



June 9, 2025

Brittany Church, MPA  
Chief Family Health Systems  
Executive Office of Health and Human Service  
3 West Rd, Cranston, RI, 02920

Re: Written Response to State of RI EOHHS Proposed Amendment to The Rhode Island Medicaid State Plan

Dear Ms. Church:

Please accept this letter in response to the June 2025 Community Health Worker Program Changes to the Medicaid Program for the RI State Plan. I submit this response in my capacity as the Executive Director of RI College's Institute for Education in Healthcare (IEH) and the administrator for the Community Health Worker Association of RI (CHWARI), which is housed within the IEH.

In 2022 when the RI Medicaid State Plan was expanded to include CHW services, CHWs felt seen and affirmed. The broad parameters that informed the CHW Medicaid Program afforded ample time for individual work with clients and allowed CHWs' engagement with clients to reflect culturally responsive practices that respected client self-determination. The original contents and fiscal structure of the 2022 CHW Medicaid Program was a resource for responding to the social determinant needs, such as homelessness, poverty, and other traumas, that contributed to clients' medical and behavioral health challenges; CHWs responded to these immediate needs while building connections for clients with traditional systems of care to promote health and wellness of vulnerable communities. It is both ironic and unfortunate that the very things that made the CHW Medicaid Program such a strong fit for the work of CHWs have all but been stripped away in the June 2025, 4.1-version. These changes may reflect responses to the abuse and fraud of a small group of individuals; however, in contrast to the CHW and client centric approach of the 2022 program, the changes reflected in version-4.1 are so limiting that they are antithetical to the very practices central to CHWs. Moving forward with the current version is sure to cause devastation to critical resources supporting the availability of CHWs to serve RI's most vulnerable communities.

Please know that the IEH-CHWARI stands with EOHHS in the need to hold perpetrators of fraud and theft accountable. At this same time, the IEH-CHWARI asks that EOHHS reconsider the extreme revisions to its CHW Medicaid Program with a return to client centered services and an appreciation for the difference the CHWs make in the lives of clients. It is not the role of the IEH-CHWARI to dictate what should be done to EOHHS but to be a partner whose experience and knowledge of CHW and related practices may be of assistance to EOHHS during this challenging time.

[www.ric.edu/ieh](http://www.ric.edu/ieh) Rhode Island College Alger Hall  
Suite 242 600 Mt. Pleasant Ave. Providence, RI 02908

As RI's professional association for CHWs, the IEH-CHWARI benefits from the memberships of 1100 CHWs and 930 allies who range from CHW employers to policy and practice experts. Our collective membership is skilled in communicating their needs and suggestions, which serves as a resource for informing this response. In addition to the strength of our membership, the IEH-CHWARI serves as a primary training resource supporting the training and certification preparation of RI's CHWS. RI's is fortunate to have several CHW certification training partners to choose from, including but not limited to RIPIN, Clinica Esperanza, Community Health Innovations of Rhode Island, Parent Support Network, and the new CHW training program at Roger Williams University.

Since 2019, the IEH-CHWARI have facilitated 21 cohorts of the CHW Core training that is required as part of the RI Certification Board's (RICB) certification requirements. Across these 21 cohorts, 427 CHWs have been trained and another 31 CHWs are on target to complete training this July 2025. In addition to the Core training, the IEH-CHWARI offers specialization training recognized by the RIBC with corresponding certification; these trainings include HIV for CHWs and Direct Care Staff, Cardiovascular Disease and Diabetes Management, and Building Holistic Relationships with Older Adults: A Community Health Work, Person Centered & Social Determinants of Health Approach (a joint project with RIPIN). In addition to core and specialized training, the IEH-CHWARI also offers a specialized three-year CHW apprenticeship program that is funded by the Health Resources and Services Administration (HRSA). It is from the IEH-CHWARI's rich relationships with and knowledge of its member CHWs and employer partners that the IEH-CHWARI offers an important context from which to reconsider the changes proposed in the RI CHW Program Manual.

It is clear from the results of Community Health Worker (CHW) Medicaid audit that changes are required to ensure the integrity of program funds and to ensure the continuity of the CHW workforce, including independent CHWs. Within the proposed changes to the Community Health Worker Medicaid Program, it seems that the unique role and function of CHWs as they engage and support vulnerable clients in identifying complex needs and building bridges to connect these clients to systems of care is absent in both the definition and allowable scope of work. The proposed changes certainly provide a vehicle to limit the scope of services that will limit the fraudulent practices of those who abused the program. However, the impact of this action has resulted in limitations to allowable scope of practice for CHWs, which has reciprocal impacts to the care provided to clients. Finding a balance to support the stewardship of the program dollars and the continuity of those CHW services that contribute to transformative changes in clients' lives is essential to the success of the Medicaid Program and client outcomes. Perhaps it could be useful for EOHHS to consult with stakeholders, such as CHWARI, RIPIN, and the United Way, whose neutral postures related to CHW and Medicaid billing could assist with creating an authentic alignment between the Medicaid's goals to eliminate fraud, waste, and abuse, while informing a path to the fiscal and practical integration of CHW knowledge and skills that are fundamental to client care.

