

Community Health Workers Play an Important Role in Improving Health



Key Takeaways:

- Community Health Workers (CHWs) are trusted members of the health care team that can meet people where they are and assist with behavior change to [improve health](#).
- CHWs can also help direct people to resources related to social barriers to care such as healthy food, transportation, and other services.
- There are different models to support CHWs as part of the health care workforce, and it will be important to clearly define their roles and consider consistent training parameters to support sustainable reimbursement models.

Community Health Workers (CHWs)

Defining the Role of CHWs

The American Public Health Association (APHA) defines a [Community Health Worker \(CHW\)](#) as a “frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served” and facilitates access to health and social services to improve the quality of care.

CHWs represent the communities they serve, playing different roles to enhance and advocate for community health and wellness. CHW is a broad term that can encompass [many professional titles](#), including community health representatives, outreach specialist/worker, and community health educator, along with numerous roles, such as promoter, navigator, and care or case manager. An estimated 65,000 people serve as CHWs in the U.S., and the [workforce](#) is projected to grow 11% over the next decade.

CHW Activities and Responsibilities

CHWs provide services to patients across the care spectrum, including assisting people with care coordination and navigating the health care system. [Medicare](#) and [Medicaid](#) have defined CHW services to include:

- Health promotion, wellness coaching, self-management education;
- Translation services;
- Health system navigation, such as scheduling appointments and accompanying patients to office visits;
- Advocacy on behalf of patients and their families;
- Patient-centered assessments to better understand health and social needs;
- Assistance accessing social services;
- Coordination of care transitions, including after emergency department (ED) discharges; and
- Social and emotional support.

CHWs work with underserved and marginalized communities, including uninsured individuals, people who reside in rural areas, non-English speakers, and individuals with complex health care needs. CHWs play an important role in closing gaps in care that many people experience.

CHWs Improve Individual and Community Health

Deployment of CHWs shows multiple benefits, [including](#):

- Promoting healthy behaviors;
- Improving chronic disease control;
- Addressing mental health issues;
- Improving patient satisfaction and quality of care;
- Reducing ED visits and hospitalizations;
- Reducing health disparities;
- Reducing costs and improving return on investment (ROI); for example, [Medicaid](#) saw an average ROI of \$2.47 for every dollar invested.

Current Requirements for CHWs

States typically set the training and certification requirements, scope of practice, and Medicaid reimbursement levels for CHWs when contracted directly with the state. Under state Medicaid programs, states are responsible for Medicaid managed care contracts, implementation of programs for dual-eligible beneficiaries, including those that use CHWs, and maintaining the State Plan that may further define rules for CHWs. States can also apply for Section 1115 Demonstration Waivers to implement innovative programs that may include CHWs.

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Medicare. The 2024 Medicare Physician Fee Schedule (PFS) [Final Rule](#) included payment changes under Medicare Part B for certified/trained personnel, including CHWs. Effective January 1, 2024, under the Medicare fee-for-service (FFS) payment rule, CHWs are eligible for reimbursement for providing Community Health Integration (CHI) services when working under a Medicare-billing practitioner if they are certified and trained under applicable state policies. If the state where the CHW resides does not have formal training or certification requirements, the state is obligated to establish training based on the identified core competencies from the National C3 Council, a third-party organization.

Medicaid. There are no federal [Medicaid](#) requirements for the training or certification of CHWs. Rather, it is dependent

on the state where the CHW resides to govern Medicaid-related requirements. Currently, there are [29 states](#) that reimburse CHWs under their Medicaid programs, and those states have flexibility to approve the list of entities that can certify CHWs, specific training programs or curricula, and the specific number of training or supervised practice hours to be eligible for practice.

