THW Billing Guidance Document

Oregon Health Authority

Transformation Center

May 2025

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Executive summary

Traditional health workers (THWs) are trusted individuals from their communities who may also share socioeconomic ties and lived experiences with health plan members. THW is an umbrella term for multiple specific worker types who have historically provided person and community-centered care by bridging communities and the health systems that serve them. THWs increase the appropriate use of care by connecting people with health systems, advocate for health plan members, support adherence to care and treatment, and empower individuals to be agents in improving their own health.

Traditional health workers include:

- Community health workers (CHWs)
- Birth doulas
- Personal health navigators (PHN)
- Peers: Peer wellness specialists (PWS) and peer support specialists (PSS)
    - PSSs can be specific to families, youth, adult addictions or adult mental health.
- Tribal health workers

THWs can be paid for providing services to Medicaid members using a variety of payment models and funding streams, including fee-for-service billing. THWs can provide services in traditional clinical settings or non-traditional settings like in the member's home or in a community setting.

This document aims to clarify billing processes and requirements for traditional health workers by providing:

- An overview of the billing process.
- Instructions on how to bill for THW services.
- Details about various payment models for THWs.
- Links to payment-related resources for CCOs and their clinical and community partners.

Overview

Traditional health workers (THWs) are an integral part of the Oregon health system. THWs work in many settings around the state to address health and social needs in their community. The state of Oregon and the Oregon Health Authority (OHA) are invested in the advancement and integration of THWs as a key strategy to reach the triple aim of better health, better care and lower costs. THWs are crucial to achieving health equity and improved access to care. The Oregon Health Plan and Oregon's coordinated care organizations (CCOs) offer multiple ways to pay for THW services.

This document provides:

- An overview of the billing process.
- Instructions on how to bill for THW services.
- Details about various payment models for THWs.
- Links to payment-related resources for CCOs and their clinical and community partners.

This document was prepared for the OHA Transformation Center by the Oregon Rural Practice Based Research Network.

The Transformation Center is the hub for innovation and quality improvement for Oregon's health system transformation efforts to achieve better health, better care and lower costs for all. The center identifies, strategically supports and shares innovation at the system, community and practice levels. Through collaboration, the Transformation Center promotes initiatives to advance the coordinated care model.

Oregon Rural Practice Based Research Network (ORPRN) is a statewide network of primary care clinicians, community partners and researchers dedicated to studying the delivery of health care, improving the health of Oregonians and reducing rural health disparities. Since ORPRN's start in 2002, they have completed more than 80 funded projects and are nationally recognized for expertise in practice facilitation and implementing patient-centered primary care home practice redesign initiatives. ORPRN's mission is to improve health and equity for all Oregonians through community engaged research, education and policy.

Accessibility

Language Access Services Policy

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille

- Large print
- Audio and other formats

If you need help, please contact:

- Web: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/index.aspx
- Email: Transformation.Center@odhsoha.oregon.gov
- Phone: 971-304-9642, 711 TTY. We accept all relay calls
- Mail: Transformation Center 421 SW Oak St., Suite 750, Portland, OR 97204

About traditional health workers

THWs are trusted individuals from their communities who may also share socioeconomic ties and lived experiences with health plan members. THW is an umbrella term for multiple specific worker types who have historically provided person- and community-centered care by bridging communities and the health systems that serve them. THWs increase the appropriate use of care by connecting people with health systems, advocate for health plan members, support adherence to care and treatment, and empower individuals to be agents in improving their own health.

Traditional health workers include:

- Community health workers (CHWs)
- Birth doulas
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- Peers: Peer wellness specialists (PWSs) and peer support specialists (PSSs)
    - PSSs can be specific to families, youth, adult addictions or adult mental health.
- Tribal health workers

THW training and certification

THWs must be trained and certified by the state. To become a THW in Oregon, an individual must:

1. Complete an OHA-approved training, qualify under the Legacy Clause or receive reciprocity. See more details below.
2. Complete an OHA-approved oral health training.
3. Create an account and apply through Oregon's Health Workforce Registry.
4. Complete a background check.

Note: Spanish-speaking individuals may submit a THW application in Spanish after completing steps 1 and 2 above.

Other pathways to becoming a state-certified THW include the Legacy Clause or reciprocity.

The **Legacy Clause** allows individuals who have been actively working as THWs and have lived experience to receive an exemption from some THW training requirements. To qualify for the Legacy Clause:

- CHWs, PWSs or PHNs must have verifiable evidence of working or volunteering in that role for at least 3,000 hours in the last five years.
- PSSs must have verifiable evidence of working or volunteering as a PSS for at least 2,000 hours in the last five years.
- Birth doulas must have verifiable evidence of attending 10 births and providing 500 hours of community work supporting birthing persons and families as a birth doula.

Steps to apply to be a THW through the Legacy Clause are:

1. Complete an OHA-approved oral health training.
2. Obtain at least one letter of recommendation from any previous employer for whom THW services were provided within the last five years.
3. Apply through Oregon's Health Workforce Registry.
4. Complete a background check.

Reciprocity allows THWs who are certified in Washington or Idaho to receive an exemption from some of Oregon's THW training requirements to provide THW services in Oregon. To qualify for reciprocity:

1. Complete and submit the reciprocity form.
2. Complete an OHA-approved oral health training.
3. Complete a background check.

Training and certification are the first steps toward a THW being able to bill Medicaid for covered services provided to members. For a THW to bill for covered services, additional steps are required. See details in the THW requirements for billing section below.