The IEH-CHWARI respectfully requests your attention to the sections below and asks you to invite the support of other partners to assist with revisions to the proposed CHW program changes that will balance ethical use with responsiveness to client needs through CHW services.

- Section 1.2 – consideration of the role of the CHW in the RI Medicaid Program to reflect the RI Certification Board definition of a CHW
- Sections 2.3 and 2.4 - Standing Orders and General Referrals-Prohibited Practices & Licensed Practitioner of the Healing Arts (LPHA) Referral Requirements

- Section 2.5.3 – clarification of the conflict of interest for individual and organizational CHW Providers
- Section 3 – expansion and broader contextualization of Medicaid covered CHW services & Section 7.5 - CHW Billing Transition, Coding, and Prior Authorization Requirements
- Section 5 – RI Medicaid CHW Certification Requirements

## **Section 1.2 – Consideration of the Role of The CHW in the RI Medicaid Program**

In the RI Medicaid Community Health Worker Program Manual version 4.1, EOHHS has excluded the components of the CHW's scope of practice from healthcare or social services as well as the cultural contexts that are central to CHW's work. The amendment of the definition of CHWs is important to the alignment and reconsideration of scope of work contexts and allowable practice time for billing. The definition from the RICB continues to guide the training content and certification preparation for CHWs, which are direct links that inform the integrity of their contributions to the community.

The RICB's definition is shared below for your consideration<sup>1</sup>:

*Community Health Workers are frontline public health workers who are trusted members of the community they serve. This trusting relationship enables them to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery.*

*Community Health Workers 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. Community Health Workers hold a unique position within an often rigid health care system in that they can be flexible and creative in responding to specific individual and community needs.*

*The unique strength of Community Health Workers is their ability to develop rapport with people and other community members due to shared culture, community residence, chronic condition, disability, language, and life experiences. They are also able to enhance the cultural and linguistic appropriateness of care and help to counteract factors such as social exclusion, poverty, and marginalization.*

*An important role of the Community Health Worker is to advocate for the socioeconomic, environmental, and political rights of individuals and their communities. Community Health Workers often link people to needed health information and services.*

*Community Health Workers address the social and environmental situations that interfere with an individual or community achieving optimal health and well-being.*

This definition stands as a resource for qualifying and connecting CHWs and their practices across systems of care in RI. This definition speaks to the integrity and important work of CHWs and may serve as a guide to EOHHS as it considers modifications to the role of CHW in its Medical Program.

## **Sections 2.3 and 2.4 - Standing Orders and General Referrals-Prohibited Practices / Licensed**

## **Practitioner of the Healing Arts (LPHA) Referral Requirements**

The IEH-CHWARI appreciates the important roles that Licensed Practitioner of the Healing Arts (LPHA) play in monitoring and facilitating care needs. However, it is worth considering the other less clinical pathways that can be instrumental in engaging clients in accessing health and behavioral health care services, where accessibility and historical issues of systemic oppression can hinder a client's engagement in traditional systems of care. The presence of a CHW provides a resource for helping move clients from the avoidance of accessing care out of shame or fear to a transformation, where a client's sense of agency emerges as they find the courage to pursue care due to the partnership of a CHW.

Are there matters related to social determinants of health that EOHHS would be willing to explore the services of a CHW as a strategy for engaging vulnerable clients in health and behavioral health care with the goal of connecting clients to LPHAs? If all referrals originate from LPHAs, it is likely that Medicaid services will be lost to the most vulnerable individuals who are not linked to health care or behavioral health care systems and providers. Furthermore, the availability of CHW services and supports are likely to diminish overtime both at the organizational and independent CHW levels, which will certainly have consequences for RI citizens and its Medicaid eligible clients.

Perhaps EOHHS could benefit from consultation with stakeholders whose neutral postures related to CHW and Medicaid billing could explore the potential benefits of creating flexibility with parameters that promotes opportunities to use the skills of CHWs to meet clients where they are as a first step in their engagement in traditional systems of care.

### **Section 2.5.3 – Clarification of the Conflict of Interest for Individual and Organizational CHW Providers**

Considering the presence of organizations that both bill for CHW services and provide their own CHW training for certification, the framing in this section is unclear and could benefit from some clarification. Can you provide clarification on the contexts of the term, *independence*? Are there organizational or staffing limitations that would either support or conflict with the required separation of the financial from certification and training activities?

