Important Covered Benefit: Community Health Worker (CHW) Services

At Alameda Alliance for Health (Alliance), we value our dedicated provider partners and appreciate all of the hard work you do to protect the health and well-being of our community. We have an important update we want to share with you.

Community Health Worker (CHW) Services became a Medi-Cal covered benefit on Friday, July 1, 2022. According to the California Department of Health Care Services (DHCS), CHW services are preventive health services designed to prevent disease, disability, and other health conditions or their progression as well as to prolong life and promote physical and mental health. CHWs may include individuals known by several job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below. Through their community connection and engagement, CHWs will advance the California Advancing and Innovating Medi-Cal (CalAIM) initiative's efforts to provide health care equity through culturally competent services.

The CHW's supervising provider must be a licensed provider, hospital, outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The entity must be contracted with the Alliance and all CHW supervising providers will need to be credentialed by the Alliance. **Supervising providers must submit a completed Community Health Worker (CHW) Supervising Provider Attestation Form included in this notice.** Supervising providers must be enrolled in fee-for-service (FFS) Medi-Cal, if applicable. Supervising providers can enroll in Medi-Cal through the PAVE Provider Portal at **https://pave.dhcs.ca.gov/sso/login.do**.

Once the Alliance approves the attestation form through our credentialing process, providers can start getting reimbursed for these services on or after their effective date.

The following CPT codes may be used for the services listed below by the supervising provider when submitting claims for CHW services:

CPT Code	Description	Duration	Number of Patients	Maximum Units	Rate
98960	Self-management education and training, face-to-face or telehealth.	30 minutes	1	4 per day If continued care is needed after 12 units, a plan of care will be required	$26.66
98961	Self-management education and training, face-to-face or telehealth.	30 minutes	2-4		$12.66 per patient
98962	Self-management education and training, face-to-face or telehealth.	30 minutes	5-8		$9.46 per patient

Required allowed modifiers:

Questions? Please call the Alliance Credentialing Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.6176**
www.alamedaalliance.org

Allowed Modifiers	Place of Service	Description
U2	All	Used to denote services rendered by the community health worker
U2, 93	02	Used to denote services rendered by the community health worker via telehealth, audio only, not delivered in patient's home
U2, 95	02	Used to denote services rendered by the community health worker via telehealth, interactive only, not delivered in patient's home
U2, 93	10	Used to denote services rendered by the community health worker via telehealth, audio only, delivered in patient's home
U2, 95	10	Used to denote services rendered by the community health worker via telehealth, interactive only, delivered in patient's home

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Community Health Worker (CHW) – Supervising Provider Attestation Form

The Alameda Alliance for Health (Alliance) Community Health Worker (CHW) – Supervising Provider Attestation Form is a written agreement between the Alliance and the representative agency listed below. This form supports applying for the CHW services. The form indicates that the supervising provider attests that the CHW meets the requirements as documented by the California Department of Health Care Services (DHCS) APL 24-006. Please update this required form if there are any changes to the supervision of a CHW or when a new CHW is added.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please complete all fields in this form for **each** CHW providing services under a supervising provider.
3. The supervising provider and CHW must complete, sign, and date this form.
4. Please submit the completed form to the Alliance Credentialing Department via fax at **1.510.995.3761** or email to **distgrpCredentialing@alamedaalliance.org**.

For questions, please call the Alliance Credentialing Department at **1.510.747.4522**. You can also call the Alliance Provider Services Department at **1.510.747.4510**.

PLEASE NOTE: If you are not able to attest to the following, please provide a detailed explanation on a separate sheet.

SECTION 1: SUPERVISING PROVIDER REQUIREMENTS

Credentialing Status (please select all that apply):

- ☐ I am an existing provider who is a ***credentialed*** Alliance provider
- ☐ I am directly contracted with the Alliance
- ☐ I am enrolled in fee-for-service (FFS) Medi-Cal, if applicable

I attest that I represent one (1) or more of the following entities (please select all that apply):

- ☐ Community-Based Organization (CBO)
- ☐ Hospital
- ☐ Licensed Provider
- ☐ Local Health Jurisdiction (LJH)
- ☐ Outpatient Clinic

SECTION 1: SUPERVISING PROVIDER REQUIREMENTS (cont.)

☐ I certify that the supervised CHW meets the minimum qualifications and will provide records of **ALL** of the following documents if audited:

- Evidence of CHW experience.
- Evidence of selected CHW pathway which can fall under (1) Work experience pathway ***OR*** (2) Certificate pathway.
    - Under the Certificate pathway, the CHW has training in the following areas: violence prevention certification, communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education, and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the supervising provider. Certificate programs must also include field experience as a requirement.
- CHW completed the annual minimum of six (6) hours of additional training.
- CHW has lived experience that aligns with and provides a connection between the CHW and the member or population being served. Lived experience may include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one (1) or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

SECTION 2: CHW ASTHMA PREVENTION SERVICES - SUPERVISING PROVIDER REQUIREMENTS (IF APPLICABLE)

☐ I certify that the supervised Asthma prevention services CHW meets the minimum qualifications and will provide records of **ALL** of the following documents if audited:

- Unlicensed asthma preventive service providers must be supervised by either a physician, physician assistant, nurse practitioner, clinic, hospital, local health jurisdiction, or community-based organization.
- Asthma preventive service providers must have completed either of the following:
    - A certificate from the California Department of Public Health Asthma Management Academy, or
    - A certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma with core competencies in the following areas:
        - Basic facts of asthma's impact on the human body, including asthma control
        - Roles of medications
        - Environmental control measures
        - Teaching individuals about asthma self-monitoring
        - Implementation of a plan of care
        - Effective communication strategies including at a minimum cultural and linguistic competency and motivational interviewing
        - Roles of a care team and community referrals
    - And both of the following:
        - Completed a minimum of 16 hours of face-to-face client contact focused on asthma management and prevention.
        - Four (4) hours annually of continuing education on asthma.

