>• Indian Health Service, Health Information Management (HIM) Development Program <i>IHS</i>

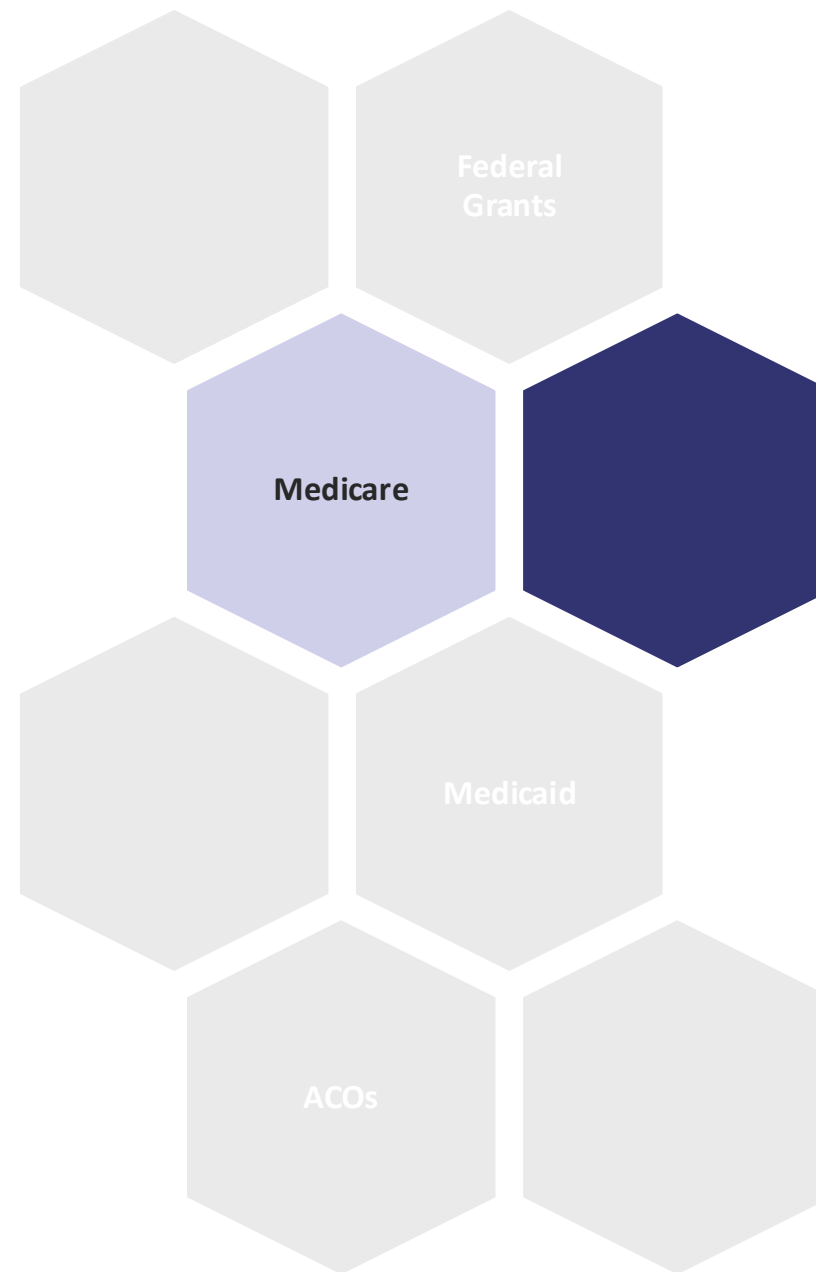
There are also opportunities for CHW inclusion in federal health care reforms

Below are a few federal health care reforms supporting CHWs integration into health care systems.

- **National Health Care Workforce Commission (§5101)**—includes CHWs as primary care professionals
- **Grants to Promote the Community Health Workforce (§5313)**
 - CDC grants to promote positive health behaviors and outcomes in medically underserved communities
 - Center for Medicare and Medicaid Innovation (CMMI)
- **Area Health Education Centers (§5403)**—CHWs added to mandate for interdisciplinary training
- **Hospital Readmission Reduction (§3025)**—high potential for CHW role; see [MA example](#)
- **Patient-Centered Medical Homes (§3502)**—CHWs as part of “community health teams”
- **Patient Navigator Program (§3509)**—HRSA heavily favors employing CHWs
- **Maternal, Infant, and Early Childhood Home Visiting Programs (§2951)**—via [grants to states, varies by county](#)

Key concepts in CHW financing

Medicare Financing Mechanisms



Selected CHW financing opportunities through Medicare

Medicare is a federal program under the Center for Medicaid and Medicare Services that serves anyone age 65 and older, and a portion of people under 65 with certain disabilities or conditions.

Medicare has traditionally used fee-for-service reimbursements. CMS annually updates the amount of reimbursement given for each activity in the *Medicare Physician Fee Schedule*. Because the Medicare budget is fixed, changes to reimbursement rates typically involve reallocating existing funds; any increase to the overall budget requires legislative approval.

Until 2024, Medicare providers could use APMs, such as bundled payment and risk-based contracts to receive payment for CHW activities. **In 2024, however, CMS published the [2024 Medicare Physician Fee Schedule Final Rule](#) that has newly established codes to include reimbursement for CHW activities related to SDOH services. See the CMS press release [here](#). More information provided on [this slide](#).**

Financing Opportunities for CHWs Through Medicare

Dual-Eligible Special Needs Plans (D-SNPs)

Dual eligibility programs may include CHWs as part of their care teams

Bundled Payment

Fixed payments for all clinically related services for one healthcare event or diagnosis can be designed to include CHWs

Fee-For-Service Reimbursement

New Medicare ruling has provided reimbursement codes for SDOH-related services

2024 Medicare Physician Fee Schedule (PFS) Final Rule

In 2024, CMS added CHWs to the annual Medicare guidance for the first time. The 2024 Medicare Physician Fee Schedule (PFS) Final Rule went into effect January 1, 2024.

- Includes Medicare payment for services **performed by CHWs** and adds those services to the telehealth services list
- Includes **navigation services** as a paid service
- Allows CHWs working at **CBOs** to be included in payment rule
- Adds **SDOH screens** as a paid service with CHI services to be billed monthly or as medically necessary following evaluation/management visit
- **Allows CHCs to bill** for a number of services without direct supervision

[Calendar Year \(CY\) 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet](#)

[Press Release: CMS Physician Payment Rule Advances Health Equity](#)

[CY 2024 Physician Fee Schedule Final Rule](#)

[Primer for organizations that want to implement SDOH codes with accompanying webinar](#)

Implementation of the CY 2024 Medicare Physician Fee Schedule

With the addition of CHW services to the PFS, many health systems and CBOs and other CHW employers are developing plans to implement this rule. In preliminary conversations, PIH-US has found that organizations that have already implemented the codes have found successes and challenges in the implementation process.



- The codes for CHW services are already available in medical billing systems, allowing clinics to bill immediately if they have the necessary IT infrastructure
- Many CHW services can fall within the specified codes, and the ability to add on additional increments of time is a significant strength



- The PFS does not include specific guidance on how providers and clinical organizations can contract with CBOs to provide CHW services
- There is still a lack of provider awareness on the role of CHWs in connecting patients to social supports, and many CHWs are not yet aware of the opportunity to bill, leading to underutilization of codes.

Background on Medicare Advantage (MA)

If you have Original Medicare, the government pays for your Medicare benefits.

Some people replace their Original Medicare with Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” in which private companies are approved by Medicare and can have different offerings

This is different than a Medicare Supplement Insurance (Medigap) policy.

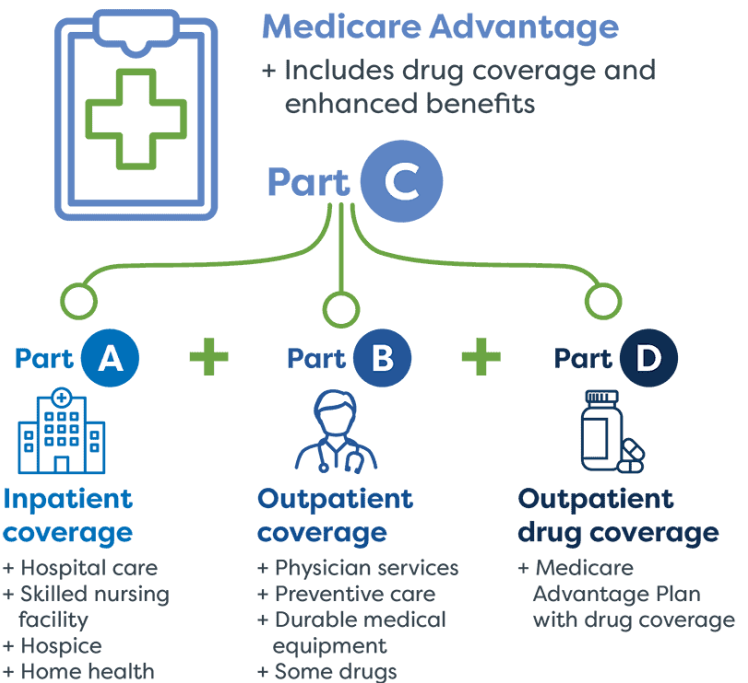
Medicare Advantage plans do not have to follow the same Physician fee schedule as Original Medicare Plans

Requirements and Payment

You must have Medicare Parts A and B and live in the plan’s service area to be eligible to join. People with permanent kidney failure generally can’t join a Medicare Advantage Plan.

In addition to your Part B premium, you usually pay one monthly premium for the services included in a Medicare Advantage Plan. Each Medicare Advantage Plan has different premiums and costs for services, so it is important to compare plans in your area and understand plan costs and benefits before you join.

Medicare Advantage Plans Benefits



Source: Nascenia Health. (2025, September 15). *About Medicare and Medicare Advantage*. [Link](https://www.medicare.gov/health-drug-plans/health-plans)

MA plans generally include benefits for SDOH and non-clinical services, presenting more opportunities for CHW employment and financing

A non-exhaustive list of Special Supplement Benefits that may be provided by Medicare Advantage plans

Meals (beyond limited basis)

Transportation for Non-Medical Needs

Food and Produce

Pest Control

Social Needs Benefits

Indoor Air Quality Equipment and Services

Structural Home Modifications

General Supports for Living

Services Supporting Self-Direction

Payment for Services through Medicare Advantage

CBOs

- Can contract with MA to provide supportive services to enrolled managed care members through special supplemental benefits or regular supplemental benefits
- Contract with an enrolled Medicare health provider for FFS reimbursement for “*incident to*.”

Clinical Practices/Hospitals

- Can contract with MA to become a network provider and bills directly for *incident to*.
- Contract with CHWs to provide supportive services to enrolled managed care members through regular or special supplemental benefits.

Medicare Advantage: Dual Eligible Special Needs Plans (D-SNPs)

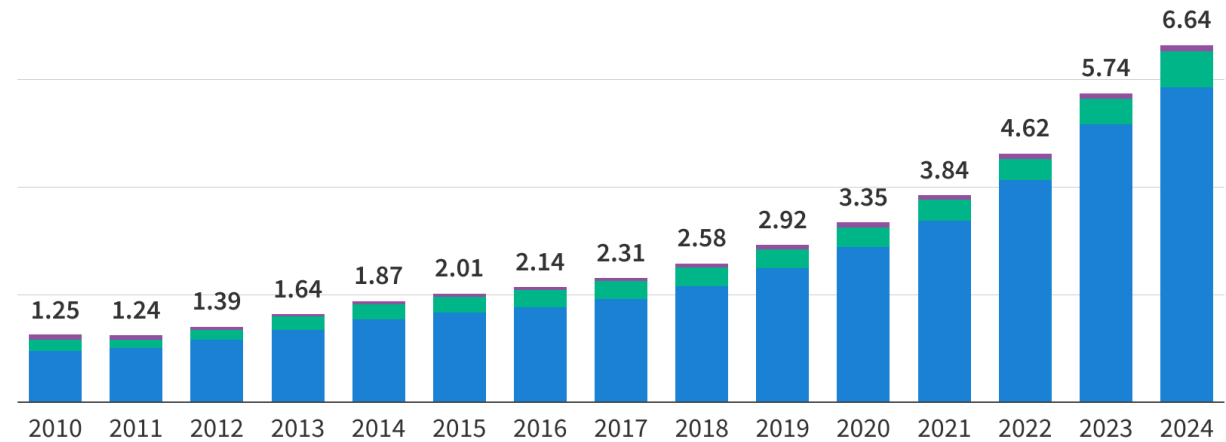
Dual-eligible Medicaid and Medicare individuals may qualify for expanded services through **dual-eligible special needs plans (D-SNPs)**, administered through Medicare Advantage. Given the increased resource needs for this population and ultimate goals of integrated care, CHWs may also be ideally placed to deliver care under these plans.

- 88% of Special Needs Plan (SNP) enrollees are in plans for beneficiaries dually enrolled in both Medicare and Medicaid (D-SNPs); in 2024, 5.85 million people were enrolled in D-SNPs.
- In the current setup, dual eligibility programs may include CHWs as part of their care team and finance them with either unrestricted funds, administrative budgets, or Medicaid/Medicare reimbursement.
- [California and Massachusetts](#) have dual-eligibility programs that mention CHWs as a distinct part of the care team, however there is minimal available documentation on how CHWs are paid. More information can be found [here](#).

Number of Beneficiaries in Special Needs Plans, 2010-2024

In millions

■ Dual Eligible Special Needs Plans (D-SNPs) ■ Chronic or Disabling Conditions (C-SNPs) ■ Institutional (I-SNPs)

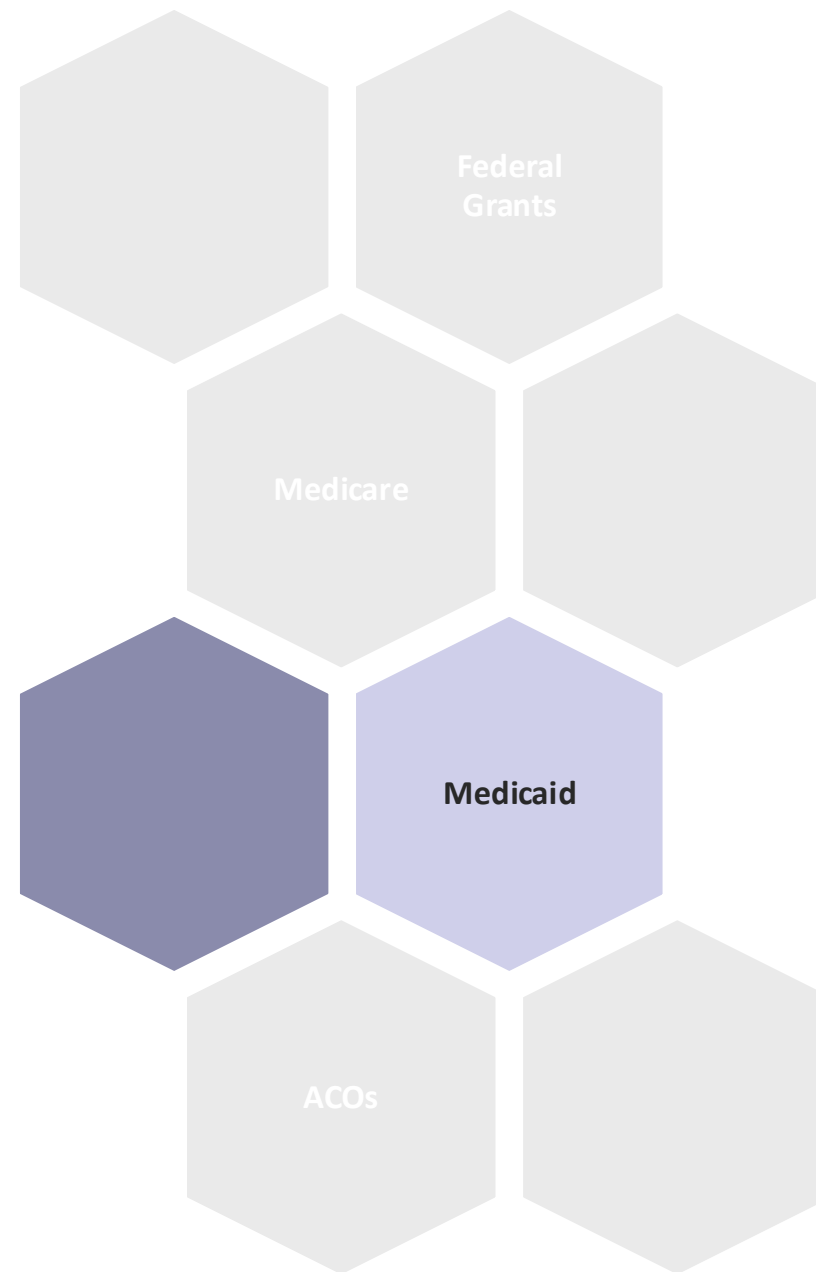


Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024.

KFF

Key concepts in CHW financing

Medicaid Financing Mechanisms



Selected CHW financing opportunities through Medicaid

Medicaid is a joint federal and state program that helps cover medical costs for people with limited income. **Each state runs its own program, which means eligibility requirements, benefits, and payment structures can vary from state to state.**

States have recently started adding CHWs to Medicaid reimbursement programs.

As the implementation process unfolds, it will be essential to develop systems that incorporate the work of CHWs and CBOs, who are important actors in screening and delivering SDOH services.

The next slides summarize select financing opportunities that could allow for participation and adequate compensation for CHWs and CBOs.

See this [PIH policy brief](#) for more information on CHWs and Medicaid.

Financing Opportunities for CHWs Through Medicaid

State Plan Amendments (SPAs)

CHWs can receive payment for a defined scope of services

Section 1115 Medicaid Waivers

CHWs payment can be written into short-term demonstrations using various payment structures

Operational Budgets of MCOs and Contracts; Inclusion in PMPM Rates

CHWs services can be paid for through the PMPM (managed care), operational budget or through subcontracted CBOs

Alternative Payment Mechanisms (APMs)

Gives incentive payments to provide high-quality and cost-efficient care; can apply to a clinical condition, a care episode, or a population.

Medicaid: State Plan Amendments (SPAs) for CHW financing

The Medicaid **state plan** is the legislative agreement between a state and federal government describing how that state administers its Medicaid and CHIP programs.

State plans describe the groups of individuals to be covered, services to be provided, methodologies for reimbursement and administrative activities underway in the state.

A state plan **amendment** is a permanent change to the state plan that can then be implemented through the state Medicaid office. A state may submit an amendment to CMS to make program changes, corrections, & updates.

In terms of CHWs, states may submit to expand their list of CHW services, reimbursed on a fee-for-service basis.

Example: Minnesota's CHW Reimbursement

MN was the first state to allow direct reimbursement for CHW services under the state Medicaid plan, [submitting an SPA in 2007](#). This plan allows fee-for-service reimbursement of CHW services if a CHW meets certain educational requirements. The most current version of Minnesota's SPA can be found [here](#).



Pros

- Permanent/lasting change



Cons

- Must be approved by legislature and CMS – can be administratively burdensome

A note on reimbursement for preventive services...

In 2014, a rule change to the Medicaid Preventive Services Rule ([42 CFR 440.130\(c\)](#)) made it possible for states to submit a SPA to [allow coverage of preventive services](#) delivered by a non-licensed provider, if recommended by a licensed practitioner.

Examples of CHW Services covered by SPAs

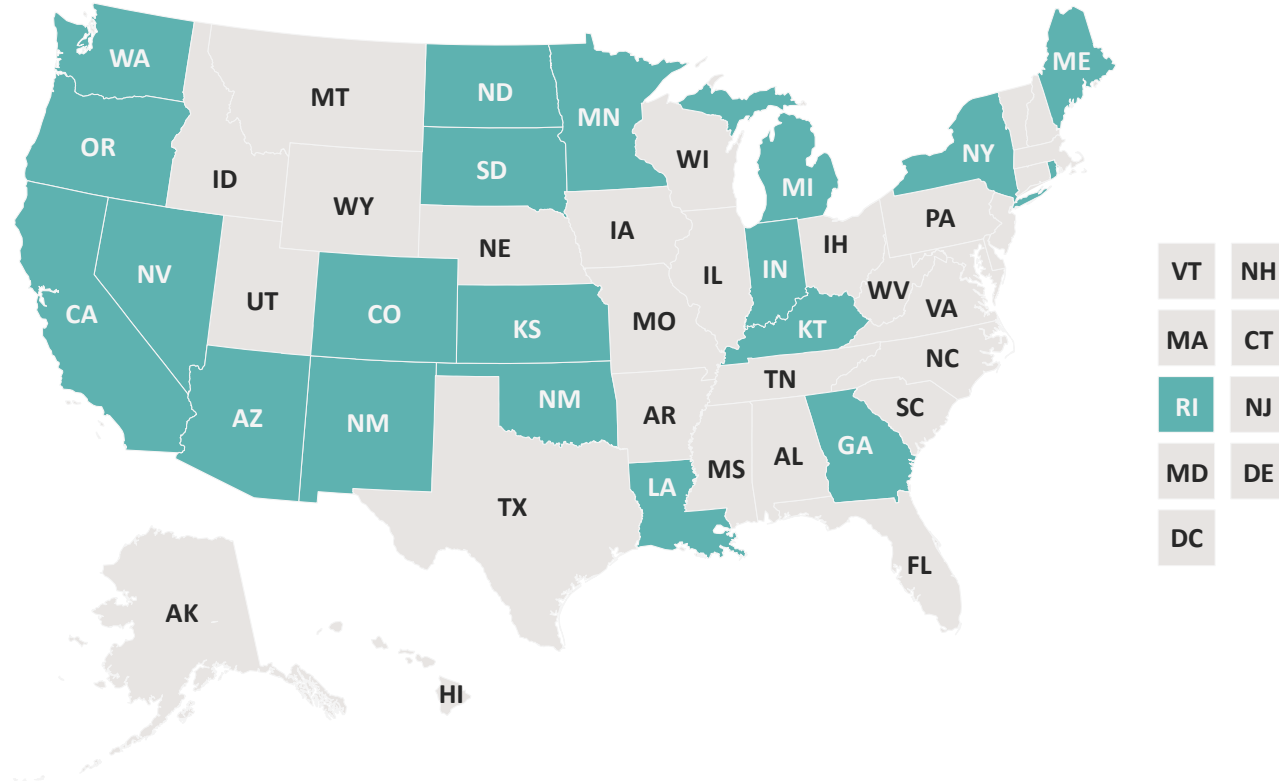
The following list highlights example benefits commonly offered under Medicaid programs.

- **Care coordination** services, including helping patients make appointments, routine preventative care, self-managed care of chronic illness, using telehealth technology, and arranging transportation to Medicaid-covered appointments
- **Systems navigation services**, where cultural mediation is necessary because of language barriers, social or economic status, or health literacy
- **Health education**, on diabetes, parenting, and blood pressure to equip Medicaid members with proven strategies for preventing or managing these conditions
- **Patient advocacy**, helping patients and Medicaid members access high-quality, respectful, and equitable care
- **Clinical support** such as health screenings and home visits, arranging transportation, translating and interpreting health information, and promoting treatment follow-ups.
- **Community outreach** and engagement in various settings, including homes, schools, hospitals, clinics, shelters, local businesses, and community centers.
- **Health coaching** for specific lifestyle changes such as smoking cessation, and weight management
- **Home visit support** for health education and cultural facilitation

This list is neither comprehensive nor consistent across states and excludes common reimbursement limits on services like transportation or childcare. For complete, current details, consult each state's Medicaid Provider Manual.

CHW SPAs across the U.S.

Map of U.S. States that currently have State Plan Amendments Authorizing Reimbursement of CHW Services



Adapted from: [NASHP](#), Updated 2025

Additional Resources

Primary documents for each SPA can be found [here](#).

State approaches to financing through SPAs can be found in [this](#) NASHP article.

More information on CHW SPAs can be found in [this](#) Kaiser Family Foundation article.

More information on covered services and reimbursement rates for each state is covered [in this summary of State Plan Amendments](#) (MARC & KCCHWC).

Model language for a state CHW SPA can be found [here](#). Recommendations for developing and implementing a SPA can be found [here](#).

Although most states implement their SPAs using the same CPT codes, reimbursement rates for the codes vary considerably

Most CHW SPAs have adopted fee-for-service (FFS) payment methods using three standard CPT codes (98960–98962) that cover education and training for patient self-management. **While these states utilize the same codes, reimbursement rates vary significantly, with base rates ranging from \$9.70 to \$35.00 per half hour.** For comparison, the average reimbursement for 30 minutes of Medicare CHW-delivered CHI services is \$50.26.

Notable deviations:

- [Maine](#) incorporated CHWs into existing SPAs administered for primary care homes through PCP Plus
- [North Dakota's](#) SPA reimburses CHRs, specifically, using a tribal T code at \$519 per encounter (daily rate).
- [West Virginia](#) reimbursement is not in a SPA, but is [allowed \(not required\)](#) through Medicaid health homes, where CHWs may join care teams paid via a fixed per-member payment
- Rhode Island reimburses based on a T code for new emerging technologies, (T1016) at a rate of \$12.71, \$16.53, or \$4.66 per 15 minutes, depending on the setting.

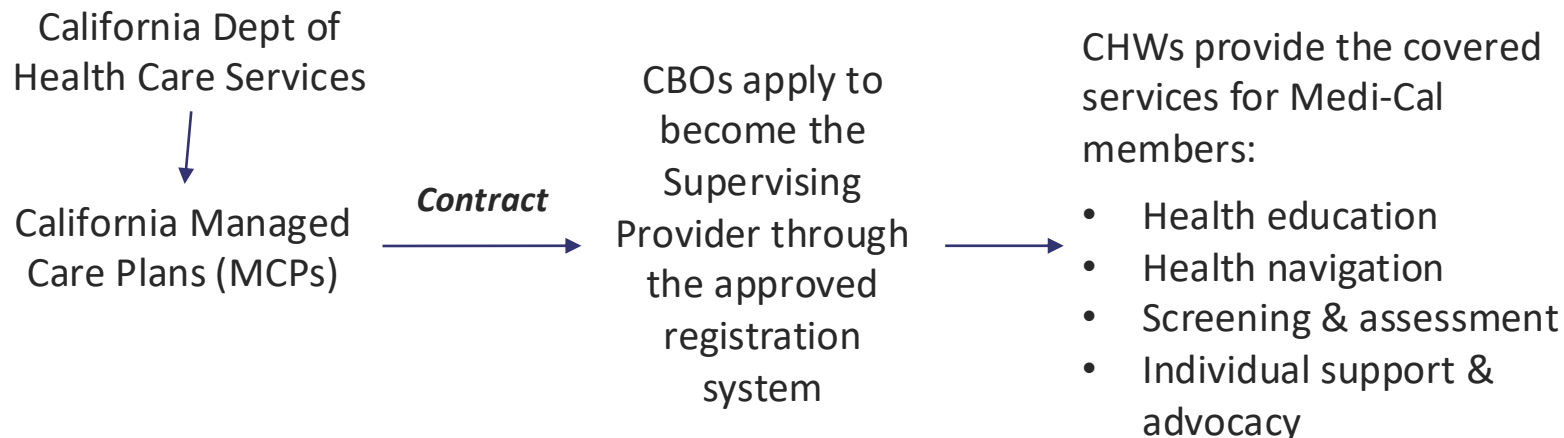
State	CPT 98960	CPT 98961 (per person)	CPT 98962 (per person)
Arizona	23.29	11.06	8.15
California	26.66	12.66	9.46
Indiana	26.56	12.82	9.42
Kansas	9.70	4.67	3.43
Kentucky [†]	22.53	19.88	8.03
Louisiana [†]	18.11	6.04	2.79
Michigan	17.23	8.32	6.14
Minnesota	21.56	10.41	7.43
Nevada	18.34	8.82	6.44
New Mexico	30.00	10.00	10.00
New York	35.00	16.45	12.25
Oregon	25.19	12.06	8.82
South Dakota	32.43	16.22	11.35

[†]Kentucky and Louisiana also have additional FQHC PPS reimbursement options. KY has written in a fee adjustment as necessary.

Certain states have taken steps to include CBOs in SPAs

Many states impose specific requirements on organizations seeking to bill for Medicaid services, one of the most common being the inclusion of a licensed medical practitioner on the care team. However, CBOs employing a significant number of CHWs often lack formal contracts with licensed medical providers, and as a result they frequently do not meet the eligibility criteria for reimbursement. **To address this challenge, several states have developed CBO-specific pathways that enable these organizations to participate in Medicaid billing for the services they deliver.**

California's Reimbursement Pathway



Additional State Examples

Arizona

- In March 2024, AHCCCS created a new provider type called “CHW Organization”
- CBOs and tribal organizations are eligible to bill for CHW services by certified CHWs and CHRs.

South Dakota

- In April 2019, SD Medicaid added CHWs to the list of services a Medicaid recipient may be eligible for.
- A CBO can bill for CHW services after becoming a CHW Agency with SD Medicaid.

Source: California Department of Health Care Services. (2024, July 16). *Innovative partnerships: El Sol and Health Net's community health worker (CHW) benefit journey* [Webinar slides]. [Link](#)

Source: Arizona Health Care Cost Containment System (AHCCCS). (2024). *Community health workers and community health representatives*. [Link](#)
South Dakota Department of Social Services. (2025, January). *South Dakota Medicaid billing and policy manual: Community health worker services*. [Link](#)

Inclusion of CBO partners in SPA implementation

Healthcare delivery organizations/health plans and CHW organizations/CBOs can both benefit from a partnership to deliver CHW services to patients.

Example: health net & El Sol Neighborhood Educational Center (California)

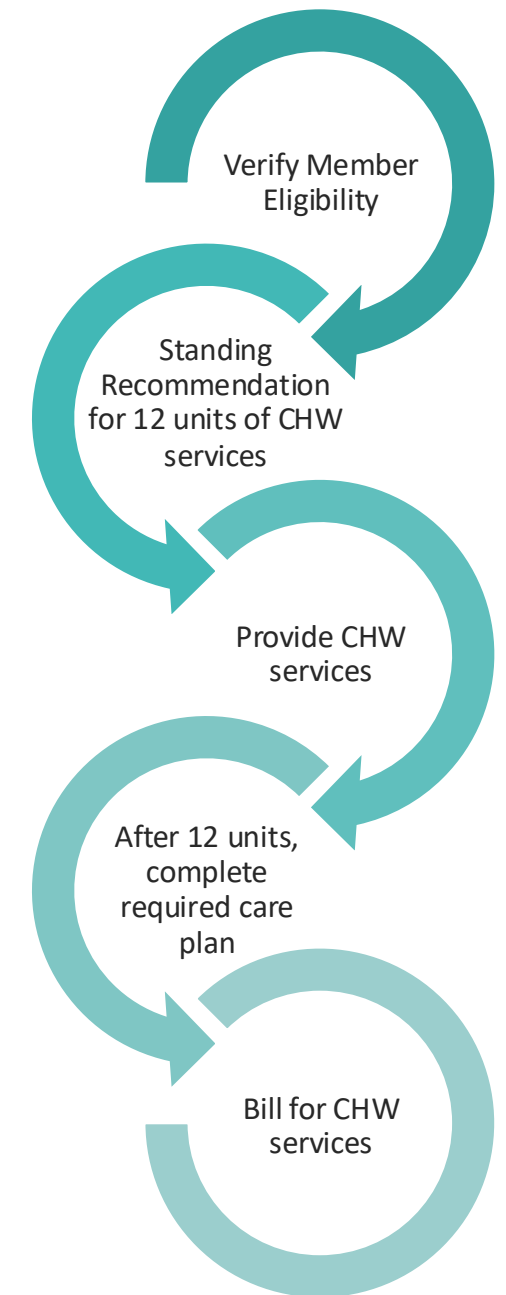
The Medi-Cal CHW benefit, available since July 1, 2022, allows Medi-Cal members to receive services from CHWs.

Health net contracted with 50 CBOs, which represent more than 650 CHWs, that are providing services in 14 California counties.

- The need for CHWs to assist Medi-Cal members exceeds the number of paid CHWs
- Many CBOs lack the the administrative capacity to engage with health plans
- Integrating CHW-related health plan services into community sites such as food banks, shelters, and barbershops, is complex and challenging.

Factors that contributed to success:

- Trust building
- Co-developed approach
- Sustainability plan
- MCO investment in capacity building
- Administrative capacity
- Provider incentives for CHW services
- Financial tools to accelerate CBO revenue from claims
- Fair and flexible contracting
- Innovative partnership models



health net's CHW workflow

State Example: Arizona's SPA and Implementation Challenges

Arizona's SPA is noteworthy for its attempt to phase in both medical professionals and CBOs as "providers" that can reimburse for CHW education and preventative services.

The opportunity for CBOs to submit claims is a step towards a more community-centered health system; however, in practice, the process for reimbursement may have barriers in implementation that impede CBOs from participating.

CHW & CHR services reimbursement process



CBO Challenges in Implementation

- The technology, infrastructure, and training needed for billing is complex and costly, and CBOs generally do not have the capital to build these systems
- The process for registering as a provider is time- and effort-intensive, which strains the CBO's already-limited resources
- Low reimbursement rates don't bring enough revenue for CBOs to invest in creating this infrastructure and limits their participation

Medicaid: Defined payment through Section 1115 waivers

➤ **Section 1115 Waiver:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

States may use this type of waiver to test different benefit designs or new models for delivering care.

Some states have used these waivers to pay for CHWs in models that focus on specific Medicaid populations.

May use to test a design before requesting an SPA.



