Community Health Workers at Scale in New York City: A Health Equity Strategy

The NYC Health Department CHW Policy Working Group Team Convened by Acting Commissioner and Chief Medical Officer Dr. Michelle Morse and Deputy Chief Medical Officer Dr. Toni Eyssallenne

NYC Department of Health and Mental Hygiene
CHW Strategic Plan and Policy Agenda 2025-2026

NYC Health

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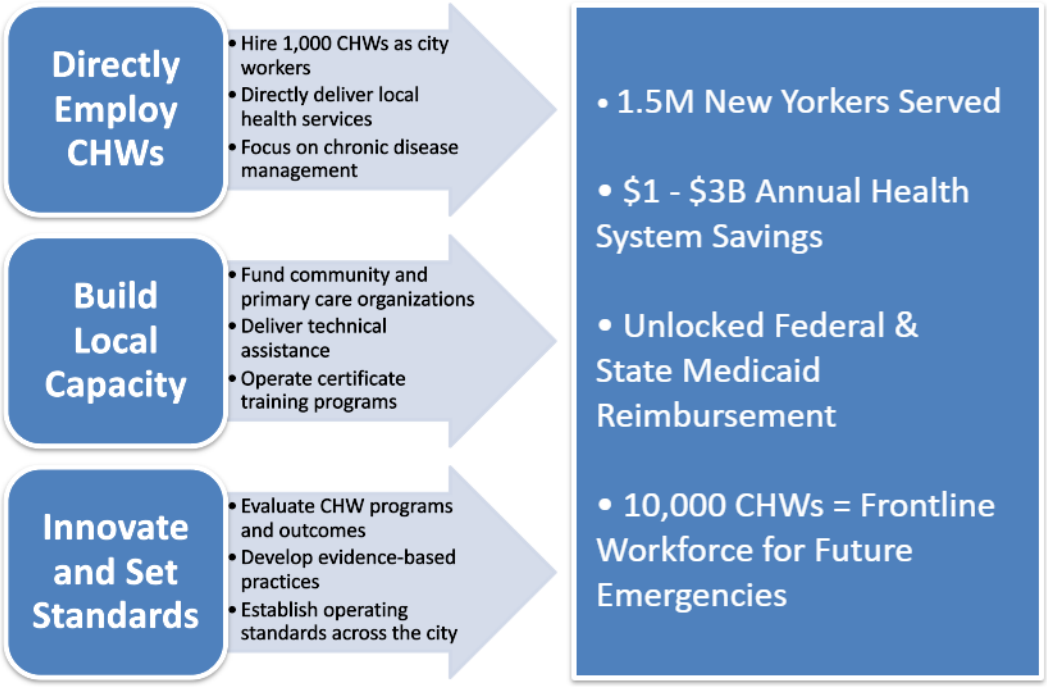
Executive Summary

Community health workers (CHWs) are trusted community members who provide health education, patient advocacy, and navigation support across health and social care systems. In New York City (NYC), an estimated 3,500 to 4,500 CHWs are employed in health care systems, independent health providers, community-based organizations (CBOs), and government agencies. Their impact was demonstrated during COVID-19 through the Public Health Corps (PHC), where nearly 500 CHWs improved vaccination, testing, and treatment and connected New Yorkers to essential services. Using available data, we estimate that scaling the workforce to 10,000 CHWs by 2030 could directly serve 1.5 million New Yorkers at an annual cost of $1.1 billion, supported by city, state, federal, and private funds. After program costs are taken into account, this investment would yield an estimated $1 billion to $3 billion in annual net savings by improving health outcomes, lowering health care costs and strengthening NYC's economy and job market. To realize these projected savings, it is vital to invest city funds and work with the New York State Department of Health (NYSDOH) on evidence-based, implementation-informed improvements to Medicaid reimbursement policy. These steps are essential to ensuring sustainable funding for CHW services that benefit New Yorkers and improve health and longevity for our city.

Key Roles for the NYC Department of Health and Mental Hygiene (Health Department)



Introduction: Investment, Integration, and Impact

CHWs are trusted community members who provide health education, patient advocacy, and navigation support across health and social care systems. In addition to their training, they often carry lived experience that shapes their impact. CHW is a broad term that encompasses peer educators, violence interrupters, patient navigators, doulas, health advocates, outreach workers, and many other public health professionals. The CHW serves as a bridge among health care systems, social services, and CBOs to improve access to services and to facilitate healthier outcomes for the communities served.[i] Based on available state[ii] and national[iii] data, we estimate there are approximately 3,500 to 4,500 CHWs working in NYC, of whom 15% to 20% are employed by large health care systems, 15% to 20% are employed by independent clinics and providers, 30% to 35% are employed by CBOs, and 20% to 25% are employed by government.[iv]

The NYC Health Department outlines its strategy to address chronic disease in the report *Addressing Unacceptable Inequities: A Chronic Disease Strategy for New York City* and through the HealthyNYC vision, emphasizing upstream factors to extend life expectancy, improve quality of life, reduce chronic disease inequities, and mitigate the effects of climate change. CHWs are a critical part of advancing this strategy. Here, we describe and estimate the impact of CHWs in addressing chronic diseases, which drive life expectancy inequities and increase risks during pandemics and climate-related emergencies.

During the COVID-19 pandemic, NYC Health + Hospitals (NYC H+H) and the NYC Health Department launched the PHC. Nearly 500 CHWs played a critical role in improving vaccination, testing, and treatment outcomes and connecting New Yorkers to essential services such as transportation, food, housing, and job training.[v,vi] A key activity in the NYC Health Department's Inaugural Chief Medical Officer (CMO) Strategic Plan, PHC demonstrates how CHWs serve as trusted partners to successfully bridge public health and health care.[vii]

CHWs operate across a variety of settings, including health care, public health, and community-based sites. To sustain this workforce at scale, funding will need to come from multiple sources including the city, state, and federal governments; managed care organizations; philanthropic sources; and employers that directly hire CHWs and support their salaries. The path to scale and fiscal viability has begun to be charted by many states, including NYS. NYC and NYS have a strong foundation of CHW work, both in targeted health areas (serious mental illness, substance use, tuberculosis (TB), HIV, postpartum people, and newborns) and in service delivery within safety-net institutions.

