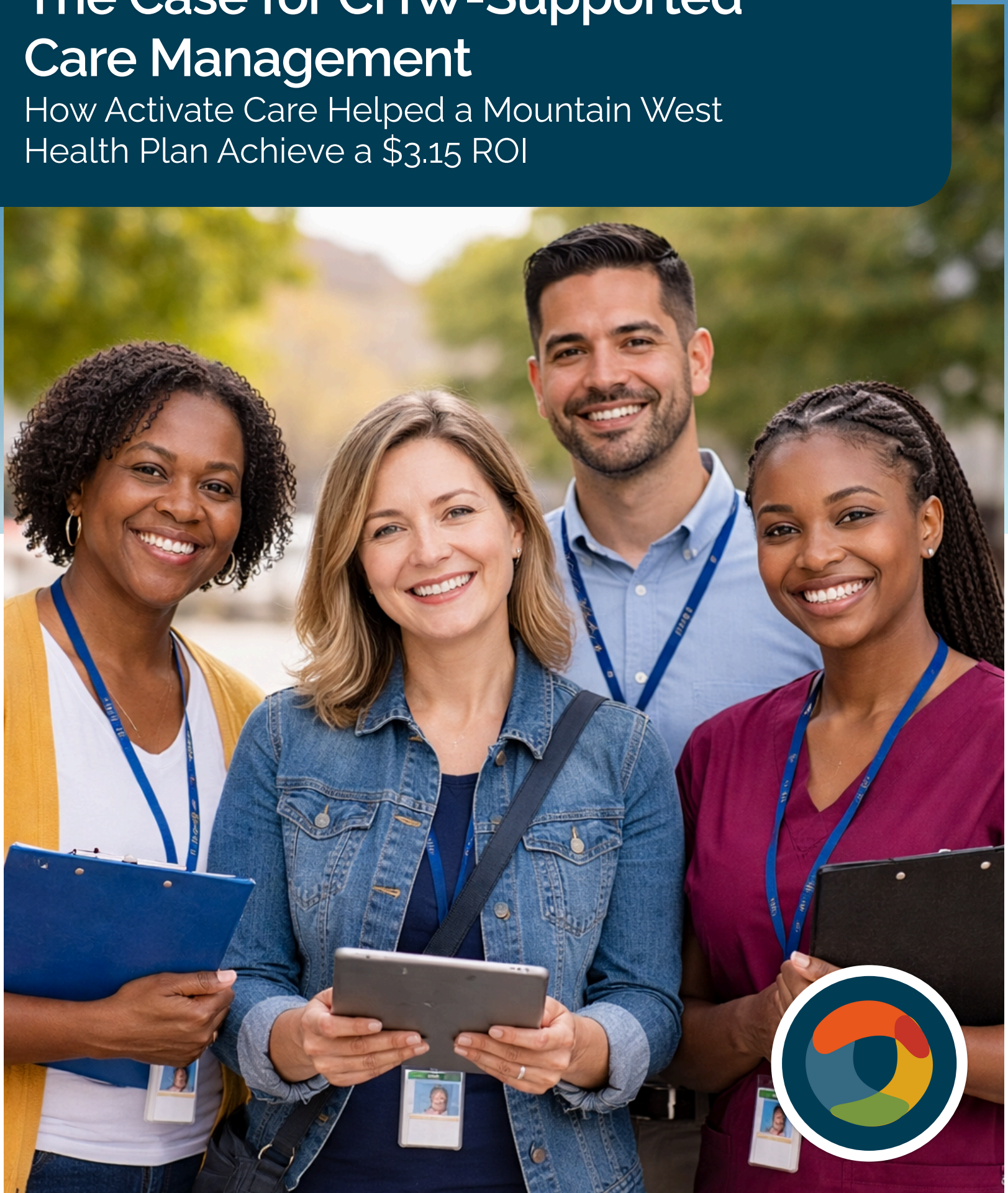
The Case for CHW-Supported Care Management

How Activate Care Helped a Mountain West Health Plan Achieve a $3.15 ROI



EXECUTIVE SUMMARY

Activate Care's community health worker (CHW) workforce delivered a $3.15 return on investment for every $1 invested for a Mountain West health plan serving Medicaid, Medicare, and dual-eligible special needs (D-SNP) populations. This white paper examines how integrating Activate Care's CHW workforce into its existing care management program delivered significant cost savings.