Pros

- States have significant flexibility in what they can do
- Changes are renewable



Cons

- Requires CMS approval
- Changes are temporary (3-5 years)
- Changes must be “budget neutral”

Example: “Community Connectors” Demonstration in Arkansas

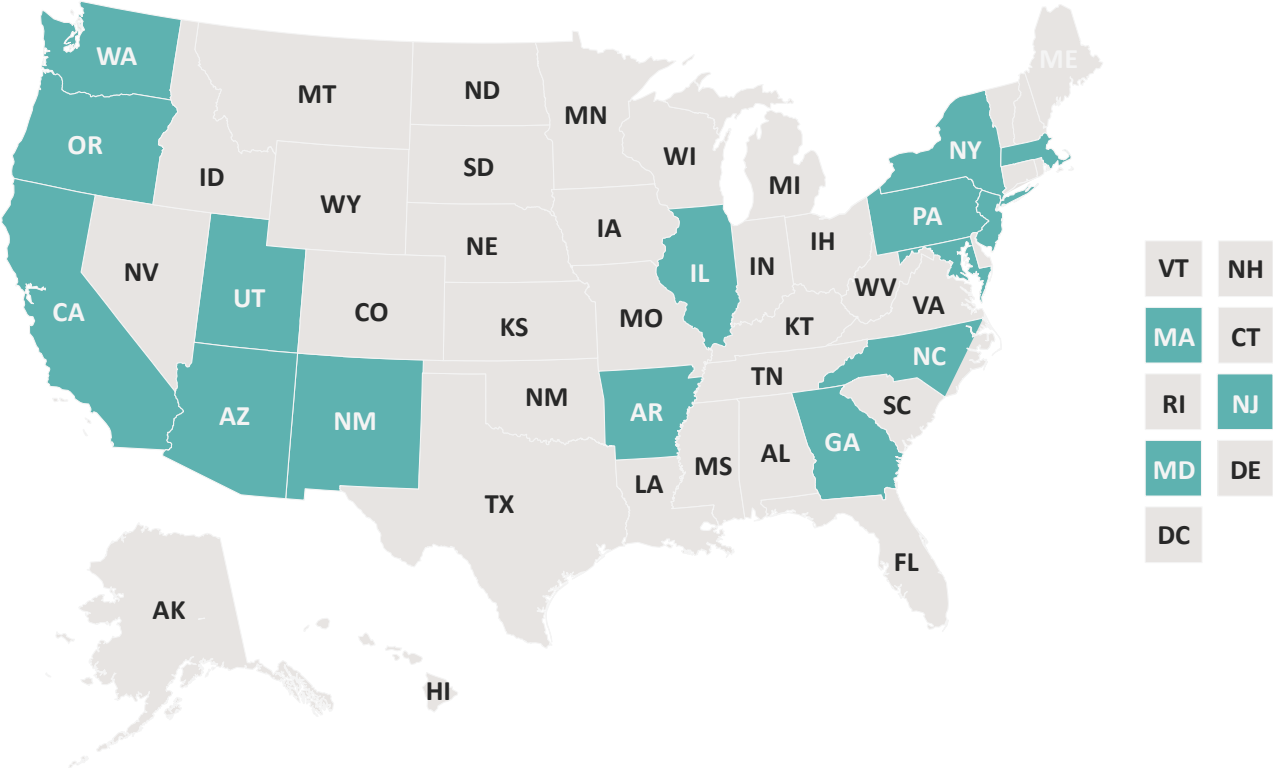
CHWs conducted outreach to people receiving homebased care and referred to community services and in-home non-medical support and showed 3:1 net savings on total cost of care for participants.

State expanded these services as part of regular Medicaid operations.

See KFF for list of [list of approved Section 1115 Medicaid Waivers](#).

CHW-related 1115 waivers across the U.S.

Map of U.S. States that currently have 1115 Demonstration Waivers Authorizing Payment of CHW Services



Additional Resources

More information on 1115 waivers that include CHWs can be found [here](#).

Adapted from: [NASHP](#), Updated 2025

Examples of 1115 demonstration waivers that include CHWs

State	1115 Waiver Components Related to CHWs
Washington	<p>Allows CHWs to be paid through two components:</p> <ul style="list-style-type: none"> Justice involved pre-release services includes CHW services to assist with screening, navigation and referral. HRSN services includes case management, navigation, and referral, which will be used to pay for CHW services for both managed care and Medicaid without a managed care through regional community hubs and a native hub.
Georgia	<ul style="list-style-type: none"> Finances Resource Mothers, which is a population-specialized CHW model funded through a managed care capitation model, provides one component of the postpartum service array. The state is waiting on approval from the CMS on a proposal that would recognize CHWs as practitioners under the Medicaid Rehabilitation Option specific to implementation of the Certified Community Behavioral Health Clinic service type. This service will aim to target mental health and addiction needs for members of all ages.
Massachusetts	<ul style="list-style-type: none"> Up to \$8 million (total computable) in expenditure authority will be made available for the first 4 years of the demonstration, to fund various initiatives ,including CHW workforce development – e.g., cultural competency training, trauma-informed training, CHW certification, training staff on new policies and procedures. Transition ~80% of DSRIP funding to ongoing base funding (includes CHWs)
New Jersey	<ul style="list-style-type: none"> Includes a set of CHW pilot programs that earmarks \$25 million over the five-year waiver period for MCOs that choose to participate and implement and evaluate specific interventions using CHW services.
North Carolina	<ul style="list-style-type: none"> Includes CHWs as care management extenders within their “Tailored Plan” care management model and include them as eligible provider in behavioral health programs.

On March 4,2025 CMS [issued a bulletin](#) rescinding CMS guidance on Health-Related Social Needs (HRSN), announcing that future state applications to cover HRSN services will be evaluated on a case-by-case basis for consistency with federal Medicaid statutes and regulations

Section 1115 Reentry Waiver, Care Transitions for Justice-Involved Individuals

Critical Elements of 1115 Reentry Waiver

- **Coverage for Pre-Release Services:** Provide reimbursement for select pre-release services up to 90 days before release, including case management, substance use disorder medications, and a 30-day supply of all prescriptions at release. States can offer additional benefits.
- **Provider Flexibility:** States may use community-based, in-reach, correctional, or embedded carceral health providers for pre-release services. Embedded providers must follow Medicaid policies and coordinate handoff to community providers.
- **Eligibility and Enrollment:** States must suspend Medicaid during incarceration and ensure enrollment occurs at intake or at least 45 days before release.
- **Capacity Building and IT Support:** States may request time-limited federal matching funds to develop health IT systems, train staff, and enhance operations to support implementation.
- **Reinvestment Requirements:** States must reinvest federal funds from carceral health services into community-based care or initiatives that improve health access and quality for justice-involved individuals

The Section 1115 reentry waiver is distinct from the general 1115 waiver and specifically aims to support care transitions for eligible individuals approaching release from incarceration. Goals of the waiver include:

- **improving access to healthcare and social services**
- **enhancing health outcomes**
- **reducing avoidable hospital use**
- **promoting successful community reintegration**

States with 1115 Reentry Waivers that include CHW Services



California

CHW services will align with CHW state plan and will be reimbursed accordingly



Michigan

CHWs work in collaborators with provider to establish client relationships, conduct a needs assessment, develop a person-centered care plan, and make appropriate linkage and referrals to supportive services



Illinois

Covers CHW services for reentrants, includes victim service workers/advocates for violence prevention



New Mexico

Covers CHW roles through the state housing model and potentially covered to provide [SBIRT](#) services

Comparison of SPA and Waiver Processes and Timelines

SPA Process & Timeline

Legislation

- State-dependent
- Political environment dependent

Document Preparation

- Form for SPA

CMS review (2-4 months)

CMS approval time (months)

1115 Waiver Process & Timeline

Legislation

- State-dependent

Data and narrative describing request

Public comment period and hearings

State review of comments and revisions

CMS evaluation of completion
• (~2-3 weeks)

CMS review
• Consideration of all comments
• Legal review
• (months)

CMS Approval
• No less than six months

Medicaid: Payment through Managed Care Organizations (MCOs)

Medicaid managed care delivers health benefits through contracts between state Medicaid agencies and managed care organizations (MCOs). In this arrangement, **MCOs accept a set per member per month (PMPM) payment, also known as a capitation rate, from the state Medicaid, to provide health services, and a corresponding PMPM payment is then passed down to clinical practices.**

More than 2/3 of the Medicaid population is covered by MCOs.

Services provided by MCOs can vary considerably from state to state and can include services from home visits to interpretation services. Some states require MCOs contracts to include CHW services or to directly employ CHWs and can set guidelines on if CHW core competencies need to reflect CHW certifications in their state.



Pros

- MCOs may have more flexibility to cover services not covered by Medicaid
- States can impose requirements for services covered, staffing ratios, etc. – standardizing offerings & evaluation



Cons

- Upfront investment in convincing MCOs to use budgets to hire CHWs and requirements for hiring may need to start simple

More on capitation rates...

[Capitation rates](#) are based on principles of actuarial soundness, risk-adjust methods to account for enrollee health status, MCO performance incentives, and operating costs.

Appropriate capitation rates are important because they provide a financial incentive to keep out of the hospital through preventive and timely care to keep costs within the rate. If the capitation rate is insufficient or inadequately risk-adjusted, MCOs could have a financial incentive to undertreat patients or discourage enrollment of patients with more complex and expensive health needs to minimize costs.

Financial Incentives for MCOs to Address SDOH

Many states have included **financial incentives** in MCO contracts to address complex conditions such as chronic disease, mental health, see right).

Given that CHWs already address many of these conditions in the community, CHWs are highly effective partners for MCOs in reaching performance goals.

State Examples of SDOH-related Financial Incentives in MCOs

- [Washington](#) offered incentive payments to build infrastructure for education, certification, integration of Community Health Aide Program (CHAP)-certified providers into tribal health programs
- [Oregon](#) made policy recommendations to share incentives with community partners for contributions to achieving incentive measures.
- [Minnesota](#) receives a “risk corridor calculation adjustment” for health care disparity outcomes. Points are awarded when disparity gap improves, deducted when worsens.

Survey of State Medicaid Financial Quality Incentives (2021)

Any financial quality incentive

States with at least one financial quality incentive linked to a specified performance area

28

Specified financial quality incentive performance areas

Mental health

25

Chronic disease management

21

Perinatal/birth outcome

20

Substance use disorder

17

Potentially preventable events

16

Dental

10

Health disparities

9

Nursing facility quality

6

Member satisfaction

5

LTSS rebalancing

5

Note: Data are as of July 1, 2021. There were 37 responding MCO states. DE, MN, NM, and RI did not respond to the 2021 survey.

Source: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2021.

KFF

Additional Strategies for Financing CHW Services within MCOs

In Lieu of Services (ILOS)

Services provided as substitutes for standard covered services

- Voluntary
- Must be a cost-effective, medically appropriate substitute
- Requires state approval
- Unlike value-added services and quality improvement activities, costs relating to ILOS can be considered when developing the medical portion of the MCO capitation rate.

[Oregon](#) uses ILOS to fund CHW services

Value-Added Services (VAS)

Any services that the MCO voluntarily agrees to provide and funded by the MCO through administrative or profit margin funds, rather than Medicaid dollars.

- Voluntary
- Requires state approval
- Helps attract, retain, and better serve enrollees.

Many MCOs such as [Blue Cross Blue Shield of New Mexico](#) have included SDOH services that can be provide by CHWs.

Quality Improvement Activities

Activities that are counted as expenses incurred to enhance the quality of care they provide to their members. These costs are part of the overall healthcare spending and are often tracked through metrics like the [Medical Loss Ratio \(MLR\)](#).

- Voluntary
- QI plans require state approval

[Texas](#) allows MCOs to categorize services provided by CHWs as a quality improvement cost instead of as an administrative expense.

Creating a low-resource payment infrastructure to allow CHWs and CBOs to participate in Medicaid

As noted in previous slides, traditional financial infrastructures significantly impede CBO and CHW participation in health system payment models.

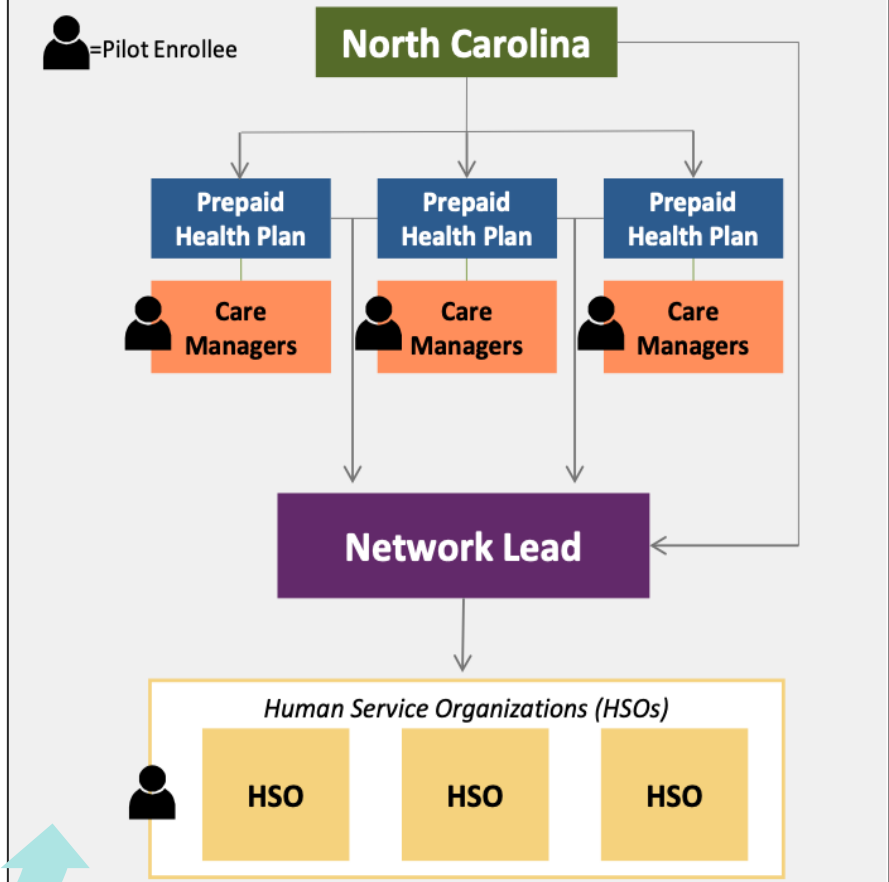
- It necessitates a large capital investment to set up and maintain the system
- The finite terms of Medicaid contracts could deem any investment into the system obsolete after the end of contract.
- Fee-for-service models create financial strain for small organizations, as they must cover upfront costs while awaiting reimbursement

Fixing the system requires **acknowledging the limited resources of CBO partners and exploring ways to work *with* existing CBO systems.** Refer to this [PIH-US Policy Brief](#) for more information on approaches to including CBO in Medicaid financing structures

Example: North Carolina Healthy Opportunities Pilots

The [Healthy Opportunities Pilots](#), implemented under NC's Medicaid 1115 waiver, [noted similar payment infrastructure inequities](#) and designed a system in which Human Service Organizations (HSOs) can collect claims information from individuals using simplified, lower-tech methods, and then transfer the information to the health plan via a network lead hub entity where information is translated into a claim. In 2023, Milbank Foundation [published their early lessons from implementation](#).

North Carolina Healthy Opportunity Pilots



Medicaid: Alternative payment models (APMs)

➤ State Medicaid programs are exploring many [alternate payment models](#) (APMS) to improve quality and continuity of care while reducing costs, with a particular focus on addressing the SDOH. Many of these models have the potential to incorporate CHWs as key members of the workforce.

Patient Centered Medical Home (PCMH): model of organizing primary care so patients receive care that is coordinated by a primary care physician, supported by information technologies for self-care management, delivered by a multi-disciplinary team of allied health professionals, and adherent to evidence-based practice guidelines.

Medicaid Health Home: builds on PCMH but goes further by requiring integration of physical and behavioral health services, and also extends care coordination beyond medical services to include social and community supports.

Bundled payment: A single payment is issued for one episode/encounter, even if multiple services and providers are involved. Provider has flexibility to spend on CH services and can improve predictability, reduce cost variation, and provide financial incentives to improve care coordination among providers and across health care settings. There are different models of administering bundled payments. It may be administratively challenging. Read more from [London, 2017](#).

Risk contracts: Most often observed in Accountable Care Organizations (ACOs, which will be discussed in further detail in the context of Medicare on subsequent slides) where groups of providers come together to provide quality care. In this model, providers are at greater financial risk.

Simulations are currently underway to introduce Medicare-like ACOs into Medicaid models. The [National Association of Accountable Care Organizations](#) lists state programs that are implementing Medicaid ACOs.

APMs that include CHWs

Below are examples of APMs designed to CHWs and incentivize a shift toward whole-person care. As new models emerge, it will be essential to include robust evaluation metrics that measure community engagement in care delivery and emphasize long-term health outcomes, which are key to moving both practices and payers toward community-based care.

Vermont

[Blueprint for Health](#)

- Using a multi-payer model to support PCMHs
- Will allow hiring of staff (such as CHWs) to support community needs and form community partnerships.

California

- [Building an APM](#) for CHCs to deliver value-based care outside of the PPS system.
- Authorized by [Senate Bill 184](#)

Maine

[Primary Care Plus](#)

- Provides a higher PMPM rate for comprehensive care; includes coordination, screenings, and care transition
- Practices required to do a needs assessment and develop a plan for providing CHW services, either through direct hiring or contracts/partnerships.

Idaho

[Healthy Connections](#)

- A medical home model that offers a higher PMPM payment to "Tier 2" and "Tier 3" medical homes, in which CHWs can be employed as part of the coordination team

Medicaid Health Homes APM and CHWs

States with Medicaid Health Homes can offer enhanced care coordination and management for Medicaid beneficiaries with complex needs. **CHW core roles align closely with the key services provided by Medicaid Health Homes, making CHWs a well-suited profession for implementation efforts.** Areas of service overlap are highlighted in **green** on the diagram (right).

West Virginia has incorporated CHWs in their health home model,

The Medicaid Health Home Model (HH) is distinct from the Patient-Centered Medical Home Model (PCMHs)

- HHs are specifically for **Medicaid beneficiaries with chronic illnesses**; PCMH can apply to the broader population.
- HHs focus on **person-centered, team-based care coordination with a strong focus on behavioral health and SDOH**, PCMH focuses on delivering comprehensive, patient-centered primary care to a broader population.
- Both models may exist in the same state.

Six Core Services of Medicaid Health Homes



Risks associated with traditional payment mechanisms used by Medicare and Medicaid

➤ The majority of CHWs aim to work as close to or within communities as possible, **yet traditional payment systems rely on hospital and clinic-focused billing mechanisms and can risk medicalizing CHWs in a range of ways.**

ASPECT OF SYSTEM

ASSOCIATED RISKS

Billing Codes

The codification of clinical and non-clinical services may miss many CHWs services, or broadly group multiple CHW services under the same code



- Organizations that employ CHWs may not deliver unbillable services, significantly limiting coordinated health activities, especially in the fee-for-service models
- There is less flexibility in paying for multiple services if they are grouped under broad categories
- Narrowed CHW scope, under-utilized skillset & decreased effectiveness

Payment Infrastructure

The current payment infrastructure requires filing claims for reimbursable services.



- CBOs/LHDs lack resources to file claims → can't participate in insurance structures
- CBOs unlikely to invest in building a billing infrastructure that allows CHWs to get reimbursed, given the capital and ongoing costs → shifts CHWs into clinical settings skewing job opportunities and wages away from community organizations

Limited/Traditional Evaluation

Funder evaluations focus on claims, referral, and clinical data, which do not comprehensively include CHW and SDOH-related process, output, and outcome metrics.



- Evaluations may underestimate the CHW's role in achieving outcomes
- Can create inaccurate interpretations of CHW outcomes and impact
- Can devalue closed-looped referrals + impact of resource availability on outcomes

CHWs and Medicaid Expansion

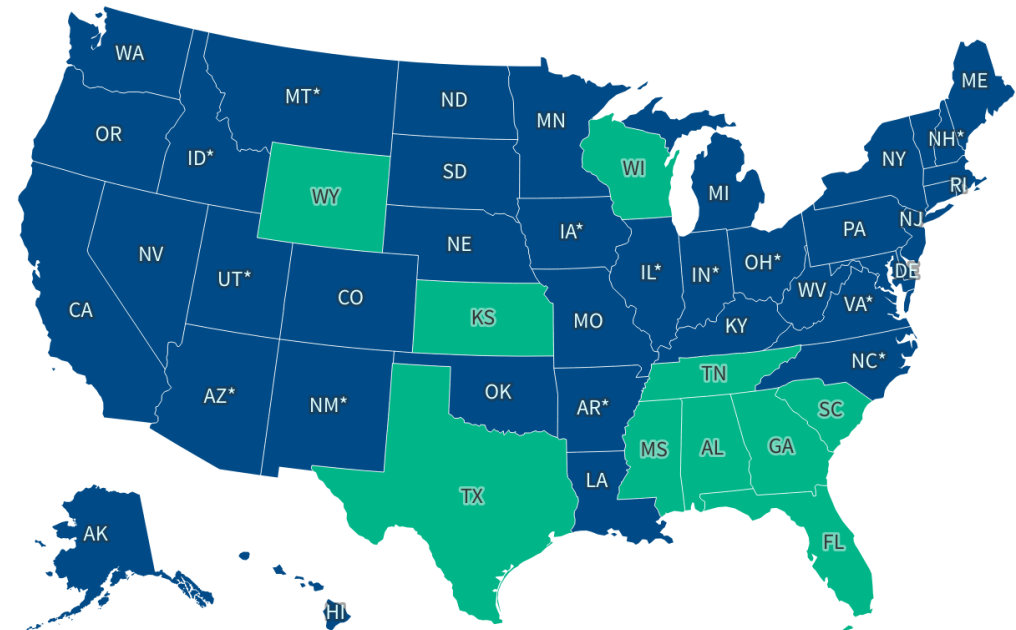
Medicaid expansion through the Affordable Care Act (ACA) extends Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level (\$20,120 for an individual in 2023) and provides states with an enhanced federal matching rate (FMAP) for their expansion populations.

Importantly, Medicaid expansion is a separate policy decision from Medicaid payment of CHWs, and it is possible for states to cover CHW services through Medicaid without expanding eligibility (and vice-versa).

Medicaid expansion will indubitably mean an increase in people who will need support in the Medicaid enrollment process. CHWs are in the perfect position to effectively educate individuals on benefits, assist them through enrollment, and start their screening process.

Status of State Medicaid Expansion Decisions, Feb 2026

■ Adopted and implemented (41 states including DC) ■ Not adopted (10 states)



Note: * State has a trigger law that would end expansion coverage or require states to take steps to mitigate increases in state costs if federal funding for the expansion is reduced.

Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion and Searing, Adam. "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States." Say Ahhh! Georgetown Center for Children and Families, November 27, 2024

<https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/>

Medicaid expansion can have a significant impact on clinical diagnosis and management

“Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions” – Health Affairs

The National Health and Nutrition Examination Survey examined the diagnosis and treatment of diabetes, hypercholesterolemia, and hypertension in relation to health coverage enrollment.

Conclusions

- Health insurance coverage was associated with higher rates of diagnosis of diabetes, hypercholesterolemia, and hypertension among nonelderly adults
- There was evidence of improved management and control of these conditions among those with coverage.

“Early Coverage, Access, Utilization, and Health Effects Associated With the Affordable Care Act Medicaid Expansions” – Annals of Internal Medicine

A study from the University of California compared changes in health insurance coverage, access to and utilization of medical care, and health for low-income adults in states that expanded their programs and those that didn't.

Conclusions

- An increase in insurance rates for low-income individuals was associated with more frequent use of care and increased rates of diagnosis of diabetes and high cholesterol.

State examples: CHW roles in Medicaid enrollment

Example: Nebraska

Nebraska's Department of Health and Human Services provided training sessions to CHWs so they can help individuals enroll in Medicaid.

Topics covered include:

- Eligibility criteria
- Coverage details
- How to explain why a person would want to enroll in Medicaid
- How to assist someone in enrolling in Medicaid
- How to share resources to answer questions regarding Medicaid enrollment

Nebraska does not currently have a formalized statewide infrastructure for CHWs, however they do have a [CHW Consultant-Trainer program](#) with 11 CHWs. They also distribute information to CHWs through this [website](#).

Example: Missouri

Health networks in Missouri have employed CHWs to help enroll individuals in Medicaid.

"HCC Network operates several health clinics throughout Missouri with [CHWs] who are available by appointment to assist with questions and applications...We'll help them through the application, we'll answer any questions they have, we'll get the application to the state, and we'll continue to follow through with it until there's a decision on the application...If there's any other information or proof they need to send in, we can help them with that"

"A [CHW], Georgia Rodgers, was added to the NOVUS Community Health and Outreach team. She is trained in Medicaid enrollment assistance and is also a Certified Application Counselor through [CMS]. She is currently conducting Medicaid outreach in Cape Girardeau and surrounding areas, the same community that she has resided in for 39 years."

Overview of Medicaid Work Requirements

On July 4, 2025, the budget reconciliation bill was signed into law, introducing several major changes to the Medicaid program—most notably, **the federal mandate for Medicaid work requirements**, which must be implemented by December 31, 2026.

Work Requirement Provisions

- Individuals ages 19-64 in ACA expansion group (or a waiver) are required to work or participate in qualifying activities for at least 80 hours/month to qualify for Medicaid
- Seasonal workers qualify if average monthly income meets the standard
- Exempts parents with children ≤ 13 and medically frail individuals.
- Requires verification of compliance for 1+ consecutive months preceding the month of application and 1+ months between eligibility redeterminations
- Bars individuals who are noncompliant with work requirements from accessing subsidized Marketplace coverage.
- Allocates \$200M to states and \$200M to HHS for FY 2026 implementation support.
- Allows the Secretary to exempt states until December 31, 2028, if the state is demonstrating a good faith effort to comply

Example: Arkansas & Medicaid Work Requirements

In 2018, Arkansas's Medicaid work requirement led to over 18,000 disenrollments by the end of the year. A 2019 [NEJM](#) and a [2025 HSR study](#) both concluded that the policy failed to increase employment and contributed to a higher uninsured rate among eligible populations

Key challenges/issues included :

- High administrative burden
- Communication failures
- Confusion about requirements
- Difficulties with the reporting system
- Literacy barriers
- Low success rates in reaching enrollees

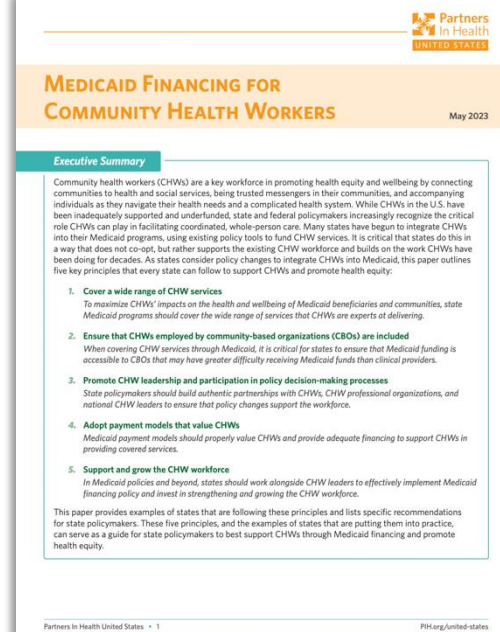
Given their ability to build trust and navigate complex social contexts, CHWs are well-positioned to assist with the communication, literacy, and engagement challenges associated with implementing work requirements.

PIH-US Resources on Medicaid Financing and CHWs

In 2023, PIH-US published a policy paper and two briefs on CHW Medicaid Financing that focus on how state Medicaid agencies can work with organizations to incorporate CHW roles into payment systems.

PIH Policy Paper [Medicaid Financing for CHWs](#)

Accompanying Blog Post [PIH Accompanying Blog Post](#)



PIH Policy Briefs

- [Using Medicaid to finance CHWs based within CBOs](#)
- [Using Medicaid funds to support a broad scope of work for CHWs.](#)



PIH-US Policy Paper: Medicaid Financing for CHWs



“Medicaid Financing for Community Health Workers”

- Aims to actively contribute to supporting sustained investments in community health workers by recognizing their value, preserving what makes them unique and effective, and promoting community health worker leadership in policy-making processes.
- Examines best practices from states and recommends five key principles that every state can follow to fund community health workers through Medicaid and promote health equity.
- Provides key reference information for PIH-US and our partners and can be used for advocacy.
- Informed by our work with community health workers around the world and in the U.S., as well as by national partners and experts.

[Link to Paper](#)
[Link to Blog Post](#)

MEDICAID FINANCING FOR COMMUNITY HEALTH WORKERS

May 2023

Executive Summary

Community health workers (CHWs) are a key workforce in promoting health equity and wellbeing by connecting communities to health and social services, being trusted messengers in their communities, and accompanying individuals as they navigate their health needs and a complicated health system. While CHWs in the U.S. have been inadequately supported and underfunded, state and federal policymakers increasingly recognize the critical role CHWs can play in facilitating coordinated, whole-person care. Many states have begun to integrate CHWs into their Medicaid programs, using existing policy tools to fund CHW services. It is critical that states do this in a way that does not co-opt, but rather supports the existing CHW workforce and builds on the work CHWs have been doing for decades. As states consider policy changes to integrate CHWs into Medicaid, this paper outlines five key principles that every state can follow to support CHWs and promote health equity:

1. Cover a wide range of CHW services

To maximize CHWs' impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.

2. Ensure that CHWs employed by community-based organizations (CBOs) are included

When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers.

3. Promote CHW leadership and participation in policy decision-making processes

State policymakers should build authentic partnerships with CHWs, CHW professional organizations, and national CHW leaders to ensure that policy changes support the workforce.

4. Adopt payment models that value CHWs

Medicaid payment models should properly value CHWs and provide adequate financing to support CHWs in providing covered services.

5. Support and grow the CHW workforce

In Medicaid policies and beyond, states should work alongside CHW leaders to effectively implement Medicaid financing policy and invest in strengthening and growing the CHW workforce.

This paper provides examples of states that are following these principles and lists specific recommendations for state policymakers. These five principles, and the examples of states that are putting them into practice, can serve as a guide for state policymakers to best support CHWs through Medicaid financing and promote health equity.

PIH-US CHW Financing Policy Paper: Recommendations for states

The PIH policy paper “*Medicaid Financing for CHWs*” discusses five principles for state Medicaid agencies to consider when trying to design CHW financing policies:

1. Cover a wide range of CHW services

To maximize CHWs’ impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.

2. Ensure that CHWs employed by community-based organizations (CBOs) are included

When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers

3. Include CHWs in policy decision making processes

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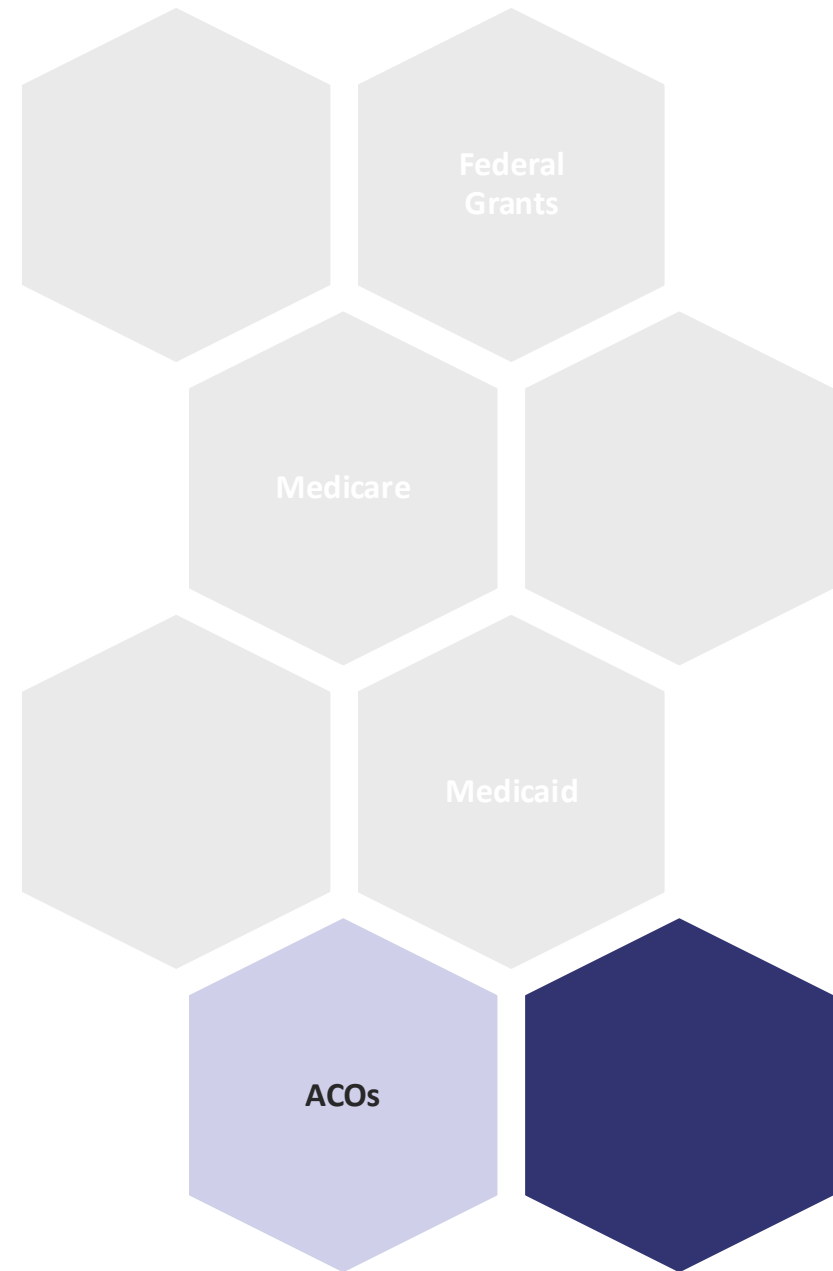
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Organization of the paper

- Discusses the context behind the principles
- Describes how states can implement each principle
- Shows two state examples for each principle
- Gives specific policy recommendations for each principle

Key concepts in CHW financing

Accountable Care Organizations (ACOs)



Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers who voluntarily form partnerships to collaborate and share accountability for the quality and cost of care delivered to patients. Both Medicare and Medicaid can have ACOs.