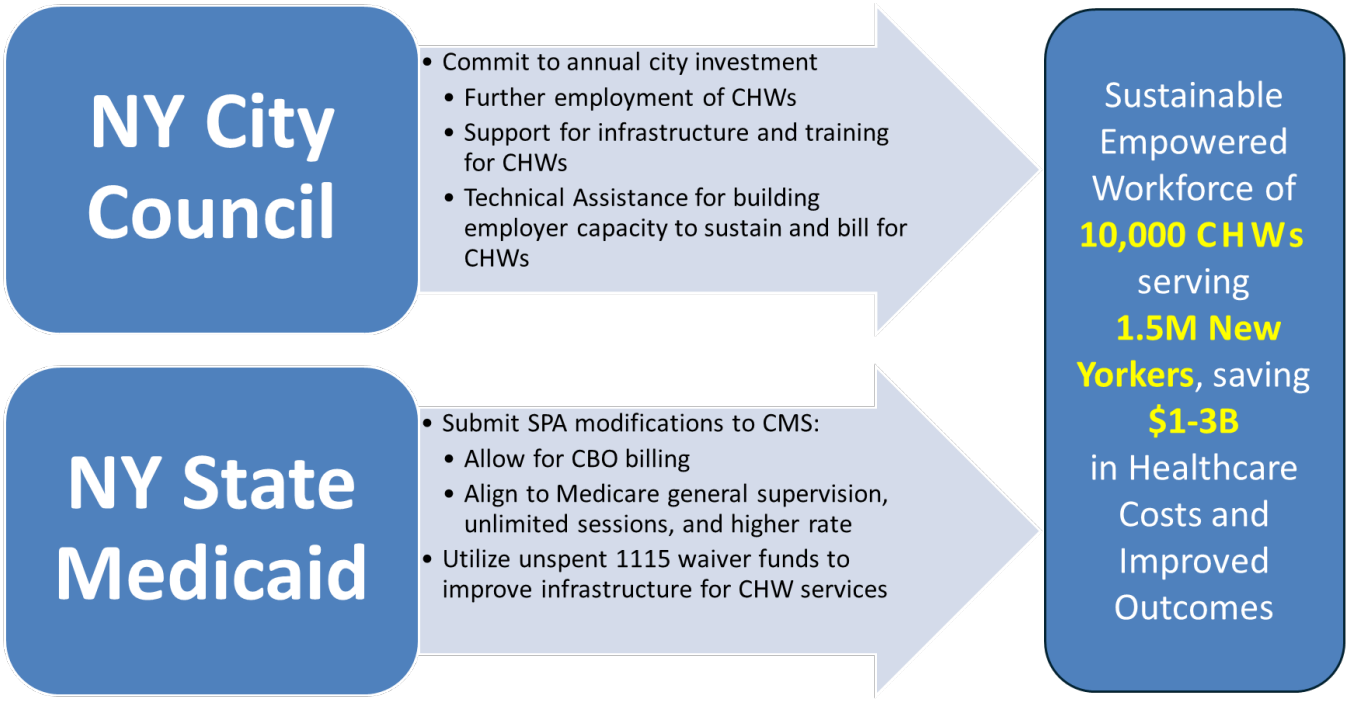
Using available programmatic data and national research, we estimate the costs, impact, and return on investment (ROI) of deploying CHWs across NYC to address chronic disease. We project that 10,000 CHWs embedded in NYC health care, public health, and social services sites could directly serve 1.5 million New Yorkers by 2030 at an annual cost of $1.1 billion. Our estimates of the sources of support for this workforce depend on the impact to NYC of changes to Medicaid under U.S. H.R. 1 - Public Law 119-21. Our estimates also assume that NYS enacts critical policy changes to expand support for CHW services. We estimate the annual costs will be shared across funding sources, with NYS (primarily Medicaid) contributing $215 million to $230 million (19% to 21%), the federal government (Medicare and the federal share of Medicaid) contributing $285 million (25%), and NYC along with other sources contributing $610 million to $630 million (54% to 56%). Without such state policy changes, a significantly larger share of CHW service delivery costs would fall to NYC and other local sources. Across all scenarios, the investment is expected to generate $1 billion to $3 billion in annual net savings for New Yorkers, after accounting for program costs.

In summary, a robust CHW mobilization across NYC would:

- **Deploy 10,000 CHWs by 2030** to serve 1.5 million New Yorkers, reduce chronic disease inequities, improve community safety, and build a frontline workforce for future public health emergencies.
- **Generate between $1 billion and $3 billion in annual health system savings** after accounting for program costs by investing in CHW services that reduce hospitalizations, improve chronic disease outcomes, improve affordability, and lower emergency department use.

And would require:

- **An investment of $660 million annually from city tax funds, grant funding, Medicaid plans, and employer contributions** to unlock Medicaid and Medicare reimbursement, support services not yet billable, and test scalable CHW models in high-need communities.
- **The expansion of current reimbursement mechanisms** to ensure sustainable payment for these activities, with coordinated state and city commitment and investment as outlined in the figure below:



CHWs Drive Impact, Nationally and Locally

The value of CHWs has been demonstrated through more than 60 years of research and evaluation, driving national progress in workforce recognition, sustainable financing, and care integration.[viii] Research shows that CHW-led interventions significantly improve chronic disease outcomes[ix,x] and contribute to increased self-efficacy, medication adherence, and patient engagement, particularly in communities that have historically experienced health care distrust.[xi] Appendix A highlights notable national success stories of CHW implementation and ROI. These CHW programs demonstrate both health and social impacts, such as meeting health-related social needs for managed care members, reducing A1C levels, and lowering rates of low-birth-weight deliveries, as well as strong financial returns, with some CHW-led interventions yielding up to $9 for

every dollar invested. As is the case nationally, CHWs in NYC operate across a range of contexts, from hospital systems to neighborhood-based organizations, sharing a common foundation of trust-building and culturally responsive care to help clients achieve their health goals.