In this white paper, you will find:

Literature Review: Existing evidence for the ROI of social care interventions

Methodology: Details around how cost savings were estimated

Program Design: Key components of the CHW-supported care management program

Actionable Insights: Implementation lessons for health plans scaling CHW programs

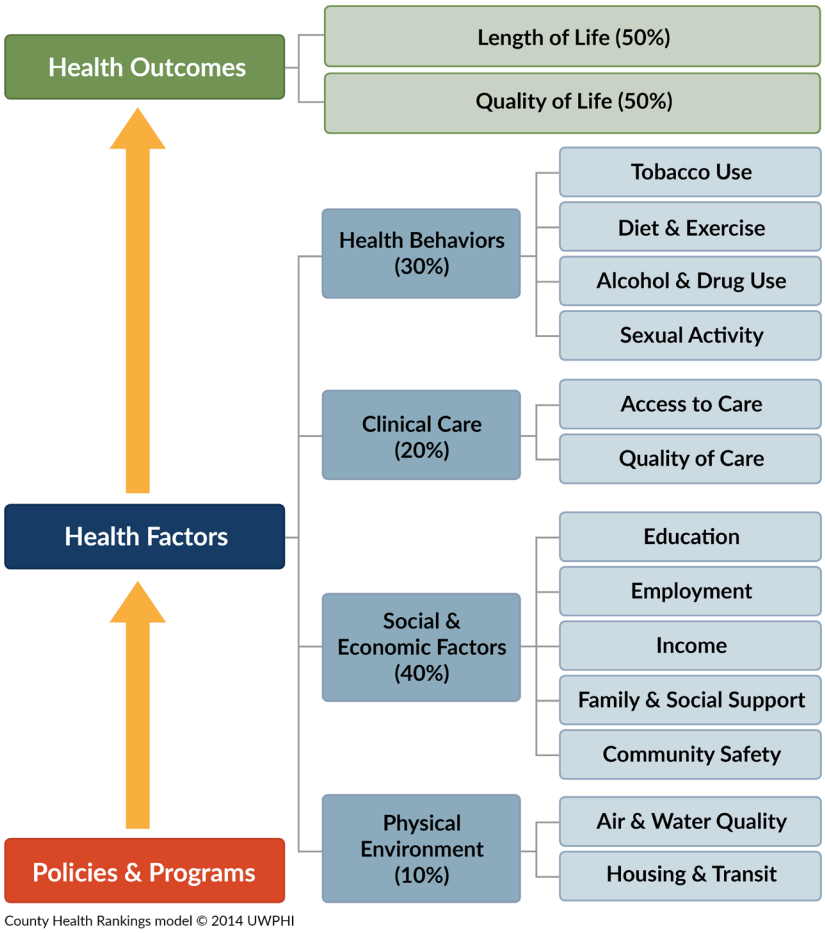
Health plans face mounting pressure to manage costs, improve quality metrics, and address health equity gaps, challenges that traditional care management approaches often fail to solve. CHWs bridge this gap by connecting members to social services, supporting medication adherence, facilitating care coordination, and building trust with hard-to-reach populations.

As value-based care models expand and social care becomes integral to population health strategies, integrating a CHW workforce offers health plans a scalable solution to improve outcomes while controlling costs. The results presented here demonstrate that investing in community health workers is not just a health equity imperative; it's a sound business strategy.

OVERVIEW

Healthcare costs in the United States continue to rise, with projections that spending will reach 20% of GDP by 2033, of which nearly half will be paid through government-supported insurance programs. While multiple factors are at play, social drivers of health—the conditions in which people live, work, worship, and play—are a significant part of the story. Research suggests that up to 80% of health outcomes stem from non-clinical factors that manifest at the individual level as health-related social needs (HRSNs), including housing instability, food insecurity, and lack of transportation. Despite growing recognition of their importance, the healthcare system—including traditional care management programs run by health plans—has struggled to systematically address these needs.

