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What Are the Roles of Community Health Workers in Medicaid Managed Care? Results from a National Study

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Abstract

Managed care organizations (MCOs) are increasingly engaging community health workers (CHWs) to support service delivery for their members, particularly in the realm of social determinants of health. Some states now require MCOs to offer CHW services. Although the roles and activities of CHWs working in other contexts (eg, clinics, hospitals, community-based organizations) are well established, there is sparse knowledge about how MCOs are operationalizing CHW roles and whether CHW activities differ based on whether CHWs are employed directly by MCOs or contracted through other organizations. In 2021, 2 CHW professional associations and a university partnered to conduct a national cross-sectional survey of CHWs working with MCOs. Respondents ($n = 146$) represented 29 states. CHWs employed by MCOs reported receiving significantly more training and benefits from their employers than CHWs who were contracted through other organizations. MCO-based CHWs were more likely to support members with high-cost conditions and high service use, whereas contracted CHWs were more likely to engage in population-focused interventions, which may produce less immediately visible financial returns. Health plans would do well to ensure the CHWs they support, whether through contract or direct hiring, receive appropriate compensation and training, and have the freedom to engage in the full range of CHW roles, including community-level interventions.

Keywords: community health workers, Medicaid, managed care organizations, social determinants of health

Background

Medicaid managed care provides for the delivery of Medicaid health benefits, and in some cases long-term services and support, through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).[1] States provide MCOs a fixed monthly premium or ''capitation rate'' for each enrollee.[1,2] As of 2021, 41 states (including DC) have contracts with Medicaid MCOs to provide services for Medicaid enrollees.[2] Over 53 million people or 69% of all Medicaid members nationwide received services through MCOs as of July 2019.[2]

States are increasingly requiring MCOs to adopt population health strategies that address enrollees' social determinants of health (SDOH) such as housing, transportation, and food security.[3,4] One particularly popular strategy is providing community health worker (CHW) services.[3] These frontline public health professionals who serve as liaisons

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between under-resourced communities and health and social services systems[5] are widely recognized as a workforce with a unique ability to address SDOH through individual-[6] and community-level interventions.[7]

For several decades, CHWs, including *promotores* and tribal community health representatives, have worked in a broad variety of agencies that are well integrated into communities. Specifically, many work in community-based organizations, whereas others are integrated into tribal, public health, and health care (eg, Federally Qualified Health Centers) agencies.[8–10] CHWs in these settings are widely trusted by those they serve, often sharing similar backgrounds and life experiences.[7–10]

Members of this workforce have organized themselves into dozens of professional associations at local, state, regional, and national levels to promote professional self-determination.[11,12] Through national research, they have also established roles and competencies including conducting community outreach, offering care management, providing culturally appropriate health education, and advocacy, among others—which guide their work.[13]

New Mexico-based Molina Healthcare was a pioneer in employing CHWs in a managed care context, with their efforts resulting in a reduction in emergency department (ED) visits, hospitalizations, prescription use, and overall costs of care among a group of enrollees with frequent ED visits.[14]

In the past decade, an expanding evidence base demonstrating that CHWs are cost-effective,[14–18] reduce hospitalizations,[19] and improve health outcomes for populations experiencing health inequities[20] has prompted some MCOs to incorporate CHWs into their teams. Although some health plans hire them directly, others contract with outside organizations (eg, community-based organizations or health services organizations) to provide CHW services to plan members. These CHWs have largely been supported through administrative costs.

The workforce of CHWs employed by MCOs is likely to expand. As of 2021, 10 states had opted to issue MCO contracts that included some requirement for health plans to support CHW services, and another 6 states had plans to do so in the following year.[21] Michigan's most recent contract includes a provision for a CHW-to-enrollee ratio of 1:5000,[22] whereas New Mexico has specified that 3% of enrollees must receive CHW support.[23]

Health plans in Pennsylvania are required to implement community-based care management plans to prevent unnecessary hospital admissions and emergency visits, and plans may include both CHWs and contracts with community-based organizations to provide health-related social services.[22] Oregon recently created 16 regionally based coordinated care organizations (CCOs) to provide medical services to Medicaid members, and explicitly directed CCOs to provide their members access to services provided by ''traditional health workers,'' including CHWs.[24]

The Centers for Medicare & Medicaid Services (CMS) allows for payment of CHW services through managed care contracts, but it has not issued guidance on how CHW services in managed care must be delivered. As such, health plans have great latitude in terms of how they implement CHW program models and interact with contracted community-based organizations. Although a few state contracts require that CHWs carry out specific activities such as supporting care coordination or conducting health assessments,[22] in general, little is known about how health plans are operationalizing CHW roles.

