

To: Executive Office of Health & Human Services, Division of Healthcare Delivery Contracts & Quality

From: Dr. Tonya Glantz, Executive Director, RI College Institute for Education in Healthcare and Administrator to the Community Health Worker Association of Rhode Island

As you know, Community Health Workers (CHWs) improve health outcomes, ensure healthcare quality and equity, and reduce healthcare expenditures by ensuring access to needed services that prevent hospital utilization. Rhode Island is a national leader in deploying CHWs across a range of populations and settings, and has shown vision in providing Medicaid reimbursement for CHW services. It is critical to avoid losing these important gains, and to ensure Medicaid reimbursement is feasible in practice, while eliminating fraud, waste, and abuse.

CHWARI acknowledges the serious impact that the proposed regulatory changes have on the continued work of Independent CHWs, where the impact is likely to have more consequences to RI's BIPOC CHWs. CHWARI recognizes the presence of RI Independent Community Health Works (see information on page 22) led by Koren Carbuccia, CEO & Founder, as a critical voice for responding to the proposed changes to Medicaid reimbursement for Independent CHWs.

Rhode Island Community Health Worker stakeholders strongly recommend that EOHHS establish a comprehensive community 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. Considering the implications of the regulatory changes for Independent CHWs, RI Independent Community Health Works, whose areas of expertise is the training, support, and advocacy for independent CHWs, should be included in consultation. The focus of this consultation should be on identifying the best practices for operationalizing reimbursement policy and procedure in a way that safeguards access to services for the vulnerable populations that CHWs are uniquely positioned to serve.

The Medicaid Community Health Worker Providers Manual Version 4.1 creates serious barriers to reimbursement for CHW services and is already driving unintended consequences by reducing access to needed care. In the spirit of collaboration, we offer the attached 'working document' in which we have identified areas in the manual that create obstacles, explain their impacts, and recommend options for a more effective approach. This document was created by a cross-section of individuals and organizations with broad knowledge of CHW work in RI.

We believe these recommendations will improve patient outcomes and will help save Medicaid money*. (See data below.)

Preserving robust CHW services is not only essential for addressing patients' social and behavioral needs—it is also a critical strategy for stabilizing and strengthening Rhode Island's systems of care. Amid a growing primary care workforce crisis, CHWs offer vital support to overburdened physicians by extending the reach of clinical teams, improving care coordination,

and addressing non-medical drivers of health. Evidence from health services research demonstrates that effective integration of CHWs into care teams improves clinical outcomes, enhances patient engagement, and reduces avoidable emergency department use and hospitalizations. *Rather than narrowing eligibility or coverage, Rhode Island should lean into CHW services as a high-value strategy to reduce Medicaid total cost of care and reinforce the primary care foundation of its health system.*

We reiterate our request for a stakeholder consultation process and hope that the attached document can contribute to a meaningful dialogue that results in the shared goal of preserving CHW services to improve the health of Rhode Islanders, reducing healthcare expenditures, and eliminating fraud, waste, and abuse.

Thank you for your valuable time,

Dr. Tonya Glantz, Executive Director, RI College Institute for Education in Healthcare and Administrator to the Community Health Worker Association of Rhode Island

Lina Roman, CCHW, CHWARI Advisory Council Member, Ambassador to the National Association of Community Health Workers, CHW Supervisor at Rhode Island Support Network, and Founder of RI Latinx Support Group, for CHWs

Koren Carbuccia, CEO & Founder, Rhode Island Independent Community Health Works (RIICHW) Certified CHW Supervisor & Perinatal Doula; Board Member, Brown University Institutional Review Board; Co-Director, Interdisciplinary Navigation Partnership, Alpert Medical School of Brown University

****Evidence from health services research suggests that preserving effective and appropriate coverage of CHW services will reduce Medicaid expenditures.***

ASTHO has compiled a [summary](#) of evidence on CHW effectiveness, including the evidence for return on investment displayed in the below graphic. For example, in Pennsylvania, a [randomized controlled trial](#) found that a CHW program yielded a return of \$2.47 for every \$1 invested, saving \$4200 per Medicaid beneficiary per year. Robust CHW services are a promising strategy to reduce Medicaid total cost of care in Rhode Island, outweighing short term savings projected in the SPA.

