FINANCING COMMUNITY HEALTH WORKERS: WHY AND HOW

The future is now in many communities

National Community Voices Initiative at the Center for Primary Care at Morehouse School of Medicine
and
The Northern Manhattan Community Voices at the Columbia University Center for Community Health Partnerships

Abstract

A growing body of research is demonstrating the contribution of community health workers (CHWs) to increased access and high-quality, efficient health care. Despite the emerging evidence that justifies expanded use of CHWs, a significant barrier is the lack of stable, mainstream financing. This policy brief highlights the rationale for and the methodologies that have been created to use available mainstream health care financing for CHWs. This policy brief demonstrates that the barrier of lack of ongoing financing for CHWs is being tackled successfully by a range of organizations that purchase, manage, and/or deliver health care and describes why and how these innovators have managed to do so.

Introduction

Community health workers (CHWs) are community members who work almost exclusively in community settings and serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care.[1] The literature indicates that CHWs increase access to health care for vulnerable populations and improve outcomes related to health knowledge, health status, and behavioral change.[2]

The Community Voices Initiative of the W.K. Kellogg Foundation supports the creation of sustainable, effective strategies to increase access to health services for vulnerable populations and to deliver high-quality health care in more cost-effective ways. In sorting out what works, Community Voices has identified and supported community health workers as a promising strategy. At the same time, Community Voices has also cited the lack of mainstream funding as a barrier to the expanded use of CHWs, noting that funding is often pieced together for CHWs, with the attendant restrictions on time frames, scopes of work, program size, and prescribed population groups or issues.[3]

The National Fund for Medical Education has recently released a report on the four major funding models for CHWs.[4] The study highlights the rarity of CHW programs that have resulted in permanent funding, and says that many study interviewees noted the need to expand state, federal, and third-party payments, especially Medicaid, to cover CHWs.

This policy brief will describe the accomplishments of five organizations that are moving from patchwork funding or "soft money" for CHWs, i.e., time- and scope-limited grant funding, to ongoing and stable financing streams. These organizations have designed and implemented more stable funding approaches for community health workers by using available health care financing streams, such as the Medicaid program. The brief will describe the rationale and finance methods instituted in diverse health care settings represented by Community Voices grantees in Colorado (Denver Health), Michigan (Ingham County Health Department), and New Mexico (University of New Mexico School of Medicine and Molina Healthcare of New Mexico). It will also describe two additional types of organizations with sustainable financing approaches— a community-based organization in Ohio (the Community Health Access Project) and a managed care plan in New York (Community Premier Plus).

The policy brief begins with a description of the organizations and their settings, presents the rationales for funding CHWs as driven by the organizations' interests and financing parameters, and highlights the specific and concrete financing methodologies they have established.

The Settings

The following descriptions of the sites showcased in this policy brief are intended to provide the context and setting within which diverse organizations have created a rationale and financing methodology

for CHWs tailored to their specific needs, thereby providing a range of examples for other organizations to draw upon, whether those organizations purchase, manage, or deliver health care.

Colorado: Denver Health Community Voices

The Denver Health and Hospital Authority (DH) integrates acute hospital and emergency care with public and community health to deliver preventive, primary, and acute care services.[5] The range of services includes 398 licensed beds, nine family health centers, and 12 school-based health centers serving one-third of Denver's population annually, as well as public health functions for the City and County of Denver. DH is the only certified, public-owned, hospital-based, Federally Qualified Health Center (FQHC) in Colorado.[6] The population served by DH is 55 percent Hispanic and 15 percent African American. Special populations served include high-risk pregnant women and their babies, the homeless, the chronically mentally ill, substance abusers, people with infectious disease, and prisoners.

DH is the major safety net provider for the Denver metropolitan area: it has 10 percent of the beds in the metropolitan area while providing 40 percent of all uncompensated care. Despite the extent of uncompensated care, DH has remained in the black every year since 1991. The care provided by the system extends beyond its commitment to the uninsured and underserved. DH is a major provider of services for Medicaid recipients, children eligible for the Child Health Plan, and persons eligible for the Colorado Indigent Care Program.

Through its work as a Community Voices grantee, DH is an innovator in the design and financing of CHW roles in a public safety net setting. DH employs approximately 12 CHWs to conduct culturally effective outreach with underserved populations and to provide services that include community-based health screening and health education, assistance with enrollment in publicly funded health plans, referrals, system navigation, and care management.[7]

Michigan: Ingham County Community Voices

Ingham County's population is 280,000, of which 117,000 reside in the City of Lansing. City residents are very diverse; 65 percent are white, 22 percent African American, 10 percent Hispanic, and 3 percent Asian. Lansing is a federally designated resettlement area for refugees, a majority of whom come from northern Africa, Asia, the Middle East, countries of the former Soviet Union, and Cuba. Nearly 19 percent of Lansing's population and 14 percent of families live below the poverty line.

In response to the ongoing engagement and mobilization of Ingham County residents, a community "will" has emerged and has steadily grown to improve health access, address issues of health equity, and revitalize Lansing's neighborhoods. In addition to the active engagement of residents, there is a rich tradition of collaboration among organizations (public and private nonprofits—large and small) within Ingham County. The Access Committee of the Capital Area Health Alliance has led a community process to develop and monitor an "Action Plan for an Organized System of Health Care in the Capital Area." The plan includes goals and strategies for health coverage, outreach, zero disparity, oral health, mental health, and substance abuse. The Power of We Consortium (*www.powerofwe.org*) is a community collaborative body that measures indicators of community well-being and strengthens connections among community improvement initiatives—many with a focus on the social determinants of health.

The Ingham County Health Department (the home of Community Voices) provides staff support for the collaborative processes described above and leads program development in response to the community's health access policy agenda. In conjunction with community partners, the health department assisted with the development of an innovative health coverage plan (Ingham Health Plan) and strengthened its primary care clinics (by earning FQHC Look Alike status). With Community Voices support, the health department partnered with community-based organizations in developing effective outreach models through community health workers. Each of these initiatives, i.e., expanded health coverage, enhanced primary care system, and outreach through community health workers, relies on mainstream health financing to sustain operations. Through partnerships and the leveraging of local investments with state and federal

funds, the community has achieved results—nearly 60 percent of the community's uninsured have access to organized health care.

New Mexico: Community Voices and Molina Healthcare of New Mexico

New Mexico Community Voices (NMCV) is an initiative of the Center for Community Partnerships within the Health Science Center of the University of New Mexico (UNM). NMCV facilitates state and community efforts to improve access to and quality of health services.[8] New Mexico has one of the highest rates of the uninsured and underinsured in the United States, with 29 of its 33 counties designated as medically underserved areas and health profession shortage areas.[9] NMCV participates in or supports an extensive partnership of various provider, policy, and advocacy groups intent on using health resources efficiently, increasing access, and reducing the number of people without health care. NMCV, together with the Coordinated Systems of Care Community Access Program of New Mexico (CSC-CAPNM), has funded the administrative staff and operations of the coordination and integration of care for high-risk patients, i.e., individuals who require health and related services of a type or amount beyond that required by the general membership of managed care plans.