Figure 1: Drivers of Health Outcomes



Traditional care management programs aim to reduce costs for high-risk populations. Yet, they often fail to address members' social needs, despite evidence that HRSNs are among the primary cost drivers. Health plans that do recognize the importance of social care often struggle to deliver results because they may assign these responsibilities to individuals who lack the specific training, community connections, and cultural competency required to effectively address housing instability, food insecurity, transportation barriers, and other critical needs.

Figure 1 Source: County Health Rankings & Roadmaps: https://www.countyhealthrankings.org/sites/default/files/media/document/CHRR_2014_Key_Findings.pdf

20-100+

Case managers typically carry caseloads of 20-100+ members and lack the capacity to provide the intensive, trust-based support that addressing social needs requires. This gap has left health plans searching for scalable solutions that can bridge clinical care and social support.

Community health workers bridge this gap.

CHWs are trusted members of the communities they serve, often sharing lived experiences, language, and cultural backgrounds with the populations they support. This shared identity enables CHWs to build authentic relationships and navigate barriers that traditional healthcare providers and case managers cannot easily overcome. Unlike clinical staff, CHWs specialize in connecting members to community resources, supporting behavior change, and addressing the practical challenges that prevent individuals from managing their health effectively.

Research demonstrates that CHW interventions improve health outcomes across diverse populations. However, deploying CHW programs at scale presents its own challenges: recruiting and training qualified workers, integrating them into existing care teams, maintaining quality and consistency, and demonstrating the economic viability of such a model. These implementation barriers have prevented many health plans from fully leveraging CHW workforces, despite their proven effectiveness.

Activate Care addresses these challenges by providing health plans with a comprehensive CHW workforce solution: recruiting, training, deploying, and supervising community health workers who are embedded within health plan care management teams, working alongside case managers to address members' HRSNs. Activate Care's CHWs conduct in-home visits, connect members to community resources, provide care coordination support, and help navigate barriers to care. This approach enables health plans to scale CHW interventions without building the program from scratch, while maintaining quality, consistency, and measurability across their populations.

To demonstrate the financial viability of this approach, Activate Care partnered with a Mountain West health plan to measure the return on investment of CHW-supported care management. The results, detailed in this white paper, provide health plan executives with concrete evidence that social care interventions can deliver meaningful cost savings while improving member outcomes.

Patient Centered Outcomes Research Institute (PCORI)

Social Needs Interventions to Improve Health Outcomes
PCORI commissioned an interactive evidence map on the topic of social needs interventions that measure health outcomes. Social needs interventions arose as a topic of interest from a 2019 PCORI call for evidence synthesis topic nominations.

Social needs interventions focus on an individual's immediate nonmedical needs not traditionally attended to by the medical system. Locating high-quality evidence on interventions addressing social needs is time consuming, making it difficult for communities, health systems, purchasers, payers, and other stakeholders to know which interventions work for which populations.

LITERATURE REVIEW

Community health workers have demonstrated effectiveness in improving health outcomes, but questions about the financial viability of such programs have limited widespread adoption by health plans. To understand the existing evidence base for return on investment and contextualize the ROI findings reported later, Activate Care conducted a systematic review of the literature on programs addressing HRSNs among populations similar to those served by health plans.

Review Methodology

We identified relevant studies through three primary sources: the SIREN Evidence & Resource Library, the PCORI Social Needs Interventions to Improve Health Outcomes database, and the Commonwealth Fund ROI Calculator. To be included, studies needed to meet four core criteria:

Intervention focus
Programs must address HRSNs. Interventions that focused solely on patient navigation or care management were excluded.

Target population
Studies must focus on low-income, Medicaid, Medicare, or dual-eligible populations. Programs targeting specialized populations (e.g., pediatric-only, diabetes-only, etc.) were excluded.

Intervention components
Interventions must include elements comparable to CHW-supported care management, including screening, referrals to community-based resources, and behavioral coaching.

Outcome reporting
Studies must report efficacy results. Feasibility or implementation studies without outcomes were excluded.

This search process yielded over 300 titles and abstracts for review. We reviewed abstracts for all papers in the PCORI database. For the SIREN library, which contains over 2,000 papers, we applied filters to focus on peer-reviewed research using randomized controlled trials or pre-post designs with comparison groups, targeting the elderly, Medicaid-insured, or Medicare-insured population. These filters yielded 54 additional abstracts for consideration.

