June 27, 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 Program Manual (June 2025 v 4.1)

Dear Ms. Church,

The **Alliance for Community Health Worker Employers** aims to strengthen the role of Community Health Workers (CHWs) in supporting the health and well-being of Rhode Island communities. We are a group that brings together diverse organizations to ensure accountability, promote shared decision-making, and foster a united voice for policy change. We advocate for the importance of CHWs, support their recognition, and encourage best practices to make a real difference in our communities. Our Advisory Committee includes important organizations like 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 group has helped shape these comments, what we say here reflects our collective views.

While we recognize and appreciate the Executive Office of Health and Human Services for its work providing essential services to those in need, we are deeply concerned about the potential negative impact of the new policy updates. These updates, if implemented, will severely restrict access to essential services for our most vulnerable populations, exacerbating existing health disparities and creating additional barriers to care for groups that are already marginalized.

We respectfully request that you carefully consider the following recommendations to ensure that provider requirements do not make it unfeasible for providers to offer access to CHW service for Medicaid beneficiaries who have the most limited access to care. CHW initiatives play a crucial role in our community, helping to bridge gaps in the healthcare delivery system and saving the state money by addressing needs that often go unrecognized before they become more costly. These suggestions will help facilitate the ongoing effectiveness and impact of both CHW services and other associated Medicaid programs.

- ✓ **Establish a Stakeholder Consultation Process**
  - ✓ We strongly recommend that EOHHS establish a comprehensive stakeholder consultation process to develop a feasible and equitable approach to updating the Medicaid CHW benefit, aiming 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.

Section 2.3 Standing Orders and General Referrals- Prohibited Practices (pg13)

2.3. Standing Orders and General Referrals-Prohibited Practices

Effective May 19, 2025, the following referral practices are not allowable for Medicaid reimbursement of CHW services:

- Generalized standing orders not specific to the beneficiary's diagnosis or risk factor through publicly available orders by a LPHA;
- Orders issued by an LPHA who does not maintain a clinical relationship with the beneficiary;
- Open-ended or non-specific authorizations that reference CHW services as "recommended" without a formal, dated order.

⚠ **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.

- ✓ **Allow for organizational Standing Orders to be used specific to the context of a particular organization and the work their CHWs perform.** The American Academy of Family Physicians [1] Recognizes the effectiveness of their use. Eliminating the use of Standing Orders will place unnecessary burdens on physicians and limit access to these much-needed services.

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[1] 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.

- ✓ Allow patients to refer themselves to CDC-approved health education programs that focus on prevention or self-management of chronic conditions.
- ✓ Ensure organizations keep clear records of patient attendance and the material covered in each session. This includes maintaining signed and dated attendance logs (either electronic or paper) to provide if audited.

Section 2.4.3 Direct Clinical Knowledge of the Beneficiary's Condition or Risk (page 15)

> *2.4.3. Direct Clinical Knowledge of the Beneficiary's Condition or Risk*
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> The requirement for "direct clinical knowledge" by the LPHA is consistent with federal Medicaid regulations, including 42 C.F.R. § 440.130(c), 42 C.F.R. § 440.230(d), and CMS guidance that preventive services may be delivered by non-licensed providers (e.g., CHWs) but require that such services are based on a LPHA's appropriate clinical information for service authorization.
>
> "Direct clinical knowledge" means that the LPHA has obtained firsthand, professional insight into the beneficiary's health condition or risk factors through one (1) or more of the following:

The requirements for "direct clinical Knowledge" by the LPHA (Licensed Practitioner of the Healing Arts) order for CHW services present significant operational and administrative challenges. This additional burden mitigates the integration of CHWs into existing population health program models, which have proved essential for delivering comprehensive care to Rhode Island's most vulnerable populations.