An Institute for Medicaid Innovation survey found that MCOs are engaging with CHWs to address SDOH, particularly housing, but the survey did not address specific CHW roles.[25] There is little information about whether CHWs employed by MCOs may differ from CHWs working in other settings. A 2018 study of MCOs in Arizona revealed that CHWs did not participate in some fundamental roles outlined by the Community Health Worker Core Consensus Project[13] including conducting individual and community assessments and participating in evaluation and research.[26] It is also unclear whether CHW activities and populations served may differ based on whether CHWs are employed directly by MCOs or contracted through other organizations.

This national study aimed to examine the roles and activities of CHWs supported by MCOs. It also aimed to assess whether there are differences between CHWs who are hired directly by MCOs and those who work at organizations that are contracted by MCOs to provide CHW services.

Methods

The research team developed its study methodology based on prior recommendations for conducting research with CHWs.[27] Based on longstanding relationships, a university (LSU Health Sciences Center—New Orleans) and 2 CHW associations (the National Association of Community Health Workers [NACHW] and the Louisiana Community Health Outreach Network [LACHON]) partnered to conduct this study. Additional project advisers with expertise in the CHW workforce provided guidance.

The research team collaborated to develop a list of topics to be covered in the survey including demographics, CHW roles and activities, populations served, and work environment (eg, training, benefits, income). Questions were based on a prior survey[28] and updated based on team input.

The online REDCap survey was distributed through NACHW's member newsletter, as well as LACHON's listserv of over 400 people. The research team also contacted over 20 local, state, and regional CHW networks and associations to promote nationwide distribution. The team contacted a dozen national stakeholder organizations, including trade organizations and policy think tanks to request support in distributing the survey to MCOs. The survey was open from March to July 2021. Eligibility criteria included being 18 years of age and either working as a CHW at an MCO or at an organization that receives an MCO contract for CHW services. Participants were offered the opportunity to enter a raffle for a prepaid $50 Visa gift card. All research procedures were approved by the IRB at LSU Health Sciences Center.

All data were analyzed using SPSS version 26. Basic descriptive statistics were calculated. Chi-squares or 2-sided Fisher's exact tests were used to assess differences between groups for categorical variables and *t*-tests were used for continuous variables. *P*-values <0.05 were considered significant.

Results

A total of 146 CHWs working in 29 states completed the survey. The largest proportion (27.4%) of respondents worked in the west, followed by the midwest (22.6%), the mid-Atlantic (18.5%), the south (16.4%), and the northeast (15.1%). A total of 53 (36.3%) respondents worked at an

MCO, whereas the remaining 93 (63.7%) worked at a local health or social service organization. No one reported being an independent contractor.

Their mean age was ~44 years. About 90% of respondents identified as women. Nearly 40% were African American (AA)/Black, about 30% were White, and roughly 1 quarter identified as Hispanic/Latinx. Over a third (37.7%) had completed some college. The same proportion had a bachelor's degree, and 13.7% reported having a graduate or professional degree. There were no significant differences in age, gender, race/ethnicity, or education between CHWs employed by MCO and those who were contracted. On average, MCO-based CHWs had been at their positions for significantly longer (3.8 years) than contracted CHWs (2.4 years).

There were significant differences in income, with about a quarter of MCO-based CHWs earning $50,000 or more annually, as compared with just 14% of contracted CHWs earning at that level. The number of work hours per week was also significantly different. About 1 in 7 contracted CHWs worked less than 30 hours per week, whereas all MCO-based CHWs worked 30 hours or more. Among both groups, 15.1% worked over 40 h/week. Demographics are summarized in Table 1.