Molina Healthcare of New Mexico is one of three managed care plans serving Medicaid recipients in the state. Molina is based in California and has health plans in several states that focus primarily on Medicaid and low-income populations. The plan emphasizes member outreach, low-literacy programs, and care management. As a major provider in Molina Healthcare of New Mexico's network, the University of New Mexico's Health Sciences Center (HSC) is partnering with the plan and CSC-CAPNM in carrying out its care management function. NMCV, through the UNM Health Sciences Center, provides the care coordination outreach that assists Molina with its overall health care coordination of members. UNM HSC, through the initial support of NMCV, recruits, trains, and coordinates CHWs within the plan's provider network, as a partner and member of the overall care management team.

Ohio: Community Health Access Project (CHAP)

A movement is under way in Ohio to strengthen the connection between funding and outcomes in the delivery of health and human services. The Ohio Department of Jobs and Family Services has fostered and funded initiatives that produce specific results through contracts for services for at-risk individuals. These initiatives involve partnerships with other local, state, and national organizations, including the Ohio Department of Health, the Osteopathic Heritage Foundation, the Richland County Foundation (a network of 35 churches, The Friends of CHAP), and the federal Health Resources and Services Administration (HRSA).

The Ohio county departments of Jobs and Family Services (Franklin, Knox, and Richland counties) negotiated outcome-focused contracts for the services provided by the Community Health Access Project, a nonprofit organization whose mission is to improve health and social outcomes. CHAP provides outcome-focused care coordination for at-risk populations. CHAP is also working with federal, state, and county partners to further develop and promote basic principles and a model for producing positive outcomes that are tied to financing.

CHAP began in urban Mansfield (Richland County) in 1999 with the goal of eliminating health disparities through the efforts of community health workers to overcome barriers to health care and employment. CHAP has since expanded to rural Knox County and urban Franklin County, which includes Columbus. CHAP provides community-based care coordination to improve health and social outcomes for individuals isolated by cultural, geographic, and economic barriers, focusing on the production of specific results. A fundamental challenge that CHAP addresses is to identify those at risk and to ensure that they connect to medical care. Culturally isolated and impoverished populations often do not receive medical care early, resulting in debilitating and much more expensive health status outcomes.

In the CHAP model, CHWs are part of an outcome-

focused care-coordination team that uses social and clinical "pathways" to achieve specific results and outcomes. To understand the setting in which CHAP and its funding partners make use of CHWs, it is helpful to review the principles and the "pathways" that are being applied to help health and social services systems direct financing to achieve specific results.

CHAP's care coordination is driven by three principles, which have been developed as part of a national collaborative effort supported by HRSA. These principles have been formally affirmed by the Ohio Chapter of the American Academy of Pediatrics.

1. Identify those most at risk.
2. Confirm their connection to evidence-based intervention.
3. Measure the outcome in both health/social improvement and cost savings.

Consistent with these broad principles, Drs. Sarah and Mark Redding applied the experience they gained in Alaska, which relies extensively on CHWs, to design the "Pathways Model." This model provides a standardized and accountable structure to document the care coordination that identifies and links those most at risk to the evidence-based activities and interventions necessary to achieve measurable, positive outcomes. The "pathway" of steps that needs to be taken to reach a positive outcome is reimbursed based on the achievement of specific performance measures and a final outcome.

One example of the "Pathways Model" is the "Pregnancy Pathway," in which an at-risk pregnant teen is identified and engaged in care coordination. Barriers to care such as language issues or lack of health insurance and transportation are identified and overcome. Receipt of prenatal care is confirmed and ongoing follow-up is provided. The pathway is not considered complete and final payment is not invoiced until the positive outcome is achieved, i.e., a healthy, normal birth-weight infant. The method that links a pathway and reimbursement will be described in the rationale and methodology section of this policy brief.

CHAP is currently utilizing more than 40 pathways addressing health, social, and education issues. CHWs play key roles in care coordination teams with direct service providers, helping to create and maintain the connections with health and social services that are essential for achieving positive outcomes.

New York: Community Premier Plus

Community Premier Plus (CPP) is a private, not-for-profit health plan serving persons eligible for Medicaid managed care, Family Health Plus (for adults between the ages of 19 and 64 who do not have health insurance and are not eligible for Medicaid), and Child Health Plus (the state's insurance plan for children).[10] CPP is targeted to the medically underserved living in the Bronx and northern Manhattan. In 2004, CPP received the highest ranking for quality and member satisfaction among Medicaid health plans by the New York State Department of Health.[11] The North Manhattan Community Voices Collaborative has spotlighted the contributions of CHWs, with CPP exemplifying a model approach.

CPP employs two CHWs and they are an integral part of the plan's quality improvement function. CPP hires individuals drawn from the community who carry out community health worker functions related to health education. The plan's Quality Improvement Committee determines health education targets based on its analysis of Health Plan Employer Data and Information Set (HEDIS) data and quality improvement priorities set by the state and city.[12]

The Rationales and Methods for Financing Community Health Workers

Each of the organizations highlighted in this policy brief is concerned with health care access, quality, and cost. Depending on its mission and the financing mechanisms available to it, each organization looks to CHWs for the value added relative to a specific emphasis on access, quality, and/or cost. Most importantly, their decision to support CHWs is based on the analyses they are undertaking to assess the impact of CHWs, and they are utilizing and adapting available mainstream financing mechanisms such as Medicaid. While federal Medicaid policy does not specify that CHWs can be directly reimbursed, the financing approach of the organizations described in this policy brief generally take advantage of one or more of the following opportunities:

- Medicaid managed-care organizations can utilize portions of capitated payments to employ CHWs or contract with provider organizations for CHWs.

- Selected organizations, such as public health agencies and FQHCs, can be reimbursed for Medicaid administrative costs to support outreach and coordination activities performed by CHWs.

- Health systems and provider organizations can utilize CHWs to improve their financial bottom line.

The following descriptions present the financing policies and methods of the organizations, including a brief summary of their analyses of the value of CHWs to date that are driving their financial commitments.

Denver Health and Hospital Authority

Rationale and Methodology. There are numerous financing mechanisms available to Denver Health as an integrated health system. The system has the usual contracts with the state, health plans, and commercial insurance carriers for the provision of medical services. In addition, DH has some unique financial mechanisms as a publicly owned health authority and a FQHC. These unique arrangements include coverage plans for the uninsured through leveraged Disproportionate Share Hospital payments (DSH),[13] an alternative Medicaid reimbursement methodology for costs associated with outreach and Medicaid eligibility determination, and funding from city and county governments to cover a portion of uncompensated care costs. Within these financing parameters, as a safety net provider serving a large uninsured population, DH is focused on having its patient population covered, appropriately utilizing services, and receiving the most cost-effective interventions to improve their health. DH is mission-driven (serving persons with low-income) with a focus on the bottom line. In spite of the challenges, the Denver Health and Hospital Authority has never incurred a deficit.

DH is a strong proponent of the idea that community health workers can contribute in many ways to carry out the mission of the health authority. With the support of grant (soft) funds, DH has been an innovator in the design and evaluation of roles performed by community health workers. This innovation is grounded in rigorous evaluation of not only the outputs of CHWs, such as the number and types of services and referrals provided, but also of the financial impact of CHWs on the health system. Functions performed by CHWs that have a demonstrated return on investment are transferred from soft (grant) funding to hard (mainstream) funding. Of the 12 community health workers employed by DH, four have been transferred from grant funding to mainstream funding.

