Rhode Island Medicaid Community Health Worker Program Manual

June 2025
Version 4.1

Revision History

Version	Date	Sections Revised	Reason for Revisions
1.0-3.0	July 2022-February 2025	Archived revisions	
4.0	May 2025	Substantive changes to program rules, billing and compliance requirements	Update
4.1	June 2025	Technical corrections to compliance dates and certification deadlines; Inclusion of emergency regulations reclassifying CHWs as high-risk providers, requiring BCI fingerprinting and site visits for enrollment and revalidation; Clarified the definition of "direct beneficiary" engagement to specify when LPHA authorization is valid; Added definitions for inducements, marketing materials, and direct clinical knowledge to reinforce Medicaid inappropriate member targeting; Clarified that prior authorization is only required when CHW services exceed the established daily or monthly limits; Updated Appendix terms.	Update

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1. Introduction

1.1. Purpose and Coverage

This Rhode Island Medicaid Community Health Worker (CHW) Program Manual (hereinafter referred to as the "CHW Program Manual" or “Manual”) outlines the conditions, allowances, limitations, and prohibitions related to the reimbursement of CHW services under the Rhode Island Medicaid Program.

Pursuant to R.I. Gen. Laws § 42-7.2-2, the Rhode Island Executive Office of Health and Human Services (EOHHS) is the designated Single State Medicaid Agency and the principal authority responsible for establishing Medicaid policies, procedures, and program rules—including those governing the Rhode Island Medicaid CHW Program.

Version 4 of the CHW Program Manual includes substantive updates and newly added compliance safeguards, introduced in response to increased incidents of fraud, waste, and abuse (FWA) identified within the Rhode Island Medicaid CHW Program as of October 2024. These changes, informed by national best practices, aim to strengthen program integrity, protect the health and safety of Medicaid beneficiaries, and ensure appropriate stewardship of Medicaid funds.

This CHW Program Manual supersedes all prior versions, and any formal or informal guidance related to CHW Services under the RI Medicaid Program and is the controlling authority for CHW-related Medicaid reimbursement, effective May 2025.

1.2. Background and Role of Community Health Workers in the Rhode Island Medicaid Program

Community Health Workers (CHWs) are trusted frontline public health professionals with strong ties to the communities they serve. CHWs act as bridges between individuals and complex health systems, particularly for populations facing social, structural, or systemic barriers to care and unmet needs.

The CHW model is nationally recognized by entities such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and other state Medicaid agencies for its role in improving health outcomes, promoting inclusive care, and increasing access to care. National associations including the National Academy for State Health Policy (NASHP), and the Association of State and Territorial Health Officials (ASTHO) have endorsed CHW integration as a strategy for strengthening Medicaid delivery systems.

In 2022, Rhode Island launched CHW Services as a budget initiative for covered Medicaid benefit to support a comprehensive, person-centered, and accessible health system. CHW Services are a key part of EOHHS' strategy to:

- Support culturally responsive engagement with underserved communities;
- Strengthen chronic disease prevention and health education efforts;
- Improve navigation of covered health services and community resources; and
- Address upstream challenges that contribute to preventable or avoidable negative health outcomes.

CHWs deliver non-clinical supportive services. They are not licensed clinicians and may not perform clinical assessments, diagnoses, therapy, or treatment planning. CHW Services include:

- Health system navigation;
- Health education and coaching;
- Service coordination; and
- Assistance accessing Medicaid-covered services.

While CHWs are integral contributors to care teams, they are not substitutes for licensed or unlicensed healthcare professionals, such as case managers, therapists, or behavioral health providers. CHWs must operate strictly within their defined scope of practice as established by EOHHS and the Rhode Island Certification Board (RICB).

Under the 21st Century Cures Act (Section 5005(b)) and 42 C.F.R. § 455.410, all providers furnishing Medicaid services, including CHWs, must be screened and enrolled with the State Medicaid Agency (SMA).

1.3. Scope of Policy and Governing Authority

This CHW Program Manual governs the administration, coverage, and reimbursement of CHW Services delivered to Medicaid-eligible beneficiaries, as authorized under state and federal law.

This Manual establishes guidelines for:

- Medicaid-covered CHW Services;
- Authorization and referral requirements;
- Uniform requirements across all delivery systems, including Fee-For-Service (FFS), Managed Care Organizations (MCOs), and delegated or subcontracted delivery systems operating under CMS-approved Medicaid State Plan or Section 1115 Waiver authority;
- Medicaid program rules related to scope of service, documentation, provider qualifications, and billing compliance.

This CHW Program Manual does not govern:

- Employment, supervision, or duties of CHWs outside of the Medicaid context;

- Services not billed to Rhode Island Medicaid;
- Certification procedures overseen by the RICB;
- Workforce or professional development grants or training initiatives funded by other sources, such as the Rhode Island Department of Health (RIDOH).

All CHW Services must comply with:

- R.I. Gen. Laws § 42-7.2-2 (State Medicaid Agency designation);
- 42 C.F.R. § 440.230(d) (medical necessity and sufficiency of services);
- Sections 1905(a) and 1905(r) of the Social Security Act (Medicaid-covered services and EPSDT requirements).

All CHW services billed to Rhode Island Medicaid must fully comply with the criteria, procedures, and definitions established in the Medicaid State Plan, this CHW Program Manual, and all applicable federal and state Medicaid laws and regulations, to be eligible for Medicaid reimbursement.

1.4. Billing and Legal Advisement Disclaimer

This CHW Program Manual provides a summary of the requirements that CHWs and billing entities must follow to qualify for Medicaid reimbursement. Providers are expected to consult additional documents, including:

- Medicaid Provider Manuals, including any billing compendia or companion guides;
- Relevant federal and state laws and regulations; and
- EOHHS policies and applicable program appendices.