THW training and certification resources:

- OHA-approved THW trainings
- OHA-approved oral health trainings
- Oregon Health Workforce Registry
- Spanish language THW application
- THW application tips
- Reciprocity form

THW requirements for billing

THWs must meet certain requirements to bill for Medicaid services:

- Complete **training and certification** (see details above).

- Obtain a **National Provider Identifier (NPI)** (request an NPI from CMS).
- **Enroll as a Medicaid provider** with the Oregon Health Plan (see OHA's provider enrollment webpage). The Provider Enrollment Guide also has detailed instructions on enrollment.
- **Enroll as a provider with your CCO** (contact your CCO for details).
- Arrange for **clinical supervision** by a licensed health care provider (see details below).

THW clinical supervision: THWs, except doulas, must be supervised by a Licensed Health Care Professional (LCHP) to bill for services. The services provided by the THW must be within the scope of practice of the licensed health care provider. The LCHP is responsible for the THW's work. LCHPs who can supervise THWs include:

- Physicians
- Nurse practitioners
- Physician assistants
- Dentists
- Dental hygienists with an expanded practice permit
- Ph.D. psychologists
- PsyD psychologists
- Licensed clinical social workers
- Licensed professional counselors

In addition to clinical supervision, many THW programs are managed by clinic or organization staff who are not licensed health care providers. This is not a substitution for clinical supervision requirements.

Health care service organization requirements for THW billing

Health care service organizations can include community-based organizations, health clinics, hospitals, behavioral health institutions and more. To bill for THW services, an organization must:

- Enroll with the Oregon Health Authority as a billing provider. View the application on the Provider Enrollment webpage. Search for "Billing provider (clinic/group billing)."
- Enter into an agreement with a CCO to provide THW services, typically through a contract structured as a payment model or an agreement for the CCO to fund services through a Medicaid spending flexibility.
- Offer supervision by a licensed health care provider. Often this means employing or partnering with a licensed health care provider.

There are no special requirements for providing THW services; however, more requirements may apply to certain types of organizations, especially clinical or behavioral health organizations. For example, a certificate of approval (COA) is required for certain organizations that employ unlicensed providers to deliver behavioral health services. A COA is not required for peers to provide covered services in settings outside

of specialty behavioral health settings, like a primary care clinic or community-based organization.

While not required, health care service organizations with THW programs typically provide administrative support for THW billing. This often includes:

- Guidance and support for documentation, including information systems or documentation collection forms.
- A process to verify patient's current Medicaid coverage.
- Creating and sending claims to CCOs on a regular basis (as often as daily, or at least quarterly).

CCO requirements for THW billing

CCOs must meet a variety of requirements according to their contract with the Oregon Health Authority. Some requirements are specific to THWs, including:

- Receiving, reviewing and paying claims for covered services provided by credentialed and approved health care providers with whom the CCO has a contract.
- Designating a THW liaison: Each CCO is required to have a THW liaison to support advancement of THWs in their CCO and community.
- Reporting: Submit regular deliverables on THW integration, utilization and payment models (learn more on the CCO traditional health worker deliverables webpage).
- Meeting other requirements for THW networks and service provision outlined on the CCO traditional health worker webpage.

About Medicaid billing

Billing is the process of submitting a claim to a CCO or OHA for services provided to Oregon Health Plan (OHP) members. A claim is a form with details about the service(s) provided to a member, requesting payment for services.

Key Terms

Oregon Health Plan (OHP): OHP is Oregon's medical assistance program. It provides health care coverage for people from all walks of life. This includes working families, children, pregnant adults, single adults and seniors.

Coordinated care organization (CCO): A CCO is a network of all types of health care providers who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

Open Card: A fee-for-service (FFS) option for some OHP members that allows individuals to see any healthcare provider who accepts OHP. Individuals with other health insurance coverage (for example, an employer-sponsored health plan) must be an Open Card member and tribal members are allowed to remain on Open Card.

Health care provider: an individual who is trained and licensed to provide health care services to Oregon Health Plan members. Examples include THWs, nurses, social workers and physicians.

Health care service organization: an organization or business that is licensed to manage and bill for the provision of health care services. Examples include health clinics, hospitals and community-based organizations.

Member: an individual living in Oregon who is eligible for and has signed up to receive health care benefits through the Oregon Health Plan.

Claim: a request for payment for health care services, including details about the service(s) provided, patient/member, health care provider, location of services, and diagnosis or reason for service(s).

Encounter: proof of services provided, including information about the services provided.