RETURN ON INVESTMENT (ROI) STUDIES ON CHW INTERVENTIONS

Nevada CHW ROI Study: Health Plan Hired Three CHWs to Work With an Average of 37 Patients Each for 30-60 Days

Average medical costs decreased from \$1,223 pre-intervention to \$983 post-intervention.

Maryland CHW Outreach Program on Healthcare Utilization

Patients saw savings of \$2,245 per year with a total saving of \$262,080 across 117 patients per year.

Kentucky Homeplace Program ROI Study Rural Health Information Hub

The ROI was \$11.20 saved for every \$1 spent on CHW training.

New Mexico: 448 High-Resource-Consuming Medicaid Managed Care Clients Received Support From CHWs for Six Months

Total cost differential across categories of services provided was \$2,044,465 less post-intervention compared to pre-intervention.

Social ROI Research Report on CHWs in Cancer Outreach and Education Across the United States

CHWs generated lifetime benefits of \$12,348 per person served by a CHW, or \$851,410 by every CHW that serves at least 69 individuals per year.

East Texas ROI From Employment of CHWs in Two Hospitals Working with Emergency Department Patients

There was an ROI ranging from 3:1 to over 15:1.

Denver Health Community Voices Program Piloted a CHW Outreach Program for 590 Men

The ROI was \$2.28 for every \$1 spent with a total annual savings of \$95,941.

CMMI Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative

An investigation of over a hundred innovative care delivery models revealed that only those using CHWs lowered cost (\$138 per beneficiary per quarter).

[ASTHO, "Community Health Workers: Evidence of their Effectiveness." 2025](#)

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Working Document:

Issues, Impacts & Recommendations on Medicaid Community Health Worker Providers Manual Version 4.1

Medical necessity requirements: HRSN and SDOH

([Manual v4.1, 2.2. p. 12-13](#))

Excerpts:

▲ Note Regarding HRSN and SDOH: Health-Related Social Needs (HRSNs) such as housing instability, food insecurity, or transportation barriers may not be used as standalone criteria to establish medical necessity. HRSNs may be considered only as secondary factors when linked to a diagnosed or at-risk condition supported by clinical documentation. *HRSNs alone do not establish medical necessity.*

The need for Medicaid CHW services must be substantiated through documented and objective health indicators, including but not limited to:

- A diagnosed chronic health or behavioral health condition;
- Rising-risk clinical indicators (e.g., elevated blood pressure, blood glucose, BMI);
- Documented health risk behaviors (e.g., tobacco use, alcohol use, substance use disorder);
- One (1) or more emergency department visits;

- One (1) or more inpatient or psychiatric hospitalizations;
- One (1) or more stays at a detoxification or stabilization facility;
- Two (2) or more missed clinical appointments;
- A documented HRSN that contributes to a clinical risk or interferes with treatment adherence for an eligible diagnosis.¹

Issue: Addressing HRSN and social determinants of health (SDOH) is a core role of CHWs in Rhode Island and nationally, and is a vital component of their interventions in evidence-based practices. We acknowledge that operationalizing reimbursement of services to address Medicaid beneficiaries' HRSNs presents challenges. As-written, this section presents several barriers to interpretation and implementation.

- First, HRSN by definition are health-related, and contribute to clinical risk and/or interfere with treatment adherence. If one critically appraises the evidence around CHW interventions (i.e. the many studies cited in previously shared [ASTHO document](#)), it's made clear in the methodology sections that addressing HRSN is a central part of CHW work. Thus, while the traditional CHW role has been thought of as one that revolves around providing education and support for chronic conditions such as hypertension or diabetes, the reality is that the vast majority of studies that have shown impact have a center in HRSN. Therefore, this policy change stands in contrast to evidence-based medicine.

- Second, documenting the linkage between clinical indicators and HRSNs raises practical and evidentiary questions, and places an undue burden on referring providers—particularly in the case of prevention services, where HSRNs contribute to risk for medical outcomes and healthcare expenditures that have not yet occurred. For instance, it is exceptionally rare for a primary care provider to explicitly document the connection between transportation insecurity and asthma exacerbation in the medical record, even when transportation may be a key driver of outcomes. Changing provider documentation behavior requires paradigm shifts, and years of time to implement. In the meantime, requiring Licensed Practitioner of the Healing Arts (LPHA) documentation of the connection between HRSN and clinical outcome—particularly for prevention—is unrealistic and unaligned with professional standards.
- Third, CHWs' roles on care teams often focuses specifically on HRSNs, leveraging expertise that clinicians do not bring.