SECTION 3: AGREEMENTS AND REQUIREMENTS OF CHW ROLE

☐ I certify that the supervised CHW has requirements to provide records of **ALL** of the following documents if audited:

- Completed CHW Services Benefit - Recommendation Form by the provider for the member to receive CHW Services.
- Dates and time/duration of services and nature of services.
- Written Care Plan for the member who receives 12 or more units of CHW services with **ALL** of the following elements:
    - Specify the condition for which the service is being ordered and be relevant to the condition.
    - Include a list of other health care professionals treating the condition or barrier.
    - Include written objectives that specifically address the recipient's condition or barrier affecting their health.
    - List the specific services required for meeting the written objectives.
    - Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.
- Member's Care Plan is reviewed at least every six (6) months.

SECTION 4: CHW CAPACITY

What types of services will the CHW provide? (Please select all that apply):

☐ **Health Education:** Promote member health or address barriers to physical and mental health care by providing information or instruction on health topics.

☐ **Health Navigation:** Provide information, training, referrals, or support to assist members in accessing health care, understanding the health care delivery system, or engaging in their own care.

☐ **Screening and Assessment:** Provide screening and assessment services that do not require a license and assist members with connecting to appropriate services to improve their health.

☐ **Individual Support or Advocacy:** Assist members in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well when not duplicative of other covered benefits.

Select any specialties that the CHW may have:

☐ Asthma
☐ Behavioral Health
☐ Children's Prevention Care
☐ Developmental Disability/Delay
☐ Diabetes
☐ Emergency Room, Transitions of Care
☐ Heart Disease
☐ Homelessness/Housing
☐ Justice Involved
☐ Maternal Health
☐ Substance Use Disorder
☐ Violence Prevention
☐ Other: _____

SECTION 7: ACCESSIBILITY

Please indicate what types of accessibility the CHW services organization has (please select all that apply):

- ☐ **Parking:** Parking spaces for cars and vans are accessible. Pathways have curb ramps between the parking lot, office, and drop-off places.
- ☐ **Exterior Building:** Curb ramps and other ramps to the building are wide enough for a wheelchair or scooter user. Handrails are on both sides of the ramp. There is an accessible entrance to the building. Doors open wide enough to let a wheelchair or scooter user enter. Doors have handles that are easy to use.
- ☐ **Interior Building:** Doors open wide enough to let a wheelchair or scooter user enter. Doors have handles that are easy to use. Interior ramps are wide enough and have handrails. Stairs, if present, have handrails. If there is a platform lift, it can be used without help.

  If there is an elevator:
  - The public and patients can use it at all times the building is open.
  - It has easy-to-hear sounds and Braille buttons within reach.
  - It has enough room for a wheelchair or scooter to turn around.
- ☐ **Restroom:** The restroom is accessible and the doors open wide enough to allow a wheelchair or scooter and are easy to open. The restroom has enough room for a wheelchair or scooter user to turn around and close the door. There are grab bars that allow easy transfer from wheelchair to toilet. The sink is easy to get to and the faucets, soap, and toilet paper are easy to reach and use.

After Hours Phone Number: _____

SECTION 8: DIVERSITY, INCLUSION, AND EQUITY (DEI)

The Alliance is dedicated to DEI. To help ensure we are promoting this value, please fill out this section.

Race and Ethnicity (optional):

- ☐ African, African American, or Black
- ☐ Alaska Native, American Indian, or Indigenous
- ☐ Asian, Asian American
- ☐ Hispanic, Latina/e/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other: _____

Available Language(s) **Spoken** Other Than English (please select all that apply):

- ☐ Spanish
- ☐ Chinese
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Arabic
- ☐ American Sign Language (ASL)
- ☐ Skilled medical interpreter
- ☐ Other: _____

Available Language(s) **Written** Other Than English (please select all that apply):

- ☐ Spanish
- ☐ Chinese
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Arabic
- ☐ Other: _____

SECTION 5: PUBLIC PROVIDER DIRECTORY INFORMATION

The Alliance would like to accurately present the CHW organization's contact information on our website and Provider Directory. Please provide the following information:

CHW Organization's Location Name: _____

Street Address of Service Location(s) (please provide all associated street addresses):

Group Affiliation(s): _____

National Provider Identifier (NPI) Number: _____

Phone Number (please provide all associated phone numbers:

_____

Website URL (for each service location, if applicable):

Paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS) paneled provider):

_____

Are you accepting new patients for CHW services?

☐ Yes ☐ No ☐ Accepting existing patients only

SECTION 6: PROVIDER'S AFFILIATED MEDICAL GROUP OR INDEPENDENT PHYSICIAN/PROVIDER ASSOCIATIONS (IPA) INFORMATION

National Provider Identifier (NPI) Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Website URL for Each Physician Provider of the Affiliated Group or IPA (if applicable):

Opening Hours of Service Location (include the availability of evening or weekend hours):

_____

SECTION 9: SIGNATURES

Supervising Provider Full Name (printed): _____

Supervising Provider Signature: _____ Date: _____

Supervising Provider NPI Number: _____

Billing Provider Tax ID Number: _____

Billing Provider NPI Number: _____

CHW Full Name (printed): _____

CHW Signature: _____ Date: _____

Sources:
APL 24-006 – www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2024/APL24-006.pdf