Considerations in Designing a Benefit for Community Health Worker (CHW) Services

This document was created by CHW Solutions,
in partnership with the SD DOH and CHWSD.

Revised
2024/02/06

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This report was supported by the Grant or Cooperative Agreement Number 5NU380T000225-04, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Center for Disease Control and Prevention or the Department of Health and Human Services.

SECTION 1 - COMMUNITY HEALTH WORKER OVERVIEW

WHO ARE COMMUNITY HEALTH WORKERS?

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an extraordinarily close understanding of the communities they serve.[1]

Their cultural competence and understanding of patients' circumstances and backgrounds allows CHWs to act as liaisons between the healthcare system, social services and the community. Additionally, CHWs facilitate access to services, and improve the quality and cultural relevance of service delivery including health education.

WHO DO COMMUNITY HEALTH WORKERS SERVE?

CHWs generally work with underserved or high-risk patients of all ages. Individuals are referred (or self-refer) to CHWs when they need assistance:

- understanding their health condition.
- self-managing a chronic disease.
- navigating health or social service systems.
- accessing resources in their community.

Given their scope of practice, Community Health Workers are ideal for addressing gaps in care, Social Determinants of Health (SDoH) or Health Related Social Needs (HRSN).

According to the US Department of Health and Human Services[2], Social Determinants of Health (SDoH) are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples of SDoH include:

- Access to healthcare
- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Relatedly, the Centers for Medicare and Medicaid Services (CMS) define Health Related Social Needs (HRSN) as an individual's unmet, adverse social conditions that contribute to poor health[3]. These needs, including food insecurity, housing instability, unemployment, and/or lack of reliable transportation – can drive health disparities across demographic groups. Extensive research indicates that SDoH and related HRSN can account for as much as 50% of health outcomes.[4]

WHERE DO COMMUNITY HEALTH WORKERS DELIVER THEIR SERVICES?

CHWs provide care and services in a variety of settings: client homes, provider offices, hospitals, social services agencies, schools and in the community at large.[5] Their ability to work in-person with patients allows CHWs to build trust with patients and to attain a first-hand perspective on their patient's environment.

WHAT TYPE OF TRAINING AND CERTIFICATION DO CHWS RECEIVE?

There is not a national standard for Community Health Workers' curriculum. Training can vary from on-the-job experiences to certificate programs, which are usually offered through community colleges or statewide CHW associations. Many employers

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[1] American Public Health Association (APHA) definition, 2021.
[2] Healthy People 2030, Office of Disease Prevention and Health Promotion, US Department of Health and Human Services, website accessed 12.19.2023.
[3] Addressing Health-Related Social Needs in Section 1115 Demonstrations, Centers for Medicare and Medicaid Services, December 6, 2022.
[4] Addressing Social Determinants of Health: Examples of Successful Evidence-based Strategies and Current Federal Efforts. Department of Health and Human Services, Office of Health Policy Report, April 1, 2022.
[5] Building a Community Health Worker Program: The Key to Better Care, Better Outcomes & Lower Costs. July 2018.

require a high school diploma or GED and certification is required for Medicaid reimbursement in many states (including the state of South Dakota).

WHERE DO CHWS WORK?

The Bureau of Labor Statistics estimates that there were 67,200 community health workers employed in a variety of settings around the Unites States in 2022[6]. A breakdown of common CHW employers is as follows:

- 20% work with organizations that provide social assistance.
- 17% work with employers that provide ambulatory healthcare services.
- 15% work for local government, excluding education and hospitals.
- 10% work in hospitals (state, local and private).
- 10% in religious, grantmaking, civic, professional or similar organizations.

WHO PAYS FOR CHW SERVICES?

- Medicaid – a recent 50-state survey found that 25 states pay for CHW services – either directly through their Medicaid programs (15 states), or indirectly through managed care organizations (MCOs) – (10 states).[7]
- As of January 2024, CMS began covering and reimbursing "community health integration" services when provided by a CHW to individuals enrolled in fee-for-service Medicare. These services must be ordered and billed by a "billing practitioner" and focused on addressing unmet Social Determinants of Health (SDoH) needs that interfere with the ability to execute a medically necessary plan of care.[8]
- Philanthropic grants and investments from governmental agencies often provide support for CHW programs. This type of funding is often unpredictable and insufficient to sustain CHW programs long-term.
- Managed care contracts - Some states have arrangements with managed-care organizations (MCOs) to allow them to bill for CHW services as part of administrative costs. These funding arrangements may include value-based payments, fee-for-service, and bundled payments added onto capitated rates.[9]
- Internal funding - Lastly, some health care providers and payers have opted to internally finance CHW programs based on an or assumption or demonstration of reduced costs.[10]

HOW DO CHWS IMPROVE POPULATION HEALTH?