Impact: As-written, this language causes confusion, reduces access to medically necessary services, and places undue burden on clinicians. Without revision, it is likely to increase Medicaid expenditures by reducing evidence-based services to address health-related social needs.

Recommendation: Return to allowing HRSN Z-codes as a primary diagnosis, and engage in a stakeholder consultation process to develop a feasible and appropriate approach to reimbursement for this core CHW role.

Standing orders and general referrals

([Manual](#) 2.3. p. 13-16).

Excerpts:

⚠ Clarification: Prior program guidance may have allowed LPHA “recommendations” without a corresponding diagnosis or individualized service order. That interpretation has been rescinded to align with federal Medicaid requirements under 42 C.F.R. § 440.130(c) and CMS State Medicaid Director Letter #13-006, which mandate that preventive services be explicitly authorized by a LPHA. Therefore, all CHW services must be based on a formal LPHA-issued service order that is tied to a documented medical diagnosis or clinically relevant risk factor as described in Section 2.2 of this Manual. Retroactive diagnosis from an LPHA is strictly prohibited for allowable reimbursement under Medicaid Program rules.

Standing orders, recommendations, or template authorizations without the LPHA interacting with the Medicaid beneficiary for a diagnosis are prohibited. CHW services

initiated under prohibited practices will be subject to payment denial, audit disallowance, or recoupment.

Referrals from a LPHA shall only be allowed for a maximum of six (6) months from the date of issuance by the LPHA.

2.4.Licensed Practitioner of the Healing Arts (LPHA) Referral Requirements

To initiate Medicaid CHW Services, a Rhode Island-licensed LPHA must issue a formal service order prior to CHWs rendering services to Medicaid beneficiaries for reimbursement. Consistent with 42 C.F.R. § 455.510, the ordering LPHA must be enrolled with RI Medicaid. CHWs may not begin or bill for services without this authorization, or for services authorized by a LPHA who is not enrolled as a RI Medicaid provider.

All LPHA-issued orders must:

- Be issued by a health professional licensed in the State of Rhode Island;
- Be based on direct clinical knowledge of the beneficiary’s condition or risk (See Section 2.4.3);
- Clearly document the specific CHW service, associated diagnosis, and the rationale for CHW involvement;
- Be retained in the CHW provider record for at least ten (10) years in accordance with RI Medicaid documentation policies.

Failure to document this referral in accordance with Medicaid program rules will result in claim denial, audit finding, or disallowance.

Issue: LPHA 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.

Impact: 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 LPHAs 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 LPHAs that is likely to be untenable given competing time pressures. These challenges may make it difficult or even impossible for provider organizations 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.

Recommendation: We recommend that the Executive Office of Health and Human Services (EOHHS) allow for an organizational Standing Order to be used to deliver recognized evidence-based programs and take the following actions to enhance the effectiveness of health service delivery:

- We ask you to consider allowing the use of Standing Orders prepared and signed by employed or contracted clinicians that are specific to the context of a particular organization and the work their CHWs perform. The American Academy of Family Physicians recognizes the effectiveness of their use. ([See this reference.](#))
- **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

CHWs as Supervisors of CHWs

([Manual](#) 2.4.2. p. 15).

A CHW cannot order, refer, or supervise their own services or those of another CHW. Services may not be provided to family members, cohabitants, or others with whom a personal relationship exists (see Section 2.5 of this Manual). Such offerings should be made through personal choice options available for Medicaid beneficiaries.

- **Issue:** It is a best practice for Community Health Workers to advance to supervisory roles, and oversee teams of other CHWs. The phrase “A CHW cannot order, refer, or **supervise** their own services or those of another CHW,” conflates orders and referrals for services with supervision of those services.
- **Impact:** Including a prohibition on CHW supervisors causes confusion for organizations where CHWs are already serving in that role, and works against career advancement strategies that stakeholder groups across the state have promoted in recent years.
- **Recommendation:** Strike the term “or supervise” from this section.

Prohibition on Marketing

([Manual 2.6. p. 18](#))

Excerpt:

2.6. Prohibition on Marketing to Induce Medicaid Utilization

CHWs and CHW-affiliated provider organizations are strictly prohibited from engaging in marketing, advertising, or promotional activities intended to induce Medicaid beneficiaries to utilize CHW services or to steer them toward specific providers or non-Medicaid-covered services. These prohibitions are grounded in federal Medicaid anti-kickback statutes (42 U.S.C. § 1320a-7b(b)) and 42 C.F.R. § 455.2.

