



## A Hard Day's Work: Promoting Sustainable Financing for Community Health Workers

In this white paper, we discuss the importance of community health workers (CHWs) and how they are essential to addressing health disparities in our communities. We then offer an overview of the current financing landscape of CHWs, with a particular lens on how the COVID-19 pandemic shaped financing. Lastly, we share recommendations for state and federal policymakers to create sustainable funding for CHWs.



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### I. Introduction

Over the past two years, the world has been recovering from the devastating effects of the COVID-19 pandemic. In the United States, the coronavirus burdened our unprepared health care system, exposing the deep cracks in the way we pay for, deliver and consume health care. Despite significant health care spending in the United States — over \$4 trillion in 2020 alone<sup>1</sup> — over 1 million individuals in the U.S. have lost their lives to the coronavirus since the start of the pandemic.<sup>2</sup> Furthermore, the pandemic has disproportionately impacted communities of color. For instance, non-Hispanic Black people account for 34% of deaths related to COVID-19, yet they make up only 12% of the total U.S. population.<sup>3</sup>

People of color face more barriers to achieving optimal health than their white counterparts due to structural racism — systems and institutions that have perpetuated and influenced health disparities on the basis of race.<sup>4,5,6</sup> The social determinants of health — the conditions in which people are born, live, learn, work, play, worship and age — have been shown to have direct implications for people’s health.<sup>7</sup> These social determinants determine approximately 80% to 90% of a person’s health outcomes,<sup>8</sup> with only 10% to 20% determined by medical care.<sup>9</sup> Physicians, nurses, physician assistants, surgeons and other health care providers who work in traditional clinical settings are all trained to address health from a clinical or medical standpoint, despite the fact that 80% to 90% of

## Community Health Workers' Role In Factors Outside the Clinic That Contribute to Health Outcomes (Social Determinants of Health)



health outcomes are attributed to factors outside the clinic. Factors such as access to nutritious food, safe outdoor spaces and clean air are all typically outside the scope of a physician to address, but all have a very acute impact on a person's health. This is where community health workers (CHWs) come in. CHWs are trusted members of the community and have a shared culture, language or experience, and they can play an integral role in addressing factors outside of the clinic to improve overall health of communities. CHWs have been shown to have a significant return on investment. If integrated into care teams for Medicaid beneficiaries, CHWs would return \$2.47 for every \$1 invested.<sup>10</sup> CHWs also have been shown to significantly reduce the need for readmission into hospitals.<sup>11,12</sup> See our key recommendations below.

### Key Recommendations

Policymakers at the state and federal levels have opportunities to move toward sustainable financing models for CHWs. Our current health care payment system limits the ability to pay for the types of services CHWs provide. Our recommendations include options for our current system, as well as a recommendation to reorient our system to pay for health.

- » State and local governments should partner authentically with CHWs and community leaders during any grant-making processes to ensure genuine understanding of community issues and needs.
- » States should pursue Medicaid funding for CHWs using a per member per month payment structure to CHW organizations rather than a per visit structure.
- » The federal government should authorize sustainable grant funding for the public health workforce, including CHWs, building on the successes of the American Rescue Plan in boosting vaccination rates in Black and Latino communities.
- » Policymakers should work to transform our health care payment system to pay for health care quality, value and equity, and not just unit services.

Community health workers, known as *promotores de salud* in Spanish-speaking communities, include many different public health workforce members, including peers, navigators, doulas and more.<sup>13</sup> CHWs are front-line public health workers who are trusted members of a particular community or have a highly developed understanding of the community being served.<sup>14</sup> Because of their unique relationship to the communities they serve, CHWs are trusted links between health and social services and community members.<sup>15</sup> CHWs can play many roles and perform many duties from community education and outreach to informal counseling, social support and advocacy.<sup>16</sup>

During the COVID-19 pandemic, CHWs played an invaluable role in spreading vaccine efficacy education and information, building trust in communities, and connecting isolated community members with critical resources.<sup>17</sup> The types of services CHWs provide have the potential to address the root causes of poor health outcomes, including addressing social determinants of health.<sup>18</sup> These services could look like connecting a client with a food pantry to address food insecurity or helping a client fill out a housing application or job application to achieve housing and financial security.