Please see our comment above regarding standing orders, which are, by definition, almost always issued by LPHAs who do not have direct clinical knowledge of the patient. Exceptions should be made to this section for CHW services delivered to patients who meet criteria outlined in organizational standing orders that are specific to the service or program being offered, even if the LPHA signing the standing order does not have "direct clinical knowledge" of the patient's particular condition.

We recommend that EOHHS consider the following:

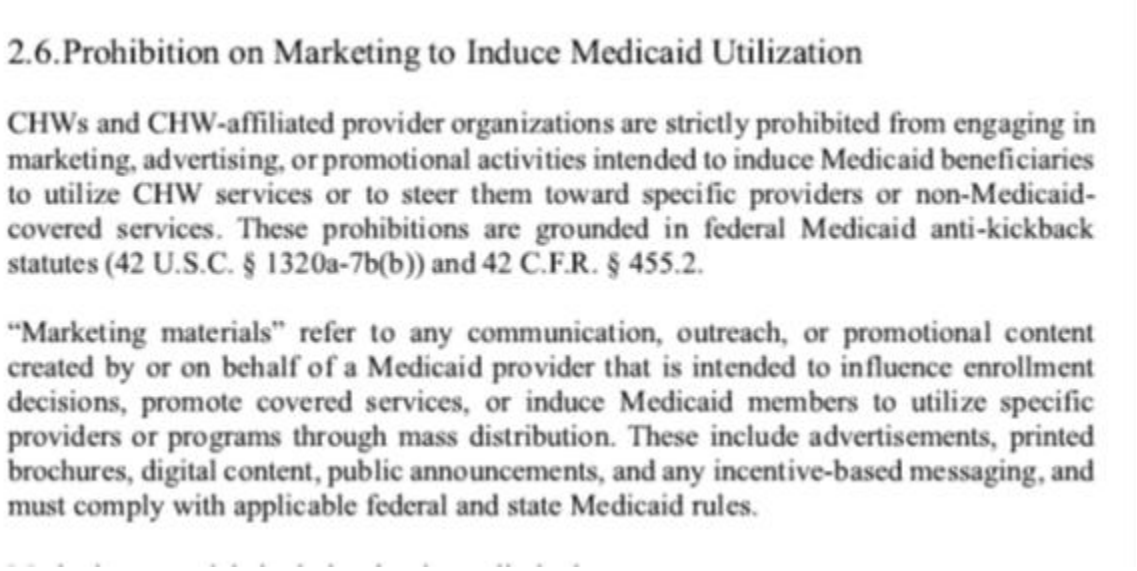
- ✓ The newly established requirements will likely have a disproportionate impact on vulnerable populations served by Medicaid. Specifically, individuals who are disengaged from primary care, those experiencing homelessness, and people with disabilities—particularly those with behavioral health conditions—will 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, underscoring the urgent need for policy changes.

- ✓ 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.

We recommend EOHHS:

- ✓ Allow for organizational **standing orders** to facilitate effective population health strategies. The American Academy of Family Physicians [2] recognizes the effectiveness of their use. Eliminating the use of Standing Orders will place unnecessary burdens on physicians and limit access to CHW services for beneficiaries who are in the most need.

Section 2.6 Prohibition on Marketing to Induce Medicaid Utilization (page 18)



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.

The current prohibition on marketing does not align with the CDC's guidance for designing, promoting, and implementing social marketing strategies for health education and programming. The ban on using incentives also contradicts current best practices for

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[2] 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.

evidence-based group health education programs. Even CMS's new Make America Healthy Again (MAHA) strategy emphasizes the importance of promoting evidence-based prevention, including offering incentives for sustained health lifestyle changes. [3]

We recommend EOHHS:

- ✓ Delete this section of the manual entirely or significantly narrow the rules to target the conduct that you are trying to address.