CHWs working at an MCO were significantly more likely to receive numerous benefits including paid time off, health or dental insurance, retirement, transportation benefits, raises, tuition, and paid parental leave. There were also significant differences in access to employer-

Table 1. Demographics of a National Sample of Community Health Workers Working with Medicaid Managed Care

Variable	*All CHWs (N=146), n (%)*	*MCO (N=53), n (%)*	*Contracted (N=93), n (%)*	P
Age, range	22–72	25–72	22–70	
Age, mean (SD)	43.8 (12.6)	45 (11.5)	43.2 (13.2)	0.406
Years in current position, range	0–24	0–10	0–24	
Years in current position, mean (SD)	2.9 (3.7)	3.8 (2.3)	2.4 (4.2)	**0.013**
	n (%)	*n* (%)	*n* (%)	P
Gender				0.190
Woman	127 (87.0)	43 (81.1)	84 (90.3)	
Man	12 (8.2)	5 (9.4)	7 (7.5)	
Prefer not to identify	2 (1.4)	1 (1.9)	1 (1.1)	
No response	5 (3.4)	4 (7.5)	1 (1.1)	
Race/ethnicity				
African American/Black	58 (39.7)	20 (37.7)	38 (40.9)	0.729
White	45 (30.8)	20 (37.7)	25 (26.9)	0.195
Hispanic/Latinx	37 (25.3)	9 (17.0)	28 (30.1)	0.113
American Indian/Alaska Native	6 (4.1)	2 (3.8)	4 (4.3)	1.0
Asian	2 (1.4)	0 (0.0)	2 (2.2)	0.534
Native Hawaiian/Pacific Islander	1 (.7)	0 (0.0)	1 (1.1)	1.0
Another race (biracial)	1 (.7)	1 (1.9)	0	0.363
Education				0.107
Less than high school	2 (1.4)	0 (0.0)	2 (2.2)	
High school or GED	9 (6.2)	2 (3.8)	7 (7.5)	
Some college or 2-year degree	55 (37.7)	20 (37.7)	35 (37.6)	
Bachelor's degree	55 (37.7)	23 (43.4)	32 (34.4)	
Graduate or professional degree	20 (13.7)	4 (7.5)	16 (17.2)	
No response	5 (3.4)	4 (7.5)	1 (1.1)	
Annual income				**0.000**
<$20,000	12 (8.2)	0 (0.0)	12 (12.9)	
$20,000 to <$30,000	22 (15.1)	3 (5.7)	19 (20.4)	
$30,000 to <$40,000	38 (26.0)	7 (13.2)	31 (33.3)	
$40,000 to <$50,000	45 (30.8)	29 (54.7)	16 (17.2)	
$50,000 to <$60,000	19 (13.0)	7 (13.2)	12 (12.9)	
$60,000+	7 (4.8)	6 (11.3)	1 (1.1)	
No response	3 (2.1)	1 (1.9)	2 (2.2)	
Hours worked per week				**0.029**
29 or less	13 (8.9)	0 (0.0)	13 (14.0)	
30–40	110 (75.3)	45 (84.9)	65 (69.9)	
41 or more	22 (15.1)	8 (15.1)	14 (15.1)	
No response	1 (.7)	0 (0.0)	1 (1.1)	

Bold values are statistically significant.
CHW, community health worker; MCO, managed care organization; SD, standard deviation.

Table 2. Employer-Offered Benefits, Resources, and Training for a National Sample of Community Health Workers Working with Medicaid Managed Care

