Barriers and Strategies to Operationalize Medicaid Reimbursement for CHW Services in the State of Minnesota: a Case Study

Kathryn E. Gunter, MPH, MSW[1], *Megan K. Ellingson, MHA*[2], *Megan Nieto, CHW*[2], *Ron Jankowski, MD*[2], *and Jacob P. Tanumihardjo, MPH*[1]

[1]Section of General Internal Medicine, University of Chicago, Chicago, IL, USA; [2]CHW Solutions, St. Paul, MN, USA.

Integrated medical and social care via community health worker (CHW) services is a growing area of interest, particularly among health care organizations that offer care for underserved populations. Establishing Medicaid reimbursement for CHW services is only one step to improve access to CHW services. Minnesota is one of 21 states that authorize Medicaid payment for CHW services. Despite available Medicaid reimbursement for CHW services since 2007, the actual experience of many Minnesota health care organizations in obtaining reimbursement for CHW services has been challenging due to barriers at multiple levels (e.g., clarifying and operationalizing regulation, navigating complexity of billing, building organizational capacity to reach key stakeholders at state agencies and health plans). This paper provides an overview of the barriers and strategies to operationalize Medicaid reimbursement for CHW services in the state of Minnesota, through the experience of a CHW service and technical assistance provider. Based on lessons learned in Minnesota, recommendations are made to other states, payers, and organizations as they navigate processes to operationalize Medicaid payment for CHW services.

J Gen Intern Med 38(Suppl 1):S70–S7
DOI: 10.1007/s11606-022-07925-3

INTRODUCTION

Community health workers (CHWs) are an evidence-based model to enhance care coordination, support care of patients with chronic conditions, and improve diabetes-related outcomes (e.g., glycemic control).[1–6] Integrated medical and social care via CHW services is a growing area of interest, particularly among health care organizations that care for underserved populations. In integrated medical and social care, the CHW role can include delivering services that address the *medical needs* of individuals with simultaneous efforts to address *unmet social needs* that present barriers to health. For example, for a client with diabetes who reports food insecurity, the CHW may provide self-management skill building support and tailored diabetes education in the home. The CHW may also connect the client to a range of community-based resources (e.g., support enrollment in Supplemental Nutrition Assistance Program (SNAP), offer navigation to farmers' markets that offer SNAP-Ed for food demos, nutrition classes, and locations that match SNAP dollars for twice the amount of produce). Many organizations that integrate CHW services are also seeking opportunities to describe the business case for CHW services (e.g., analysis of preventable ED/inpatient utilization, piloting shared risk/return framework for payors and providers) and long-term financial strategies to sustain the CHW role in integrated medical and social care.

Medicaid reimbursement for CHW services (e.g., self-management education, targeted case management services, home visits, health promotion activities) provides access to CHW support for underserved populations (e.g., beneficiaries with two chronic conditions, beneficiaries receiving targeted case management services, beneficiaries with complex behavioral or physical health needs). Currently, Minnesota is one of 21 states that authorize Medicaid payment for CHW services and one of seven states to allow CHWs to provide services under the state plan.[7] However, in practice, obtaining reimbursement for CHW services has been challenging. Barriers include the following: (1) lack of clarity around Medicaid reimbursement policies and procedures; (2) electronic billing system barriers and complexities; (3) Medicaid fee schedule reimbursement rates that are insufficient to cover the costs of delivering CHW services; and (4) factors such as the expertise and capacity of organizations to navigate administrative hurdles.[8]

CHW Solutions is a CHW service and technical assistance provider based in St. Paul, MN, that provides direct services through a dedicated CHW team. Additionally, CHW Solutions provides clinical oversight of CHW activities and billing support for organizations lacking internal expertise with billing for CHW services. CHW Solutions' team delivers integrated medical and social care via a CHW Medicaid billing model by combining health education, self-management skill

We confirm that this work is original and has not been published elsewhere or been presented at any prior conferences, nor is it under consideration for publication elsewhere.

Received April 2, 2022
Accepted October 31, 2022
Published online March 2, 2023

building and community resource connection into each CHW visit. CHWs ensure patients are connected to their local care team, including primary care and managed care organization (MCO)–based coordinators, regardless of health system affiliation.