At a minimum:

- ✓ EOHHS **establishes** a transparent communication process for approving marketing strategies
- ✓ **Rescind** prohibition on practices that seem to directly conflict with **CMS Innovation Center's 2025 Strategy to Make America Healthy Again[4]:**

- ✓ **It is crucial to align** marketing strategies with evidence-based health communication strategies and best practices identified by the CDC, such as those illustrated in the CDC's National Diabetes Prevention Program Marketing and Recruitment tools. This strategic alignment will ensure that our marketing efforts are effective and impactful.[5]
- ✓ We suggest establishing a process for programs based on evidence-based strategies and practices to ensure EOHHS approves its marketing materials.
- ✓ **Allow** for marketing materials to include:
  - Brochures and handouts
  - Television, radio, or internet advertisements
  - Flyers or posters in public places
  - Social media posts
  - Website content directed promoting group education
  - Direct mailings to prospective or current members

3.4. Care Planning with Multidisciplinary Team and Collateral Services (page31)

[3] https://www.cms.gov/files/document/strategic-direction-webinar-slides-2025.pdf

[4] https://www.cms.gov/files/document/strategic-direction-webinar-slides-2025.pdf

[5] 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.

3.4. Care Planning with Multidisciplinary Team and Collateral Services (To Sunset Effective May 19, 2025)

⚠ Until May 19, 2025, CHWs may bill for:

- Multidisciplinary Care Planning Participation: Collaborating with clinical or multidisciplinary teams when the beneficiary is present.
- Collateral Services: Coordinating, administrative activities or researching services outside of the beneficiary's presence.

⚠ Effective May 19, 2025, both services will sunset and will no longer be allowable for reimbursement under Rhode Island Medicaid Program rules. Only services directly delivered to the beneficiary will be eligible for reimbursement. This sunsetting is consistent with RI Medicaid's focus on direct-beneficiary engagement and in line with state and federal program integrity requirements.

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

We recommend EOHHS:

- ✓ **Restore billing for specific non-direct collateral services.**
  - Immediately restore non-direct collateral services while further research is conducted on how Rhode Island Medicaid reimburses non-direct collateral services for other professions and identifies additional safeguards that may be appropriate for the program. Not allowing Care Planning with a Multidisciplinary Team as a billable CHW service will result in limitations on the CHWs' full integration into healthcare teams, affecting how the CHWs are perceived and utilized and, ultimately, limiting their positive impact within the healthcare sector.
- ✓ **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 service delivery but remains the focus if 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 service provision but remains the focus. Examples include calling providers, contacting shelters, and conducting research.

5.1. Individual Certification and Timeline Requirements (page 40)

5.1. Individual Certification and Timeline Requirements

5.1.1. RICB CHW Certification Standards

CHW services may only be delivered by:

- Individuals who hold current RICB certification as a CHW; or
- Individuals enrolled in a transitional certification plan, valid only through May 18, 2025 (see Section 5.1.2.)

5.1.2. Sunsetting of Transitional Certification

Transitional certification is a temporary designation for individuals who:

- Are enrolled in an RICB-approved training program or certification plan;
- Are affiliated with a Medicaid-enrolled provider organization; and
- Are actively working toward RICB certification requirements.

✓ Allow Community Health Workers who are making reasonable and documented progress toward completing their certification to be reimbursed**.** A grace period for these workers will improve access to essential health services in our communities.

This change addresses a gap in tracking workforce development by placing 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 the best practices for CHW professional development. Furthermore, it contradicts established practices of using registered apprenticeships as a tool 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 RI.[6] and the Rhode Island Department of Labor and Training, in partnership with Apprenticeship Rhode Island[7]: CHW Apprenticeship Program.

- ✓ **Allow** organizations to seek reimbursement for CHWs on the certification path, provided the organization can demonstrate to EOHHS its training and oversight program, such as evidence of employed CHWs achieving certification. Alternatively, aspiring CHWs who participate in a registered trade apprenticeship program could be eligible to bill.