Disclaimer: **This Manual is not a substitute for legal advice and does not serve as an official interpretation of law. In case of any conflict between this guidance and state law, federal law or CMS directives, the latter shall prevail. This Manual is subject to change in accordance with legal, regulatory, or policy updates.**

In accordance with EOHHS regulations, noncompliance with Medicaid billing requirements may result in:

- Claim denials or recoupments;
- Civil or administrative penalties;
- Referral to enforcement agencies, including the Medicaid Fraud Control Unit (MFCU).

At the time of publication of this Manual, Medicaid CHW services are reimbursed under Rhode Island Medicaid's Fee-for-Service (FFS) delivery system. However, EOHHS reserves the right, consistent with federal and state Medicaid authority, to transition CHW services to the managed care delivery system through amendment of its managed care

organization (MCO) contracts, State Plan, or Section 1115 Demonstration authority as appropriate.

This Manual includes references to both FFS and managed care delivery systems to ensure that CHW providers understand the additional enrollment and claims processing requirements that may apply under Managed Care Organizations (MCOs). Should CHW services transition to the managed care delivery system in the future, EOHHS will provide advance notice and guidance to affected providers.

1.5. Purpose and General Policy Requirements

This CHW Program Manual establishes the conditions under which Medicaid covered Community Health Worker (CHW) Services are eligible for Medicaid reimbursement under the Rhode Island Medicaid Program (RI Medicaid).

The primary purpose of this Manual is to define the coverage, compliance, and billing standards required for Medicaid CHW Services, ensuring alignment with federal and state Medicaid regulatory frameworks. These standards are intended to support RI Medicaid's goals of:

- Improving access to care;
- Enhancing beneficiary health outcomes;
- Addressing unmet healthcare needs; and
- Reducing avoidable health care costs.

To qualify for Medicaid reimbursement, all CHW Services must:

- Be medically necessary, as defined in Section 2.0 of this Manual, and authorized by a Licensed Practitioner of the Healing Arts (LPHA) licensed in the State of Rhode Island and enrolled with RI Medicaid pursuant to 42 C.F.R. § 455.410;
- Be directly tied to a documented health condition and delivered within the CHW's defined scope of practice;
- Be performed by a CHW who is certified through the Rhode Island Certification Board (RICB) and enrolled with RI Medicaid through the State's designated Fiscal Intermediary (FI), and if included as an in-plan benefit, credentialed through a Managed Care Organization (MCO), or a delegated entity;
- Be delivered one-on-one or in small group formats, consistent with medical necessity, documentation requirements, and program rules described herein;
- Be non-duplicative of services provided by other licensed Medicaid professionals, such as case managers, therapists, or care coordinators;
- Be accurately documented in accordance with Medicaid program integrity standards and audit requirements;
- Adhere to all applicable federal and state rules, including but not limited to:
    - R.I. Gen. Laws § 42-7.2-2 — Designating EOHHS as the Single State Medicaid Agency;

  - 42 C.F.R. § 440.230(d) — Requiring that Medicaid services be medically necessary and sufficient in amount, duration, and scope;
  - Sections 1905(a) and 1905(r) of the Social Security Act — Governing the scope of Medicaid benefits and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21.
- Comply with telehealth requirements associated with the delivery of CHW Services as specified in this Manual.

EOHHS retains the authority to conduct pre-payment and post-payment reviews, audits, and compliance monitoring to ensure that CHW Services meet all applicable medical necessity, documentation, and delivery standards.

Services that do not comply with these requirements are subject to denial, disallowance, or recoupment of funds.

1.6. EOHHS Oversight and Enforcement for Non-Compliance

EOHHS reserves the right to take enforcement actions consistent with its authority under R.I. Gen. Laws § 42-7.2 and 42 C.F.R. § 455 Subpart E.

EOHHS may suspend, terminate, or deny Medicaid billing privileges for any CHW or provider who:

- Commits fraud, waste, or abuse;
- Violates program requirements;
- Submits false or misleading claims;
- Allows unqualified individuals to deliver Medicaid-covered CHW services;
- Endangers the health, safety, or welfare of Medicaid beneficiaries.

EOHHS may refer suspected violations to the MFCU, the Office of Program Integrity (PI), or other enforcement bodies. Remedies may include:

- Payment suspension;
- Provider disqualification;
- Civil monetary penalties;
- Exclusion from participation in state and federal healthcare programs.

EOHHS will continue evaluating the CHW Program to incorporate national best practices, strengthen program integrity, and support the delivery of high-quality, cost-effective, and person-centered CHW Services in Rhode Island.

1.7. Reader Guidance and Symbols Key

This Manual contains visual cues and references to aid readers identify important compliance items, timelines, and requirements:

Symbol	Meaning
⚠	Compliance Warning – Indicates a time-sensitive rule, prohibited practice, or audit risk.
🔁	Transition Alert – Denotes a policy change or transition from an older practice (e.g., new code replacing old one).
➤	Cross-Reference – Directs the reader to another section of the Manual for further detail.

These symbols are used throughout the document to improve comprehension and draw attention to key elements that may affect billing, documentation, or service delivery compliance.

For a consolidated summary of key implementation dates and deadlines, refer to Section 9: Compliance Calendar. This section lists transition dates for new codes, referral rules, enrollment requirements, and EVV deadlines.

2. Medical Necessity Requirements for CHW Services in the Rhode Island Medicaid Program

2.1. General Definition of Medical Necessity for a Medicaid Covered Service in Rhode Island Medicaid

Under the Rhode Island Medicaid Program (hereinafter referred to as "RI Medicaid"), a service is considered medically necessary if it meets the following criteria:

> *Medical Necessity refers to medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health-related condition, disease, or its symptoms.*

For Medicaid-eligible individuals under the age of twenty-one (21), medical necessity also includes all Early and Periodic Screening, Diagnostic, and Treatment services (hereinafter referred to as "EPSDT") that are necessary to correct or ameliorate a physical or mental condition identified through screenings, in accordance with Section 1905(r) of the Social Security Act (hereinafter referred to as "SSA").