The NYC Health Department has long invested in CHW programs to improve health outcomes and reduce inequities across the city's diverse communities, including programs serving people returning from incarceration, survivors of violence, new parents, youth needing sexual and reproductive health education, and individuals at risk of infectious diseases. One of the most notable examples is the sustained investment in CHW services to support people living with HIV. Both NYC and NYS have funded CHW training and employment to help individuals navigate social and health systems, coordinate care, and stay engaged in treatment. While HIV is an infectious disease, it shares important similarities with chronic conditions such as diabetes or asthma, as effective management depends on long-term engagement in care. CHW integration in HIV care has been critical to "bending the curve" on HIV and reducing, though not eliminating, health disparities. This integration has occurred both through direct employment in public health clinics and service providers, and through sustainable partnerships with CBOs that employ CHWs with lived experience. These lessons demonstrate how CHWs can be embedded into systems of long-term care management, offering valuable insights for addressing other chronic conditions across NYC.

Building on NYC's commitment to people-centered care and valuing lived experience, the NYC Health Department's investment in the doula and birth worker workforce reflects a parallel approach to supporting CHWs more generally, grounded in legislation, funding, and programmatic leadership. Groundbreaking research, such as the By My Side study on the effectiveness of doulas for birthing people,[xii] alongside initiatives such as the Citywide Doula Initiative,[xiii] highlight the city and state's longstanding commitment to supporting community-based workers who serve pregnant people. To address persistent health disparities in noncommunicable chronic diseases, a similar level of sustained investment and infrastructure is needed to support CHWs more broadly.

Other successful CHW implementations include the Harlem Health Advocacy Partners (HHAP) program, which provides health education, navigation, coaching, and advocacy for residents of NYCHA housing developments. Program successes include a higher percentage of participants reporting controlled blood pressure, participant satisfaction with program services, and acceptance of social service referrals. Additionally, the Violence Prevention Initiative supports members of violence-impacted communities through resources, referrals, and coaching in response to traumatic violent events. From 2010 to 2019, program areas reported an average 40% reduction in shootings, compared with a 31% reduction in comparison areas.[xiv] These programs, along with others supported by the NYC Health Department, underscore the city's deep commitment to developing the CHW workforce and advancing its impact on the health and well-being of New Yorkers.

Public Health Corps: The City's Historic CHW Investment

Building on NYC's successful CHW programs, PHC was launched in 2021 to support COVID-19 vaccination, prevention, treatment, and social needs screening and referral. PHC included two arms, one embedded within NYC H+H, the nation's largest public health care system, and the other within the NYC Health Department. This overview focuses on the community-based CHWs supported by the NYC Health Department, which continues to adapt to serve the chronic disease challenges and social inequities facing marginalized communities across the five boroughs.

The NYC Health Department's PHC has become a foundational workforce capable of responding to future public health emergencies while driving chronic disease prevention and health promotion efforts. During the COVID-19 pandemic, CHW outreach in 75 NYC communities delivered over 18 million tailored vaccine education contacts using a multipronged communication approach, boosting COVID-19 vaccine uptake from 44% to 76% and making 337,000 referrals to non-COVID health and social services.[xv] Additionally, PHC responded during the 2022 mpox outbreak by providing health education and supporting access to vaccinations, serving as the infrastructure for the NYC Health Department's mobile, community-based public health outreach.[xvi]

With the end of the COVID-19 public health emergency, PHC expanded the existing work of the Neighborhood Health Services in the Bronx, Harlem, and Brooklyn and priority neighborhoods in Queens and Staten Island to address health inequities and improve both respiratory and chronic disease outcomes through outreach, health education, and resource navigation. At present, PHC works with over 200 partners including CBOs; faith-based organizations; local businesses; clinical sites including Federally Qualified Health Centers (FQHCs), small practices, and large health systems; and city agencies such as NYCHA. PHC has strengthened public trust by maintaining a consistent, local presence, helping residents overcome barriers such as insufficient (or no) health care coverage, limited English proficiency, and poor transportation, and delivering culturally responsive services to underserved neighborhoods. In 2024, PHC consisted of 218 CHWs and 56 support staff including supervisors, program managers, and other administrative roles. PHC reached over 262,000 community members through outreach activities, conducted over 75,900 health education activities covering vaccines, diabetes, nutrition, hypertension, mental health, and opioid overdose prevention, and provided over 214,500 referrals to vaccination sites, food access resources, and health care and social services providers. The CHW workforce under PHC is currently employed through short-term contracts and grants, highlighting the need for sustainable funding mechanisms.

A Defining Moment for Expanding State and Local CHW Investments

From 2016 to 2020, the number of CHWs billing Medicaid across the country increased by over 600%, and the total number of CHW services provided to Medicaid beneficiaries grew 23-fold, led largely by states that adopted direct CHW billing.[xvii] Currently, 24 states reimburse CHW services through their Medicaid programs with an additional three states in the process of implementation.[xviii] Covered services typically include care coordination, navigation, coaching, advocacy, and clinical support.[xix] This rapid expansion reflects growing recognition of CHWs as vital to improving population health and advancing health equity.

