Financing Strategies for Integrating Community Health Workers & Other Enabling Services in Your CHC

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With special thanks to Charlotte Community Health Clinic, MedNorth Health Center, Piedmont Health Services, and Rural Health Group

Session Objectives

- By the end of this session, the attendee will be able to:
  - Identify best practices for integrating CHWs and other enabling service providers into the care team
  - Identify potential strategies for financing services provided by CHWs or similar roles

Agenda

- Why this topic at this time?
- Integration of CHWs and Enabling Services Best Practices
- Financing Strategies
- One CHC's Approach
- Q&A

Who’s in the room?

Why this topic at this time?

Why this topic?

- Increasing recognition of importance of enabling services & CHW services on health outcomes and in value-based payment
- Increasing opportunities in North Carolina for recognition of CHWs
- Increasing pressure on CHC finances could endanger programs

Enabling Services

- Enabling services are non-clinical services that enable individuals to access health care and improve health outcomes. Examples of enabling services include case management, translation/interpretation, transportation, health education, enrollment assistance, and more.

- Health center patients who used enabling services have a higher likelihood of...
  - Getting enrolled in health insurance coverage
  - Getting a routine checkup
  - Getting a flu shot
  - Being satisfied with care

Enabling Services

UDS Categories of Enabling Services

- Case management
- Community health workers
- Transportation
- Outreach
- Health education
- Eligibility assistance (includes assistance in obtaining program eligibility, including PAP and health insurance coverage options)
- Translation/interpretation services
- Other

UDS Categories of Enabling Services Personnel

- Care managers
- Health education specialists
- Outreach workers
- Transportation workers
- Eligibility assistance workers
- Interpretation personnel
- Community health workers

Community Health Workers

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

American Public Health Association

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Community Health Workers in NC

- In NC, the NC Community Health Worker Association certifies CHWs
- NCCHWA offers levels for certification to promote advancement and pathways for CHWs in North Carolina
- CHW Level 1 offers two options for certification
  - CHW Standardized Core Competency Training Track
  - CHW Legacy Track

Integration Best Practices

What challenges have you had with integrating CHWs or other enabling service staff into the Care Team?

What has helped with integrating CHWs or other enabling service staff into the Care Team?

CHWs and other enabling services staff should be included in the leadership and design of programs.

Key Elements of Successful Program Integration

Hiring:	A clear vision for the CHW program, CHW's role, AND a realistic implementation plan and timeline.
Training:	Invest in onboarding staff, initial training, and have a plan and workflow in place for evaluating skills and ongoing training needs.
Supervision:	Effective CHW supervision and mentoring is vital to CHWs and CHW program success. CHW supervisors should ideally be experienced CHWs or have a good understanding of the CHW role. Specific training for CHW supervisors is available.
Respect for CHW Culture and Roles:	Respect for CHWs begins with understanding their role and impact. Healthcare organizations that have a commitment to advancing learning from the expertise CHWs bring to the table are more likely to be successful in sustaining effective CHW programs. It is important that leaders and respected champions are able to speak to the role and benefits of CHWs and empower CHWs to share data and stories regularly.
Program Evaluation:	The structure of a CHW program (hiring, training, supervision) that incorporates a methodical program plan, and measurements of impact will create a powerful recipe for improving health outcomes and healthcare costs. It is important to track both process and outcome measures.

Barriers to Integration: Recent NC CHC Assessment

- Unclear job functions, roles, and processes
- Lack of standard screening for non-medical health related needs
- Challenges with identifying and tracking key performance indicators→ hard to demonstrate success

Documenting Enabling Services

- Association of Asian Pacific Community Health Organizations Enabling Services Data Collection Implementation Companion

Resources

- AHEC CHW Integration and Optimization Tool: www.ncahec.net/practice-support/community-health-worker-program-2

- The National Council of CHW Core Consensus Standards: www.c3council.org

- CHW Common Indicators Project: www.chwcre.org

Financing Strategies

Medicare: Community Health Integration Services

- Community Health Integration (CHI) are personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self management of illnesses, diseases, or conditions.
- Effective January 1, 2024, CMS implemented CHI services and began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for CHI services. CHI services are part of the suite of care management services billable by FQHCs.

https://www.nachc.org/wp-content/uploads/2024/04/CHI-Reimbursement-Tips.pdf

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Medicare: Community Health Integration Services