Private Accreditation Bodies. Several private, national organizations provide voluntary accreditation opportunities for those interested in becoming CHWs. These programs seek to create standards to define required training and core competencies:

- The [URAC CHW Program Accreditation](#) is designed to help CHW organizations improve patient outcomes and reduce health care costs. URAC's accreditation evaluates organizations based on multiple standards, including workforce development, scope of practice, and performance.
- NCQA also offers accreditation to organizations that may employ CHWs, including health plans, health systems, hospitals, and accountable care organizations. NCQA's [Health Outcomes](#) (formerly Health Equity Accreditation) and [Community-Focused Care](#) (formerly Health Equity Accreditation Plus) Accreditation Programs evaluate how organizations use data to address population health and differences in health outcomes and cultivate community-based partnerships to connect patients to non-medical or social needs resources.
- The Joint Commission has a [Behavioral Health Care and Human Services](#) accreditation for organizations that provide community-based services for populations needing addiction treatment, child welfare, mental health programs, tele-behavioral health, group homes, and foster care. These are among the circumstances where CHW services are most utilized.

Establishing Core Competencies: The [National C3 Council](#), formerly known as the CHW Core Consensus (C3) Project, defines CHW roles and competencies, including cultural mediation, coaching and social support, individual and community advocacy, and service coordination and navigation skills. The Council also works to establish national consensus on CHW standards. The Council's common core roles and competencies have been endorsed, supported, and used by more than 15 national public health organizations and professional associations and used by at least 20 state policy initiatives.

Quality Measurement: [The Community Health Worker Center for Research & Evaluation](#) develops community-informed tools to measure how CHWs contribute to health and social outcomes. Rather than accrediting programs, the Center focuses on defining shared process and outcome measures that reflect CHW work at the individual, community, and systems levels. Its work helps organizations, policymakers, and funders understand the value of CHWs while emphasizing the conditions and supports CHWs need to be effective.

Financing Models to Support CHWs

Most funding for CHWs has been through short-term (2-3 years) grants and contracts and focuses on specific goals, such as raising immunization rates or reducing infant mortality. Short-term funding [models](#) may limit CHWs from achieving their full potential to improve individual and community health.

There are some examples of programs with more sustainable financing models. These programs are funded through revenues that cover CHW services or incorporate CHWs into the budget of a state or community program. Many sustainable CHW funding streams come from Medicaid, given the needs of Medicaid beneficiaries.

Section 1115 Demonstration Waivers. Section 1115 Waivers are used by State Medicaid programs to gain CMS approval for payment and delivery pilot programs that may offer benefits beyond traditional Medicaid funding structures. Waivers usually last 3 to 5 years but can be renewed. Though states have considerable flexibility with these waivers, they are limited by budget neutrality requirements, which mandate that the demonstration project cannot cost more than what the federal government would have spent on Medicaid without the waiver. One successful example is Arkansas’s [“Community Connectors”](#) program, in which CHWs connect individuals receiving home care to community services and in-home non-medical support.

Additionally, a special form of the 1115 Waiver, known as Delivery System Reform Incentive Payments (DSRIP), provided funding for innovative health system reforms, although the model is being phased out. In 2013, DSRIP grants financed the establishment of the Community Care Collaborative (CCC) as an integrated system for low-income recipients in central Texas. These [grants](#) supported CHWs in providing navigation for ED users, chronic disease and self-management support, and “neighborhood engagement” in San Antonio.

State Plan Amendments (SPAs). Unlike 1115 Waivers, SPAs are more permanent if approved by CMS. Many states have piloted programs under the 1115 Waiver and subsequently made them permanent through SPAs. For example, in 2025, [North Dakota](#) submitted a SPA authorizing reimbursement for services provided by CHWs and community paramedics. [Minnesota](#) was the first state to develop and implement a Medicaid SPA for CHW reimbursement, and a new [amendment](#) for financing CHW services was approved in 2025.

Under the Affordable Care Act, the Medicaid Health Home SPA allows states to design “health homes” for comprehensive care coordination for Medicaid beneficiaries. States were given enhanced funding for the first few quarters to ensure implementation of this integrated care model. These homes were established with the explicit requirement that they target patients with two or more chronic conditions and a behavioral health diagnosis. [Several states](#) have utilized CHWs in their Health Homes.