In 2023, NYS approved Medicaid reimbursement for CHW services for priority populations through a State Plan Amendment (SPA), and in 2024 expanded reimbursement pathways through its 1115 Health Equity Reform (NYHER) waiver. Under the SPA, reimbursable services include health advocacy, health education, system navigation, and community violence prevention services when ordered and supervised by a Medicaid billing provider.[xx] The waiver expands the scope of Medicaid coverage to include services such as housing navigation, food security support, and care coordination, functions that closely align with CHW competencies. These state-level policies are consistent with NYC's long-standing investments in CHW programs that have demonstrated measurable impact. While NYC does not directly control Medicaid funds, it is well positioned to align existing CHW efforts with new state funding streams, deepen program integration, and advocate for sustained investment, further solidifying our position as a national leader in CHW integration.

Despite the opportunity for sustainability created through the recent changes in state policy, many CHW employers across the state continue to face challenges in accessing financial support for their programs. For

example, most CBOs are not eligible to bill Medicaid for CHW services under the NYS SPA. And while the waiver does provide an opportunity for expanded billing by CBOs, its current design does not require covered services to be delivered by CHWs, nor does it cover many of the services provided by CHWs.[xxi] These gaps in reimbursement policy, along with implementation challenges faced even by eligible Medicaid billers such as FQHCs, create inequities in sustainable CHW employment. They also restrict access to funds needed to expand impactful community programs. While recent policy advances are promising, further advocacy is needed to ensure that more organizations delivering vital CHW services are adequately compensated for doing so.[xxii] Key policies that will need to be implemented by NYSDOH and its Office of Health Insurance Programs to address these barriers and provide adequate opportunity for long-term CHW sustainability include:

- **Enabling CBO billing**: Modify SPA requirements to allow CBOs to directly bill for CHW services, reflecting their central role in delivering culturally responsive, community-rooted care. (See Appendix B: Billing Strategies and Needed Changes in Medicaid Billing Policy for CBOs.)
- **Aligning with Medicare policy**: Adopt key flexibilities introduced under the Medicare Community Health Integration (CHI) benefit effective January 1, 2024, including removing the 12-unit annual cap on billable services, matching reimbursement rates, and allowing CHWs to operate under "general" rather than "direct" supervision, facilitating more community-based work.[xxiii]
- **Extending service time limits**: Increase the 30-minute monthly cap to reflect the time needed for CHWs to build trust and deliver effective support.
- **Improving reimbursement rates and reducing administrative barriers**: Ensure payments are sufficient to support sustainable CHW employment and streamline billing to reduce administrative burden. (See Appendix C for estimates of needed CHW reimbursement rates for sustainability.)
- **Supporting program-level accreditation**: Promote accreditation of CHW training programs to ensure workforce quality while lowering entry barriers for CHWs from diverse backgrounds.
- **Addressing infrastructure needed to grow CHW workforce:** Utilize unused 1115 Waiver funds to develop greater training and professional development systems as well as job placement programs to build out the CHW workforce across potential NYC employers.
- **Exploring carve-outs or directed payments through MCOs:** Incentivize CHW employment and needed infrastructure in CBOs.

These changes by NYS combined with efforts by NYC would help unlock the full potential of CHWs and maintain long-term workforce capacity across a range of care settings.

Estimating the Fiscal and Public Health Impact of CHW Expansion

Using methods adopted from peer-reviewed research, we estimate that in 2024 PHC led to an estimated 220 preventable hospitalization events avoided among deeply engaged participants, such as NYCHA residents receiving health coaching. Using conservative Medicaid cost estimates, avoided hospitalizations, and reduced acuity among those who are hospitalized accounted for $4.8M in savings.[xxiv] (See Appendix D: Estimated Savings in 2024 from Prevented and Reduced Acuity of Hospitalizations by PHC in NYC.)

The NYC PHC demonstrates measurable impact on health outcomes and cost savings, making a strong case for long-term investment. While these results from PHC demonstrate the value of CHWs in NYC, it represents just one segment of the broader CHW landscape. We estimate that NYC requires 10,000 CHWs citywide across public health, health care, and CBOs to deepen and expand their impact on chronic disease. (See Appendix E's

Summarized Estimate of CHW Need in NYC.) NYC has an opportunity to scale and sustain a more robust CHW infrastructure, reaching an estimated 1.5 million New Yorkers by 2030 at an annual cost of approximately $1.1 billion. (See Appendix F: Estimated System Cost of CHWs.)

The projected ROI for scaling CHW services across NYC's health system is significant. Based on conservative estimates of engagement levels, we project total annual savings of $1 billion to $3 billion after accounting for program costs through reductions in avoidable hospitalizations and lower acuity. This includes higher ROI from intensive, personalized CHW services (15% of the workforce, often delivered by CBOs) and moderate ROI from broader community engagement (85%). Overall, the net ROI of $1 billion to $3 billion substantially exceeds the estimated $1.1 billion annual cost of sustaining a CHW workforce of 10,000. (See Appendix G: Estimated Savings from CHW Interventions in NYC.)

Realizing these savings, however, requires the critically important policy changes outlined in the previous section to provide sustainable support for this workforce. Appendices H1 (Estimated Financial Sources Needed for Ongoing Support of CHWs Under E*xisting* NYS Policy Conditions and Low Impact of H.R. 1) and H2 (Estimated Financial Sources Needed for Ongoing Support of CHWs Under *Ideal* NYS Policy Conditions and Low Impact of H.R. 1) compare funding sources under the current policy environment and limited impact of H.R. 1 with those under a more favorable NYS policy environment. With the proposed NYS policy changes and limited impact of H.R. 1 on the city, the ongoing costs of supporting this workforce could be covered by:

- NYS: 20%
- Federal support: 25%
- Other sources: 55%

Other sources include city tax funds, managed care organizations, and philanthropic organizations, as well as support from employers that directly hire CHWs. Additional resources will be needed to build the upfront infrastructure required to leverage new billing opportunities, particularly for CBOs. The NYHER waiver is a key source of these funds, supplemented by philanthropic and health care system support.

While estimates of funding sources will shift depending on federal legislation, the core opportunity is clear: CHWs have consistently demonstrated their capacity to reduce costs. At a time of reductions in federal funding, their role is even more vital.