The current framing raises concerns for the abilities of smaller agencies with limited administration roles to engage in both CHW Medicaid billing and agency-based training. Multiple agencies deliver CHW training; this diversity of training allows agencies to prepare their staff to focus on special populations or areas of practice as a part of the preparation for certification as CHWs. For instance, Clinica Esperanza delivers their training in a bilingual manner in tandem with a medical interpreter program; this approach uniquely prepares graduated CHWs to effectively serve the exact client-base of their organization. The IEH-CHWARI believes that limitations placed on the availability of training or agencies' abilities to provide their own training to support their CHW workforces would adversely impact the both the CHW workforce and those they serve.

### **Section 3 & 3.4 – Medicaid covered CHW services / Care Planning with Multi-Disciplinary Team and Collateral Services**

The significant reduction of allowable services to clients both with 24-hour and monthly timeframes

and the sunsetting of collateral services are incongruent with the role and function of CHWs. These changes are sure to hinder the extensive work that CHWs engage in to build relationships with vulnerable clients and to assist clients in addressing health and behavioral health needs that are often linked to oppression, poverty, and other areas of challenge.

Within the three categories of Medicaid Covered Services: 1) Health Promotion and Coaching; 2) Health Education and Training; and 3) Health System Navigation and Resource Coordination, it would be helpful to gather more data on the time CHWs require to deliver these services. Specifically, CHW's engagement, relationship building, and maintenance of relationships in support of retention in care and positive care outcomes occur at different levels of service and require varied amounts of time. The initial engagement, relationship building, and navigating systems of care and providers with a client reflects one of the most intensive aspects of service delivered. Other time intensive services occur when clients experience a crisis, such as homelessness, unemployment, medical and behavioral health emergencies and during transitions in within systems of care. These areas of service require time, and the limitation of 2-hours per 24-hour period stands in stark contrast to what is often needed to meet clients where they are so that they can meet healthcare and behavioral health needs. Outside of these more intensive phases of services, decreased time for services is more common to meet clients' needs.

The termination of multidisciplinary team and collateral services as of May 19 stands as a contradiction to what clients need from CHWs that often requires resource research, system navigation, and collaboration with other members of the care team. These activities occur in partnership with clients to achieve health and behavioral health outcomes and often intersect with social determinant of health needs that contribute to stability and positive health and behavioral health outcomes. The removal of these services contradicts an essential function of CHW that will not only impact services and client outcomes but also the quality and responsiveness of other medical and behavioral health providers who have come to rely on CHWs to gain better insight into and relationship with the clients they share.

Perhaps the area of allowable services and adjustments to the service time limits could be adjusted to reflect levels of time during different phases on the service delivery process. This area is one where it could be useful for EOHHS to consult with stakeholders whose neutral postures related to CHW and Medicaid billing could help to inform a more authentic alignment between the Medicaid services, allowable hours of care, and consideration for how to accommodate the important roles of multidisciplinary teaming and collateral services.

## **Section 5 – RI Medicaid CHW Certification Requirements**

The IEH-CHWARI supports the importance of CHW certification and values what certification signifies for integrity of the work that CHWs do. Certainly, revisions to the duration to certification and parameters related to billing for uncertified CHWs are important considerations. The IEH-CHWARI encourages EOHHS to consider opportunities to find a goodness of fit between organizations' struggles to hire certified CHWs with the availability of training and the intensity of the certification process.

Is there a balance to be found between an acceptable amount of time as CHWs who have successfully completed the required training and work toward certification with billing under the

supervision of an authority figure in the organization? The IEH-CHWARI's partners have suggested exploration of:

- A revised limitation for billing prior to certification with suggestions for a 6-9-month period.
- The role of Registered CHW Apprenticeship programs as eligible for billing during a limited pre-certification period.

Perhaps this area could also benefit from the input stakeholders whose neutral postures related to CHW and Medicaid billing could help to inform a modification to billing and certification questions that consider potential workforce pipelines exacerbated by training limitations and certification requirements and the desire of sustainability of a CHW workforce that remains true to employing people with lived experience of health inequity and socio-economic struggles.

The work that Community Health Workers do in RI reflects an essential service the deserves consideration and inclusion within the Medicaid Program in ways that uphold essential practices. We look forward to working with you to re-align the guidelines so that trained, dedicated, honest professionals can continue to improve lives in the culturally-informed and client-centered way that is integral to Community Health Workers.

In partnership,



Tonya Glantz, MSW, PhD  
Interim Executive Director  
Institute for Education in Healthcare  
Administrator, Community Health Worker Association of Rhode Island

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<sup>1</sup> RI Certification Board, 2022. Retrieved from <https://www.ricertboard.org/cchw>