We provide an overview of the barriers and strategies to operationalize Medicaid reimbursement for CHW services based on lessons learned in Minnesota. We recommend how other states, payers, and organizations can more effectively operationalize Medicaid payment for CHW services.

Legislative Context

In 2005, Minnesota became the first state to implement a standardized CHW curriculum.[8] In 2007, the Minnesota Legislature approved fee-for-service (FFS) Medicaid reimbursement for CHWs delivering health education and care coordination services.[8] The provisions of the bill (HF 1078) are codified under several statutes, and HF 1078, Subdivision 49, is summarized in Figure 1.[9–11] In 2013, the Centers for Medicare and Medicaid Services (CMS) clarified regulations authorizing preventive services provided by CHWs and issued guidance that State Plan Amendments (SPAs) would be required to receive approval for Medicaid to cover the proposed services.[12] States may develop SPAs with CMS to modify how Medicaid programs are run in order to provide different services, including expanded authority for CHWs to provide services.[13] In 2013 a SPA was approved in Minnesota and effective in 2015 and allowed for reimbursement of CHW services, only for health education services.[14]

The requirements for CHW MN Medicaid reimbursement are published in the Minnesota Health Care Programs (MHCP) CHW Provider Manual and are summarized in Figure 2.[15] In Minnesota, critical requirements include the following: CHWs must complete a qualified certificate program, a clinician must order and provide general oversight of the services, and service documentation must follow Medicaid standards.

BARRIERS AND STRATEGIES TO LEVERAGE AVAILABLE MEDICAID REIMBURSEMENT FOR CHW SERVICES IN MINNESOTA

Although Medicaid reimbursement was approved in Minnesota in 2007, many organizations struggled to operationalize and access reimbursement for CHW services. Starting in 2017, CHW Solutions encountered barriers and established strategies for delivering CHW services, seeking reimbursement, and providing technical assistance to organizations working with CHWs. CHW Solutions focused on developing sufficient organizational capacity, clarifying regulation, navigating billing processes, securing adequate financing, engaging with payers, and enhancing bi-directional communication and care coordination (Table 1).

Organizational Capacity. A single organization often lacks the expertise and administrative capacity required to both obtain reimbursement for CHW services and advocate for sustainable financing models. CHW Solutions built a team prepared to navigate policies and systems, build relationships with key external stakeholders (e.g., DHS, payers), provide clinical oversight of CHWs, and develop expertise in medical billing.

Regulation. When regulatory language lacks clarity, organizations struggle to translate regulations into direct CHW service delivery, submitting claims, and successfully receiving payment. Figure 2 summarizes reimbursement requirements from the MHCP CHW Provider Manual, for example: "The service must involve teaching the patient how to self-manage their health (including oral health) in conjunction with the health care team." Organizations are left to interpret what constitutes teaching how to self-manage (e.g., individual patient education, skill building, navigation to resources) and how to work in conjunction with a health care team (e.g., clinic co-location, remote consultation with teams while serving patients in community settings). CHW Solutions

Community health worker

(a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Figure 1 Community Health Worker Excerpt of Bill HF 1078, Subdivision 49. Citation: 2021 Minnesota Statutes. 256B.0625 COVERED SERVICES. https://www.revisor.mn.gov/statutes/cite/256B.0625. Published 2021. Accessed March 25, 2022.

1. CHWs must complete a qualified certificate program using approved CHW curriculum.
2. The CHW must work under the supervision of a qualified health care provider.
3. CHWs and the organizations they work for must enroll with DHS as Medicaid providers.
4. The service must involve teaching the patient how to self-manage their health (including oral health) in conjunction with the health care team.
5. Services provided to Individuals and groups of any size are covered.
6. The content of the patient education plan or training program is consistent with established or recognized health/dental care standards and may be modified as necessary for the clinical needs, cultural norms, and health literacy of individual patients.
7. CHW services must be ordered by a Minnesota Health Care Program enrolled physician, APRN, dentist, mental health professional, or non-enrolled registered nurse or public health nurse working for an enrolled organization.
8. Documentation requirements:
   a. An order for services
   b. Patient education plan or training program used
   c. Periodic assessment of progress and the need for ongoing CHW services
   d. Date of service
   e. Start and end time of the service
   f. Whether the service was individual or group and if group, number of patients present, summary of the session's content, the CHWs signature and printed name
9. Claims must be submitted electronically using form 837P using the following CPT codes:
   a. 98960: 1:1
   b. 98961: 2-4 patients
   c. 98962: 5-8 patients
   d. 98962 (U9): more than 8 patients