Getting to 10,000 CHWs by 2030 to Reduce Chronic Disease Inequities

The NYC Health Department is well positioned to lead a comprehensive expansion of the CHW workforce. By building on its history of supporting CHWs, it can fundamentally transform how the city addresses chronic disease, health equity, and emergency preparedness. Drawing from the proven success of PHC, which delivered 18 million vaccine education contacts and generated $4.8 million in annual savings, it is possible to scale CHW services to reach 1.5 million New Yorkers by 2030 with an estimated return of between $1 billion and $3 billion annually. (See Appendix I: Pandemic Response: Closing Vaccination Equity Gaps.) As the city expands the CHW workforce by 5,500 to 6,500, the NYC Health Department's experience in training and employing CHWs, along with its broader infrastructure of community relationships, educational resources, programs, data systems, and partnerships, will be vital to supporting this growth.

In this work, there are three key roles for the NYC Health Department:

1. Directly Deploy CHWs:

- **Scale internal capacity**: Mobilize resources, convert unfilled positions to permanent CHW positions focused on chronic diseases, and expand agency-led platforms that support CHW employers.
- **Expand Article 28 billing**: Complete Certificate of Need approval to enable Medicaid reimbursement at all NYC Health Department sites.
- **Create CHW hubs in each Neighborhood Health Action Center (NHAC)** to serve as a coordination point for training, supervision, and deployment of resources, strengthening the CHW infrastructure while anchoring services in trusted institutions. Expand the NHAC model to include one site in Queens and one site in Staten Island.
- **Strengthen emergency response infrastructure**: Maintain a deployable CHW workforce of 200-plus people for future respiratory pandemics, extreme weather events, and emerging health threats.
- **Conduct demonstration projects** such as the 2025 Jamaica Sexual Health Clinic pilot now underway.
- **Invest in an additional 1,000 CHW city-employed workforce as a part of the 10,000 needed across the city**. A city-funded and unionized workforce allows for positive impacts on worker protections and helps to strengthen the overall public mobilization for CHWs.

2. Build Local Capacity:

- **Support 1,000 additional CHWs** across FQHCs, small practices, and CBOs through NYC REACH and PHC technical assistance, trainings, and shared staffing models for program design, billing, and operations. (For more information on the NYC Health Department training program, see Appendix J: NYC REACH's CHW Accelerator Program Curriculum.)
- **Integrate CHWs into major Health Department contracts** with community partners to establish CHW workforce development in chronic disease as a standard deliverable.
- **Establish CHW hubs** in priority neighborhood public health locations in each borough to coordinate services across local CBOs.
- **Foster CHW leadership** and professional development in collaboration with local, state, and national CHW organizations.

3. Innovate, Evaluate, and Set Standards:

- **Track health outcomes:** Measure A1C control, blood pressure management, preventive care uptake, and emergency department utilization among CHW-served populations using electronic health record integration.
- **Document cost savings:** Quantify avoided hospitalizations, reduced emergency department visits, and improved medication adherence using Medicaid claims analysis and control group comparisons.
- **Assess workforce sustainability:** Evaluate CHW retention rates, career advancement, compensation, and job satisfaction across employment settings using annual workforce surveys.
- **Measure community-level impacts**: Assess impacts on community trust, civic engagement, and social cohesion among participants through qualitative and mixed methods and community health assessments.

- **Advance training opportunities and standards:** Further develop and integrate NYC Health Department CHW training curriculum and standards based on C3 Core Consensus standards for utilization and modelling across NYC.
- **Create pathways for sustainable funding:** Support efforts to expand and optimize CHW billing policies and encourage managed care participation to ensure scaling and sustainability of the workforce.[xxv]

This expansion represents more than workforce development — it establishes CHWs as essential public health infrastructure capable of addressing both chronic health inequities and acute emergencies while generating substantial ROI through improved health outcomes and reduced health care costs. Success requires coordinated action across city agencies, state Medicaid policy reform, and sustained financial commitment to this evidence-based approach to health equity.

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Appendices

A. National Examples of CHW Impact

Key Chronic Disease-Focused CHW Programs in the United States		
Program	**Program Overview**	**Impact**
Individualized Management for Patient-Centered Targets (IMPaCT)	*Place:* Philadelphia *Site*: Academic health center *Population:* Medicaid members with chronic diseases *Ratio of CHWs to client*: 1:10 *Intervention focus*: coaching and care navigation	In randomized trials, it showed a **38% reduction in hospital days** and a **$2.47 return on every $1 invested**, largely from reduced inpatient utilization among Medicaid beneficiaries. The model has been **adopted by over 50 organizations across 18 states.**[xxvi]
South Side Health Collaborative and ACCESS Community Health Network	*Place:* Chicago *Sites:* Community health centers *Population:* Uninsured and Medicaid-insured clients with diabetes and/or asthma *Intervention focus*: Home care for coaching and care navigation	CHW interventions resulted in a **reduction in pediatric asthma ER visits by 39%** and improvement in caregiver quality of life.[xxvii]
Massachusetts State-Supported CHW Ecosystem[xxviii]	*Place:* State of Massachusetts *Sites*: Various, integrated into care teams across hospitals, public health agencies, and CBOs *Population*: Pediatric Medicaid members with asthma *Intervention focus:* Care navigation and coaching	A study on Massachusetts' expansion of CHW models to address pediatric asthma found that over a one-year period, **$566.58 per patient** or a **total of $774M** (in 2019 US dollars) in MassHealth expenditures could be saved across the 1,367 children in the study.[xxix]
Medicaid Managed Care Organization (MCO)	*Place*: Pittsburgh *Sites*: Medicaid Managed Care *Population*: Medicaid members *Ratio of CHWs to client:* 3 CHWs to 4 neighborhoods *Intervention focus*: Care navigation	CHWs addressed **housing (for 28% of MCO members), food (17%), clothing (28%), utilities (11%), transportation (41%), and child care needs (43%)** and helped members address **quitting tobacco/smoking behavior (39%) and alcohol use disorder (15%).**[xxx]
Diabetes Impact Project - Indianapolis Neighborhoods (DIP-IN)	*Place*: Marion County, IN *Sites*: Public hospital system-based *Population*: Communities with high rates of diabetes *Ratio of CHWs to client:* 2 CHWs in each community *Intervention*: Diabetes management education, screening, and resource referral	Participants had a **significant reduction in A1C** and had **2.3 times increased odds of two or more A1C measures** in the year. The CHW program was also associated with **12% lower odds of ED visits** and **19% lower odds of hospital admission.**[xxxi]

