

June 9, 2025

Brittany Church
RI Executive Office of Health and Human Services
3 West Road
Cranston, RI 02920
By Email To: Brittany.Church@OHHS.ri.gov

Re: Community Health Worker Proposed Amendments to the RI Medicaid State Plan

Dear Ms. Church,

RIPIN welcomes the opportunity to comment on the Executive Office of Health and Human Services (EOHHS) proposed Amendments to the Medicaid State Plan for the Community Health Worker Services (CHW). For three decades, RIPIN has successfully implemented a “peer model,” hiring staff from the communities we serve. Today, our team of nearly hundred CHWs (about 75% certified, the other 25% on the path to certification) helps tens of thousands of Rhode Islanders navigate special education, access healthcare, and healthy aging annually, making us one of the State’s leaders in CHW programming. Nearly all RIPIN CHWs are funded through other grants and funding streams, not through Medicaid billing. RIPIN does Medicaid under the CHW benefit to lead evidence-based group health education training programs.

RIPIN recognizes the need for revisions to the State Plan to provide additional clarity regarding billing practices and to outline service limitations to ensure alignment with program goals and funding parameters. We support the State’s continued investment in CHW services by making them a covered Medicaid benefit. CHWs are a proven resource to improve health outcomes and reduce overall healthcare costs. These proposed changes, however, are extremely impactful and may make it impossible for RIPIN or other similar organizations to provide services through the Medicaid benefit.

RIPIN has supported the delivery of evidence-based programming in the State since 2012. We manage the Community Health Network in partnership with the RI Department of Health. We utilize the chronic disease Self-management education (SME) programs identified by the Centers for Disease and Control (CDC) and the Administration for Community Living (ACL) as proven programs to help individuals learn skills to manage symptoms, improve eating and sleeping habits, reduce stress, and maintain a healthy lifestyle.*

Health Education and Training:

RIPIN has serious concerns about several of the proposed changes to the **Health Education and Training for individuals and groups of beneficiaries** (*Section 13C.1 Preventative Services*). These changes could severely hamper the delivery of health education programs and services that have a proven impact on health outcomes. Specifically, the requirement for the preapproval of training materials as written and the new requirement for a prescription or order for CHW Services could significantly disrupt the current delivery model.

* <https://www.cdc.gov/chronic-disease/living-with/index.html>



Health Education and Training services provided by CHWs are covered when the CHW provides the education and/or training using **established pre-approved** training materials.

CHW services must be **medically necessary and recommended by prescribed or ordered by a licensed practitioner of the healing arts (LPHA)** within the scope of their practice under State law.

We **strongly** recommend that EOHHS:

✓ **Identify** evidence-based programs aligned with the CDC and ACL recommendations and require programs outside of the approved list to seek additional approval.

✓ **Clarify** the process and timelines for approval of new programs, and the criteria the State will use to grant or deny approvals.

✓ Allowing organizations to utilize a **standing order** for access to CHW services. Even if a statewide standing order creates program integrity risks, organizations with their own clinical staff or consultants should be allowed to craft standing orders specific to their circumstances. Standing orders are commonplace in large clinical healthcare settings, including for example, allowing nurses to dispense pain medications quickly without a specific doctor's order. In the context of evidence-based programs, the clinical criteria for program participants are often made clear in the development of the evidence-base for the program. Even when RIPIN receives referrals from clinicians, they are often sent to us in a batch manner (for example, all patients with pre-diabetes at a practice) that would not lend itself well to individual prescriptions or orders.

Standing orders and protocols allow patient care to be shared among non-clinician members of the care team. Studies have demonstrated the efficacy of implementing stand order protocols to improve patient care. The Centers for Disease Control and Prevention (CDC) strongly recommends the use of standing orders to increase the delivery of care services.†

Service Limitations:

With regard to the proposed changes to the **Service Limitations**, RIPIN **recommends** the following adaptations:

✓ Align CHW service limits with evidence-based program fidelity without requiring prior authorization. The Self-Management Resource Center (SMRC)‡ is the guiding body for program research and development, with over 38 years of experience, focused on the goal of helping people better manage their chronic health conditions. The SMRC sets program fidelity guidelines that require a minimum number of:

- Participants (**8-12**)
- Hours per class (many at **2.5** hours)
- Must be facilitated by **2** trained leaders

†

https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/potential_standing_orders.html#:~:text=Standing%20orders%20are%20written%20protocols%20that%20authorize,physicians%20to%20focus%20on%20more%20complex%20care.

