COMMUNITY HEALTH WORKERS

in Kansas

MARC
MID-AMERICA REGIONAL COUNCIL

KC Regional
COMMUNITY
HEALTH WORKER
Collaborative

COMMUNITY
HEALTH WORKERS
Kansas Department of Health and Environment

AGENDA

- Who are Community Health Workers?
- How do we sustain CHWs in Kansas?
  - Kansas Medicaid
  - Medicare
- How do organizations braid funding streams to sustain CHWs?
- How do Community Health Workers add value to care teams?

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WHO ARE COMMUNITY HEALTH WORKERS?

HOW CAN THEY HELP KANSANS?

Are you familiar with CHWs?

What type of organization do you represent?

CHWS ARE FRONTLINE HEALTH WORKERS

A Community Health Worker is a **frontline public health worker** who is a trusted member of the community they serve.

This relationship allows the worker to:

- Serve as a **bridge** between health and social services and the community.
- Provide clients more **access** to services.
- Improve the **quality** of service.
- Increase health **knowledge** in the community through outreach, education, counseling, social support and advocacy.

Source: apha.org/apha-communities/member-sections/community-health-workers

CHWS IMPROVE CLIENT INTERACTIONS

- Build relationships in their community.
- Embody empathy, creativity and resourcefulness.
- Develop peer-to-peer relationships of trust.
- Communicate openly.
- Strengthen care teams.
- Engage clients at multiple points.
- Address social determinants of health.

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CHWS STRENGTHEN CARE TEAMS

Community Health Workers fill an important role in the health care system.

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CLIENT ENGAGEMENT

CHWs engage clients at multiple points along the continuum of care.

WHAT IS A CHWS SCOPE OF PRACTICE?

- **Individual Support**: Assist individuals with setting goals and removing obstacles to better health.
- **Care Coordination**: Link people to information and help them find and navigate health and social services.
- **Health and Community Liaison**: Help people communicate with health and social service systems.
- **Health Education**: Provide culturally appropriate health education to individuals, organizations and communities.
- **Advocacy**: Recognize gaps and advocate for the health needs of individuals and communities.

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WHAT IS A CHW'S SCOPE OF PRACTICE?

- In Kansas CHWs may become certified through the Kansas CHW Coalition.
- Education Pathway
  - Complete the KDHE approved CHW core curriculum training through the Kansas CHW Coalition or certified Kansas CHW education provider.
  - 100 classroom hours + 60 service-learning hours.
- Workforce Pathway
  - Complete 800 hours over three years plus three letters of recommendation to document work and/or volunteer experience.
- Reciprocity Pathway
  - Take a Missouri approved CHW core curriculum training.

Source: https://kschw.org/certification/

HOW DO WE SUSTAIN CHWS IN KANSAS?

MEDICAID IN KANSAS: BACKGROUND

- Sustainability can include:
  - Incorporating full-scope of CHW work into an organization's budget, policies and workflows.
  - **Braiding and blending funding.**
    - Using multiple funding sources (grants, contracts, insurance, etc.) to pay for CHWs' salaries and work in an organization.
  - CHWs salaries become part of the organization's operating budget.
- National Association of Community Health Workers Definition:
  - "organizations have achieved sustainable financing for CHW positions when they do not rely on time-limited funds, like grants or contracts; and when support for CHWs is part of the organizations' regular budgets."

Source: https://nachw.org/wp-content/uploads/2023/12/sustainable-financing-of-community-health-worker-employment.pdf?mc_cid=eefa4742c3&mc_eid=7e5da22c9a

MEDICAID IN KANSAS: BACKGROUND

- Medicaid is a state-federal partnership, jointly administered by states and federal Centers for Medicare and Medicaid Services (CMS).
- CMS and the state agree on a State Plan:
  - What services are covered.
  - How clinical providers are reimbursed.
- State Plans can be changed through agreement between a state and CMS - State Plan Amendment (SPA).
- CMS approved KS SPA request to include CHW services in KS Medicaid.
- The KS CHW SPA went into effect on July 1, 2023.
- Rate increase went into effect July 1, 2024.

CHWS IN KANSAS MEDICAID

	KANSAS REQUIREMENTS
Scope of Work	CHWs can conduct the following activities: • Screening and assessment for health-related social needs (social determinants of health). • Health promotion and coaching. • Health system navigation and resource coordination. • Health education and training. • Care planning.
Supervision	CHWs must be supervised by Physicians, Dentists, Advanced Practice Registered Nurses, Licensed Mental Health professionals and Physician Assistants.

