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HEALTH POLICY

Billing Medicaid for Community Health Worker Services: The Promise, Pitfalls, and Path Forward

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This commentary examines the implications of the Community Health Worker (CHW) Access Act introduced by Congress. If passed, primary care practices would be able to receive reimbursement for CHW services. CHWs are lay members of the community that help people address the social determinants of health, understand their health, and get the health care they need, especially in communities where resources are scarce. They have been shown to improve health outcomes, yet many serve in unpaid positions and their services have not been readily reimbursable in the healthcare system. We highlight the potential of the Bill to facilitate the uptake of CHWs in primary care. This is particularly important at a time when the provision of primary care is scarce. We examine the potential and pitfalls of the Bill and recommend implementation strategies to support the uptake of CHWs into primary care. This commentary aims to inform stakeholders about the Bill's broader impact on primary care and future CHW sustainability.

Keywords: Community Health Workers, Community Medicine, Health Care Financing, Health Care Systems, Medicaid, Patient Navigators, Outcomes Assessment, Policy, Reimbursement Mechanisms, Social Determinants of Health

CHW Emergence in the US

Community health workers (CHW) help people with important issues like finding safe housing, accessing medical care, and dealing with food insecurity. They have been shown to help people stay healthier and avoid going to the hospital unnecessarily, and thus they allow clinicians to maintain their focus on patients' health.[1] The literature on CHWs in the United States dates to the mid-1960s. Initially called neighborhood health aides, CHWs improved the health of migrant workers, the poor, and other underserved populations. They primarily addressed the social determinants of health and assisted with healthcare navigation.[2] Evidence supports the value of their work and their cost-effectiveness in primary care and public health.

In 1999, Texas enacted legislation to identify the CHW role as a profession and demonstrate its impact on health outcomes. Two years later, the American Public Health Association recognized CHWs as a profession, facilitating the tracking of the profession by the Department of Labor. The US Department of Health and Human Services estimated there were 86,000 CHWs working in the US in 2000.[2]

CHW Payment

In 2010, the Affordable Care Act called for the integration of CHWs into primary care, but without resources to make integration feasible.[3] It is estimated that 33% of CHWs serve in unpaid positions. Employed CHWs are often funded through time-limited research grants and demonstration projects. In 1999, Alaska Medicaid made CHW services payable, facilitating a model for sustainability,[2] at least at the state level.

Introduced on March 7, 2024, by Sen. Bob Casey (D-PA), the CHW Access Act integrates CHWs into Medicare/Medicaid by enabling reimbursement, requiring Medicaid coverage of CHW services with enhanced federal matching funds.[4] The bill has been referred to the Committee on Finance, supported by more than 200 community health worker networks and public health organizations. The bill has not advanced since being introduced and Sen. Casey is no longer in office. Nonetheless, the states continue to make headway. As of March 2025, the New York State Medicaid Program covers CHW adult services, joining the ranks of just over half of other state Medicaid programs.[5]

The Promises

The Medicaid funding pathway offers promise for establishing a CHW workforce in primary care and a potential model for other payers.[6] This is helpful during a time when primary care has struggled to keep up with demand and the growing health-related social needs of patients. Among other services, CHWs follow-up on referral loops, accom-

pany patients to appointments, and advocate for community-based resources and programming. In New York State (NYS), CHW services can be delivered either in one-on-one or group-based settings, offering options to accommodate patients.[5] Moreover, the Medicaid funding pathway offers promise for attracting more people to the profession at a time when a substantial number of positions have been traditionally unpaid.

The Problems

The devil is in the details. The prerequisites for reimbursement make implementing a CHW program in safety-net primary practices challenging. For example, in NYS, CHWs must complete a minimum number of training hours, meet specific competencies, and be certified. The absence of a national certifying agency, combined with the limited availability of CHW training programs in local communities, leaves potential CHWs and practices struggling to find practical solutions that meet certification requirements.[7] Notwithstanding these challenges, the CHW community continues to debate the necessity of formal credentialing for their role and its impact on their vocational identity.[8] Moreover, once hired, CHW services can only be delivered under the supervision of a Medicaid-enrolled, licensed, billable provider. The provider must be identified before a CHW can begin submitting claims.