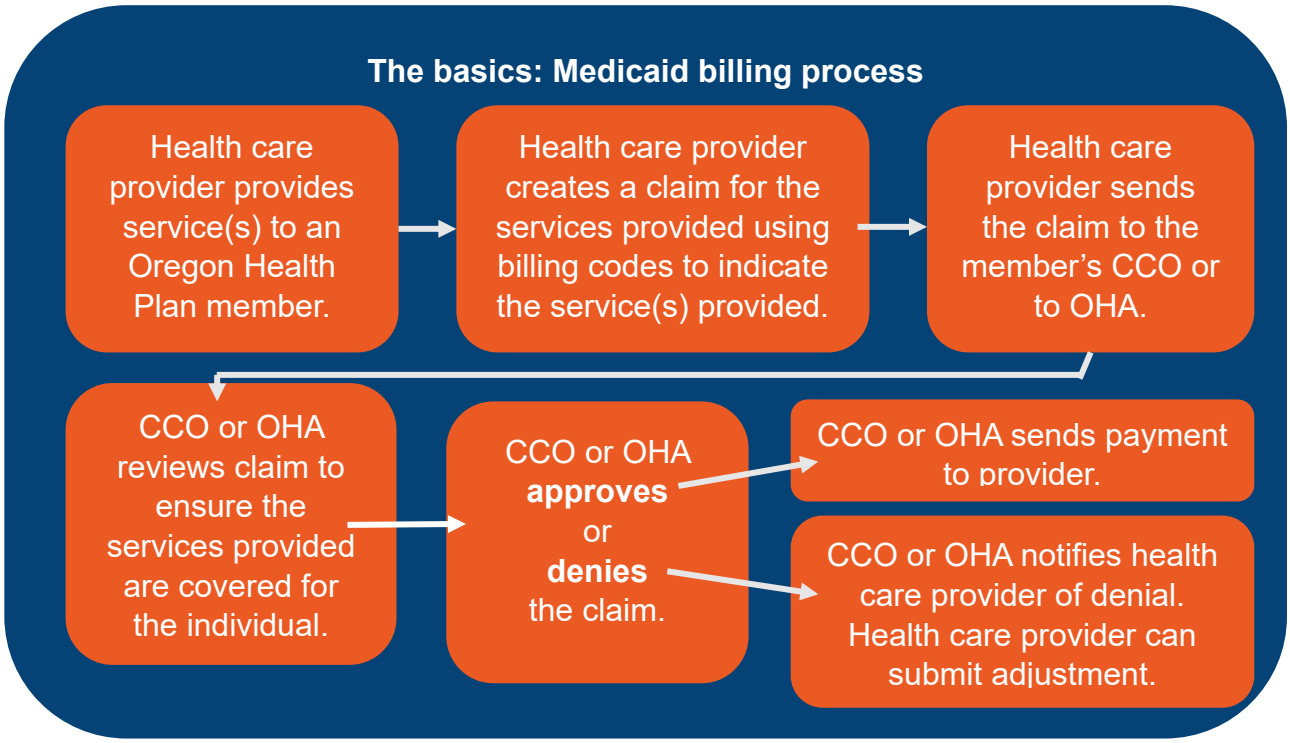
Claims and encounters both provide proof of health care services provided. Claims differ from encounters by including cost information and a request for payment. Encounters are often used in value-based payment models, where services are not billed individually, but proof of the services provided is still required.

The billing process steps include:

1. **Provide and document service:** A health care provider (for example, a THW) provides a service to a patient. The health care provider or the health care service organization (for example, a clinic) that the provider works for should verify that the patient's health coverage is active on the date of service and the services provided are covered for the patient before providing them.
2. **Create a claim or an encounter:** The health care service organization that the health care provider works with creates a claim or encounter for the services provided using billing codes to report the services provided according to a nationwide standard (known as Current Procedural Terminology [CPT]/Healthcare Common Procedure Coding System [HCPCS] Codes). Claims or encounters also include information about the health care provider, the patient's diagnosis, and the location where services were provided.
3. **Submit claim or encounter:** The health care provider sends the claim or encounter to the patient's CCO, OHA Open Card/fee-for-service or other health insurance company based on the individual's coverage.

a. For CCO members: Claims are sent to the CCO.
b. For OHA Open Card/fee-for-service members: Claims are sent directly to OHA.
c. For patients with other health insurance: Other insurers must be billed before billing a CCO or OHA.

4. **Claim review:** The CCO reviews the claim and determines whether the services are covered for the patient, based on the information submitted on the claim and the agreement between the CCO and health care service organization or provider.
    a. **Claim approved:** If the claim is approved, the CCO sends payment to the provider. The CCO also sends the approved claim to the state (Oregon Health Plan) as proof of services covered.
    b. **Claim denied:** If the claim is denied, the CCO notifies the health care provider of the denial. The health care provider can adjust and re-submit the claim if there are errors.



Typical responsibilities in the billing process include*:

- **Health care provider** (for example, a THW, social worker or doctor)
    - Enroll as a Medicaid provider.
    - Provide covered medical services to Oregon Health Plan members.
    - Document services provided, including information about the patient (name, date of birth, Medicaid ID number), date of services, patient's

diagnosis (reason for providing services), location of services, and specific services provided.
    - Meet federal and state requirements for training, education and certification.
- **Health care service organization** (for example, a clinic or community-based organization)
    - Provide administrative support to the health care provider, typically including forms or online systems for documentation, verifying eligibility (Medicaid coverage) of the patient, sending claims to CCOs or other insurance providers, receiving payment for services from CCOs and paying providers for their services.
    - Contract with the CCO to provide health care services for Oregon Health Plan members.
    - Enroll as a Medicaid provider.
    - Create and send claims or encounters to the CCO or Oregon Health Authority.
    - Maintain state or federally required certification depending on the type of organization and services provided.
- **Coordinated care organization (CCO)** (an organization that provides Medicaid coverage to eligible individuals)
    - Contract with health care service organizations to provide services to members (options for contract structures are known as payment models).
    - Receive, process and pay claims to health care service organizations.
    - Pass claims on to the Oregon Health Authority.
    - Set minimum payment rates for covered services (the amount health care providers are paid for their services).
    - Contract with the Oregon Health Authority to be a Medicaid insurer.
    - Meet state and federal requirements for Medicaid providers.
- **Oregon Health Authority (OHA)** (OHA manages the state Medicaid plan, known as the Oregon Health Plan)
    - Contract with CCOs to administer the Oregon Health Plan.
    - Determine which services are covered by the Oregon Health Plan.
    - Receive claims from CCOs or other providers and pay for covered health care services for Oregon Health Plan members.
    - Administer Medicaid in partnership with the federal government, including implementation of regulations and requirements according to the State Plan.
    - If an OHP member does not enroll with a CCO, they are an Open Card member. OHA contracts directly with the health care service organization or provider and receives claims directly.