Two CHWs have been transferred to mainstream funding based on their positive contribution to men's health. Their impact on the health system has been demonstrated through analysis of utilization, charges, reimbursements, and payer sources for a sample of underserved men nine months before and nine months after initial contact with a community health worker. The analysis found that although total visits increased, total charges decreased. These utilization changes—increases in primary care and medical specialty visits and reductions in urgent care, behavioral health, and inpatient visits—resulted in a reduction in uncompensated charges of $206,485 ($275,313 annualized). Calculating the return on investment (the ratio of savings as a result of the intervention divided by the program costs) yielded a savings of $2.28 for every dollar invested by Denver Health in the CHW program, translating to $95,941 in annual savings.[14]

Two additional health workers have been transferred to mainstream funding based on their positive contribution to women during and after pregnancy. The Free Pregnancy Testing Program provides barrier-free pregnancy tests and uses community health workers (health advisors) to conduct the pregnancy tests, assist women in scheduling an appointment with an enrollment specialist, and identifying a medical home.[15] DH conducted an analysis of the degree to which access to services was increased for underserved pregnant women, the concurrent increase in DH deliveries, and the increase in revenue for the health system. Access to services was increased for underserved pregnant women with a concurrent increase in DH deliveries (78 percent of non-DH patients at the time of the pregnancy test delivered at DH), resulting in net revenue of $295,919—a return on investment of $6.69 for each dollar spent.

Finance Methodology. Once positive results from the return on investments analysis are established, the information is presented to officials within DH, including its board of directors. The chief financial officer (CFO) reviews analyses conducted that will reduce costs and/or increase revenues and accordingly recommends actions. For the two analyses described above, decisions resulted in changing the source of financing from grant funding to the organization's operating budget (mainstream funding).

Next Steps. Denver Health is now advancing its analysis of value by comparing the health status benchmarks of mothers who delivered at the system, and their infants, following participation in the free pregnancy testing initiative, with other mothers and infants served by the system during the same period. Variables will include beginning prenatal care in the first trimester, number of prenatal visits, birth weight, and Neonatal Intensive Care Unit (NICU) admissions. Denver Health is preparing to publish this analysis along with the analysis of the financial impact of the free pregnancy testing initiative.

A new return on investment analysis will soon be initiated to assess the costs and contributions of community health workers in their role of assisting families with Medicaid applications. Several CHWs are assigned to neighborhoods to help uninsured families apply for Medicaid as a part of their health screening activities. Other community health workers perform these functions in neighborhood clinics or in school-based health centers. Due to a recent change in state policy, a positive return on investment for outreach activities performed by CHWs may be somewhat easier to achieve than under the previous policy. Prior to the policy change, Denver Health, as a FQHC, received a capped "outstationing payment" to create opportunities for pregnant women and children to apply for Medicaid at locations other than welfare offices. The capped payment was far below the costs for these activities. Since Denver Health is the only publicly owned, hospital-affiliated FQHC that currently performs outstationing services, the state modified a rule to permit DH to share (on a 50-50 basis with Medicaid—federal funds) the certified, uncompensated administrative costs associated with outstationing activities.[16] Under this new policy, Denver Health has already received increased reimbursement to partially cover the costs of its specialty eligibility workers and the two men's health initiative CHWs who take applications in the field. Denver Health has not yet claimed any costs of other CHWs assisting with the enrollment process. If the return on investment analysis can demonstrate positive returns for CHWs in their role of outreach and assisting families with Medicaid applications, Denver Health will likely transfer additional CHW positions from soft money to mainstream health care financing.

Michigan, Ingham County Community Voices

Rationale and Methodology. While the Ingham community's focus includes access, quality, and cost, the policy driver is access. The community has adopted a three-part strategy for reducing its uninsured population. The first step was to expand health coverage. In 1998, the Ingham Health Plan (IHP) was created; it is a coverage program that provides primary care, specialty care, outpatient lab, x-ray, and prescription drugs to low-income, uninsured county residents and those eligible for the state's Adults Benefits Waiver (ABW) program. In addition to co-payments charged to enrollees, the primary source of financing is provided through a special DSH payment. The special financing mechanism combines local funds from county tax revenues, state funds designated for ABW enrollees, and federal Medicaid matching funds. Financing is available to cover the costs of approximately 16,000 enrollees.

The next steps simultaneously focused on expanding the provider network and on active outreach to find and assist uninsured persons with enrollment in Medicaid or IHP. Private providers willing to serve Medicaid and IHP enrollees were recruited—both primary care and specialty providers. The Ingham County Health Department earned FQHC "Look Alike" status and with it came Medicaid full-cost reimbursement (up to the Medicare cap). As a result, the health department reduced its cost subsidy of health care for Medicaid recipients; the funds were instead used to expand services for the uninsured. Having accomplished new health coverage and increased health care capacity, the challenge became finding the uninsured and assisting them with Medicaid or IHP enrollment and promoting appropriate utilization of their health care benefits.

While IHP financing and provider capacity would support an enrollment of 16,000, actual enrollment reached a plateau around 14,000. This set the stage for new models for outreach through community health workers.

For many years CHWs have been successfully utilized by the health department in outreach activities with women during and after pregnancy and by community-based organizations (under contract with the department) to help refugees access health care services. In the first instance, mothers previously on welfare are recruited as community health workers to help low-income pregnant women access early prenatal care and preventive health care for their infant. For refugees, community health workers from the same culture provide care coordination, transportation, and translation services.

Several years ago, the health department began to partner with neighborhood organizations to develop new models of neighbor-to-neighbor outreach, and with organizations serving communities of color to develop new, culturally appropriate outreach models. These partnerships are natural outgrowths of community practices developed through Community Voices. Consistent with these practices, community-based organizations are encouraged to view the health department and other institutions as their resources, while the health department and other institutions are learning to view community-based organizations as their assets. In this regard, the outreach models utilize the assets of community health workers—trusting relationships—to connect people to one another and with community resources, thereby tapping the knowledge, skills, and resources of community members and institutions alike. The outreach strategies to improve access and appropriate effective utilization of services are integrated with engagement and mobilization of residents to improve community health.[17]

The local rationale for financing CHWs is supported most dramatically by the increasing proportion of individuals with health coverage and linkages to services. Local evaluation by Ingham Community Voices documents that almost 60 percent of individuals without health insurance now have coverage through IHP.[18]

The contribution of CHWs to increased access is demonstrated by the performance data in Exhibit 1, which presents data from Fiscal Year (FY) 2006 on the outputs of the six community-based organizations utilizing CHWs (0.5 to 2.0 full-time equivalents [FTEs] per organization) related to the following objectives:

- Provide outreach in low-income neighborhoods and in communities of color
- Enroll those eligible in health coverage plans
- Provide information and links to health and social support services
- Engage community members in community improvement activities