CHWS IN KANSAS MEDICAID

	KANSAS REQUIREMENTS
Qualifications	To provide services in Kansas Medicaid, CHWs must be certified through a CHW certification recognized by the Kansas Department of Health and Environment. Accept Kansas CHW Coalition certification.
Coverage limits	Services provided by CHWs are limited to: • Four units (or 2 hours) per day, per member and • twenty-four units (or 12 hours) per month, per member.

CHWS IN KANSAS MEDICAID

	KANSAS REQUIREMENTS
Billing	Supervising licensed practitioner must bill for the CHW services. CHWs can provide services face-to-face with the member, individually or in a group, in an outpatient, home, clinic, or other community setting.
Rates	CHW services are billable in 30-minute increment at the following (current) rates. $22.20 individual patient (CPT 98960) $10.78 per patient for 2-4 patients (CPT code 98961) $7.77 per patient for 5-8 patients (CPT code 98962)

MEDICARE

- CMS 2024 Medicare Physician Fee Schedule.

- Created three new categories of services addressing social determinants of health (SDOH):
  1. Community Health Integration (CHI) services.
  2. SDOH Risk Assessment.
  3. Principal Illness Navigation / Principal Illness Navigation – Peer Support.

COMMUNITY HEALTH INTEGRATION

- Two new payment codes for 60 minutes/month and each additional 30 minutes/month:
  - Ordered by a Medicare billing practitioner (physician, physician assistant, nurse practitioner).
  - Performed by a licensed or trained "auxiliary personnel," which can include CHWs, under general supervision.
  - Virtually or in person.
- CHI Services include:
  - Person-centered assessment and action planning.
  - Coordination to health and community-based services.
  - Health education.
  - Building patient self-advocacy skills.
  - Facilitating behavior change.
  - Providing social and emotional support.
- Subject to Part B deductible and co-insurance.
- Verbal or written consent is required and must be document in medical record.

COMMUNITY HEALTH INTEGRATION

- S initiating visit with a Medicare billing practitioner:
  - Assesses and identifies SDOH.
  - Establishes a treatment plan, orders CHI.
  - Examples include E/M, psychiatric diagnostic, annual wellness visits.
- CHI services must address SDOH needs identified as a barrier to diagnosis and treatment of the problem identified during the initiating visit.
- CHI can be performed by a third party (Ex. CBO).
- Requires clinical integration (Ex. plan, monthly CHI encounter notes, clinical integration meetings, re-evaluation) and documentation in the medical record.
- An individual who provides CHI services must be certified or trained to perform all the included service elements or meet state licensure requirements, if applicable.

COMMUNITY HEALTH INTEGRATION

- Billing
  - No limit or cap as long as services are medically necessary and delivered according to a care plan.
    - Question regarding whether there is a limit for FQHC/RHCs.
  - Can be provided concurrently with other Medicare care management services such as Chronic Care Management or Transitional Care Management.
  - Bill on aggregate time spent providing CHI on behalf of the beneficiary.
  - Code to bill for initial 60-minutes per calendar month.
  - Code to bill for subsequent 30-minutes per calendar month.
  - Only one provider can bill for CHI for the same beneficiary in a calendar month.

SDOH ASSESSMENT

- CMS created a code to pay for SDOH risk assessment conducted during an E/M visit.
  - Can be billed once every six months.
- Must be furnished by a practitioner on the same date as an E/M, behavioral health or annual wellness visit.
- Must be documented in the medical record.
- SDOH assessment must be a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs and utility difficulties.

PRINCIPAL ILLNESS NAVIGATION

- Like CHI except for patients with high-risk serious conditions that are expected to last at least three months and there is a significant risk of decline.
  - Requires initiating visit.
  - Performed by auxiliary personnel under general supervision.
  - Code to bill for initial 60-minutes per calendar month.
  - Code to bill for subsequent 30-minutes per calendar month.
- Designed to help patients navigate through the health system and care needs and support.
- Patients may or may not have social support needs but will have more health system facing needs.
- Principal Illness Navigation-Peer Support (PIN-PS)
  - Separate code to recognize peer support specialists working with individuals with behavioral health needs.

PRINCIPAL ILLNESS NAVIGATION

- Provided by certified or trained personnel and can include patient navigators or peer support specialists.
  - If a state does not have regulations, auxiliary personnel must have relevant training in PIN services and in the applicable high-risk condition, illness or disease.
  - For PIN-PS, auxiliary personnel must have training that meets SAMHSA's National Model Standards for Peer Support Certification.
- CMS wants navigators to have lived experience or training to better understand patient perspective.