Community Health Access Project (CHAP)[xxxii]	*Place*: Several counties across Ohio *Sites*: CBO *Population*: Census tracts with high rates of low birth weight *Intervention*: Pathways model of identification of risk, resource referral, and closed loops	Women enrolled in CHAP had **significantly lower adjusted odds of low-birth-weight** delivery. With the program **preventing an estimated one low birth weight per 11 clients,** the long-term **cost savings was over $5 for each dollar invested.** [xxxiii]
AccessHealth SC	*Place*: Several Counties across South Carolina *Sites*: Health and Social Service Organizations *Population*: High-risk, low-income patients *Intervention*: Outreach, referrals, and care navigation	Four different CHW programs across SC were assessed to measure reduced hospitalizations/ED visits and improved access and equity. There was an **ROI of up to $9 per $1 invested.**[xxxiv]

B. Billing Strategies and Needed Changes in Medicaid Billing Policy for CBOs

	CHW Employed at Medicaid-Enrolled Licensed Provider and Services Ordered by a Licensed Provider		CHW Employed at CBO			
	CHW directly under super-vision of Medicaid biller within licensed facility	**CHW under super-vision of Medicaid biller outside licensed facility**	**CHW employed by CBO credentialed at licensed provider**	**CHW employed by CBO that belongs to SCN**	**CHW employed by CBO that is part of an IPA**	**Indepen-dent CBOs**
CHW Work Setting	FQHC, hospital, or NYC Health Depart-ment clinic	Social service settings outside the facility's licensed clinic	CBOs that employ CHWs and provide services to patients of a licensed provider	CBOs join SCN; CHWs provide navigation, education, coaching	CBOs affiliated with IPA that is a Medicaid biller	CBOs not Medicaid billers
Reimburse-ment under State Plan Amendment?	Yes	No	Yes (licensed provider bills)	No under SPA	Unknown/ unlikely	No
Policy Status	Policy changes needed to enhance uptake; address FQHC same-day billing	Policy changes needed to allow billing under SPA; waiver-approved services billable in some instances	Licensed provider billing allowed; policy changes needed to allow CBO billing under SPA	Policy changes needed to allow CBO billing under SPA; waiver-approved services billable	IPAs cannot use Medicaid billing number to support CBOs without their own; policy changes needed to allow billing by CBO under SPA	Policy changes needed to allow CBO billing under SPA

C. Estimates of Needed Reimbursement Rate for Improved CHW Billing Uptake

To improve uptake of CHW billing and more accurately compensate for the complete value of CHW services, reimbursement rates must be raised commensurate with evidence-based programs in peer states, as shown in the table below.

PHC Evaluation Measures	Data	Source
Approach #1: Match peer state rate of reimbursement with cost-of-living adjustment		
New Mexico's CHW and CHR benefit rate (per 30 minutes)	$50.10	NM Physician Fee Schedule[xxxv] Study of CHW Cost Effectiveness for NM Medicaid Managed Care[xxxvi]
Cost of Living Adjustment New Mexico to New York	$79.66	Forbes Advisor Cost of Living Calculator[xxxvii]
Increase in Reimbursement Rate from Current NYS Medicaid Rate	**128%**	**Calculation**
Approach #2: Match peer state rate of reimbursement with cost-of-living adjustment		
Estimated CHW Salary and Fringe and Supervision Costs	$112,500	See Appendix F
Number of Working Hours (per year)	1,715	Assuming 49 weeks at 35 hours/week
Reimbursable Hours (50% of total work is billable)	857	See Appendix E
Necessary Reimbursement Rate to Cover Expenses in Billing (per hour)	$131.20	Calculation
Necessary Reimbursement Rate to Cover Expenses in Billing (per 30 minutes)	$65.60	Calculation
Increase in Reimbursement Rate from Current NYS Medicaid Rate	**87%**	**Calculation**
Approach #3: Align to New York adjusted Medicare rate for CHW Services		
Medicare Rate in NYC (Manhattan), Non-Facility Rate for Community Health Integration Services (per hour)	$88.58	Medicare Physician Fee Schedule[xxxviii]
Medicare Rate in NYC (Manhattan), Non-Facility Rate for Community Health Integration Services (per 30 minutes)	$44.29	Calculation
Increase in Reimbursement Rate from Current NYS Medicaid Rate	**27%**	**Calculation**

D. Estimated Savings in 2024 from Prevented and Reduced Acuity of Hospitalizations by PHC in NYC

PHC Evaluation Measures	Data	Source
Individuals reached by PHC in 2024	116,000	PHC 2024 individual encounters through individual-level/patient outreach
Deep engagement rate	1%	Deep engagement assumes more than 10 CHW interactions over 24 months[xxxix]
Deeply engaged individuals	1160	Calculation
Admissions per patient year for non-CHW supported patients	0.64	Reference[lviii]
Admissions per patient year for CHW-supported patients	0.45	Reference[lviii]
Avoided admissions	220	Calculation
Estimated total (facility and professional) Medicaid cost per admission	$16,478	Reference[lviii]
Avoided costs due to avoided admissions	**$3,631,751**	**Calculation**
Case-mix-adjusted per admission cost for non-CHW supported patients	$17,302	Reference[lviii]
Case-mix-adjusted per admission cost for CHW-supported patients	$15,159	Reference[lviii]
Savings per admission	$2,142	Calculation
Admissions with CHW support via PHC	522	Calculation
Savings from decreased acuity of admissions	**$1,118,197**	**Calculation**
Total Estimated Medicaid Cost Savings	**$4,749,948**	**Calculation**