Studies meeting our inclusion criteria were categorized as high, medium, or low priority for further review based on the study design and similarity to a CHW-supported care management intervention. High-priority papers received detailed review and data extraction; lower-priority papers were not examined beyond the abstract. Randomized control trials (RCTs) and quasi-experimental designs were assigned the highest priority. Medium-priority papers included RCTs with significant program differences or quasi-experimental designs with partially relevant programs. Low-priority papers included pre-post designs without comparison groups, qualitative studies, and papers without full-text availability.

Return on Investment Findings

Rigorous ROI analyses for CHW programs remain limited. Our review identified only four studies that directly computed ROI. These studies consistently reported positive returns, ranging from **$1.40 to $2.92** per dollar invested.

However, two critical limitations temper enthusiasm for these findings. First, there was significant uncertainty around these estimates. Second, publication bias likely inflates reported returns—programs with negative or neutral ROI are far less likely to publish their financial results, creating a literature that may overstate the actual return on investment.

This literature review reveals a fundamental gap: while CHW programs show promise, health plans lack substantial evidence to justify large-scale investment. The case study presented in this white paper addresses this gap by providing real-world evidence for a positive return on investment for a CHW-supported care management program.

PROGRAM DESIGN & IMPLEMENTATION

Activate Care deployed CHWs to work alongside the health plan's care management team, which included nurses and social workers serving as the primary case managers. The program served members enrolled in Medicaid, Medicare, and Dual Eligible Special Needs Plans (D-SNPs).

Enrollment Pathways

Members became eligible for CHW support through four pathways:

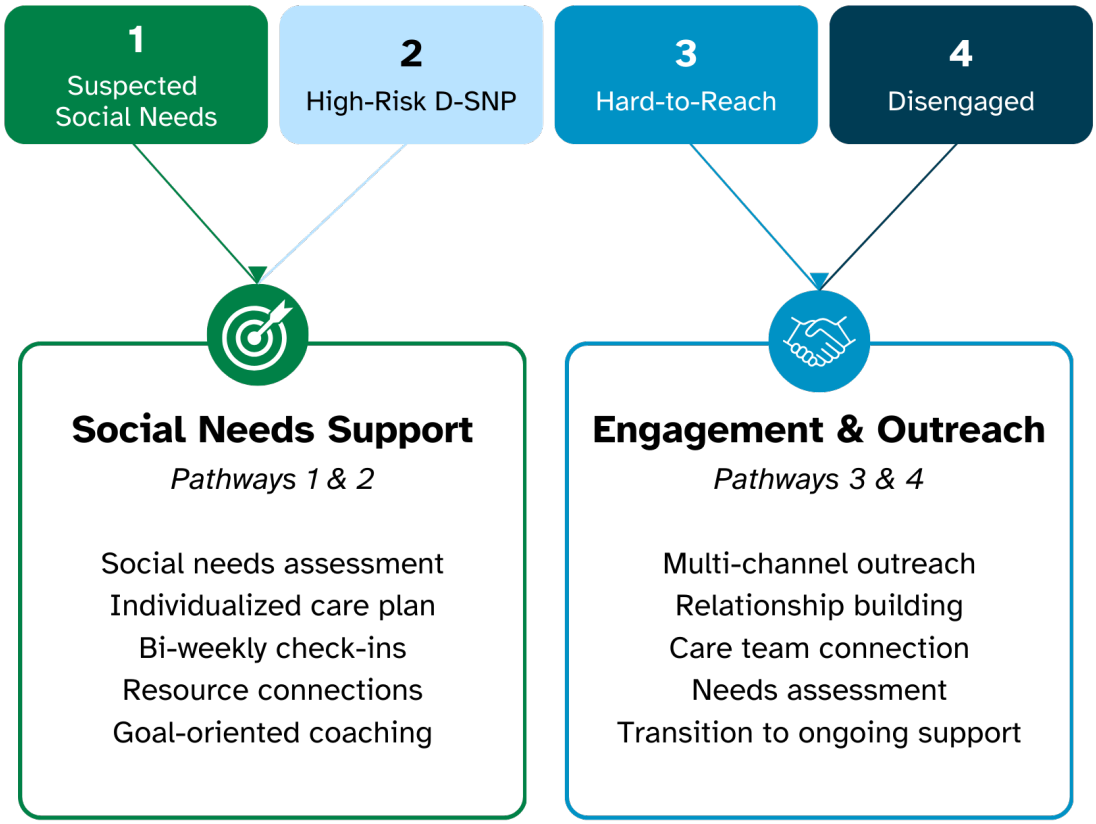
Suspected Health-Related Social Needs: Case managers could refer Medicaid and Medicare members with suspected HRSNs to a CHW at any point during care management.