CHW programs often focus on patient populations with chronic or high-risk conditions and researchers have found them to be effective in:

- improving glycated hemoglobin (A1c) scores.[11]
- reducing blood pressure.[12]
- improving symptoms for children with asthma.[13]
- improving pregnancy and perinatal outcomes.[14]
- increasing appointment-keeping and medication adherence.[15]
- improving rates of smoking cessation.[16]

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[6] Occupational Outlook Handbook – Community Health Workers, US Bureau of Labor Statistics Website (accessed 11-15-2023).
[7] State Community Health Worker Models – State Tracker, December 10, 2021 – NASHP.org website.
[8] Federal Register, Volume 88, No. 220, Thursday, November 16, 2023.
[9] How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs and Reduce Disparities; Families USA: Washington DC 2016.
[10] Sustainable Financing of Community Health Worker Employment, NASHP, 2020.
[11] Effect of a Community Health Worker Intervention Among Latinos with Poorly Controlled Type 2 Diabetes: the Miami Healthy Heart Initiative randomized clinical trial" JAMA Internal Medicine 2017, 177: 948-954.
[12] A Community Health Worker-led Intervention to Improve Blood Pressure Control in an Immigrant Community with Comorbid Diabetes: Data from Two Randomized Controlled Trials Conducted in 2011-2019. American Journal of Public Health, 2021, 111: 1040-1044.
[13] Community Health Worker Home Visits for Medicaid-enrolled Children with Asthma: Effects on Asthma Outcomes and Costs. American Journal of Public Health 2015, 105: 2366-2372.
[14] Community Health Worker Impact on Knowledge, Antenatal Care and Birth Outcomes: A Systematic Review. Material Child Health 2022, 26: 79-101.
[15] Effectiveness of Community Health Workers in the Care of People with Hypertension. American Journal of Preventive Medicine, 2007, 32: 435-447.
[16] Effect of a Smoking Cessation Intervention for Women in Subsidized Neighborhoods: A Randomized Control Trial. Preventive Medicine, 2016, 90: 170-176.

HOW DO CHWS IMPROVE PATIENTS' EXPERIENCE OF CARE?

CHWs are uniquely positioned to improve patients' access to care and utilization of preventive services. Studies have found that CHWs are able to:

- increase cancer screenings.[17]
- improve access to primary care.[18]
- improve rates of follow up care for conditions like pediatric asthma and hypertension.[19],[20]

Additionally, research shows that CHWs are also able to improve patients' experience of care.

- One study found that CHW interventions improved patient-reported quality of hospital discharge communication.[21]
- Another study found that CHW intervention improved patient-reported quality of primary care.[22]

HOW DO CHWS REDUCE THE COST OF CARE?

Evidence shows that CHW programs can be cost effective and a valuable addition to the health care team.

- One study found that a CHW program focused on patients with diabetes, obesity, tobacco dependence or hypertension generated an ROI of $2.47 for every dollar spent on intervention.[23]
- Another study documented an ROI of $2.28 for every dollar invested in CHW intervention, which was largely achieved by shifting patients' use of inpatient and urgent care services to primary care.[24]
- A third study found that CHW interventions targeted at "super utilizer" patients generated an ROI of $1.81 for every dollar expended. These savings were derived from reductions in medical and pharmacy costs, and reduced acute admissions, acute readmissions, and urgent care visits.[25]

ARE CHW SERVICES RELEVANT FOR PEOPLE WITH COMMERCIAL HEALTH INSURANCE AND THE EMPLOYERS WHO SPONSOR IT?

It is well-established that Social Determinants of Health (SDoH) (the context in which people are born, live, work, play, worship, and age) affect a wide range of individuals' health, functioning, outcomes, and risks.[26] While the effect of SDoH on Medicaid and underserved populations is well-understood, studies have also determined that a significant portion of commercially insured populations are affected by them as well.

- A recent study[27] examined records of 5.1M commercially insured individuals around the US, and found that 27% lived in zip codes where the median income was at or below 200% of the federal poverty line.
- Five percent (5%) of the study population self-reported a barrier to getting health care or medications in the past year.

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[17] Community-based, Pre-clinical Patient Navigation for Colorectal Screening Among Older Black Men Recruited from Barbershops: the MISTER B Trial. American Journal of Public Health 2017. 107: 1433-1440.
[18] Community Health Workers as Healthcare Navigators in Primary Care Chronic Disease Management: A Systematic Review. Journal of General Internal Medicine, 2021, 36: 2755-2771.
[19] A Randomized Controlled Trial of Parental Asthma Coaching to Improve Outcomes Among Urban Minority Children. Archives of Pediatric Adolescent Medicine, 2011, 165: 520-526.
[20] Linking Community-based Blood Pressure Measurement to Clinical Care: A Randomized Controlled Trial of Outreach and Tracking by Community Health Workers. American Journal of Public Health. 1999, 89: 856-861.
[21] Patient-centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Internal Medicine, 2014, 174: 535-543.
[22] Effect of Community Health Worker Support on Clinical Outcomes of Low-income Patients Across Primary Care Facilities: A Randomized Clinical Trial. JAMA Internal Medicine, 2018, 178: 1635-1643.
[23]Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment, Health Affairs 39, No 2, 2020, p 207-213.
[24] Community Health Workers as an Integral Strategy in the Reach US Program to Eliminate Health Inequities," Health Promotion Practice, 15 no. 6, 2014, p 795-802.
[25] Community Health Worker Return on Investment Study Final Report, Center for Program Evaluation, School of Community Health Sciences, University of Nevada, Reno. 2017.
[26] Healthy People 2030 website, US Department of Health and Human Services.
[27] Social Determinants of Health Challenges are Prevalent Among Commercially-Insured Population, Journal of Primary Care and Community Health, Volume 12: 1-10, 2021.