Broader use of CHWs in the health care system represents a critical opportunity to build more accessible and community-based models of care.

Looking Ahead: The Future of CHWs

Broader use of CHWs in the health care system represents a critical opportunity to build more accessible and community-based models of care. CHWs are trusted, proven, cost-effective members of the health care workforce who contribute to improving the health of individuals and communities. CHWs have demonstrated value in improving patient outcomes, reducing health care costs, and increasing the focus on the social and structural barriers of patients’ experience that may not be addressed in traditional clinical settings. To support long-term CHW integration across the health care system, clearly defined roles, consistent training and standards, and sustainable funding are needed.

Selected Examples of How Health Plans Leverage Community Health Workers

Health plans recognize the important role of community health workers (CHWs) as trusted participants in the health care workforce to encourage behavior change that results in better patient outcomes, lower costs, and helps people access support for complex social needs.

Aetna/CVS — Improving Health Outcomes for Members with Chronic Conditions

The [Aetna Medicare Community Health Worker \(CHW\) Program](#) improves health outcomes by addressing member HEDIS care gaps through local, in-person outreach and phone-based support for members. CHWs are frontline public health workers who are trusted members of the community or have a deep understanding of the populations they serve. They provide culturally appropriate support for social determinants of health and healthy lifestyle changes, helping members understand and manage chronic disease risk factors through education on diet, physical activity, self-monitoring and connection to local community resources.

CHWs work closely with providers and community partners as part of the program to deliver coordinated, whole-person care. By reducing barriers, supporting follow-up care, and helping prevent hospital readmissions through inpatient member visits, this community-based approach strengthens engagement, reduces disparities, and supports value-based care.

Cigna Foundation —CHW Pilot Taking on Diabetes in Underserved Communities

The [Community Health Worker Pilot](#) is designed to help reduce health inequities by providing personalized support (in-person or virtually) by matching community health workers with customers who have been diagnosed with diabetes and live in higher-risk communities that are negatively impacted by social determinants of health (SDOH). Together, they co-create goals to meet those needs and overcome barriers affecting their health and ability to access care. The health workers connect these customers to benefits, services, and SDOH resources such as food and transportation to support better health outcomes. Cigna has launched in-person segments of the pilot in Memphis, TN and Houston, TX, as well as three virtual segments for its Medicare, Medicaid and Commercial lines of business. Members have lost weight, decreased their cholesterol levels, lowered their blood pressure, and decreased their A1C (blood glucose levels). This work complements

broader investments by The Cigna Group Foundation through its [Health Equity Impact Fund](#), which supports nonprofit partners in [Hartford](#) and [Houston](#) advancing community-based interventions including community health worker engagement, transportation support, and culturally appropriate care.

As part of the Community Health Worker pilot, health coaches proactively meet Cigna customers with diabetes to better understand their unique needs and barriers to better health. The coaches then connect those customers with programs, offerings, and organizations that can help them better manage their diabetes and offer more personalized support. That support is aligned with their health care providers, who can use that information to help drive better outcomes.

Kaiser Permanente — Supporting Patients with Universal Screening for Social Needs

[Kaiser Permanente](#) offers social health screening every year to every member who schedules a primary care appointment. In addition to social health screening during primary care visits, additional screening takes place in key specialty departments and the hospital. Because social determinants of health (SDOH) significantly impact a patient's ability to manage their physical health needs, screening helps understand the role social needs play in a patient's ability to focus on their physical health.

When needs are identified, and the patient would like assistance, low-medium risk patients are automatically routed to the National Community Support Hub for team support and high-risk patients are referred to Kaiser Permanente's community health worker team. Community health workers are experts in supporting patients in getting their social needs met, helping with navigating the health care system, and building patient confidence and trust, all of which ultimately lead to better health outcomes.

Kaiser Permanente's evaluation of these efforts has shown positive results, including a decrease in total hospital days, increased primary care appointments, high rates of member satisfaction, and a positive ROI.