Approaches to Braided and Blended Funding Strategies

CHW Sustainability

Braided and Blended Funding

Braiding: Funds from multiple funding streams are used to support the total costs of a common goal. Each individual funding stream maintains its specific program identity, meaning that funds from each specific funding source must be tracked separately.

Blending: Mixing multiple funding streams together to support the total costs of a common goal. Funding sources lose there program-specific identities, meaning that costs do not have to be allocated or tracked separately by funding source.

- Strategies organizations may employ to combine funding streams and enhance support for a specific goal or initiative.
- Intentionally merging various funding streams to lessen reliance on a single source, like Medicaid.

Braided and Blended Funding: Clinic Integration

CHW Strategies and Sustainability

Different strategies work for different clinics/organizations

- Primary Care/ Private Medicine
- Federally Qualified Health Center
- Rural Health Center
- Rural vs Urban location
- Patients are different
- Patient's insurances vary
- Uninsured
- Undocumented
- Travel time
- Identify funding streams
- Identify eligible populations and compare requirements

Reimbursement amounts are weighted based off type of facility and location.

Approaches to Braided and Blended Funding Strategies

CHW Sustainability

Technical Assistance

- CHW Training
- CHW Integration
- Workflow
  - How CHWs receive referrals
- Billing
  - For Medicaid claims having the U7 modifier
- Documentation
  - Capturing requirements for billing
- Clinic reports
  - Insurance types, uninsured percentages
  - Type of Diagnosis
  - Quality Improvement

Braided and Blended Funding: Clinic Integration

CHW Strategies and Sustainability

Braiding and Blending Funding Strategies

- Kansas Medicaid CHW State Plan Amendment

- Medicare Opportunities include:
  - Community Health Integration
  - Chronic Care Management
  - Transitional Care Management
  - Remote Physiological Monitoring
  - Principal Care Management
  - Principal Illness Navigation
  - Behavioral Health Integration

All organizations should verify with their Billing Manager on proper billing for your organization.

Medicaid Services vs Medicare CHI services Scope of Work

Medicaid:

- Face to Face/ Telehealth
- Screening and Assessment
- Health Promotion and Coaching
- Health System Navigation and Resource Coordination
- Health Education and Training
- Care Planning

Medicare CHI:

- Does not have to be face-to-face
- Person-Centered Assessment and Action Planning
- Coordination to health and community-based services
- Health Education
- Building patient self-advocacy skills
- Facilitation Behavior change
- Providing Emotional Support
- **Must** address social determinates of health (SDOH) needs identified by the provider

You **must** document in the patient's chart.