“Marketing materials” refer to any communication, outreach, or promotional content created by or on behalf of a Medicaid provider that is intended to influence enrollment decisions, promote covered services, or induce Medicaid members to utilize specific providers or programs through mass distribution. These include advertisements, printed brochures, digital content, public announcements, and any incentive-based messaging, and must comply with applicable federal and state Medicaid rules.

Marketing materials includes, but is not limited to:

- Brochures and handouts

- Television, radio, or internet advertisements
- Flyers or posters in public places
- Social media posts
- Website content directed at member acquisition or retention
- Direct mailings to prospective or current members

Prohibited practices include, but are not limited to:

- Offering free food, gift cards, transportation, or other incentives at locations where Medicaid members congregate (e.g., food pantries, shelters, or public housing) to drive utilization of Medicaid services through non-allowable marketing activities;
- Promoting services as “free” or at “no cost” without clarifying that the services are provided under their Rhode Island Medicaid benefit, or that Medicaid eligibility rules apply;
- Hosting community events where access to food, giveaways, or social supports is contingent to the scheduling of a Medicaid-reimbursable visit;
- Providing referral bonuses or incentives to community members, staff, or other organizations for connecting individuals to CHW services;
- Cross-promoting unrelated business activities owned or operated by the CHW or affiliated organization (e.g., herbal supplements, legal services, wellness coaching, housing placement services, access to promotional events), unless those activities are Medicaid-covered and explicitly authorized by EOHHS or a delegated entity (e.g., MCO);
- Including QR codes, links, or handouts for non-Medicaid commercial services during outreach or client engagement sessions funded by Medicaid.

Issue: Prohibitions on marketing in this section are simultaneously unduly broad, and unduly restrictive.

Impact: Health promotion services offered through group classes are particularly affected by a prohibition on information-sharing about their availability. Educational classes must be able to recruit participants in order to be feasible. Statewide efforts to share information about CHWs, such as RIDOH’s [Community Health Worker Resource Map](#), might also be impacted.

Recommendations: We request that EOHHS align marketing policy with [CDCynergy](#) Lite marketing strategies, particularly for Community Health Worker (CHW) health education and coaching services that utilize CDC-approved and/or recognized evidence-based programs. We suggest establishing an EOHHS approval process for programs based on evidence-based strategies and practices.

We ask that you amend and allow marketing materials to include, but not be limited to:

- Brochures and handouts
- Television, radio, or internet advertisements
- Flyers or posters in public places
- Social media posts
- Website content directed at member acquisition or retention
- Direct mailings to prospective or current members

Allowable and prohibited activities for health system navigation and resource coordination

([Manual 3.3.2. p. 28](#))

Excerpt:

Assisting with Appointment Scheduling and Preparation: Scheduling and preparing for medical appointments—helping the beneficiary schedule appointments for Medicaid-covered services and preparing for the visit, such as reviewing logistics or health questions to ask the provider. This includes coaching on paperwork, directions, or how to explain symptoms or medical history. Coaching beneficiaries on how to explain symptoms or describe medical history during visits. ⚠ **Note:** CHWs may not bill for time spent accompanying a beneficiary to a medical appointment.

Issue: Accompaniment is a core role of CHWs. We recognize the need to avoid duplicative services. However, CHW accompaniment to medical appointments facilitates a broad array of transformative and low-cost services for beneficiaries with the most barriers to health. When accompanying clients to medical appointments, CHWs serve as cultural intermediaries, helping providers and patients understand each other in plain language; reinforce patients' understanding of diagnoses and treatment plans; identify and resolve barriers to care; support patient follow-through and adherence; build trust between health systems and historically disenfranchised communities; and advocate for equitable and culturally attuned treatment.

These are unique, non-duplicative services that contribute to better outcomes and are best achieved through CHW accompaniment to appointments.

Impact: This prohibition disproportionately impacts Medicaid beneficiaries with the most barriers to care. In particular, people with cognitive difference or decline, lower levels of digital, health and written literacy, people with limited English proficiency, people with complex chronic conditions, and people with trauma and behavioral health conditions. Accompaniment to appointments is a key strategy to ensure that the healthcare system works for these populations, and holds the potential to improve outcomes and reduce the costs of hospitalization through facilitating preventive care.