EXHIBIT 1

Community Health Worker Performance, Fiscal Year 2006

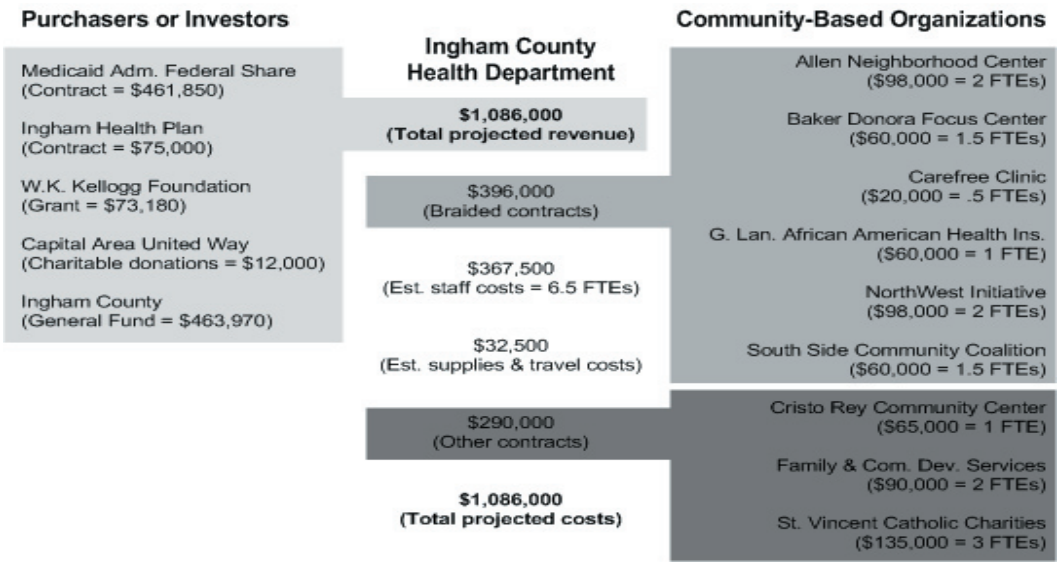
Factor	Q1 (10/05-12/05)	Q2 (1/06-3/06)	Q3 (4/06-6/06)	Q4 (7/06-9/06)
Residents contacted	1,924	2,198	2,198	2,730
Initial interactions	621	733	1,163	1,250
Follow-up interactions	1,524	1,795	1,014	1,253
Group interactions	499	630	1,419	1,870
Enrollments in Medicaid or Ingham Health Plan (IHP)	289	224	393	368
Number of linkages provided and/or information topics covered during outreach interactions	5,887	9,318	8,751	NA
Number of linkages provided and/or information related to community improvement	673	730	901	NA

SOURCE: Ingham County Health Department

NOTES: Outreach workers may have one or more interactions with a resident during the reporting period; enrollments include new enrollments in Medicaid, conversion from IHP to Medicaid, and new enrollments in IHP, an interaction may include multiple linkages or information provided to the resident; and linkages/information for community improvement is one of the topics that may be covered during outreach.

In addition, CHWs effectively target outreach to vulnerable populations. In FY 2006, the Ingham County Health Department targeted its outreach to low-income pregnant women, mothers with infants, and the Native American community. During the year, CHWs assisted 394 pregnant women and mothers with infants enrolled in Medicaid in accessing prenatal care or well-child

EXHIBIT 2
Mainstream Financing of Community Health Workers
FY 2007 Community Outreach System



SOURCE: Ingham County Health Department

visits and implementing plans of care, and helped 34 Native Americans access health services.

CHWs employed by community-based organizations also helped immigrants, refugees, and language minorities access more than 4,000 clinic visits and health screenings by providing transportation, translation, and other supportive services.

Finance Methodology. The Ingham County Health Department has utilized a progressive Michigan Medicaid Policy, first initiated in 1990, to support outreach activities by CHWs.[19] In 2005, the Michigan Department of Community Health (MDCH), with approval from the Centers for Medicare and Medicaid, refined the policy to make more explicit the reimbursable activities and cost-sharing arrangements for Medicaid outreach. Activities include increasing public awareness about Medicaid eligibility and benefits; assisting with Medicaid applications; providing translation and transportation services; and promoting the utilization of preventive health services, such as well-child visits. When these administrative functions are carried out by local health departments under contract with the Michigan Medicaid Program, local expenditures can earn federal Medicaid matching funds on a 50-50 basis.[20]

Through this state policy, Ingham County has leveraged local investments (with Medicaid federal funds) to create its community system of outreach based on community health workers. Over a million dollars of mainstream health care financing is invested annually in this community outreach system. Twenty-one FTE community health worker positions are supported through the financing, and since many work on a part-time basis, there are approximately 30 employees. Most of the community health workers are employed through community-based organizations. Exhibit 2 illustrates the multiple funding sources, the numbers and settings of CHWs, and the role of the health department as intermediary with community-based organizations. The system's activities and costs are divided as follows: outreach to current and potential Medicaid recipients (a weighted average of 85 percent of costs) and outreach activities associated with IHP members or non-Medicaid activities (15 percent of costs).

Prior to the contract period, the health department is busy securing and bundling funds from multiple sources to sustain or enhance the community's outreach system. The initial focus is on generating funds that can be matched with Medicaid funds (the federal share). The county's general fund is the primary source of matching funds; secondary sources include private funds generated through the United Way's annual campaign and grant funds from the W. K. Kellogg Foundation. The department develops budget requests through the county's budget process; the requests are justified using information produced by the community that supports the need for, and performance of, community health workers. As a part of the annual United Way campaign, employees of health care organizations are permitted to designate the "health outreach initiative" as a charitable contribution. These private donations, along with the department's decisions about the allocation of Community Voices grant funds, are added to the pool of available funds for CHWs. Through a budget process similar to the county's, the department requests funds from the Ingham Health Plan Corporation for its portion of outreach costs.

Once funding levels are established, the health department enters into contracts with the Ingham Health Plan Corporation for outreach services and with MDCH for the federal share of Medicaid outreach costs. The contracts contain approved budgets and contract provisions that outline program and financial requirements. The contract with the MDCH specifically binds the health department to the state Medicaid outreach policy as the basis for claiming the federal share (50 percent) of its outreach costs. The contract further requires the health department to use cost allocation methodologies that comply with federal Office of Management and Budget Circular A-87 in establishing its quarterly claim for federal funds. MDCH agrees to pay the department for half of the Medicaid outreach costs that are reported in quarterly program and financial reports.[21]

With funding levels established for the budget year, CHW positions within the health department can be confirmed. These positions include 5.5 FTE positions in the department's Maternal and Infant Outreach unit and one full-time Native American outreach position. With funding established for contractual services, the health department can negotiate outreach contracts with community-based organizations. There are two types of contracts: braided contracts involving multiple funding sources and other contracts supported by only two funding sources (county and Medicaid—federal share).

To simplify administration for community-based organizations and to enhance accountability to the various funding sources, **braided contracts** are negotiated with six community-based organizations. Five of these community-based organizations provide outreach services in low-income neighborhoods and one focuses its outreach within the African American community. This single contract specifies all the program and reporting requirements of the various funding partners, including information that is necessary for the health department to determine Medicaid's share of costs associated with the activities of community health workers. Specifically, quarterly reports are required that specify the number and percentage of outreach activities (interactions) that took place during the period with current and potential Medicaid recipients. Cash advances and payments to community-based organizations are linked with these quarterly reporting requirements. In addition to paying for outreach services, the health department provides technical assistance on the development and maintenance of outreach databases, provides training on Medicaid and IHP eligibility and benefits, and provides shared learning opportunities for CHWs.