- ACOs are a natural employer of CHWs given their attention to addressing the SDOH through primary care and care coordination.
- The goal of ACOs is to simultaneously improve health and patient experiences, and to reduce per capita costs.
- ACOs must have a strong primary care foundation, and may integrate other specialists, hospitals, nursing homes, etc. to promote a high degree of care coordination.
- When an ACO succeeds in both delivering high-quality care and efficiently spending health care dollars, it shares in the savings it achieves.
- ACOs may be interested in working with Medicare or Medicaid, although it is primarily a Medicare model. [Here are a list of states that have Medicaid ACO activities.](#)

ACOs are paid based on the risk model they commit to (upside only or upside/downside)

Upside Only Risk

If quality and patient satisfaction are maintained or improved and there are savings relative to the predicted costs, approximately 50 percent of the savings is paid to the ACO.

This encourages ACO participants to keep patients in good health, and if ill, to provide optimal care through a team-based approach.

Upside and Downside Risk

Health care professionals receive shared savings for managing costs and hitting quality and satisfaction benchmarks but will also be liable for expenses that exceed the Medicare spending budget.

CMS is moving towards more ACO programs that have this two-sided risk structure.

Accountable Care Organizations (ACOs) Risk Models

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ACOs must have a strong primary care foundation, and may integrate other specialists, hospitals, nursing homes, etc. to promote a high degree of care coordination.

ACOs and SDOH

In 2022, the [Institute of Accountable Care interviewed 14 ACOs](#) on the opportunities and challenges they saw in addressing SDOH. Of note, employing CHWs was not mentioned in their discussion, signaling a need for more education on this essential workforce.

Findings from Institute of Accountable Care Roundtables

- Stated the importance of SDOH but have not yet figured out how to fully assess for them or how to comprehensively address them.
- Recognize the need for flexibility in how SDOH are screened, and the need for multiple access points.
- Have started to ideate on avenues for connecting, partnering, and/or referring to CBOs.
- Identified closed loop communication as an important factor in determining if SDOH needs are being met.

Comments on Sustainability Challenges

- Identified the strengths and limitations of community partners
- Recognized importance of limiting unnecessary reporting
- Agreed on the importance of mutual decision making with partners
- Discussed their own role in helping organizations make a business case for social services by sharing their data, facilitating relationships with health plans through their well-established relationships with payers, considering funding CBOs directly, and helping organizations get hospital community benefit dollars from their affiliated hospitals.

Medicare-like ACO programs have been implemented for Medicaid beneficiaries

Several states are leveraging State Innovation Model (SIM) awards to implement Medicaid ACO-like organizations.



Massachusetts

- The ACO contracts with an MCO to create a full network of care that includes primary care, specialists, behavioral health, and hospitals or the groups of primary care providers coordinate the full range of services for beneficiaries by working with a network of specialists and hospitals.
- Began to pay for health-related nutrition and housing supports beginning in 2020, referred to as Flexible Services.
- Many of the ACOs with the Medicaid program are also Medicare ACOs and many also serve privately insured patients. This effort is part of a comprehensive restructuring of MassHealth through ACOs with shared savings and mandatory but limited downside risk.



Minnesota

- Minnesota's statewide ACO programs for Medicaid are called Integrated Health Partnerships (IHP). This program changed focus to move to accountable care processes with shared savings payment for physical, behavioral, and pharmacy care that includes quality measurement.
- Managed care organizations are required to work with IHPs, but the IHPs serve all Medicaid patients in the state regardless of whether they receive benefits through fee for service or managed care.

Colorado, Connecticut, Delaware, Idaho, Iowa, Maine, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont are also exploring and implementing Medicare-like ACOs for Medicaid beneficiaries.

Financing options through Medicaid ACOs are similar to the options available to Medicaid MCOs

Financing Opportunities by Employer Type



Health Providers, Health Practices, Community Health Centers, Hospitals

- Clinical entities can directly participate in ACOs using either operating funds or value-based payments to cover the cost of CHWs.
- They contract with other ACOs so CHWs can provide supportive services to attributed Medicare enrollees.



Community Based Organizations

- CBOs can contract with ACO/health provider for CHWs to provide supportive services to attributed Medicare members.
- Contract with participating Medicare health providers for fee-for service reimbursement for "[incident to](#)" payments.

Blending and Braiding to Finance CHW Services

States should explore a range of long-term financing strategies, considering a blended and braided model that leverages both public and private funding sources. This approach helps balance the limitations of one funding stream with the strengths of another, creating a more sustainable and resilient financing structure.

Blending refers to the process of combining dollars from various funding sources into a single pool of funds. In this approach, the individual funding identities dissolve and the funds are used collectively toward a shared objective.

Braiding involves using multiple funding streams concurrently to support a specific service, while each source retains its distinct identity. This approach typically demands strong coordination and collaboration among grant leads to ensure aligned efforts, comprehensive monitoring and evaluation, and progress toward a shared goal.



Example: Braiding Approaches for SDOH with Medi-Cal

In a recent [publication](#) by the Center for Health Care Strategies (CHCS), several organizations receiving Medi-Cal funding outlined their approaches to braiding financial resources to support the delivery of care addressing (SDOH), including CHW services. The three examples presented below demonstrate how blended and braided financing strategies can effectively sustain and scale CHW programs.

Approach #1: Single Funding Source Staffing

- Braids in one funding source to provide a set of services to one type of client.
- The team employed to provide this set of services is all paid through reimbursements from this single source

Approach #2: Single Client, Single Source Braiding

- Multiple funding sources support the same program, but each individual client's services are billed to only one of the funding sources

Approach #3: Sequencing

- Integrated funding sources providing sequential delivery of distinct services to the same client base and staffed by the same team."

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[Health Systems Integration](#)

[Return on Investment Calculations for CHW Programs](#)

[CHWs and the Aging Population](#)

[State by State Comparison](#)

[Appendix \(Evidence Deep Dive\)](#)

CHWs and Medicaid Expansion

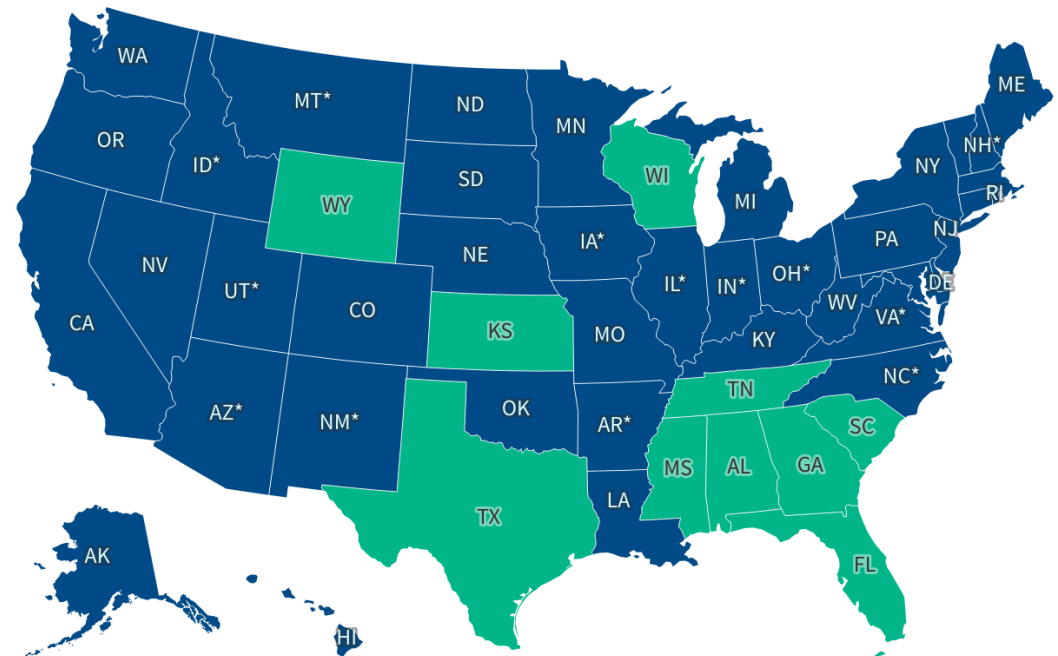
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■ Adopted and implemented (41 states including DC) ■ Not adopted (10 states)



Note: * State has a trigger law that would end expansion coverage or require states to take steps to mitigate increases in state costs if federal funding for the expansion is reduced.

Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion and Searing, Adam. "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States." Say Ahhh! Georgetown Center for Children and Families, November 27, 2024

<https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/>

Medicaid expansion can have a significant impact on clinical diagnosis and management

“Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions” – Health Affairs

The National Health and Nutrition Examination Survey examined the diagnosis and treatment of diabetes, hypercholesterolemia, and hypertension in relation to health coverage enrollment.

Conclusions

- Health insurance coverage was associated with higher rates of diagnosis of diabetes, hypercholesterolemia, and hypertension among nonelderly adults
- There was evidence of improved management and control of these conditions among those with coverage.

“Early Coverage, Access, Utilization, and Health Effects Associated With the Affordable Care Act Medicaid Expansions” – Annals of Internal Medicine

A study from the University of California compared changes in health insurance coverage, access to and utilization of medical care, and health for low-income adults in states that expanded their programs and those that didn't.

Conclusions

- An increase in insurance rates for low-income individuals was associated with more frequent use of care and increased rates of diagnosis of diabetes and high cholesterol.

State Example: Michigan's Enrollment Assisters

Although Medicaid can significantly improve a person's health, barriers to enrollment can deter people from joining. **CHWs are perfectly positioned to be [enrollment assisters](#), because they have the skills, trust, and connections necessary to reach newly eligible individuals** from marginalized and under-resourced communities.

Example: Michigan Primary Care Association (MPCA) Enrollment Assisters

MPCA assessed the similarities between the activities of an enrollment assister and a CHW utilizing the Community Health Worker Core Consensus (C3) Project list of CHW core roles. **They found commonalities in all ten core CHW roles, demonstrating the potential to strengthen Medicaid expansion outreach through cross-training the CHW and enrollment assister workforces.** Several health centers in Michigan have embraced the cross-training model and employed enrollment assisters to meet the increased demand for enabling services.

MPCA provides a range of resources and assistance to support this shift in activities, including:

- **data tracking tools** that allow enrollment assisters to capture referrals and applications for services and supports beyond health coverage,
- **health coverage literacy training** for CHWs
- broad training on enabling services and **networking opportunities** for enrollment assisters and CHWs.

State examples: CHW roles in Medicaid enrollment

Example: Nebraska

Nebraska's Department of Health and Human Services provided training sessions to CHWs so they can help individuals enroll in Medicaid.

Topics covered include:

- Eligibility criteria
- Coverage details
- How to explain why a person would want to enroll in Medicaid
- How to assist someone in enrolling in Medicaid
- How to share resources to answer questions regarding Medicaid enrollment

Nebraska does not currently have a formalized statewide infrastructure for CHWs, however they do have a [CHW Consultant-Trainer program](#) with 11 CHWs. They also distribute information to CHWs through this [website](#).

Example: Missouri

Health networks in Missouri have employed CHWs to help enroll individuals in Medicaid.

"HCC Network operates several health clinics throughout Missouri with [CHWs] who are available by appointment to assist with questions and applications...We'll help them through the application, we'll answer any questions they have, we'll get the application to the state, and we'll continue to follow through with it until there's a decision on the application...If there's any other information or proof they need to send in, we can help them with that"

"A [CHW], Georgia Rodgers, was added to the NOVUS Community Health and Outreach team. She is trained in Medicaid enrollment assistance and is also a Certified Application Counselor through [CMS]. She is currently conducting Medicaid outreach in Cape Girardeau and surrounding areas, the same community that she has resided in for 39 years."

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CHW integration: Federally Qualified Health Centers (FQHCs)

FQHCs are federally designated community clinics meeting strict requirements to provide primary and preventive care. They are ideal settings for CHWs to connect individuals to the health system. *Of note*, although sometimes used interchangeably, “Community Health Center (CHC)” is a broader term for any community-based provider serving underserved populations, regardless of FQHC status.

CHWs roles in FQHCs can include health screenings, patient education, resource referrals, coordinating transportation, community outreach, follow-up after clinic visits, and patient’s enrollment into insurance programs, among many other activities.

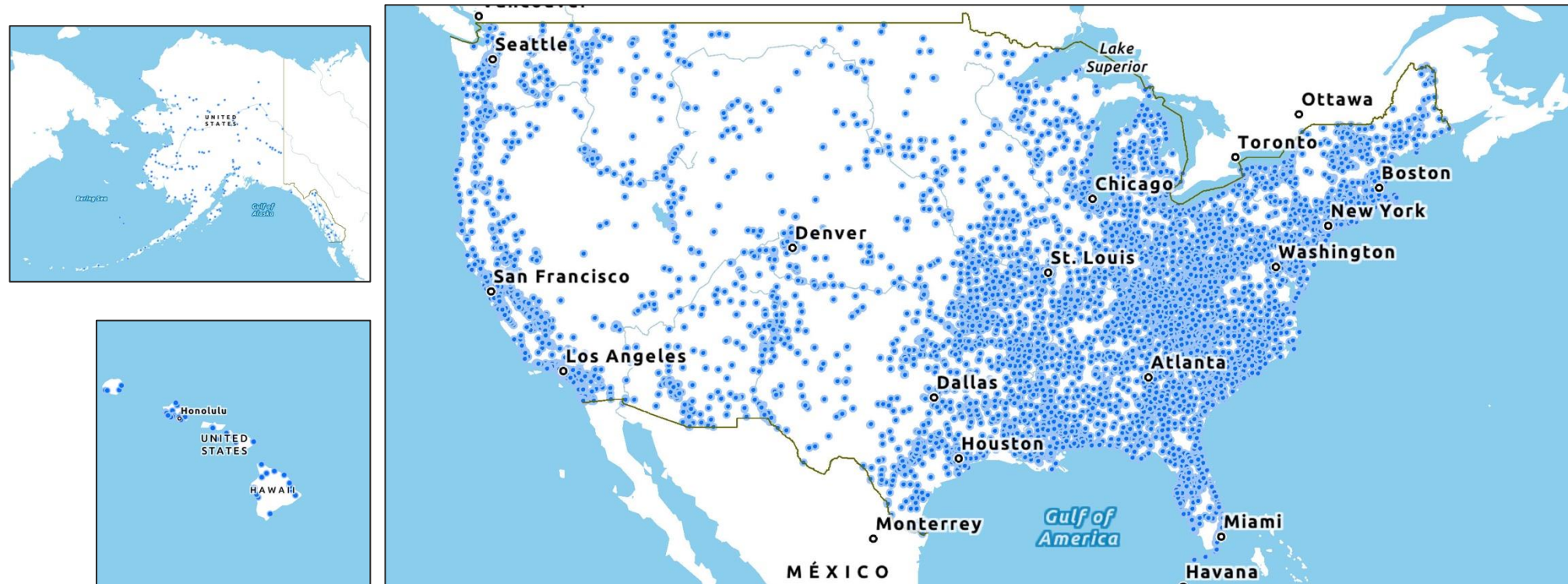
Integrating CHWs into these settings requires understanding roles and team dynamics, existing financing and payment mechanisms, and potential opportunities to unlock funding to make CHW employment in FQHCs attractive and sustainable.

This section provides background on FQHCs and explores opportunities to integrate CHWs into FQHC teams, operations, and funding structures.

CHW integration into Federally Qualified Health Centers (FQHCs)

Across the country, there are 1,383 official Federally Qualified Health Centers (FQHCs), operating a total of 17,566 service sites. In addition, there are 149 FQHC look-alikes manage 591 service sites. In total, the number of FQHC-related health centers and service sites to approximately 19,689 nationwide.

Distribution of HRSA health-delivery sites across the United States (2025)



FQHCs provide primary and preventive care to communities with underserved populations

FQHC is a federal designation by the Health Resources & Services Administration (HRSA). They are public or private nonprofit health care organizations that meet certain criteria under the Medicare and Medicaid Programs and receive funds under Section 330 of the Public Health Service Act.

There are four key components that define an FQHC and help them serve underserve communities:

Located in areas of high need

Provide a comprehensive set of services including medical, dental, vision, behavioral health, and enabling services.

Open to everyone, regardless of insurance status or ability to pay, and offer sliding fee scale options to low-income patients

Governing board that is at least 51% patients.

Which facilities may be an FQHCs?

- Community health centers (CHCs)
- Migrant health centers
- Health care for the homeless health centers
- Public housing primary care centers
- Outpatient health programs or facilities operated by a tribe, tribal organization, or by an urban Indian organization

*CHC “look-alikes” provide same sort of services as FQHCs but did not receive a Section 330 grant from the Public Health Service Act

FQHCs work within a federal payment structure called the Prospective Payment System (PPS)

Under PPS, FQHCs are paid a **predetermined rate** that encompasses reimbursement for all services provided during a single visit, adjusted annually for inflation.



The PPS rate structure is designed to provide **financial certainty and reduce the incentive to deliver unnecessary health care services** as can occur through fee-for-service systems.



PPS can be **restrictive and encounter-based**. An FQHC can only receive the PPS money if certain criteria are met during the encounter.



PPS Eligibility Criteria for Patient Encounters

1. The service is provided **within the four walls** of a clinic.
2. The service is defined as an **allowable encounter/ set of services** as defined under PPS.
3. Only **one billable service is provided to a patient per day** (with the exception that a medical visit and a dental visit can be provided on the same day).
4. The service is **rendered by a billable provider** type.

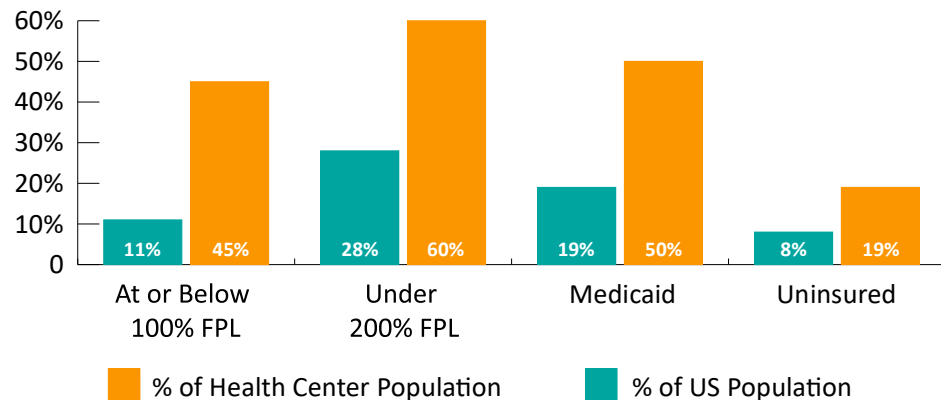
Medicaid MCOs and FQHCs

MCOs have the flexibility to set their own rates for FQHC payments but must pay the FQHCs no less than they would other contracted entities for similar services. If the total payment to an FQHC is less than the PPS amount, the state must pay the difference quarterly through a reconciliation process and supplemental payment (called a wraparound payment).

Populations served by CHCs/FQHCs largely overlap with those that work with CHWs

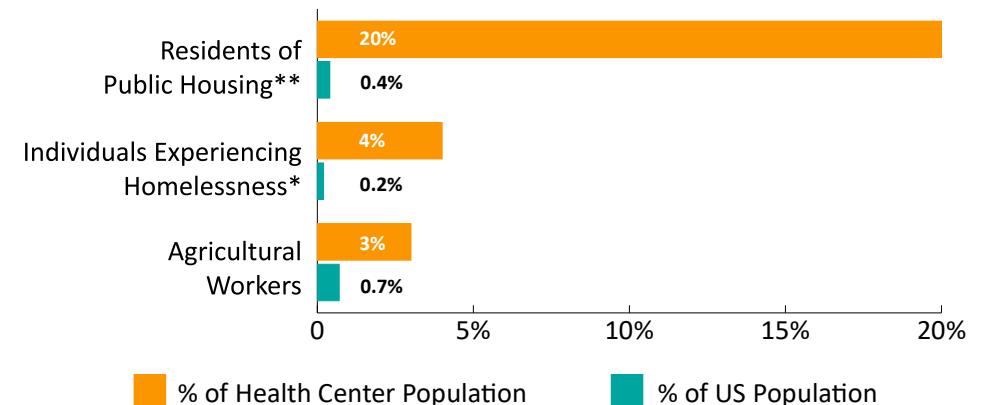
CHCs are in under-resourced areas and have a service population that largely overlaps with the communities served by CHWs. 60% of CHC patients live under 200% of the federal poverty level. **CHWs are the optimal workforce to help bridge CHC patients to community services, or conversely, connect community members to their local CHC.**

CHC Demographics, Income and Insurance Distribution



Note: FPL = Federal Poverty Level was \$13,590 per year for an individual in 2022. * Medicaid alone and not in combination with other insurance.
 Sources: (1) 2022 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.
 (2) U.S. Census Bureau, 2022 American Community Survey 1-Year Estimates, Tables S1701, S2704, S2701

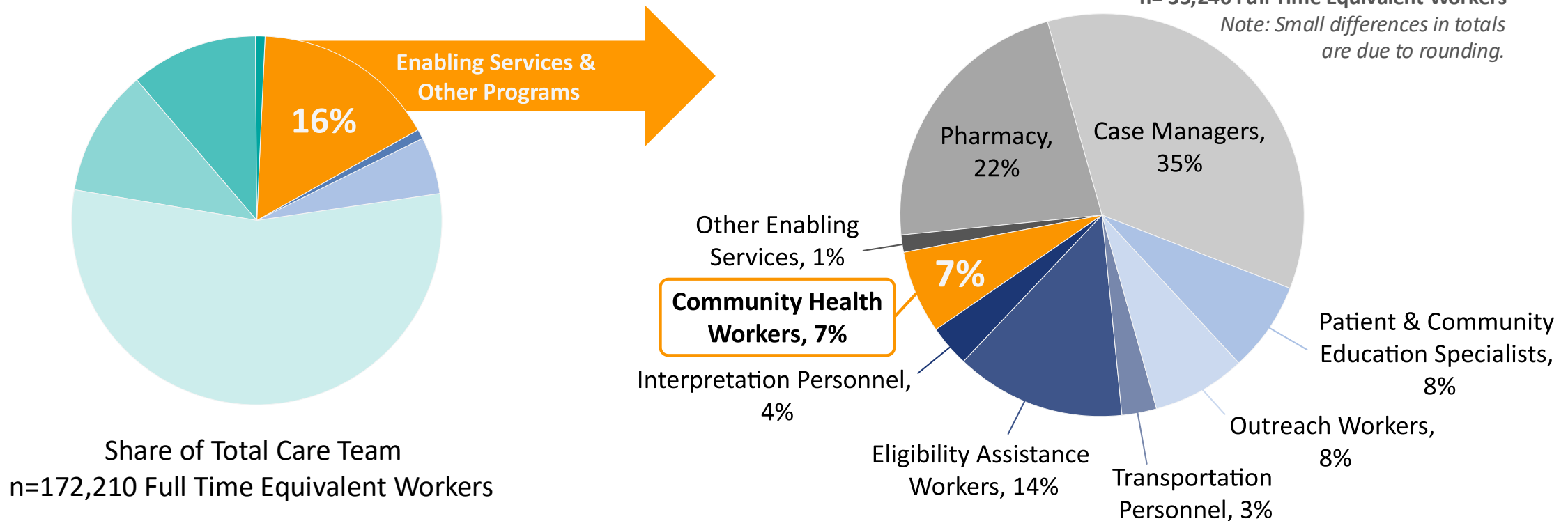
Health Centers Serve a Disproportionate Share of Populations with Complex Needs



Sources: (1) 2022 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. (2) Findings from the National Agricultural Workers Survey (NAWS). Agricultural-Worker Population Estimates. (3) U.S. Department of Housing and Urban Development. The 2022 Annual Homeless Assessment Report (AHAR) to Congress, December 2022. (4) U.S. Department of Housing and Urban Development. Assisted Housing Dataset, 2022 Based on 2010 Census.
 *Number of individuals experiencing homelessness in the US reflects the point-in-time analysis.
 **Health center population defined as public housing patients includes all patients served at a health center located in or immediately accessible to a public housing site. National data includes the total number of people receiving housing assistance, including dependents, from all relevant HUD programs.

CHWs currently make up 7% of the CHC “Enabling Services” staff

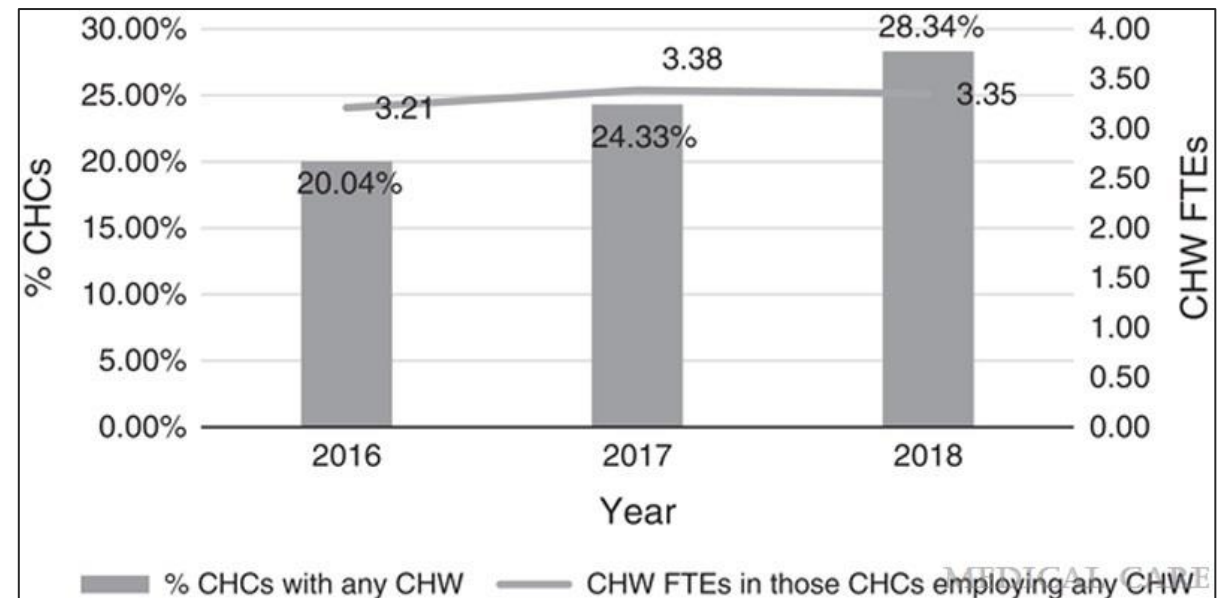
➤ Out of the 16% full-time staff who work on “enabling services”, approximately 7% are currently CHWs. Enabling services are defined as non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes.



An increasing proportion of CHCs are employing CHWs to work with their patients

- Data from the FQHC Uniform Data System shows that the **proportion of CHCs that reported working with CHWs increased** from 20.04% in 2016 to 28.34% in 2018 (average growth rate of 41%)
- Compared to CHCs without CHWs, since 2016, **CHCs with CHWs tended to serve more Black, Hispanic, and Medicaid patients**, as well as patients with special needs such as limited English proficiency, HIV diagnosis, and substance use disorder
- **CHCs that employed CHWs relied more on foundations/private grants**, while CHCs without CHWs rely more heavily on HRSA BPHC grants
- CHCs with CHWs tend to be in **urban areas** and in states with an approved DSRIP program

CHWs in CHCs, 2016–2018



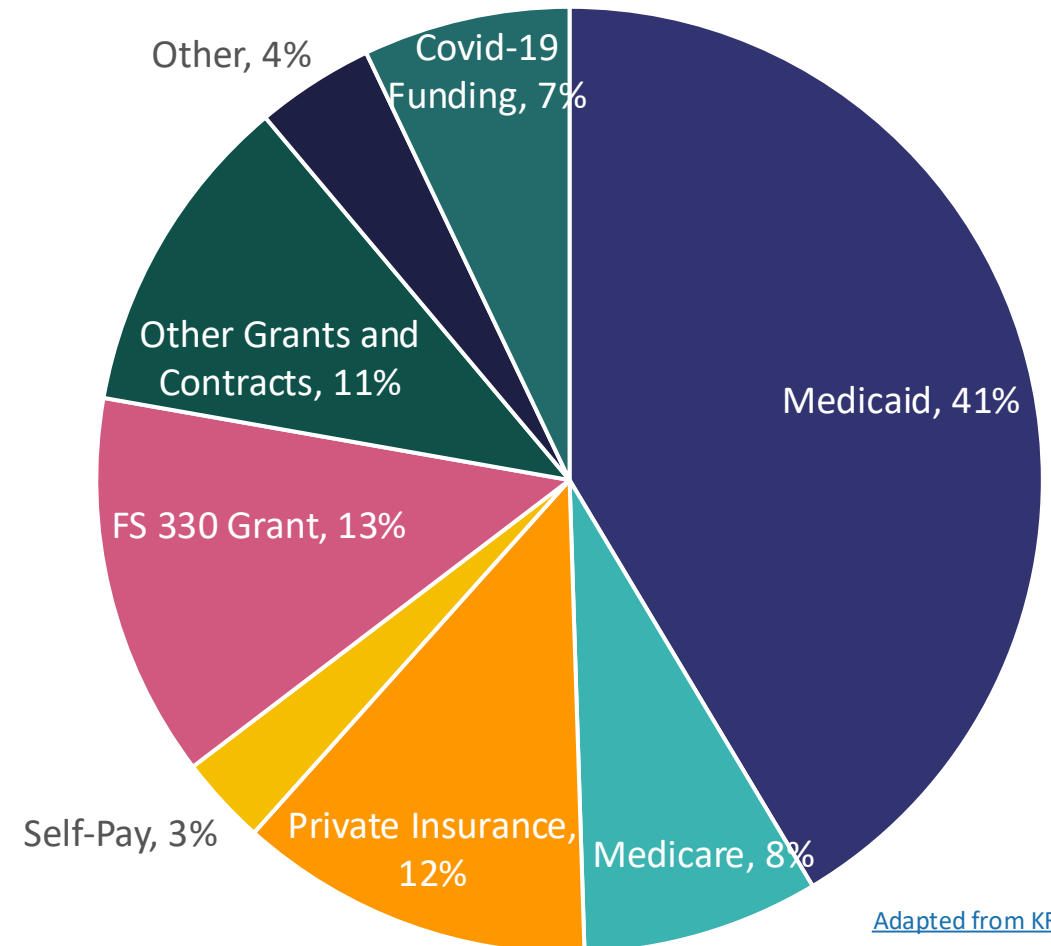
The percentages of CHCs with any CHW FTEs are shown for years 2016, 2017, and 2018 in the bar graph. Among the percentages of CHCs with any CHW FTEs, the actual CHW FTEs are shown in line.

Source: Crespo R, Christiansen M, Tieman K, Wittberg R. An emerging model for community health worker–based chronic care management for patients with high health care costs in rural Appalachia. *Prev Chronic Dis.* 2020;17:E13. doi:10.5888/pcd17.190316. [Link](#)

States and FQHCs have found ways to supplement or modify the PPS to allow for more flexibility and potential funding for CHWs

- States have **some flexibility in the scope of services** considered in the PPS rate development calculation and must have a process to adjust PPS rates to reflect changes to the scope of services provided by the FQHC.
 - [HRSA 330 grants](#) allow CHW expenses to be considered “enabling services”.
 - Some states use a higher annual inflation rate when setting PPS rates.
 - Other states use an “enhanced” PPS rate whose supplemental payments incentivize FQHCs to provide specified services, such as case management.
- FQHCs may file a claim for both a PPS encounter and for additional Medicaid-covered services that are not included in the PPS rate.
- Some FQHCs may pay for additional or ancillary services using a different methodology. The chart on the right shows the diversity of funding sources used by FQHCs in 2021.

CHC (Including FQHCs) Funding Sources Nationwide , 2021



Adapted from KFF

*Does not include Look-Alikes

State example: Louisiana's Medicaid SPA supports payment for CHW services through the FQHC PPS

In 2022, Louisiana passed a SPA to support CHW reimbursement based on an alternative payment methodology (APM), allowing for reimbursement outside of the current PPS rate for CHW services provided in FQHC and rural health center settings.

The CHW services must be related to a specified chronic disease, documented unmet SDOH need, or pregnancy.

LA SPA Reimbursement Eligibility Qualifications

- CHWs must have completed a state-recognized training curriculum approved by the Louisiana CHW Workforce Coalition, or provided 3,000 hours of documented work experience as a CHW
- The supervising provider must maintain documentation of CHW qualifications
- The activities must relate to the diagnosis of one or more chronic health conditions including behavioral health, documented or suspected unmet health-related social need, or pregnancy

- Reimbursement will be based on published salary information, including benefits, and administrative overhead.
- One CHW salary is approximately \$42,000, based on the Bureau of Labor Statistics data.
- Individual and group services are both allowed; scope to bill for group activities.