- The initiating visit, which is a separately billable and reimbursable service from CHI services, may be any one of the following:
  - Evaluation and Management (E/M visit (CPT 99212-99215)
  - Annual Wellness Visit (AWV) (CPT G0438, G0439)
  - Transitional Care Management (TCM) (CPT 99495-99496)
- Initiating Visit Must:
  - Precede the start of CHI services
  - Be performed by the same billing provider who will also furnish and bill for subsequent CHI services, regardless of whether the initiating visit is an E/M, AWV, or TCM encounter
  - Identify the unmet SDOH needs which "significantly limit" the practitioner's ability to diagnose or treat health conditions and thus, the patient's ability to receive treatment and self-manage such health conditions
  - Establish a patient-centered treatment plan that specifies how addressing unmet SDOH need(s) would remove barriers to diagnosis and treatment
  - If it is an AWV, the practitioner identifies and documents that an unmet SDOH need prevents or inhibits the AWV personalized prevention plan from being carried out
  - Establish the CHI services as incidental to the practitioner’s Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent CHI services
  - Be performed by Physicians (MD,DO), Nurse Practitioners (NP), Physician Assistants (PA), or Certified Nurse Midwives (CNM)

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Medicare: Community Health Integration Services

- Eligible Patients
  - Medicare Part B beneficiaries
  - Provide consent for services
  - Have unmet SDOH need(s) that interfere with, or present a barrier to, the diagnosis and treatment of the problems identified during an initiating visit
  - Have been seen for an initiating visit prior to the start of services

- Auxiliary Personnel
  - What they may do (under general supervision, and after the initiating visit has taken place):
    - Obtain patient consent for services (verbal or written)
    - Provide CHI services
    - Document CHI service activities and time spent on such activities in the medical record
    - Communicate any newly identified SDOH concerns to the billing practitioner for review

https://www.nachc.org/wp-content/uploads/2024/04/CHI-Reimbursement-Tips.pdf

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Medicare: Community Health Integration Services

Service Elements, Coding & Billing

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
G0019	CHI services may be billed once per calendar month after at least 60 minutes of services performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner. CHI activities address unmet SDOH needs that are significantly limiting the ability to diagnose or treat problems(s) identified in an initiating visit: Patient-centered assessment • Coordination with home- and community-based resources • Health education • Developing self-advocacy skills • Patient behavioral change facilitation • Facilitate and provide social and emotional patient support	Auxiliary personnel under general supervision, or the billing provider may choose to personally deliver these services.	G0019: $77.95 OR G0511: $54.67 (only valid through July 1, 2025, for FQHCs transitioning to individual codes)
G0022	CHI services, each addtl' 30 minutes per calendar month.		G0022: $48.52 OR G0511: $54.67 (only valid through July 1, 2025, for FQHCs transitioning to individual codes)

• *The reimbursement rate is based on the 2025 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI. Code descriptions taken from the AAPC's HCPCS Level II 2025 Manual.*

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Medicare: Advanced Primary Care Management

- Medicare's Advanced Primary Care Management (APCM) services deliver personalized and supportive care through streamlined care plans, proactive coordination, and integrated digital communication tools.
- APCM, which bundles primary care services with care management and communication technology-based services (CTBS), is designed to overcome common challenges in primary care, such as gaps in continuity of care and insufficient reimbursement for comprehensive services.
- Chronic Care Management (CCM), Transitional Care Management (TCM), and Principal Care Management (PCM) are the care management services bundled in this primary care driven APCM program.

Medicaid Care Management

"CHWs are explicitly permitted to be part of the care management team in managed care via the Standard Plan and Tailored Plan contracts and are permitted to assist in administering Healthy Opportunities Pilot care management services. CHWs are working directly at the Medicaid health plan level and in other provider and community-based settings, including local health departments, in NC Medicaid today."

Quality or Value Payments

Resources

- Reimbursement Strategies for Employers of Community Health Workers: https://www.marc.org/sites/default/files/2022-10/CHW_Sustainability_Toolkit_FINAL_10-11-22_0.pdf

One CHC’s Approach

Organization – Program Background

Urban FQHC/CHC in New Hanover County, Wilmington

8134 patients served in 2024

All patients receive care management services regardless of payer source

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May 2022 – Hired first CHW (Spanish-speaking) as part of the Healthy Opportunities Pilot*

- *HOP Services: Housing case management, Transportation, Healthy Home Good, Essential Utilities Set up, Holistic, Food Services (DPP/Nutrition classes) -