Figure 2 Summary of Minnesota health care programs community health worker reimbursement requirements. Abbreviations: CHW, community health worker; APRN, Advanced Practice Registered Nurse; CPT, current procedural terminology. Adapted from the Minnesota Department of Health. Minnesota Health Care Programs Community Health Worker Provider Manual. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357.Published July 2020. Accessed March 28, 2022.

developed and then articulated to the Department of Human Services (DHS) a model of CHW patient education that includes the following: health education, self-management skill building, and community/resource connections. The legislature gives authority to State agencies to develop administrative rules. Therefore, DHS has the capacity to modify rules based on their priorities and interests, thus shaping how CHW services are structured, delivered, and sustained (e.g., to bill for CHW services for groups larger than 8 DHS added a U9 modifier to CPT code 98962).

Billing. The basic steps of billing for CHW services initially proved to be complicated, burdensome, and unsuccessful. Billing requires specific steps including confirming eligible CHW services for reimbursement; navigating how rendering, ordering, and billing providers are referenced on claims; and identifying how billing may vary based on location of CHW (e.g., community-based organization or federally qualified health center (FQHC)). CHW Solutions iteratively discussed the structure of CHW activities and reimbursement with DHS to clarify and modify implementation and payment for CHW services. This process yielded strategies to clarify acceptable services (e.g., preventive education, education for patients with diabetes diagnosis), confirm specific diagnosis and provider codes for claims, improve efficiency of dual-eligible beneficiary claims processing, and document CHW services in compliance with DHS rules (e.g., patient education plan, date of service). After confirming a CHW service model aligned with established regulations and rules, it was possible to submit claims to Medicaid for services provided, troubleshoot denied claims, and clarify the necessary content for future claims.

Government Financing. The average cost to deliver one unit of CHW services exceeds the current Medicaid fee schedule for CHWs.[8] The current reimbursement rate for one-on-one CHW health education services (CPT code 98960) in Minnesota is $20.99 per 30-min unit. Even once higher reimbursement rates are negotiated with managed care organizations, CHW service providers must deliver patient education activities at 80% FTE in order to break even under the current rates and benefit scope for CHW services. For example, the cost for a 30-min unit of CHW services can range from $60 to $100 and varies depending on the context of service delivery (e.g., travel time and associated costs, outreach, care coordination, phone calls data tracking needs, etc.). Organizations need to advocate to increase rates of Medicaid reimbursement for CHW services. CHW Solutions directs external funding sources (e.g., grants) to underfunded CHW activities until reimbursement rates are sufficient to cover full cost of services.

Payer Financing. CHW Solutions engages payers in pilot projects to demonstrate proof of concept for CHW services, and CHW service value to MCOs and their members. Grant-funded initiatives provide a setting to engage CHW provider organizations, payers, and public health organizations to address strategies to improve outcomes for shared populations. In this context, payers identify ways to implement CHW services with their members, including patients referred from FQHCs (e.g., closing care gaps, connecting members to community-based programs, addressing social determinants of health). Pilot projects demonstrate the value of CHW services, and provide a foundation for renegotiating MCO rates for CHW services.

Table 1 Barriers and Strategies to Leveraging Available Medicaid Reimbursement for CHW Services in Minnesota