High-Risk D-SNP: D-SNP members with specific clinical and social risk factors that triggered a "high risk" designation were automatically eligible for CHW support upon enrolling in care management.

Hard-to-Reach Members: When case managers could not successfully contact eligible members, they referred them to a CHW. The CHW worked to establish initial contact, build rapport, and facilitate enrollment into care management.

Disengaged Members: Members who stopped responding to their case manager were referred to a CHW to re-establish the relationship and reconnect them with their care management team.

Figure 2 - Enrollment Pathways & CHW Service Models



CHW Activities

Community health workers performed different activities, depending on the referral source. For Medicaid and Medicare members with suspected HRSNs and high-risk D-SNP members, CHWs would engage the member, identify and evaluate their health-related social needs, and then work with the individual to develop a care plan comprising goals to address one or more of those needs. The CHW would provide ongoing support through at least bi-weekly check-ins, referrals to community-based resources, and coaching to help the member achieve their goals. For hard-to-reach and disengaged members, CHWs would conduct both virtual and community-based outreach to help engage them. Once reached, CHWs would connect the member with a case manager and, if the member had any health-related social needs, begin supporting them alongside the case manager.

All of these activities were documented in the health plan's internal care management platform. Activate Care received weekly data extracts to support quality assurance, outcome reporting, and ongoing program evaluation.

METHODOLOGY

Study Design

This study employed a pre-post comparison design to evaluate the return on investment of CHW-supported care management from a payer perspective. The analysis included members who began receiving CHW support between January 1, 2025, and April 14, 2025. The enrollment window closed on April 14, 2025 to ensure adequate time for claims adjudication. With a 6-month (180-day) follow-up period and a 45-day adjudication lag (capturing 99% of paid claims), this cutoff ensured complete data through November 26, 2025, the date of the latest paid claim in the available data.

The primary outcome was total cost of care, which was used to compute return on investment as the cost savings minus program costs divided by cost savings. Program costs are based on the monthly fee the plan paid to Activate Care. Cost savings were calculated by comparing total allowed claim amounts (the maximum reimbursement approved by the health plan) during the 6 months before baseline with those during the 6 months after baseline. The 6-month pre-post comparison window was chosen because it was the longest possible observation period, given that the program launched in 2025. This timeframe aligns with the literature, which shows that 6- and 12-month comparisons are the most common evaluation periods. Secondary outcomes included changes in emergency department visits and costs, as well as inpatient hospitalizations and costs.