Other outreach contracts support community health workers in assisting refugees and new immigrants with accessing and utilizing health care services. For example, St. Vincent Catholic Charities and Family and Community Services provide these services through care coordination, translation, and transportation supports. Cristo Rey Community Center helps Spanish-speaking residents access health care and related human services.

Next Steps. In FY 2007, the Ingham County Health Department intends to pilot a new role for community health workers—patient navigators—in the primary care clinics of its FQHC. Two patient navigators will join clinical teams managing patients with diabetes and hypertension. Patient navigators will provide a critical

link between the clinics and community resources, including CHWs employed by community-based organizations. They will link patients with community-based exercise and nutrition education opportunities in convenient and comfortable locations for residents. The pilot will determine whether patient navigators, as part of the clinical team treating patients with chronic disease, can improve the self-care and management of diabetes and hypertension and thereby reduce disease-related complications such as heart disease, stroke, kidney disease, adult-onset blindness, and lower limb amputations.

New Mexico Community Voices and Molina Healthcare of New Mexico

Rationale and Methodology. Molina Healthcare of New Mexico is at the center of New Mexico's financing strategies for community health workers and capitation is at the heart of the payment mechanism. The rationale for the utilization of CHWs is guided by the health plan's strategic interest in expanding its market share (access) and the interrelated aspects of increasing the effectiveness (quality) and efficiency (cost) of medical care. Molina's case managers form a team with CHWs as **field case managers**. In this role, the primary contribution of CHWs is contacting high-risk plan members, connecting them with a medical home, and overcoming barriers to appropriate utilization of services.

While the focus of Molina Healthcare of New Mexico's use of CHWs is on case management and care coordination, the involvement of CHWs also contributes directly and indirectly to Molina Healthcare of New Mexico's marketing strategy. The direct impact on marketing is that enrollment materials describe enhanced benefits that include CHWs. As a result, Molina assumes that more Medicaid recipients will select the plan for their services. There is also an indirect influence on enrollment through the state's automatic (default) enrollee assignment process, when higher plan performance scores translate into more patients being automatically assigned to the plan. Molina recognizes that CHWs contribute to improved plan performance, as measured by HEDIS and Consumer Assessment of Health Care Providers and Systems (CAHPS) (member satisfaction) scores. Molina has entered into an agreement with the Health Sciences Center of the University of New Mexico's Family and Community Medicine Department to assign CHWs to selected patients enrolled with the health plan. This agreement is based on a successful one-year pilot (initially a one-year project started in May 2005) between Molina and CSC-CAPNM, along with other organizations. The focus of the pilot was to improve access to necessary health services, prevent overutilization and underutilization of services, and assist in care management for patients with substance abuse and behavioral health issues, as well as physical health problems and psychosocial issues. Patients with these co-morbidities who were missing medical appointments were referred by Molina Healthcare of New Mexico to CHWs to provide follow-up activities. These activities were funded by NMCV through a contract with First Choice Community Health Care and supervised by the CSC-CAPNM staff housed in the UNM Family and Community Medicine Department's Office of Special Projects (FCM-OSP).

The pilot examined changes in health outcomes and the cost of care if members received appropriate health care services, as measured by the Domain Assessment Tool, the Early Case Identification score, and the health care costs over a period of six months. Forty plan members were referred to field care coordinators during the pilot period. Fifteen members completed the program. Changes in utilization for five members completing the program led to a cost savings of $7,676 within the period of the pilot.[22] For some plan members, there were cost increases rather than cost savings, reflecting a reduction in underutilization. Over time, it is expected that the improved social and health care management will generate cost savings by reducing the overutilization of hospitalization and other high-cost services. The preliminary study is being used to design a longitudinal analysis to test this hypothesis and document such savings.

Finance Methodology. Under a contract with the New Mexico Human Services Department, Molina Healthcare of New Mexico receives a monthly (capitation) payment for each Medicaid recipient enrolled with the plan. Molina in turn contracts with its provider network for the delivery of medical and other services—some of which is paid for on a capitation basis. As a major provider in Molina's network, the University of New

Mexico's Health Sciences Center and FCM-OSP are partnering with the plan in carrying out its care coordination function. Through an agreement between the plan and the university, FCM-OSP is responsible for the recruitment, training, and start-up payroll for community health workers functioning as field case managers. Through a monthly capitation mechanism, UNM will be reimbursed by Molina Healthcare of New Mexico for determined referrals to two community health workers who work with Molina's case managers as field case managers. Molina refers high-risk members (with medical, behavioral, and psychosocial needs) to UNM for care coordination and pays UNM a monthly capitation fee per patient for field case management services. Case managers from Molina meet monthly to establish individualized goals for care coordination, to monitor progress, and to close cases when goals have been achieved. The caseload size for a field case manager, by current agreement, is 25 patients.

While UNM has utilized grant funds through the NMCV support for the start-up costs associated with the hiring and training of new CHWs, future expansion and sustainability of the program will be drawn from revenue from the capitation fees (mainstream funding from Medicaid managed care) to cover the operating costs of the field case managers.

Next Steps. Molina Healthcare of New Mexico has additional high-risk patients in the Albuquerque area that could benefit from field care coordination; however, the current capacity of UNM limits this possibility. To address this challenge, several steps are under way. Molina and UNM are designing special studies to refine their model of case management and field case management to improve the effectiveness and efficiency of the model. Concurrently, discussions are under way to expand the number of Molina patient referrals and the number of field case managers in areas outside of the Central CSC-CAPNM catchment area. There are additional considerations for targeted care management to increase Molina plan member participation in specific primary and prevention program areas. For example, underutilization of oral health services by at-risk populations such as pregnant women and children is a major concern for Molina in the southern counties of the state. Care management strategies could be applied to this population of Molina plan members and offer significant reduction in costs associated with oral health diseases that go untreated during pregnancy. Such an expansion would require new partnerships and approaches to members in rural and border areas of the state.

Ohio Community Health Access Project

Rationale and Methodology. Public purchasers are concerned about the affordability of services and accountability for results. As a high-capacity, community-based organization, CHAP is demonstrating to state purchasers, including the Ohio Department of Jobs and Family Services and the Ohio Department of Health, that outcomes can be achieved affordably by identifying individuals most at risk, using evidence-based interventions, and measuring the results. Using mainstream funding, state purchasers contract for care coordination to identify individuals most at risk and assure that they connect to evidence-based interventions.

The contracts in each county vary in strategy, but each provides payment for production steps along a defined "pathway" to a desired outcome. Final payment is not received until a positive outcome is documented, e.g., an at-risk pregnant woman delivers a normal birth-weight infant, or a child who was behind on immunizations is confirmed to be up to date. By tracking the steps and time utilized by care coordinators to achieve the outcomes, CHAP can establish a fair price for its outcomes in this pay-for-performance system.

The rationale for considering CHWs integral to the production of positive health and social outcomes is demonstrated each time a pathway is completed and leads to such outcomes. At the same time, the CHWs benefit from payment and financial incentives. In addition to their salary and benefit package, individual CHWs can earn financial incentives in the form of biweekly bonuses based on the number of pathways completed and related performance measures achieved. CHWs have clearly demonstrated through these contracting arrangements and available financial incentives that they can engage community members most at risk and assure that they connect to critical preventive care services. More than 30,000 contractually tied pathways have been produced and confirmed through supervision as well as outside auditors.