E. Calculation of CHW Need in NYC

Estimation Type	Notes/References	Calculation of Needed CHWs
Baseline estimate for full time CHWs working 100% of capacity	3 per 10,000 for adults living in metro area with household income less than $25,000[xl] 1 per 10,000 for adults living in metro area with household income more than $25,000 NYC (estimated populated 8.5M) poverty rate: 1 in 4 New Yorkers (income estimates of $47,190) [xli] **HRSA estimates (1 to 3 CHWs per 10,000) are likely very conservative for the NYC market**	NYC population: 8.5 million 75% above poverty rate need 1 per 10,000: 637.5 25% below poverty rate need 3 per 10,000: 637.5 **Total: 1,275 CHWs**
Adjusted based on actual CHW capacity to deliver services	~50% of time spent by REACH team on service delivery **Time constraints related to actual service delivery indicate a doubling of CHW capacity needed** (two times HRSA estimate = 2 to 6 CHWs per 10,000)	75% need 2 per 10,000: 1,275 25% need 6 per 10,000: 1,275 **Adjusted total: 2,550 CHWs**
Adjusted based on intensity of service delivery, challenges of NYC	% of adults in NYS with one, two, or three or more chronic conditions: 24.1%, 18.4%, 32.4%, respectively[xlii] 21% of adults struggle with mental illness and 5% with Serious Mental Illness[xliii] **CHW need should be adjusted based on chronic disease prevalence and complexity of NYC health market (Using HRSA as a base, 25% need 3 to 4 CHWs per 10,000, 75% need 8 to 12 per 10,000)**	25% of NYC needs 3 to 4 CHWs per 10,000: 637 to 850 75% need 8 to 12: 5,100 to 7,650 **Adjusted total: 5,738 to 8,500 CHWs**
Using IMPaCT Care CHW model	CHWs had a case load of 55 individuals with two chronic diseases on Medicaid or uninsured[xliv] **CHWs need to be staffed to facilitate more intensive engagement to achieve desired health outcomes and estimated savings**	NYC population with Medicaid or uninsured: ~5 million **50% have two or more chronic conditions** **Total: 45,450 CHWs** **Adjusted total based on estimated uptake of 25% (1.1 million people):**

		11,364 CHWs
Adjusted based on global research for CHW need	The only comprehensive assessment of the required CHW population ratio is based on a study done in Africa that estimated a need for 11 to 29 CHWs per 10,000 people. In this estimate, CHWs spent 65% of their time in care delivery, including primary care and maternal health.[xlv] **Evaluation of global CHW models indicate a high need for CHW service delivery. At present, NYC health providers mitigate some of this demand.**	Based on entire NYC population: **Total: 9,350 to 24,650**
Conclusion: Estimated need in NYC: 10,000 CHWs		

Summary of Estimation of CHW Need in NYC	
Estimation Type	**Estimated Range of CHWs**
HRSA Baseline	1,275
Adjusted HRSA Baseline for Capacity per REACH experience	2,550
Adjustment for NYC Chronic/Mental Health Burden	5,738 to 8,500
IMPaCT Care CHW Model Estimation based on case load for 25% uptake of NYC Medicaid or uninsured patients with two or more chronic conditions	11,364
Estimation based on Universal Coverage through Primary Care CHWs in Global Health context	9,350 to 24,650
Triangulated Final Estimate	**10,000 CHWs**
NYC's health complexity calls for scaling CHW workforce beyond conservative benchmarks	

F. Estimated System Cost of CHWs

CHW System Components	Cost	Evaluation Type
Number of CHWs	10,000	See Appendix C
CHW salary	$75,000	Estimate
Fringe, supervision, overhead	50%	Estimate
Total cost per CHW	$112,500	Calculation
System Cost (per 10,000)	**$1.1 billion**	**Calculation**

G. Estimated Savings from CHW Interventions in NYC

CHW Cost Components	CHW Allocation (estimate)	Cost (per year)	Low ROI	High ROI	Estimated Savings (per year)	
Total cost for 10,000 CHWs		$1.1 billion				
Intensive engagement	15%	$168 million	$2	$9	$337 million	$1.5 billion
Broader engagement	85%	$1 billion	$1	$1.5	$956 million	$1.4 billion
Total					**$1.29 billion**	**$2.95 billion**