- The study further identified significant differences in health care utilization patterns, based on employees' zip codes. For example, the study identified a population of "high utilizers" of emergency room services and found that 34% of this population came from low-income zip codes, while only 9% of this population was comprised of employees from wealthier zip codes.

Additionally, a recent survey conducted by the National Business Group on Health (NBGH)[28], found that large employers are interested in offering insurance coverage that goes beyond the traditional definition of health care, to address the drivers of health and well-being. For example, 84% of large employers surveyed indicated that they were considering health care access/literacy as part of their health and wellness strategy for employees.

[28] Large Employers' 2020 Health Care Strategy and Plan Design Survey, NBGH, August 13, 2019.

SECTION 2 - AN OVERVIEW OF CHWS IN SOUTH DAKOTA

WHAT IS THE HISTORY OF THE CHW WORKFORCE IN SOUTH DAKOTA?

Community Health Workers in South Dakota date back to early 1965, with the first Community Health Representative (CHR) program in the country launching in Pine Ridge, South Dakota.[29] This first CHR program established by the Oglala Lakota Tribe led Indian Health Service (IHS) to develop a CHR workforce across the country, with most tribal nations directly employing CHRs. In South Dakota, the nine (9) tribal nations have employed CHRs for over fifty years.

Beyond the CHR workforce in South Dakota, no formal CHW programs were established until statewide efforts to develop and sustain the workforce began in early 2020. Prior to 2020, the South Dakota Department of Health (SD DOH) strategically worked to develop the framework for a CHW workforce in South Dakota. Beginning in 2015, the SD DOH conducted interviews with key stakeholder organizations in South Dakota. Based on the feedback provided in these interviews, the SD DOH partnered with the South Dakota Department of Social Services (SD DSS) to facilitate a workgroup to develop key recommendations for CHWs in South Dakota.

Recommendations of this 2016 work group then led the SD DSS to draft a State Plan Amendment to the South Dakota Medicaid State Plan to submit to Centers for Medicare and Medicaid Services (CMS) fee for service reimbursement for CHW services. Beginning April 1, 2019, South Dakota became the third state in the country to have a state Medicaid program reimburse for CHW services using a fee-for-service reimbursement model. Despite being the third state to have CHW Medicaid reimbursement, South Dakota did not have formal CHWs working in South Dakota beyond the well-established CHR workforce as of 2019.

WHAT ORGANIZATION LEADS THE DEVELOPING CHW WORKFORCE IN SOUTH DAKOTA?

To assist in promoting, supporting, and sustaining the CHW workforce in South Dakota, the SD DOH launched the Community Health Worker Collaborative of South Dakota (CHWSD) in January of 2020. The SD DOH and the CHWSD, along with SD DSS, all utilize and promote the American Public Health Association's 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."[30]

The CHWSD worked diligently in 2020 (during the COVID-19 pandemic) to develop the foundation for the organization – including a brand, website, awareness materials, presentations, etc. Additionally, knowing the importance of Medicaid reimbursement on the sustainability of the future CHW workforce in South Dakota, the CHWSD team worked to understand Medicaid reimbursement for CHWs and developed a strong working relationship with SD Medicaid.

Due in part to the COVID-19 pandemic, the SD DOH was awarded a CDC grant in June 2021 which included a specific objective to develop a sustainable public health infrastructure, including CHWs. The SD DOH and the CHWSD worked to extend this funding opportunity to organizations across South Dakota to train (or cross-train) individuals to work as CHWs. Additionally, this funding opportunity provided substantial expansion opportunities for the CHWSD and partner organizations to provide technical assistance and support to newly developing CHW programs as well as established CHR programs.

HOW ARE CHWS TRAINED IN SOUTH DAKOTA?

Beginning in 2016, the first CHW training program launched in South Dakota at Lake Area Technical College, with a second training program launching at Southeast Technical College in 2022. Additionally, some CHWs in South Dakota have trained through approved training programs in Minnesota. Based on key recommendations from the SD DOH and SD DSS co-led workgroup in 2016, the Indian Health Service CHR training program is an approved and grandparented-in training program for CHRs in South Dakota.

As of 2023, training programs in South Dakota are required to align with the certification requirements for CHWs in South Dakota. Training programs are required to have a minimum of 200 hours of training and a minimum of 40 hours of shadowing. The training

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[29] Native Voices, National Library of Medicine. https://www.nlm.nih.gov/nativevoices/timeline/510.html.

[30] Community Health Workers. American Public Health Association (APHA). 2023.

requirements for certification also require training programs to align with a training outline, as defined by the CHWSD. This training outline was developed using evidenced-based training curriculum requirements from a national CHW training and workforce study. The full training requirements for a CHW training program in South Dakota can be found at https://chwsd.org/training-requirements/.

DOES SOUTH DAKOTA HAVE CERTIFICATION FOR CHW SERVICES?