A service shall be considered medically necessary when it is rendered for any of the following purposes:

- To address a life-threatening condition or to alleviate pain;
- To treat an injury, illness, or infection;
- To improve or maintain physical or mental functioning consistent with community standards for the diagnosis or condition;
- To provide care related to maternity and the postpartum period;
- To prevent the onset of a serious disease or illness;
- To address a condition that may result in physical or behavioral health impairment; or,
- To support age-appropriate growth and development, or to attain, maintain, or regain functional capacity.

This definition aligns with the requirements and authorities under 42 C.F.R. § 440.230(d), Sections 1905(a) and 1905(r) of the Social Security Act, and R.I. Gen. Laws § 42-7.2-2.

EOHHS retains sole discretion, subject to state and federal law, to determine whether a service meets the criteria for medical necessity under RI Medicaid.

2.2. Medical Necessity Requirements for Community Health Worker (CHW) Services

Effective May 19, 2025, EOHHS will only reimburse for CHW services that meet all the following criteria:

- Are medically necessary as defined in Section 2.1 of this Manual;
- Are clinically appropriate and the most cost-effective alternative for the identified need; and
- Are delivered directly to the Medicaid beneficiary.

Effective July 1, 2025, the LPHA's NPI must be included on the CHW claim in the Ordering/Referring Provider (OPR) field. The CHW provider must also retain the signed LPHA referral in the beneficiary's record for audit purposes.

Each referral from an LPHA is valid for a six (6) month period from the date of issuance.

CHW services are considered medically necessary only when provided to a Medicaid beneficiary who meets at least one (1) of the following criteria:

1. Has one (1) or more diagnosed chronic physical or behavioral health conditions; or
2. Is at risk of developing a chronic physical or behavioral health condition as identified by clinical indicators and documented by a LPHA.

⚠ **Important Note Regarding Rendering Services Prior to LHPA Authorization**: Medicaid reimbursable CHW services must not be rendered or billed until an LPHA has authorized services through a signed referral. Any time spent engaging with the beneficiary prior to the LPHA authorization is not reimbursable. Authorizations cannot be retroactively applied to CHW interactions that occurred before the date.

⚠ **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]

CHW services must support the clinical treatment goals established by the LPHA and may not duplicate other Medicaid-covered roles or services, such as case management, care management programs, home stabilization services, or licensed behavioral health supports.

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.

CHW Services May Be Billed to Medicaid Only If:

- The service is authorized by a Rhode Island-licensed LPHA;
- The service is medically necessary, as defined in Section 2.2 of this Manual;
- Documentation includes the LPHA's name, license type, license number, and clinical justification.

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

[1] Starting on July 1, a HRSN diagnosis alone (Z code as primary) does not establish medical necessity or authorization for CHW Services and shall be denied for claims reimbursement.

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.

2.4.1. Who Qualifies as an LPHA?

EOHHS recognizes the following professionals as LPHAs if licensed in the State of Rhode Island:

- Physicians (MD or DO)
- Advanced Practice Registered Nurses (APRNs)[2]
- Physician Assistants (PAs)
- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Licensed Independent Clinical Social Workers (LICSWs), Licensed Clinical Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs)

[2] An APRN is a certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA) as defined in R.I. Gen. Laws Chapter 5-34.2, or certified clinical nurse specialist (CNS), and who functions in a population focus. An APRN may serve as a primary or acute care provider of record. APRNs are listed as LPHAs eligible for Medicaid CHW Services.

- Licensed Psychologists
- Certified Nurse Midwives, Certified Professional Midwives
- Dentists, Licensed Dental Hygienists
- Podiatrists
- Licensed Occupational Therapists
- Licensed Chemical Dependency Professionals
- Pharmacists

These providers must be actively licensed in Rhode Island and practicing within the scope of their profession.

2.4.2. Who Does Not Qualify as an LPHA?

The following professions are not authorized to order CHW services under Medicaid:

- Community Health Workers (CHWs)
- Case Managers (unless separately licensed as a qualifying LPHA)
- Care Coordinators (without clinical licensure)
- Social service staff (without a clinical license)
- Clerical staff, health aides, or unlicensed support personnel
- Peer support specialists (unless independently licensed as an LPHA)
- Outreach workers, navigators, promotors without clinical licensure
- Housing Navigators
- Other licensed or unlicensed care professional not explicitly stated in Section 2.4.1 of this Manual.

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.

2.4.3. Direct Clinical Knowledge of the Beneficiary's Condition or Risk

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:

- A face-to-face or telehealth clinical encounter with the beneficiary;
- Review of the beneficiary's current medical records or care plan;
- Ongoing involvement in the beneficiary's treatment, care coordination, or case management;
- Communication with other treating providers that contributes to the LPHA's informed clinical judgment.

This knowledge must be current, relevant, and sufficient to support the referral and medical necessity determination for CHW services.

The following do not meet the standard for "direct clinical knowledge":

- General awareness of the beneficiary's Medicaid eligibility or demographic status;
- Prior referrals without a current clinical review;
- Administrative review or processing of non-clinical documentation (e.g., social needs screening forms alone);
- Secondhand information from CHWs or non-clinical staff without verification by the LPHA;
- Standing orders or blanket referrals not tailored to the individual beneficiary.

2.5. Prohibition on Self-Dealing and Conflict of Interest for Individual and Organizational CHW Providers

EOHHS requires strict adherence to Medicaid program integrity rules to prevent fraud, waste, and abuse (FWA) in the Rhode Island Medicaid Program.