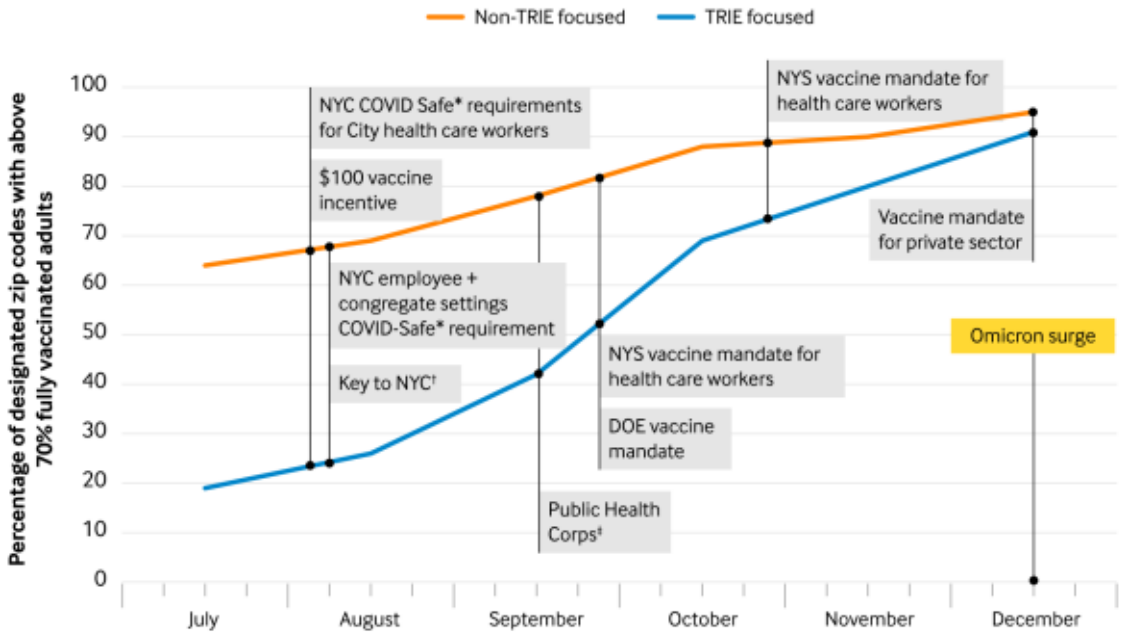
H1. Estimated Financial Sources Needed for Ongoing Support of CHWs Under *Existing* NYS Policy Conditions and Low Impact of H.R. 1

Payment for CHWs	Cost	Calculation
Total cost of providing CHW services	$1.1 billion	See Appendix E
Percentage billable to Medicaid	~30% of CHWs in clinical settings at 40% of time billable = 12% ~35% of CHWs are at CBOs but must be in SCN and providing specified HRSN services (~20%) at 40% of time billable = 8% —> Total % Billable = 20% ($220 million)	Estimate based clinical billing available through SPA and selective CBO billing available through waiver; post estimated loss of Medicaid coverage due to HR1
Percentage billable to Medicare	Remainder of clinical CHWs working in Medicare-funded employers ~10% ($110 million)	Estimate based on early uptake of new Medicare benefit
Cost of CHWs borne by CTL, grant funding, MCO, and employer contributions	**70% ($770 million)**	**Remainder based on Medicare/Medicaid shortfall**

H2. Estimated Financial Sources Needed for Ongoing Support of CHWs Under *Ideal* NYS Policy Conditions and Low Impact of H.R. 1

Payment for CHWs	Cost	Calculation	Policy Conditions to Achieve
Total cost of providing CHW services	$1.1 billion	See Appendix E	
Percentage paid by State (Medicaid)	21% ($230 million)	Estimate based on SPA and waiver coverage; post loss of Medicaid coverage due to HR1[xlvi]	Allow for CBO billing of Medicaid for CHW services Removal of CHW frequency limit Medicaid requirement of MCOs to utilize CHW services
Percentage paid by federal (Medicare direct billing and coverage of a portion of State Medicaid)	25% ($285 million)	Estimate based on early uptake of new Medicare benefit and federal portion of Medicaid	Improve uptake of CHW services and reimbursement by Medicare providers
Percentage paid by local sources (CTL, grant funding, MCO, and employer contributions)	**54% ($610 million)**	**Remainder after Medicare/Medicaid coverage**	

I. Pandemic Response: Closing Vaccination Equity Gaps



TRIE = Taskforce on Racial Inclusion & Equity, DOE = Department of Education, NYC = New York City, NYS = New York State

* NYC COVID Safe is a requirement to show proof of vaccination or testing negative for Covid-19.

† Key to NYC is a mandate requiring that anyone age 5 and older show proof of vaccination to enter indoor dining, fitness, entertainment, and certain meeting spaces.

‡ The launch of Public Health Corps allowed PACE to increase the number of contracts with CBOs from 33 in July 2021 to 64 in September 2021.

Source: NYC Health

J. NYC REACH's CHW Accelerator Program Curriculum

The NYC Health Department's NYC REACH program aims to advance primary care through support and innovation. NYC REACH partners with primary care practices, pharmacies, and CBOs and provides training, resources, and technical assistance with optimizing health information systems, quality improvement, and value-based initiatives to better serve their patients and communities. NYC REACH offers a CHW Accelerator Program — a structured training program designed to prepare the next generation of CHWs across NYC. This program combines a robust series of virtual trainings, aligned with the National C3 Council's CHW core competencies, with immersive, on-the-job experience either at the NYC Health Department's Gotham Center location or at participating clinical practice sites. CHWs are required to complete our training series of 12 virtual modules prior to deployment. The trainings address the National C3 Council's 11 core competencies and equip CHWs with the skills needed to improve health, aid community development, and increase access to systems of care.

Training Type	NYC REACH Accelerator Program Trainings	C3 Core Competencies Addressed
Interpersonal and Communication Skills Trainings	Behavioral Health PHQ9 Training	Communication, Interpersonal skills and relationship-building, capacity building, advocacy, individual and community assessment, outreach, professionalism and conduct
	Behavioral Health Language and Engagement Training	
	Coping Strategies	
	Implicit Bias Training	
	Public Health Communication and Misinformation	
	Advocacy Training	
	A Day in the Life of a Community Health Worker	
Clinical Skills Trainings	Foundations of Public Health	Education and facilitation
	Hypertension and QI Training (Parts I and II)	
	Diabetes Prevention and Self-Management Training	
Technology Skills Trainings	Microsoft 101 Training	Service coordination and research
	Community Platforms Training	

We aim to expand access to our CHW training offerings to NYC educational institutions and community partners. New York, like most other states, does not have statewide requirements for CHW training programs. By following the C3 standards, which are approved and used by policymakers, funders, trainers, and health and social service organizations nationwide, we will ensure that our trainings are comprehensive and increase our likelihood of future accreditation by NYS. Our long-term vision is for these partners to adopt and adapt the CHW Accelerator curriculum, equipping students and community-based staff with the foundational skills and recognized competencies needed for public health careers.

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