Recommendation: Rescind the prohibition on billing for time spent accompanying a beneficiary to a medical appointment.

Non-Billable Activities: Eligibility and enrollment assistance, public benefits

([Manual 3.3.2.](#), p. 29, and [4.1.](#), p. 35)

Excerpt:

Eligibility and Enrollment Assistance: Completing Medicaid redeterminations, SNAP forms, housing applications, or other public benefit paperwork. Acting as an eligibility worker or performing enrollment assistance functions beyond helping the beneficiary understand what documents to bring or where to go.

Unlinked or Unapproved Benefit Navigation: Navigating public benefits without a direct link to medical necessity or LPHA authorization is not covered:

- Non-Clinical Navigation Tasks: Completing SNAP, housing, or unemployment applications.
- General Resource Referrals Without Follow-Up: Providing lists or general referrals with no personalized support or service documentation.

Issue: Restricting which social determinants of health a community health worker can address with patients is unduly punitive given the nature of their role. They are tasked with assessing needs and assisting patients with overcoming barriers to health and overall care.

Impact: Eligibility and enrollment assistance is often a first point of contact for vulnerable populations seeking public benefits. By classifying these services as non-billable, organizations may deprioritize or reduce these services due to lack of funding. Individuals—especially those with disabilities, limited English proficiency, or low digital literacy—will face barriers to accessing essential benefits like Medicaid, SNAP, or housing assistance. Also, organizations may be forced to wait until a client’s situation escalates into a legal crisis (e.g., eviction, loss of healthcare) to assist. This reactive approach is **less efficient and more costly** than early intervention from a CHW.

Assisting participants with SNAP, housing, and other benefits applications often involves interpreting eligibility rules and navigating complex bureaucracies, as well as advocacy skills to resolve denials or delays. CHWs’ unique core competencies position them to effectively support vulnerable participants with these challenges.

Recommendation: Remove the Non-Billable Activities restriction. Allow billing for all CHW services to address SDOH, as each has a valuable role in supporting patient health and welfare.

Allowable place of service for CHW activities

Hospitals/Institutions

([Manual 4.2 p. 35](#), and [4.4., p 37](#))

Excerpts:

Settings and Service Contexts That Are Excluded: Institutional care settings, including: Nursing homes, Inpatient hospitals, Residential treatment facilities; Group residential or shared living environments; Habilitation programs, day programs, or employment support settings; Schools; Blocking time for visits or activities occurring in these settings; Group services that do not meet individual medical necessity documentation for each beneficiary. See Section 4.4 of this Manual for more information.

Institutional Care Settings: Nursing home, Residential treatment facilities, Intermediate care facilities (ICFs), group homes or shared living residences, day programs, day habilitation centers, or sheltered workshops.

Emergency Rooms or Inpatient Hospitals: CHWs may not deliver services during inpatient stays or in ERs while the individual is under clinical supervision, unless the CHW is part of a certified hospital team, and the services are distinctly separate and not duplicative, or part of a capitated hospital bundled rate.

Issue: Restrictions on providing care within Emergency Rooms, Inpatient Hospitals, or institutional settings are unduly restrictive and pose a significant barrier to patient care.

Impact: CHWs often play important roles in patient care plan transitions, especially those who may be fearful or mistrusting of healthcare systems. CHWs develop a relationship with the patient close to their discharge, facilitate some of the challenging community-based discharge planning and execution (i.e. delivery of medical equipment and supplies, picking up of medicine, etc). They are also helpful when a trauma or death has occurred and family members are in shock and are unclear how to take next steps. A CHW trained in trauma-informed approaches can assist with transporting family back home, informing key family and community members, organizing religious support from their community, etc. Excellent hospital-based care often stops at the door—a CHW allows that work to continue to full fruition, within the patient’s community. Emergency room CHWs are excellent at supporting patients who overutilize the ED due to substance abuse or homelessness to establish and maintain relationships with a primary care provider. CHWs engage them in conversation, develop trust, and continue to support them as they access appropriate shelter or other housing services. Because CHWs have similar lived experience, they know the challenges participants face and can establish rapport and common ground with them. **Within hospital and institutional care settings, CHWs are critical for patient flow, patient satisfaction, decrease in inappropriate use of emergency departments, increasing patient cooperation with care recommendations, and so much more.**

Recommendation: Revise this restriction to allow for key components of patient care planning and coordination within these locations. Setting a reasonable hourly limit per admission would allow their positive impact on patient care to continue.

