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Medicaid billing for community health worker services growing, but remains low, 2016-2020

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Abstract

Despite the recognized value of Community Health Workers (CHWs) in improving health outcomes, the integration of CHWs into Medicaid continues to be a challenge. This study examines the trends in CHW billing for Medicaid services across states from 2016 to 2020. We conducted an exploratory descriptive analysis of the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) 2016-2020 to identify trends in direct billing for CHW services, including beneficiaries served, total services rendered, payment type, place of service, and procedure codes used for services billed by CHWs. The number of CHWs billing Medicaid increased by 638% between 2016 and 2020. However, by 2020, there were still only 731 CHWs billing Medicaid in the 9 states examined with one state (Ohio) accounting for 77.7% of all Medicaid beneficiaries identified with CHW direct billing. The total number of CHW services grew nearly 23-fold, with 37.7% overall provided in patient homes. Significant billing inconsistencies were observed, including the use of non-designated procedure codes. Overall CHW billing in Medicaid remained low as of 2020, with the exception of Ohio. Understanding factors associated with Ohio's expansion could yield important insights for current efforts to improve access to CHWs for Medicaid beneficiaries.

Key words: community health workers (CHWs); medicaid reimbursement; health workforce; healthcare billing trends.

Introduction

There is growing recognition that Community Health Workers (CHWs) are vital healthcare providers in the United States, trusted for their deep community understanding, and high-value partnerships with low-income, underserved, and racial and ethnic minority communities.[1] CHWs often represent the communities they serve and play an essential role in helping patients with complex needs navigate the health care system, bridge language barriers, and get connected with community resources.[2] There is substantial evidence that CHWs can improve patient health and reduce avoidable hospitalizations by addressing social determinants of health (SDOH).[2-4]

While evidence on return on investment (ROI) is more mixed, at least one study found a favorable ROI for Medicaid payers of $2.47 for every dollar invested.[5] However, health systems need help navigating how to successfully bill Medicaid for CHW services.[6] Medicaid funding is widely considered to be insufficient and, when combined with a lack of clarity on what is eligible for reimbursement, health systems are struggling to fully embrace CHWs.[7-9] Despite the evident enthusiasm from payers, policy leaders, and patient advocates, the integration and reimbursement infrastructure for CHWs in Medicaid—a crucial system for the nation's vulnerable populations—remains inconsistent across states.[9,10]

Unlike Medicare, which maintains a singular infrastructure for integrating emerging healthcare professions such as CHWs, Medicaid operates under a distinctly different framework, due to its federal-state partnership and the individual management of state Medicaid plans. In 2013, the Center for Medicare and Medicaid Services (CMS) implemented a rule allowing states to include CHW services in the reimbursement for preventive services.[11] Since this change, states have been independently developing their pathways for incorporating CHWs and their services into their Medicaid plans, using a variety of reimbursement mechanisms, ranging from direct fee-for-service (FFS) to indirect methods, such as per-member-per-month fees, grants, or administrative costs, with other states currently considering making CHW services eligible for reimbursement.[8] As of the end of 2022, 22 states adopted direct reimbursement mechanisms, with 11 states employing FFS and 12 managed care-related cost mechanisms (Washington employs both).[12-15] An additional 8 states adopted indirect reimbursement policies that allowed grants or administrative funds to cover CHW services.

Due to data limitations, prior studies of CHWs have primarily relied on data from single health systems, models,[2-5] states, or regions to evaluate the uptake of CHW services.[6,8,16] Further, efforts to document CHW reimbursement policies have been single snapshots in time,[12,14,15] while policies are rapidly evolving. This study addresses these prior limitations by conducting a longitudinal analysis of the newly available

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national Medicaid claims dataset called the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF),[17] which includes claims line data for professional services provided by CHWs. While there is a substantial reporting lag of approximately three years, this new resource is the most comprehensive national data available on CHW billing and covers a period of rapid changes in state adoption of CHW reimbursement policies. This exploratory analysis of TMSIS data allows us to identify trends over time in the number of CHWs billing Medicaid, the number of services provided, and the number of beneficiaries served between 2016 and 2020. The findings from this study can inform future modifications to billing rules in an effort to increase the financial viability of using CHWs, especially for patients with complex social needs.