Level	Barriers in Minnesota	Strategies applied by CHW provider organization
Organizational capacity	**Minimal existing capacity:** need to build expertise and capacity to navigate policies and payment systems	Built a team with range of expertise (e.g., provide clinical oversight, expertise in medical billing) Sought external consultation for other areas of expertise (e.g., attorney in health care law to establish HIPAA policies and forms, write contract templates)
Regulation	**Interpreting rules:** lack of clarity around DHS compliance and rules around CHW activities and billing	Discussed rules and compliance around billing for CHW services directly with DHS to determine options to structure CHW activities, develop workflow for activities, and bill for relevant activities Identified specific contact at DHS with expertise in CHW reimbursement
	Operationalizing rules: ambiguity in language of regulations presented barriers to CHW implementation	Piloted best practices to deliver services and meet state requirements, for example: • Emphasized CHW visits include health education, self-management skill building, and resource connections Outlined a specific model to deliver CHW services and submitted a formal letter to DHS to seek feedback on the suggested model and assess compliance with regulation
Billing	**Eligible CHW services:** CHW services are a non-covered benefit under Medicare	Sought options to improve efficiency in billing processes, for example: • DHS approved a process to authorize payment for CHW services at 100%, improving reimbursement for CHW services. Previously had to bill Medicare, obtain denial of payment, and seek 100% payment from Medicaid.
	Eligible CHW services: lack of clarity regarding types of services under CPT codes related to CHW services	Clarified eligible CHW services, for example: • As part of state workgroups, clarified with DHS "health education services"[1,2] and activities • Worked with DHS to add U9 modifier to CPT code for CHW service provided to groups of >8 patients[1]
	Eligible diagnosis codes: lack of clarity regarding what diagnosis codes were acceptable to use	Clarified eligible diagnosis codes, for example: • DHS clarified "diagnosis related patient education services" applied to preventive and intervention education[2] • Utilized ICD-10 code (z71.89, "Other specified counseling") when providing health education services
	Rendering provider: DHS initially required alpha-numeric code for CHW provider numbers to bill for services; format led to early claim rejection	Clarified codes required to describe rendering provider in claims, for example: • CMS allows NPI codes for CHWs but few CHWs were using NPIs in Minnesota • CHW Solutions confirmed with CMS that CHWs can have NPIs • NPIs replaced alpha-numeric codes and improved claims submission and review process
	Ordering provider: DHS requires services ordered by a Minnesota Health Care Program–enrolled provider (e.g., MD, Advanced Practicing Registered Nurse, mental health professional)	Contracted with a physician Medical Director; benefits of working with a medical director include: • Provide guidance so CHWs follow criteria, messages and best practices outlined in standing orders Regular huddles with CHWs to discuss complex cases and determine needs for ongoing CHW services • Ensure CHWs are supported and operating in an appropriate role within a health care team
	Billing provider: billing providers should use an NPI number to submit claims	Identified that CHWs should apply for and can successfully submit claims with NPIs CHW Solutions clarified with each payer which provider number is required for each claim field
	Free care policy: without policy organizations must limit services	DHS established a free-care policy[3] to assure that organizations can bill Medicaid for services for patients who have Medicaid and can also provide the same services to other populations without Medicaid for free
	Service documentation: DHS requires specific documentation of CHW services	Documented CHW services (e.g., in Electronic Health Record, on forms) in compliance with documentation required by DHS (see Fig. 1)
	Billing in different types of healthcare settings: challenges with co-locating external CHWs at an FQHC	Piloted an approach of CHW co-location in FQHC and reached out to state agency (e.g., DHS) to explore options to implement CHW services long-term. DHS clarified how expenses would need to be documented to continue co-location (e.g., account for CHW expenses for non-Medicaid patients under separate budget)
Government financing	**Rates:** reimbursement rates for CHW services are not sufficient	• Advocated to increase state Medicaid reimbursement rates • Identified that local public health and FQHCs may need to allocate some external funds (e.g., grant funding) to fill gaps until CHW reimbursement rates are sufficient to cover the full cost of service delivery
	Payer engagement: lack of relationships with payers	

(continued on next page)

Table 1. (continued)

