

Date: June 6, 2025

To:

Brittany Church

Executive Office of Health and Human Services

3 West Road

Cranston, RI 02920

**Subject: Public Comment on Proposed State Plan Amendment – Community Health Worker Services**

Dear Ms. Church,

The **Rhode Island Alliance for Community Health Worker Employers** writes to comment on the proposed State Plan Amendment (SPA) regarding Community Health Worker (CHW) services, as outlined in the public notice dated May 9, 2025.

The Alliance for Community Health Worker Employers advances the status of Community Health Workers (CHWs) as a foundation for the health and well-being of Rhode Island communities. We are a cross-sector collaborative that strives for multi-stakeholder accountability, shared governance, and a unified voice for policy efforts. By championing the interests of organizations, advocating for the recognition and support of CHWs, and promoting best practices, we aspire to make a lasting impact in communities. The Alliance's Advisory Committee includes RIPIN, Brown Health (formerly Lifespan), Integra, Family Service RI, Progreso Latino, the Community Health Workers Association of RI (CHWARI), EBCAP, and ONE-NB. While this whole committee has had input on these comments, the views expressed here do not necessarily reflect the views of any particular organization.

We commend the Executive Office of Health and Human Services for its commitment to ensuring that essential services are effectively delivered to those in need, enabling Rhode Island residents to access high-quality, affordable, and sustainable health and social services. While we appreciate EOHHS's dedication, we would like to address several concerns and propose suggestions to enhance the implementation of this policy and safeguard the access of these essential services for the most vulnerable populations:

1. Effectiveness of CHW Role (SPA pg. 1)
2. LPHA Referrals and Sign-Off Requirements (SPA, pg. 3)
3. Daily and Monthly Limits on CHW Services (SPA, pg. 3)
4. Provider Qualifications (SPA, pg. 3)
5. Collateral Services Provisions (SPA, pg. 4)

Our concerns, presented in detail with suggestions for improvement, are as follows.

### 13.C.1 Preventive Services

#### 1. Effectiveness of CHW Role (SPA pg. 1)

##### 13.C.1 Preventive Services

##### Community Health Worker Services:

##### Description of the services and each of the component services:

Community Health Worker (CHW) services is a preventive health service to prevent disease, disability, and other health conditions or their progression; to prolong life; and/or to promote physical and mental health and efficiency.

CHWs are frontline public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community. As trusted leaders, they often serve as a link between their community and needed health ~~care or social~~ services. CHWs help to improve access to, quality of, and cultural responsiveness of service providers. These trusting relationships enable them to serve as a liaison/link/intermediary between health ~~care/social~~ services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery. CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as engagement, community education, social support and advocacy. CHWs hold a unique position within an often-rigid health care system in that they can be

By removing the word social and adding “care” to the word health the revised language conflicts with the Rhode Island Certification Board’s definition of Community Health Worker and does not fully reflect the definition of CHWs established by the U.S. Bureau of Labor Statistics<sup>1</sup> or that of the American Public Health Association<sup>2</sup> definition of a CHW and their roles. This alteration could limit the scope and practice of the full role that is commonly recognized and diminish the vital community-clinical linkages that CHWs build. While not all CHW services are reimbursable under Medicaid, we suggest that the SPA reflect the definition of CHWs as presented in the U.S. Bureau of Labor Statistics or the American Public Health Association to preserve the integrity of the nationally accepted definitions. This definition was first developed by the CHW Section and codified through APHA policy in 2009.

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<sup>1</sup> <https://www.bls.gov/oes/2023/may/oes211094.htm>

<sup>2</sup> <https://www.apha.org/apha-communities/member-sections/community-health-workers>

We recommend that the Executive Office of Health and Human Services (EOHHS) preserve the original SPA language in this section to align with the U.S. Bureau of Labor Statistics and the American Public Health Association definitions.

### 13.C.1 Preventive Services

#### 2. Medical Necessity and LPHA Referral Requirements (SPA pg. 3)

~~— Care planning with a beneficiary's interdisciplinary care team as part of a team-based, person-centered approach to prevent disease, disability, and other health conditions, prolong life, and/or promote physical and mental health and efficiency by meeting a beneficiary's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention for members with chronic condition management needs.~~

CHW services do not involve diagnosis, clinical care or treatment, or counseling. 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. Orders by a LPHA must be reviewed for continued medical necessity and renewed at least every six (6) months.

The documentation and referral requirements associated with LPHA (Licensed Practitioner of the Healing Arts) orders for Community Health Worker (CHW) services present significant operational and administrative challenges. These burdens hinder the effective integration of CHWs into existing population health program models, which have proved essential for delivering comprehensive and coordinated care to Rhode Island's most vulnerable populations.