CHW Integration Across the Health System: From Community to Tertiary Care

CHWs play an essential role across the health system—from assisting individuals in community organizations to address upstream drivers of health, to supporting patients in tertiary care facilities by helping them understand their conditions and coordinating their safe transition back to the community. **For CHWs to effectively accompany individuals throughout their health journey, strong linkages between health systems and the community are critical.**

Over the past decade, new frameworks have emerged to better integrate community and clinical care, positioning CHWs as vital connectors beyond traditional health systems and emphasizing whole-person care as a central goal.

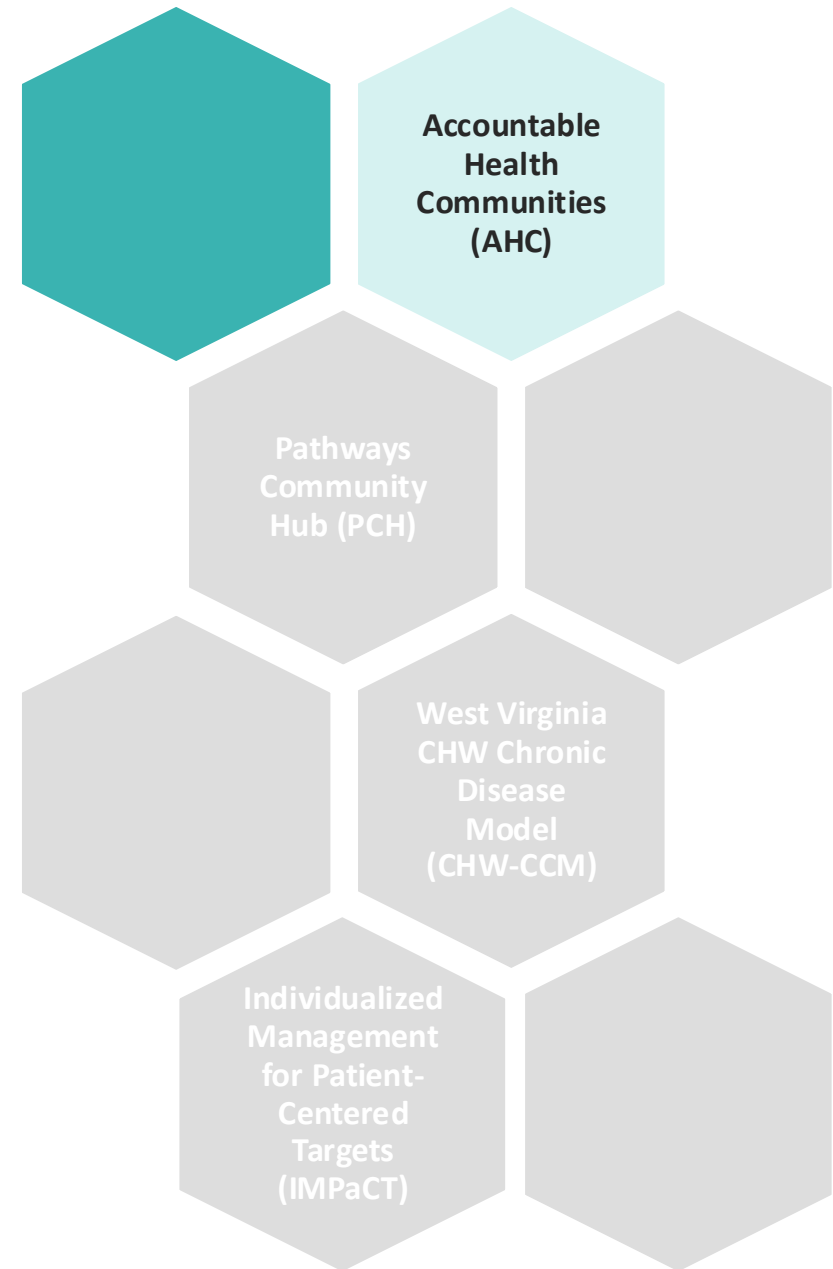
This section explores four different models integrating CHW initiatives across various components of the health and hospital system.

Example 1: Accountable Communities for Health (ACH/AHC)

Accountable Communities for Health or [Accountable Health Communities](#) integrate prevention and public health with health care and SDOH to improve health outcomes, reduce costs, and provide whole-person care.

Many states and local communities currently are or have previously implemented and tested elements of Accountable Communities for Health in their health initiatives.

The Funders Forum on Accountable Health has a catalog of ACH and ACH-like initiatives across the US that can be found [here](#).



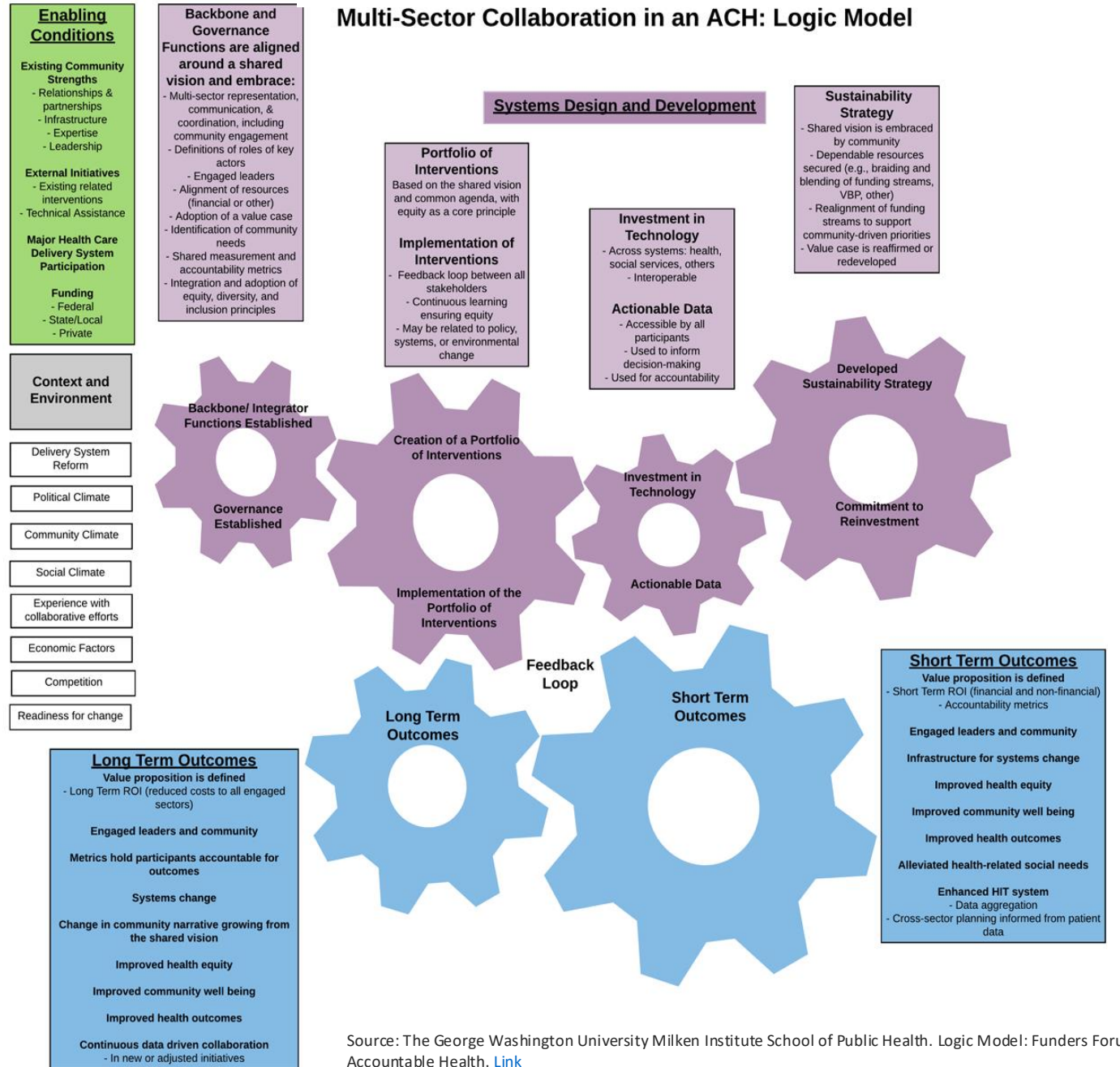
AHCs are guided by 10 principles/features

1. A **“backbone” organization** which serves as convener and integrator for a defined geographic area - may or may not serve as a fiduciary agent
2. A **governance structure** with respected community leaders, which builds on a history of collaboration in addressing the health of the community while engaging diverse consumer perspectives.
3. Effective **cross-sector alignment** among health care providers, health plans, public health, community and social services, education, business and labor.
4. An **actively engaged group of community leaders and stakeholders** to establish a shared vision, goals, and agenda, with full community engagement in decision making regarding use of resources and investment in community capacity for shared decision-making.
5. A strong **community-focus**, although may emphasize vulnerable/marginalized populations.
6. **Aligned data systems** that emphasize accessible data with accountability indicators across sectors and participants for planning, coordination of care and services across a continuum of health and social determinants, and for QI and evaluation.
7. A **business case** and return on investment defined for all sectors engaged.
8. Effective **collaboration** across all participating organizations.
9. Multiple funding sources for **sustainability**.
10. Quality improvement and **continuous learning**.

Logic Model for Multi-Sector Collaboration in an AHC

This logic model created at the George Washington University illustrates how the 10 principles in AHCs work together.

The gears illustrate the interconnected ways that **enabling conditions, environmental context, systems design and development, and short- and long-term outcomes interact** to drive continued learning in accountable health initiatives.



Multi-Sector Collaboration in an ACH: Logic Model

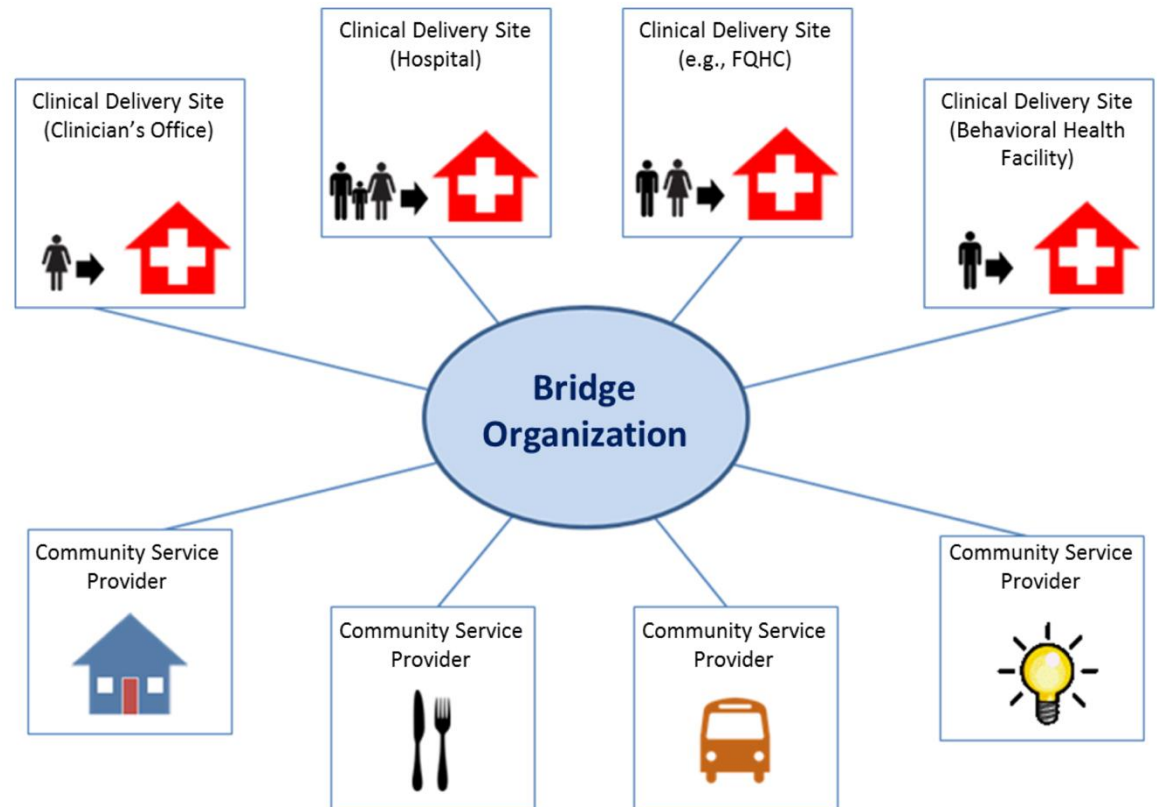
The Center for Medicaid and Medicare Services Innovation (CMMI) AHC model

CMS funded a five-year innovation program between May 2017- April 2022 that tested whether systematically identifying and addressing health-related social needs of Medicare and Medicaid beneficiaries through AHCs would impact total health care costs and utilization.

Program Design

CMS funded bridge organizations to serve as “hubs”, which were responsible for coordinated efforts to:

- **Identify and partner** with clinical delivery sites
- Conduct systematic health-related social needs (HRSN) screenings and make referrals
- **Coordinate and connect** community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
- **Align model partners to optimize community capacity** to address health-related social needs



Key Features of the CMMI AHC Model

Service provision occurred along three tracks or pathways (below), each with a specific evaluation approach.

Track 1: Awareness

- Increase beneficiary awareness of available community services through information dissemination and referral

Track 2: Assistance

- Provide community service navigation services to assist high-risk beneficiaries with accessing services

Track 3: Alignment

- Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet HRSN (required of all organizations)
- **Creation and maintenance of a resource inventory** of available community services and community service providers to address each of the domains included in the screening tool
- Testing the **effectiveness of referrals** to increase beneficiary awareness of community services using a rigorous mixed method evaluative approach
- Testing **the effectiveness of community services navigation** to aid beneficiaries in accessing services using a rigorous mixed-method evaluative approach
- **Partner alignment** at the community level and implementation of a quality improvement approach to address beneficiary needs

The role of CHWs in the CMMI AHC model

- AHC activities such as screening, navigating, and bidirectional communication, **rely on staff like CHWs** to facilitate linkage to care among health systems and community organizations.
- To implement AHC programming, most sites used a combination of existing staff and newly hired **screening staff, including CHWs**.
- Hiring dedicated screening staff **increased clinical site participation** by reducing burden among existing staff but also led to **decreased awareness among** clinicians of the health-related social needs (HRSN) screening results - either because the results were not part of the health record system, or they were not reviewed by the clinicians.
- To improve HRSN navigation, sites used warm hand-offs to pass information to clinicians after screening, **employed CHWs as navigators**, and supported beneficiaries using such techniques as motivational interviewing and trauma-informed approaches.

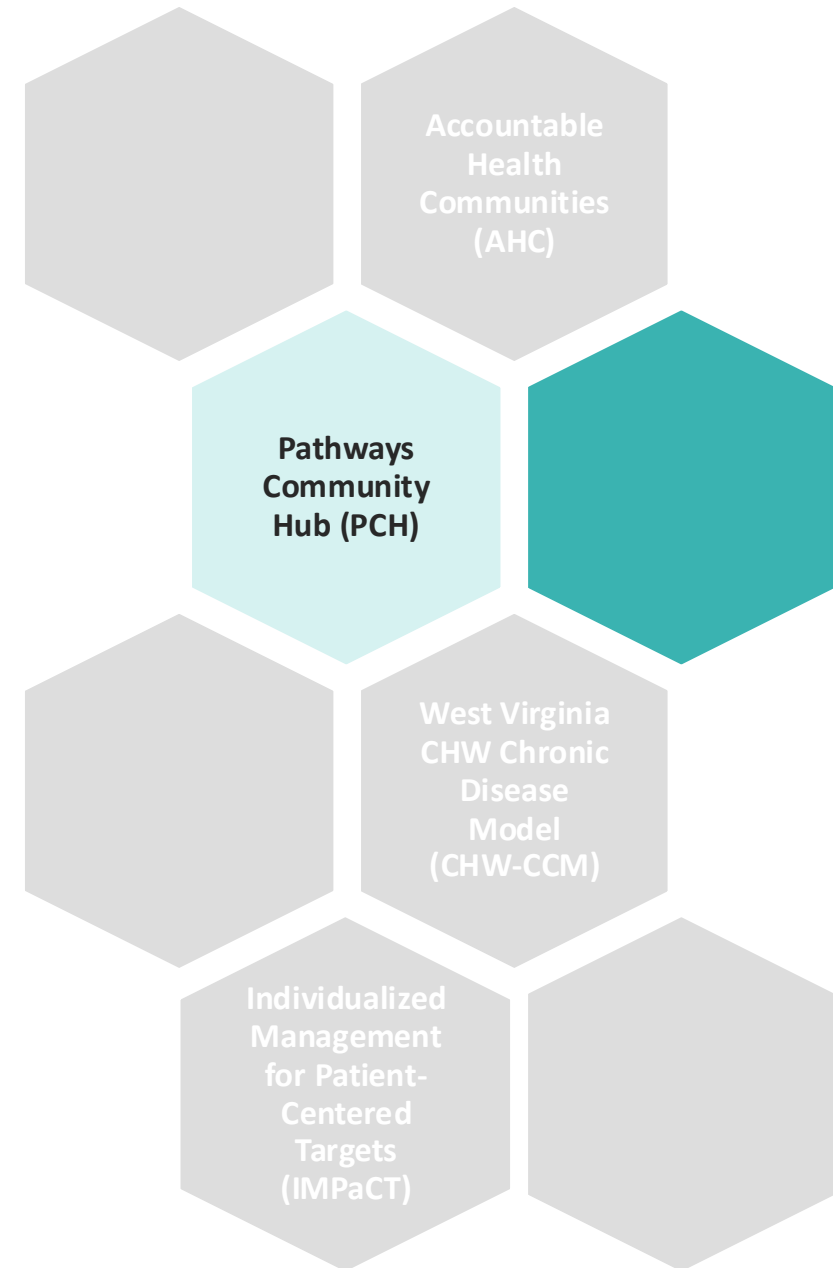
Rocky Mountain Health Plans, New Mexico

- Rocky Mountain partners with five regional organizations, known as community leads, to improve partner engagement and accountability.
- Rocky Mountain recognized that **the HRSN screening staff had needs themselves**. To support screening staff, Rocky Mountain provides gift-card incentives to staff who meet mutually agreed-upon screening goals.
- To sustain efforts to address HRSN, community leads highlighted the **importance of providing front-desk staff with training and career growth opportunities, in addition to higher pay**.

While CHWs can be valuable members of AHC teams, the usual challenges in pay, career pathways, information sharing, and data accessibility were persistent and would still need to be addressed.

Example 2: Pathways Community HUB (PCH)

“A **Pathways Community HUB (PCH)** is an organized, outcome focused, pay for performance **network of community-based organizations that hire and train community health workers (CHWs)** to reach out to those at greatest risk, identify risk factors and barriers, and assure connections to medical, social, and behavioral health services.”



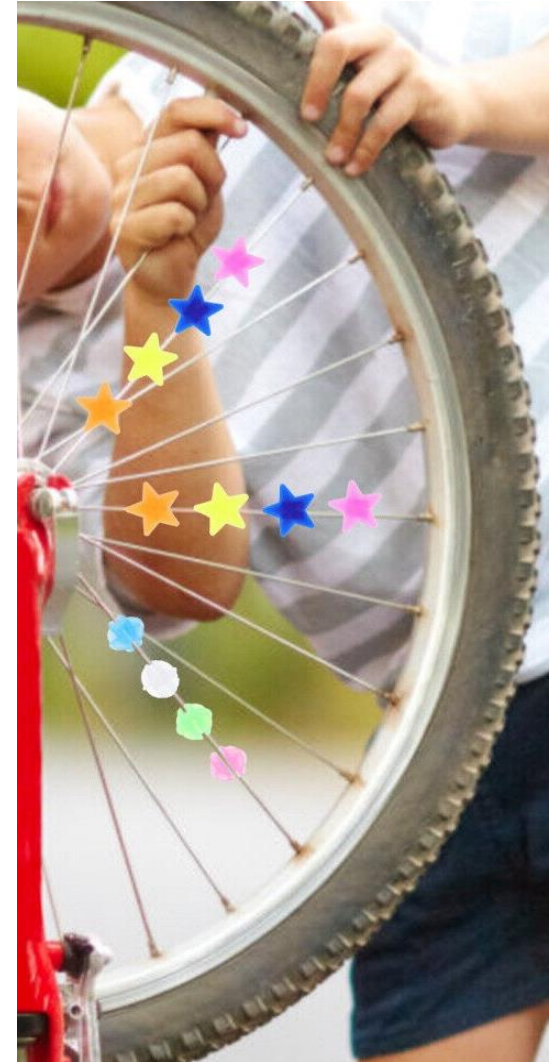
General background on hub models

A “hub” is a general term for a backbone organization that can facilitate coordination between health and SDOH providers.

They can be operated by government entities, health systems, or CBOs and create workflows that consider the unique circumstances and histories of the local environment.

Hubs vary in their governance, funding, operations, approach care coordination, the population they serve, and the nature of their interactions and relationships with other partner organizations.

Although diverse, hubs all have the common goal of combining their community partnerships and trusted relationships with administrative and technological capacity to help community members bridge their clinical health with essential social support provided by organizations in the community.



Elements of a Successful Hub

Click [here](#) for more information on hub models



Planning and Governance

- Established trust with both social service agencies and health care institutions and collaboration across the community
- Balance of stakeholder interests, especially between social service agencies and health care institutions
- Engaged social service organizations as equal partners and promoting shared-decision making



Funding

- Management of uneven funding between health care and social services, limitations in billing for Medicare, and blending multiple funding sources
- A sustainable funding approach utilizing longer-term options such as a Medicaid 1115 waiver.
- Champions at various levels of government to foster a conducive policy environment and secure financial and administrative support for backbone organizations
- Payment mechanisms for CHWs and social workers involved in care coordination



Data Infrastructure

- Systems to transfer patient information between health care and social service providers, and manage challenges related to data privacy, accountability, and varying resource levels.
- Standardized methods for collecting and integrating data to support consistent monitoring and effective program evaluation.



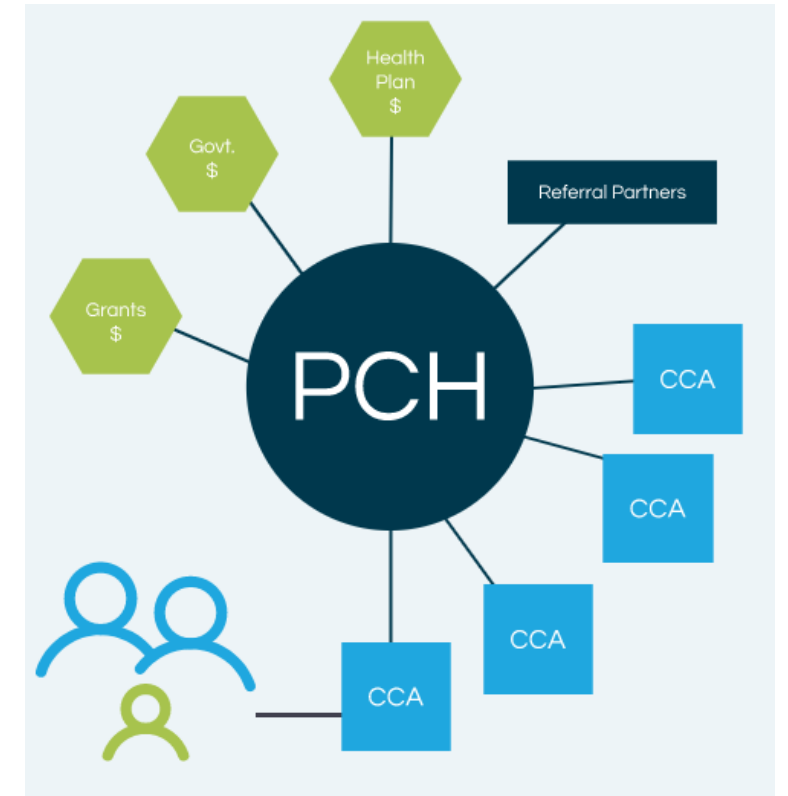
Scope and Populations Served

- Integrated services across primary care, behavioral health, dental care, obstetric care, health education, and family planning.
- Aligned support for housing, nutrition, public assistance enrollment, substance use treatment, and interpersonal violence services.
- Organized efforts within a geographic focus areas, often in collaboration with large health systems.
- A population focus, such as high health care utilizers, older adults, pregnant individuals, veterans, or the unhoused population.

The PCHI Pathways Community Hub

The Pathways Community Hub is a specific hub model created by the Pathways Community Hub Institute. In this model:

- The **HUB contracts with CBOs** that hire CHWs and managers to create a service care network, also known as “**Care Coordination Agencies (CCAs)**.”
- The **CCAs included in the network collect data in a standardized way**: using data collection tools, Standard Pathways, and standard reporting.
 - “Pathways” are tools used by CHWs to identify and track individually modifiable risk factors.
 - There are 21 Pathways currently certified, detailed on a subsequent slide.
- Model is **financially sustainable and unrestricted**; multiple funding streams enable service provision to wide range of clients and are uninhibited by funding restrictions that might otherwise make vulnerable populations ineligible for services;

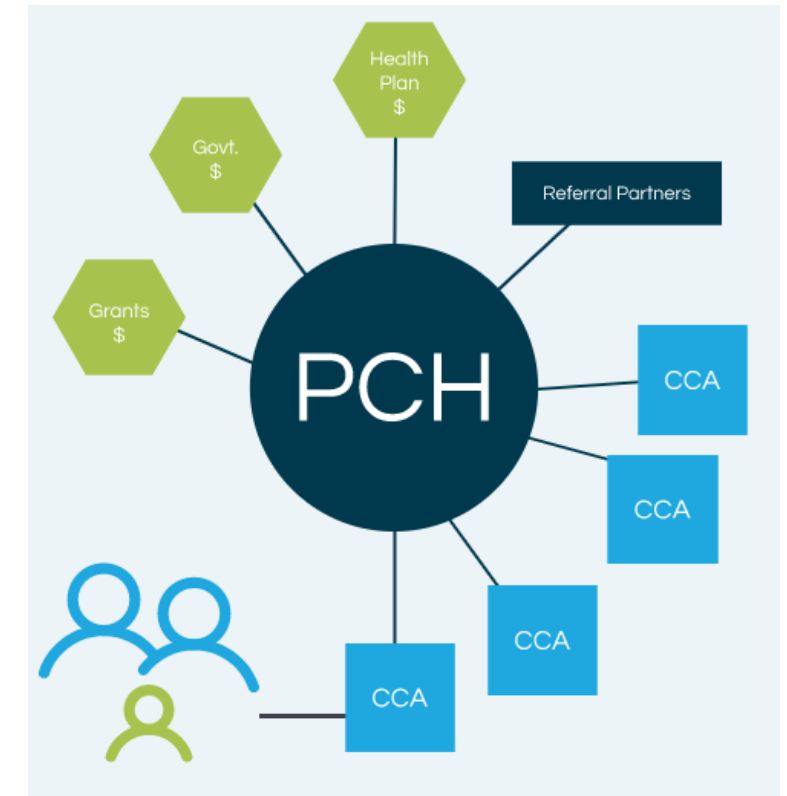


Source: Pathways Community HUB Institute: PCH: Community Care Hub Model. (n.d.). [Link](#)

The PCHI Pathways Community Hub

The PCH model was developed in the early 2000s by two physicians, Drs. Mark and Sara Redding, based on their experiences working with CHWs in Alaska, where CHWs were already an embedded part of the team.

- In the first version of the model, CHWs worked with high-risk pregnant patients. However, while SDOH were being addressed individually, **care coordination and cross-communication were missing.**
- In the second iteration, the model included a HUB that coordinated care, and tracked metrics all the way from care initiation to outcome (i.e., Pathways) [leading to significant improvement in outcomes.](#)
 - In this iteration, the model included a monetary incentive for CCAs (i.e., the community health workers' employers) after the HUB clients achieve measurable, positive outcomes



Entities using the PCH model are now required to have certification from the PCH Institute to ensure they are meeting all standards.

More on the PCHI Pathways...

CHWs offer supports and services that fall into the 21 Pathways listed below. Pathways facilitate outcome-based payment and promote addressing client needs. **In the PCHI model, 50% of payments to a HUB and CCAs are tied to “closed” pathways.**

Current Certified Pathways

- Adult Education
- Developmental Referral
- Employment
- Family Planning
- Food Security
- Health Coverage
- Housing
- Immunization Referral
- Learning
- Medical Home
- Medical Referral
- Medical Adherence
- Medical Reconciliation
- Medical Screening
- Mental Health
- Oral Health
- Postpartum
- Pregnancy
- Social Service Referral
- Substance Use
- Transportation

Outcome-Based Payment

A pathway is considered **“closed”** when a measurable outcome that is meaningful to the participant has been achieved.

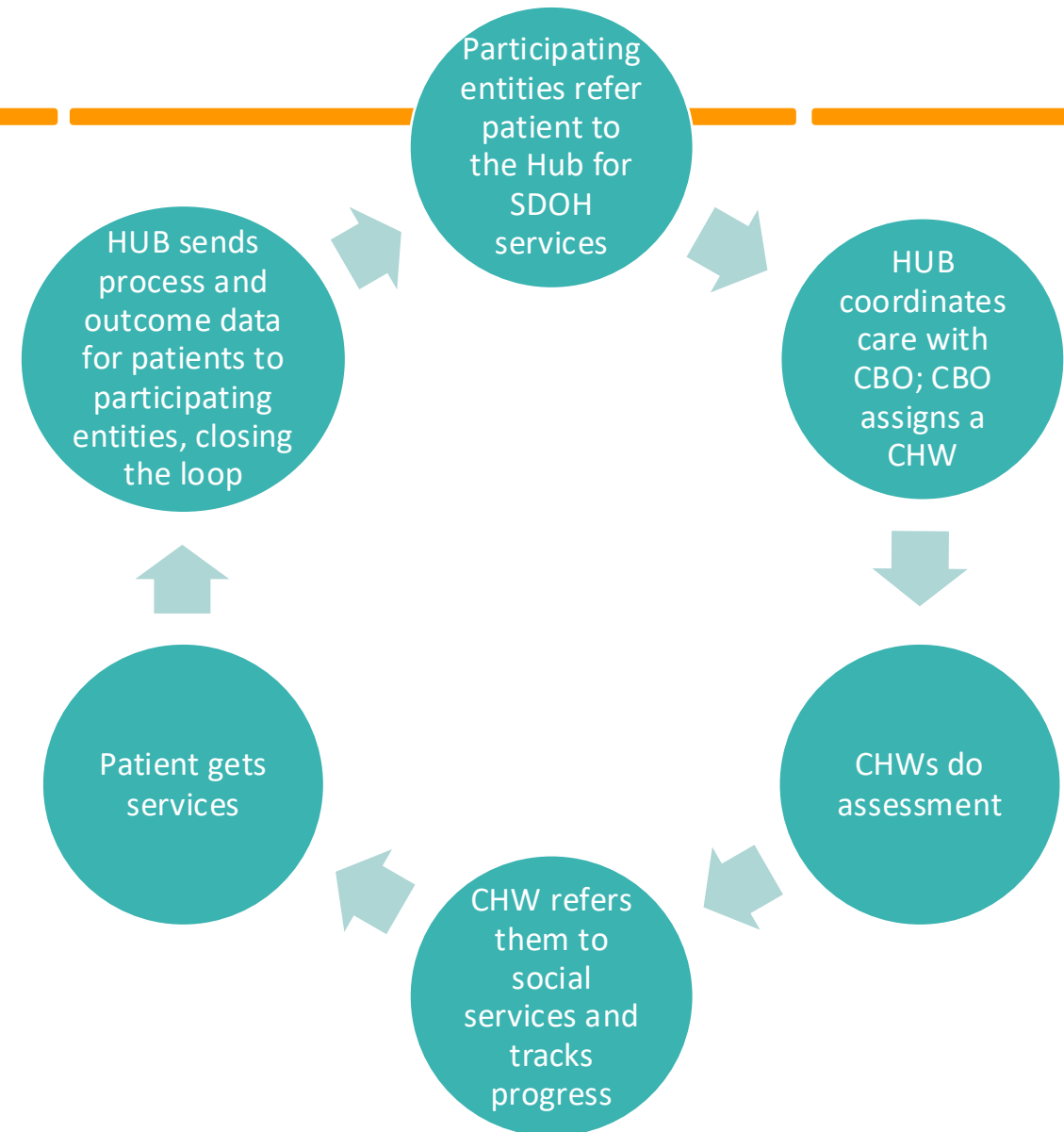
If the intended outcome is not reached, the Pathway is closed as **“finished incomplete,”** while documenting the CHWs’ efforts to address and mitigate the identified risk for evaluation purposes.

Within the model, each standard Pathway is assigned a unique billing code and modifier, along with a reimbursement value based on the Pathway’s complexity. The hub and CHW are reimbursed at the closure of the pathway closure.