Level	Barriers in Minnesota	Strategies applied by CHW provider organization
Payer financing (e.g., managed care organizations)		Engaged with payers in projects that explore proof of concept for CHW activities and services. These projects are an important part of building relationships and can: • Quantify reach, test early implementation strategies, and articulate costs • Assist payers with understanding CHW role and how CHWs may reach populations of interest • Assure CHW service providers can reach members with social determinants of health needs • Show MCOs how CHWs engage members in health education and self-management skill building activities
	Rates: DHS rates are not sufficient; MN MCO rates initially comparable	Renegotiated rates with MCOs.
Cross-sector collaboration	**Convening resources and funding across sectors:** one sector or organization alone cannot address barriers to financing, billing, sustainability	Participated in cross-sector initiatives and pilot projects to demonstrate value of CHW activities. For example: • Collaborated with DHS and payers on efforts that supported value of CHW activities[1,2,4] • Participated in projects funded by CDC and HUD to evaluate role of CHWs (e.g., increase home visiting[4]); • As an outcome of participation in cross-sector initiatives, DHS updated the state provider manual's language regarding provision of CHW services (the manual includes rules to guide provision of all Medicaid services in MN[5]) • Provided technical assistance to State Health Department and local health departments to integrate CHWs into community settings, supporting residents with pre-diabetes and hypertension[6] • Collaborated with Minneapolis Health Department (MHD) to pilot care delivery and payment strategies for FQHCs, as part of an initiative to integrate medical and social care for patients with diabetes[7]
	Reaching populations who are not eligible for Medicaid	Collaboration with other organizations/sectors helped support access to grants and other funding to reach uninsured populations who may not access CHW services (e.g., uninsured patients, immigrant patients)
Bi-directional communication and coordination	**Other communication and coordination**	Developed strategies to enhance patient outreach and tailor CHW services to specific settings: • Implemented standing weekly huddle with health care teams to review patient progress, goals, referrals • Involved CHWs in clinic-based groups, classes, and activities, providing a setting for patients to meet CHW before referral, supporting patient engagement, helping patients understand purpose of CHW visit
	Technology	Explored options for secure access to patient-level data to improve CHW workflow, outreach, and collaboration with health care team, for example: • Troubleshoot issues accessing secure external email messages. Some clinics have IT/computer system safe-guards that require a multi-step process to open secure email messages. This is cumbersome, disrupts workflow, and can delay coordination. • Establish contracts that allow secure access to the EMR for CHWs. CHWs can document their activities which helps standardize CHW services and facilitates communication/coordination with health care teams.

Abbreviations: *CHW, community health worker; MN, Minnesota; DHS, Department of Human Services; NPI, National Provider Identifier; EMR, electronic medical record*

Citations: [1]***Minnesota Partnership on Pediatric Obesity Care and Coverage***. http://www.mnaap.org/work-groups/pediatric-obesity/. Published 2018. Accessed March 25, 2022. [2]***Healthy Communities Task Force - CHW Financial Sustainability Work Group.*** https://chwsolutions.com/wp-content/uploads/2018/12/HCTF-CHW-Billing-Education-Information-and-Resources-December-2018.pdf. Published December 2018. Accessed March 25, 2022. [3]***Minnesota Department of Human Services.*** Billing Policy Overview: Free-care policy. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008924#free. Published March 2022. Accessed March 29 2022.[4]***Minnesota Department of Health.*** Minnesota Healthy Homes Strategic Plan. https://www.health.state.mn.us/communities/environment/healthyhomes/docs/hhplan2012.pdf. Published November 2012. Accessed March 25, 2022. [5]***Minnesota Department of Health.*** Minnesota Health Care Program Community Health Worker Provider Manual. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357. Published July 2020. Accessed March 25, 2022. [6]***Partner-SHIP 4 Health.*** SHIP and Healthcare. https://partnership4health.org/health-care/. Published October 2017. Accessed March 28, 2022. [7]***Minneapolis Health Department.*** Health care partnerships. https://www2.minneapolismn.gov/government/programs-initiatives/healthy-living/place-based-strategies/health-care-partnerships/. Published October 2022. Accessed February 2, 2023

Cross-sector Collaboration. One sector or organization alone cannot address all barriers to financing, billing, and sustainability of CHW services. Cross-sector collaboration (i.e., collaboration that can occur across social services, community development and other community-based organizations, health care organizations, government agencies, and/or payors) yields opportunities to solve problems and identify new strategies. Organizations that care for underserved patients and those without insurance, like FQHCs, would like to have options to connect patients to CHWs. Cross-sector collaboration can facilitate access to resources and more varied funding sources that may not be accessible to organizations working in isolation. For example, in 2018, partnership across a local public health department, CHW Solutions, and FQHCs created an ideal setting in Minneapolis to test CHW service implementation options, deliver CHW services, and pursue reimbursement over 4 years.[16] *Bridging the Gap: Reducing Disparities in Diabetes Care*, a Merck Foundation–supported initiative, blended expertise, administrative capacity, and organizational missions across three sectors, and piloted opportunities to link FQHC patients (including uninsured patients) with CHW services via diabetes care transformation.[16] In this initiative, philanthropic grant funding supported CHW services for uninsured patients. Additionally, grant funding helped fill the gap between the cost of implementing CHW services and the current reimbursement rate for CHW services in the FQHC context, a new setting to test CHW service delivery and payment strategies with an external CHW provider organization.