Methodology

We relied on four foundational reports on CHW billing in Medicaid (including the National Association of State Health Policy, the Commonwealth Fund, and Kaiser Family Foundation)[12-15] to identify which states allowed direct CHW billing by year during the period of 2016-2020. When reports conflicted, we reviewed official state records to reconcile differences (see Supplement S1 for state policy documentation summary). We focused on states with direct reimbursement policies prior to 2018 (to allow a minimum of a 12-month calendar year gap between adoption and implementation.) We excluded claims from Alaska and claims under Indian Health Services (IHS) from all states from the T-MSIS analysis, as IHS and the state of Alaska allow for a broader scope of practice than the traditional CHW model that includes many clinical services.[18]

Ultimately, 12 states were identified as having direct reimbursement policies in place for the traditional CHW model before 2018, 3 of which (Maine, Minnesota, and West Virginia) are excluded from the analysis due to T-MSIS data quality issues, leaving nine states (California, Indiana, Michigan, North Dakota, Ohio, Oregon, Vermont, Washington, and Wisconsin) as the focus of our analysis. We conducted a descriptive analysis of CHW claims in the T-MSIS Analytic Files (TAF) for those 9 states.

We examined CHWs Medicaid billing from 2016 through 2020, highlighting the number of CHWs, beneficiaries served, total CHW services rendered, the characteristic of the services, and the procedure codes billed in aggregate and by state. To identify CHWs, we incorporated data from the National Plan and Provider Enumeration System (NPPES) spanning 2016-2020 for providers with an active National Provider Identifier (NPI) for at least one day in each calendar year. We counted all FFS or managed care encounter claims in which the rendering or billing provider's primary NPI taxonomy code was the CHW taxonomy code (172V0000X) as a CHW service. When counting CHW providers, we made the decision to exclude 51 organizational CHW providers that had no individual CHW provider NPI associated with the records, since this obscured the exact number of CHWs engaged in service delivery. However, services provided by organizational CHW providers *were included* in the analysis of beneficiaries served and total services provided. The number of unique beneficiaries served by CHWs used the encrypted beneficiary ID. Through the T-MSIS claim line data, we also determined the procedure codes (HCPCS level I (CPT®) and level II) that CHWs billed, as well as the characteristic of the services, including payment type (FFS or managed care) and place of service. CHW services were only counted if the services were billed in a state with direct reimbursement policies in the given year.

Results

The number of individual CHWs directly billing Medicaid from 2016 to 2020 shows a surge of 638%, growing from 99 to 731. The total volume of CHW services provided to Medicaid beneficiaries also grew, increasing nearly 23-fold, from 15 125 to 357 511. Similarly, the number of unique beneficiaries receiving CHW services rose more than 25-fold, from 2917 to 76 070. (See Figure 1)

Figure 2 displays growth in the number of beneficiaries served from 2016 to 2020 by state, revealing that in this sample of nine states, the increase in CHW billing is predominantly taking place in Ohio, which adopted direct CHW billing in 2017. By 2020, Ohio accounted for 77.7% of all beneficiaries served by CHWs through direct billing in the 9 states examined. California had the second-highest percentage at 12.2, and Oregon, the state with the longest history of direct billing among the 9 states, came in third with 4.8% of total beneficiaries served in 2020. Two states (North Dakota and Vermont) had no CHW claims identified.

Table 1 presents CHW services, including payment type and place of service from 2016 to 2020. Managed Care encounters constituted 87.6% of the total services, while FFS accounted for 12.4%. The most frequent location for CHW services (37.54%) was home settings. Ambulatory care offices accounted for 26.7%, while schools and other locations represented smaller shares at 6.0% and 13.2%, respectively. The percentage of office-based services, however, did increase steadily, growing from 16.3 to 30.8 between 2016 and 2020.