Outcome-based contracting using pathways has demonstrated its greatest value as a regional approach deployed across multiple agencies. Regional contracting approaches are yielding a stronger focus on effective interventions for at-risk populations and reducing service duplication. Care coordination within communities can often be duplicative and not tied to performance measures. For example, at-risk pregnant women may have multiple care coordinators from separate agencies and structures do not typically exist to support accountability for results.

Outcome-based contracting across a network of agencies within a community started in Ohio's Richland County and is expanding to other communities. This approach, the "community hub," is based on the premise that multiple agencies within each community can focus on working together to achieve specific outcomes. Key conditions are identified by the community and community leadership. The population most at risk for these conditions is defined. The community then works together using outcome-focused production models like pathways to reach each at-risk individual, ensure that they connect to care, and measure the final result. A central registration process at the community hub eliminates care coordination duplication. Pathways agreed upon at a community level create standard performance and quality measures, while at the same time encouraging agencies to use their expertise and ingenuity to produce results.

The agencies providing care coordination in a community hub include health departments, outreach programs (like CHAP), children's services, mental health, rehabilitation centers, and community clinic programs. Prior to establishing a hub, some communities had general networks but very few had specific strategies to ensure commonly shared and unduplicated results for their community.

The *Help Me Grow* contract in Richland County has provided one of the best examples of building a community hub. This contract supports seven separate agencies in reaching out to pregnant women and young children in Richland County. Prior to development of the hub, local research showed that care coordinators were not effectively reaching women most at risk. A new contract was developed focusing services on geographic areas with a high-risk population, i.e., census tracts with the greatest risk of low birth-weight infants. Duplication of care coordination was eliminated by requiring each agency to register newly identified clients with the community hub. The previous contract provided payment based on documented service activities such as phone calls and home visits. The new contract withheld part of the payment until specific performance measures were documented, including initial engagement and assessment of the client, confirmation that barriers were overcome and evidence-based services were received and an outcome was achieved, i.e., a healthy, normal birth-weight baby.

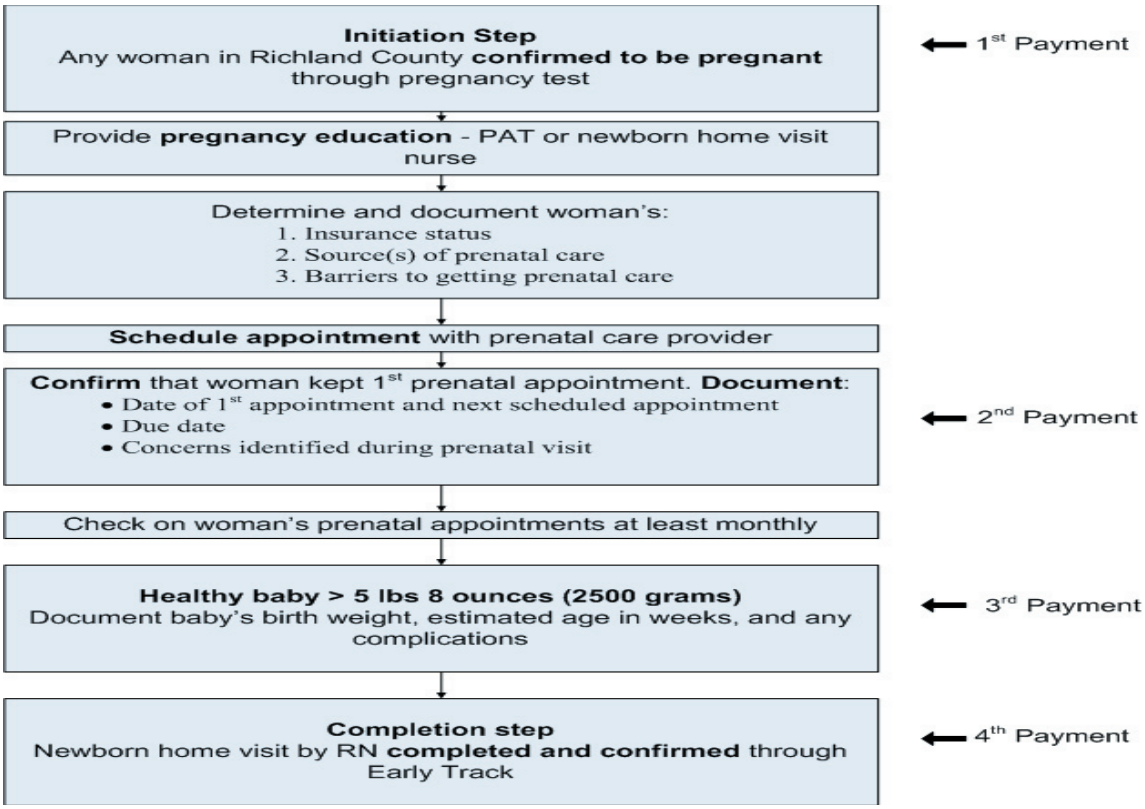
Exhibit 3 displays the "pregnancy pathway," presenting the activities and the outcome that are documented as performance measures are aligned with payment.

When introduced, the community hub contracting approach that pays for results was not uniformly popular among agencies accustomed to activity-based invoicing for services. Several agencies that were determined to demonstrate success took the lead. They began focusing outreach in the most at-risk census tracts and in housing projects.

In the year prior to the new contract, 2004–2005, research demonstrated that only 19 pregnant women from those census tracts had been served. When the contract began to require that the pregnant women served would be residents of the most impoverished and at-risk census tracts, the number of at-risk individuals served increased dramatically to 146 over one contract year. In addition, duplication of service was eliminated and specific performance points and outcomes were required for full payment. All seven programs serving the population demonstrated the ability to meet the challenge, with all seven bringing in their contracted dollars for the year. Joe Mudra, Director of the Richland County Youth and Family Council that launched the first community hub, said, "Agencies are now not only achieving outcomes, but doing so in areas of our community where the greatest disparities exist, helping our collaboration to eliminate disparity." [23]

Ongoing research is being undertaken to measure the impact of the model on birth outcomes such as low

EXHIBIT 3
Pregnancy Pathway



SOURCE: CHAP.

birth weight. Findings thus far are positive and will be reported when control group comparisons can be demonstrated.

One of the greatest barriers to outcome-based funding experienced to date by these initiatives comes from the purchasers themselves. The change from paying for service activities to paying for health and social outcomes is a dramatic shift, requiring modifications in contracting and accountability approaches. The will of community agency leaders to join together effectively to reach specific outcomes is critical and appears to provide the most significant gains in efficiency and results.