Despite significant evidence of the effectiveness of CHWs in improving health outcomes and generating a high return on investment,<sup>19,20,21</sup> CHWs remain largely undercompensated and unrecognized. CHWs report that they still experience situations where they are part of care teams and are confused for social workers. Providers do not know what role CHWs serve and do not know how to correctly integrate them into effective care teams.\* There remains a need to widely educate policymakers and health systems about the effectiveness and necessity of CHWs.

\*These findings were reported at a listening session hosted by Families USA in November 2021. CHWs from across the country attended this listening session and shared their experiences working on the front lines of the COVID-19 pandemic.



*CHWs are trusted members of the community and have a shared culture, language or experience, and they can play an integral role in addressing factors outside of the clinic to improve overall health of communities.*

## II. Payment landscape

CHWs are largely funded through a patchwork system of financing, including time-limited grants and fee-for-service care.<sup>22</sup> There has been important growth in these funding streams in many parts of the country, but there also have been lessons learned from those increased funding streams for future CHW funding efforts. If we do not heed these lessons, we will not be able to — at long last — build a CHW workforce as a full part of our health care system and public health policy approach.

### a. Recent gains in funding: public health grants

Employers of CHWs, such as community-based organizations (CBOs), typically use federal or state-level grant funding for CHW salaries. These funding streams received a significant boost in the last two years, as described below. However, these grants are often awarded for specific projects or services and created without community input. This often results in grants omitting funding for the wraparound administrative staff necessary to ensure CHWs can provide their services efficiently and sustainably.<sup>23</sup>

*[Federal grant funding] allows me to pay for CHWs, but then overhead costs are always much more challenging. I'm a big proponent of good infrastructure for CHW programs, and it's sometimes easy to fund CHWs themselves, but not always supervisors, managers, the HR components that are related to bringing on so many new hires. These are some of the challenges that I've experienced.*

*– Amy Richardson, chief community health officer, Siloam Health*

During the peak of the COVID-19 pandemic in the United States, the federal government passed the American Rescue Plan Act, allocating more than \$7 billion to hire, train and deploy a public health workforce, which included CHWs.<sup>24</sup> While this massive investment in communities was indicative of Congress' acknowledgement of the importance of the community-based workforce, employers of CHWs faced barriers to hiring, training and deploying CHWs and sometimes even faced barriers to applying for federal supports.<sup>25</sup>

*Even though funding is available right now, when looking longer term and working to get grants to fund different locations, it's still inadequate to meet the need for the CHW-to-population ratio. If we wanted to dramatically scale up and really build the community-based workforce that is at the basis of an equitable and just health system, we need a lot more CHWs than we currently have. That is what we've struggled with, especially when you focus on making sure CHWs are paid a living wage with benefits — that quickly diminishes even a grant that sounds big at first. So, while there's definitely been more funding available than we've seen in the past, it's still inadequate, especially with overhead and infrastructure costs.*

*– Erin Polich, senior project lead, Partners in Health*

Many CHWs are employed by CBOs, which are nonprofit, nongovernmental or charitable organizations that identify and implement programs that address specific community needs.<sup>26</sup> CBOs play an integral role in the health of the community and are uniquely positioned to provide direct assistance and supports to the communities they serve, providing services such as food or transportation, and even integrating with electronic health records to contact providers.<sup>27</sup> CBOs served on the front lines of the COVID-19 response, connecting communities to essential resources, including wellness checks, vaccine clinics and vaccine education.<sup>28</sup> Despite playing an essential role in the pandemic response, CBOs that served some of the most hard-to-reach communities reported that applying for federal grants during the COVID-19 pandemic was difficult due to administrative barriers and capacity.<sup>29</sup> In fact, some CBOs were deemed ineligible to apply for federal grants due to their small size.<sup>30</sup> This represents a larger issue with the federal grant process, especially for CBOs and other community-based members and institutions. Not only are there bureaucratic barriers, but applications are often lengthy and complex, requiring large amounts of staff capacity and expertise to apply. Current granting methods are largely unsustainable and inequitable, resulting in a deficit of adequate funding for CHWs.<sup>31</sup>