‡ https://selfmanagementresource.com/wp-content/uploads/Quick_Overview_Adopting_SMRC_Programs.pdf



Trained CHW program leaders / facilitators also need some time, often on the day of, day before, and/or day after the class to connect with specific participants. Assuming a 2.5-hour class taught by two CHW leaders, with the potential for brief contact before or after class, an organization would need to be able to bill 5.5 to 6 hours with respect to each beneficiary on the day of the class. Investing less time than this (especially using one CHW leader instead of two) would run afoul of program fidelity rules.

While we do not bill Medicaid for 1:1 CHW services, we have also heard that investing more than two hours in a day on a given patient is quite common in acute situations, e.g. the day of an eviction of a medically fragile patient. We recommend that EOHHS adopt weekly limits of 8-10 hours per patient, rather than daily limits.

Provider Qualifications:

With regard to the proposed Provider Certification requiring:

All newly enrolled CHWs Individuals must be certified by the Rhode Island Certification Board as a CHW.

Effective October 1, 2025, all currently enrolled CHWs must be fully certified by the Rhode Island Certification Board.

RIPIN remains the largest employer of CHWs within the state. We are recognized nationally for our expertise in developing and integrating CHW programming within systems of care. As part of our registered trade apprenticeship model, we plan that each new employee will require approximately 18 months to achieve certification.

CHWs generally learn on the job, and on-the-job supervised work experience is an integral part of the certification process. Since they are working while training, CHWs-in-training are typically paid. If organizations can't seek reimbursement for CHWs in training, it will become nearly impossible for organizations to hire and training aspiring CHWs and therefore make it nearly impossible for CHWs to become certified. RIPIN recommends EOHSS:

✓ Allow organizations to seek reimbursement for CHWs on the path to certification, so long as the organization can demonstrate to EOHHS its training and oversight program, potentially for example be evidencing a pattern of employed CHWs achieving certification. Alternatively, aspiring CHWs who participate in a registered trade apprenticeship program (which RIPIN operates) could be eligible to bill.

Technical Comments, Questions, and Specific Suggested Revisions:

Below, we provide various technical questions, comments, and specific suggested revisions to the Amendment.

Define process and timelines for how training materials will be approved.

Under Payment Methodology:

It is unclear if the Amendments will support the delivery of evidence-based programs facilitated by **two** CHWs as required by the SMRC. Please clarify.



The SPA changes the group education code from a 15-minute to a 30-minute increment. Please clarify that the reimbursement rate for the code will be adjusted accordingly. (RIPIN considers the current rate inadequate, so doubling the rate would be the minimum adjustment to consider.)

Consider removing the limit of 8 people for group Health Education. As stated previously, program fidelity requires a minimum number of 8 participants, but cohorts can go higher than the minimum. The maximum class size under the most common program fidelity requirements is 12. Please consider a limit of 15 people per class.

Conclusion

CHWs have become an integral and necessary part of Rhode Island's service and support delivery systems of care, particularly for our most vulnerable populations. RIPIN supports EOHHS' clear conviction that CHWs represent a significant value added to the RI Medicaid system and its commitment to ensuring the sustainability of these client-focused programs.

However, proposing many of the changes to the language can be highly problematic and undermine many of EOHHS's stated goals in establishing the program. RIPIN strongly suggests that EOHHS engage with the community to develop policies to ensure that the CHW model continues to be a workable strategy to provide health care services and support to Medicaid enrollees.

Please do not hesitate to reach out to us for any further information that may be helpful to you. We are a long-term partner of EOHHS and the communities this initiative is meant to serve, and we are dedicated cheerleaders for CHW services. We are more than happy to help in any way we can.

Sincerely,

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