Public/Open Spaces

([Manual](#) 4.2 p. 35, and 4.4., p 37)

Excerpt:

Public or Open-Access Areas: Spaces where HIPAA privacy cannot be ensured, such as bus stops, train stations, parks, cafeterias, shopping spaces, unpartitioned or open community rooms and waiting areas without private seating.

Issue: While well-intentioned, the prohibition against meeting in public and open-access areas is damaging to efforts to serve the Medicaid beneficiaries most in need of CHW services.

Impact: People experiencing homelessness, people experiencing or fleeing from domestic violence, people with substance use and trauma history, and people with mobility barriers are among those who will lose accessibility due to this restriction. Both CHWs and clients can be put in danger when domestic violence and addiction are factors in the client's living setting.

Recommendation: Rescind this restriction, or work with stakeholders to develop an equitable and accessible approach that preserves privacy while not excluding the most vulnerable from needed care.

Individual certification and timeline requirements

([Manual 5.1. p. 40](#))

Excerpt:

⚠ *Transitional Certification Expiration:* The transitional pathway expires on May 19, 2025, for CHWs who are not yet enrolled with RI Medicaid. CHWs actively enrolled under transitional status as of May 19, 2025, must obtain full RICB certification by October 1, 2025. Failure to meet this deadline will result in disenrollment, ineligibility for Medicaid reimbursement and potential provider disallowances. Only fully certified CHWs may bill for Medicaid services after this date unless explicitly approved under the waiver for currently enrolled CHWs under the provision noted below.

Issue: This change creates uncompensated responsibilities on CHWs and employers. It has abruptly and unnecessarily limited 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: Rhode Island College's Health Resources and Services Administration (HRSA) CHW training and apprenticeship program that is supported through the Community Health Worker Association of Rhode Island in partnership with the Rhode Island Department of Labor and Training, Building Futures Rhode Island, and numerous employer partners.

Impact: This change creates challenges to sustainability and fidelity, by closing an important pathway to CHW onboarding, and disproportionately creating barriers for communities experiencing concurrent workforce barriers and dire need of CHW services.

Recommendation: We request that CHWs who are verifiably 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. 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
- And/or other milestones, possibly including a requisite number of CHW hours worked under supervision.

CHW's affiliation requirements, NPI number
([Manual 5.2.3. p. 41-42](#))

Excerpt:

⚠ Effective October 1, 2025, all CHWs must:

- Be affiliated with a Medicaid-enrolled group or organization;
- Obtain a National Provider Identifier (NPI) (via the NPPES system at <https://nppes.cms.hhs.gov>); and,

- Complete enrollment with the Medicaid Fiscal Intermediary (FI) through a billing group or delegated entity.

Issue: This requirement medicalizes the role of CHWs.

Impact: This added language is an extra level of bureaucracy that is fundamentally challenging the ability of people with limited professional experience in healthcare to navigate; yet, it is precisely these people who will improve health outcomes and generate return on investment.

Recommendation: Withdraw the requirement for individual CHWs to obtain NPI's.

Criminal Background Check (BCI) Requirements ([Manual 5.4. p. 46-49](#))

Excerpt:

⚠ Effective May 22, 2025, under an emergency regulation filing with the Rhode Island Secretary of State, all CHWs must complete a Rhode Island Bureau of Criminal Identification (BCI) check as a condition of enrollment or reenrollment with the FI. This will be used to assess an individual's suitability for participation in the Medicaid program. CHWs are classified as "high-risk" providers and must ensure that they have met the background check requirements or an EOHHS approved Good Moral Character exemption under Section 6.5.

The BCI will be used to assess the CHW's suitability to participate in the Medicaid program, consistent with state law and program integrity requirements.

BCIs must be kept current and are required to be renewed at the time of Medicaid revalidation in accordance with Rhode Island Medicaid provider enrollment policies.

Background checks are essential for safeguarding Medicaid beneficiaries and ensuring CHWs meet consistent standards of professionalism, ethics, and public safety.

Issue: Community Health Workers share lived experience with the communities they serve, and bring this expertise to bear in creating trust and equity between these communities and systems of care – particularly in contexts where such trust has historically been violated. Designating CHWs as "high-risk" is stigmatizing, and activates a long history of abuse and neglect by government and institutions against BIPOC communities. One form of historical abuse has been disproportionate justice system involvement, and one avenue of redress is providing culturally competent CHW services to people who have been involved in the justice system. Erecting barriers to employment through a BCI requirement, and imposing categorical limits on future eligibility, works against best practices of community care.