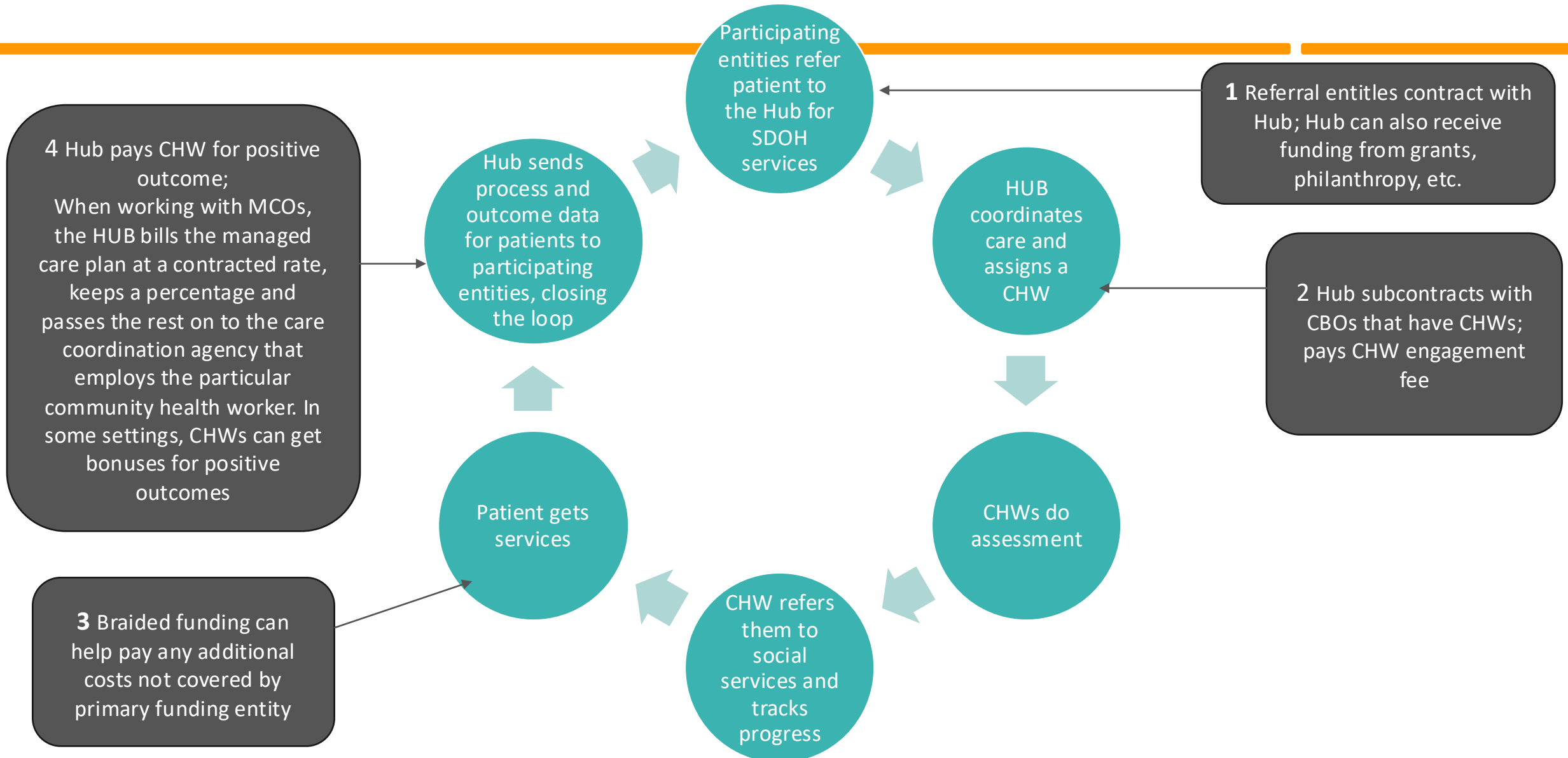
Key benefit #1: The PCH model integrates health systems and community through a PCH HUB

This is beneficial because it...

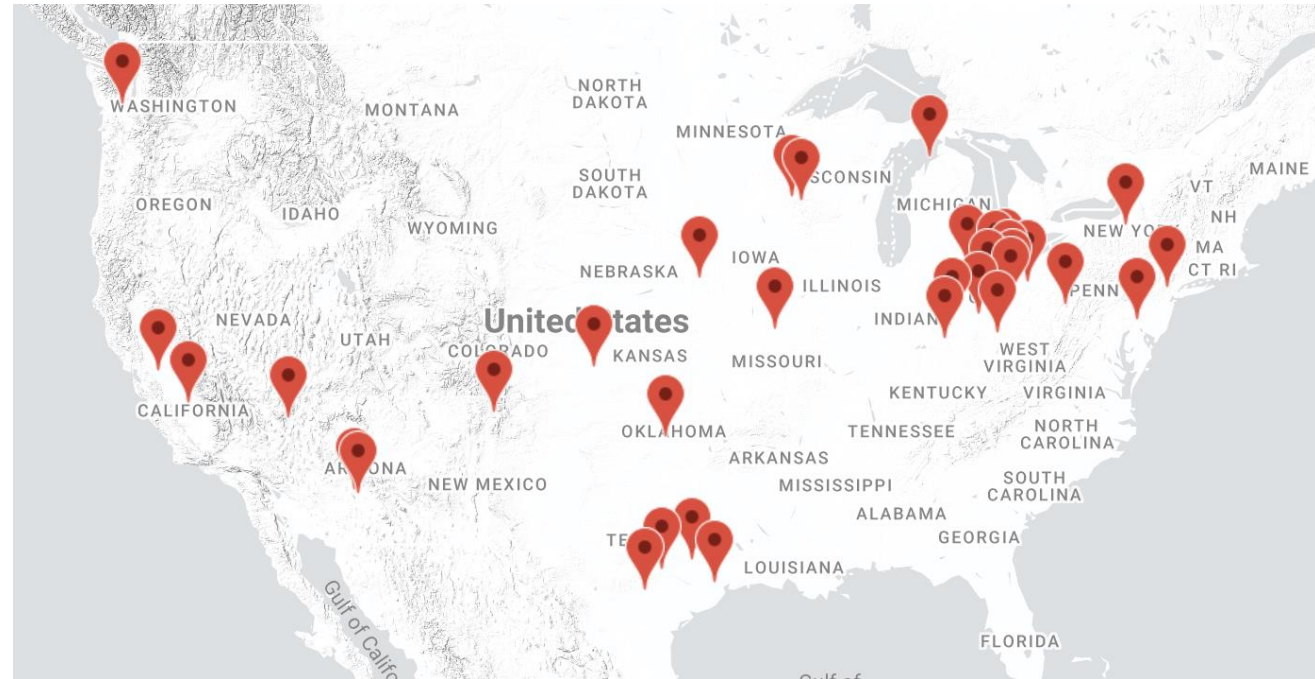
1. Strategically **places coordination efforts with a CBO that is recognized and trusted by community** (i.e., casts net into community less likely to seek out medical system directly)
2. Takes the **burden of administration away** from the CBOs and PHPs
3. Offers a **neutral, centralized mechanism for care coordination** without referral bias to one organization or PHP
4. Is a regional entity, and **encourages greater regional/local investment**



Key benefit #2: PCH relies on diverse funding streams to provide services



States with PCHs



Ohio

California

Missouri

Minnesota

New Jersey

Kansas

Nevada

Texas

New York

Nebraska

Arizona

Wisconsin

New Mexico

Michigan

Pennsylvania

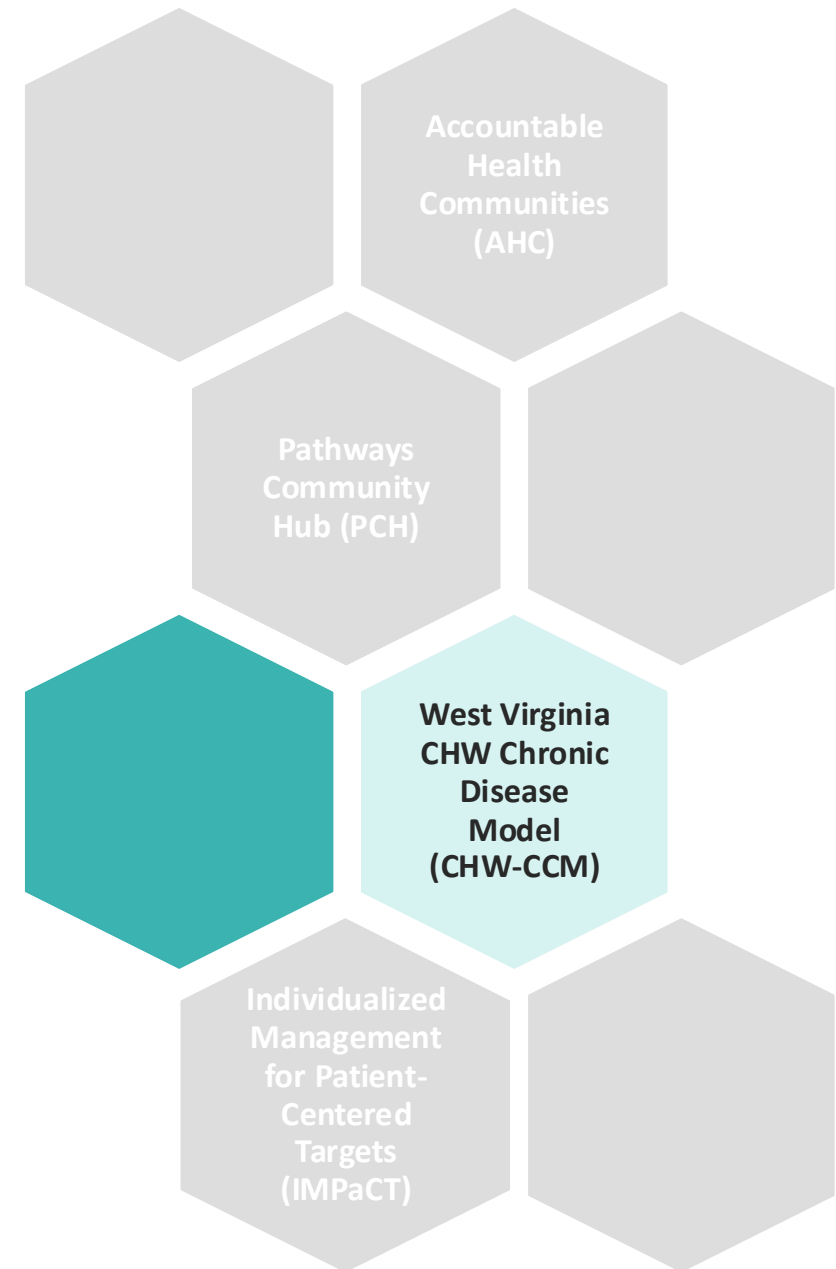
Washington

Delaware

The Administration of Community Living (ACL) has invested in a similar “hub and spoke” model called the Community Care Hub. More information on this model can be found in the [CHWs and the Aging Population Section](#) of this deck.

Example 3: West Virginia CHW Chronic Care Management (CHW-CCM) Model

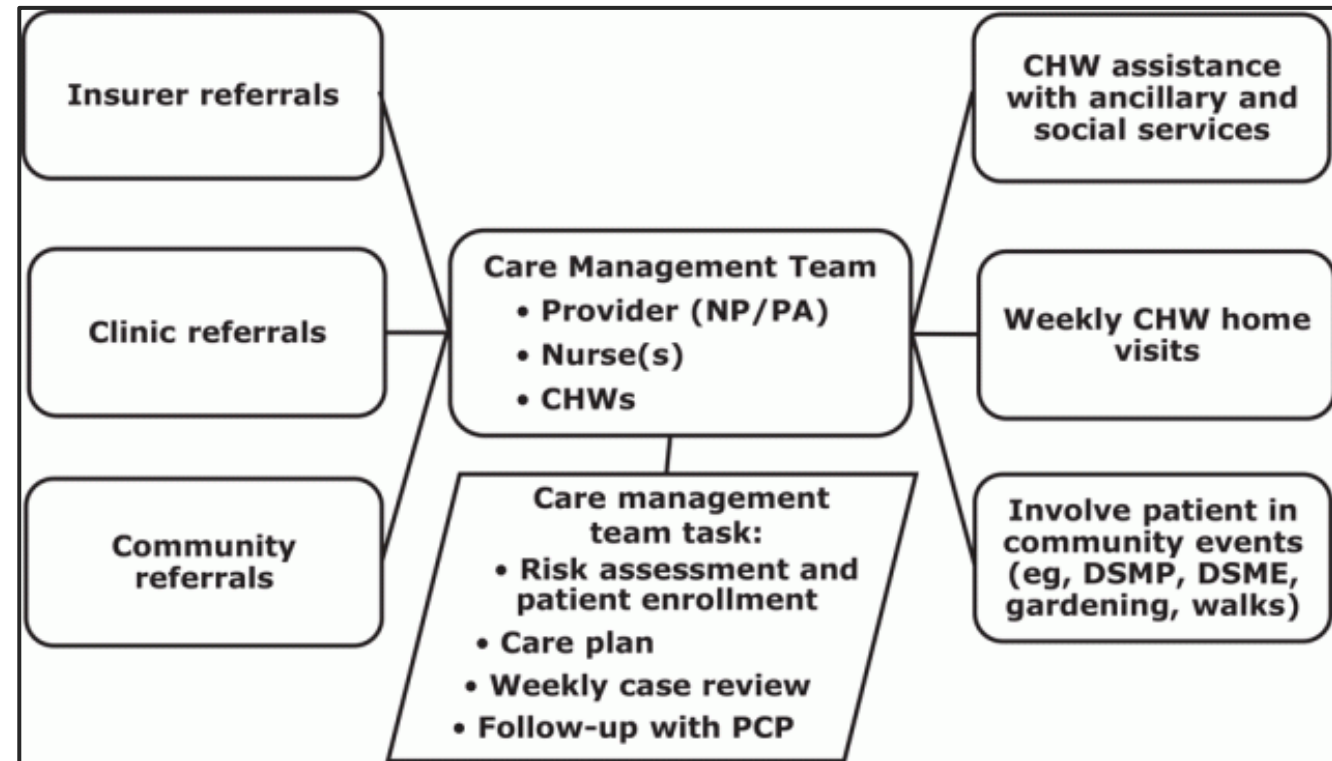
The West Virginia Community Health Worker–Based Chronic Care Management (CHW-CCM) Model was developed under a CMS Health Care Innovation Award in 2012, with the aim of improving outcomes and lowering costs for high-risk diabetes patients and has since been replicated across multiple disease processes.



West Virginia's CHW Chronic Care Management Model (CHW-CCM)

Program Details

- Clinic enrolls high-risk patients with diabetes, heart disease, COPD
- CCM Care Management team includes a mid-level provider, a nurse, and CHWs.
- Patient enrollment through provider referrals, insurance partners who identify their high-risk members for referral, or community partners.
- The CCM team assesses patients' level of risk and enrolls eligible patients in intensive care coordination
- Once enrolled, the team works with the primary care provider to create care plans and regularly follows up with patients.



CHWs in the CCM Model



1. CHWs receive instructions for patient care at CCM team meetings and are in regular contact with team nurse.

- CHWs are full-time, permanent employees of the sponsoring clinics.
- Directly supervised by mid-level or nurse.



2. CHWs arrange a time to meet with patients in homes on a weekly basis.

- CHWs review care plan with patients, check medication adherence, review and update self-management goals, and discuss issues that affect their lives.
- The most common issues that patients bring up are social, literacy, and economic barriers to their health.



3. As patients gain control over conditions, CHWs reduce visit frequency.

- CHWs do not drop patients entirely. CHW interpersonal support is a strong motivator for patients to maintain control of their conditions.
- Initially a CHW's caseload is 25-30 patients. As patients gain control over conditions, the CHW reduces the frequency of home visits to 1-2x/month, taking on new patients. CHWs then ultimately have a caseload of 40 to 50 patients.
- Health insurance payers pay for continued CHW visits and receive data that demonstrate patients' continued control of their conditions, given implications for cost savings.

A role for physician champions

*"A factor that influenced the increase in the rate of enrollment was **the emergence of physician champions in the health centers**. Physician champions emerged as they observed how patients who had difficulties in managing their conditions would rapidly improve. This led physicians to be more assertive in identifying high-risk patients in their care and referring them to care coordination by the CHWs. Gradually, other providers in the practice would take notice..."*

CCM model sustainability

The CCM Model was funded primarily by MCOs although start-up funding came from multiple funding streams.

Start-up Funding

- Funding comes from national foundations, small private and family foundations, hospital conversion foundations, and government grants.
- The first health centers that adopted the model used grant funding to cover startup costs, enabling health centers to begin as soon as they were ready.
- Health centers that have committed to the model are adding CCM teams and CHWs beyond the scope of the grant funding.

Payer Engagement

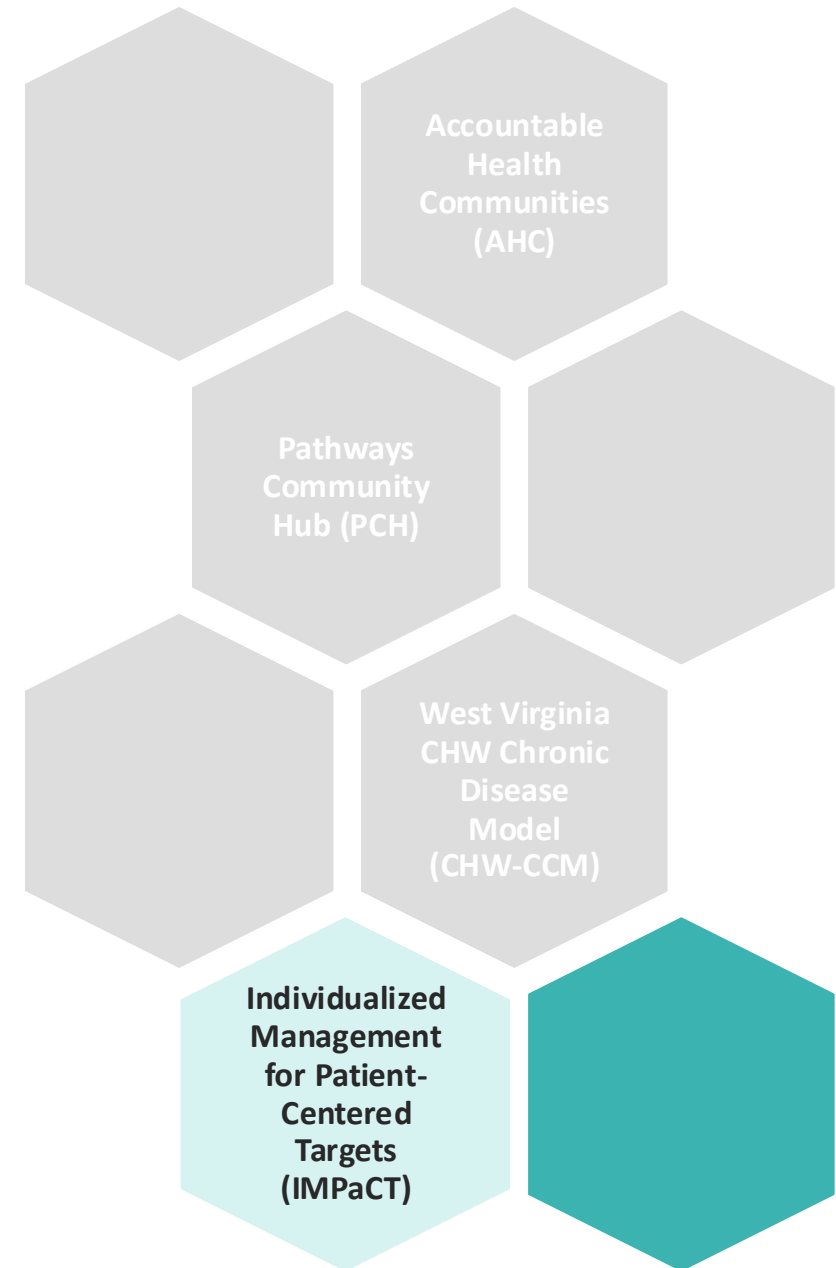
- Engaging payers from the beginning of the project was critical to success.
- Payers' familiarity with the model grew as they observed its dissemination in a 3-state region (Ohio, Kentucky West Virginia), and they ultimately saw the value of the CHWs and agreed to use their own data to make the business case.
- The program uses a fee-for-service structure and is moving towards a value-based payment model.

Cost & Savings

- In an early analysis, one MCO estimated a savings of \$5,000 per patient over a 4-month period.
- As savings are realized, the payers agreed to share savings with FQHCs.

Example 4: Individualized Management for Patient-Centered Targets (IMPACT) Model

The [Individualized Management for Patient-Centered Targets \(IMPACT\) Model](#) is a standardized, clinical system-based model, that pairs CHWs with high-risk patients in the clinic to improve their outcomes over a period of six months. The IMPACT model has shown an [ROI of \\$2.47](#) to an average Medicaid payer within the fiscal year.



The IMPaCT Intervention

Intervention



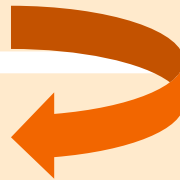
Goal Setting

- Semi-structured interview with open ended social determinant screener
- Self-determined goal-setting, choosing one goal at a time



Tailored Support

- 6-month time frame
- Monthly in-person visits, weekly communication
- Hands-on support in coaching, tracking, advocacy, educational resources, navigation, social activities and support groups
- Inpatient assistance in discharge planning



Connection to Long-Term Support

- Support groups
- Community connections and social networking

Standardized approach to:

- Hiring (education req, behavioral interviews)
- Training (one month)
- Workflows (case load of 55 pt/yr)
- Supervision (managed by MSW with clear scope)
- Documentation (audits, assessments, performance dashboard)
- Intervention (manuals, in-person and online training, and software for documentation and reporting)

Organizational readiness support through:

- Key stakeholder engagement
- Centralized CHW staff with 6-CHW teams
- Coordinators responsible for enrollment and Q/A
- Program Director managing operations and budget
- Budget for CHWs to do activities with patient
- Preliminary exploration to understand context and tailor materials
- EMR privileges for CHWs

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State legislation: Supporting multiple aspects of CHW programming



State law can play a key role in building effective and equitable CHW programs, advancing policies that address multiple aspects of CHW programs to establish infrastructure, creating a shared professional identity among a valued workforce, and integrating systems to effectively meet the needs of communities.

- CHW advisory body

Infrastructure



- CHW definition & scope of practice

Professional Identity



- CHW certification or training process
- Standard curriculum with core skills

Workforce Development



- State financing and incentives for services
- Integration into team-based care

Financing



Legislative action is *not* a requirement for improvement in any of the above areas, but supportive legislation can be highly influential in obtaining buy-in and advancing programmatic goals. Legislation may require or recommend certain activities, and states vary in their approach.

State legislation best practices

Legislation cannot singularly achieve the goal of a valued and supported CHW workforce, but many states have made great strides through bills that:

- Create certification programs/requirements that outline career advancement pathways
- Establish standardized training curricula to provide a standard for CHW competencies.
- Offer sustainability and flexibility in funding. More financing-related best practices found [on slide 62](#).
- Include CHWs in decision-making spaces; the establishment of a CHW Advisory Body may itself be supported and shaped by legislation.
- Detail appropriate hiring criteria to ensure that CHWs are from the communities they serve.

[See additional examples and information here](#)

[State policymakers should look to include CHWs in shared decision-making processes](#) to avoid creating unintentional barriers to entering the workforce or successfully delivering care in the community.

Recommendations for promoting inclusion:

- **Working groups** pursuing CHW-related policies should be comprised of at least 50% self-identified CHWs such as in [Illinois](#), [Maryland](#), and [Oregon](#).
- **CHW policies** [should not exclude](#) non-certified CHWs from practicing in the workforce, even as other policies encourage certification.

Federal Legislation: Rural Health Transformation Program

President Trump passed the budget reconciliation bill H.R. 1 on July 4, 2025, which significantly reduced federal health spending. Due to concern over rural hospitals facing closure following the cuts, lawmakers added in a \$50 billion addition to the bill to establish a Rural Health Transformation Program (RHTP) to support rural health systems.

States can apply for up to \$10 billion per year from the RHTF between FY26-FY30 by submitting a state-approved Rural Health Transformation Plan to CMS. The application's list of potential activities include a number of opportunities to fund CHWs as part of the budget (examples below).

Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.

Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.

Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the CMS Administrator.

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Return on investment (ROI) studies of CHW programs

Numerous studies have explored the impact that CHWs have on the health and well-being of historically and currently marginalized populations.

In recent years economic studies (such as Returns On Investment studies, "ROIs") have become an increasingly popular way to show the utility and significance of investing in the community health workforce.

While many published ROIs have demonstrated the substantial impact CHW interventions can make in community health, there are both benefits and drawbacks to anchoring an intervention's value on ROI (see [slide 97](#)).

This section will give a general overview of using ROI to describe the economic value of CHW programs, discuss the advantages and disadvantages, and provide specific ROI calculators created for CHW/public health programs.

A note on CHW ROIs

"For many countries the economics are a strong case that [still] need to be complemented...The solution is making a case that is not just economic, but also holistic to a given country's specific social context, whether that is fomenting job development, economic opportunity, rural development or women's empowerment, or making health more affordable and accessible."

-Dr. Angela Gichaga, CEO of Financing Alliance for Health

Three types of economic evaluations used for community health

The three most common types of economic evaluations used to describe public health programs are return on investment (ROI) studies, the cost-benefit analysis (CBA), and the cost-effective analysis (CEA). This section will focus on ROI economic evaluations, which has become an increasingly popular way to discuss the impact of CHW programs.

Return on Investment (ROI)

ROI ascertains the financial return of a specific dollar investment. The goal is usually to identify a tangible metric (such as hours saved), and calculate this metric into a financial return (such as dollars saved or dollars made)

$$\frac{\$ \text{ Gained} - \$ \text{ Cost of Investment}}{\$ \text{ Cost of Investment}} = \text{ROI}$$

Cost-Benefit Analysis (CBA)

A CBA assigns a dollar value to health outcomes, including life, which is difficult to do. If the benefit-cost ratio is greater than \$1, it implies that the program or intervention produces more benefit than it costs.

$$\frac{\$ \text{ Value of all Benefits}}{\$ \text{ Value of all Costs}} = \text{CBA}$$
$$\begin{aligned} & \$ \text{ Value of all benefits} - \$ \text{ Value of all costs} \\ & = \text{Net benefits} \end{aligned}$$

Cost-Effective Analysis (CEA)

A CEA calculates a cost-effective ratio (CER) or incremental CER (ICER) which relates the costs of a program to a key outcome or benefit. There is only one defined effect unit that is costed for each intervention that is being compared. E.g., Cost/case prevented

$$\frac{\text{Cost of Intervention}}{\text{Effect of Intervention}} = \text{CER}$$
$$\frac{\text{Difference in Cost of Intervention}}{\text{Difference in Effect of Intervention}} = \text{ICER}$$

What is ROI?

A **return on investment (ROI) analysis** is a way to calculate net financial gains (or losses), taking into account the financial resources invested as well as the amount gained through increased revenue and/or reduced costs.

The net financial return (*\$Gained - \$Cost of Investment, numerator*) from the intervention or program describes the financial gains from implementation, which are generated by changes in quality, efficiency, and utilization of services, or in the form of financial payments.

The cost of investment (*denominator*) is the total cost of developing and operating the intervention or program.

$$\frac{\$ \text{ Gained} - \$ \text{ Cost of Investment}}{\$ \text{ Cost of Investment}} = \text{ROI}$$

Example:

An intervention which requires an investment of \$200 and results in a \$300 gain, would give an additional 50% ROI.

$$(\$300 - \$200) / \$200 = 50\% \text{ ROI}$$

Example Return on investment (ROI) studies for CHWs

Penn Center for CHWs, University of Pennsylvania Health System

[Penn Center for CHWs](#) employed a team of CHWs and financed their salaries through their operational budget and cost savings elsewhere in the system that amounted to \$2.47 per every dollar invested.

Clinics and Organizations in South Carolina

The Center for Applied Research and Evaluation and the Center of Community Health Alignment showed [returns ranging from \\$0.66 to \\$9.72](#) in averted costs across four organizations and clinics in South Carolina.



ROI...for whom?

In calculating ROI, or any economic analysis, **it is critical to define whose perspective defines a cost or a gain.** The perspective shapes the evaluation of the intervention or the program and determines overall ROI.



Perspectives on Costs



Perspectives on Gains

Cost	Perspective	Gain	Perspective
Direct Medical (e.g. hospital bills)	Patients, Payors, Employers, Society	Direct Medical (e.g. hospital savings)	Patients, Payors, Employers, Society
Direct Non-Medical (e.g. transportation, daycare)	Patients, Society	Direct Non-Medical (e.g. Saved wages)	Patient, Society
Indirect (e.g. lost time from work)	Patients, Employers, Society	Indirect (e.g. fewer sick days)	Patients, Employers, Society
Intangible (e.g. lost quality of life, pain)	Patients, Society	Intangible (e.g. productivity, engagement in the community)	Patients, Employers, Society

Example: CHW workforce ROIs done by health systems may underestimate the ROI from the public health perspective, because hospitals may not perceive CHWs impact on their patients' morale and quality of life as a gain. Moreover, hospital systems may be more interested in short-term outcomes that do not always coincide with the longer-term gains achieved by CHWs. **Excluding intangible or longer-term gain of CHW programs can ultimately lead to a smaller calculated ROI that underestimates the value of CHW programs in the health and hospital system.**

Benefits and drawbacks of using ROI to address population health and SDOH

Ultimately, there are both benefits and drawbacks to using ROI; decision-makers should ensure that ROI calculations are not used exclusively to drive programmatic choices but treated as one of many inputs in a larger decision-making process.

Benefits

- ROIs for public health interventions typically show significant returns.
- Using dollar comparisons can help groups advocate for public health funding in terms of *investment and savings*, rather than *cost*.
- ROIs can improve communication and engagement between diverse stakeholders by establishing shared language and understanding of expectations or needs.
- If there is consensus on the variables going into the ROI, it can strengthen data collection systems and capture change over time.

Drawbacks

- Comprehensive ROIs are difficult to estimate. Data systems vary in their robustness; some do not have enough data points for key variables and external influences like geographic variation can radically change the ROI calculation.
- Different studies factor different variables into ROI equations, making comparison challenging.
- ROIs readily accommodate medical costs averted by improved health (e.g. reduced hospitalizations related to asthma), but it is harder to assign dollar values to life-years saved, or intangible effects such as increased well-being or empowerment.
- Many benefits of public health interventions are realized over many years and may not factor into a funder's ROI calculation. Also, ROI can steer decision-makers towards oversimplifying decisions to fund interventions without weighing factors outside the dollar amounts used in an ROI, like equity benefits.

Potential Use Cases for ROI studies in CHW programming

Fully acknowledging the benefits and drawbacks of ROI studies for CHW programs, there are some cases where estimating ROI may be beneficial if done comprehensively and equitably.

- The **evaluation of cost savings of new interventions**. This is useful in situations where the new intervention/strategy is at least as effective as the comparison.
- To communicate an investment case for an intervention as a **tool for advocacy**.
- When considering the **macroeconomic impact** of an intervention—such as the impact on gross domestic product.
- To **maximize revenue** in a for-profit setting
- For **evaluating cross-sectoral investments** which aim to promote health and development.
- To estimate how already planned interventions will affect revenue and operating costs, to **optimize quality and financial performance**.

When discussing ROI, it is essential to include:

- Who receives the 'savings' or economic benefits.
- The key findings, limitations, ethical or equity considerations not captured, and how these could affect patients, policy or practice.
- The limitations of the calculation decisions made, and the methods used to value economic benefits.
- Discussion of the generalizability or transferability of results across different settings and over time, especially the variables that most significantly drive the ROI.

CHW ROI calculator #1: Health Begins/SCAN Foundation

In October 2023, Health Begins launched a newly expanded [ROI calculator](#), created in collaboration with the Commonwealth Fund and the SCAN Foundation.

The calculator is based on a robust scan of the evidence-base.

The calculator estimates the ROI of social needs interventions using pre-populated data drawn directly from national averages, benchmarks, and research.

The evidence-base used for this calculator was based on a [review](#) of 82 published studies on the impact of social services on healthcare utilization and costs.

The calculator strives to provide fair estimates of costs accrued by CBOs.

- Because of the time lag in published evidence, the calculator includes an inflation adjustment to better estimate current costs faced by CBOs.
- Sets a 10% administrative cost that is automatically incorporated into the reimbursement models.
- Shared savings is set at 50%.
- Ultimately, these changes means CBO costs are set to be higher, taking a more realistic approach to CBO costs.

2 Calculator Options

Quick Calculator

A quicker calculation, using prepopulated health utilization and cost data

Legacy Deep Dive Calculator

Manual entry of data and ability calculate multiple interventions at once

Health Begins ROI calculator CHW Evidence Base

The ROI calculator measures a “care management” intervention that groups CHW programs with social worker-led models and multidisciplinary teams.