Bi-directional Communication and Coordination. Access to patient-level data improves CHW workflows, outreach, patient engagement, and service efficacy. Leveraging technology and other communication strategies can enhance outreach to patients and tailor CHW services to specific settings. The Minneapolis Health Department supported FQHCs to pilot the use of a bi-directional electronic social needs screening and referral platform, NowPow, to link patients with community-based organizations, including CHW Solutions. The platform presented pros (e.g., secure messaging, organization of referrals for shared populations) and cons (e.g., separate platform for FHQC staff to navigate, the relative administrative capacity of organizations to handle referrals and communication through additional electronic platforms). In the absence of ideal technology strategies, effective tools to coordinate and communicate with organizations can include the following: secure fax, secure email, regular meetings, standard forms, and tailoring referral processes and communication methods to the needs or preferences of individual organizations (e.g., sharing referrals via secure fax, communicating via weekly huddle, supporting electronic referrals and real-time communication and access to data by creating secure remote user electronic medical record access for external CHW).

LEVERAGING AVAILABLE MEDICAID REIMBURSEMENT FOR CHW SERVICES: RECOMMENDATIONS FOR OTHER ORGANIZATIONS, PAYERS, AND STATES

Establishing Medicaid reimbursement for CHW services is only one step to improve access to CHW services. To leverage available Medicaid reimbursement, organizations, payers, and states need to bridge the gaps between interpreting regulations, translating them to direct service delivery, submitting claims, and successfully receiving payment for CHW services (Table 2).

Organizations should prepare to encounter and work through barriers and strategies at multiple levels, and chart a multi-year path to navigate regulatory, financing, billing, and sustainability issues. Observing Minnesota's experience with a narrow scope of services (e.g., patient education) for reimbursement, South Dakota intentionally designated a broader scope of services to be paid by Medicaid (e.g., Health System Navigation and Resource Coordination, Health Promotion and Coaching, Health Education).[17] As others navigate practical steps to implement CHW services, they should begin by connecting with contacts at state agencies (e.g., DHS) to offer specific examples of service provision and billing scenarios to assess compliance with state guidelines. This is a necessary part of the process and will support efforts to deliver CHW services and receive payment.

Organizations should be prepared to troubleshoot errors with claims upfront. For example, submit a few claims to work through all the details before submitting large batches of claims. A medical director role provides infrastructure for CHW activities and helps articulate value of CHW services. Regarding government and payer financing, CHW provider organizations and MCOs should plan to build relationships over time; this will support navigating reimbursement steps long-term. Communicate the value of the CHW role and request/supply rates that are sufficient to sustain CHW services.

CONCLUSION AND FUTURE DIRECTIONS

FFS Medicaid payments for CHW services can provide sustainable funding to reach Medicaid recipients with CHW services. The Minnesota experience of navigating reimbursement echoes some challenges in Oregon, where coordinated care organizations (CCOs, similar to accountable care organizations) also report barriers with FFS payments (e.g., state guidance on CHW billing policy, acceptable billing codes).[18] Strategies to address these problems should include technical assistance for organizations to navigate implementation of CHW services, billing structures, and reimbursement processes. Although Medicaid FFS payment for CHW services provides options for reimbursement, the process is cumbersome and confusing, hindering uptake of CHW services, and Medicaid funds do not cover services delivered to uninsured patients. Continuing to identify and eliminate the

Table 2. Recommendations for Other States and Health Care Organizations Seeking Options to Deliver and Receive Payment for Community Health Worker (CHW) Services