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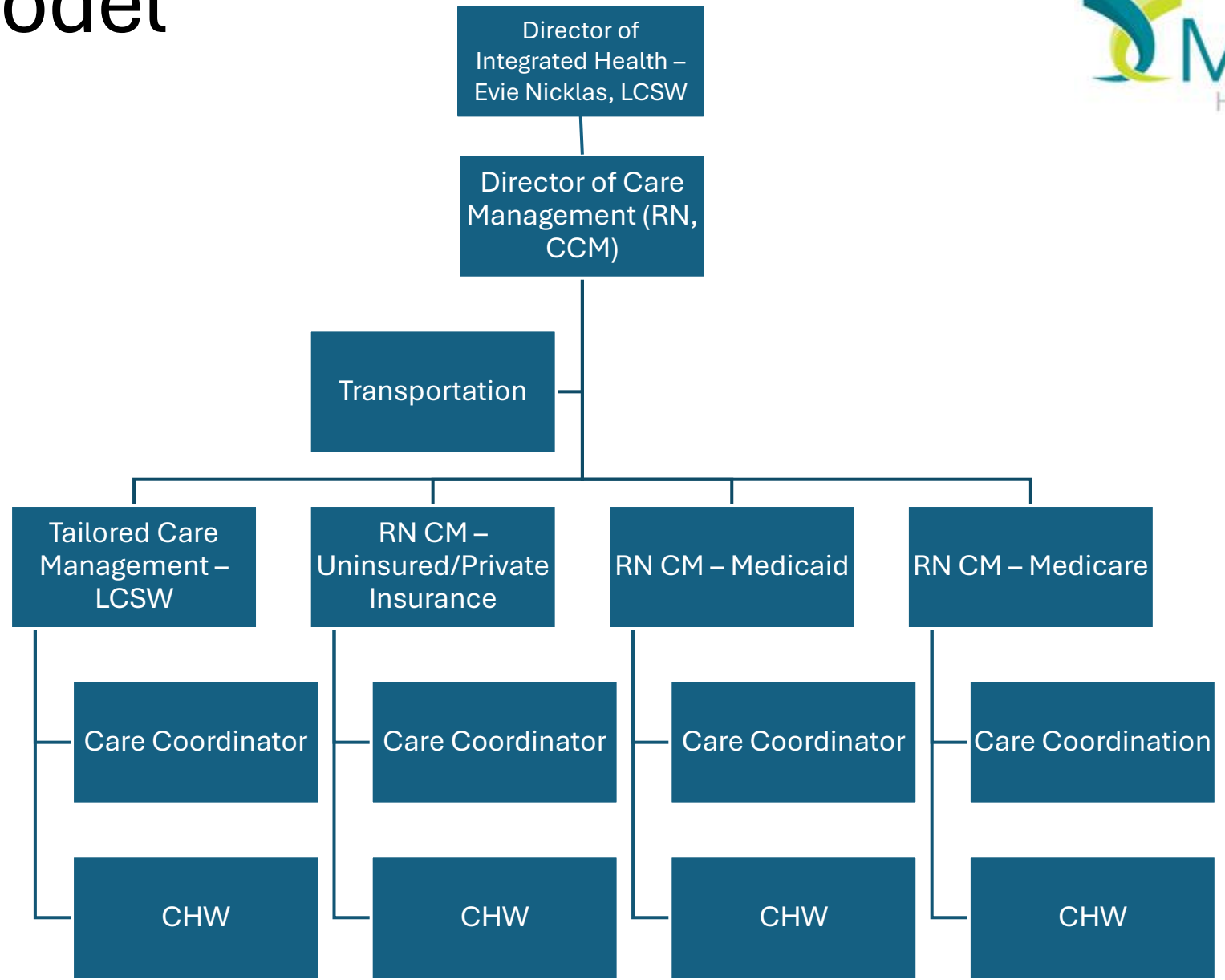
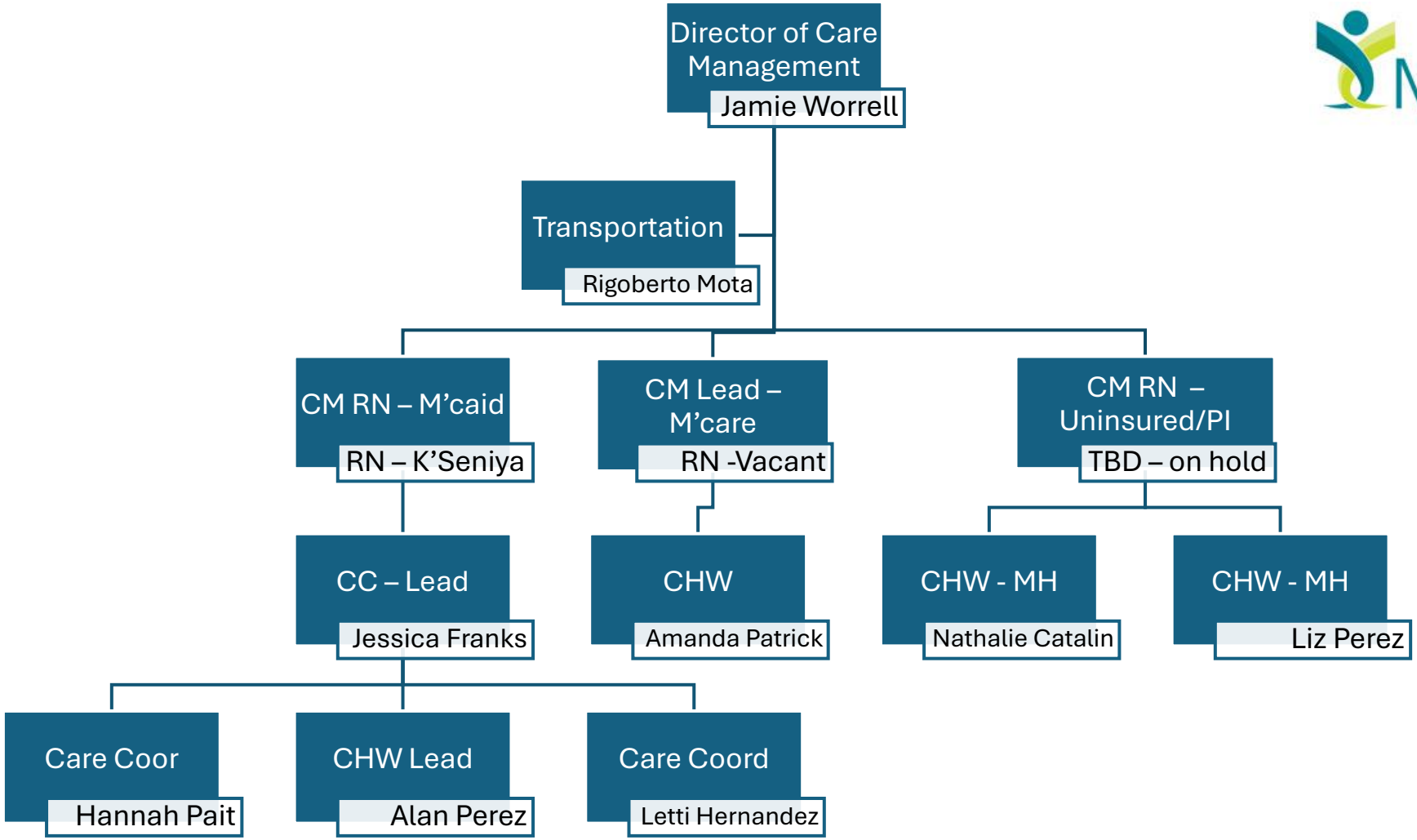
Our Care Model: The same care to every patient regardless of payer source