CHWs and affiliated organizations must avoid all real, potential, or perceived conflicts of interest when delivering services and follow ethical and legal prohibitions as described in the following sections. These prohibitions are in place to uphold Medicaid program integrity, protect public funds, and ensure ethical boundaries between CHWs, organizational providers, and beneficiaries.

Violations of these standards may result in:

- Claim denial;
- Recoupment of payments;
- Provider disenrollment;
- Referral to the Medicaid Office of Program Integrity (PI);
- Referral to the Rhode Island Attorney Medicaid Fraud Control Unit (MFCU); or,
- Exclusion from participation in any federally or state-funded healthcare program.

2.5.1. CHW Self-Dealing and Conflicts of Interest

CHWs must operate with the highest degree of professional integrity and avoid all real or perceived conflicts of interest when delivering services under Rhode Island Medicaid. The following self-dealing practices are prohibited:

- Self-Referral or Self-Authorization: A CHW may not refer, authorize, or supervise services for themselves.
- Services for Family or Household Members: CHWs may not deliver services to family members or household residents, regardless of medical necessity or eligibility.
- Collusive Arrangements: CHWs and providers may not engage in reciprocal referrals or billing loops intended to increase reimbursement.
- Supervision Within Conflicted Relationships: CHWs may not be supervised by persons with whom they have a familial, romantic, domestic, or financial relationship.

2.5.2. Organizational and Program-Level Conflict of Interest

Organizations employing CHWs must establish and enforce policies to prevent internal conflicts, including:

- Internal Organizational Referrals: Must not occur between departments that financially benefit without clear firewalls and disclosure to EOHHS or EOHHS' delegated entities (e.g., MCOs) regarding a potential or perceived conflict.
- Supervisory Conflicts: Management staff must avoid direct oversight if they could benefit from CHW service volume.
- Cross-Referral Between Medicaid Services: Billing must be distinct and non-duplicative from peer supports, case management, care management, housing stabilization, or behavioral programs offering complementary or similar services allowed under the CHW Medicaid benefit and already included in other Medicaid capitated rates and agreements.
- Financial Oversight and Internal Controls: Organizations must implement financial management protocols to prevent improper billing and ensure that CHW services are tracked, invoiced, and reconciled separately from other Medicaid services. This includes:
    - Internal segregation of duties (e.g., separating CHW supervision from billing staff);
    - Regular reconciliation of service logs and claims;
    - Internal audits or quality assurance reviews to detect overbilling or duplication;
    - Documented compliance training for all staff involved in Medicaid billing and program operations.

Organizations failing to uphold these standards may face audit findings, recoupments, or disqualification from the Medicaid Program.

2.5.3. Conflict of Interest in CHW Certification and Training

Entities that provide CHW certification training or supervision must follow strict standards of independence and ensure that CHW certification processes under the RICB do not compromise billing integrity. The following conflicts of interests should be addressed:

- Independence of Training and Billing Functions: CHW training providers must maintain policies prohibiting individuals with a financial interest in billing from being involved in evaluating or certifying CHWs for the purposes of Medicaid reimbursement.
- Prohibition on Billing for Training or Continuing Education Time: Training programs may not bill Medicaid for CHW service hours that occur during certification, internships, practicums, or other pre-employment training not related to the delivery of Medicaid CHW Services. These hours must be:
    - Clearly designated as non-billable.
    - Separated from direct service delivery in schedules, records, and time logs.
    - Excluded from any claim submission under CHW billing codes.

This separation ensures that Medicaid funds are used solely for direct services that are medically necessary, LPHA-authorized, and properly documented under Medicaid Program rules and requirements.

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.

For additional policies, practices, prohibitions, CHWs and CHW affiliated providers should consult EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program: https://eohhs.ri.gov/providers-partners/medicaid-managed-care

If CHW Services become an in-plan benefit in managed care or other EOHHS delegated entities, CHW providers are be subject to additional marketing requirements under MCO provider agreements related to allowable marketing activities.

2.6.1. Use of Government Affiliation or Logos

CHWs and affiliated organizations shall not imply or state that marketing materials, services, or events are endorsed by the Rhode Island Executive Office of Health and Human Services (EOHHS), the Centers for Medicare & Medicaid Services (CMS), or any other governmental body unless such endorsement or partnership has been explicitly approved in writing. This includes unauthorized use of state seals, agency logos, or language suggesting governmental sponsorship or approval.

Violations of these marketing prohibitions may result in:

- Claims denial or recoupment;
- Suspension or termination of Medicaid billing privileges;
- Referral to the Program Integrity Unit or MFCU;
- Fines and penalties assessed by EOHHS, CMS, MCOs due to unauthorized use of government affiliated logos and marketing materials up to $25,000 per individual misled by improper marketing under § 438.704(b);
- Provider disenrollment or exclusion from Medicaid participation.

3. Medicaid Covered Community Health Worker (CHW) Services

⚠️ Effective May 19, 2025, Medicaid Covered CHW Services are allowable for the following three (3) service categories:

1) Health Promotion and Coaching;
2) Health Education and Training; and
3) Health System Navigation and Resource Coordination.

These services must align with 42 C.F.R. § 440.130(c), which governs preventive services under Medicaid, and must be classified as preventive, non-clinical services delivered under the supervision or direction of a licensed practitioner of the healing arts recognized by the State Medicaid Agency (EOHHS), in accordance with federal requirements.

Any service that does not fall within these three (3) categories is not eligible for Medicaid reimbursement as a covered CHW service.

⚠️ Effective May 19, 2025, previously billable CHW services categorized as Collateral Services and Multidisciplinary Care Team Planning will sunset. These services will no longer be eligible for Medicaid reimbursement under the CHW benefit after this date.

3.1. Health Promotion and Coaching

3.1.1. Definition of Health Promotion and Coaching

Health Promotion and Coaching is interactive, one-on-one or group-based support to help a beneficiary understand, manage, or reduce the risks of a diagnosed chronic condition. Activities must involve direct coaching or motivational support linked to LPHA-documented goals.