As Black Lives Matter Rhode Island writes in an open letter to EOHHS, "CHWs with CORI backgrounds are often uniquely qualified to serve vulnerable populations, particularly in communities most affected by poverty, incarceration, addiction, and systemic racism. Through lived experience, rehabilitation, and service, these individuals have not only transformed their own lives, they have become pillars of community healing, outreach, and empowerment." The letter continues

It is both unjust and counterproductive to penalize CHWs for past convictions when their present work is rooted in healing, prevention, and justice. Any effort to increase oversight must be paired with protections that prevent the exclusion of competent and committed individuals who have earned their role in society.

Impact: People with lived experience of incarceration, substance use, disability, homelessness, and poverty will lose access to trusted messengers who can provide connection to care. The workforce will become less reflective of the Medicaid beneficiary population, and will cut off pathways out of poverty through employment for beneficiaries with these experiences.

Recommendation: Rescind designation of CHWs as “high risk” providers. Defer to employers on BCI requirements. Remove or minimize categorical exclusions on page 47.

Daily and monthly billing limits

([Manual 7.5. p. 59](#))

Excerpt:

To ensure Medicaid program integrity, the following aggregate billing limits apply across all CHW codes and service types:

- **▲ Daily Limit (Effective May 19, 2025):** No more than two (2) hours (120 minutes) per beneficiary, per day.
- **▲ Monthly Limit (Effective July 1, 2025):** No more than twelve (12) hours (720 minutes) per beneficiary per calendar month

These limits apply cumulatively, regardless of the number of service categories used. Providers must submit a prior authorization (PA) request to exceed these limits (see Section 7.5.5).

Issue: 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.

Impact: 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—require fidelity in delivery and are 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.

Recommendation: 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 ([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. 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 while providing more program integrity protections than a daily 8-hour limit.

Primary diagnosis (z-codes)

([Manual 7.5.3. p. 60, etc.](#))

Excerpt:

Primary Diagnosis: ⚠ Effective July 1, 2025, Z-codes (Z55–Z65) may not be used as the primary diagnosis. Use of Z-codes as the sole diagnosis will result in claim denial.

Issue: As stated in previous comments, addressing SDOH and HRSN is both a priority in healthcare and a core role of CHWs.

Impact: Prohibiting use of Z-codes for diagnosis will reduce access to medically necessary SDOH and HRSN services that improve outcomes, and is likely to result in an increase in Medicaid expenditures over time. This policy also prevents pediatric practices from assigning Community Health Worker (CHW) services to newborns, as most infants lack formal medical diagnoses. Early identification of newborns is a critical healthcare priority. It supports timely vaccinations, fosters positive family engagement with healthcare systems, and enables the delivery of integrated behavioral health services. CHWs play a vital role in conducting early childhood assessments and supporting families during this foundational stage.

Recommendation: Rescind disallowance of HRSN Z-codes as a primary diagnosis for CHW billing, or extend sunset period and engage in a stakeholder consultation process to develop a feasible and appropriate approach to reimbursement for this core CHW role.

Request for Inclusion from RI Independent Community Health Works

Rhode Island Independent Community Health Works (RIICHW) is the only CHW-founded and CHW-led organization in Rhode Island formally contracted with the Department of Health to support Independent Community Health Workers (ICHWs) across the state with certification, compliance, and business development — including a first-of-its-kind, 70-hour Rhode Island Certification Board (RICB)-aligned ICHW Core Training Program and ongoing technical assistance.



RIICHW serves as a cultural and structural bridge between state systems and underserved communities — particularly BIPOC, multilingual, and disabled ICHWs — who have historically been excluded from formal workforce pathways.

We are respectfully requesting that Rhode Island Independent Community Health Works (RIICHW) be included as a formal stakeholder in all future CHW workforce planning and policy development. As the statewide support system for Independent Community Health Workers, RIICHW plays an essential role in ensuring their success, sustainability, and equitable inclusion. Without intentional investment in community-rooted leadership, we risk undermining the very equity goals CHWs are meant to advance.

Koren Carbuccia

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Certified CHW Supervisor & Perinatal Doula

Board Member, Brown University Institutional Review Board

Co-Director, Interdisciplinary Navigation Partnership, Alpert Medical School of Brown University