We believe it is crucial to consider the following points:

- ✓ The newly established requirements will likely have a disproportionate impact on vulnerable populations served by Medicaid. Specifically, individuals who are disengaged from primary care, those experiencing homelessness, and people with disabilities—particularly those with behavioral health conditions—will face considerable obstacles in accessing necessary services. This could exacerbate existing health disparities and create additional barriers to care for groups that are already marginalized.
- ✓ The administrative burdens imposed on primary care physicians are substantial. They include the time-consuming and complex documentation processes required to meet the new standards, as well as the adjustments needed for electronic medical record (EMR) systems to accommodate these changes. This translates to a significant increase in workload for healthcare providers that is likely to be untenable given

competing time pressures. These challenges may make it difficult or even impossible for providers to receive reimbursement under the proposed guidelines, creating financial strain on practices and further complicating the delivery of effective CHW services to vulnerable patients.

Addressing these burdens is critical to ensure that CHWs can effectively support population health initiatives without compromising access to care for those who need it most.

**We recommend that the Executive Office of Health and Human Services (EOHHS) take the following actions to enhance the effectiveness of health service delivery:**

✓ **Allow for an organizational Standing Order to be used to deliver recognized evidence-based programs.**

We ask you to consider allowing for the use of Standing Orders prepared and signed by employed or contracted clinicians that are specific to the context of a particular organization at the work their CHWs perform. The American Academy of Family Physicians<sup>3</sup> recognizes the effectiveness of their use. Eliminating the use of Standing Orders entirely will place unnecessary burdens on physicians and limit access to these much-needed prevention and self-management programs for the most vulnerable population.

✓ **Delay Implementation of Proposed Changes**

In addition to allowing organization-specific standing orders, we also propose that EOHHS postpone the implementation of replacing the term “recommended” with “prescribed or ordered” by a Licensed Public Health Authority (LPHA). We recommend delaying implementation until January 2026. This adjustment period is crucial for ensuring that the necessary updates can be made without disrupting the quality of care provided to patients.

✓ **Establish a Stakeholder Consultation Process**

We strongly recommend that EOHHS create a comprehensive stakeholder consultation process to develop a feasible and equitable approach to updating the Medicaid CHW benefit to eliminate fraud, waste and abuse. This initiative should gather insights and advice from stakeholders, including CHWs, healthcare providers, community organizations, and representatives from vulnerable populations. The focus of this consultation should be on identifying the best practices for operationalizing LPHA orders and the associated documentation requirements for services offered to individuals facing significant barriers to accessing healthcare

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[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://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.)

### 13.C.1 Preventive Services

#### Community Health Worker Services

##### Service Limitations (SPA pg. 3)

###### Service Limitations

CHW services cannot be duplicative of any other Medicaid State Plan or waiver services provided to the beneficiary.

Services provided by a Community Health Worker are limited to two (2) hours in a twenty-four (24) hour period, not to exceed twelve (12) hours per calendar month per recipient without prior authorization. If medically necessary, prior authorization can be requested for additional services.

The proposed limitations on CHW services are misaligned with established evidence-based practices and greatly restrict the flexibility required for critical emergency interventions. Many situations that require CHW involvement simply cannot be effectively managed within the confines of a two-hour window, potentially compromising the quality of care and support provided to patients. For example, a CHW intervention with a medically fragile patient who has just been evicted may require more than a couple hours.

One notable example of these limitations in practice is their effect on access to recognized evidence-based programs. Programs such as Chronic Pain Self-Management and Chronic Disease Self-Management—both of which are endorsed by the CDC—are typically delivered in sessions lasting 2.5 hours. As a result, the current proposed daily billing limit hinders the implementation of these critical programs, that have proven effective strategies for improving health outcomes for beneficiaries.

**We urge you to reevaluate the limitations imposed on CHW services to align them more closely with evidence-based practices** and to allow for acute or emergency interventions to which CHWs are so well suited. For instance, the EOHHS Peer Based Recovery Support Services Provider Billing Manual<sup>4</sup> (page 5-6) sets Medicaid service limits for peer recovery services, which allow for a per-day limit of 32 fifteen-minute units, effectively equating to eight hours of service. In contrast, the restrictions proposed for CHW services create an unnecessary disparity that compromises the effectiveness of this essential workforce. Adjusting these limitations to better reflect the needs of the community and the evidence-based practices that support patient care will enhance the quality of services delivered and contribute to better health outcomes for those we serve.