Our Model


Director of Integrated Health – Evie Nicklas, LCSW
Director of Care Management (RN, CCM)
Transportation
Tailored Care Management – LCSW
RN CM – Uninsured/Private Insurance
RN CM – Medicaid
RN CM – Medicare
Care Coordinator
Care Coordinator
Care Coordinator
Care Coordination
CHW
CHW
CHW
CHW

Care Management Model –
Medicaid, Medicare, Uninsured and Private Insurance



Criteria for Referral to Care Management Program (internal)

High Emergency Room/Inpatient utilization

Medication/Treatment Non-adherence

Social Determinants of Health gap

Specialty Care referral issues (e.g., scheduling appt., Cape Fear HealthNet applications, charity care @ Novant, etc.)

Follow up on Missed appointments (based on appointment type & urgency)

Care Management Workflow

Roles/Responsibilities – CHW

- Participate in Care Management rotation
  - SDOH gaps addressed
  - Address immediate pt. needs
  - Warm hand-off from providers
- Carry caseload of 40- 45patients
  - Complete Health Risk Screens
  - May conduct home visits – safety checks
  - Complete & Address SDOH screens
  - Implement care plan (with CM)
    - Address/complete care plan action items
  - Participate in multidisciplinary pt. care meetings

Roles/Responsibilities – Care Managers

- Review ED/IP list and assign to CHW/CC as appropriate (based on provider review during huddle)
- Medication/Treatment Adherence
  - Conduct necessary screenings (i.e., PHQ 9, GAD, etc. to determine root of non-adherence)
- Participate in Care Management rotation
  - Address immediate pt. needs
- Carry Caseload of 40 - 45 patients
  - Complete Health Risk Screens
  - May conduct home visits or refer to CHW/CC
  - Refer to CC/CHW for SDOH needs
- Determine case reviews for multidisciplinary pt. care meetings

CHW Financing

- Care Mgmt. Medicaid: Care management fees, PMPM, SDOH fees, Healthy Opportunities Pilot billing (in the black)
- Care Mgmt. Medicare: ORH/CHG funding for RN; ACO 9 revenue; United Healthcare MA VBC, billing for TCM or APCM to begin (in the black)
- Uninsured/Private Insurance: New Hanover County grant pays for 2 CHWs, VBC United Healthcare (analysis in progress)
- Tailored Care Mgmt. Medicaid: Care Mgmt. billing through Trillium (in the black)

Get in touch

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