*These are not necessarily requirements, nor is this a comprehensive list of responsibilities; it is intended to demonstrate the typical roles each entity is responsible

for in the billing process. More details about specific responsibilities and requirements are below.

Important considerations for the billing process include:

- Medicaid is the payer of last resort; if a patient has Medicare or any other health insurance coverage, the other insurance must be billed before billing Medicaid.
- It is important to verify the patient is an Oregon Health Plan member on the date they received service(s) to be reimbursed for the services provided.
- Claims are at the core of the billing process and must be entered into the Medicaid Management Information System (MMIS). Health care providers or organizations may not be required to enter their claims into MMIS. Data sharing processes should be included in any contract agreement for health care services.
- Some provider types may bill the Oregon Health Authority directly for services. Most THWs are not eligible to bill the Oregon Health Authority directly, and they must work with a health care service organization. Doulas and peers working with certain organizations are the exception and can directly bill OHA.

General billing and encounter information and resources:

- Oregon Health Plan billing
- How to submit and adjust claims
- Verify patient eligibility, enrollment and service coverage
- Oregon Medicaid professional billing instructions (how to create and submit a claim)
- MMIS professional claims instructions (how to create and submit a claim using MMIS)
- Presentation on billing basics
- Encounter data submission guidelines
- OHP encounter data information

OHA fee schedule (Note that CCOs set payment rates for health care services provided through their networks, please see your CCOs fee schedule for more precise information.)

THW billing guides

THW-specific billing guides provide detailed information and guidance about how each THW type can bill for services. The steps in these billing guides apply to all payment model types. Learn more about payment models below.

Billing guides provide guidance on fee-for-service (FFS) billing, which is at the core of most billing processes or payment models. No matter the payment model, THWs must meet requirements for training, certification and supervision described above to be paid by the Oregon Health Plan for providing covered services to members. Alternative

payment models (not FFS) can offer flexibility in daily practice and can provide more stability for health care service organizations by providing consistent payment for THW programs. Regardless of payment model, services provided must adhere to the same requirements and documentation standards. CCOs are required to send claims (known as "passing claims") for each individual service they cover for each of their members.

Billing guides

Community Health Worker Billing Guide

Doula Billing Guide

Peer-Delivered Services Billing Guide

Personal health navigator and tribal health worker billing guides were not published at the time of this resource.

For more information, search for provider types on the How to Submit and Adjust Claims to OHA webpage under Handbooks, Tips, and Step-by-Step Guides or contact your CCO's THW liaison.

THW billing codes

Billing codes are used to report the services provided by a health care service provider according to a nationwide standard. This standard is known as the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes. Each code corresponds to services within that health care provider's scope of practice.

Each provider type (or THW type) can bill for certain services or codes. The only codes that THWs are approved to bill for are those reflected in the billing guides (linked above) and referenced below). For questions about codes, please contact OHA's Provider Services at dmap.providerservices@oha.oregon.gov.

Note that encounter-based arrangements may not require a billing code but must align with covered services associated with a billing code.

THWs must provide services that are within their scope of practice. Find details on scopes of practice in the THW Toolkit.

Community health worker services

Current community health worker billing codes and examples are:

Billing code	Description	Example(s)
97535	Self-care management training (per 15 minutes)	• Activities of daily living (ADL) and training to help with ADLs • Meal preparation

Billing code	Description	Example(s)
	Training for self-care or home management, direct one-on-one contact (per 15 minutes)	• Safety procedures • Instructions in using assistive technology devices or adaptive equipment • Educating patient about scheduling medical appointments and communicating with medical providers • Teaching patient how to access their health care information online (for example, accessing MyChart or similar online health platform) • Teaching patient how to access transportation options for self-management of transportation needs
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require presence of a physician or other qualified health care professional (typically about 5 minutes of care)	• Check in with an established patient on their well-being, health care or other needs, discuss treatment questions or next steps • Ongoing patient care management, potentially including relaying information to providers on behalf of a client as part of managing care, including follow up on referrals or appointments
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (per 15 minutes)	• Counseling or evaluation of family issues, diet and exercise, high risk behavior(s), avoidance of injury, dental issues • Preventive medicine individual counseling services provided face-to-face to help foster healthy living and/or avoid illness/injury • Research community resources, keep updated and informed
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (30 minutes)	• Counseling or evaluation of family issues, diet and exercise, high risk behavior(s), avoidance of injury, dental issues • Preventive medicine individual counseling services provided face-to-face to help foster healthy living and/or avoid illness/injury • Facilitating communication between medical providers and client to help ensure medical instructions are understood • Research community resources, keep updated and informed