Sharlene Neuman, Director of the Richland County Jobs and Family Services and primary funder of regional pathway production, notes that "those in communities who have the responsibility to fund programs can and should change the way programs are funded in an effort to encourage outcomes. However, it isn't easy. If the intent is to make a difference, then communities must maximize resources and benefits by demanding accountability for positive results."[24]

Next Steps. Shifting from a focus on activities to outcomes will require continued work and innovation on many levels. At the individual level, each care coordinator, CHW, and provider serving those most at risk must continue to develop more effective strategies to achieve results. At the community level, continuing innovation is needed to make the transition to producing outcomes across organizations. Continuing development of the community hub contracting approach is under way to support the best utilization of resources across a community, reach at-risk individuals, and hold providers financially accountable for achieving results.

For this approach to move forward, policymakers and purchasers must evaluate and refine contracting methodologies. Medicaid managed care organizations, such as Buckeye Community Health Plan, have been

developing CHW and related services for a number of years. They are joining other Ohio Medicaid managed care organizations to strengthen the focus on outcomes and results. Local and state political leadership is also key, as demonstrated by leaders such as Richland County Commissioner Ed Olson, who declared that his county's contracts would focus on results, and state leadership like Governor Ted Stickland, Senator Bill Harris, and Representative Bill Harnett, who promote strategies that help move duplicative and activity-based systems to focus on results.

Leadership from national organizations is also emerging, such as Communities Joined in Action, the American Academy of Pediatrics, and the federal Centers for Medicare and Medicaid. HRSA is working with a national group of purchasers, policymakers, researchers, and community programs to identify and highlight standard tools and methods to focus funding on outcomes, to be published in spring 2007.

New York, Community Premier Plus

Rationale and Methodology. Within the State of New York's regulatory framework for managed care organizations, Community Premier Plus (CPP) must address a number of disease management and health education topics such as immunizations, HIV/AIDS, lead testing, cancer screening, diabetes, and asthma. Many of these topics overlap with HEDIS quality measures (the New York version is called QARR—Quality Assurance Reporting Requirements). In addition, New York City's Department of Health and Mental Hygiene requires special studies on topics of concern. Several years ago, in response to these frameworks and the analysis of member data, CPP began using CHWs as health educators to improve its quality measures for diabetes and asthma. Over time the methods have been refined, and CPP believes that the activities of the CHWs contribute to the plan's improving quality measures.

The two CHWs employed by CPP were active with community causes prior to their employment. While not formally trained in health education, in many ways they are self-taught through on-the-job training and by taking advantage of continuing education. One CHW specializes in asthma and the other CHW specializes in diabetes.

The CHW who specializes in asthma is involved in a number of activities and functions. The activities are intended to help CPP members with asthma increase their knowledge about asthma and ways to improve management of the disease. The CHW conducts weekly asthma workshops in the format of a four-part series to inform members (and non-members from the community) of the physiology of the disease, medication compliance, asthma action plan, triggers, etc. In addition to active outreach to invite members to the workshops, the CHW makes home visits to members whose condition is deemed more "severe" based on internal risk stratification criteria, and provides such services as education, environmental risk assessments, and medication compliance checks. These are all skills the CHW has gained through years of on-the-job training and continuing education through the Asthma Training Institute. CPP believes that these efforts support its overall goals for asthma medication compliance, which is a HEDIS/QARR measure.

There is a counterpart diabetes workshop, which is advertised to all CPP members with diabetes as well as to non-members. In this monthly workshop, participants are taught physiology, nutrition habits, lifestyle changes, why each exam/lab for diabetes is important, self-blood glucose monitoring, etc.

In addition, these CHW health educators assist in the creation of CPP's Healthy Living educational series, a series of booklets on different health topics, many of which are directly tied to HEDIS/QARR quality measures. The health educators provide community outreach and education in different venues (schools, churches, doctors' clinics, health fairs, other public events). At these events, the health educators provide education by distributing flyers/booklets and conducting preplanned workshops or one-on-one counseling to those who may have received a diabetic or hypertensive screening.

Due to the positive contribution of CHW health educators to plan performance, these positions are funded by mainstream financing, i.e., these individuals are paid from the administrative budget set aside from overall premium revenues, including Medicaid capitation revenue. There is no specific cost reimbursement, nor were the positions initiated or sustained by grant funding.

Next Steps. Based on the positive contributions of CHWs on quality measures for asthma and diabetes, CPP may hire additional health educators within the next two years. One target for CHW expansion includes the cardiovascular program, addressing hypertension, cholesterol, and congestive heart failure.

Conclusion

The organizations presented in this policy brief are demonstrating that there are three essential factors that permit CHWs to compete successfully for scarce health and human services resources:

- Analytical capacity
- Community and organizational "will"
- The recognition and use of mainstream funding

Emerging research on CHW effectiveness may entice an organization to consider integrating CHWs into its strategies to improve access to health care and its quality and efficiency, but local analytical capacity must be sufficient to demonstrate an organization's impact on the populations they serve. Moreover, organizations that focus their analysis on improving—rather than proving—the effectiveness of their strategies are the ones making the most progress in reaping the benefits of CHWs.

Strong community and organizational "will" is required to promote and sustain innovation and nurture the policy goals of accessible, high-quality, and efficient health care. Finally, there must be recognition by state and local policymakers (purchasers, managers, and health care providers) of the potential in existing mainstream funding sources, such as Medicaid, to finance improved care and outcomes through strategies using CHWs.

Acknowledgments

The Community Voices Program Office, National Center for Primary Care at Morehouse School of Medicine, funded this policy brief through the Center for Community Health Partnerships at the Columbia University Medical Center. The policy brief was prepared by Public Sector Consultants Inc., Lansing, Michigan. The contributions of the following individuals who participated in interviews and provided information and guidance are greatly appreciated. Contact information is generously offered by individuals at each site.

Colorado

Elizabeth M. Whitley, RN, PhD
Director, Community Voices
Denver Health
(303) 436-4071
lwhitley@dhha.org

Rachel Everhart, MS
Statistical Research Specialist
Community Voices
Denver Health

Peg Burnette
Chief Financial Officer
Denver Health

Michigan

Melany Mack
Community Voices Coordinator
Ingham County Health Department
(515) 887-4568
mmack@ingham.org

Ronald Uken
Coordinator
Power of We Consortium
Ingham County Health Department
(517) 887-4558
ruken@ingham.org

Bruce Bragg
Health Officer
Ingham County Health Department

New Mexico

Wayne Powell, MA
Project Director
New Mexico Community Voices
Associate Director
Center for Community Health Partnerships
(505) 272-4004
wpowell@salud.unm.edu

Kelly Ann Cieciorka, MPA/HAS
Manager, Quality Analysis
Molina Healthcare of New Mexico
(505) 348-0217
kelly.cieciorka@molinahealthcare.com

Diana Madrid
Manager, Medical Services
Molina Healthcare of New Mexico

Edna Walker
Supervisor, Care Coordination
Molina Healthcare of New Mexico

Mary E. Guevara
Program Coordinator
Coordinated Systems of Care
Community Access Program of
New Mexico (CSC-CAPNM)

Patricia Saavedra
Field Case Manager
Coordinated Systems of Care
Community Access Program of
New Mexico (CSC-CAPNM)

Delores Gomez
Field Case Manager
Coordinated Systems of Care
Community Access Program of
New Mexico (CSC-CAPNM)

Fornessa T. Randal
Executive Director
Coordinated Systems of Care-Community Access
Program of New Mexico (CSC-CANM
(505) 272-2339
frandal@saludunm.edu