In early 2022, the first trained CHWs began providing services to patients and clients across South Dakota. With the developing workforce and the opportunity for Medicaid reimbursement for services provided to Medicaid recipients, the CHWSD worked with the SD DOH and SD DSS to develop a certification program for CHWs in South Dakota.

Certification for CHWs and CHRs in South Dakota requires an individual to complete/provide the following:

- A short application to share contact and demographic information
- Completion of an approved SD CHW or CHR training program
- A supervisor or instructor reference
- A background check – including a state fingerprint background check

The full list of certification steps can be found here: https://chwsd.org/certification-steps/.

WHAT IS THE STATUS OF THE CURRENT CHW WORKFORCE IN SD?

As of December 15, 2023, there are over 215 practicing CHWs and CHRs across South Dakota. Of the 215, 130 are CHWs and 85 are CHRs. The workforce continues to grow as individuals continue to enroll in training programs for early 2024 classes. Of these 215 CHWs and CHRs, 75 are Certified in South Dakota, as of December 15, 2023.

CAN CHW PROGRAMS IN SOUTH DAKOTA BE SUSTAINABLE?

As South Dakota is one of the few states to have CHW reimbursement through a state Medicaid program, CHW programs in South Dakota are able to use Medicaid reimbursement, as well as Medicare reimbursement (as of January 1, 2024) and other sustainability efforts, calculated cost savings, and ROIs, to “braid” funding to support program sustainability.

While each CHW program takes a unique approach to CHW programming and sustainability, SD Medicaid reimbursement allows programs to receive significant reimbursement for services provided to not only cover the time of a CHW working directly with the Medicaid recipient, but also time for the CHW to travel to/from home/community visits, and the for the CHW to document services provided.

With an hourly equivalent reimbursement rate of $64.86 for individual CHW services provided to a Medicaid recipient, coupled with the average CHW wages in South Dakota of $17 to $22 per hour, Medicaid reimbursement can often cover not only the hour spent with the Medicaid recipient, but also an additional hour to two hours of CHW time. South Dakota has the highest reimbursement rate of any Medicaid program reimbursing for CHW services, allowing for reimbursement rates to impact salary recouperation beyond the time that is directly reimbursed for.

Based on data obtained from SD Medicaid, from July 1, 2023, through December 1, 2023, SD Medicaid has reimbursed over $112,000 in CHW claims to SD CHW programs. Additionally, there are over 40 organizations that have completed all prerequisites to bill SD Medicaid for CHW services. Claims for CHW services will continue to increase as programs continue to begin billing SD Medicaid for CHW services. See Section 3 below for more details on Medicaid reimbursement for CHW services in South Dakota.

In addition to SD Medicaid, as of January 1, 2024, Community Health Integration (CHI) services are able to be billed to Medicare when ordered by a “billing practitioner” and provided by a trained/certified CHW. This will further expand sustainability efforts of CHW programs and will lead to CHW programs continuing to grow and develop. While not all details regarding reimbursement are fully defined at this point (particularly for dual-eligible patients – enrolled in both Medicaid and Medicare), CMS continues to release more information to assist CHW programs in successfully billing CMS for CHW services. See Section 4 below for more details on Medicare reimbursement for CHW services.

WHAT TYPES OF ORGANIZATIONS EMPLOY CHWS IN SOUTH DAKOTA?

A variety of organizations in South Dakota employ CHWs – from medical and clinical programs to community-based organizations, to tribal programs and EMS programs. In South Dakota, all three health systems (Avera, Monument, and Sanford) employ CHWs, as well as all FQHCs in the State. Additional independent hospitals and clinics also employ CHWs in South Dakota.

In addition to medical and clinical CHW programs, community-based organizations, such as homeless shelters and social services support organizations also employ CHWs in South Dakota. A complete list of CHW programs in South Dakota can be found here: https://chwsd.org/chw-chr-sites/.

WHAT ARE THE SUCCESSES OF CHWS IN SOUTH DAKOTA?

Successes of CHW programs in South Dakota are numerous – and have benefitted both individual patients and organizations. Individual patient/client success stories can be read here: https://chwsd.org/success-stories/. These accounts illustrate how South Dakota CHWs have impacted health outcomes of South Dakota residents in the following areas:

- Ensuring medication compliance
- Helping individuals access financial and housing assistance
- Accessing community resources to address food insecurity and health benefits
- Facilitating clear communication between the patient and healthcare providers

SECTION 3 - CHW SERVICE MODELS IN SOUTH DAKOTA

Historically, the primary payor of CHW services in South Dakota has been the State's Medicaid program. (South Dakota's Medicaid program is provided on a fee-for-service basis and administered by the State's Department of Social Services.) More recently CMS began covering and reimbursing CHW services for the fee-for-service Medicare population under certain circumstances (effective January 1, 2024). The service models for both programs will be discussed in-turn below.

SOUTH DAKOTA MEDICAID SERVICE MODEL[31]

PROVIDERS

A Community Health Worker (CHW) agency is required to be enrolled with South Dakota Medicaid to be reimbursed for services. Organizations in South Dakota seeking Medicaid reimbursement for CHW services much employ Certified CHWs.