Level	Topic	Recommendation
Organizational capacity	Planning	Prepare to encounter barriers and develop strategies at multiple levels as part of your process. Prepare to work through barriers over months or years.
	Seek expertise	Build a team with individuals who can navigate policies and systems, build relationships with key external stakeholders (e.g., DHS, payers), provide clinical oversight, and bring expertise in medical billing. In the absence of a team with these skills, seek support and expertise from external consultants. Independently, FQHCs may not have expertise in all areas and therefore should consider consulting with an external organization to ease administrative burden and problem solving.
Regulation	Clarify rules and ask questions	When regulations/rules are unclear, ask questions and clarify implementation, billing, and reimbursement opportunities with state/regulatory agencies, health care organizations, and payers. Offer specific examples of service provision or billing scenarios for regulators to review and react to. Develop an approach to CHW service provision and reimbursement that works in one organizational context and follows all of the states' rules; modify approach as you implement in other settings (e.g., FQHCs).
Billing	Billing questions and billing scenarios	It is easier for a payer to react to a denied claim than to explain how a theoretical claim may be processed in their systems. Submit a small number (3–5) claims to test the system. Claims may be denied multiple times before they are paid. Be persistent and prepared for this work up front. Use these test claims to work through all details before submitting large batches of claims. Over time, claims help demonstrate value of CHW services by providing payers insight into CHW reach and activities.
	Medical director	Establish a medical director role. Clinical supervision enhances CHW services via best practices and signed standing orders: • Establish parameters to guide care and support CHW teams with reaching at-risk patients • Use of standing orders is common medical practice; use for CHW service delivery is easily understood within medical teams • Standing orders provide an opportunity to articulate CWH value and help payers appraise the content and structure of CHW Services (e.g., health education, self-management skill building and community resource connection) • Pay for CHW services at a rate that covers the cost of delivering services.
Financing	Government	• Improve coordination/articulation of best practices for CHWs. For example, Minnesota Department of Health (MDH) could develop statewide standard CHW activities and messages for various conditions, and train CHWs to follow them. The MDH Health Care Homes Learning Collaborative provides an example to model training and resources.[1]
	Payers	Intentionally engage with CHW services providers, for example: articulate the value you expect from CHW services, pilot CHW service delivery to your highest risk members, and pay sufficiently to cover the costs of ongoing CHW service delivery.
	Value case for CHW services	Maintain relentless pursuit of sustainable funding for best practice CHW services, communicate the value of the CHW role, request rates that are sufficient to make CHW services sustainable
Cross-sector collaboration	Relationships with other sectors	Plan for cross-sector collaboration as part of your process. Build relationships across sectors including state agencies, public health organizations, payers, and health care organizations.
	Funding and resources	Identify options to convene funding and resources from multiple entities. Plan for ongoing resources to cover CHW services for uninsured patients. Access Medicaid funding for publicly insured people, and direct public health grants and philanthropic funding to CHW services for uninsured populations.
Bi-directional communication and coordination	Tailor communication and coordination strategies	Prepare to work with organizations across sectors (e.g., Federally Qualified Health Centers, payers) to develop and tailor referral processes and communication methods about shared populations; test multiple methods and technologies until effective and sustainable solutions are achieved.

[1] *Health Care Homes Learning Collaborative MDH Learning Center.* https://www.health.state.mn.us/facilities/hchomes/collaborative/lms.html#lmstraining1 *Accessed March 28, 2022*

problems that accompany CHW reimbursement through FFS payment will ease the burdens on CHW service providers.

Ultimately payments outside of FFS payment (e.g., global budgets, capitated payments) may be critical for supporting care transformation that delivers proactive care for patients with complex needs.[18] However, for many organizations, payment outside of FFS payment is not accessible or attainable at this time. Professionals in community and public health sectors have the content and implementation expertise to deliver CHW services, and FFS payments for CHW services can be a pragmatic first step under available reimbursement options to pilot and deliver services to address medical and

social needs. Regardless of the approach, payment levels must be sufficient to cover the full costs of delivering CHW services.

CHW service delivery and financing mechanisms are an integral part of the larger effort to build robust models of integrated medical and social care. CHWs represent an available intervention, and CHWs have demonstrated their value in health care and community settings. Leveraging all available CHW payment interventions will sustain services and advance health equity.