Table 2 provides a detailed analysis of CHW services for Medicaid beneficiaries from 2016 to 2020, categorized by HCPCS codes. The table shows that codes officially designated by state Medicaid policies for CHW services are not, in fact, the most frequently used codes in practice. This mismatch reveals a gap between state policy intentions and real-world billing behaviors. Nationally, the vast majority of services (88.8%) fell under a few frequently used codes, such as therapeutic behavioral services (H2019, 33.5%), supported housing (H0043, 10.0%), and community psychiatric supportive treatment (H0036, 9.6%). Only 11.2% of all CHW services were billed under the codes explicitly outlined in state Medicaid policies.

Limitations

This study has several limitations that may impact the depth and accuracy of our analysis. First, while it was our intention to be exhaustive, we acknowledge that our document review of Medicaid policies may not be complete; often original documents are not easily accessible, or they reference source documents that we could not find. To address this, we compared our analysis with other organizations' policy reviews. When results were inconsistent, we went back to the source data to re-review. Source links for our analysis are provided in the supplement (Supplement S1).

Other limitations relate to T-MSIS TAF. At the time of the analysis, T-MSIS TAF data were only available through 2020

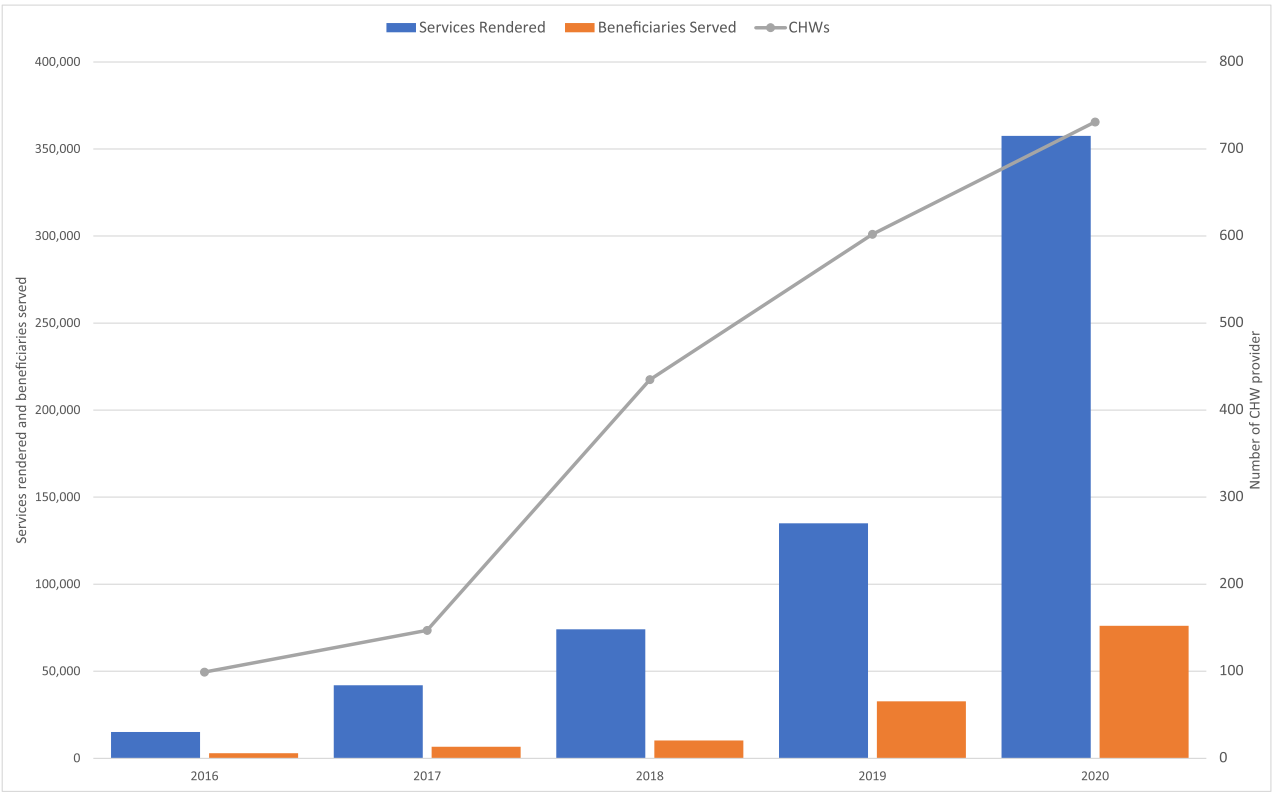

Figure 1. Trends in the number of CHW providers, medicaid services rendered, and beneficiaries served in states with direct policies (2016-2020). Source: T-MSIS database, analysis conducted by authors. Notes: 1. Nine states included in analysis: CA, IN, MI, ND, OH, OR, VT, WA and WI. Data from MN, MN, and WV are excluded due to data quality issues; data from the Indian Health Service and AK are excluded because of differences in the scope of practice of CHW-like professions. 2. The number of CHW providers includes individual providers who submitted at least one claim in the T-MSIS associated with an individual NPI and reported the CHW code (172V0000X) as their primary taxonomy. 3. The number of services rendered encompasses claims submitted by CHW providers with individual or organizational NPIs under any type of CPT/HCPCS codes. 4. Beneficiaries served were calculated based on Encrypted Beneficiary Identifiers in the T-MSIS database.