In South Dakota, the term "Community Health Worker" is inclusive of Community Health Representatives (CHRs) – individuals who have completed an approved CHR training program through Indian Health Services.

QUALIFYING CONDITIONS & BARRIERS

CHW services are intended to prevent or delay progression of disease, disability, and other health conditions. Under South Dakota Medicaid CHW services are focused on individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for individuals with a documented barrier that is affecting the individual's health.

Qualifying conditions for CHW services include:

- Asthma
- Cancer
- COPD
- Depression
- Diabetes
- Heart Disease
- Hypercholesterolemia
- Hypertension
- Mental health conditions
- Musculoskeletal and neck/back disorders
- Obesity
- Pre-diabetes
- High-risk pregnancy
- Substance use disorder
- Tobacco use
- Use of multiple medications (6 or more classes of drugs)

The following are examples of barriers affecting and individual's health that could result in CHW services being necessary:

- Geographic distance from health services results in inability to attend medical appointment or pick-up prescriptions.
- Lack of phone results in the individual going to the emergency department instead of scheduling a medical appointment.
- Cultural/language communication barriers results in the individual not following a medical professional's recommendation.

REQUIRED ORDERS

CHW services must be ordered by a physician, physician assistant, nurse practitioner, certified nurse midwife, or dentist.

[31] Community Health Worker Services, South Dakota Billing and Policy Manual, Updated November 2023.

SERVICE PLAN

Services must be delivered according to a CHW Service Plan written by the ordering provider, or a qualified healthcare professional supervised by the ordering provider. The ordering provider must specify the condition or barrier that the service is being ordered for and the duration of the service. An order may not exceed a period of one year.

COVERED SERVICES

CHW Services must be related to an intervention outlined in the individual's CHW Service Plan. Services must be provided face-to-face, via telemedicine or via two-way audio-only when the recipient does not have access to audio/visual telemedicine technology. Up to five (5) units of individual services may be performed in a clinic setting in a plan year to allow for the initial establishment of a CHW/recipient relationship after which services are only allowed to be provided in a home or community setting. A CHW may attend medical appointments with a recipient. Group services may take place in a meeting room of a medical setting. Covered services include:

- Health system navigation and resource coordination including helping a recipient find Medicaid providers to receive a covered service, helping a recipient make an appointment for a Medicaid covered service, arranging transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, helping a recipient find other relevant community resources and programs such as support groups, food pantries, or utilities assistance programs, and implementing a component of the CHW Service Plan addressing a Social Determinant of Health (SDoH). In order to attend an appointment with a recipient the CHW must have written consent from the recipient.
- Health promotion and coaching including providing information or education to recipients that makes positive contributions to their health status such as cessation of tobacco use, reduction in the misuse of alcohol or drugs, improvement in nutrition, improvement of physical fitness, family planning, control of stress, pregnancy, and infant care including prevention of fetal alcohol syndrome.
- Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects such as immunizations, control of high blood pressure, control of sexually transmittable disease, prevention and control of diabetes, control of toxic agents, occupational safety, and health and accident prevention. The content of the education must be consistent with established or recognized healthcare standards.

REIMBURSEMENT AND CLAIMS

Covered services will be reimbursed at the lessor of the provider's usual and customary rate or the rate on the Community Health Worker fee schedule. (At the time of this writing, the South Dakota Medicaid reimbursement rate for single-patient CHW services was $32.43 per 30-minute unit.)

CHW Services must be billed on a CMS 1500 claim form. CHW services may only be billed using one of the following CPT codes:

- 98960 – self-management education & training 1 patient – 30 minutes, $32.43 reimbursed
- 98961 – self-management education & training 2-4 patients – 30 minut3es, $16.22 reimbursed, per member
- 98962 – self-management education & training 5-8 patients – 30 minutes, $11.35 reimbursed, per member

UNITS OF SERVICE

Services are only billable if at least 16 minutes of service were provided. Providers must use the following table to determine how many units should be billed.

Unit	Time
1 Unit	16-45 minutes of service
2 Units	46-75 minutes of service
3 Units	76-105 minutes of service
4 Units	106 minutes of service or more

No more than 4 units of any combination of 98960, 98961, or 98962 are billable on a single date of service. A recipient is limited to 104 units of service in a plan year from July 1 to June 30.

SOCIAL DETERMINANTS OF HEALTH Z-CODES

CHW agencies may bill SDoH diagnosis codes as primary or secondary diagnosis codes.

SOUTH DAKOTA MEDICAID LESSONS LEARNED

As South Dakota was one of the first states to allow for Medicaid reimbursement for CHW services, there have been many lessons learned when reimbursing for CHW services, including:

- There is a need for referrals to be provided by many different providers and provider types. For example, an emergency room provider should be able to refer to CHW services, as many patients don't have an established PCP who could refer to CHW services.
- It is important for CHWs to provide services in the home and community setting. SD Medicaid caps the number of hours that a CHW can provide services in the clinic setting to just 5 units (2.5 hours) per Medicaid year. This allows the CHWs to better connect with the patients they are working with and identify needs within their home that are barriers to their health.
- It is important for referring providers to refer patients to CHW services based on SDoH needs and allow the CHW agency to use diagnosis codes that are related to SDoH. This not only allows Medicaid to collect better data regarding referral reasons, but also allows providers to refer for the appropriate reasons.
- It is also important for CHWs from non-medical/clinical programs to be able to bill Medicaid for CHW services provided. For example, some Medicaid recipients only receive services because they are connected through a community-based organization. This then allows the recipient to establish care based on the services provided by the CBO CHW.
- Rate setting is also important for CHW programs as it helps to sustain the CHW position and program. As CHWs are working within the community and home setting, the rate needs to be enough to not only cover the CHWs hour of services provided, but also to cover travel time and expenses. South Dakota Medicaid reimburses at the highest rate of all states that reimburse for CHW services, with an increase from the hourly equivalent of $40 an hour to $60 an hour in 2021, with subsequent annual increases since then.
- In addition to utilizing the group CPT codes for group education opportunities (especially evidence-based educational programs), group CPT codes are often used to bill for families where children and/or parents are Medicaid recipients and the CHW services provided collectively impact the family as a whole. For example, if a mom with two children is receiving CHW services (on behalf of the two children who are Medicaid recipients), although the children are the recipients, the education is provided to the mom, and thus billed at a group rate for the two children.
- Given that Medicaid reimbursement for CHW services is still rather new to South Dakota, limited data is available at the time of this writing regarding the number of units used per patient, per Medicaid year. Broadly speaking, many other states have not set a cap on number of units per year and/or have a higher number of units per month and/or per year than South Dakota. South Dakota continues to monitor claims data to identify if the 104 units per year, per Medicaid recipient is sufficient. It may also be beneficial for SD Medicaid to allow for more units based on a case-by-case basis.

Overall, the SD CHW Workforce has really excelled at reimbursing for CHW services due to the open communication between CHW programs, the CHWSD, and SD Medicaid.

SECTION 4 - FEE-FOR-SERVICE MEDICARE MODEL

APPROACH

As discussed above, community health workers are often utilized by healthcare providers to assist patients in addressing barriers and challenges caused by health-related social barriers. The Centers for Medicare and Medicaid Management (CMS) recently made the policy decision to reimburse primary care practitioners when they incur additional time and resources helping patients remove health-related social barriers.[32]

Under the fee-for-service Medicare framework, CHW services are eligible for reimbursement when they are ordered and overseen by the physician or nonphysician practitioner who manages the patient in the community.

More specifically, the new CMS rules states that, **Community Health Integration** (CHI) services are eligible for reimbursement when provided by "auxiliary personnel, including CHWs" who render services "incident to", and under the "general supervision" of a **billing practitioner**.

Under the CMS rule, CHI services "consist of activities to address Social Determinants of Health (SDoH) need(s) that are significantly limiting the practitioner's ability to diagnose or treat problem(s)". These services include:

- A person-centered assessment
- Practitioner-, home- and community-based care coordination
- Health education
- Building patient self-advocacy skills
- Healthcare access/health system navigation
- Facilitating and providing social and emotional support
- Leveraging lived experience, when applicable

INITIATING VISIT/REQUIRED ORDERS

Prior to the delivery of CHI services, a patient must participate in a pre-requisite **CHI Initiating Visit** with their regular primary care practitioner (billing practitioner). This **billing practitioner** should be the same practitioner who provides continuity of care to the patient in the community. This visit is conducted during an evaluation and management (E/M) appointment and is performed by the billing practitioner who will also furnish the CHW services in subsequent calendar months.

During the CHI initiating visit, the billing practitioner identifies and/or screens for Social Determinants of Health needs (including but not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities) that significantly limit the practitioner's ability to diagnose or treat the patient. The focus of the CHI service plan is to address the specific SDoH need(s) that are interfering with, or presenting a barrier to, diagnosis and treatment of the patient's problem(s). (Note: the E/M visit is billed separately from the subsequent delivery of CHI services.)

CHI SERVICE PROVISION

A billing practitioner may arrange to have CHI services provided in-house or by auxiliary personnel who are external to, and under contract with the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of "incident to" and other requirements and conditions are met, and if sufficient clinical integration exists between the third party and the billing practitioner.

COVERED SERVICES

After the CHI initiating visit is complete, a CHW can provide the following types of activities:

- Person-centered assessment – performed to better understand the individualized context of the intersection between the SDoH need(s) and the problem(s) addressed in the initiating E/M visit.
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding of cultural and linguistic factors.

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[32] Federal Register, Vol. 88, No. 220, Thursday, November 16, 2023.

- Facilitating patient-driven goal-setting and establishing an action plan.
  - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
- Practitioner-, home-, and community-based care coordination.
  - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).
  - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit, or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
  - Facilitating access to community-based social services (e.g. housing, utilities, transportation, food assistance) to address the SDoH need(s).
- Health Education – helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals and preferences, in the context of the SDoH need(s) and educating the patient on how to best participate in medical decision-making.
- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDoH need(s), in ways that are more likely to promote personalized and effective diagnosis and treatment.
- Healthcare access/health system navigation.
  - Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDoH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

UNITS OF SERVICE/BILLING CODES

CHI services are billed on a calendar-month basis by the billing practitioner. The initial unit of CHI service is a duration of 60 minutes of service per calendar month and can be billed under the "G Code" of G0019. Subsequent time in the calendar month can be billed in 30-minute increments under the "add-on" G Code of G0022. There is currently no frequency limitation on code G0022 as long as time spent is reasonable and necessary. (CMS will monitor utilization of the add-on code and reserves the right to evaluate this policy in future rulemaking.)