Billing code	Description	Example(s)
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (45 minutes)	• Counseling or evaluation of family issues, diet and exercise, high risk behavior(s), avoidance of injury, dental issues • Preventive medicine individual counseling services provided face-to-face to help foster healthy living and/or avoid illness/injury • Facilitating communication between medical providers and client to help ensure medical instructions are understood • Research community resources, keep updated and informed
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (60 minutes)	• Counseling or evaluation of family issues, diet and exercise, high risk behavior(s), avoidance of injury, dental issues • Preventive medicine individual counseling services provided face-to-face to help foster healthy living and/or avoid illness/injury • Facilitating communication between medical providers and client to help ensure medical instructions are understood • Research community resources, keep updated and informed
99406	Smoking and tobacco use cessation counseling visit; intermediate (between three and 10 minutes)	• Individual behavior change intervention services, including counseling and/or intervention services directed at high risk behaviors like tobacco use • Includes the use of validated instruments to determine the patient's opinion related to behavior change and providing input on a plan to change behavior with action and motivation
99407	Smoking and tobacco use cessation counseling visit; intermediate (greater than 10 minutes)	• Individual behavior change intervention services, including counseling and/or intervention services directed at high risk behaviors like tobacco use • Includes the use of validated instruments to determine the patient's opinion related to behavior change and providing input on a plan to change behavior with action and motivation
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST)	• Individual behavior change intervention services, including counseling and/or intervention services directed at high risk

Billing code	Description	Example(s)
	and brief intervention (SBI) services (15 to 30 minutes)	behaviors like alcohol use and substance abuse • Includes the use of validated instruments to determine the patient's opinion related to behavior change and providing input on a plan to change behavior with action and motivation
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services (greater than 30 minutes)	• Individual behavior change intervention services, including counseling and/or intervention services directed at high risk behaviors like alcohol use and substance abuse • Includes the use of validated instruments to determine the patient's opinion related to behavior change and providing input on a plan to change behavior with action and motivation
99600	Unlisted home visit service or procedure	• Other health assessment, coaching or education services provided at the patient's home
G0176	Activity therapy, such as dance, music, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems (45 minutes or greater) Restrictions: E512-E512, F1010-F984, G300-G3183, R457-R457, Z62810-Z720	• Art or movement therapy designed to treat mental health issues
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems (45 minutes or greater) Restrictions: E512-E512, F1010-F984, G300-G3183, R457-R457, Z62810-Z720	• Services aimed at alleviating patient discomfort, allowing the patient to cope or control mental health issues
H0032	Mental health service plan development by non-physician; plan should include modifying goals,	• Development of a patient-specific plan to address mental health, potentially including needs assessments, planning, and/or releases of information to services

Billing code	Description	Example(s)
	assessing progress, planning transitions and addressing other needs Restrictions: F0150-F99, G300-G3183, Z62810-Z718	
H0033	Oral medication administration, direct observation — medication taken by mouth in the presence of a health care provider Restrictions: F0150-F99, G300-G3183, Z62810-Z7189	• Observation of or assistance with taking oral medication • Commonly associated with drugs like methadone where ensuring the patient has taken the medication is important
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood Restrictions: F1010-F1999, Z0389-Z0389 1:1 and A000-Z0283, Z029- Z9989 0:11	• Samples typically include urine or hair, and handling of specimens requires a documented chain of custody to ensure the integrity of the specimen
H2014	Skills training and development (per 15 minutes) Restrictions: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Providing patient with skills and ability to enable independent living, including managing illness and treatment • Training typically focuses on managing skills for daily living and community integration for patients with functional limitations due to psychiatric disorders
H2016	Comprehensive community support services (per diem or each day)	• Mental health and substance abuse services to help patients meet recovery and rehabilitation goals, reduce psychiatric and addiction symptoms and develop community living skills • May include coordination of services, support during a crisis, development of system monitoring and management skills, monitoring medication, related visits to social services offices with client, and help in developing independent living skills • Working with partner organizations to create referral relationships and improve services, including attending community meetings
H2032	Activity therapy (per 15 minutes)	• Music, dance, creative art or any type of play that is not for recreation, but related to the

Billing code	Description	Example(s)
	Restrictions: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	care and treatment of the patient's disabling mental health problems
98960	Education and training for patient self-management using a standard curriculum, face-to-face with the patient (and possibly a caregiver or family member) (30 minutes)	• Physician-prescribed training to enable the patient to self-manage their illness or disease with a health care provider • Standard curricula used in this education or training could include (but is not limited to) the diabetes self-management education and support (DSMES), Living Well with Chronic Conditions or others • Outreach to determine patient eligibility for services • Accompany patient to medical appointment along with education about managing medical appointments • Facilitate successful engagement with health programs the patient is eligible for, if recommended (for example, utilization of health coaching or access to gym membership)
98961	Education and training for patient self-management using a standard curriculum, face-to-face with the patient (and possibly caregiver or family member) in a group of two to four patients (30 minutes)	• Physician-prescribed training to enable the patient to self-manage their illness or disease with a health care provider • Standard curricula used in this education or training could include (but is not limited to) the diabetes self-management education and support (DSMES), Living Well with Chronic Conditions or others • Host group visit to service provider or resource event • Facilitate successful engagement with health programs the patient is eligible for, if recommended (for example, utilization of health coaching or access to gym membership)
98962	Education and training for patient self-management using a standard curriculum, face-to-face with the patient (and possibly caregiver or family member) in a group of five to eight patients (30 minutes)	• Physician-prescribed training to enable the patient to self-manage their illness or disease with a health care provider • Standard curricula used in this education or training could include (but is not limited to) the diabetes self-management education and support (DSMES), Living Well with Chronic Conditions or others

Billing code	Description	Example(s)
		• Host group visit to service provider or resource event • Facilitate successful engagement with health programs the patient is eligible for, if recommended (for example, utilization of health coaching or access to gym membership)
D9992	Dental case management, care coordination	• Dental care coordination, including connecting patients to dental care, supporting and facilitating access to dental care

For more details about CHW billing and coding, see the CHW Billing Guide.