This service must be delivered in person, face-to-face with the beneficiary. Telehealth, including audio or video communication, is not permitted for Health Promotion and Coaching unless explicitly approved in writing by EOHHS under extraordinary circumstances (e.g., public health emergencies or state-issued flexibilities).

CHWs may bill for Health Promotion and Coaching when the services meet all the following criteria:

- Tied to a diagnosed health condition;
- Medically necessary, as determined and documented by a Licensed Practitioner of the Healing Arts (LPHA); and
- Provided directly to the Medicaid beneficiary.

3.1.2. Allowable and Prohibited Activities for Health Promotion and Coaching

Allowable Activities:

- Chronic Condition Management Support: Supporting beneficiaries in managing a chronic condition (e.g., pre-diabetes, hypertension, anxiety), reinforcing self-management goals aligned with clinical care plans.

- Motivational Interviewing and Goal Setting: Using motivational interviewing to help a beneficiary identify barriers and commit to health-related behavior change; assisting with short- and long-term health goal setting.

- Evidence-Based Health Coaching (Not Health Education): Delivering personalized health coaching using pre-approved evidence-based techniques and standardized materials.

- Health Action Planning and Tracking: Helping beneficiaries set and track action plans for health improvement (e.g., quitting smoking, improving diet).

- Condition-Linked Lifestyle Change Support: Discussing lifestyle modifications linked to diagnosed conditions (e.g., hypertension, diabetes), and reinforcing LPHA recommendations.

- Post Hospitalization Coaching: Assisting in implementing discharge plans to avoid hospital readmission.

- Medication Support Education (Non-Clinical): Reinforcing medication adherence through habit-building tools by assisting beneficiaries with understanding prescribed medication regimens, helping them develop reminder strategies (e.g., using pill boxes, alarms, reminder tools or calendars). ⚠ **Note**: CHWs cannot adjust medications, provide clinical pharmacologic advice, or administer medications.

- Behavioral Health Self-Management Tools (Non-Clinical): Teaching behavioral health self-management techniques (e.g., mindfulness, breathing exercises) consistent with LPHA treatment goals.

- Cultural and Linguistic Health Coaching: Using culturally and linguistically appropriate methods to reduce health disparities.

Prohibited Activities:

- General or Non-Medical Life-Coaching: General life coaching or coaching that is not tied to a diagnosed health condition or medical risk from the

medical necessity. Examples of such "life skills" are cooking (unless tied to a chronic condition), house cleaning or organizing, job readiness or resume building, legal advice, and coaching on social or behavioral matters unrelated to diagnosed health condition (e.g., relationship or marital advice, emotional growth).

- Wellness or Lifestyle Support without Medical Necessity or Justification: Providing general wellness coaching or lifestyle tips (e.g., "how to stay motivated" or "how to be more productive") without a specific health condition or risk tied to the session. Teaching yoga, meditation, or exercise classes, even if health oriented is not allowable. Providing exercise supervision or physical activity support (e.g., walking with a beneficiary, coaching them through workouts, personal training or fitness training) is not allowable.

- Therapeutic or Clinical Behavioral Services: CHWs may not offer therapy, clinical advice, or crisis support.

- Fitness Monitoring, Instruction, or Progress Evaluation: CHWs may not monitor vital signs or physical performance, supervise exercise routines, or develop individualized workout plans.

- Cooking Demonstrations or Grocery Trips: Grocery trips are not allowable. For cooking demonstrations, it must be linked to healthy eating education through approved evidence-based materials. These are only billable when it is 1) Directly tied to a medical diagnosis or risk (e.g., diabetes); and 2) Conducted 1:1 and documented in the health plan through an evidence-based curriculum under the supervision of an LPHA. Otherwise, food tours, cooking demos, or grocery coaching are not allowable.

- Engaging in Spiritual or Religious-Based Coaching: Health promotion services must be secular and evidence-based. Services using faith-based frameworks are not eligible for Medicaid reimbursement.

- Activities Duplicating other Medicaid Provider Roles: Delivering services that fall under the responsibility of other provider types (e.g., Direct Support Professionals, licensed therapists or behavioral health clinicians, or case managers or nurses).

- Billing Simultaneously While Other Covered Services are Being Delivered: Billing simultaneously when the beneficiary is already receiving another Medicaid-covered service (e.g., during a medical or behavioral health visit). Coaching a beneficiary during a provider appointment, such as being present during a doctor's visit and claiming coaching time is not allowed to be billed.

- Service Delivery to Ineligible Individuals or Contexts: Providing coaching to family members or caregivers, unless the beneficiary is present and actively engaged. Leading group sessions without clear, documented individual engagement or connection to each participant's medical necessity. Coaching or delivering services to individuals who are not Medicaid beneficiaries, including family members or general community participants.

If an activity does not meet all three (3) core criteria—medically necessary, LPHA-authorized, and tied to the beneficiary's diagnosis or health goal—or is listed as a prohibited activity, it is not billable.

Group sessions must:

- Be limited in size (No more than eight (8) beneficiaries per group session by a single CHW facilitator);
- Include documentation of each beneficiary's diagnosis and LPHA authorization; and,
- Demonstrate individualized engagement and interaction.

Documentation must include beneficiary name, date/time, goal tracked, LPHA linkage, and specific coaching content.

3.2. Health Education and Training

3.2.1. Definition of Health Education and Training

Health Education and Training is standardized, evidence-based health education services provided one-on-one or in small groups to address a specific, LPHA-documented health risk or chronic condition. These services must be directly tied to a beneficiary's medically necessary condition or risk and aim to prevent disease, reduce disability, or promote health maintenance.

This service must be delivered in person, face-to-face with the Medicaid beneficiary. Telehealth, including telephone- or video-based communication, is not permitted for Health Education and Training unless explicitly authorized in writing by EOHHS for limited use cases (e.g., during declared public health emergencies).