and, therefore, may not reflect more recent CHW billing practices. Additionally, three states were excluded due to data quality issues related to missing billing NPI numbers in 20% or more of records.[19] This, plus the exclusion of Alaska, where CHWs can provide clinical services, affects the generalizability of our findings to those states. Lastly, claims data only enable us to track direct billing by CHWs identified through NPI numbers, potentially leading to a significant undercount of CHW services provided to Medicaid beneficiaries. Only one state (Oregon) required CHWs to obtain an NPI, making it possible that we missed a large amount of claims with no CHW NPI. However, even in Oregon where NPIs were required, the number of claims remained low and stable over time.

Discussion

This is the first study to track growth in direct CHW Medicaid billing nationally. Our findings suggest that while overall, there was substantial growth in direct billing by CHWs between 2016 and 2020, this was driven largely by one state. Ohio adopted direct CHW billing in 2017, and 3 years later accounted for 77.7% of beneficiaries with direct CHW billing in 2020. California which adopted CHW billing a year earlier accounted for considerably fewer (12.2%) of beneficiaries in 2020, despite being a substantially larger state. Among the remaining states examined, direct billing by CHWs remains low overall, including in Oregon which allowed direct billing by CHWs in 2012 and required CHWs to obtain an NPI. The absence of any CHW claims in North Dakota and Vermont was curious. It is possible CHW visits in those two states did occur, but were not captured in the analysis because CHWs are not required to obtain NPIs in those states.

Overall, by 2020, there were just 731 CHWs identified in Medicaid claims. While this is just for nine states, we know that nationally there were 18 204 CHWs registered with NPPES that year,[20] and 57 180 reported in Bureau of Labor Statistics (BLS) data.[21] It may not be surprising that there is still a long way to go before CHW billing becomes commonplace in states that allow direct billing. The roll-out of policies enabling billing has been slow and extremely fragmented across the country. This likely has made communications about the changes more difficult. Indeed, the heterogeneity in how services were billed, with so few using approved CHW codes, suggests this to be the case. We found a majority of claims attributed to CHWs were actually for services provided by other related, but distinct professions, such as peer support. While some of these may have allowed for higher reimbursement, others were the same or lower, leading us to believe that lack of knowledge of CHW coding played a part.

Further, qualitative studies suggest that low reimbursement rates, the administrative burden of filing a claim, and delays in payment discourage participation.[22-24] For example, in the case of CHW services in Minnesota, at $20.99 for a 30-minute CHW encounter, reimbursement does not adequately cover the cost of delivering services, which can be as high as $60 to $100 when accounting for travel time, administrative costs,