One of the more challenging logistical barriers is identifying eligible patients. NYS Medicaid members receiving care coordination through a Health Home, Health Home Care Coordination Organization, Certified Community Behavioral Health Clinics, or Assertive Community Treatment programs are ineligible for CHW services.[5] It is not always possible or easy for primary care practices to identify programs their patients are currently enrolled in outside their health system. If they were to enroll these patients and later find out they are ineligible, they would not receive reimbursement for any services the CHW had rendered. This misstep will result in a sunk cost. The underlying issue is that someone must actively monitor and identify these problems to address and resolve them effectively. Safey-net primary care practices do not necessarily have the administrative bandwidth to do so.[9]

Finally, the One Big Beautiful Bill Act (OBBBA) significantly reduces federal support for Medicaid through various measures, including fewer matching funds due to decreased Medicaid enrollment and cuts to the enhanced Federal Medical Assistance Percentage for Medicaid expansion. While it does not mention CHW specifically, the OBBBA has implications for their work. For example, the act creates greater need with fewer resources, preventing CHWs from assisting patients with confusing work policies, twice a year Medicaid reenrollment, and education regarding any state-enacted cost-saving steps and restrictions.[10] Ultimately, the OBBBA will worsen the financial strain on and increase the need for CHWs. It severely undermines the CHW Access Act by weakening the fragile infrastructure that currently stands to support CHWs.

Potential Solutions

It is important to tackle the aforementioned problems as well as systems-level pre-implementation challenges that the current bill does not address. Innovative solutions are needed to ensure success. Building on the work of Schriger et al,[9] we identified Medicaid policy gaps and proposed potential solutions, Table 1. We characterized the feasibility (low, medium, high) of our proposed solutions based on billing precedents via Medicaid that could be adopted without significant resource allocation. The potential impact was deemed high when these solutions directly addressed a barrier that has been previously noted in the literature by potential adopters.[9] For example, we suggest funding for start-up costs, not just reimbursement for CHW services. Given the significant administrative burden, it may be best to invest in a hub-and-spoke cost-bundling approach for start-up. In this model, primary care practices (spokes) can access a central billing specialist (hub) assigned to their region. This specialist would help them maximize patient coordination, properly use billing codes for CHWs and efficiently submit claims. A precedent-setting example includes Vermont's Hub and Spoke for Opioid Use, where from 2013 to 2015, the number of patients served increased by roughly 211% and the number of participating providers increased by 64%.[11] This would also provide a central system to track patients and prevent duplicate CHW billing and missed reimbursements. Another less feasible solution is reimbursement for team-based delivery. This would encourage practices to learn how to work with CHWs within a team-setting and clarify team roles. The current bill does not address this longstanding issue.[12,13] We anticipated impact would be high, as it leverages the skill sets of CHWs within teams. However, we rated the feasibility of this occurring through the bill as low, given that similar programs, such as the Collaborative Care Medicaid Program, are still being studied.

Pathway Forward

Implementing these solutions will enhance the uptake of CHW services, ultimately improving healthcare access and outcomes. As policymakers move forward with the CHW Access Act, prioritizing implementation factors will be crucial to achieving success. Failure to prioritize these factors risks undermining the successful implementation of this important and historic leap in cementing the integration of CHW services in the US healthcare system. It is more critical than ever to study the effects of the OBBBA on the integration of CHW services and to strategically allocate resources to sustain their role in improving healthcare quality and access, or risk losing their integration altogether.

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Table 1. **Top Levers to Target When Integrating CHW Medicaid Reimbursement Programs in Primary Care Safety-Net Practices**

Policy Gap	Resource Dependent Theory Construct[14]	Consolidated Framework for Implementation Research Construct[15]	Proposed Solution(s)	Feasibility (low, medium, high)	Impact (low, medium, high)
External Pressures	Resource Scarcity: Funding for start-up costs	Outer Setting: Medicaid rules	Increased cost-based rates (for FQHCs) or Cost-bundling for start-up (eg, Vermont's Hub and Spoke for Opioid Use Disorder Treatment)[11]	Medium	High
Organizational Response	Interdependence Plan: Partnerships for resources, data sharing	Individuals: Leadership knowledge and beliefs about CHWs (eg, stigma, bias)	Mentoring networks for leadership and CHWs; Resources for team-training to clarify roles (eg, Collaborative Care Medicaid Program)[16]	High	Medium
		Inner Setting: CHW role ambiguity; organizational readiness for change/ implementation of CHW role	Incentives for team-based delivery	Low	High
Intervention Fit	Cost-benefit: Benefits for adopting outweigh the costs Adaptability: flexible policies to address resource gaps	Innovation Characteristics: Relative advantage (vs the status quo) Adaptability (tailoring the CHW billable services rendered to match local needs)	Expand allowable CHW billable services (eg, language interpretation; coverage for preventive services, not just chronic conditions); unlimited number of billable CHW units/hours per member	Medium	Medium
Implementation Process	Power Dynamics: Control over resources	Process: Workflows for training staff, mapping billing codes	Shared-data model; local collaboration agreements	Low	High

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Conflicts of Interest

None.

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