	All CHWs (N=146), n (%)	*MCO (N=53), n (%)*	*Contracted (N=93), n (%)*	P
Benefits				
Paid time off (vacation, sick time, personal time, etc.)	129 (88.4)	53 (100.0)	76 (81.7)	**0.000**
Health/dental insurance	125 (85.6)	52 (98.1)	73 (78.5)	**0.001**
Mileage reimbursement or other transportation benefits	122 (83.6)	50 (94.3)	72 (77.4)	**0.010**
Disability or life insurance	103 (70.5)	49 (92.5)	54 (58.1)	**0.000**
Pension or retirement plan	97 (66.4)	44 (83.0)	53 (57.0)	**0.002**
Raises	83 (56.8)	47 (88.7)	36 (38.7)	**0.000**
Tuition	74 (50.7)	47 (88.7)	27 (29.0)	**0.000**
Paid training	70 (47.9)	24 (45.3)	46 (49.5)	0.731
Paid parental leave	44 (30.1)	30 (56.6)	14 (15.1)	**0.000**
Unpaid training time	18 (12.3)	9 (17.0)	9 (9.7)	0.203
Childcare	5 (3.4)	1 (1.9)	4 (4.3)	0.653
None	7 (4.8)	0 (0.0)	7 (7.5)	**0.049**
Resources				
Computer	126 (86.3)	50 (94.3)	76 (81.7)	**0.044**
Cell phone	116 (79.5)	48 (90.6)	68 (63.7)	**0.018**
Copier	113 (77.4)	42 (79.2)	71 (76.3)	0.837
Personal protective equipment	102 (69.9)	28 (52.8)	74 (79.6)	**0.001**
Shared office	66 (45.2)	24 (45.3)	42 (45.2)	1.0
Tablet	53 (36.3)	19 (35.8)	34 (36.6)	1.0
Own office	35 (24.0)	10 (18.9)	25 (26.9)	0.318
Training				
Core competencies	106 (72.6)	41 (77.4)	65 (69.9)	0.440
Motivational interviewing	86 (58.9)	43 (81.1)	43 (46.2)	**0.000**
Advocacy	73 (50.0)	33 (62.3)	40 (43.0)	**0.038**
Specific health topic	69 (47.3)	34 (64.2)	35 (37.6)	**0.003**
Chronic disease	64 (43.8)	34 (64.2)	30 (32.3)	**0.000**
Navigation	56 (38.4)	17 (32.1)	39 (41.9)	0.289
Peer support	48 (32.9	18 (34.0)	30 (32.3)	0.856
Leadership	47 (32.2)	25 (47.2)	22 (23.7)	**0.005**
Medical interpretation	24 (16.4)	10 (18.9)	14 (15.1)	0.643
Languages	10 (6.8)	4 (7.5)	6 (6.5)	1.0

Bold values are statistically significant.

provided computers and cell phones. Contracted CHWs were significantly more likely to be provided with personal protective equipment. Just under 3 quarters of all CHWs (72.6%) reported that their employer provided training in CHW core competencies. MCO-based CHWs were significantly more likely to receive training in motivational interviewing, advocacy, a specific health topic (eg, HIV), chronic disease, and leadership. Table 2 includes these results.

Across workplaces, about 4 in 5 CHWs engaged in outreach (83.9%) and care coordination and case management (79.5%). Roles varied between MCO-based and contracted

Table 3. Professional Roles Reported by a National Sample of Community Health Workers Working with Medicaid Managed Care

	All CHWs (N=146), n (%)	*MCO (N=53), n (%)*	*Contracted (N=93), n (%)*	P
Conducting outreach	121 (82.9)	45 (84.9)	76 (81.7)	0.820
Care coordination, case management	116 (79.5)	42 (79.2)	74 (79.6)	1.0
Advocacy for individuals and communities	113 (77.4)	36 (67.9)	77 (82.8)	0.063
Culturally appropriate health education	105 (71.9)	36 (67.9)	69 (74.2)	0.448
Coaching and social support	100 (68.5)	44 (83.0)	56 (60.2)	**0.005**
Providing direct services	78 (53.4)	20 (37.7)	58 (62.4)	**0.006**
Individual and community assessments	69 (47.3)	32 (60.4)	37 (39.8)	**0.025**
Building individual and community capacity	56 (38.4)	18 (34.0)	38 (40.9)	0.480
Cultural mediation	47 (32.2)	12 (22.6)	35 (37.6)	0.068
Participating in evaluation and research	45 (24.0)	12 (22.6)	33 (35.5)	0.136

Bold values are statistically significant.