Christine Hollis, MPS, MPH, CHES
Evaluator
New Mexico Community Voices
Health Sciences Center
University of New Mexico

Ohio

Mark Redding, MD, FAAP
Medical Director (Volunteer)
Community Health Access Project
Ocie Hill Neighborhood Center
445 Bowman Street, PO Box 1986
Mansfield, Ohio 44901
(419) 525-2555

Sarah Redding, MD, MPH
Director of Evaluation
Community Health Access Project
Ocie Hill Neighborhood Center
445 Bowman Street, PO Box 1986
Mansfield, Ohio 44901
(419) 525-2555

New York

Dr. Harris K. Lampert
President and CEO
549 W. 180th St.
New York, NY 10033
(917) 521-7012

Helen Lee Syn, Manager
Disease Management
Community Premier Plus

Center for Community Health Partnerships
Columbia University Medical Center

Allan Formicola, DDS, MS
Vice Dean, Center for Community Health Partnerships
Columbia University Medical Center
Program Director
Northern Manhattan Community Voices
(212) 304-6418
ajf3@columbia.edu

Irina M. Polanco-Ventura, PT, MA, CHES
Associate Program Director
Northern Manhattan Community Voices
(212) 304-7031
imp2101@columbia.edu

Jacqueline Martinez, MPH
Senior Program Director
New York State Health Foundation
(212) 664-7656
martinez@nyshealth.org

Public Sector Consultants Inc.

Suzanne Miel-Uken
Vice President and
Senior Consultant for Health and Human Services
Lansing, Michigan
(517) 484-4954

Ronald Uken
Consultant
Lansing, Michigan
(517) 887-4558

[1]See National Center for Primary Care, Morehouse School of Medicine, *Community Health Workers and Community Voices: Promoting Good Health* (Atlanta: National Center for Primary Care, October 2003), 2.

[2]See Susan M. Swider, "Outcome Effectiveness of Community Health Workers: An Integrated Literature Review," *Public Health Nursing* 19 (January/February 2002): Abstract.

[3]See National Center for Primary Care, Morehouse School of Medicine, *Community Health Workers and Community Voices,* 40.

[4]See C. Dower, M. Knox, V. Lindler, and E. O'Neil, *Advancing Community Health Worker Practice and Utilization: The Focus on Financing* (San Francisco, CA: National Fund for Medical Education, 2006).

[5]See Denver Health and Hospital Authority, *Fact Sheet* (Denver, CO: Denver Health, 2006).

[6]States pay FQHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services, adjusted for any increase or decrease in the scope of services. See Health Resources Services Administration website: *www.bphc.hrsa.gov.*

[7]See Elizabeth M. Whitley, Rachel M. Everhart, and Richard A. Wright, "Measuring Return on Investment of Outreach by Community Health Workers," *Journal of Health Care for the Poor and Underserved* 17*,* No. 1 (February 2006 Supplement), 6.

[8]Wayne Powell, Christine Hollis, Mario de la Rosa, Deborah Helitzer, and Daniel Derksen, "New Mexico Community Voices: Policy Reform to Reduce Oral Health Disparities," *Journal of Health Care for the Poor and Underserved* 17*,* No. 1 (February 2006 Supplement), 96.

[9]See *Performance Measurement: Community Access Program,* Molina Healthcare of New Mexico, May 2005–July 2006.

[10]See *www.ins.state.ny.us.*

[11]See Community Premier Plus Earns Top Ranking, *Hispanic PR Wire* (March 2005). [Online, accessed 12/11/06.] Available: *http://www.hispanicprwire.com/news.php?1=in&id=3928&cha=9.*

[12]HEDIS is NCQA's tool used by health plans to collect data about the quality of care and service they provide. HEDIS consists of a set of performance measures that tell how well health plans perform in key areas: quality of care, access to care, and member satisfaction with the health plan and doctors. HEDIS requires health plans to collect data in a standardized way so that comparisons are fair and valid. Health plans can arrange to have their HEDIS results verified by an independent auditor.

[13]The Medicare and Medicaid programs distribute extra payments to hospitals that treat a disproportionate share of indigent patients. See Barbara Wynn, Theresa Coughlin, Serhiy Bondarenko, and Brian Bruen, *Analysis of the Joint Distribution of Disproportionate Share Hospital Payments* (a project memorandum prepared for the Assistant Secretary of Planning and Evaluation, Department of Health and Human Services by RAND under contract with the Urban Institute, September 20, 2002).

[14]See Whitley, Everhart, and Wright, 6–15.

[15]See Elizabeth M. Whitley, Rachel M. Everhart, *Free Pregnancy Testing: Improving Access and Bottom Line of Denver Health,* (Denver, CO: Community Voices, Denver Health, 2006).

[16]Under 42 U.S.C., Section 1902(a)(55), as implemented pursuant to 42 C.F.R., Section 435.904, the Colorado Department of Health Care Policy and Financing must provide an opportunity for low-income pregnant women, infants, and children under age 19 to apply for Medicaid at locations other than welfare offices. The rule increases the reimbursement to Denver Health Medical Center clinics since they qualify to certify eligible expenditures for federal financial participation (FFP) under 42 C.F.R., Section 433.51, and allows those facilities to receive additional FFP for eligible expenditures that are not reimbursed under the current outstationing payment methodology. Hospital providers that are public-owned facilities qualify to certify eligible expenditures for FFP under 42 C.F.R., Section 433.51.

[17]See Melany Mack, Ronald Uken, Jane Powers, "People Improving the Community's Health: Community Health Workers as Agents of Change," *Journal of Health Care for the Poor and Underserved* 17*,* No. 1 (February 2006 Supplement): 16–25.

[18]Ingham County Health Department calculation of the percentage of adults covered by IHP (15,710 as of 10/1/06) divided by the adults indicating in the Behavioral Risk Factor Survey that they were without health insurance (27,386 in 2003). This calculation underestimates the number of adults covered. An update will be provided in early 2007.

[19]In 1990, in response to federal regulation (42 CFR 431.615), a Michigan cost-sharing policy was first established for Medicaid services and administration carried out through local health departments. The federal regulation requires states to reimburse the reasonable costs of Title XIX (Medicaid) services and administration provided by Title V (Maternal and Child Health) grantees. Local health departments in Michigan are grantees of the state's Maternal and Child Health program. State and local Maternal and Child Health officials, including advocacy organizations such as the Maternal and Child Health Council, successfully led this policy initiative in Michigan.

[20]See Michigan Medicaid Policy Bulletin MSA 05-29*, http://www.michigan.gov/documents/MSA_05-29_126413_7.pdf.*

[21]Since local matching funds are required to earn federal Medicaid funds, the case for outreach including the use of community health workers must be made locally through various decision processes. These challenging local processes restrain the growth in Medicaid Administration expenditures. In spite of these challenges, Ingham County, with its public will to improve access, has been able to utilize Michigan's Medicaid outreach policy to find nearly 60 percent of its uninsured persons and help them establish a medical home (Ingham Community Voices, Ingham County Health Department).

[22]See Community Access Program Performance Measurement Report, Measurement Period June 1, 2005 to November 30, 2005 (Molina Healthcare of New Mexico), 3.

[23]Interview with Mark Redding, MD, October 2006.

[24]Ibid.