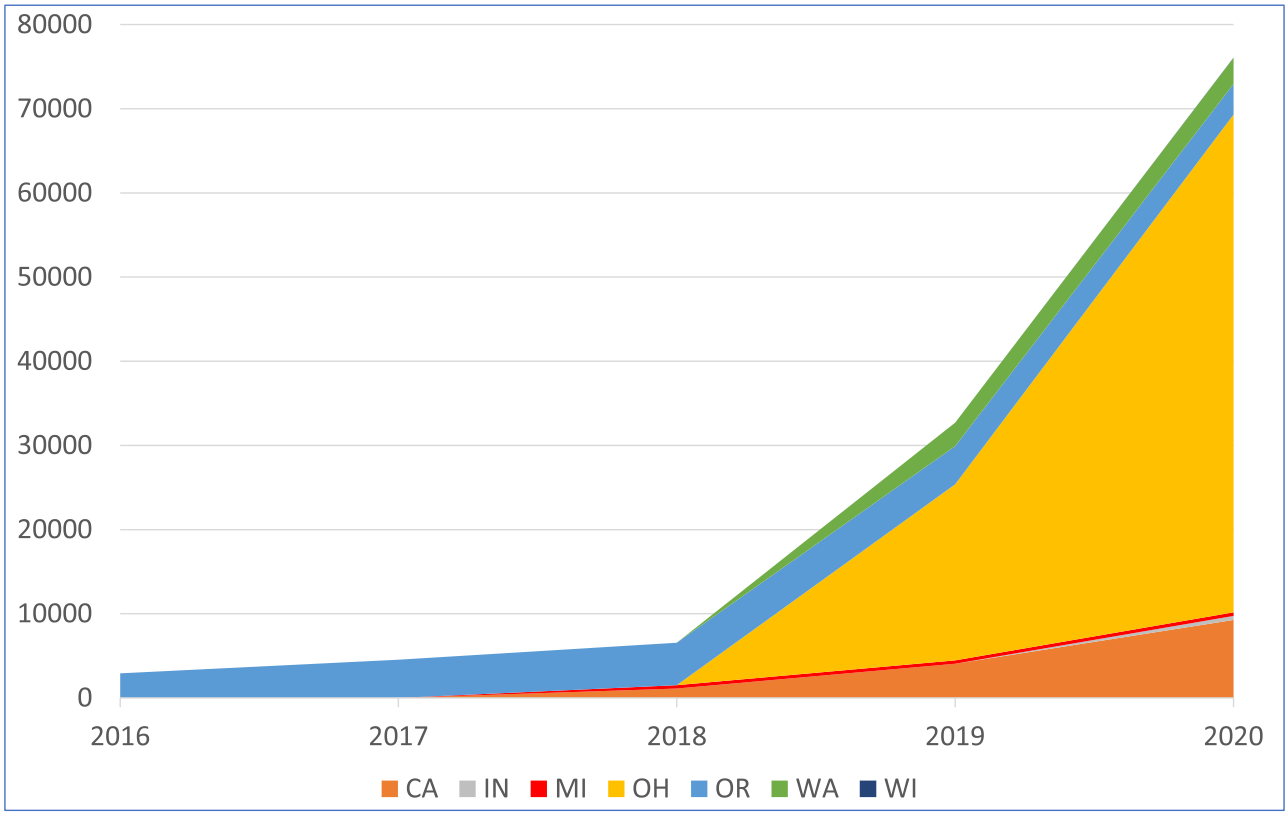

Figure 2. Trends in number of CHW beneficiaries in states with direct reimbursement policies by state, 2016-2020. Source: T-MSIS database, analysis conducted by authors. Notes: 1. Nine states included in analysis: CA, IN, MI, ND, OH, OR, VT, WA, and WI. Data from MN, MN, and WV are excluded due to data quality issues; data from the Indian Health Service and AK are excluded because of differences in the scope of practice of CHW-like professions. 2. Beneficiaries served were calculated based on Encrypted Beneficiary Identifiers in the T-MSIS database.

Table 1. CHW service claims in community mental health centers by billing type, program, and place of service in states with direct policies (2016-2020).