Doula services

Doula services can be billed using the full or partial global doula benefit. Services must be documented for each encounter (or visit), including assessment of any patient needs beyond routine care and referrals made. Doulas are the only THW type that can bill the Oregon Health Authority directly, they can work independently and bill directly for their services but must enroll as a doula billing provider with OHA to do so. Specific billing codes for doula services are:

Billing code	Description	Example(s)
T1033	Global doula benefit, to be billed once per pregnancy, after the delivery date Modifier: HD	Full global doula benefit with support at delivery includes two visits before delivery, doula support on day of delivery and two visits after delivery. Maternity support visits can be at birthing person's home or at an office visit.
T1033	Support visit (per visit, up to two prenatal and two postpartum visits)	Doula support visits prenatal or postpartum
T1033	Doula support on delivery day Modifier: 22	Doula services for the day of delivery only

For more details about doula billing and coding, see the Doula Billing Guide.

Peer-delivered services

Billing codes for peer-delivered services are:

Billing code	Description	Example(s)
G0177	Training and educational services related to the care and treatment of a patient's disabling mental health problems (45 minutes or greater) Diagnosis: E512-E512, F1010-F984, G300-G3183, R457-R457, Z62810-Z720	• Services that alleviate patient discomfort and allow the patient to cope or control mental health issues
H0023	Intensive in-home behavioral health treatment services (IIBHT) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Learn more about in-home behavioral health treatment (IIBHT) on the IIBHT webpage
H0023	Alcohol and/or drug outreach, Behavioral health outreach service (planned approach to reach a targeted population) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Targeted outreach to individuals with alcohol and/or drug addiction
H0039	Assertive community treatment, face-to-face (per 15 minutes) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Team-based multidisciplinary approach to reduce extent of hospital admissions, improve individual's quality of life and improve function in social situations by providing focused, proactive treatments • Services are typically provided to individuals with severe and persistent mental illness with a high level of functional impairment
H0046	Home-based behavioral habilitation (60 minutes) Diagnosis: F0150-F0391, F04-F09, F200- F70, F78-F99 Modifiers: when an individual has been approved for HCBS 1915 (i) plan, use Modifier HW, along with HK	• Services provided in the patient's home related to skills to improve behavioral health and community living experiences, support to learn or improve skills and activities of daily living

Billing code	Description	Example(s)
H2011	Crisis intervention services (per 15 minutes) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Coaching, social support to intervene during a crisis
H2011	Mobile crisis intervention services (MCIS) (per 15 minutes) See mobile crisis intervention services and stabilization services billing guide	• Mobile coaching, social support to intervene during a crisis
H2014	Skills training and development for independent living and illness management (per 15 minutes) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Providing patient with skills and ability to enable independent living, including managing illness and treatment • Training typically focuses on managing skills for daily living and community integration for patients with functional limitations due to psychiatric disorders
H2023	Supported employment (per 15 minutes)	• Help individuals with serious mental illness get a job, stay employed and continue treatment • Help ensure rehabilitation and productive employment
T1013	Sign language or oral interpreter services	• Language interpretation services for patient
T1016	Case management (per 15 minutes) Diagnosis: F1010-F1999, Z0389-Z0389 1:1 and A000-Z9989 0:11	• Peer can act as a central point to manage or coordinate care for an individual • Case management can include, but is not limited to, evaluation of a condition, the development and implementation of a care plan, the coordination of medical resources and the appropriate communication to all parties
H0038	Self-help/peer services (per 15 minutes) Diagnosis: F1010-F1999, Z0389-Z0389	• Specialized therapeutic interventions to support and help individuals in recovery and integration into the community • Provide understanding, coping skills, empowerment, mentoring and other supports

Billing code	Description	Example(s)
		• Help individuals with serious and persistent mental disorders cope with stress and achieve personal wellness

For more details about peer billing and coding, see the Peer-delivered Services Billing Guide.

Payment models

Payment models are agreements between health care providers (for example, a health clinic or community-based organization) and CCOs to pay for health care services. Payment models can be structured to incentivize improvements in the quality or value of services provided or to provide flexibility in service delivery while meeting federal and state requirements for provision of health care services.

No matter the payment model, for services to be reimbursed or paid for by the Oregon Health Authority, they must be covered services or pre-approved alternative services by the Oregon Health Plan. The Oregon Health Authority, with approval from the Centers for Medicare and Medicaid Services (CMS), determines which services are covered. Learn more about which services are covered in Oregon by viewing the Prioritized List of Health Services. Certain payment models can be limited to specific settings, providers or types of services. The scope of a payment model is typically determined in negotiations between the health care service organization and the CCO.

Learn about unique CCO approaches to payment models in the payment model guidance document.

Fee-for-service (FFS)

FFS is a payment model where the CCO or the Oregon Health Authority pays a set amount for each individual covered service that a health care provider provides to a patient.

Benefits

- More straightforward contract; FFS is the most basic payment model
- Generates claims data about THW services, helping to demonstrate the impact of THWs in health care provision

Challenges

- Requires specific documentation of each individual service provided, often based on the amount of time spent

- Services must be aligned with specific codes

How it works:

1. Contract: CCO and health care service organization agree to fee-for-service contract for provision of specific services.
    a. Exception: In some cases, THWs or organizations with THWs can bill the Oregon Health Authority directly for services, known as Open Card/fee-for-service billing. This does not require a contract with a CCO. Learn more about Open Card coverage in the Open Card handbook.
2. Provide services: THW provides and documents covered services to a member.
3. Create a claim: Generate a claim based on the documentation of services provided, including information about the patient and service(s) provided using billing codes.
    a. Claims sent directly to the Oregon Health Authority should be billed based on their fee schedule (find the relevant fee schedule on the fee schedules webpage). Claims sent to the CCO should be billed based on the CCO's fee schedule (find your CCO's fee schedule on their website).
4. Send claim: Send claim to CCO or the Oregon Health Authority.
5. Review claim: CCO or Oregon Health Authority reviews the claim and approves or denies the claim. If approved, payment is sent to the claimant. If denied, the claimant can adjust the claim, send the claim to another insurer or bill the patient directly.