CHW Sustainability

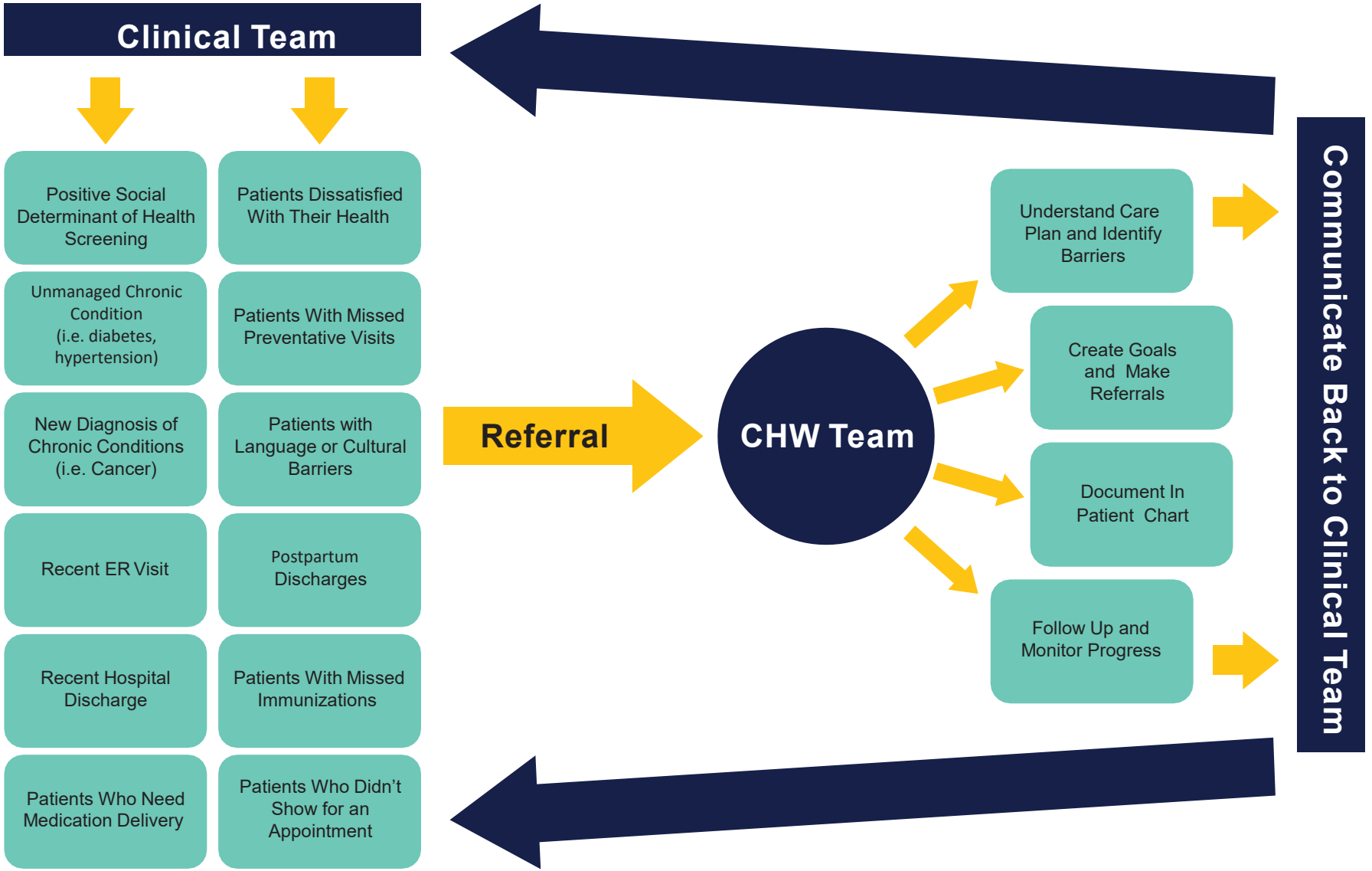
Documentation

CHWs must have access to the EHR system

CHW Template

- Time In/Out **or**
  - Visit Duration
- Certified CHW: Yes or No
- Type of Visit
  - Face to Face
    - Group
    - Individual
  - Phone
  - Email
- SDOH needs addressed
  - Transportation
  - Food Insecurity
  - Housing
- Visit
  - First Visit
  - Follow-up
- Type of Referral made
  - Medical
  - Dental
  - Prenatal/ Maternal Health
  - Food Assistance
  - Insurance Assistance
  - Housing Assistance
  - Prescription Assistance
  - Alcohol/Substance Abuse
  - Behavioral Health Service

Community Health Worker Clinical Team Workflow



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Braided and Blended Funding: Clinic Integration

Calculating CHW Sustainability						
Instructions:	Input your CHWs salary and your facility rates for Medicare					
CHW Salary/Benefits						
CHW Hourly Rate (Include hourly rate plus benefits: if salary is $18 per hour and benefits are estimated at 27%, input $22.86)						**$22.86**
Hours Worked and Reimbursement Options						
	CHW Salary		weekly	40	$914.40	
			monthly	160	$3,657.60	
Medicaid Codes						
Medicaid CHW		Patient Reimbursement		# patients/grou	# billing units	Total
		1:1 pt (30 mins)	$22.20	N/A	50	$1,110.00
		2-4 pt group	$10.78	4	2	$86.24
		5-8 pt group	$7.77	8	2	$124.32
			Medicaid weekly total			$1,320.56

Braided and Blended Funding: Clinic Integration

Service	CCM		TCM		RPM		PCM		CHI		PIN	
Time Requirements	20 minutes		30 minutes		20 minutes		30 minutes		60 minutes		60 minutes	
Additional Allowable Time	Each additional 20 minutes.				Each additional 20 minutes.		Each additional 30 minutes.		Each additional 30 minutes.		Each additional 30 minutes.	
Qualifications	Two or more chronic diseases.		Discharged from approved facility.		Data collection at least 16 days.		Single chronic condition.		SDOH limit's ability treat problems.		Serious high-risk condition.	
Kansas Weighted Reimbursement Rate	FQHC/RHC	Primary	FQHC/RHC	Primary	FQHC/RHC	Primary	FQHC/RHC	Primary	FQHC/RHC	Primary	FQHC/RHC	Primary
	$58.80	$62.58	$190.63	$206.72	$17.56	$19.97	$57.30	$61.91	$74.03	$80.56	$74.03	$80.56
			$257.99	$279.62	$42.01	$47.27	$43.71	$47.27	$46.35	$50.26	$46.35	$50.26
	Each 20 minutes		7 days or 14 days		Setup or setup and monitoring.		First 30 minutes, each additional 30 minutes.		First 60 minutes, then each 30 minutes.		First 60 minutes, then each 30 minutes.	