Payment type	2016		2017		2018		2019		2020		All years	
Managed care encounter	13 431	88.07%	33 556	79.58%	62 719	84.04%	121 753	89.77%	316 416	88.51%	547 875	87.63%
FFS Claim	1819	11.93%	8610	20.42%	11 911	15.96%	13 871	10.23%	41 095	11.49%	77 306	12.37%
Place of service												
Home	1433	9.40%	18 587	44.08%	36 359	48.72%	52 571	38.76%	125 724	35.17%	234 674	37.54%
Ambulatory care office	2482	16.28%	6943	16.47%	16 670	22.34%	30 800	22.71%	110 082	30.79%	166 977	26.71%
School	1281	8.40%	1592	3.78%	4601	6.17%	11 070	8.16%	19 122	5.35%	37 666	6.02%
Non-residential substance abuse treatment facility	6341	41.58%	1142	2.71%	939	1.26%	4036	2.98%	8466	2.37%	20 924	3.35%
Community mental health center	2842	18.64%	4182	9.92%	5258	7.05%	5668	4.18%	2729	0.76%	20 679	3.31%
Other	871	5.71%	3632	8.61%	3889	5.21%	7478	5.51%	24 705	6.91%	40 575	6.49%
Missing	—	0.00%	6088	14.44%	6914	9.26%	24 001	17.70%	66 683	18.65%	103 686	16.58%

Source: T-MSIS TAF, 2016-2020, analysis conducted by authors. 1. Nine states included in analysis: CA, IN, MI, ND, OH, OR, VT, WA, and WI. Data from MN, MN, and WV are excluded due to data quality issues. Data from AK and IHS claims are excluded because of differences in scope of practice of CHW-like profession. 2. CHW services billed by individual CHWs and by organizational CHW providers are both included.

care coordination, and other factors.[6] Further, a study using Current Population Survey data found that states with Medicaid reimbursement policies did not have higher wages or lower turnover compared to those with no Medicaid reimbursement, signaling that Medicaid reimbursement may not be leading to sustainable CHW careers.[25] In a similar vein, CHWs employed in state and local health departments have raised concerns regarding compensation, noting its impact on their willingness to remain in the public health workforce.[7] On the positive side, it is possible that now that Medicare reimburses for CHW services provided under the supervision of a Medicare billing practitioner or community-based organization (CBO),[26] the increased funding streams for the CHW workforce could make it more financially viable for providers to hire them, and therefore have a possible spillover effect on Medicaid.

Another implication of our findings is that there is clearly a mismatch between payment policy and practice. While the service codes most frequently identified are consistent with the community health worker role, such as supported housing

Table 2. CPT/HCPCS codes frequently used by CHWs for medicaid billing in states with direct policies (2016-2020).

Code	Code description	State(s) designated CPT code for CHW direct billing	Service count	% of all CHW Service
Designated Codes for CHW Services in State Medicaid Policies*				
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood	OR	27 061	4.3%
H2014	Mental Health and Community Support Services—Skills training and development, per 15 minutes	OR	24 842	4.0%
T1016	Case management, each 15 minutes	OR	5829	0.9%
H2016	Comprehensive community support services, per diem	OR	5778	0.9%
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	OR	1760	0.3%
H0032	Mental health service plan development by non-physician	OR	1359	0.2%
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (15, 30, 45, 60 min increments)	OR	967	0.2%
H0033	Oral medication administration, direct observation	OR	962	0.2%
99211	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, that may not require the presence of a physician or other qualified health care professional	OR	730	0.1%
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol	OR	451	0.1%
H2032	Activity therapy, per 15 minutes	OR	163	0.03%
98960-98962	Education and training for patient self-management (individual or groups of 2-4 or 5-8 patients; could include caregiver/family) using a standardized curriculum by a qualified, non-physician healthcare professional, 30 minutes	IN, LA, NV, SD, OR	69	0.01%
Sub-total			***69 971***	***11.2%***
Frequently Used Codes not Explicitly Listed in Medicaid Policy for CHW Billing				
H2019	Therapeutic behavioral services, per 15 minutes	N	208 945	33.5%
H0043	Supported housing, per diem	N	62 641	10.0%
H0036	Community psychiatric supportive treatment, face to face, per 15 min	N	60 163	9.6%
H2015	Comprehensive community support services, per 15 minutes	N	25 039	4.0%
H0038	Self-help/peer services, per 15 minutes	N	23 030	3.7%
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, intermediate care facilities for individuals with intellectual disabilities(ICF/IID) or institution for mental disease (IMD), part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	N	18 641	3.0%
90837	Psychotherapy 60 minutes	N	11 348	1.8%
H0006	Alcohol and/or drug services; case management	N	11 133	1.8%
All other codes			132 732	21.3%
Sub-total			***553 672***	***88.8%***
Total			**623 643**	**100%**