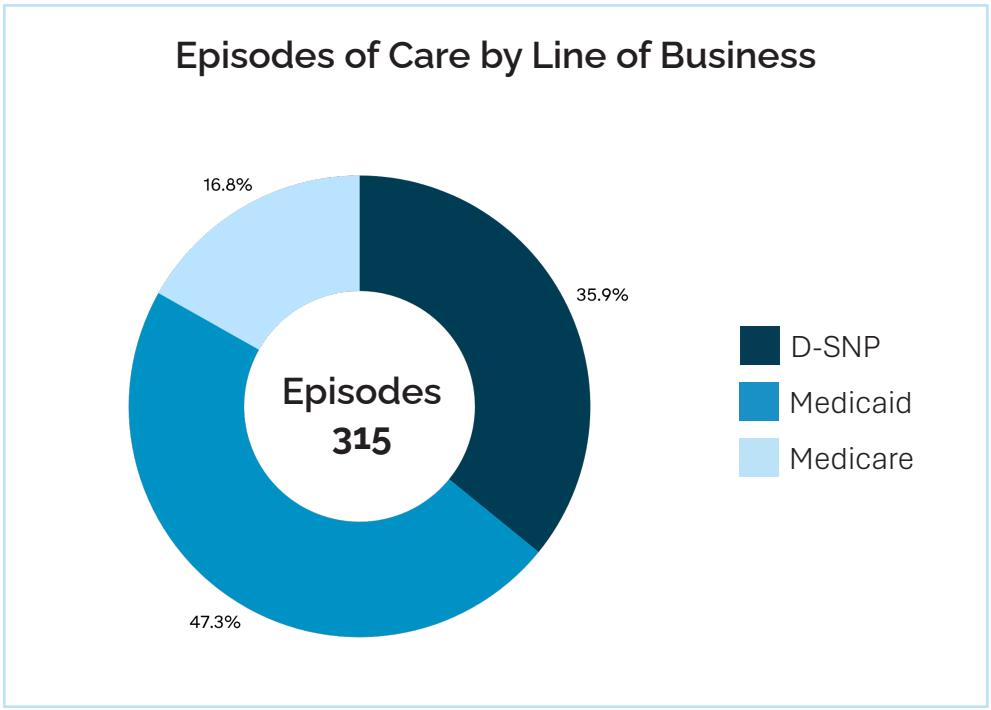
The primary analysis examined outcomes across all four enrollment pathways. Secondary analyses focused on three specific subgroups: high-risk D-SNP members, Medicaid-only members, and hard-to-reach members. These subgroups were selected based on their clinical and operational importance to the health plan.