Learn more about fee-for-service billing on the Oregon Health Authority billing webpage.

Value-based payment (VBP)

VBP refers to a range of payment models that incentivize high-value health care provision. In value-based payment models, the CCO pays health care providers a variable amount based on the health care provider meeting specific goals or metrics. These metrics can be process oriented (for example, percent of patients receiving screening services) or outcome oriented (for example, initiation and engagement in preventive health care treatment). Metrics are pre-determined during the contracting process by the CCO and health care provider.

Many value-based payment models are tracked using encounters rather than claims. Encounters typically require information like: patient name, patient date of birth, Medicaid ID number, diagnosis (reason for services), location of service(s), and service(s) provided.

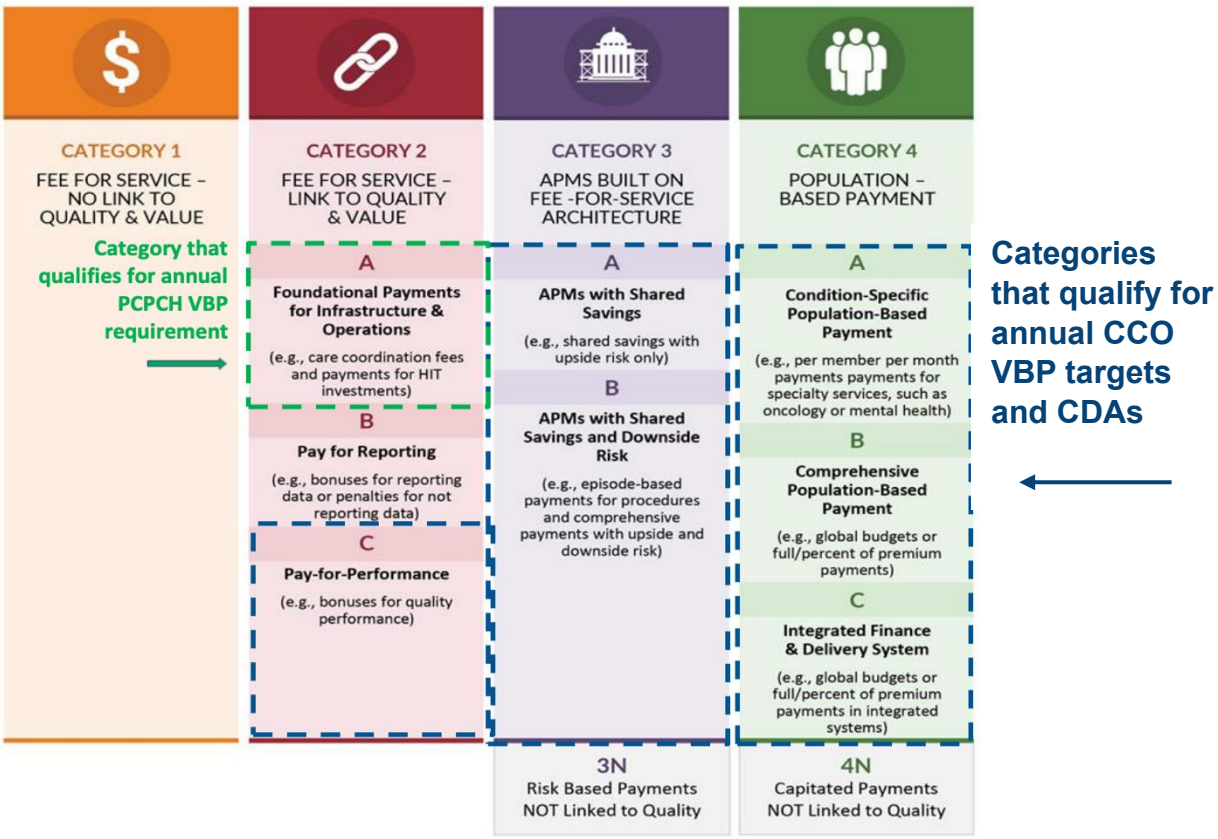
Benefits

- Health care providers can earn more for meeting specific goals or metrics that improve health care or health outcomes.

- There are many ways to structure value-based plans to meet the needs of CCOs, health care service organizations, providers and communities.
- Can help CCOs meet contract requirements or incentive measures.

Challenges

- Requires data collection and analysis according to agreed-upon goals or metrics
- Lack of standardized quality measures specific for THWs.
- May result in additional requirements or restrictions based on the funding stream used by the CCO.



How it works:

1. Contract: CCO and health care service organization agree to provide services based on a value-based payment model. There are many value-based payment model types, described in the visual above and the Value Based Payment Roadmap. Metrics are determined in the contracting phase.
2. Provide and document services: THW provides services based on contract with CCO. Documentation is typically based on encounters for covered services and encounter data is sent to the CCO.

3. Data monitoring: Data for the metrics agreed upon in the contract are monitored and reported on.
4. Encounters review and payment: CCO reviews encounter and metric data and provides payment to the health care service organization according to the contract.