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<sup>4</sup> <https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-04/Peer%20Based%20Recovery%20Billing%20Manual%20v1.1.pdf>

If there must be a daily limit, we recommend aligning with the peer recovery daily limit of 8 hours. EOHHS should also consider replacing the daily limit with a weekly limit (perhaps of roughly 12 hours) to allow flexibility for acute interventions but provide more program integrity protections than a daily 8-hour limit.

### 13.C.1 Preventive Services

#### Provider Qualifications (SPA pg. 3)

Provider Qualifications:

Qualified CHWs are:

~~1. All newly enrolled CHWs~~ individuals must be certified by the Rhode Island Certification Board as a CHW; or

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

~~2. Individuals who have a plan for working toward RI certification, to be achieved within 18 months.~~

Certification by the Rhode Island Certification Board includes the following requirements:

- Completion of six months or 1,000 hours of paid or volunteer work experience within the last five years;
- Completion of 50 hours of supervised work;
- Completion of 70 hours of education; and
- Submission of a portfolio, which is a collection of personal and professional activities and achievements.

While this change addresses a gap in tracking workforce development, it lays out additional, uncompensated responsibilities on CHWs and employers. It will abruptly and unnecessarily limit services to Medicaid recipients that could otherwise be delivered by providers who follow best practices for CHW professional development. Rhode Island employers have established practices of using registered apprenticeships to recruit, train, and retain highly skilled workers. These proven workforce development strategies combine on-the-job learning with related instruction to master an occupation. Examples of such programs include the Health Resources and Services Administration (HRSA) Program at the Rhode Island College (RIC) Institute for Education in Healthcare in partnership with the [Community Health Worker Association of Rhode Island](#)<sup>5</sup> and the Rhode Island Department of Labor and Training, in partnership with [Apprenticeship Rhode Island](#)<sup>6</sup>:CHW Apprenticeship Program.

**We request that CHWs who are on track to complete the required certification process be allowed to seek reimbursement.** A grace period for these individuals will enhance access to necessary health services in our communities.

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<sup>5</sup> <https://chwari.org/chw-apprenticeship-program/>

<sup>6</sup> <https://www.bfri.org/ari-explore/>

To qualify for reimbursement during this transitional period, CHWs could be asked to meet the following criteria:

- ✓ **Enrollment and Monitored Completion of 70 Hours of Relevant Training per Rhode Island Certification Board**
- ✓ **Enrollment in Registered Apprenticeship Programs that provide 50 hours of supervised work**

### **13.C.1 Preventive Services**

Covered Services – Collateral Services (SPA pg. 4)

#### **Community Health Worker Services Payment:**

##### Payment methodology:

Service time billed must be for ~~either direct contact with a beneficiary (in person or through telehealth), as medically necessary and as prescribed by a physician or licensed practitioner of the healing arts within their scope of authorized practice under State Law, or for collateral services on an individual basis. Collateral services are those delivered on behalf of an individual beneficiary but that are not delivered in that beneficiary's presence/directly to the beneficiary. The collateral service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.~~

~~Rates established are inclusive of travel time and time spent conducting outreach to a new patient not yet receiving any CHW services. CHWs may not bill for time spent on travel, outreach, documentation, or activities not directly delivered to the beneficiary.~~

We urge you to reconsider the restrictions on non-direct collateral services rather than eliminating them entirely. Community Health Worker (CHW) programs are already burdened with numerous non-billable activities. Collateral services include calling around to shelters and low-income housing providers, liaising with clinical providers, and identifying appropriate supports in a patient's community. These tasks are absolutely at the core of a CHW's work, and they are clearly identifiable to a specific patient. Like direct services, they should be properly documented to provide an audit trail. Carving collateral support out of billable time undermines the CHW role without any material program integrity benefit.

#### **We recommend restoring billing for specific non-direct collateral services.**

We ask that you restore non-direct collateral services while further research is conducted how Rhode Island Medicaid reimburses non-direct collateral services for other professions and identify additional safeguards that may be appropriate for the program.

**Provide flexibility in Medicaid reimbursement for effective CHW Services in the following situations:**

- ✓ **Working with parents, guardians, or individuals with Power of Attorney** when the dependent beneficiary is not present during the delivery of services but remains the focus of those services, provided that these services are medically necessary.
- ✓ **Collaborating directly with the beneficiary's healthcare team** when the beneficiary is not present during the delivery of services but remains the focus, as long as the services are medically necessary.
- ✓ **Establishing a limit on reimbursable units for medically necessary non-direct collateral services** when the beneficiary is not present during the provision of services but remains the focus. Examples include calling providers, contacting shelters, conducting research, etc.

We appreciate your attention to these matters and welcome further discussions if necessary.

The Alliance for CHW Employers

**Commented [DB1]:** I think reiterating the request for a focused community consultation to develop an effective approach to these priorities would be good at this point.