Unlike Medicaid policies in many states (including South Dakota), CMS does not provide billing codes or reimburse for CHI services provided in a group setting.

CLAIMS SUBMISSION AND REIMBURSEMENT

According to the CMS final rule, CHI services must be provided incident to the professional service of a physician or other statutorily qualified practitioner, who must bill for those services. Auxiliary personnel who provide these services must be under the (general) supervision of the physician (or other practitioner) and the provided service must be reasonable and necessary for diagnosis and treatment of illness or injury. Individual CHWs, CHW agencies and community-based organizations (CBOs) lack this statutory benefit, and subsequently cannot bill Medicare directly as is the case in many states for Medicaid (including South Dakota). It is important to note that CHW agencies and community-based organizations in many states (including South Dakota) are allowed to and have been billing Medicaid directly. These agencies will need to develop new systems, contract arrangements and workflows with clinics to access the new Medicare reimbursement for CHI services.

As of this writing, reimbursement rates for CHI services are understood to be as follows:

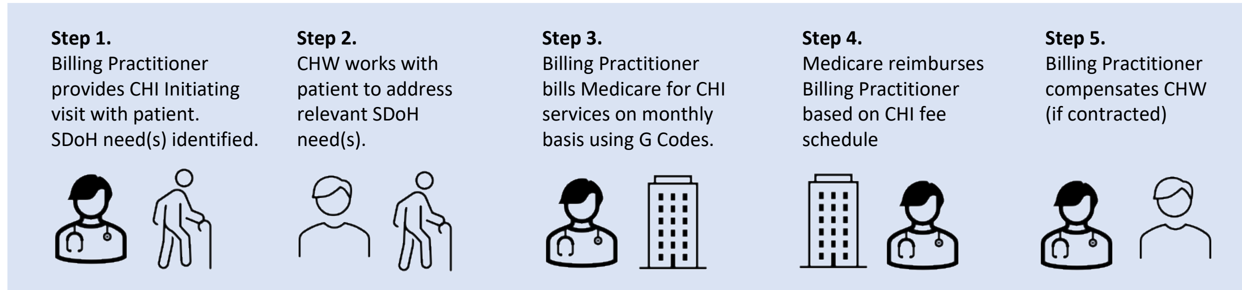
- G0019 - Initial First Hour of First Visit Per Month - $79 per hour
- G0022 - Subsequent Encounters - $49 per subsequent 30 minutes

TRAINING/CERTIFICATION

All auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements and authorized to perform them under applicable State law and regulations. (In South Dakota, the requirement is for CHWs to be certified through the Community Health Worker Collaborative of South Dakota.)

HIGH-LEVEL PROCESS FLOW

A high-level depiction of the fee-for-service Medicare approach to CHI service provision is included below:



SECTION 5 - CHW SERVICES OFFERED BY COMMERCIAL HEALTH INSURERS

PRESBYTERIAN HEALTH PLAN – NEW MEXICO[33]

In 2019, New Mexico Presbyterian Health Plan, based in Albuquerque, began offering CHW services to its commercial health insurance customers as optional add-on benefit. (Customers who elect to provide CHW services for their employees pay an additional per member per month fee.)

CHW STAFFING

New Mexico Presbyterian Health Plan staffs their offering with a team of employed CHWs and supervisors, targeting a ratio of 1 CHW per 10,000 members. These staff are located across the state of New Mexico and provide full coverage to statewide employers.

INTERVENTIONS

The CHW team can engage with employees and family members telephonically, virtually or via home visits. The team supports all family members living with the employee, regardless of insurance coverage.

The Presbyterian Health Plan CHW team is able to:

- assist employees and their families with Social Determinant of Health (SDoH) needs.
- access necessary providers and services.
- understand their health condition and treatment plan.
- navigate their benefits and the health care system.

ACCESS/REFERRALS

Employees with the CHW service benefit can self-refer to CHWs. The Presbyterian team also receives referrals from employers' Employee Assistance Programs (EAPs) and analyzes employers' claims data to identify employees and family members with "gaps in care" (missed immunizations, screenings, etc.).

REPORTING

Presbyterian Health Plan is able to demonstrate value to employers by documenting the number of employees & family members contacted, and the number and types of interventions delivered (including gaps in care that have been closed and SDoH needs addressed.)

In addition to receiving specific intervention data, employers understand that CHW services help:

- employees to remain healthy and productive.
- manage the cost of medical expense for their population.

SUMMARY

Presbyterian Health Plan officials report that employers understand the impact that Social Determinants of Health (SDoH) have on their employees, and they are looking to insurers to offer solutions to this need.

[33] Based on an interview with a New Mexico Presbyterian Health Plan executive, January 3, 2024.