CHWs may bill for Health Education and Training when the services meet all the following criteria:

- Tied to a diagnosed medical or behavioral health condition or documented risk factor.
- Medically necessary, as determined and documented by a Licensed Practitioner of the Healing Arts (LPHA).

- Delivered directly to the Medicaid beneficiary, with medical necessity documented in the record.

CHW services may not duplicate federally required care coordination services provided by MCOs, Health Homes, or LTSS programs.

3.2.2. Allowable and Prohibited Activities for Health Education and Training

Allowable Activities:

- Chronic Disease Prevention and Self-Management: Providing education to help beneficiaries recognize symptoms, manage medications, and implement lifestyle changes related to chronic conditions such as diabetes, obesity-related diseases, asthma, or cardiovascular disease.

- Tobacco and Substance Use Reduction: Educating beneficiaries on strategies to reduce or quit tobacco or substance use. May include motivational interviewing, harm reduction, or connections to cessation and behavioral health programs. ⚠ ***Note***: CHWs may not deliver clinical smoking cessation services, prescribe medications, or provide individual or group counseling that would fall under the scope of licensed behavioral health or clinical providers. All tobacco use reduction education must be authorized by a LPHA and documented as medically necessary.

- Nutrition and Physical Activity Education (Non-Clinical): Basic health education, nutrition and exercises and movement for wellness or chronic condition management. (E.g., reading nutrition labels, walking basics). ⚠ ***Note***: This does not include personalized dietary plans, dietary prescriptions, medical nutrition therapy, or fitness instruction.

- Family Planning and Prenatal Risk Reduction: Educating on safe sexual health practices, birth control options, and prenatal health to support maternal and child health and reduce high-risk behaviors during pregnancy.

- Injury Prevention and Environmental Health Risks: Providing education about reducing risk of injury (e.g., falls), occupational health hazards, and environmental health concerns such as lead, mold, or air pollution.

- Preventative Health Promotion: Teaching about the importance of preventive screenings (e.g., cancer, blood pressure, diabetes) and recommended immunizations, and helping beneficiaries understand when and how to access them.

- Medication Adherence Support: Educating beneficiaries on prescribed medication use and adherence (excluding any clinical interpretation or dispensing tasks).

- Post-Hospitalization Literacy Support: Helping beneficiaries understand discharge paperwork or follow-up care plans if authorized by LPHA.

- Trauma and Health Education: Basic information tied to clinical treatment plans (e.g., trauma and chronic disease link) aligned with the care plan and medical necessity documentation.

Prohibited Activities:

- Activities without Medical Necessity or LPHA Authorization: Delivering general health talks without individualized medical necessity. Community health talks or generalized outreach without proper documentation are not allowable.

- Use of Non-Evidence-Based or Informal Materials: Using non-evidence-based, informal, or anecdotal materials. Unvalidated or informal education tools are not allowed.

- Activities Beyond CHW Scope: Providing clinical nutrition therapy or meal plans (reserved for dietitians), leading exercise or fitness classes (e.g., yoga, aerobics, personal training) or performing assessments, screenings, or educational tasks reserved for other licensed providers (e.g., nurses, counselors).

- Services Delivered Without the Beneficiary Present or Engaged: CHW services may not be billed when delivered solely to family members, caregivers, or others unless the Medicaid beneficiary is present and actively participating. Group sessions must be individually documented and clearly linked to each participant's diagnosis and LPHA authorization. ⚠️ ***Note:*** For limited exceptions related to pediatric or medically complex beneficiaries requiring caregiver support, see Section 4.3: Special Provision – Pediatric and Family Engagement Exception.

- General Education in Community Outreach or Tabling Events: Health education provided in large-scale public or community events (e.g., health fairs, outreach days, resource tables) is not billable under Medicaid, even if the content is evidence-based. These settings do not meet the requirement for individualized, medically necessary, LPHA-authorized services delivered directly to a Medicaid beneficiary.

- Education via social media, Videos, or Pre-Recorded Content: Posting, sharing, or producing health education through platforms like YouTube, Instagram, TikTok, podcasts, or pre-recorded presentations is not a billable CHW service. These forms of delivery do not allow for verification of

medical necessity or individualized engagement, and they fall outside the scope of direct one-on-one or approved group service formats.

- Undifferentiated Education for Mixed or Unscreened Groups: Conducting group education sessions with mixed participants — including non-Medicaid beneficiaries — without individualized medical necessity documentation for each attending Medicaid beneficiary is not reimbursable. Each participant must have a documented LPHA authorization and medically necessary reason for participation for the session to be billed to Medicaid.

If an activity does not meet all three (3) core criteria—medically necessary, LPHA-authorized, and tied to the beneficiary's diagnosis or documented health risk—or is listed as a prohibited activity, it is not billable under Medicaid.

Group sessions must:

1. Be limited in size (No more than eight (8) beneficiaries per group session by a single CHW facilitator).
2. Include documentation of each beneficiary's diagnosis and LPHA authorization.
3. Demonstrate individualized engagement and interaction.

3.3. Health System Navigation and Resource Coordination

3.3.1. Definition of Health System Navigation and Resource Coordination

Navigation and Resource Coordination involves one-on-one support to help Medicaid beneficiaries access health services and community resources.

CHWs are not case managers, clinical providers, or eligibility workers, but instead assist beneficiaries in understanding and navigating systems of care.

Navigation and Resource Coordination may be delivered in-person or via telehealth options. See section 3.3.3. for additional information regarding appropriate use of telehealth for Navigation and Resource Coordination.

CHWs may bill for Navigation and Coordination services when the following criteria are met:

1. Are delivered one-on-one;
2. Are medically necessary and LPHA-authorized; and
3. Do not duplicate other covered case management activities.