Additionally, grants for CHWs are often limited in scope to certain activities or services, such as diabetes education or nutrition counseling.<sup>32</sup> CHWs are able to provide a much broader range of services, targeted at addressing root causes of health disparities. Grant design that does not engage community leaders from inception of a grant leads to inefficiencies and poor use of public funds. While CHWs and the larger public health workforce received grant funding from the federal government during the coronavirus pandemic, the funding was distributed by the Centers for Disease Control and Prevention (CDC) with a different set of expectations depending on the congressional legislative package. The Coronavirus Aid, Relief, and Economic Security (CARES) Act aimed to use the funding to increase access to services related to COVID-19, such as testing and vaccinations, while the American Rescue Plan Act allowed for a broad use of funding to build the public health



*“A livable wage is part of the social determinants of health, and as community health workers we focus a lot, all the time, on social determinants of health for our clients... We’re taking care of the community and we also need to take care of ourselves. If we are able to get equitable pay so that we don’t have to worry about scrambling to pay bills or make ends meet, or have to wear different hats and work different jobs, we can better serve the community the way they deserve.”*

***- Jennifer Gonzalez,  
Community Health  
Worker***

workforce.<sup>33,34</sup> The American Rescue Plan approach is clearly preferable. After the end of the public health emergency, it is critical that states and the federal government work with community leaders and agencies to create grant funds that provide consistent and broad funding to support the work of CHWs.<sup>35</sup>

At the federal level, the Health Resources and Services Administration announced the availability of grants to broadly train, educate, hire and deploy the CHW workforce. The Community Health Worker and Health Support Worker Training Program targets health professions schools, academic health centers, state and local governments, and any other public or private nonprofits that train CHWs and the public health workforce more broadly.<sup>36</sup> This is an important step in the direction of more comprehensive federal grant funding not tied to COVID-19 response.

#### **b. Recent gains in funding: Medicaid**

States across the country have begun implementing CHW services and reimbursement into their Medicaid programs, an important step in creating sustainable funding streams for CHW services.

Historically, one pitfall for Medicaid CHW programs has been certification requirements. Most states that have introduced or passed legislation around Medicaid reimbursement for CHW services require certification, but CHW certification requirements vary across states. These inconsistencies create barriers for CHWs to meet the requirements to receive reimbursement for their services within some delivery models and can limit their ability to receive full compensation. Having CHW certification requirements that differ from state to state also highlights the need for clear definitions of CHW roles and the type of training required to complete the duties within CHWs' scope of work.

States have many options when it comes to leveraging Medicaid legal authorities to incorporate CHW benefits for their beneficiaries. Some states have authorized these activities through state plan amendments (SPAs), waivers or Medicaid health homes state plan options, while others have required managed care organizations (MCOs) to provide CHW services in care teams or through other care delivery models via MCO contracts.<sup>37</sup> For example, the Kentucky General Assembly passed HB 525 (signed by the governor in April 2022), which establishes CHW certification and requires Medicaid



*“If we have higher wages, we will attract more people to the community health worker profession, as well as improving the lives of those already in the profession.”*

***- Sornia Joseph,  
Community Health  
Worker, Retired***

and Children’s Health Insurance Plan reimbursement for services provided by certified CHWs.<sup>38</sup> While the Kentucky Office of Community Health Workers issues official certification for CHWs and defines key competencies and opportunities for continuing education, the state must now seek federal approval for a SPA or waiver or pursue other alternative payment models to begin reimbursement of services delivered by CHWs.

Additionally, California added CHW services, including preventive health services, health education, navigation, screening and assessment, and individual support and advocacy, as Medi-Cal covered benefits, effective July 1, 2022.<sup>39</sup> California’s SPA creates several Current Procedural Terminology (CPT) codes to be used for specific services by the supervising provider (defined as an enrolled Medi-Cal provider who submits claims provided by CHWs) when deemed medically necessary for enrollees with one or more chronic health conditions. Creating this mechanism for the reimbursement of services provided by nonlicensed professionals like CHWs will facilitate their deployment for home visiting services to treat asthma and other conditions, an area where CHW services have been shown to make meaningful improvements in overall health outcomes.<sup>40</sup>

Apart from its SPA, California continues to integrate CHWs into its CalAIM (California Advancing and Innovating Medi-Cal) initiative, a Medicaid program designed to utilize health plans to contract with CBOs to engage in whole-person preventive services focused on social determinants of health. CalAIM focuses on particular populations with the goal of coordinating physical health, behavioral health and social services. Increasingly, CHWs’ unique ability to provide culturally appropriate care coordination has begun to be leveraged in delivery models to provide advanced primary care to high-risk communities across the state on their terms, whether in their homes, in emergency departments or where they access other needed social services.<sup>41</sup> This is made possible by partnerships between managed care organizations participating in CalAIM and health systems that allow them to hire and deploy CHWs directly, allocating full-time equivalent funds to cover their salaries.