Organizations could be asked to meet the following criteria:

- ✓ Enrollment in Registered Apprenticeship Programs that provide 50 hours of supervised work
- ✓ Enrollment and Monitored Completion of 70 Hours of Relevant Training by Rhode Island Certification Board
- ✓ Completed training in CDC-recognized Evidence-Based Health Education Programming, on pathway to obtain certification of completion, or are facilitating under a program license.

7.5.CHW Billing Transition, Coding, and Prior Authorization Requirements (page 59)

[6] Community Health Worker Association of Rhode Island

[7] Apprenticeship Rhode Island

7.5. CHW Billing Transition, Coding, and Prior Authorization Requirements

This section outlines the transition from unit-based to session-based CHW billing, establishes service limits, describes claim requirements, and defines the prior authorization process for exceeding utilization thresholds.

7.5.1. Daily and Monthly Billing Limits

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).

The proposed limitations on CHW services are misaligned with established evidence-based practices and significantly restrict the flexibility required for critical emergency interventions. Many situations that require CHW involvement 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 of hours.

- ✓ We urge you to **reevaluate** the limitations imposed on CHW services to align them more closely with evidence-based practices, allowing for acute or emergency interventions for which CHWs are well-suited. For instance, the Peer-Based Recovery Support Services Provider Billing Manual[8] (pages 5-6) sets Medicaid service limits for peer recovery services, allowing 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 reflect better the community's needs and the evidence-based practices that support patient care will enhance the quality of services delivered and contribute to improved health outcomes for those we serve.

[8] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-04/Peer%20Based%20Recovery%20Billing%20Manual%20v1.1.pdf

A notable example of how these limitations impact access to recognized evidence-based programs is seen with the Chronic Pain Self-Management and Chronic Disease Self-Management programs, both endorsed by the CDC. These programs are conducted in sessions lasting 2.5 hours. Consequently, the proposed daily billing limit obstructs the implementation of these vital programs, which have demonstrated effective strategies for improving health outcomes for beneficiaries.

We ask EOHHS to:

- ✓ Increase the daily limit to more than two (2) hours (120 minutes) per beneficiary per day to comply with evidence-based time fidelity for specific health education programs. If a daily limit is necessary, we recommend aligning it with the peer recovery daily limit of 8 hours.

- ✓ Establish visit levels for CHW services similar to the CMS guidance in the Evaluation and Management Guide[9] When the total visit time spent with a patient exceeds a certain time-limit threshold. Requiring prolonged visits to be reported using the code for the primary CHW service and then a prolonged service code.
    - Prolonged Services for certain visits when the total visit time spent with a patient exceeds a certain time threshold. Report prolonged E/M services using Medicare-specific coding. When reporting prolonged visits, report the codes for both the primary service and the prolonged services.
    - Used for each additional 15 minutes beyond the maximum time you provide, with or without direct patient contact.
    - Or utilize Home/Residence Visit codes such as New Pt (99345) G0318 140 minutes 3 days before visit + date of visit + 7 days after

In conclusion, the Alliance has grave concerns about how the EOHHS updates disregard and undermine the significant value of CHWs in the Medicaid system and may result in making these services unsustainable.

The Alliance urges EOHHS to take immediate and meaningful steps to collaborate with the community on policies that will maintain the effectiveness of this “essential health care workforce, which is uniquely positioned to serve Medicaid enrollees in Rhode Island.

[9] https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

If you require additional information or assistance, please don't hesitate to contact us. As a long-standing partner of the Executive Office of Health and Human Services (EOHHS) and a steadfast advocate for the diverse communities impacted by this initiative, we are fully committed to providing robust support for Community Health Worker (CHW) services. We look forward to collaborating with your office to ensure that these essential services meet the needs of the individuals and families we serve. Please don't hesitate to contact us—we're here to help in any way we can.

The Alliance for Community Health Worker Employers*

** This represents the consensus view of the Alliance's advisory committee, but not necessarily the views of any individual organization.*