CHW Services may not duplicate federally required or state-plan-defined care coordination functions performed by MCOs, health homes, or long-term services and supports (LTSS) programs.

3.3.2. Allowable and Prohibited Activities for Health System Navigation and Resource Coordination

Allowable Activities:

- Connecting Beneficiaries to Medicaid Covered Services: Providing support to help the beneficiary identify and establish care with a Medicaid-enrolled primary care provider (PCP) or specialist. This may include explaining options, connecting to MCO case managers, and preparing the beneficiary to engage with the provider. Assistance with establishing care relationships, especially for new or re-engaging patients, is allowable.

- 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.

- Providing Support with Accessing Medicaid Non-Emergency Medical Transportation: Helping the beneficiary navigate the process of arranging rides through the Non-Emergency Medical Transportation (NEMT) broker or giving clear directions for how to reach a service location. Providing support on how to navigate public transportation to appointments. ⚠ ***Note:*** CHWs may not provide transportation or bill for accompanying beneficiaries during transport or bill for time spent researching transportation options for beneficiaries.

- Assisting with Telehealth Use and Technology Navigation: Helping the beneficiary understand how to use telehealth platforms (e.g., logging in to telehealth platform and basic telehealth information), and supporting participation in virtual care visits when appropriate. ⚠ ***Note:*** CHWs are not allowed to bill Medicaid for general information technology or how to purchase information technology equipment for beneficiary to access telehealth.

- Facilitating Referrals to Social and Community Supports: Helping the beneficiary connect to community-based or social service organizations, such as housing programs, food access, or behavioral health supports as described in order from the LPHA.

- Support for Re-Engagement in Care: Re-engaging beneficiaries who have disengaged from healthcare.

Prohibited Activities:

- Group-Based Delivery: Providing navigation services in a group format.

- Duplication of Other Medicaid Navigation or Case Management Services: CHWs may not bill for services that are already provided or reimbursed under other Medicaid programs, including those delivered by MCOs Medicare, commercial insurance carriers, case managers, or integrated care teams such as Certified Community Behavioral Health Clinics (CCBHCs) and Accountable Entities (AEs) through capitated or bundled payments. This also includes services provided through health homes, conflict-free case management (CFCM) organizations, or other care coordination programs authorized under long-term services and supports programs. If a beneficiary is already receiving care navigation or coordination through these channels, CHW services that overlap or duplicate that support are not reimbursable.

- General Information without Individualized Support: Distributing brochures or lists without individualized engagement.

- Performing Activities Outside CHW Scope: CHWs may not provide clinical guidance, program application/enrollment assistance, or act as eligibility workers. They cannot advise on treatment plans or interpret medical diagnoses or bill for other covered services when they are performing CHW Services.

- Transportation or Appointment Accompaniment: CHWs may not bill for time spent driving, escorting, or riding along with beneficiaries to appointments. Billing for time spent accompanying a client is not allowed under this category.

- 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.

- Clinical Advice or Scope Overreach: Providing medical advice, interpreting diagnoses, recommending treatments, or conducting assessments. Engaging in treatment planning or care decisions that should be handled by licensed providers.

To be billable for Health System Navigation and Resource Coordination, the service must be 1:1, LPHA-authorized, medically necessary, and non-duplicative of existing covered case management or care coordination services.

All Health System Navigation and Resource Coordination services must include:

- Date and time of contact;
- Specific barrier addressed;
- LPHA linkage to care plan or LPHA authorization;
- Documentation of the Medicaid-covered service referred or explained by the CHW.

Activities that do not meet these criteria are not eligible for reimbursement under CHW Services.

3.3.3. Telehealth Requirements for Health System Navigation Services

⚠️ Effective July 1, 2025, only Health System Navigation and Resource Coordination may be delivered either in person or via synchronous telehealth, including audio-only communication, as permitted under Rhode Island Medicaid policy and applicable federal law.

To ensure program integrity, HIPAA compliance, and adherence to state and federal Medicaid requirements, the following conditions must be met when CHW services are delivered via telehealth:

3.3.3.1. Legal and Regulatory Requirements

Rhode Island CHW Medicaid services must be delivered within the geographic boundaries of Rhode Island, unless specifically authorized. Therefore, CHWs and Medicaid beneficiaries must both be physically located in Rhode Island at the time-of-service delivery.

Rhode Island Law (R.I. Gen. Laws § 27-81-3): Providers delivering telehealth services must be:

- Licensed (if a clinical provider) or certified (if a CHW) under Rhode Island law;
- Enrolled in the Rhode Island Medicaid Program;
- Delivering services to a beneficiary located in Rhode Island, unless otherwise authorized by EOHHS.

3.3.3.2. Telehealth Session Requirements

⚠ Effective July 1, 2025, Services must be delivered via synchronous, real-time interaction (e.g., phone or live video). Asynchronous formats (e.g., texting, pre-recorded content) are not reimbursable. Telehealth delivery is permitted only for Health System Navigation and Resource Coordination (H0038). Telehealth is not allowed for Health Promotion and Coaching or Health Education and Training. Group-based CHW services may not be delivered or billed via telehealth.

3.3.3.3. Required Documentation for Telehealth Services

CHWs must document all of the following in the service record:

- The mode of communication (e.g., phone, Zoom);
- The physical location of both the CHW and the beneficiary (must be in Rhode Island);
- The date and time of the service;
- Confirmation that the interaction was live and synchronous;
- The LPHA referral linked to a documented diagnosis;
- All other required CHW documentation fields (see Section 7.8).

Failure to meet these requirements may result in claim denial or audit recoupment.

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.

Providers are reminded to retain all documentation of care planning and collateral services for at least ten (10) years, in accordance with 42 C.F.R. § 431.107 and the Rhode Island Medicaid Provider Agreement documentation retention requirements.