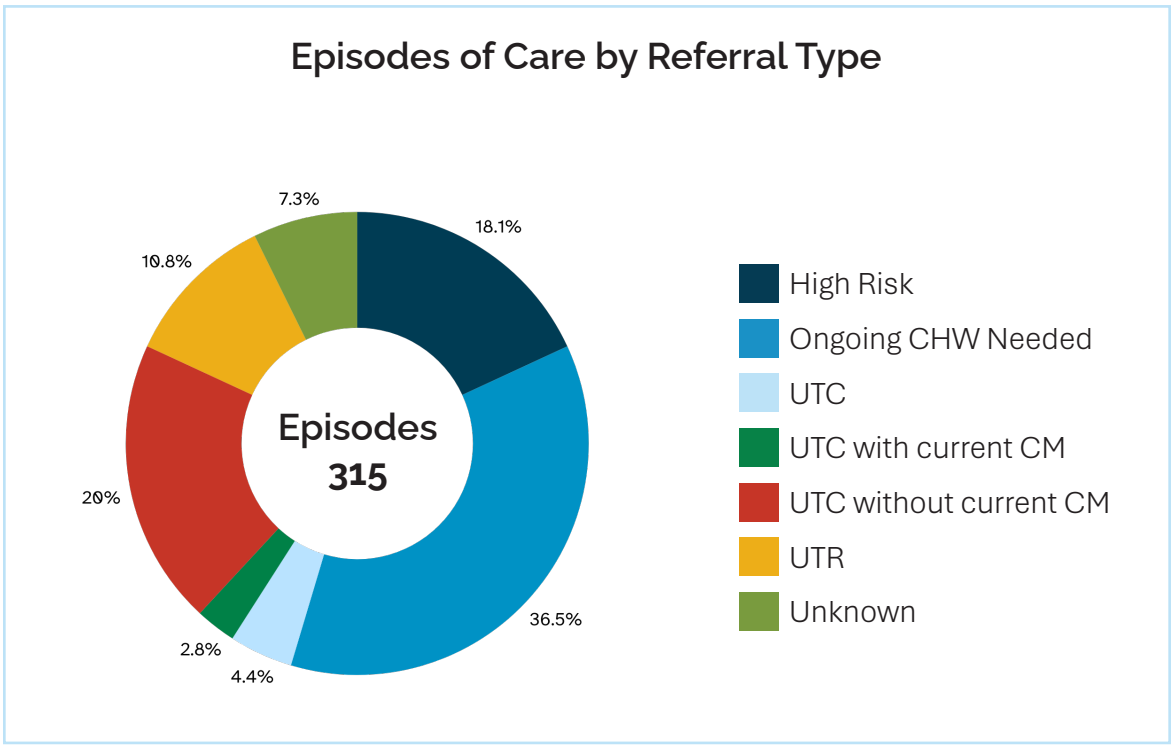
Study Population

The study population included members enrolled in eligible Medicaid, Medicare, or Dual Eligible Special Needs Plans (D-SNP) who began receiving CHW support between January 1, 2025, and April 14, 2025. To ensure complete claims data for analysis, members were required to maintain continuous enrollment with the health plan for the whole observation period (180 days before baseline through 180 days after baseline). Members who switched between lines of business (e.g., Medicaid to D-SNP) during this period were included, provided they maintained continuous coverage with the health plan. Members who disenrolled from the health plan for any reason during either the pre- or post-baseline period were excluded from the analysis. Continuous enrollment was verified using enrollment records derived from the health plan's enrollment data. Enrollment records were grouped into enrollment periods based on start and end dates, with any gap between enrollments marking the start of a new period. The enrollment period in which the member began receiving CHW services was used to determine if they met the continuous enrollment criteria.

The final analytic sample for the primary analysis included 315 members. By insurance type, 47.4% were enrolled in Medicaid, 16.8% in Medicare, and 35.9% in D-SNP plans. By enrollment pathway, 37% were Medicaid or Medicare members with suspected health-related social needs, 18% were high-risk D-SNP members, 20% were hard-to-reach, and 22% were disengaged members. The remaining 7% had unknown referral reasons.

Figure 3 - Members by Line of Business and Referral Type





Data Sources and Processing

The analysis drew on two primary data sources: medical claims and care management software. Medical claims data, spanning January 1, 2024, through November 26, 2025, were used to calculate costs and utilization outcomes. Only paid medical claims were included; pharmacy claims were excluded from the analysis. The total allowed amount—the negotiated rate between provider and payer—was used as the cost metric because it best reflects the expected cost to the health plan and aligns with ROI calculations from the payer's perspective.

Claims Processing and Cost Attribution

Processing claims data to accurately allocate costs to pre- and post-baseline periods and attribute costs to specific encounter types required a multi-step approach.

First, inpatient hospitalizations and emergency department visits were identified at the claim line level. Claim lines with a non-null diagnosis-related group (DRG) field or a bill type starting with "11" were flagged as inpatient hospitalizations. Claim lines that did not meet inpatient criteria and had a revenue code starting with "045" were flagged as emergency department (ED) visits.

Second, claims were grouped by date of service to form encounters. Claims with overlapping or continuous service dates were considered part of the same encounter. This encounter-level aggregation was used to count distinct ED visits and inpatient admissions. When an ED visit resulted in an inpatient admission, it was counted only as an inpatient admission to avoid double-counting.

Third, encounters were assigned to either the pre-baseline or post-baseline period based on their start date. Encounters that began in the pre-baseline period and extended into the post-baseline period were allocated entirely to the pre-baseline period. An encounter was assigned to the post-baseline period if it started between 1 and 180 days after the baseline date.

Baseline Date Determination

The baseline date for each member was derived from the health plan's care management software, where CHWs documented all interactions and contact attempts. Baseline was defined as the date of the first documented encounter between the CHW and the member.

RESULTS

The CHW-supported care management program delivered a positive return on investment across all analyses. Among members with baseline dates within the 103-day enrollment window (January 1 through April 14), the program generated $3.15 in savings per dollar spent. This translates to $945 in savings per member per month (PMPM).

Cost reductions were driven primarily by reductions in inpatient hospitalization costs. Across all 315 members, there were 27 fewer inpatient admissions, accounting for more than 90% of total savings. Emergency department visits decreased by 129 visits (0.41 fewer visits per member), contributing to the remaining savings.

$3.15
in savings per dollar spent

$945
savings per member per month (PMPM)

Subgroup Analyses

Return on investment varied across population subgroups, with Medicaid-only members and hard-to-reach members showing robust results.

Table 1: ROI and Utilization Outcomes by Analysis Group

Analysis	Sample Size	ROI	Change in Total Cost PMPM (% reduction)
Overall	315	$3.15	$945 (39%)
D-SNP	113	$3.18	$343 (48%)
Medicaid	149	$5.83	$736 (43%)
Hard-to-Reach	63	$10.07	$507 (54%)

Medicaid Members

Medicaid-only members (n=149) demonstrated an ROI of $5.83 per dollar spent, with monthly savings of $736 per member. This population showed substantial reductions in emergency department utilization, with 133 fewer ED visits (0.90 fewer visits per member). Inpatient costs accounted for ⅔ of total cost savings.