Acknowledgements: *The authors acknowledge Ben Tiensvold of the CHW Collaborative of South Dakota for his feedback on ways in which South Dakota modeled its CHW training based on the Minnesota experience, and Marshall Chin, MD, MPH, and Lara Pratt, MPH, for their review of the manuscript.*

Corresponding Author: *Jacob P. Tanumihardjo, MPH; Section of General Internal Medicine, University of Chicago, Chicago, IL, USA (e-mail: jtanumihardjo@uchicago.edu).*

Funding *KG, ME, MN, RJ, and JT acknowledge funding from the Merck Foundation's initiative Bridging the Gap: Reducing Disparities in Diabetes Care.*

Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. **Trump LJ, Mendenhall TJ.** Community health workers in diabetes care: a systematic review of randomized controlled trials. Fam Syst Health. 2017;35(3), 320.
2. **Walton JW, Snead CA, Collinsworth AW, Schmidt KL**. Reducing diabetes disparities through the implementation of a community health worker—led diabetes self-management education program. Fam Community Health. 2012;161-171.
3. **Collinsworth AW, Vulimiri M, Schmidt KL, Snead, CA.** Effectiveness of a community health worker–led diabetes self-management education program and implications for CHW involvement in care coordination strategies. Diabetes Educ. 2013;39(6), 792-799.
4. **Palmas W, March D, Darakjy S, et al**. Community health worker interventions to improve glycemic control in people with diabetes: a systematic review and meta-analysis. J Gen Intern Med. 2015;30(7), 1004-1012.
5. **Gary TL, Batts-Turner M, Yeh HC, et al.** The effects of a nurse case manager and a community health worker team on diabetic control, emergency department visits, and hospitalizations among urban African Americans with type 2 diabetes mellitus: a randomized controlled trial. Arch Intern Med, 2009;169(19), 1788-1794.
6. **Kangovi S, Mitra N, Norton, L, et al**. Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: a randomized clinical trial. JAMA Intern Med. 2018;178(12), 1635-1643.
7. Medicaid and CHIP Payment and Access Commission. Medicaid Coverage of Community Health Worker Services. https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf Published April, 2022. Accessed 4 Aug 2022.
8. Minnesota Community Health Worker Alliance**.** The State of the Community Health Worker Field in Minnesota. https://mnchwalliance.org/wp-content/uploads/2019/01/MNCHWA_State-of-the-CHW-Field_Dec_21_2018.pdf. Published December 2018. Accessed 30 Mar 2022.
9. CHW Toolkit: Summary of Payment and Regulatory Processes. https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/chwreg2016c.pdf. Accessed 8 Aug 2022.
10. 2021 Minnesota Statutes. 256.462 DEFINITIONS. https://www.revisor.mn.gov/statutes/cite/245.462. Published 2021. Accessed 25 Mar 2022.
11. 2021 Minnesota Statutes**.** 256B.0625 COVERED SERVICES. https://www.revisor.mn.gov/statutes/cite/256B.0625. Published 2021. Accessed 25 Mar 2022.
12. 2021 Minnesota Statutes**.** 256.4871 DEFINITIONS. https://www.revisor.mn.gov/statutes/cite/245.4871. Published 2021. Accessed 25 Mar 2022.
13. Center for Medicare & Medicaid Services. Update on Preventive Services Initiatives. *CMCS Informational Bulletin*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf. Published November 2013. Accessed 25 Mar 2022.
14. **Lloyd J, Moses K, Davis R.** Recognizing and Sustaining the Value of Community Health Workers and Promotores. Center for Health Care Strategies. http://www.chcs.org/media/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf. Published January 2020. Accessed 30 Mar 2022.
15. Center for Medicare & Medicaid Services**.** Minnesota Medicaid State Plan Amendment (SPA) 03-022. https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-13-22.pdf. Published December 2015. Accessed 25 Mar 2022.
16. South Dakota Department of Human Services**.** South Dakota Medicaid Billing and Policy Manual: Community Health Worker. https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Community_Health_Worker_Services.pdf. Published October 2021. Accessed 30 Mar 2022.
17. **George R, Gunn R, Wiggins N, et al.** Early lessons and strategies from state-wide efforts to integrate community health workers into Medicaid. J Health Care Poor Underserved. 2020; 31)2):845-858.
18. Minnesota Department of Health**.** Minnesota Health Care Program Community Health Worker Provider Manual. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=-dhs16_140357. Published July 2020. Accessed 25 Mar 2022.