Table 4. Social Determinants of Health Addressed by a National Sample of Community Health Workers Working with Medicaid Managed Care

	All CHWs (N = 146), n (%)	*MCO (N = 53), n (%)*	*Contracted (N = 93), n (%)*	P
Food	140 (95.9)	50 (94.3)	90 (96.8)	0.668
Housing	130 (89.0)	47 (88.7)	83 (89.2)	1.0
Transportation	126 (86.3)	50 (94.3)	76 (81.7)	**0.044**
Education assistance	117 (80.1)	43 (81.1)	74 (79.6)	1.0
Utility assistance	117 (80.1)	46 (86.8)	71 (76.3)	0.139
Income	114 (78.1)	37 (69.8)	77 (82.8)	0.095
Employment assistance	102 (69.9)	32 (60.4)	70 (75.3)	0.064
Translation	92 (63.0)	36 (67.9)	56 (60.2)	0.378
Violence prevention	88 (60.3)	33 (62.3)	55 (59.1)	0.729
Legal	86 (58.9)	32 (60.4)	54 (58.1)	0.862
Re-entry	66 (45.2)	20 (37.7)	46 (49.5)	0.226
Child care	65 (44.5)	22 (41.5)	43 (46.2)	0.607

Bold values are statistically significant.

CHWs in 3 of 10 key roles. Those employed by MCOs were significantly more likely to offer coaching and social support and conduct individual and community assessments, whereas contracted CHWs were significantly more likely to offer direct services. The least commonly endorsed roles among all CHWs were cultural mediation (32.3%) and participating in research and evaluation (24%). These results are summarized in Table 3.

Across settings, the vast majority of CHWs offered support for food assistance (95.4%), housing (89.0%), transportation (86.3%), as well as assistance with education (80.1%), utilities (80.1%), and income (78.1%). The only difference in services provided is that CHWs employed by MCOs were significantly more likely to connect people to transportation assistance. Table 4 contains these results.

There were several differences in the populations that CHWs reported serving. Contracted CHWs were significantly more likely to serve Black/AA and Latinx populations. CHWs employed by MCOs were significantly more likely to work with children and rural populations, as well as pregnant people and people without a primary care provider, experiencing homelessness with frequent hospitalizations, with substance use disorders, with intellectual disabilities, and rates of ED use. Table 5 outlines these results.

Table 5. Populations Served by a National Sample of Community Health Workers Working with Medicaid Managed Care

	All CHWs (N = 146), n (%)	*MCO (N = 53), n (%)*	*Contracted (N = 93), n (%)*	P
Racial/ethnic groups				
Black/African American	22 (15.1)	1 (1.9)	21 (22.6)	0.**000**
Hispanic/Latinx	22 (15.1)	1 (1.9)	21 (22.6)	**0.000**
American Indian/Alaska Native	9 (6.2)	1 (1.9)	8 (8.6)	0.156
Asian	7 (4.8)	1 (1.9)	6 (6.5)	0.423
Native Hawaiian/Pacific Islander	3 (2.1)	1 (1.9)	2 (2.2)	1.0
White	1 (0.7)	1 (1.9)	7 (7.5)	0.259
Special populations				
No primary care provider	94 (64.4)	41 (77.4)	53 (57.0)	**0.019**
Have COVID-19	94 (64.4)	35 (66.0)	59 (63.4)	0.858
Seniors	88 (60.3)	34 (64.2)	54 (58.1)	0.488
Homeless	85 (58.2)	38 (71.7)	47 (50.5)	**0.015**
Frequent hospitalization	81 (55.5)	43 (81.1)	38 (40.9)	**0.000**
Substance use	79 (54.1)	37 (69.8)	42 (45.2)	**0.006**
Physical disability	74 (50.7)	32 (60.4)	42 (45.2)	0.087
Pregnant	73 (50.0)	35 (66.0)	38 (40.9)	**0.006**
Frequent emergency department use	71 (48.6)	42 (79.2)	29 (31.2)	**0.000**
History of incarceration	63 (43.2)	27 (50.9)	36 (38.7)	0.168
Intellectual disability	62 (42.5)	29 (54.7)	33 (35.5)	**0.036**
Rural	60 (41.1)	28 (52.8)	32 (34.4)	**0.036**
Children	58 (39.7)	34 (64.2)	24 (25.8)	**0.000**
LGBTQ	51 (34.9)	22 (41.5)	29 (31.2)	0.213
Immigrants	51 (34.9)	18 (34.0)	33 (35.5)	1.0
Farm workers	28 (19.2)	5 (9.4)	23 (24.7)	**0.029**

Bold values are statistically significant.
LGBTQ, lesbian, gay, bisexual, transgender, queer/questioning.