*“With higher pay, it gives you more morale to want to do the work. A lot of people don’t understand that this work is taxing. You take in a lot of people’s problems, issues and things like that. Being able to be paid what you’re worth really lifts your morale up to want to continue to do the work.”*

**- Patrice Shelton,  
Certified Community  
Health Worker, Senior**

Medicaid SPAs also typically require supervision of CHWs by other licensed providers, treating CHWs as a benefit related to outpatient services. An unintended consequence of required supervision by non-CHWs can be a lack of understanding of the realities of CHWs' day-to-day responsibilities and the variety of issues they address with clients beyond clinical care. States should have some built-in flexibility around how this supervision is administered. For example, California's SPA does not require supervising providers to be the same provider that makes the recommendation for CHW services, or even for supervisors to be physically present when CHWs provide their services to beneficiaries. This type of flexibility allows CHWs to better perform their work and execute on their full range of services, without an over-clinicalization of their duties.

As liaisons between the health care delivery system, social services and the communities they serve, CHWs can often shoulder emotional weight and other burdens that cannot easily be quantified in medical reporting code for fee-for-service reimbursement. Many health plans that do employ CHWs directly fund them on a per member per month (PMPM) basis, also referred to as a capitated rate, where the plan is reimbursed a predetermined amount per enrolled member monthly. While we strongly recommend PMPM payment as preferable to per visit payment, the PMPM approach does have its imperfections. If the PMPM rate is set too low, it can create financial pressure on plans with beneficiaries that require more intensive CHW services or support. It also does not take into account the important role CHWs have in addressing the specific cultural needs of communities since any financial incentives for equity and quality measures the plan may meet are unlikely to trickle down into CHWs' salaries.

Despite the significant impact social determinants of health have on overall health outcomes and quality of life, our current health care system does not directly pay for flexible community-based services in a sustainable way. Although CHW financing models may create flexibility in how CHWs' time is reimbursed within the larger fee-for-service environment by establishing additional billing codes, these models will always be limited since these codes are tied to discrete health care services rather than the promotion of overall health. Our policy recommendations are targeted at this crucial flaw in our health care system's current design and structure.

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### III. Policy recommendations

#### a. Policy recommendations for our current system

CHWs should have secure funding from various sources, including Medicaid payments and grants from federal, state and local governments, and each funding source has a role to play. Medicaid offers some level of flexibility and creativity in terms of payment structure, depending on the state and its capabilities. CHWs are uniquely positioned to serve some of the most marginalized communities, including Medicaid beneficiaries. However, Medicaid funding presents its own challenges and should not be seen as the complete solution for developing a CHW workforce. Federal grants should offer wraparound supports not only to pay for CHW services but also to support training, administration and expansion of the workforce. Local and state grants should offer opportunities to support CHWs for more specific activities, and the design of these grants should be informed by community leaders. Together, these various funding streams can offer a sustained source of income for CHWs.

## RECOMMENDATIONS FOR STATES AND THE FEDERAL GOVERNMENT

### STATE RECOMMENDATIONS

States should work to include CHWs as a part of their Medicaid benefit structure. As of 2021, at least 21 states authorized Medicaid payment for CHWs in some capacity.<sup>42</sup> As mentioned above, California and Kentucky are two states that recently expanded their CHW benefits through their Medicaid programs. There are various considerations to take into account when integrating CHWs into existing Medicaid structures, including, but not limited to, the scope of services covered, supervision by another provider and certification requirements.<sup>43</sup> States have various options available to create a CHW benefit. States can use state legislation, state plan amendments, Section 1115 demonstration waivers, managed care contracts or other transformation efforts to integrate CHWs into their Medicaid programs.<sup>44</sup>