Sources: T-MSIS database, 2016-2020; 2020 Alpha Numeric HCPCS File, analysis conducted by authors. Notes: 1. Nine states included in analysis: CA, IN, MI, ND, OH, OR, VT, WA and WI. Data from MN, MN, and WV are excluded due to data quality issues. Data from AK and IHS claims are excluded because of differences in CHW scope of practice. 2. CHW services billed by individual CHWs and by organizational CHW providers are both included. 3. Codes which contain 5 numbers are Current Procedural Terminology (CPT®) system code or HCPCS Level I code. And codes started with letters and four numbers are HCPCS level II code. Since both HCPCS level I and II codes are used in Medicaid claims, we included both principal subsystems. 4. By marking as Y in this column, the code is designated by at least one direct policy state for CHW services in the state plan. 4. The numbers of services rendered encompass claims submitted by all CHW providers with type 1 or type 2 NPI and reported the CHW code (172V0000X) as their primary taxonomies.
*There are three codes with no claim and are not included in the table: 99600, G0176, and Q3014.

(H0043, 11%), non-blood sample collection for alcohol and/or other drug testing (H0048, 4.75%), and comprehensive community support services (H2015, 4.29%), relatively few of the codes used were specifically outlined as eligible services. We also found claims attributed to CHWs that are for services only physicians or other qualified mental health providers are eligible to provide, such as psychotherapy (90837, 1.8%), illustrating some of the messiness in claims data. Surprisingly, the explicitly authorized codes were among the least used. In at least one state, a third-party organization has emerged to help providers navigate the overly complex CHW policy landscape,[6] suggesting that greater policy clarity from CMS, Medicaid agencies, and regulators is needed to minimize barriers to greater use of the CHW workforce. In short, it should not be so complicated for health systems to bill for these essential services that have been demonstrated as cost-effective ways to improve patient health and quality of life.

Going forward, research should continue to track the rate of CHW growth, and explore why certain states with direct reimbursement policies are growing faster than others. We know that nine additional states adopted direct billing after 2020, and other states are currently considering adopting direct

billing for CHW services. We anticipate that uptake in states with direct billing will increase at a faster pace as CBOs and health systems figure out how to incorporate CHWs into practice and billing. A potential contributing factor in Ohio may be the widespread adoption of the Pathways Communities Hub Institute Model, which originated in the state with hubs in 29 counties as of 2019, and five more in the process of being certified in 2020.[27] Having robust community-based organizations, such as the PCHIM program, that blends and braids multiple funding streams could be a critical element for financially supporting CHWs when Medicaid reimbursement does not cover the full cost. Michigan and Washington also had PCHI Model hubs in 2019, with additional states, including Oregon and California, in the process of certifying hubs. Future research should track CHW services provided in these hubs over time and examine whether these types of models geared toward coordinating and aligning community resources facilitate greater integration and use of CHWs among Medicaid beneficiaries.

Given the high percentages of Medicaid beneficiaries with multiple chronic conditions, social determinants of health, and other barriers to achieving their full health potential, the question of how best to finance CHW services will continue to be salient in the years to come. Our findings may suggest that direct reimbursement strategies are not optimal, given the limited uptake overall. It is possible that indirect policies, such as allowing administrative funds to cover CHW services, provide greater flexibility in using CHWs, which could lead to greater access. Unfortunately, our current data does not allow us to do a reliable head-to-head comparison, since estimates of CHW services in states with indirect reimbursement policies are not available.