Table 6. Health Conditions by a National Sample of Community Health Workers Working with Medicaid Managed Care

	All CHWs (N=146), n (%)	*MCO (N=53), n (%)*	*Contracted (N=93), n (%)*	P
Diabetes	97 (66.4)	43 (81.1)	54 (58.1)	**0.006**
Mental health	86 (58.9)	41 (77.4)	45 (48.4)	**0.001**
HIV	75 (51.4)	31 (58.5)	44 (47.3)	0.229
Asthma	73 (50.0)	40 (75.5)	33 (35.5)	**0.000**
Heart disease	70 (47.9)	27 (50.9)	43 (46.2)	0.609
Tobacco	61 (41.8)	28 (52.8)	33 (35.5)	0.055
Obesity	56 (38.4)	28 (52.8)	38 (40.9)	0.172
Maternal and infant health	52 (35.6)	28 (52.8)	24 (25.8)	**0.001**
Cancer	49 (33.6)	21 (39.6)	28 (30.1)	0.276
Hypertension	47 (32.2)	20 (37.7)	27 (29.0)	0.357
Substance use	44 (30.1)	24 (45.3)	40 (43.0)	0.863
Oral health	42 (28.8)	19 (35.8)	23 (24.7)	0.184

Bold values are statistically significant.

Diabetes and mental health were the most commonly addressed conditions across sites, with 66.4% and 58.9% of CHWs, respectively, working on these conditions. CHWs at MCOs were significantly more likely to provide services related to asthma, diabetes, maternal and infant health, and mental health. Table 6 contains a summary of these results.

Discussion

This national study of the roles and activities of CHWs supported by Medicaid MCOs fills a gap in the literature, and it has several important implications.

The demographics of the sample are generally consistent with the broader CHW workforce, which is primarily women of color.[10,29] Overall, contracted CHWs appear to be in a more precarious position than MCO-based CHWs because they are earning less, which may be due to working fewer hours, earning a lower hourly wage, or some combination thereof. They also receive fewer benefits and attend less on-the-job training. MCOs, in contrast, are likely able to offer higher salaries and comprehensive benefits because they are often large, for-profit companies.

As MCOs expand their CHW workforces, they may, inadvertently or intentionally, recruit trusted CHWs away from community-based organizations with promises of higher salaries and comprehensive benefits. To ensure that community-based organizations are not depleted of their staff members, health plans may consider developing contracts with community-based organizations that include salaries on par with in-house CHWs. MCOs may also collaborate with local CHW networks to identify and hire experienced CHWs who are currently out of work.

Survey respondents generally endorsed roles and activities consistent with those of the broader workforce,[13] and it appears employers largely support these roles by training CHWs in core competencies. The low levels of CHW engagement in activities such as program evaluation mirror limited prior research on this topic and[26] suggest that some health plans may be unaware of the full range of CHW roles. The significant differences between MCO-based and contracted CHWs suggest that these entities are conceptualizing CHW positions differently. CHWs at MCOs appear to be serving enrollees who have high-cost health conditions (eg, diabetes, asthma) or use services frequently.

These CHWs are largely provided with appropriate training (eg, motivational interviewing, chronic disease) to coach enrollees to achieve outcomes such as improving medication adherence and enacting lifestyle changes. Contracted CHWs, in contrast, are providing more direct services and interacting more with populations defined by race or ethnicity.

These differences are important for several reasons. First, CHW intervention with members who have high costs of care or utilization may demonstrate a return on investment in the short term. In contrast, contracted CHWs implement longer term, population-based interventions that may produce substantial, but not immediately obvious, financial benefits. The differences in CHW activities are also relevant in the context of considering MCOs' relatively new mandate to address SDOH.