As mentioned above, there are limitations to using a SPA based on outpatient, physician-authorized home visits to incorporate CHWs into a state Medicaid program. A lack of relevant medical reporting codes as well as certification and supervision requirements allow for limited flexibility and narrow funding. Incorporating CHWs into MCO contract language can offer more flexibility, as MCOs have the ability to cover services that may not be offered under traditional Medicaid and to pay CBOs on a PMPM basis.<sup>45</sup> States can set certain requirements for MCOs, such as establishing how many CHWs must be available for beneficiaries, how many services CHWs can provide and other requirements.<sup>46</sup>

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States can incentivize uptake of CHW services and allow for payment for the full scope of CHW services by paying health care providers or CBOs a capitated rate. This allows providers the flexibility to put together care teams, which can include CHWs, to meet certain benchmarks or goals related to the quality of care. This type of payment model offers the flexibility to deliver not just clinical services but also services related to social determinants of health.<sup>47</sup>

### **FEDERAL LEGISLATIVE RECOMMENDATIONS**

There are a handful of federal legislative solutions that both Congress and the Biden administration should consider to support the CHW workforce and build on the successful CHW grants in the American Rescue Plan. The following list highlights existing policy proposals, new ideas and proposed guidance that would help to further develop the CHW workforce and recognize CHWs as integral players in health care.

***Lawmakers should support the passage of S. 3479, the Building a Sustainable Workforce for Healthy Communities Act.*** This act, co-sponsored by Sens. Bob Casey, Thom Tillis, Tina Smith and Lisa Murkowski, would support CHWs through the reauthorization of competitive grants administered by the CDC. The grants would provide financial resources that health departments need to establish new CHW programs or to grow existing programs.

***Lawmakers should support the passage of S. 3799, the Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (PREVENT Pandemics Act).*** This act, introduced by Senate Health, Education, Labor, and Pensions Committee Chair Sen. Patty Murray and ranking member Sen. Richard Burr, would support CHWs by identifying them as hands-on health promoters in our communities. Further, it would establish that the CDC and the Health Resources and Services Administration may award grants, contracts or cooperative agreements to eligible entities that aim to build a skilled, reliable CHW workforce.

***Congress should add mental health resources and training as an allowable use of funds to Section 222 of the PREVENT Pandemics Act.*** CHWs work closely with their communities to provide critical support and resources to individuals and families, which can result in shared trauma. This was exacerbated by the coronavirus pandemic, and CHWs reported severe cases of mental health distress. CHWs are members of the communities they serve and forge deep bonds with their clients as a part of their job. In order to ensure that CHWs are receiving adequate support, they need improved access to mental health resources. The PREVENT Pandemics Act would provide critical funding to build the CHW workforce and should include mental health support and training for the workforce.

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***Congress should extend grant funding for the Community Health Workers for COVID Response and Resilient Communities initiative.*** Congress should continue its support for CHWs and appropriate discretionary funding to extend the grant cycle for the COVID Response and Resilient Communities initiative past the initial three years. This grant provides funding for the work CHWs are doing to address health disparities that exacerbate the impact of COVID-19 in some populations. The development of the CHW workforce during the COVID-19 pandemic allowed for the extension of care to hard-to-reach populations across the U.S. Although the active threat of COVID-19 is not as pressing as it once was, many individuals in communities nationwide are still recovering from direct and indirect effects of the pandemic.

### **FEDERAL ADMINISTRATIVE RECOMMENDATIONS**

***The federal Centers for Medicare & Medicaid Services (CMS) should provide guidance to states on how to incorporate a CHW benefit into their Medicaid programs.*** Currently, CMS has not published any guidance on ways to incorporate CHWs into state Medicaid programs. CMS should publish such guidance to signal its encouragement of CHWs and to provide states with the technical assistance and details they need to create their own Medicaid reimbursement model for CHWs, including options for managed care, fee-for-service, primary care case management and the Medicaid health homes option. CMS should incorporate models that have utilized value-based purchasing and models that have gone past a fee-for-service methodology. Guidance from CMS would allow states to better understand the opportunities that exist and how to bring such models to their own states.

***The administration should direct the CDC to develop guidance for state and local health departments.*** The CDC provided the CHW workforce with specific toolkits and seminars about chronic health issues in their communities. The CDC also should provide guidance directed to state and local health departments on the establishment of CHWs as a workforce in their state. The CHW workforce receives grants that fund their everyday community services but oftentimes do not have access to the administrative and development grants needed to maintain the workforce. This guidance would help state and local health departments understand how to provide support, including technical assistance, grant writing and administrative services, to the CHW workforce.