Reductions in Health Care Utilization and Costs Reported in Select Studies of Care Management

Type of program	Type of evidence	Reduction in ED visits	Reduction in hospital admissions	Reduction in hospital readmissions	Reduction in hospital days	Reduction in skilled nursing admissions/days	Reduction in health care costs PMPM	Intervention cost PMPM
Multidisciplinary teams	S(6), M(2), P(1)	7% to 35% (3)	18% to 44% (4)	NS (3)	59% (1)	47%/52% (1)	\$124 to \$644 (4)	\$119 to \$417 (3)
Social worker-led models	M(2), P(2)	37% to 89% (2)	39% to 59% (3)	31% to 57% (3)	N/A	N/A	N/A	N/A
CHWs/Navigators/Coaches	S(5), M(3), P(1)	7% to 23% (2)	6% to 57% (4)	17% to 76% (3)	8% to 34% (2)	N/A	\$480 to \$773 (2)	\$81 to \$341 (4)

Summary of Social Service Intervention Costs

Type of Social Need Intervention	Unit	Number of Studies	Evidence (Unadjusted Nominal Dollars)			Evidence (Adjusted for Inflation to June 2023)		
			Minimum	Median	Maximum	Minimum	Median	Maximum
CARE MANAGEMENT								
Multidisciplinary teams**	PMPM	4	\$119	\$278	\$501	\$176	\$345	\$501
Community health workers or navigators	PMPM	4	\$81	\$134	\$341	\$129	\$148	\$422

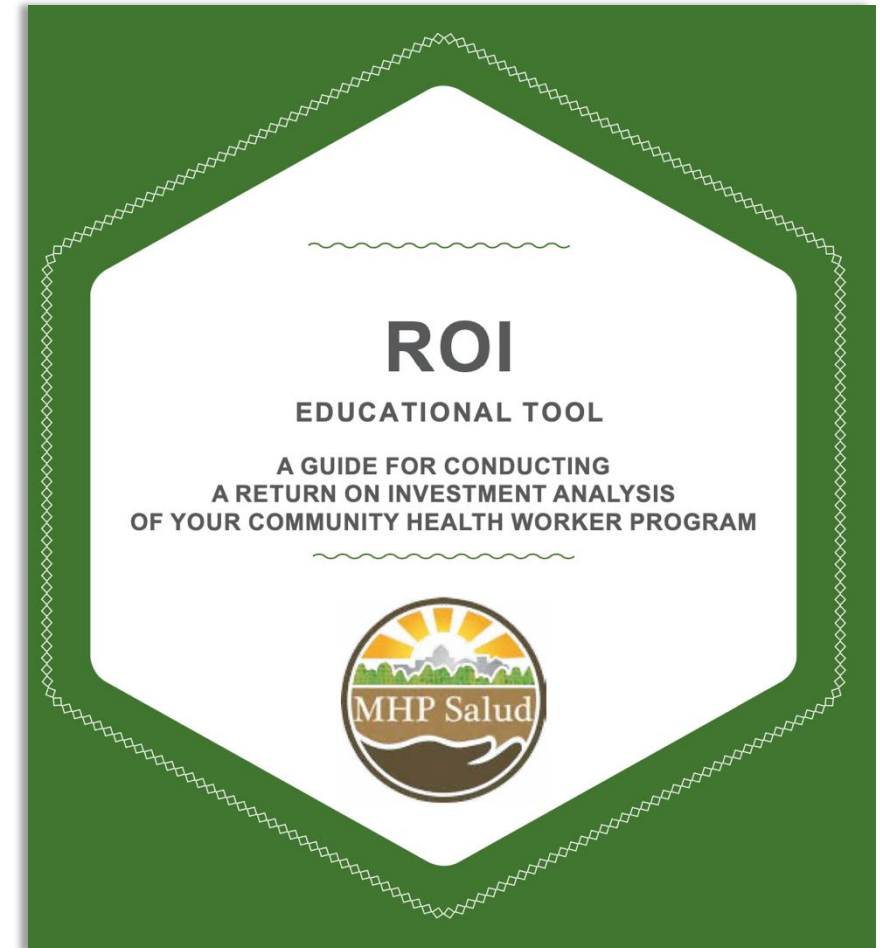
More resources on ROI can be found [here](https://healthbegins.org/wp-content/uploads/2023/10/Final-Social-Service-Intervention-Costs-READY.pdf).

CHW ROI Calculator #2: MHP Salud

MHP Salud worked with various health centers to develop a process for determining CHW program ROI, culminating in a toolkit that allows CBOs to calculate the ROI of their CHW program.

Toolkit Components

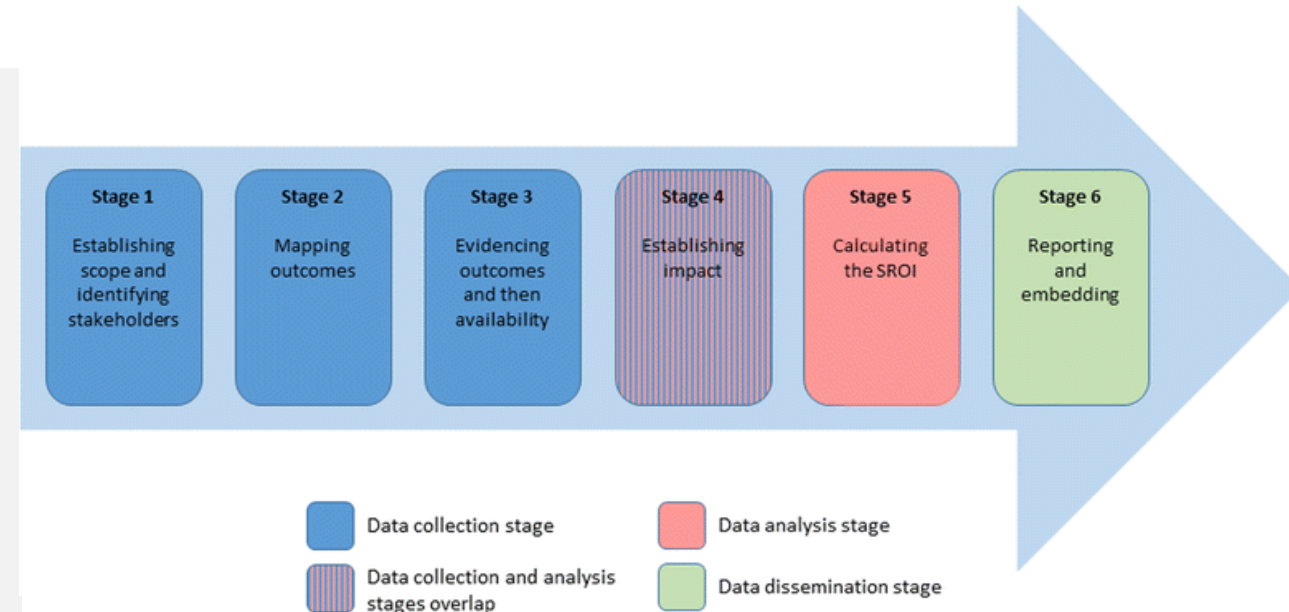
- Algorithm for collecting necessary data for ROI
- Data sheets to identify program outcomes
- Data sheets to create estimates with resources to help determine values
- Summary of assumptions
- Instructions on performing the ROI calculation



From ROI to Social ROI (SROI)

Social ROI (SROI) is a newer framework for calculating return on investment, taking into consideration health and non-health impacts, and tries to account for potential negative effect of interventions. SROI uses dollar proxies to estimate dollar amounts for interventions that are not easily assigned monetary values.

- SROI **considers the value produced** for multiple stakeholders in three dimensions of development: economic, social and environmental
- **Allows for the calculation of a benefits-to-costs ratio**; for example, a ratio of 2:1 means that \$2 of social value is created from an investment of \$1.
- Emphasizes that social value should **focus on outcomes rather than outputs**. For example, if an organization is providing diabetes education, the output of the program would be the number of education sessions, but the *outcome* is the community's increase in knowledge of diabetes management.
- **Aims to be stakeholder-specific**, calculates the SROI separately for each stakeholder and includes stakeholders in determining and valuing the outcomes.



The SROI process engages multiple stakeholders in determining appropriate outcomes and associated monetary value proxies

https://neweconomics.org/uploads/files/aff3779953c5b88d53_cpm6v3v71.pdf

Source: Banke-Thomas, A.O., Madaj, B., Charles, A. et al. Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review. BMC Public Health 15, 582 (2015). <https://doi.org/10.1186/s12889-015-1935-7>

A last note on ROIs

PIH has compiled [this list](#) of published CHW ROI studies to be used for reference and educational purposes.

While there are many published ROI studies on CHW work, **there are very few that have been able to reasonably tie CHW activities *directly* to longer-term outcomes** such as ED visits, changes in health status, etc.

Many of the outcomes used in ROI studies are a product of multiple factors in the system (housing, food insecurity, environmental factors, health systems access, etc.), so it is challenging to make direct comparisons between CHW's work- such as activities in behavior change, medication compliance, immunizations, etc. - with long-term systemic health changes, **and we do not recommend using any of the references as the gold standard at this time.**

Instead, we do recommend working in partnership with local CHWs to scan the range of ROI variables and outcomes used in different studies to create a customized and mutually agreed upon calculation that considers 1) local factors and 2) proxy variables for long-term impacts that directly link to CHW activities.



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CHWs have the expertise and background to support the aging population

There are an increasing number of programs across the US that are employing CHWs to support the aging population, and there are numerous studies that have shown the effectiveness of CHWs in improving chronic disease outcomes.

CHWs and the Aging Population

- CHWs can arrange grocery and medication delivery, assist with providing and navigating transportation, and aid in transitioning to a new living space, all of which are either proxies for falls prevention or active and healthy behaviors.
- CHWs can be effective in screening and identifying impairments in the aging population and ensure they are connected to the right health resources.
- CHW-led, multicomponent interventions that support the functional capacity of older adults with early-stage disability and frailty have been shown to improve mood and functional outcomes.

CHWs and Chronic Disease Management

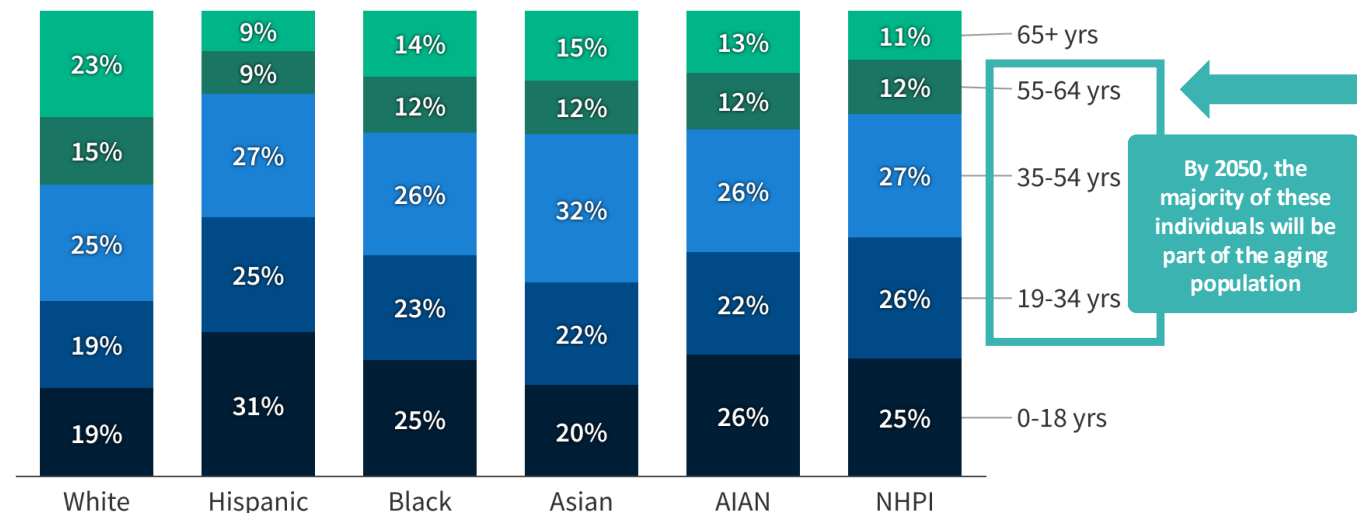
- Chronic disease interventions by CHWs appear more effective when compared with alternatives, particularly among low-income, under-resourced, and racial and ethnic minority communities.
- CHW interventions have shown to be effective in creating a modest reduction in hemoglobin compared to usual care.
- CHWs can effectively deliver cognitive behavioral training intervention for rural patients with diabetes and chronic pain.

Overview of the U.S. aging population

➤ America's aging population is growing, and in many parts of the country, current infrastructure is not equipped to provide the range of services needed for the increasingly diverse population of older adults.

- **By 2050, adults over the age of 65 will make up 23 percent of the U.S. population.** Furthermore, the demographics of the aging population will reflect the increasingly diverse population of the US.
- Health systems are largely unprepared for this complexity, and **older adults suffer a disproportionate amount of harm while in the care of the health system.**
- **Older adults are disproportionately affected by chronic conditions,** such as diabetes, arthritis, and heart disease. Nearly 95% have at least one chronic condition, and nearly 80% have two or more.
- **Multiple chronic diseases account for two-thirds of all health care costs and 93% of Medicare spending. Yet, less than 3% of U.S. health care dollars is spent on disease prevention to improve overall health.**

Total Population by Age, Race, and Ethnicity, 2023



Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian or Alaska Native. NHPI refers to Native Hawaiian or Pacific Islander. Total may not sum to 100% due to rounding.

Source: KFF analysis of 2023 American Community Survey, 1-Year Estimates.

KFF

Government-affiliated agencies focused on the aging population

Below are federal, state, and local agencies that aim to support the growing aging population that could benefit from CHWs to help navigate their medical and SDOH concerns.

Administration of Community Living (ACL)

- **Federal** agency that supports the needs of the aging and disability populations, and improves access health care and long-term services

State Unit on Aging

- **State** entity that manages coordination of state-level programs and develops and administers a multi-year state plan that advocates for and assist older residents, their families and, in many states, adults with physical disabilities.
- Functions can include certification of senior centers; planning/managing in-home services, congregate and home-delivered meals; and other aging programs.

Area Agencies of Aging (AAA)

- **Regional or local** agencies designated by a state to address the needs and concerns of the aging population
- Primarily responsible for a geographic area, also known as a planning and service area (PSA), that is either a city, a single county, or a multi-county district.
- Coordinate and offer services that help older adults remain in their homes, such as home-delivered meals and homemaker assistance, to make independent living a viable option for individuals.

Non-governmental organizations and networks addressing SDOH in aging populations

Aging and Disability Resource Center (ADRC)

- As defined in the Older Americans Act (OAA), an ADRC is an entity, network, or consortium established and designated by a state as part of the state system of long-term care, to provide a coordinated and integrated system for older adults, people with disabilities, and their caregivers.
- Must have state designation.

Community Care Hub (CCH)*

- A community-centered entity that organizes and supports a network of community-based organizations (the Community Care Network) in providing services to address health-related social needs; centralizes administrative functions and operational infrastructure and is usually a community-based organization.
- Public-Private partnership administered by the ACL.

Community Care Network (CCN)

- A group of community-based organizations organized by a Community Care Hub to deliver services to the community.
- Public-Private partnership administered by the ACL.

Senior Centers

- Serve as a gateway to the nation's aging network connecting 1 million older adults to vital community services.
- Work in partnership with other community agencies and organizations and businesses to provide access to an array of opportunities for older adults to stay safe, active, and healthy.
- Non-profit organizations

*The next slides give more information on CCHs.

A Community Care Hub (CCH) is a hub-spoke model addressing SDOH in the aging population, offering another opportunity to integrate CHWs.

CCHs are administered by the ACL, as part of its vision for coordinated person-centered care for the aging population.

CCHs

- Centralize administrative functions and operational infrastructure, including contracting with health care organizations, payment, referral management, service delivery fidelity and compliance, technology, information security, and data collection/reporting.
- Form trusted relationships with CBOs and healthcare organizations, and fostering cross-sector collaborations
- Engage with CBOs and the individuals they serve

ACL Funding for CCHs

The ACL directly funds community organizations serving as hubs to coordinate access to, and delivery of, services that address SDOH through CBO partners. Health sector entities that can contract with the hub to receive SDOH services include:

- accountable care organizations
- health plan
- managed care organizations
- hospitals
- health systems

More information on CCHs can be found [here](#)

Opportunities to integrate CHWs into Community Care Hubs (CCHs)



Community Care Hubs are funded through multiple sources. The pathway to the left describes how individuals engage with the hub.

The steps in the process highlighted in **YELLOW** indicate where the CHW can either make referrals and facilitate connections or engage in supporting activities

Example CCH: Community Care Solutions in Alabama

Community Care Solutions (CCS) is an Alabama CCH that was formed by the Southern Alabama Regional Council on Aging (SARCOA).

- Deploys **targeted interventions**, including a range of direct care transitions and care management services through a regional network of Area Agencies on Aging and direct service providers in each region.
- Holds a **care coordination contract with a Medicare Advantage (MA) plan and contracts with local hospitals and physician groups.**
- The contract with the MA plan is structured as a **capitated PMPM payment model.**
 - Risk-bearing arrangement (downside risk), with **CCS required to meet various goals to keep the full PMPM payment.**
 - As the lead entity, **CCS bears all risk on behalf of their CBO network partners**
 - **CBOs held to performance standards** on risk of exclusion from a sub-contract.



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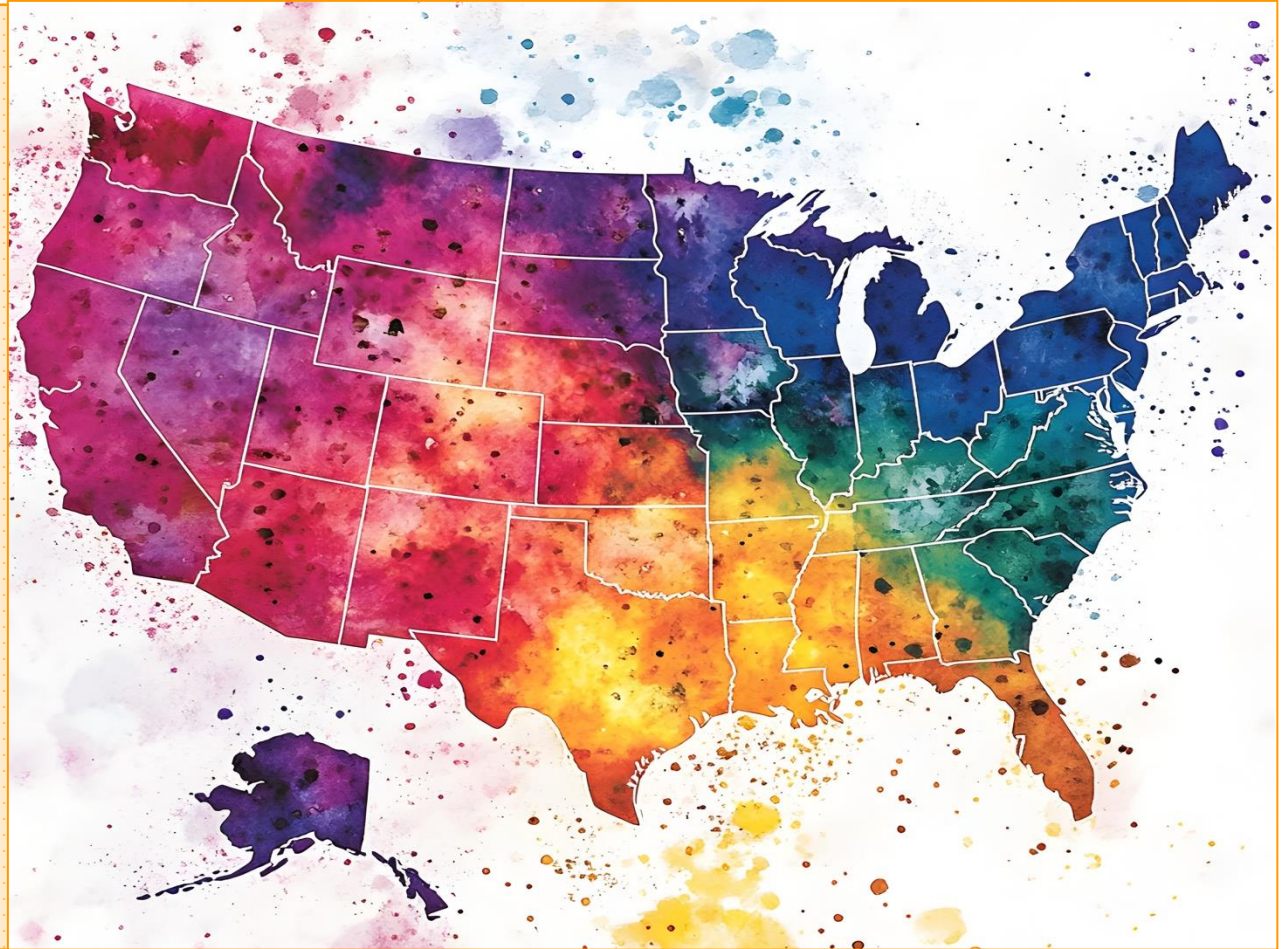
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Introduction to State-by-State Review

As previous sections have illustrated, there is immense variation among states in CHW program legislation, financing, training, and certification.

This section provides a snapshot of selected state policy and programming related to the community health workforce.



Alabama

State Legislation

- None

Financing

- None

Education, Training, and Certification

- There are a few CHW training programs offered through private/nonprofit organizations ([Wellness Coalition](#), [ConnectionHealth](#))



Source: Nations Online. Maps of the United States. (For slides 152 – 203)
https://www.nationsonline.org/oneworld/us_states_maps.htm

Alaska

State Legislation

- [HB 209](#) (1993) provides Community Health Aide Program (CHAP) grants for third parties to train community health aides as Community Health Practitioners with an exam at the end of training.

Financing

- [SPA 16-0007](#) (2017) allows all levels of certified [Community Health Aides/Practitioners \(CHA/Ps\)](#) to be reimbursed for services to Medicaid beneficiaries, however they may be considered distinct from CHWs. The CHA/P program is administered by the Indian Health Service, with additional tribal, grant, or federal Community Health Center funding.

Education, Training, and Certification

- Many CHWs in Alaska receive training through the [Alaska Primary Care Association](#), which offers a Registered Apprenticeship Program through the U.S. Department of Labor (USDOL). Upon successful completion, CHWs receive a portable credential (Certificate of Apprenticeship) issued by the USDOL.
- Within this program, CHWs can receive specialized trainings in various topics, and pursue a Certificate in Principles of Health Coaching from the National Health Careers Association.



Arizona Spotlight: An innovative, inclusive SPA highlighting systemic barriers to implementation

Arizona's SPA is noteworthy for its attempt to phase in both medical professionals and CBOs as "providers" that can reimburse for CHW education and preventative services.

The opportunity for CBOs to submit claims is a step towards a more community-centered health system; however, in practice, the process for reimbursement may have barriers in implementation that impede CBOs from participating.

CHW & CHR services reimbursement process



challenges in implementation

- The technology, infrastructure, and training needed for billing is complex and costly, and CBOs generally do not have the capital to build these systems
- The process for registering as a provider is time- and effort-intensive, which strains the CBO's already-limited resources
- Low reimbursement rates don't bring enough revenue for CBOs to invest in creating this infrastructure and limits their participation

California (1/2)

State Legislation

- [Section 6332](#) of the state's labor code contains a limited definition of CHWs.
- [AB 133](#) (Chapter 143, Statutes of 2021) authorized DHCS to design a [SPA](#) to add CHW services as a Medi-Cal covered benefit. DHCS intends to launch CHW covered services beginning July 1, 2022
- [AB 2697](#) (2022) requires managed care plans to reach out to providers and beneficiaries to inform them of available CHW Medi-Cal benefits, and ensures DHCS will continue working with community members, CHW/Ps, and advocates as the benefit rolls out.
- [AB184](#) requires the Department for Ed Visits and f Health Care Access and Information develop and approve statewide requirements and curriculum for certification
- [SB1385](#) requires MCPs to create billing pathways for CHW services during ED visits and follow-ups.

Financing

- In July 2022, CMS approved [SPA 22-0001](#), making CHW services a Medi-Cal benefit. CHWs may be supervised by a community-based organization, local health jurisdiction, licensed provider, hospital, or clinic. Managed care plans may currently contract with CBOs. In July 2024, [SPA 24-0016](#) was approved, adding CHW services in the dental setting
- [Senate Bill 1385](#) codifies requirements for MCOs to educate members and providers the available CHW benefit and create billing pathways for providers to claim CHW benefits during ED visits and outpatient follow-ups.
- CHW services are included in its [1115 Waiver](#), [1115 Reentry Waiver](#), and [BH-Connect Waiver](#).
- The 2023 state budget appropriated \$280 million to recruit, train, and certify 15,000 new CHWs.



California (2/2)

Education, Training, and Certification

- Through the [2022 statute](#), the Department of Health Care Access and Information (HCAI) was given authority to develop and implement a certificate process for CHW/P/Rs. The state, along with contracted partner [R.A.C.E. for Equity](#), is in the process of conducting community engagement sessions and reviewing existing CHW/P/R training programs to inform and develop the certification and training process.
- Currently for reimbursement, CHW/P/Rs must demonstrate minimum qualifications via a certificate of completion or work experience, have lived experience that aligns with and provides a connection between the CHW and the community or population being served; and be supervised by a licensed provider, clinic, hospital, CBO, or Local Health Jurisdiction who is enrolled in the Medi-Cal program.



Connecticut

State Legislation

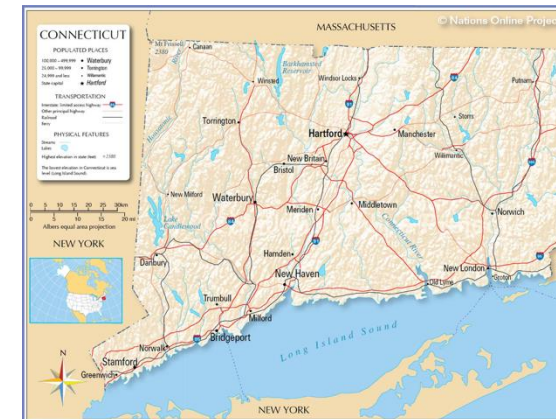
- [Public Act 17-74](#) (2017) and [Public Act 19-117](#) (2019) established a statewide CHW definition and scope of work.
- [Public Act 22-118](#), passed in 2022, requires the State of Connecticut Department of Social Services to establish a community action worker grant program.
- In 2023, [SB989](#) was passed, requiring the Department of Social Services to conduct a rate study and implement a program to provide Medicaid reimbursement to certified CHWs.
- [Bill No. 991](#) was introduced in January 2023 that would direct the Department of Social Services to design and implement Medicaid reimbursement for CHWs.

Financing

- None

Education, Training, and Certification

- CHW certification began in 2020 and is obtained based on approved [training](#) by the CT Office of Health Strategy CHW Advisory Body (CHWAB) or based on hours of experience and references. CHWAB oversees requirements and evaluates training programs. Membership roster [here](#).
- [Four organizations approved by CHWAB](#) that currently provide formal training: Gateway, [Housatonic Community College](#), [the Health Education Center](#), and [Southwestern AHEC Inc](#). These programs implement the CHWAB-approved core curriculum modeled after the [C3 Project](#).



Florida

State Legislation

[House Bill 183](#) (2021) directs the Office of Minority Health to coordinate with agencies, organizations, and providers across the state to promote the use of CHWs to improve the cultural competency of services and build individual and community self-sufficiency.

[House Bill 1381](#) (2021) requires the Department of Health to establish telehealth minority maternity care pilot programs, defines “perinatal professionals” as doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and non-licensed professionals who assist women through their prenatal or postpartum periods. This legislation requires that the pilot programs provide training to participating health care practitioners and other perinatal professionals.

Financing

- none

Education, Training, and Certification

- The Florida CHW Coalition is an approved education provider of the Florida Certification board. Certification is not a requirement in Florida.



Illinois (1/2)

State Legislation

- [HB 5412](#) (2014) adopted APHA definition and created an Advisory Board within the Department of Public Health, [setting requirements for membership](#). It prohibits CHW from performing health services that require a professional license.
- [Public Act 102-0004](#) in 2021, creating a board with within the DPH to develop and oversee CHW certification and add CHW services as a covered Medicaid benefit with a supporting SPA implementing CHW reimbursement.
- [Public Act 410 ILCS 67](#) passed in 2022 to establish a certification board and facilitate funding through Medicaid.

Financing

- Medicaid does not yet reimburse CHW services in Illinois; however, there are [recommended reimbursement options](#) by its CHW Advisory Board.
- Illinois also has a [1115 reentry waiver](#) that covers CHW services.



Illinois (2/2)

Education, Training, and Certification

- The Community Health Worker Advisory Board Act ([Public Act 098-0796](#)) has created minimum core competencies across the state for CHWs. Additionally, the Advisory Board can consider other competencies when necessary.
- The Community Health Worker Certification and Reimbursement Act ([Public Act 410 ILCS 67](#) (2021), directs the Illinois Department of Public Health (IDPH) to establish a certification program. [Certification development is currently underway](#). More information on the CHW Review Board that advises on the process can be found [here](#).
- As of 2021, [training is offered](#) through community colleges (e.g., Malcolm X College, South Suburban College) and specialized institutions (e.g., Sinai Urban Health Institute, SUHI).



Illinois Spotlight: Illinois Employer Survey 2022

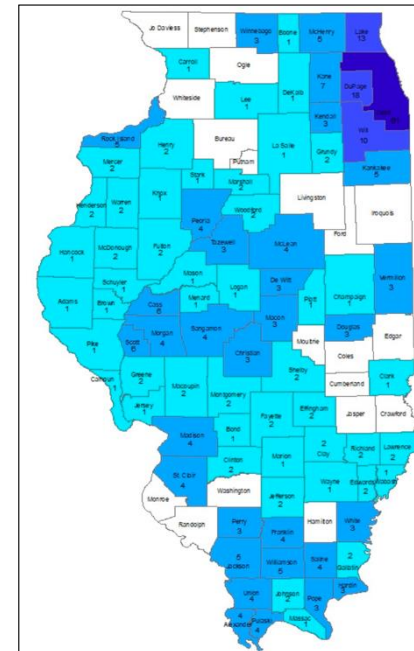
The Illinois CHW Common Indicator Employer Survey was the first CHW survey to be conducted in the state.

- Created and disseminated through a collaborative effort between the Illinois Department of Public Health (IDPH), Illinois Community Health Workers Association (ILCHWA), Sinai Urban Health Institute (SUHI), Health and Medicine Policy Research Group (HMPRG), and Illinois Public Health Association (IPHA).
- Surveyors noted that their original distribution list garnered 105 responses. However, using additional outreach strategies such as sending the survey out through FQHC and hospital contact lists, the team increased the number of respondents to 118. **Multiple avenues of outreach were key to increasing survey responses.**

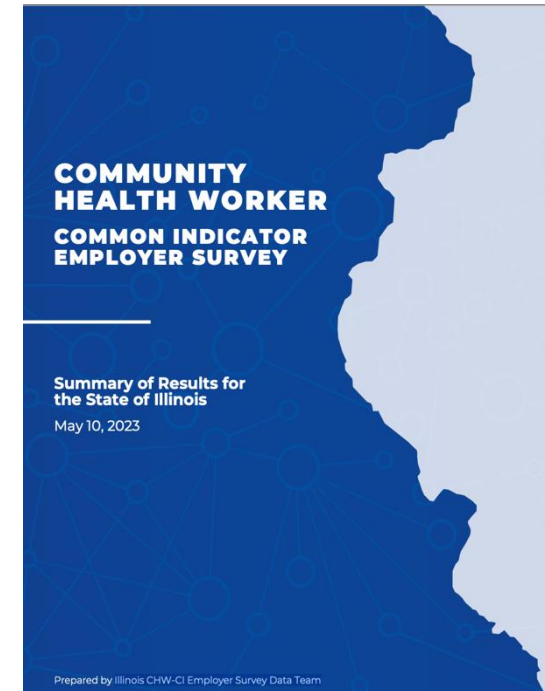
Key findings:

- The average hourly rate for CHWs was \$23.27 (part-time) and \$22.12 (full-time).
- CHW yearly earnings ranged from \$6,000 - \$55,000 (part-time) and \$12,000 - \$87,550 (full-time). The average yearly salary was \$21,186.55 (part-time) and \$42,403.95 (full-time).
- 68% of employers did not have a sustainable source of funding for CHWs

Count of CHW Organizations by County



Source: Illinois Department of Public Health, Illinois Community Health Workers Association, Sinai Urban Health Institute, Health and Medicine Policy Research Group, Illinois Public Health Association. Community Health Worker - Common Indicator Employer Survey (CHW-CI) 2022; 2022. [Link](#)



Count of Organizations

- 1 - 2
- 3 - 7
- 8 - 18
- 19 - 61

Kentucky (1/2)

State Legislation

- [HB 525](#) (2022) outlines CHW definition, eligibility, certification, and continuing education and renewal, and created an opportunity for Medicaid reimbursement.
- KRS Statutes [309.460](#), [309.462](#), and [309.464](#) (2022) outline the statutory requirements regarding CHW certification, continuing education, certification renewal and the duties of the Department for Public Health.
- Kentucky Administrative Regulation (KAR) [902 KAR 21:040](#) (2022) authorized the DPH to set administrative regulations for the certification of CHWs.
- [KRS 205.648](#) and [907 KAR 3:310](#) (2023) address CHW Medicaid reimbursement.

Financing

- [SPA 23-0002](#) was passed and implemented in 2023. CHW services that can be billed include 3 CPT codes by # of individuals served and time increments.



Kentucky (2/2)

Education, Training, and Certification

- CHW certification from [the Kentucky Office of CHWs \(KOCHW\)](#) is required for Medicaid reimbursement.
- KOCHW developed the curriculum with partner organizations, which includes 40 hours of classroom-based learning and 40 hours of verifiable mentorship.
- A legacy track exists, requiring 2,500 hours of work in the past three years to qualify.
- The Kentucky Association of CHWs (KYACHW) has a certification committee that reviews the process annually
- Certified CHWs are required to earn 10 CEUs per year, five of which must come from KOCHW-approved programming. CCHWs recertify annually.