SECTION 6 - CONSIDERATIONS FOR SOUTH DAKOTA HEALTH PLANS

As health insurance providers begin to define their own coverage and payment policies related to CHW services for their Commercial and Medicare Advantage populations, they will have a number of design decisions to consider. The purpose of this section is to inform health plans' deliberations by sharing our philosophies, observations and learnings from SD Medicaid and elsewhere.

TARGET POPULATION(S)

- Specific chronic disease populations
- Frequent emergency room utilizers
- Frequent urgent care utilizers
- Individuals without documented primary care visits
- Individuals with identified Social Determinants of Health needs

REFERRAL POLICIES/ACCESS TO CHW SERVICES

- Often, individuals who benefit most from CHW services are – by definition - not optimal users of the system. They may lack a regular primary care provider, miss out on preventive care, struggle with compliance or rely on urgent care and the emergency room for healthcare access more than the typical patient/member.
- For these reasons, policy design should make it easy for patients to access or be referred to CHW services. Policies that require "gatekeepers" or involved assessments prior to CHW access may serve as significant barriers to target patient populations.

SITE/SCOPE OF SERVICE

- A significant portion of CHW's success and value comes from their knowledge of and grounding in the local community. Community-based CHWs are more likely to have a deep understanding of local resources and agencies, and regular home visits provide a unique insight into the patient's circumstances and build trust in ways that aren't possible through phone or video call interactions.
- Relatedly, CHWs are most effective when their role allows them to "braid" health education, self-management skill building, and connect patients to all relevant community resources.
- While CHWs are clearly effective at managing and reducing medical expense, payors should resist the temptation to "narrow" the CHW role to focus solely on medical expense management. Similarly, CHW program design should recognize and utilize home visits when possible, even if phone or video calls represent a less expensive delivery option.

DIRECT BILLING

Several states (including South Dakota) allow CHW agencies to bill Medicaid directly. This "direct billing" model creates an environment in which local, CHW agencies and community-based organizations (CBOs) can operate as independent, financially sustainable, and directly accountable providers.

Indirect billing models (that require PCPs or other providers to bill for CHW services on behalf of CHW providers) have the effect of relegating community-based CHW organizations to the status of "subcontractor" – and create a more challenging financial environment in which to operate.

SERVICE DELIVERY MODEL

Health plans that are thinking about providing CHW services to their populations have several service delivery options to contemplate.

Independent CHW Organizations – Health plans can develop a network of independent CHW agencies to provide adequate access for their populations across the State. Contracts and service delivery could follow South Dakota Medicaid as a template.

CHW "Hubs" – In this scenario, independent CHW organizations could choose to create and participate in a "hub" that would serve as a contracting & billing entity on behalf of its members. Hubs would simplify health plans' network development efforts by allowing a plan to contract with multiple providers by entering into a single "hub" agreement.

Internal CHW team – Health plans could follow the lead of New Mexico Presbyterian Health Plan and establish their own "internal" team of CHWs and supervisors. Under this approach, CHW services could be provided to member populations as an administrative service, or as a per-member, per-month (PMPM) service (in the case of commercial insurance sold to employers).

Clinic/Hospital-based teams – Health plans could also conceivably contract with clinics or hospitals for CHW services. In this scenario, the health care provider organization would have an internal CHW team, and the health plan could enter into an agreement to deliver services for certain member populations.

There is no one-size-fits-all approach, and health plans may consider using multiple service delivery models to reimburse and/or provide CHW services.

DEFINING VALUE & SUCCESS

When it comes to making the case for CHW services, there are a number of metrics that could be used to establish value:

- Patient/member satisfaction
- Patient/member retention
- Employee absenteeism
- Employer satisfaction
- Employer retention
- Gaps in care
- Utilization of ED, urgent care
- Individual patient ROI

Executives at New Mexico Presbyterian Health Plan caution that hard "ROI" calculations are difficult to generate, particularly if CHWs serve patients with a broad range of conditions and SDoH needs.

It is, however, easier to calculate overall ROI for individual patients, with some ROIs showing significant cost savings. For example, a patient who has gone to the Emergency Room for non-emergency medical needs four times in the last month could easily have occurred expenses to the health plan of over $2,000 (or roughly $500 per visit).[34] In contrast, a CHW working with this same patient could spend many individual hours working with the same patient and not even exceed $2,000 in salary. Further, in this example, using the SD Medicaid hourly reimbursement equivalent of $64.86, a CHW could provide nearly 31 hours of individual services to this patient for the same cost of four ER visits.

[34] US Department of Health and Human Services, Agency for Healthcare Research and Quality. December 2020.

SECTION 7 – CONCLUSION AND NEXT STEPS

CONCLUSION

Ultimately, there is no "one-size-fits-all" approach to CHW service benefit design. Indeed, the strength of the Community Health Worker (CHW) role is due to:

- the flexibility with which it can be deployed,
- the range of services that can be delivered, and
- the types of value it can create for patients and payers alike.

As the CHW landscape continues to evolve and expand, commercial payers will have ever-increasing opportunities to harness and tailor the benefits that CHW services can bring to their covered populations.

FOR MORE INFORMATION

For more information, and to download a summarized one-pager of this report, visit www.CHWSD.org/CHWbenefit or email the CHWSD at info@chwsd.org.