Our finding that the vast majority of direct billing occurred under managed care may be a sign that value-based incentives may be more effective in encouraging the use of CHWs. States with direct reimbursement policies may wish to consider additional measures to encourage further uptake, such as increased payment and/or quality incentives for health systems to hire CHWs, as suggested by qualitative studies. Beyond the quantity of CHWs and services, it was also encouraging that the majority of CHW services were provided outside the clinic setting, including the patient's home and schools. This is consistent with a patient-centered, non-episodic role that allows CHWs to address non-clinical needs in non-clinical settings.[28,29] However, as with the quantity of CHW services, there is also cause for caution, since we also found that the percentage of services provided in office-based settings increased steadily during the study period. This may signal challenges of transportation costs and other costs related to care outside the office, such as time for relationship building, or for individual or community building capacity.[29] While office-based visits may be an important opportunity for initially connecting patients with CHWs, constraining CHW visits to clinical settings may limit their ability to address social determinants of health, and could even, arguably, be viewed as exacerbating transportation barriers CHWs are trying to help solve.

Finally, our study suggests that states and the Federal government could do more to make claims data useful for research. First, more states should require CHW to have NPIs. Only one state with direct payment methods and high-quality T-MSIS data (Oregon) required CHWs to obtain an NPI. Where we found no claims (North Dakota and Vermont), we cannot assume there were no CHW services provided. As a result, states that have adopted, or are considering adopting, state plan amendments or waivers that allow CHWs to bill for services would benefit from requiring CHWs to register for NPIs. Without the ability to track CHW activities, they will not be able to use claims data to evaluate the value of these expanded services.

Second, we saw puzzling and unexpected weaknesses in Medicaid claims, such as the use of procedure codes that are not approved in authorizing language. In fact, the procedure codes, education, and training for patient self-management (98960-98962), explicitly authorized in seven states, were minimally used (0.01% of CHW claims). All the data challenges listed above, combined with other known challenges such as lack of common definitions or scope of services covered, inadequacy of reimbursement, and burdensome documentation requirements,[9] will also need to be addressed to advance knowledge on the reimbursement strategy best suited to sustain and expand the CHW workforce and related service provision.

Potential federal avenues for enhancing CHW data outside of Medicaid claims include mandating that all licensed or certified providers, including CHWs register with NPPES, with a requirement for regular updates to ensure the data reflects the current work location and active status.[29] While not all states require CHWs to be certified, this will at least further understanding of this workforce in states where certification is needed. Regular updates will ensure policy leaders have a contemporary understanding of the workforce supply during public health emergencies when appropriate resource allocation is crucial.[30]

Other federal datasets lump multiple distinct professions with CHWs, such as peer support providers in the BLS estimates and health educators in the American Community Survey (ACS). Given the level of demographic information collected in the ACS, a more reliable code for identifying CHWs could provide additional insights about CHW characteristics, including race and ethnicity data currently lacking in other federal sources. Similarly, more reliable BLS data could provide a more accurate count of the CHW workforce, in addition to tracking CHW employment outside of healthcare settings. These collective improvements to federal data sets would significantly enhance our ability to monitor trends in the CHW workforce given current limitations documenting CHW services in claims data. Indeed, numerous organizations submitted comments related to revising the CHW standard occupation code (SOC) in response to the 2028 SOC federal register notice.[32,33]

Conclusion

The crucial role of CHWs in improving patient outcomes, quality of care, and cost-effectiveness has been demonstrated in over a decade of research. We found some encouraging signs regarding their increased use of Medicaid in a handful of states, as well as continued fidelity to the original CHW model with regard to place of service. However, we also found that the totals remain small and there is a steep increase in using CHWs in office-based settings.

A significant challenge remains in understanding the full extent of CHW use as a result of inadequate data. Our analysis has shed light on notable inconsistencies in Medicaid claims. These issues, along with other concerns such as the absence of standardized CHW definitions, insufficient reimbursement rates, and complex documentation demands, are critical barriers that need to be addressed. Doing so is essential for enhancing our understanding of how best to support the growth and effective deployment of the CHW workforce.

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Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

The authors have no conflict of interest.

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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