Kentucky Spotlight (1/2): The Kentucky Office of CHWs (KOCHW)



KOCHW, under the Kentucky Department of Public Health (KDPH), provides oversight for CHW training and certification, technical assistance for CHW organizations and partners, and communicates with KY Medicaid to inform financing policies.

- Established in the early 2000s to support the department's own Family Health Advisors positions and other CHWs across the state
- Formed so that DPH could better advise and help carry out statewide CHW policies

Factors underlying success of the office:

- Collaboration between state and community actors
- Kentucky DPH champions and other influential actors who understood the importance of community presence
- Influential physicians voicing their support
- KDPH's Family Health Advisors providing early evidence of the effectiveness of the role
- Funding streams (started with an initial block grant)
- A designated CHW coordinator and staff
- Platform to hear directly from CHWs and disseminate information directly to CHWs
- A culture of collaboration
- Tenacity to continue pushing a message through setbacks and leadership changes

Kentucky Spotlight (2/2): Enablers Behind the Approval of Kentucky's CHW SPA

HB525 and SPA #23-0002 are Kentucky's newest legislation, recognizing the CHW workforce and establishing for Medicaid reimbursement for certain CHW services.

Kentucky's SPA passed in early 2023 allowing for Medicaid reimbursement for CHW services, including health coaching, system navigation, health education and promotion.

While the foundation for HB525 was being built for years before HB525 was passed, the journey from DPH recommendations to an approved SPA was uniquely short.

Beginning in 2022, KY Medicaid collaborated with KOCHW to find acceptable codes and reimbursement rates and engaged other states to understand what they could replicate. By February 2023, a SPA was submitted to CMS and it was approved a month later. The services will begin July 1, 2023, although drafting regulations may continue afterward.

Reasons named for rapid development and successful approval of a CHW SPA:

- Being flexible through the process. KOCHW noted that Kentucky is a managed care state and largely functions using capitated rates rather than a reimbursement approach; however, KY still decided to institute reimbursement rates, and now that the SPA has been passed, KY Medicaid can work to develop a plan for implementation.
- Direct communication with KY Medicaid. KOCHW meets with Medicaid 2x monthly to inform CHW Medicaid strategy, based on feedback from CHW stakeholders and the office's own research.
- Champion in the Medicaid Commissioner.
- In previous [presentations](#) (link passcode available to ORH for OASH presentation), the Commissioner has also mentioned that continuously communicating with legislators has allowed for flexibility and efficiency.

Louisiana

State Legislation

- In 2019, through [SCR 70](#), created the Louisiana Community Health Worker Workforce Study Committee. This committee worked on providing policy recommendations to the DOH on how best to support and expand the state's CHW program.
- [HB 587](#) was passed June 2023, and establishes the Louisiana Community Health Worker Workforce Board within the Louisiana Department of Health.

Financing

- LA passed a [SPA](#) in 2022 that reimburses CHW services through Medicaid MCOs.
- LA pays for CHW services through APMs; for example, there is an [alternate payment methodology](#) for adjunct services provided by rural health clinics (RHCs) for services done during evening, weekend or holiday hour. In addition, CHWs are paid outside of the PPS rate.
- They also include CHWs services in the Healthy Louisiana Medicaid VBP model [capitated rate](#).

Education, Training, and Certification

- In 2019, the [CHW Workforce Study Committee](#) (requiring that 50% CHW members) made recommendations including opting out of certification, and rather creating standardized trainings. It has evolved into the Louisiana CHW Workforce Coalition, which is now creating criteria and a review process for training programs.
- The Louisiana CHW Institute and Louisiana Community Health Outreach Network ([LACHON](#)) also provided CHW/supervisor training, as and public education about the roles of CHWs.



Louisiana Spotlight (1/2): The LA Dept of Public Health CHW Program

The LA Dept of Public Health CHW Program

- In 2019, the LA DPH piloted a CHW program with one public health unit (catchment area) and then expanded.

Program Financing

- LA DPH partnered with Medicaid, started monthly workforce meetings, and were part of two different 1115 waivers that helped fund their CHW program.
- When designing their [SPA](#), the DOH met with a lot of resistance, in getting budgetary approval. They had trouble getting buy-in because their program was based on one pilot, legislators were not educated on CHWs.

Passing a successful SPA

- They did an ROI study that helped convince legislators of the importance of CHWs.
- Having a champion in Louisiana State University was extremely significant, as was having a statewide network relationship with CHWs on the ground.

2023	2023	2023	2023-2024
Expand outreach of CHW to Rural Hospitals and Rural Health Clinics	Expand within LA Dept. of Health	Expand locations & billing for CHWs	Workforce Expansion
<ul style="list-style-type: none"> • Cardiovascular Grant • LRHA Outreach • Participate in Community Coalitions & Collaborations • Community Outreach 	<ul style="list-style-type: none"> • 1115 CMS Waiver approved 2022 • Public Health Unit Standing Order Developed • Developing billing processes • Inclusion in LDH Business Plan 	<ul style="list-style-type: none"> • Baseline established Current agencies billing for CHW services-7. No denials as of 5/31/23 • Program expanding Partner locations • Education on billing for CHW across the state 	<ul style="list-style-type: none"> • CHW Workforce Task Force • Work with partner organizations in training CHWs

Current LA Dept of Health CHW-Related Activities



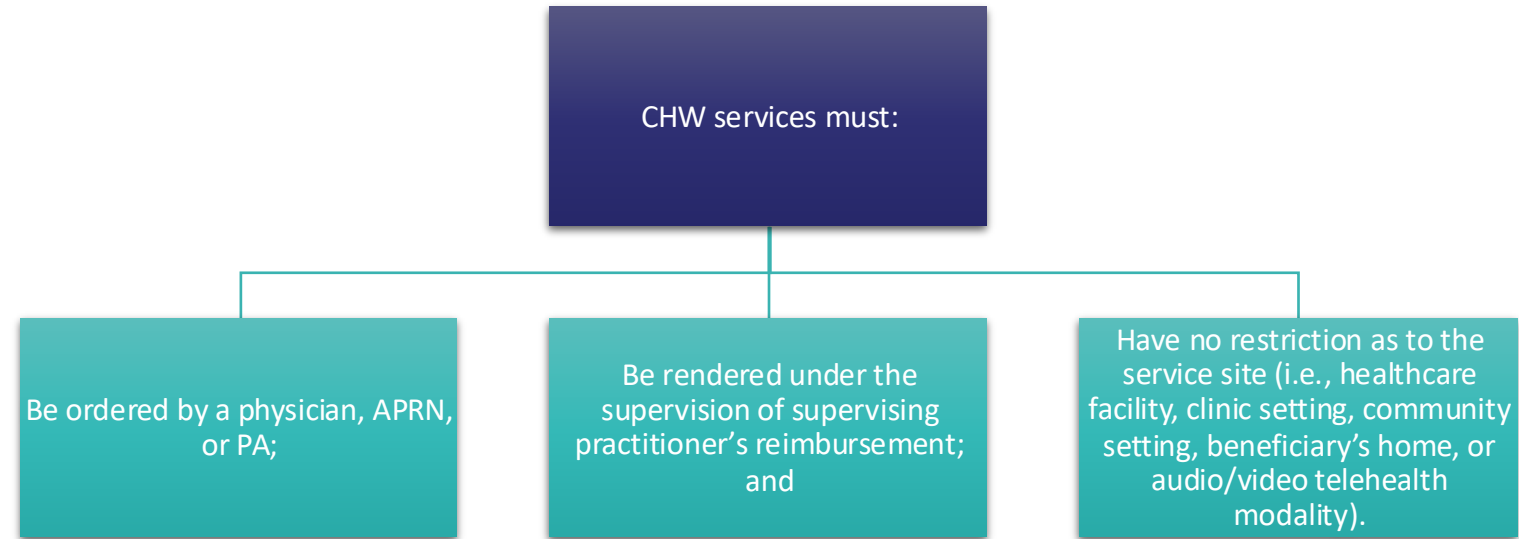
Looking Ahead...

- Currently billed CHWs are mostly employed by healthcare systems, Louisiana is looking to involve more CBOS and CHW organizations
- Develop the recently created CHW Workforce Board

Louisiana Spotlight (2/2): CHW Reimbursement through the SPA

- The SPA followed a medical model in which providers can refer out to CHW organizations
- CHWs are paid per person seen
 - Billable CPT Codes: (See Professional Service Fee Schedule)
 - 98960 – Individual CHW services
 - 98961 – Group CHW services
 - 98962 – Group CHW services
- Maximum reimbursement is two hours per day and ten hours per month per enrollee
- The physician, APRN, or PA presence in the facility is not required during the performance of the service.
- FQHCs are paid **outside** (in addition to) their prospective payment system (PPS) rate for other services.

Reimbursement Guidelines



**CHW services were added to the MCO Manual and are mandatory for MCOs. There is no need for wraparound payment as MCOs are required to cover the CHW services.*

Reimbursement Fees

CPT Code	Description	Fee
98960	Education and training for patient self-management by a qualified, non-physician health care professional: 1 patient	\$18.11
98961	As above: 2-4 patients	\$6.04
98962	As above: 5-8 patients	\$2.79

Source: Louisiana Office of Public Health Bureau of Regional and Clinical Operation

Maryland

State Legislation

- [House Bill 856](#) (2014) created a stakeholder workgroup to study and make recommendations regarding the Workforce Development for CHWs. The Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA) completed the workgroup process in April 2015.
- 2018 Community Health Worker Act ([Health-General 13-3701-3709](#)) established the State CHW Advisory Committee and requires regulations be adopted for CHW certification process and to accredit CHW certification training programs.
- [COMAR 10.68.01](#) (2019) set the requirements for an individual to be certified by Maryland Department of Health (MDH) as a certified CHW.
- [COMAR 10.68.02](#) (2019) set the requirements for CHW certification training programs to be accredited by MDH.

Financing

- Maryland has a [1115 Reentry Waiver](#) in which CHWs may be reimbursed for case management services.

Education, Training, Certification

- [MDH](#) serves as certifying body and requires training institutions to be accredited in order to offer training for CHW certification. Certification is not required



Massachusetts (1/2)

State Legislation

- Established board under MA DPH to certify CHWs (2012, see [Chapter 58, Acts of 2006 Section 110](#); and [Chapter 224, Acts of 2012](#). [Chapter 322, Acts of 2010](#), [272 CMR, 2021](#)).
- Passed law in 2007 that created a seat on the Public Health Council for a representative from the MA Association of CHWs; [2012 health reform law](#) includes similar seat for on Prevention and Wellness Trust Fund Advisory Board.

Financing

- As part [1115 waiver](#), the state has included funds for CHW certification, inclusion of CHWs in the PMPM rate, Student loan repayment options for CHWs, CHW services in ACOs, and a postpartum CHW pilot program.
- MA's [D-SNP](#) program includes CHW services.
- In 2024 the State Legislature appropriated \$200,000 for CHW training
- In 2023, MassHealth launched a [capitated primary care program](#) through its accountable care organizations, which incentivizes team-based care, including support provided by CHWs.



Key policies:

- [Certification requirements](#)
- [Training program approval policy](#)

Massachusetts (2/2)

Education, Training, and Certification

- CHW [training is offered](#) by community-based organizations, a local health department, a university, and community colleges.
- The [Board of Certification of CHWs](#) is within the Massachusetts DPH in the Bureau of Health Professions and Licensure. They can approve CHW training programs, requiring a CHW trainer in at least 40% of instructional hours.
- Until June 2023, [two pathways to certification](#): work experience pathway (requires 4,000 hours of experience) or the Training + Work experience pathway.



Key policies:

- [Certification requirements](#)
- [Training program approval policy](#)

Michigan (1/2)

State Legislation

- [Public Act No. 166](#) (2022) budgets money for CHW services that can be delivered by way of waiver, SPA, or other avenues.

Financing

- Michigan state [2021 Medicaid contract](#) states that Medicaid health plans (MHPs) are required to employ CHWs at a ratio of 1:5,000 members. These CHWs may be hired by the MHP or contracted out to a community-based organization or clinical setting. MHPs are provided an incentive through the application of a ratio multiplier for meeting the contractual ratio requirement by contracting with a community-based organization or a clinic for CHW services.
- Michigan Medicaid supports several team-based care models that include CHWs, including the [health home model](#), [targeted case management for recently incarcerated individuals](#), and behavioral health peer support services.
- Medicaid SPA [23-0020](#) (2023) covers CHW benefits including health system navigation and resource coordination, health promotion and education, and health screening and assessment for 2 hours per day and 16 visits for per month and requires CHWs to complete a skills-based training program. CHWs will be paid on a fee-for-service basis.
- In 2024, Michigan appropriated \$325,000 for CHW career centers.



Michigan (2/2)

Education, Training, and Certification

- The Michigan Community Health Work Alliance ([MiCHWA](#)) provides the CHW training, curriculum, and certification for the CHW workforce in Michigan. Certification is not currently recognized in the state legislation.
- MDHHS or Michigan Medicaid [do not require a certification](#) for reimbursement, however CHWs are required to complete a skills-based training course and continuing education training annually.



Michigan Spotlight: Conversation with Michigan CHW Alliance (MiCHWA)

Background

- Founded in 2011 under the University of Michigan School of Social Work. In 2019, the alliance became its own 501(c)3 organization and evolved to become the central information hub and an advocate for CHWs across the state.
- Members include CHWs, CBOs, allies, a small group of experts in a range of areas including policy, government affairs, Medicaid, with concentrated expertise in advocacy, lobbying, policymaking
- The majority of MiCHWA's activities fall within four categories:
 - **Advocacy**
 - **Training & Certification**
 - **Implementation** (*majority Covid-19 related activities*)
 - **Workforce Data**

Michigan Legislative Policy Development & Public Act No. 166

MiCHWA allocated time and resources to analyze data from CHWs, talk to decision-makers, make recommendations, and lobby to have the Michigan Legislature appropriate **\$28.3 million** for CHW reimbursement through Medicaid in [Public Act No. 166 Section 1616](#); now involved in drafting SPA to distribute these resources.

Training and Certification

- For the last 7 years MiCHWA has offered CHW training courses and its own certification (no state certification available).
- Recently launched 2.0 curriculum, which opens door to certification, participation in CHW registry, and receiving CEU and other trainings.
- Certified CHWs are required to have 20 CEUs every 2 years.

MiCHWA Workforce Survey

MiCHWA and the Michigan Department of Health and Human Services (MDHHS), with funding through the Centers for Disease Control and Prevention (CDC), partner on [bi-annual surveys](#) of Michigan's CHW programs and employers, collecting consistent and comprehensive workforce data for the state.

Minnesota

State Legislation

- [Minnesota Statute 256B.0625, Subd. 49](#) (2009) allows for CHWs to partake in Medicaid and receive Medicaid reimbursements for certain services.
- [Statue 144.1462](#) authorizes the commissioner of health to support collaboration and coordination between partners to expand the CHW profession

Financing

- Health plans that contract with MN's Medicaid agency are [required](#) to cover diagnosis-related patient education on self-management services provided by certified CHWs working under clinical supervision.
- Minnesota's [SPA](#) reimburses for patient health education, and in 2024 the reimbursement was expanded to include new [Community Health Integration \(CHI\) services](#) and defined by Medicare

Education, Training, and Certification

- A [state-wide standardized, competency-based educational program](#) is recognized by MN Medicaid. It is based in accredited post-secondary schools and overseen by MN State Colleges and Universities System. The curriculum is also [used by other states](#),, including MI, SD, ND, OH, NJ, SC.
- Certification is not required for employment, but it is [required](#) for reimbursement for services provided to MN Health Care Program enrollees.



https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/chwr_eg2016c.pdf
[State Community Health Worker Policies – The National Academy for State Health Policy \(nashp.org\)](#)
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONTENT&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_14_0357

Nevada (1/2)

State Legislation

- [SB 498](#) (2015) mandates the licensure of organizations and agencies who employ CHWs. However, the law does not provide for individual CHW certification or licensing.
- [Assembly Bill 191](#) and [Senate Bill 420](#) (2021) allowed NV Medicaid to cover CHW services.
- [Senate Bill 117](#) (2023) allowed Nevada Medicaid to expand the supervision and settings allowable for CHW services.

Financing

- SPA [21-0012](#) (2022) allows for the reimbursement of CHW services for health education and training for patient self-management. SPA [21-0013](#) (2022) adds CHW providers to Nevada's Alternative Benefits Plan pages. SPA [23-0028](#) (2023) updated the allowable providers who may supervise CHWs.
- Case management is not part of CHW MSM covered services. MCEs can elect to engage CHWs for case management purposes. However, those services must be funded through the administrative portion of their capitation rate.



Nevada (2/2)

Education, Training, Certification

- Certification is available for all CHWs who meet the standards and training required by the [Nevada Certification Board](#); Two tracks ([CHW I and CHW II](#)) requiring training alone vs. training and experience. The certification was developed in partnership with the NV CHW Association. Core competencies were based on competencies of the American Public Health Association (APHA), the National Community Health Association, Texas, and Massachusetts.
- The [Nevada CHW Association](#) oversees CHW curriculum and approved training programs in the state.



New Hampshire

State Legislation

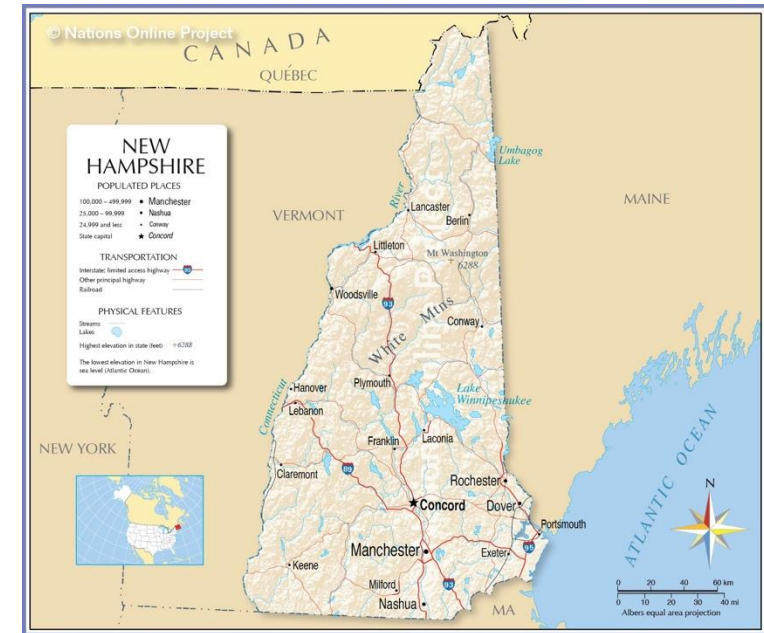
- [SB 403](#) (2024) requires the creation of a voluntary certification to create a Medicaid reimbursement pathway for “Certified Community Health Workers” (CCHW) and the submission of a SPA that will provide Medicaid reimbursement for certified CHWs.

Financing

- None

Education, Training, Certification

- Training through the [North Country Health Consortium](#) and [Southern New Hampshire Area Health Education Center](#). Both organizations, in addition to the [New Hampshire CHW Coalition](#) also have curriculums for professional development.



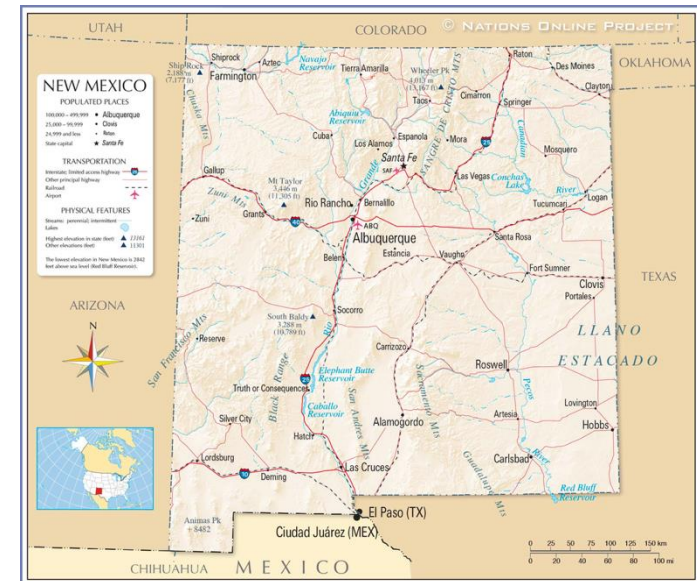
New Mexico (1/2)

State Legislation

- [SB 58](#) (2015) and [NMAC 7.29.5 Certification of Community Health Workers](#) (2015) created a voluntary, statewide certification program for CHWs through the Department of Health.

Financing

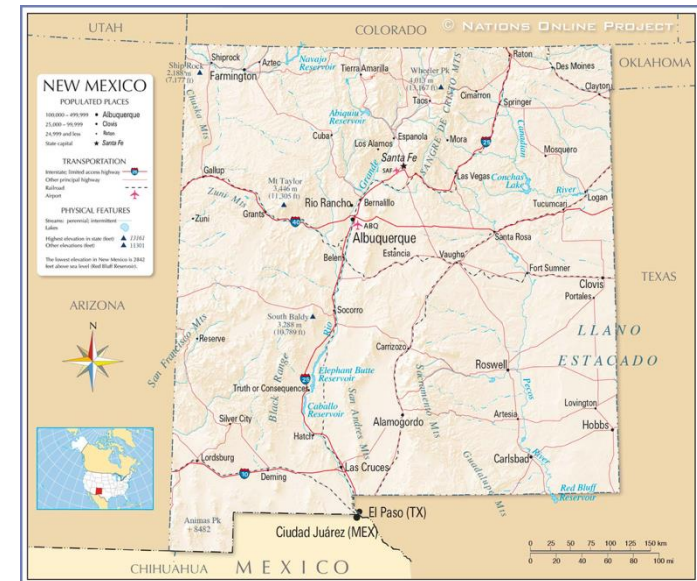
- [SPA 23-0111](#) (2023) reimburses for CHW services
- Salaries, training, and service associated costs are billed into the MCOs' administrative costs and embedded into capitated rates paid to MCOs.
- New Mexico's section [1115 reentry waiver](#) includes as CHWs services qualified incarcerated individuals within 90 days prior to release.



New Mexico (2/2)

Education, Training, and Certification

- The [NM CHW Certification Board](#) determines requirements for CHW state certification and serves in the advisory capacity for the [NM DOH Office of CHWs](#), which is charged with developing a statewide training and certification process for CHWs, processing applications and issuing certificates.
- Certification requires 100 core competency training hours with an endorsed training entity approved by the NMDOH OCHW ([list](#)), including 40 hours of experiential learning approved by the agency. [Legacy track is also available.](#)
- Two types of certification: Generalist and Specialist. Specialist certification is for CHWs who are eligible to receive specialty trainings with an approved training entity within a specialized content area if training hours of 12 or more is received consecutively.



New Mexico Spotlight: University of New Mexico's CHW Initiatives (CHWI)

Background

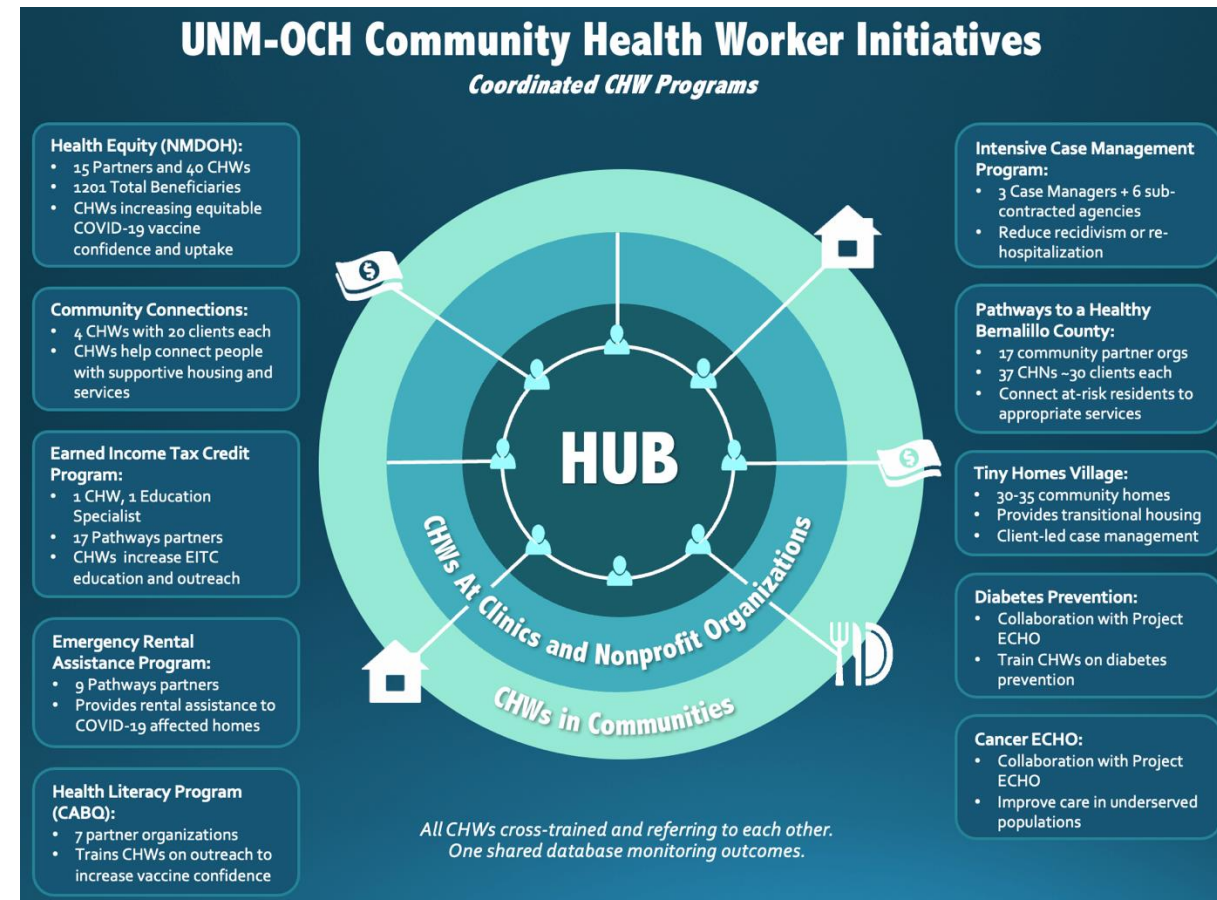
- A set of 11 programs housed in one hub (UNM's Office of Community Health). The hub develops, manages, and coordinates health programs for contracted CBOs. They also hire CHWs, offer advising, and build custom tools to increase CBO capacity.
- All Hub CHWs are cross-trained **Fixed** between programs, share the same database, and can refer to each other.

Financing

- CHWI is financed through diverse funding streams including county and state funding, contracts, city monies, grants from all over, hospitals, and departments of health.

Championing Data & Data Systems

CHWI is building a team to look at funder-identified impact data (# of trainings, cost savings, etc.) and educate funders on equitable data collection and community-specific outcome and impact metrics. In addition, one of the CHWI programs has created real-time dashboards to enable CHWs to see their own metrics regularly. This has led to improvements in implementation and team morale.



North Carolina (1/2)

State Legislation

- [North Carolina Administrative Code 10A 48B.0803](#) states that the local health department shall ensure that program planning and implementation involve community health advocates that represent populations being served in the local health department.

Financing

- As part of North Carolina's section [1115 waiver](#), provides training and certification support and gives recruitment and retention bonus payments to eligible providers, including CHWs, who make a 3-year full-time commitment to working at an organization with a panel that includes at least 30 percent Medicaid and/or uninsured members under the Behavioral Health and Long-Term Services and Supports Workforce Program
- The 1115 waiver explicitly allows CHWs to be part of managed care teams in the state. They are included as members of the care management team in both the [Medicaid Standard Medicaid Plan and Tailored Plan contracts](#). CHWs were also permitted to assist in administering [Healthy Opportunities Pilot](#) care management services.



North Carolina (2/2)

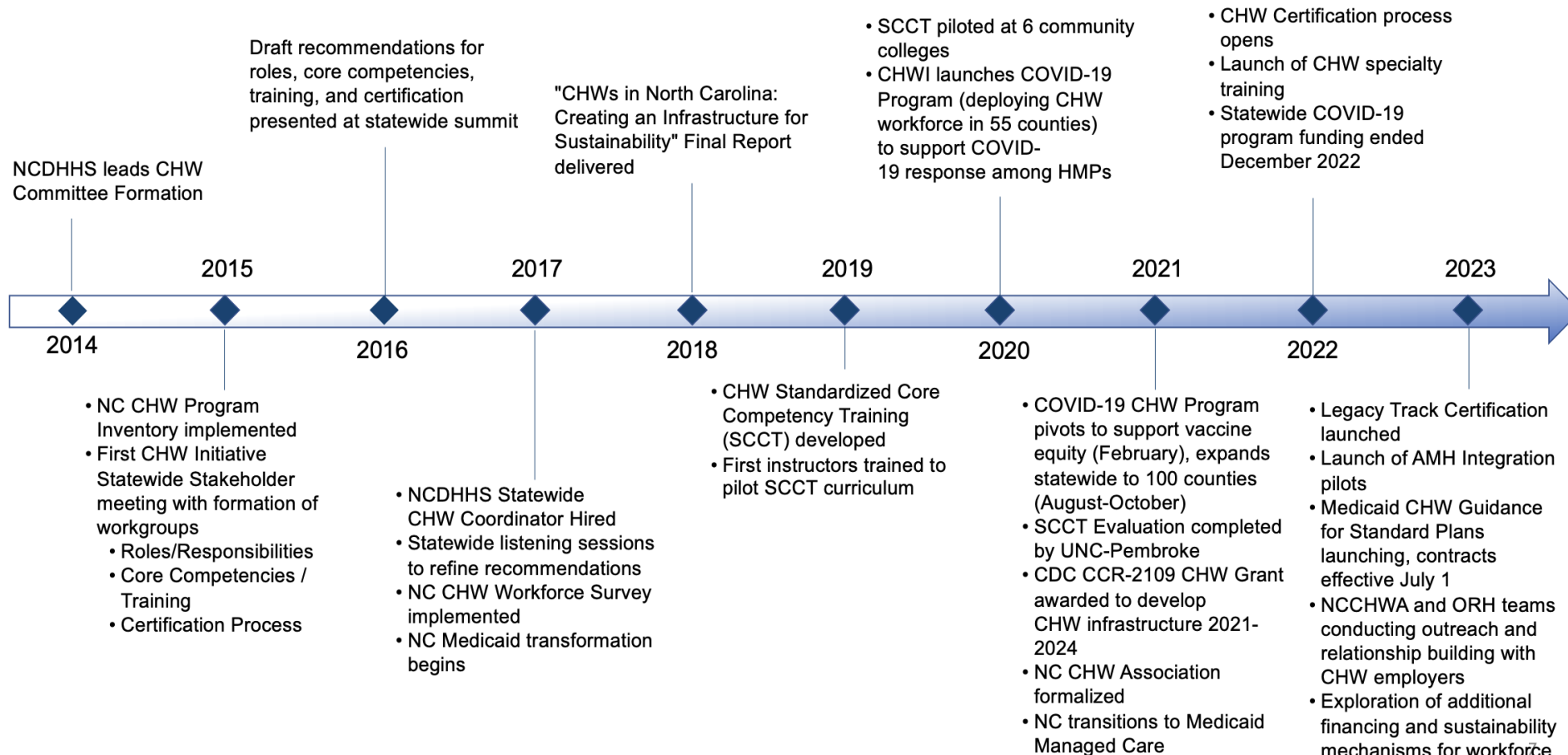
Education, Training, Certification

- The North Carolina Department of Health and Human Services (NCDHHS) Office of Rural Health received CDC CCR-2109 funds to support CHW training and certification programs.
- The [NC CHW Association \(NCCHWA\)](#) operates a Standardized Core Competency Training (SCCT) program at community colleges across the state. CHWs who complete this course are eligible for certification. A legacy track is also available for CHWs with lived experience, as well as four advanced levels of supervisory certification.
- NC AHEC, in partnership with NCCHWA and NCDHHS, provides a variety of optional, self-paced, free, [virtual training modules for CHW training](#) focused on specific topics and populations
- Since August 31, 2021, CHWs have been trained in a variety of health and social condition topics such as disease management, maternal/child health, lifestyle interventions, referrals, connections to primary care services, connections to social support services, equity, community health assessments, and more.



North Carolina Spotlight (1/4): NCDHHS Investment in a Strong Community Health Workforce

NCDHHS has been working towards statewide infrastructure for a CHW workforce since 2014. The Office of Rural Health (ORH) invested in a CHW workforce to address inequities during the Covid-19 emergency response, and in 2021 they received a 3-year, 9-million-dollar CDC grant to support the creation of a statewide CHW infrastructure.



North Carolina Spotlight (2/4): The Covid-19 CHW Program, A Statewide CHW Workforce For Emergency Response

During the pandemic, NCDHHS Office of Rural Health (ORH) contracted several organizations to hire CHWs across the state. CHWs focused on providing community-based COVID-19 education, vaccine facilitation for historically marginalized populations, and wraparound services for those impacted by COVID-19. Their work was foundational to a sustained health equity response and laid the groundwork for future community-based public health programming. All CHWs received a stipend to complete the Standard Core Competency training and receive CHW Certification.



Major components of the COVID-19 CHW Program



Flexible, Community-Based Workforce

A flexible workforce trained to provide contact tracing, case investigation, testing, vaccination, and care management support for the COVID-19 response.