Because contracted CHWs working at community-based organizations are more likely to support entire populations, rather than individuals with a specific health condition, they are likely accustomed to addressing a host of complex social issues in partnership with other community and social resources. They may have unique insight into the underlying structural conditions (eg, food deserts, environmental pollution) that cause health inequities, as well as the professional freedom to promote community-level interventions to address, and even prevent, these issues. MCOs, in contrast, appear to be addressing SDOH by asking CHWs to conduct individual assessments for social needs and making referrals, likely through social services resource locators.

This limited approach may leave CHWs in the challenging position of consistently identifying the same needs among members, without ever being able to effect change in the root causes of social issues that affect health. It may also be problematic, even if well intended, in communities where there are no resources to meet identified needs. For example, it would be questionable for CHWs to screen for intimate partner violence in a community where there are no shelters. CHWs may need time in their workdays to investigate and develop relationships with potential referral organizations. They also need structured communication strategies to provide feedback to supervisors and other community health stakeholders about resources that need to be developed or expanded (eg, food banks, new public transportation lines).

As MCOs continue to invest in CHWs, it will be critical for administrators and supervisors to learn about the full

range of CHW roles and consider how they may be applied in a managed care context. For example, if CHWs are invited to engage in their core role of evaluation, they can collaborate with MCO leaders to develop systems to document CHWs contributions to improving both individual and population health, many of which are qualitative and cannot be easily measured by utilization or quality metrics. Health plan staff may benefit from participating in CHW professional associations or communities of practice led by CHWs. In addition, organizations receiving MCO contracts could benefit from training in areas in which MCOs have expertise including care coordination and electronic health data management.

Limitations

It is important to acknowledge that this survey took place during the COVID-19 pandemic. The higher proportion of contracted CHWs engaged in direct services and with employer-provided personal protective equipment suggest that these CHWs were more likely to have been engaged in supporting testing and vaccine outreach efforts. MCO-based CHWs, in contrast, likely had the ability to work from home.

There are several other limitations to this study. It is a cross-sectional study with a relatively small sample size. CHWs participating in professional networks are more likely to have responded than those who do not, possibly creating selection bias if this group differs from CHWs who are not involved with networks. Calculating a survey response rate is not possible because there is no way to track the number of CHWs to whom networks sent the survey or how many CHWs who received the survey met the inclusion criteria. Despite these limitations, the article contributes to the field in that it is, to the team's knowledge, the first to ask CHWs about their work in MCOs or examine whether CHW roles may differ based on whether they are employed directly or contracted by MCOs.

Conclusions

CHWs supported by Medicaid managed care appear to be generally similar to the overall CHW workforce in terms of demographics, but there are some core activities in which they may be only minimally engaged. There are also important differences between those who are hired directly by MCOs and those who receive contracts from MCOs. Health plans that hire CHWs directly offer more comprehensive benefits and training and appear to direct CHW work toward improving individual health outcomes and reducing costs. Contracted CHWs, in contrast, receive fewer professional supports and are more likely to focus on improving the health of populations experiencing health inequities, which may produce less immediately visible financial returns.

As the workforce of MCO-supported CHW grows, it will be critical to recall what has historically made CHWs successful—the trust of the communities they serve and their ability to address SDOH through individual- and population-level interventions. Health plans would do well to ensure the CHWs they support, whether through contract or direct hiring, receive appropriate compensation and training, and have the freedom to engage in the full range of CHW roles, including in community-level interventions. State Medicaid agencies and CMS may consider collaborating with CHW professional associations to develop guidelines specific to the work of CHWs in managed care.

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Authors' Contributions

Dr. Wennerstrom contributed to conceptualization, methodology, investigation, formal analysis, writing—original draft, and funding acquisition. Ms. Haywood was involved in conceptualization, methodology, and data curation. Ms. Smith took care of conceptualization, methodology, data curation, and writing—review and editing. Ms. Jindal carried out data curation, writing— original draft, and writing—review and editing. Mr. Rush was in charge of conceptualization, data curation, and writing—review and editing. Prof. Wilkinson took care of conceptualization, methodology, and data curation.

Author Disclosure Statement

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