RHC's currently being paid $71.71 per G0511 code

Conflicting information from CMS on billing additional time codes for G0511 for FQHC/RHC/IHS.

Only paid 80% of allowable rate per claim.

Braided and Blended Funding- Clinic Integration

Actual case could fit Chronic Care Management

Referral to CHW: patient giving up, crying through conversation with doctor
Diagnoses: diabetes, chronic kidney disease, neurogenic bladder with catheter, solitary right kidney, major depressive disorder
Current: medical issues and financial issues

First two months: tearful, repeat sadness, feeling overwhelmed - CHW provided support, resources, care coordination, updated medical provider,

Third month: patient began eating better, taking some initiative to call on resources, started exercising to regain strength, prepare meals, establishing relationships with support systems in the community, CHW continued provided support and care coordination - less frequently.

FQHC
Chronic Care Management (CCM)
G0511- $58.80

Bill 20 min increments : $58.80 (FQHC)
one unit per patient at 15 pts = $882.00.
*Can provide CCM & CHI on same patient in the same month doubling this amount.

Primary Care Clinic
Chronic Care Management (CCM)
99487 -$134.15
99489- $72.23
99490- $62.58
G0511- $72.90

Braided and Blended Funding- Clinic Integration

Transitional Care Management Clinic Referrals

Auxiliary personnel may provide these non-face-to-face TCM services:

- Communicate with the patient
- Communicate with agencies and community service providers the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living and activities of daily living
- Assess and support treatment adherence, including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services

Primary Care Clinic
Transitional Care Management (TCM)
99495 - $206.72
99496 - $279.62

One primary care clinic that averages 116 TCM referrals a month

116 patients a month
$206.72*116 =
$23,979.52.

FQHC
Transitional Care Management (TCM)
99495 - $190.63
99496 - $257.99

Remote Physiologic Monitoring (RPM)

Patient Eligibility

Remote physiologic or patient monitoring (RPM):

- Weight
- Blood pressure
- Blood glucose
- Pulse
- Temperature
- Oximetry
- Respiratory flow rates

Variety of settings including patients' homes

Requires data collection at least 16 days in 30-day period

- **99453** – initial; set-up and patient education on use of equipment.

- **99454** – continued monitoring over 16 days.

Braided and Blended Funding- Clinic Integration

CHW Sustainability is possible

- Medicare Reimbursement Strategies
- Medicare Replacement Plans allow some, will allow others soon
- Medicaid Reimbursement
- CHWs bringing in new patients
- CHWs bringing in patients with missed visits
  - Annual Wellness Visits
- Less ER/Urgent Care visits
- CHWs assist with access to care
- Helping uninsured get insurance
- Improved Health Outcomes
- Improve self-management of chronic disease

Challenges

- Uninsured/ Undocumented clients
- Primary Medicaid Clients
- Documentation and tracking time spent
  - Allowing CHWs access to EHR
  - CHW template

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Thank You/Questions

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SOURCES

- apha.org/apha-communities/member-sections/community-health-workers
- kschw.org/certification/
- nachw.org/wp-content/uploads/2023/12/sustainable-financing-of-community-health-worker-employment.pdf?mc_cid=eefa4742c3&mc_eid=7e5da22c9a
- kschw.org/about-us
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- marc.org/document/chw-summary-medicaid-state-plan-amendments
- public-inspection.federalregister.gov/2023-24184.pdf

RESOURCES

Toolkit: Reimbursement Strategies for Employers of CHWs

- Toolkit: Reimbursement Strategies for Employers of CHWs

Kansas Medicaid:

- Approved Kansas SPA
- July 2023 Provider Bulletin
- Dec. 2023 Provider Bulletin

- Medicaid State Plan Amendments:
  - NASHP Brief
  - Summary of Medicaid SPAs Nationally

- Medicare Rule
  - 2024 Physician Fee Schedule
  - Medicare Learning Network Health Equity Services

OBJECTIVES

1. Provide background on the CHW role and scope of practice in Kansas and how CHWs complement clinical care teams.
2. Describe opportunities that exist in Medicare and Medicaid to sustain CHWs in clinical care teams.
3. Provide examples of how CHWs have improved the delivery of care in clinics.
4. Describe opportunities to braid Medicare and Medicaid funding streams and provide examples.