Care Resource Coordination Support

Provided access to social support resources, accurately and precisely identified gaps, and strengthened referral networks to address the social determinants of health



Primary Care and Behavioral Health Linkages

Increased the number of primary care and mental health referrals made in the community and addressed barriers that prevented individuals from accessing care.



Equity-focused Vaccine Support

Provided valuable support via education, community vaccine events, and connections to appointments. Collaboration with initiatives ensured deeper reach and stronger response

North Carolina Spotlight (2/4):

A Statewide CHW Workforce For Emergency Response, the Covid-19 CHW Program

The NCDHHS COVID-19 CHW Program put a spotlight on the impact, adaptability, and resilience of the community health workforce.

Social Support Referral Impact

Sep 2020 – Dec 2022

3,473,519

Individuals served by
CHWs

159,978

Referrals for SDOH
services made by CHWs

921,831

Telehealth
encounters performed by
CHWs

Vaccine Equity Impact

Feb 2021 – Dec 2022

20,540

Vaccine education events
hosted/assisted by CHWs

1,799,528

Individuals present at
CHW vaccine education
events

5,256

Vaccination clinics or
events assisted/planned
by CHWs

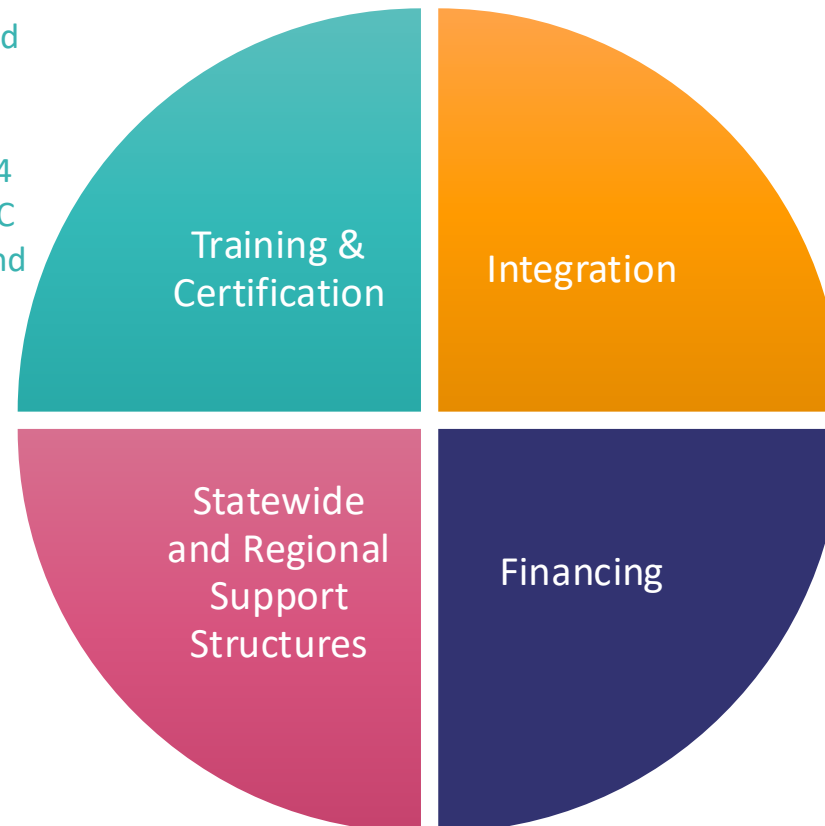
63,228

Individuals scheduled for
a COVID-19 vaccine with
the help of CHW

North Carolina Spotlight (4/4): NC CHW Initiative and Building a Statewide Infrastructure for CHWs

The NC CHW Initiative is statewide CHW initiative that will build, reinforce, and integrate a CHW infrastructure with public health and healthcare systems. This work was partially supported by a 3-year \$9 million grant ([CDC CCR-2109](#)) between 2021-2024.

- The [Standard Core Competency Training \(SCCT\)](#) offered at 13 community colleges, with online and bilingual Spanish/English courses available
- CHW [specialty training](#) modules launched by NC AHEC in 2021, with >50 modules planned by 2024
- CHW [certification](#) launched in Feb 2022 by the NC CHW Association (NCCHWA), with legacy track and advanced level certification available in 2023
- [NCCHWA](#) established in 2021
- [Quarterly convenings](#) of statewide stakeholders hosted by ORH
- [ORH CHW regional coordinators and NCCHWA CHW Ambassadors collaborate](#) to support regional CHW employers and networks
- [Landscape survey](#) of CHW employers in NC
- Convenings for [coordination of CHW data](#) collection statewide
- CHW-related [news distribution](#) via ORH, NCCHWA, and NC AHEC listservs
- [Regional CHW coalition](#) in Western NC



- [4 FQHC pilot programs](#) started, integrating CHWs into practice operations with an evaluation component
- [Area Health Education Center \(AHEC\) support for health practices](#) on CHW integration (workgroup, coaching, learning collaborative, webinars)
- ORH, NCCHWA, and additional stakeholder participation in a [health systems CHW community of practice](#) with NC-based hospitals
- NC Medicaid (Division of Health Benefits, DHB) [Medicaid strategy](#) for integrating & financing CHWs proposed in 2023. Strategy includes CHW hiring requirements, CHW-to-enrollee ratio, and community-based CHW incentive
- [Monthly touchpoints](#) with ORH, DHB, and NCCHWA to continue exploring future sustainability strategies

Ohio (1/2)

State Legislation

- HB 95 (2003) was enacted and required that the Board of Nursing issue and renew CHW certificates. [Ohio Administrative Code](#) lays out additional details
- [Section 3701.0212](#) of the Ohio Revised Code created a Center for CHW Excellence to be added to the 2023-2024 Ohio biennial budget with 2.5 million in appropriations each year in order to expand and strengthen the CHW workforce.

Financing

- [Ohio Administrative Code Rule Section 5167.173](#) (2019) requires that MCOs provide CHW or public health nurse services to Medicaid enrollees who are pregnant or capable of becoming pregnant, reside in a community served by a qualified [Community HUB](#), and were recommended to receive CHW/public health nurse services. To meet these requirements, MCOs may directly employ CHWs or contract with CBOs that employ CHWs.
- Ohio Department of Medicaid (ODM) offers two voluntary APMs: [Comprehensive Primary Care](#) and [Comprehensive Maternal Care](#). They provide enrolled practices with funding to support population health activities such as team-based care delivery, which can fund CHWs.



Ohio (2/2)

Financing (cont.)

- In 2018, CHW employers [reported](#) a mix of payment through reimbursement from Medicaid and payment from MCO contracts.
- ODM provides ten communities with high infant mortality and outcome disparities with biannual funding to support community-driven interventions to improve maternal and infant health. Nearly all communities use these grants to invest in additional CHW services.

Education, Training, Certification

- Ohio Administrative Code [Rule 4723-26-02](#) (2020) most recently codified CHW certification requirements.
- [Certification requires](#) completion of an approved training program with 100 hours of classroom training and 130 hours of a community-based practicum.
- The [Board of Nursing issues and renews certification](#) every two years based on initial training and continuing education requirements thereafter.
- Certification is not mandatory.



Rhode Island

State Legislation

- [H 5633](#) (2011) established the Commission for Health Advocacy and Equity. The recommendations from the commission may include recruitment, training, and employment of CHWs.

Financing

- [SPA 21-0012](#) (2022), allows reimbursement for certified CHWs providing certain health-related services, with services reimbursed starting July 1, 2021.
- [Medicaid accountable entities](#) (similar to ACOs) may use funds earned through the Health System Transformation Project Incentive Fund to fund CHW services.

Education, Training, Certification

- CHW training is funded by a variety of departments, private foundations, and some employers. There is no standardized curriculum for CHWs, but [certification requires education in specified areas](#).
- Certification is available for all CHWs who meet the standards by the [Rhode Island Certification Board](#). Though it is not required otherwise, the SPA notes that services must be provided by certified CHWs or those who plan to be certified within 18 months in order to be eligible for reimbursement.



Rhode Island Spotlight (1/2): State Plan Amendment for CHW Reimbursement

➤ Rhode Island's CHW SPA [21-0012](#) went into effect in 2021. Implementation of SPA stipulations is currently underway, and include these highlights:

1905a Preventive Category

The Rhode Island CHW SPA was filed under the 1905a authority, specifically in the “preventive” category, rather than as an “other licensed provider” or “rehabilitation” category.

In this category, supervision is not required, allowing Rhode Island's CHWs to be reimbursed outside of the medical model.

Medicaid Recipient Eligibility

Benefit eligibility requirements for CHW care included *“Beneficiary expressed need for support in health system navigation or resource coordination services.”*

This allows Medicaid recipients to ask for CHW care in addition to allowing a provider to determine their need for CHW services

Referral Requirement

Rather than having a primary care provider be the sole option for referral to CHW services, this SPA allows any “licensed practitioner of the healing arts” to issue a recommendation for CHW services and be eligible for Medicaid reimbursement.

Collateral Services

Collateral services are “those delivered on behalf of an individual but are not delivered in that beneficiary's presence/directly to the beneficiary.” This allows CHWs to bill for the time they spend coordinating, researching new support services, discussing with the care team.

Training and Certification

Many clinical providers saw standardized training as an important aspect of setting a standard for the workforce, however, acknowledging the importance of years of lived experience, CHWs are given a grace period of 18 months of employment in order to complete certification.

Rhode Island Spotlight (2/2): Opportunities and Challenges in Passing and Implementing the State Plan Amendment

Opportunities

- Rhode Island's SPA proposal went through three budget cycles before being passed, and a key reason for its passing was the larger state budget that existed at the time.
- Having a champion was key to passing SPA
- The SPA emphasized value in addressing health disparities, which was an important priority for the legislature.

Challenges

- ROI was not a persuasive argument because it is rarely generalizable
- While it was assumed CBOs would have a difficult time with billing, CBOs were able to adapt easier because they had no system at the time, while hospitals that had the more difficult time because their system was already so complex, specifically because of lack of NPI number

In fall 2023, Rhode Island published its first qualitative evaluation of their SPA; please reach out to Rhode Island's Department of Health [CCR-2109 team](#) for more information.



South Carolina

State Legislation

- [H. 4300](#) (2023) appropriated funds for the SC Center for Community Health Alignment to expand the CHW programs in hospital settings.

Financing

- The state has encouraged Medicaid managed care organizations to use CHWs, and there are some ongoing efforts to better integrate CHWs into the healthcare system.

Education, Training, and Certification

- A certification process was established in 2012. It is administered by the [South Carolina CHW Credentialing Council](#) (SCCHWCC) and approves educational programs, including curricula, facilitators, and preceptors, to administer South Carolina's Core Competency training for CHWs.
- SCCHWCC is led by the South Carolina CHW Association and includes representation from state health officials.
- SCCHWCC revised [the core competencies](#) and the process for training CHWs in 2019.
- Certification requires 80 hours classroom, 80 hours practicum, a core competency exam, and continuing education credits. Certification needs to be renewed every two years.
- There is a [tiered certification system](#) of three levels along with a legacy track.



South Dakota

State Legislation

- No legislation identified.

Financing

- [SPA 19-0005](#) (2019) adds CHW preventive services for specific chronic diseases as a benefit under the Medicaid State Plan.
- The SPA allows for [CBOs to register as CHW agencies](#) and bill for CHW services.

Education, Training, Certification

- [The Community Health Worker Collaborative of South Dakota](#), in partnership with the Department of Health, administers CHW certification.
- There are separate CHW and CHR certifications. Both require 200 hours of training and 40 hours of shadowing, and cover three areas: health promotion, navigation/resource coordination, and health education. More information [here](#).
- [Training programs](#) have to be approved by the Collaborative.
- Community Health Representatives (CHRs) can enter through a legacy track in the CHR training program.
- CHWs [must be certified](#) for the agency to be reimbursed for services through South Dakota Medicaid.



Texas (1/2)

State Legislation

- [Texas Health and Safety Code Chapter 48](#) required Department of State Health Services (DSHS) to create and operate a certification for CHWs across the state.
- [SB 1051](#) (2001) required DSHS to establish a training program to oversee certification.
- [HB 2610](#) (2011) required DSHS to create a statewide advisory committee to provide recommendations for CHW training, funding, and employment.
- [HB 113](#) (2023) allows Medicaid MCOs to categorize CHW expenditures as quality improvement costs.
- [HB 1575](#) (2023) requires the Health and Human Services Commission to establish a separate provider type for a CHW who provides case management services under the Case Management for Children and Pregnant Women Program.

Financing

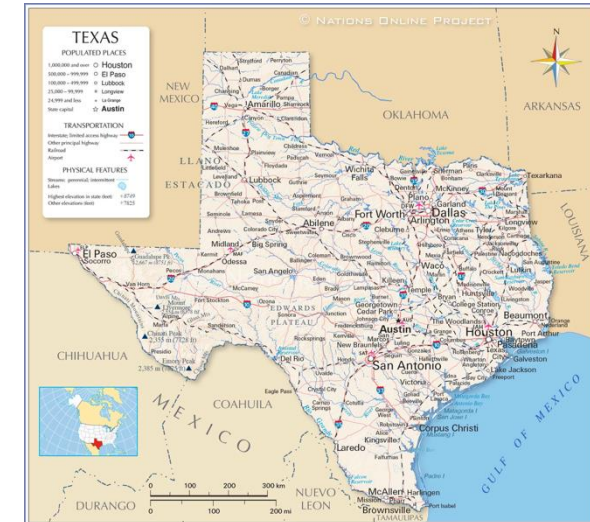
- Contracted Medicaid MCOs allow CHWs-related expenses to be included in their administrative costs/quality improvement costs. . Medicaid managed care organizations participating in the [STAR Medicaid program](#) to recognize CHW services as a quality improvement cost instead of administrative expense. Medicaid administration costs are limited by federal requirements to adhere to a [medical loss ratio](#), requiring 85% of plans costs to be on clinical care or quality improvement and limiting administrative costs to 15%. This allows managed care organizations (MCOs) to invest more in CHW services through the QI portion.



Texas (2/2)

Education, Training, and Certification

- Certification is mandatory for CHWs to be compensated for services.
- [DSHS](#) oversees the Promoter/CHW Training and Certification Program for CHWs and instructors. DSHS [approves programs](#) at community colleges, AHECs, FQHCs, and CBOs to train CHWs in [eight core competencies](#). There are two pathways to certification: experience or training. The certification is for 2 years, and there is no cost.



Washington (1/2)

State Legislation

- [Engrossed Substitute Senate Bill 5693, Section 211 \(103\)](#) (2022) appropriated \$2,087,000 to the Washington State Health Care Authority (HCA), the State's Medicaid agency to establish a [two-year grant program](#) for primary care clinics to embed CHWs as part of care teams, submit legislative reports on the impacts of the grant program, and explore longer-term reimbursement in collaboration with key partners
- [Engrossed Substitute Senate Bill 5187 \(44\)](#) (2023) appropriated an additional \$6,164,000 to maintain HCA's CHW grant through the duration of the project.

Financing

- [SPA 24-0026](#) (2024) allows for reimbursement of CHW services
- The State's [1115](#) reentry waiver provide CHW services payment for justice involved pre-release services.
- Washington's MCOs pay for CHWs though administrative costs to support case management activities through community-based CHWs who are employees of the MCO or a contracted community-based organization
- CHWs can work in health homes, which allows them to receive Medicaid funding for each patient served.



Washington (2/2)

Education, Training, and Certification

- [Training](#) of CHWs occur through the Department of Health, which has established core competencies for CHWs and offers the 10-week training free of charge. Upon completion, CHWs receive a certificate of completion. Also offers [health-specific modules](#).
- A [2019 CHW Task Force Report](#) provided recommendations for the development of CHW training, initiatives, and programs, including a framework, content, instructional and organizational considerations for CHW programs.
- There is no certification for CHWs in WA at this time.



West Virginia

State Legislation

None

Financing

- West Virginia does not reimburse for CHW services through its Medicaid program. However, payment is [allowed \(not required\)](#) via Medicaid health homes where CHWs may be part of care teams, using a fixed per member payment.
- One [CHW chronic care management program](#) (discussed in detail on the next slide) also engages insurance providers to reimburse providers for high-risk chronic disease patients

Education, Training, and Certification

- There is no statewide certification program in WV.
- The West Virginia School of Osteopathic Medicine (WVSOM)'s Center for Rural and Community Health offers a [Community Health Education Resource Person \(CHERP\)](#) training program to train CHWs to work at one or more levels among Wellness, Health Promotion, or Disease Prevention & Management. Participants receive a certificate of completion.
- CHWs working in the CHW chronic care management program (next slide) receive a core training from Marshall University School of Medicine but additional training is specific to the employing health center. [Most intensive training is on-the-job – supervision, team huddles, etc.](#)



West Virginia Spotlight : Community Health Worker–Based Chronic Care Management Model for Patients With High Health Care Costs

Background

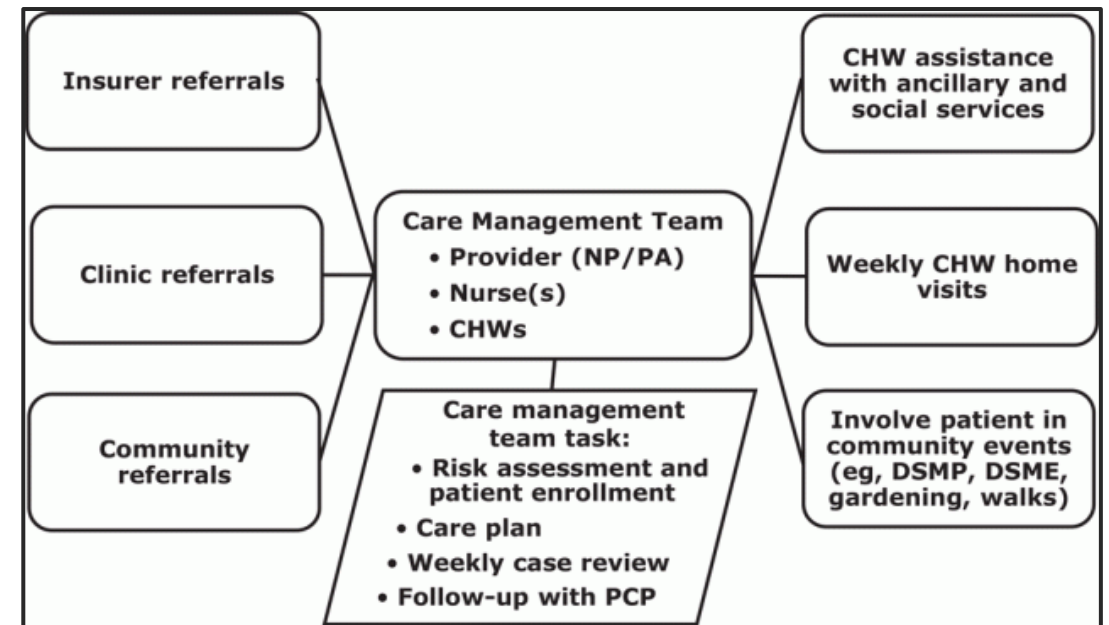
- Chronic Care Management (CCM) teams operate within clinics and serve clinic patient populations and carry out the activities indicated in the figure (right).
- Initially targeted to diabetes patients, the model has since expanded to other high-risk chronic conditions

Financing

- Program is financed through a mix of grant funding to support startup and shared savings arrangements with payers.
- Program leadership credit early and persistent [engagement with payers](#) as a critical aspect of sustainable financing.

Training

- CHWs complete a basic/core training and additional training specific to the employing health center. [Most intensive training is on-the-job – supervision, team huddles, etc.](#)



Source: Crespo R, Christiansen M, Tieman K, Wittberg R. An Emerging Model for Community Health Worker-Based Chronic Care Management for Patients With High Health Care Costs in Rural Appalachia. *Prev Chronic Dis.* 2020;17:E13. Published 2020 Feb 13. doi:10.5888/pcd17.190316 [Link](#)

Beyond the States: Indian Health Services (IHS) Community Health Representative (CHR) Program

Tribal nations have a long history of utilizing CHWs. The first CHW program ever included in legislation was the CHR Program, established in 1968, under the 1921 Snyder Act (25 U.S.C. 13).

CHRs are *“frontline public health workers who are trusted members of the community with a close understanding of the community, language, and traditions”* (IHS).

CHR functions are tailored to the context of their community, and generally include:

- Linking between clinical setting and community to facilitate access to services and improve the quality and cultural competence of service delivery
- Increasing health knowledge of patients and communities through broad range of activities (transportation health visits, outreach, education, informal counseling, social support, and advocacy)

Currently, 1,600+ CHRs represent >250 tribes in 12 IHS areas. Although federally funded by IHS, 95% of CHR programs are directly operated by Tribes under P.L. 93-638 of the Indian Self-Determination and Education Assistance Act, as amended.



Source: Indian Health Service. (n.d.). *Where we work*. U.S. Department of Health and Human Services. [Link](#)

More information about the IHS CHR Program can be found [here](#) and [here](#). Prominent models for CHR service delivery will be explored in next version of this report.

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[Appendix \(Evidence Deep Dive\)](#)

Appendix:
Evidence
Deep Dive

Systematic Reviews

Randomized Trials

Return on Investment

Chronic Disease Management

Rural Context

Case Study - El Sol's CHW/Promotores Training Center Approach

This case study describes how a CHW/P training center applied popular education throughout the CHW/P capacity-building process to advance and maintain the roots of the CHW/P movement.

This case study:

- Highlights how a CHW/P training center incorporated long-standing guiding principles underlying the CHW/P movement.
- Aims to help stimulate reflection, dialogue and action among CHW/P organizations on how to incorporate these long-standing guiding principles into their operations, in an effort to build examples of CHW/P-centered interventions that reflect values and paradigms such as health care for all, health equity and health as a right.
- Discusses the CHW/P capacity-building process and the interrelationship between the components, to gain insight into how popular education, health equity, and community transformation principles are applied throughout the CHW/P capacity-building process.
- Provides insight that can generate more reflection, dialogue and action around the process of building organizational readiness to place and support CHWs/Ps. (See *A Guide for Organizational Readiness*)

See here to learn more: [Preserving a Transformative Community Health Worker/Promotor Workforce: El Sol's CHW/P Training Center Approach](#)

Systematic Reviews

SYSTEMATIC REVIEWS: CHW interventions show consistent promise in improving health equity, mental health, chronic disease management, and more among certain populations

Effects of CHW Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations

- Interventions by CHWs appear more effective when compared with alternatives and are cost-effective for certain health conditions, particularly among low-income, underserved, and racial and ethnic minority communities.
- *Amer. Journal of Public Health, 2016, 106(4).* <https://www.ncbi.nlm.nih.gov/pubmed/26890177>

CHW Interventions to Improve Glycemic Control in People with Diabetes

- CHW interventions (13 RCTs) showed a modest reduction in Hemoglobin compared to usual care.
- *J. Gen. Intern. Medicine, 2015, 30(7).* <https://www.ncbi.nlm.nih.gov/pubmed/25735938>

Mental Health Interventions with CHWs in the U.S.

- Findings across nine studies suggest CHW-supported mental health interventions show promise, particularly given evidence of feasibility and acceptability with underserved populations.
- *J. Health Care Poor Underserved. 2018, 29(1).* <https://www.ncbi.nlm.nih.gov/pubmed/29503292>

Randomized Trials

RANDOMIZED CONTROL TRIALS (RCTs): Increased use of primary care, improved reported mental health, lower inpatient readmissions

Patient-Centered CHW Intervention to Improve Posthospital Outcomes (RCT):

- **WHAT:** CHWs worked with low-SES hospital patients to create individualized action plans for recovery; provided tailored support for at least two weeks.
- **OUTCOMES:** Increased likelihood of obtaining primary care, greater improvements in mental health, increased patient activation, lower likelihood of multiple 30-day readmissions (40% reduced to 15.2%).
- [JAMA Inter. Med, 2014, 174\(4\)](#)

CHW Support For Disadvantaged Patients With Multiple Chronic Diseases (RCT):

- **WHAT:** High-poverty, publicly insured patients with multiple chronic conditions worked with a CHW to achieve a disease management goal over six months.
- **OUTCOMES:** Improvements in mental health, increased support for disease self-management (63% compared to 38% control group), lower hospitalization (16% compared to 17.8% after six months, 23% compared to 32% after one year).
- [ASTHO CHW Evidence Summary](#)

CHW Program Successes: Return on Investment (ROI)

Nevada CHW ROI Study

- **WHAT:** Health Plan of Nevada (Medicaid managed care organization) hired three CHWs to work with an average of 37 patients each for 30-60 days on service referrals, transportation, patient education, accessing treatment specialists, and other services.
- **OUTCOMES: Total ROI Calculation: 1.81 (\$503,384 medical/RX savings versus \$278,331 program cost)**
 - Average medical costs decreased: \$1,223 PMPM pre-intervention to \$983 PMPM post-intervention. Prescription costs reduced from \$539 PMPM to \$491 PMPM.
 - Decreased number of acute admissions (-18%), readmissions (-20%), ED visits (-14%), and urgent care visits (-6%).
- *Nevada Department of Health and Human Services, May 2017. <https://bit.ly/2sBdtDu>*

Maryland CHW Outreach Program on Healthcare Utilization

- **WHAT:** CHWs in West Baltimore City conducted weekly home visits and phone calls to Medicaid beneficiaries with diabetes to provide education and maintain appropriate visits to primary care.
- **OUTCOMES: Savings of \$2,245 per patient per year. Total savings of \$262,080 across 117 patients per year,** along with improved quality of life. Driven by decrease in ED visits (-40%), hospital admissions (-33%), and Medicaid reimbursements (-27%).
- *Ethn Dis., 2003 Winter, 13(1). <https://www.ncbi.nlm.nih.gov/pubmed/12723008>*

CHW Program Successes: Return on Investment (ROI)

Kentucky

- **WHAT:** Homeplace program trains CHWs with a focus on care coordination and serves low-income clients at no charge.
- **OUTCOME:** ROI is **\$11.20 saved for every \$1 invested for trainings.**
- *Rural Health Information Hub.* <https://www.ruralhealthinfo.org/project-examples/785>

New Mexico

- **WHAT:** 448 high-resource-consuming Medicaid managed care clients in 11 counties received patient education, advocacy, and social support from CHWs for six months
- **OUTCOME:** Lowered ED costs (\$425,551 total), lowered inpatient costs (\$872,694 total), lower non-narcotics prescriptions (\$699,129 total) and narcotics prescription (\$42,091).. **Total cost differential: \$2,044,465 less post-intervention compared to pre- intervention, compared to total CHW salary costs of \$521,343.**
- *J. Community Health, 2011.* <https://bit.ly/2IFEc0Y>

Social ROI Research Report on CHWs in Cancer Outreach and Educations across the U.S.

- **OUTCOME:** CHWs generated **lifetime benefits of \$12,348 per person** served by a CHW, or **\$851,410 by every CHW that serves at least 69 individuals per year.** Compared to total direct costs (salary, benefits, administrative costs) of \$41,184 per CHW per year.
- *Wilder Research, 2012.* <https://bit.ly/2ktAKGA>

CHW Program Successes: Return on Investment (ROI)

East Texas ROI from employment of CHWs in two hospitals working with ED patients

- **OUTCOME:** ROI ranging from 3:1 to more than 15:1.
- *Rush, Carl. J Ambul Care Manage. 2012, 35(2).* <https://www.ncbi.nlm.nih.gov/pubmed/22415287>

Denver Health Community Voices Program Piloted a CHW Outreach Program for 590 Men

- **OUTCOME:** The **ROI of 2.28:1** was achieved through reduced service utilization and charges over 9 months. Monthly program costs were \$6,229, compared to a reduction in monthly uncompensated costs of \$14,244.
- *J. Health Care Poor Underserved. 2006, 17(1 Suppl).* <https://www.ncbi.nlm.nih.gov/pubmed/16520499>

CMMI Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative

- **OUTCOME:** "Of six types of innovation components... (i.e., used health IT, with CHWs, medical home intervention, focus on behavioral health, used telemedicine, workflow/process redesign intervention), only innovations with CHWs were found to **lower total costs (by \$138 per beneficiary per quarter).**" Clinicians also reported spending between 30-50% less time arranging and coordinating social services and referrals.
- *CMMS, February 2018. HCIA Meta Analysis and Evaluators Collaborative.pdf*

CHW Program Successes: Return on Investment (ROI)

Impact on Health Care Utilization and Costs of a Medicaid Community Health Worker Program in Detroit, 2018–2020: A Randomized Program Evaluation

A Detroit-based study of CHWs funded through Medicaid finds that CHWs can reduce ER use and increase outpatient care among Medicaid recipients, offsetting cost savings in the short term; however, increased outpatient care among individuals who underuse such care could contribute to cost savings in the long-term

- **OUTCOME:** Those randomized to the program had fewer ED visits and more outpatient ambulatory care resource use at 12-month follow-up than beneficiaries randomized to usual care.
- Source: Michele Heisler, et al. “Impact on Health Care Utilization and Costs of a Medicaid Community Health Worker Program in Detroit, 2018–2020: A Randomized Program Evaluation”, *American Journal of Public Health* 112, no. 5 (May 1, 2022): pp. 766-775. <https://doi.org/10.2105/AJPH.2021.306700>

The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities, 2018

The State of Maryland implemented the Health Enterprise Zone Initiative in 2013 to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions.

- **OUTCOME:** A reduction of 18,562 inpatient stays; increase of 40,488 ED visits in the period 2013–16.
- The net cost savings: \$93.4 million
- Source: Gaskin, Vazin, et al; <https://doi.org/10.1377/hlthaff.2018.0642>

CHW Program Successes: Chronic Disease Management

Chicago CHWs Improve Asthma Management among African-American Children

- **WHAT:** Trained CHWs from targeted communities provided individualized asthma education during three to four home visits over 6 months.
- **OUTCOME:** Asthma control was improved by 35% among adolescents working with CHWs
- *PubMed, 2012; 49(4).* <https://www.ncbi.nlm.nih.gov/pubmed/22348448>

Maryland Study on Effects of Nurse Care Managers and CHWs on Diabetes-Related Health Complications among African Americans

WHAT: Patients with diabetes were assigned to one of four care groups: 1) usual care, 2) usual care + nurse manager, 3) usual care + CHW, or 4) usual care + nurse manager + CHW.

- **OUTCOME:** Patients receiving services from both a CHW and a nurse case manager had the greatest declines in A1C (glycosylated hemoglobin) values, cholesterol triglycerides, and diastolic blood pressure.
- *Prev. Med., 2003, 37(1).* <https://www.ncbi.nlm.nih.gov/pubmed/12799126>

CHW Program Successes: Chronic Disease Management

Florida CHW-Led Educational Program and Service Coordination to Address Diabetes and Cardiovascular Disease

- **WHAT:** CHWs provided community-based, behavior-changed educational programs and care coordination among under-resourced, rural, ethnically disparate populations in Gadsden County.
- **OUTCOME:** The Project H.I.G.H. saw successes in motivating participants to delay or prevent diabetes and/or cardiovascular disease, and participants reported intent to take care of their health.
- *Evaluation and Program Planning, April 2016, 55.* <https://bit.ly/2kl5Lq7>

Outcomes at 18 Months From a Community Health Worker and Peer Leader Diabetes Self-Management Program for Latino Adults

- **WHAT:** CHW program provided diabetes self-management education (DSME), followed by two different approaches to maintain improvements in HbA_{1c} and other clinical and patient-centered outcomes over 18 months.
- **OUTCOME:** Participants in the CHW intervention at the 6-month follow-up had greater decreases in HbA_{1c} and in diabetes distress, maintained HbA_{1c} improvements at 12 and 18 months, had significantly fewer depressive symptoms at 18 months, had significant improvements in diabetes social support and in understanding of diabetes self-management.
- *Diabetes Care, 2018 Jul;41(7):1414-1422.* <https://doi.org/10.2337/dc17-0978>

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Community health worker home visits for adults with uncontrolled asthma: the HomeBASE Trial randomized clinical trial

- **WHAT:** RCT with 1-year follow-up between 2008 through 2011 at homes of low-income adults with uncontrolled asthma living in King County, Washington, where CHWs provided a mean of 4.9 home visits during a 1-year period to assess asthma control, self-management, and home environment and to support asthma self-management practices.
- **OUTCOME:** The intervention group had significantly greater increases in mean symptom-free days per 2 weeks (and quality of life relative to the control group).
- *JAMA Intern Med*, 2015 Jan;175(1):109-1. <https://doi.org/10.1001/jamainternmed.2014.6353>

CHW Program Successes: Rural Context

Texas lay health educators provided asthma or general health promotion education to elementary school children in a rural school district.

- **OUTCOME:** Improved asthma knowledge, self-management, and self-efficacy for managing symptoms and using metered dose inhalers.
- *J. School Health, Sept. 2008, 78(9).* <https://bit.ly/2k1s0r4>

North Dakota patient navigator/community health representative program aimed to reduce cancer disparities among American Indians.

- **OUTCOME:** Individuals with cancer who received navigation services during radiation treatment had an average of 3 fewer days of treatment interruptions.
- *Cancer Control, July 2008, 15(3).* <https://bit.ly/2k0kgWf>

Alabama CHWs delivered cognitive behavioral training intervention for rural patients with diabetes and chronic pain.

- **OUTCOME:** 80% of the program participants completed the training, of whom 95% reported satisfaction.
- *Fam. Community Health, 2018, 41(3).* <https://bit.ly/2kwjrEP>

Thank You

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