While Medicaid reimbursement and federal grants provide significant funding for CHWs, they should not be considered long-term solutions to scaling up the CHW workforce. Federal grants tend to be time limited, introducing inherent volatility in any financing model because CBOs or other employers of CHWs must continue to reapply for funding at the end of each cycle. Medicaid reimbursement is a reasonable intermediate step for financing CHW services but has its limitations as well. A better long-term solution must include a reorientation of our current health care system.

**b. Reorienting the health care system**

Our key long-term recommendation is a complete reorientation of our current health payment and delivery system toward paying for overall health. It is not a coincidence that it has been a struggle to build a CHW workforce in the United States, despite many years of evidence of CHWs’ effectiveness in community health intervention and reports of important CHW successes in other countries. The United States has a payment system built around volumes of high-end services for diagnosed illness. We must move away from our predominantly fee-for-service model toward alternative payment systems, which will allow payers to reimburse health systems and providers for the types of services that contribute to an individual’s overall health, including social determinants of health. This would include the training, hiring and deployment of an equitable and robust health care workforce, including CHWs.

There are many ways payers and providers can consider moving toward alternative payment models to support the community-based workforce. Generally, moving toward alternative payment arrangements includes linking payment to quality and value and implementing a population-based payment model featuring models such as global budgets. Policymakers can leverage existing frameworks to begin this shift toward paying for population needs to achieve health.

**Community Health Worker Funding**



*CMS should help develop Medicare and Medicaid program capacity to intervene in regard to social determinants of health, including aggressive scaling up of flexible funding and structures, such as accountable care organizations, to coordinate between CBOs, health plans and health care providers. Dramatically increasing the scope and number of CHWs in our health care system should be an important component of this strategy.<sup>48</sup>*

Oregon, for example, uses coordinated care organizations (CCOs) to administer and deliver care to its Medicaid beneficiaries. CCOs are local networks of all types of health care providers who work to prevent and manage chronic conditions.<sup>49</sup> CCOs have a budget that grows at a fixed rate and are held accountable for patient outcomes.<sup>50</sup> CCOs can choose how they reimburse providers in their organizations. Some CCOs finance their services using a capitated payment model and

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have managed care contracts, which encourage inclusion of CHWs.<sup>51</sup> By including CHWs in MCO contract language, CCOs such as Jackson Care Connect,<sup>52</sup> the Eastern Oregon Coordinated Care Organization<sup>53</sup> and AllCare<sup>54</sup> integrate CHWs into their networks. However, there are still challenges associated with this model, and scope of services covered still proves to be a barrier to the CHW workforce. Additionally, only a limited number of CHWs are employed by CCOs.

Another example of increased flexible funding can be found in Vermont, which transformed its health care system to the Vermont Blueprint for Health program. Blueprint requires participation from all commercial and public payers and is comprised of two main components: patient-centered medical homes (PCMHs) and community health teams (CHTs).<sup>55</sup> All commercial and public payers in the state of Vermont pay a fixed rate to administer the PCMHs and CHTs in the state.<sup>56</sup> CHTs support PCMHs by providing services that help people address social determinants of health, and the makeup of CHTs is wholly community-driven.<sup>57</sup> The funds used to pay for PCMHs and CHTs are flexible and can be used to hire CHWs and reach the goals of the state. However, due to a lack of education regarding the effectiveness of CHWs, only four CHWs were working for CHTs in the state as of July 2022.

#### **IV. Conclusion**

CHWs play a critical role in improving the health of people in communities throughout the United States. During the COVID-19 pandemic, CHWs served as front-line public health workers, providing critical vaccine education and building trust within communities. Unfortunately, current funding methods for CHWs are largely inadequate and unsustainable. Policymakers at the state and federal levels have unique opportunities to make sustainable investments in this critical workforce. Our current health care system largely pays for health services rather than the promotion of overall health, limiting the ways in which CHWs can be reimbursed. To achieve sustainable financing for CHWs, the health care system needs to be reoriented away from a fee-for-service payment model to ensure providers are paid to improve the health of families and individuals across the nation.

## Endnotes

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