Learn more about value-based payment models on the Oregon Health Authority value-based payment webpage, in the Value-based Payment Model Roadmap, and the Traditional Health Worker Payment Model Guide.

Find quality measures from the Oregon Health Authority's aligned measures menu or the National Quality Forum's webpage.

Medicaid spending flexibilities

Medicaid spending flexibilities are programs that offer unique payment pathways for CCOs to fund services and programs related to the social determinants of health and equity (SDOH-E). CCOs determine whether and what to cover with Medicaid spending flexibilities, within state and federal regulations. Two key Medicaid spending flexibilities can fund THW services: in lieu of services and health-related services.

In lieu of services (ILOS)

In lieu of services (ILOS) are pre-approved, cost-effective, medically appropriate substitutes to covered services. ILOS allows for services to be provided in alternative or non-clinical settings (for example, in a community or home setting).

Benefits

- Provides flexibility in provision of services, including where they are provided and by whom
- Allows for a reduced data set to be collected and reported on the services provided to members

Challenges

- ILOS are limited and new ILOS are subject to approval by state and federal partners
- Not all CCOs currently offer ILOS
- Reimbursement-based payment model

How it works:

1. CCO offers ILOS: CCOs can decide whether to offer pre-approved ILOS to their members. To begin offering ILOS to members, the CCO must add ILOS to their member handbook, ensure ILOS providers are included in their provider directory, and create policies and procedures for ILOS provider referrals.

2. Contract: CCO and health care service organization agree to provide pre-approved THW services as ILOS.
3. Provide services: THW provides services for pre-approved ILOS.
4. Document and submit services provided: Collect a reduced dataset or the standard dataset and submit to CCO for reimbursement.
5. CCO review and payment: CCO reviews data submitted and approves.
6. CCO submits ILOS provided in MMIS as typical claims, using modifiers and coding guidance from the ILOS billing guide.

Approved in lieu of services: As of October 2024, the following THW services are approved for ILOS. For further billing guidance and codes, refer to the ILOS billing guide and template for reduced dataset reporting. CCOs may not offer all approved ILOS and can set stricter requirements or restrictions on ILOS provision.

Currently approved ILOS by THW type:

THW type	In lieu of services
Peers	• Self-help/peer services • Skills training and development for mental health and/or sexually transmitted infection (STI)/HIV self-management • Comprehensive community support services • Case management
Community health workers	• Evaluation and management with existing patient • Preventive medicine counseling and/or risk factor interventions for an individual • Skills training and development, including for patients with STI/HIV • Education and training for patient self-management of STI/HIV • Comprehensive community support services
Personal health navigator, Tribal health worker	• Education and training for patient self-management of STI/HIV • Skills training and development for patient with STI/HIV • Comprehensive community support services for patient with STI/HIV

THW type	In lieu of services
Other ILOS, not specific to THW type These services can be provided by certain THWs, though additional training may be required and the ILOS must be in scope for the THW.	• Diabetes self-management program training services • Chronic disease self-management education • Infant mental health pre- and post-testing services • Lactation consultations • STI, including HIV, testing and treatment services

Learn more about ILOS and find additional resources on the in lieu of services webpage.

Health-related services (HRS)

Health-related services (HRS) is a Medicaid spending program to pay for non-covered services that complement covered benefits under Oregon's Medicaid State Plan to improve member and community health and well-being. There are two types of health-related services:

- **Flexible services**, which are cost-effective services provided to a CCO member to complement covered benefits, and
- **Community benefit initiatives**, which are community-level interventions focused on improving population health. These initiatives include members, but they are not necessarily limited to members.

Benefits

- HRS allows CCOs to pay THWs to provide non-covered services. This includes continuing THW services beyond what OHP will cover.
- Typically requires less documentation than billing for an OHP covered service.
- Supervision by a licensed health care provider may not be required.

Challenges

- HRS spending is optional and determined by the CCO, so the CCO may choose to limit funding.
- HRS must exclude OHP covered services, even if the entity providing the covered service cannot bill OHP for the service.
- HRS cannot be used to meet CCO administrative requirements.
- HRS spending must meet definitions and criteria as described in the HRS Brief.

How it works:

1. CCO HRS program development: CCOs determine whether and how to allocate their Medicaid global budget funds to HRS at the member and community levels.

2. Contract: CCO and health care service organization may agree to a memorandum of understanding (MOU) for THWs to provide health-related services. Each CCO develops their own standards for providing HRS; contact your CCO for more information on their processes and requirements.
3. Provide services: THW provides and documents health-related services based on contract or agreement with their CCO.
4. Report: Health care service organizations report on HRS provision according to their contract or agreement with their CCO.
5. Payment: CCOs pay health care service organizations based on their contract or agreement.

HRS is intended to offer flexibility to CCOs and partners. This is just one example of how the process can work with a health care service organization but could work similarly with social service or THW specific organizations. Learn more about health-related services on the health-related services webpage. Refer to the Traditional Health Workers and Health-related Services Guidance Document for examples and additional resources.

Contact

About this document: Oregon Health Authority Transformation Center at Transformation.Center@odhsoha.oregon.gov

About traditional health workers: Oregon Health Authority Office of Equity and Inclusion's THW Program at THW.program@odhsoha.orgeon.gov

About Medicaid billing: Medicaid Division of Medical Assistance Programs (DMAP) provider services at dmap.providerservices@oha.oregon.gov

Your CCO: Find CCO contact information on the Oregon Health Authority webpage.