D-SNP Members

High-risk D-SNP members (n=113) achieved an ROI of $3.18 per dollar spent, with nearly all cost savings attributable to reduced inpatient admissions. Emergency department visits showed minimal change, with slightly higher ED costs in the post-intervention period.

Hard-to-Reach Members

The hard-to-reach pathway yielded the highest return on investment at $10.07 per dollar spent, generating $507 in savings per member per month. This finding is particularly significant because it demonstrates the unique value CHWs provide in engaging members whom traditional case managers cannot reach. Without the CHW intervention, these 63 members would not have enrolled in care management, and the health plan would not have realized these savings.

Hard-to-reach members showed meaningful reductions in both ED visits (52 fewer visits, or 0.82 per member) and inpatient admissions (15 fewer). Inpatient cost reductions accounted for ¾ of total savings. However, given the small sample size (n=63), these results should be interpreted as promising early evidence rather than definitive proof of impact in this subgroup.

CONCLUSION

This case study provides real-world evidence that community health worker-supported care management can deliver substantial return on investment for health plans. The $3.15 ROI observed across 315 members over six months demonstrates that CHW interventions can generate measurable cost savings while addressing members' health-related social needs, supporting both the business case and the health equity imperative for investing in social care.

The results also illuminate an important, often overlooked application of CHW services: member engagement. The hard-to-reach pathway, which yielded a $10.07 ROI, demonstrates that CHWs possess unique capabilities in connecting with members whom traditional case managers cannot reach. Health plans should consider CHW services not only as a complement to existing care management programs but also as a standalone engagement strategy for populations with historically low response rates to outreach efforts.

Limitations

Several limitations warrant consideration when interpreting these findings. First, this study employed a pre-post comparison design without a comparison group, meaning results cannot be definitively attributed to the CHW intervention. The observed cost savings are due to activities performed by CHWs and the rest of the interdisciplinary care team, whereas only the CHW component's cost could be included in the ROI calculation. Moreover, observed cost reductions may reflect regression to the mean, pre-existing trends in utilization, or member selection effects rather than true program impact. Future work will re-evaluate this program using a difference-in-differences design, with not-yet-treated members serving as the control group for treated individuals. Second, the 6-month observation period may not capture the longer-term effects of CHW support. Third, program costs were calculated based on the enrollment window duration (103 days) rather than individual member engagement periods, which averaged approximately 60 days. This approach may underestimate true ROI if CHWs achieve impact through intensive early engagement. Fourth, some subgroup analyses, particularly those for the hard-to-reach pathway (n=63), are based on small sample sizes and should be interpreted as promising preliminary evidence that warrants validation in larger studies. Finally, these results reflect a single health plan's experience in the Mountain West region and may not generalize to health plans with different populations, market dynamics, or other care models.

Implications for Health Plans

Despite these limitations, this study offers actionable insights for health plan executives evaluating CHW workforce solutions. The consistent positive returns across diverse populations—Medicaid, Medicare, and dual-eligible members—suggest that CHW-supported care management can be a financially viable strategy for managing high-risk populations while addressing HRSNs. Health plans implementing similar programs should consider multiple deployment models: embedding CHWs within care management teams to address social needs, deploying CHWs specifically for member engagement and outreach, or combining both approaches to maximize impact across their member populations.

Contact Us

Address:
155 Federal Street, Suite 604
Boston, MA USA 02110

Contact:
Phone: 855-632-2863
Fax: 855-632-2863
Email: info@activatecare.com

Stay Connected

www.activatecare.com

linkedin.com/company/activate-care

ActivateCare

Our Mission

We provide personalized, community-based services and tools to coordinate and address health and social needs, focusing on those most in need.

Our Vision

We envision a future where every individual is connected to equitable holistic health and social supports, contributing to the creation of thriving communities.

Our Values

Respect: We respect and treat each other with dignity and kindness.
Care: We care for the people and communities we serve.
Integrity: We act with integrity and do what we say we are going to do.
Tenacity: We are tenacious about solving hard problems, as we learn and adapt along the way.