4. Non-Billable Activities, Non-Covered Services, and Allowable Place of Service

This section outlines the operational, programmatic, and situational limits on reimbursement for CHW Services under the Rhode Island Medicaid Program. CHW Services must meet all criteria for medical necessity, LPHA authorization, and proper documentation to be reimbursable. Activities that are administrative in nature, duplicate other Medicaid covered services or occur in inappropriate or non-compliant settings are not eligible for reimbursement.

Federal regulations (42 C.F.R. § 440.130(c)) require that CHW Services be preventive and non-clinical, and state policy requires services to be delivered in accordance with Medicaid integrity, provider scope, and HIPAA-compliant settings. Providers are encouraged to review this section closely to avoid improper billing, claims denial, or payment recoupment.

Medicaid reimbursement for CHW Services is strictly limited to medically necessary, LPHA-authorized, direct services provided to Medicaid beneficiaries in approved settings. Providers are strongly encouraged to consult this CHW Program Manual and applicable federal and state rules to ensure compliance.

These non-billable activities, non-covered Services, and allowable place of service are effective May 19, 2025, unless explicitly stated otherwise in this Section and Section 9.

All CHW service documentation must:

- Demonstrate individualized engagement, clearly linking the service provided to the Medicaid member's condition or risk as documented by a Licensed Practitioner of the Healing Arts (LPHA); and
- For group-based services, reference an evidence-based curriculum that is:
    - Recognized by federal public health authorities (e.g., CDC, HRSA, SAMSHA); or
    - Formally approved by EOHHS or developed in collaboration with the Rhode Island Department of Health (RIDOH), the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), or the Department of Children, Youth, and Families (DCYF) that meets evidenced-based curriculum.

Use of non-approved, non-evidence-based, or locally modified materials without explicit approval from EOHHS or its sister agencies is not allowable for Medicaid reimbursement and may result in claims denial or recoupment.

4.1.Non-Billable Activities

The following activities may support operations or service planning but are not billable under the Medicaid CHW benefit:

- Administrative and Operational Activities: These activities support operations but do not constitute reimbursable direct service to Medicaid beneficiaries:
    - General Administrative Work: Reviewing files, preparing materials, lesson planning, creating presentations.
    - Material and Facility Costs: Purchasing or covering expenses like printing, renting space, or other non-service overhead.
    - Documentation and Recordkeeping: Time spent on internal notes, data entry, reports, or logs.
- Non-Billable Time and Attendance: Time that is not directly spent engaging a beneficiary in a covered service is not reimbursable:
    - Travel Time: Driving between service sites, commuting, or travel expenses related to delivering CHW Services.
    - Idle or Waiting Time: Waiting for a beneficiary at clinics, homes, or community sites.
    - Attendance at Legal or External Appointments: Court, housing, or legal proceedings.
- Supervision and Internal Support: Activities that involve staffing or organizational oversight are not eligible for billing:
    - Supervision and Team Meetings: Staff huddles, internal case reviews, or administrative supervision.
    - Training and Professional Development: Participation in trainings, webinars, or continuing education (even if required for employment) or RICB certification.
- General Communication Without Medical Necessity: Interactions that do not meet Medicaid's requirement for medical necessity or LPHA authorization are excluded:
    - Routine or Social Check-Ins: Peer conversations, general well-being calls, or support calls without specific health purpose.
    - Undocumented or Unfocused Outreach: "Just checking in" messages that are not linked to a specific health condition or care plan.
    - Interpreter or Translator Services (Standalone): Translation is not billable unless embedded in a covered CHW service.

- 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.

- Outreach or Engagement Without Consent: Time spent attempting to engage beneficiaries without a signed release, consent, or prior contact is not billable.

- Home Visits Without Electronic Verification: ⚠️ Effective July 1, 2026, CHW home visits must comply with Electronic Visit Verification (EVV) protocols under federal law (42 U.S.C. § 1396b(l)). Any home visit not recorded through an approved EVV system will be considered non-billable.

4.2.Non-Covered CHW Services

The following services or contexts are not reimbursable under the Medicaid CHW benefit, regardless of medical necessity:

- Services Not Involving the Medicaid Beneficiary: Interactions with family members, caregivers, or other health care providers without the beneficiary present and engaged; Activities involving non-Medicaid beneficiaries, including general community events.

- Activities That Duplicate or Exceed CHW Scope: Transportation, life or wellness coaching not tied to a diagnosed condition, interpretation or translation services provided as standalone activities, lactation consulting, medical tasks including vitals, errands, accompanying to appointments, benefit enrollment assistance.

  Examples of prohibited clinical services outside the scope of CHW Services include taking vitals, interpreting labs, providing medical consultations, administering medications, or conducting physical assessments. These services are reserved for licensed clinical providers.

- 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.

- Coordination with Other Covered Services: CHW Services may not be billed concurrently with services already covered under Medicaid programs that provide case management, personal care, or habilitation supports. The following programs are excluded:

    - Long-Term Services and Supports, Home and Community Based Services waiver programs, including Conflict-Free Case Management;
    - Hospice, Nursing Facility, Eleanor Slater or Tavares enrollment segments;
    - Local Education Agency (LEA) billing, including:
        - Direct Medicaid service claims for students; and
        - Indirect Medicaid administrative claiming (MAC) or other Medicaid-funded administrative billing, and,
    - Home stabilization services.

    To enforce these exclusions, Medicaid Management Information System (MMIS) edits will prevent concurrent CHW Services billing against the applicable program codes and enrollment segments.

- Payer Restrictions: Medicaid is the payer of last resort. CHW Services may not be billed when another entity is responsible. Participants enrolled in the Program of All-Inclusive Care for the Elderly (PACE) are not eligible for CHW Medicaid billing under FSS or managed care; PACE operates under an all-inclusive, capitated model and preventative services are administer through the PACE Organization of Rhode Island.

4.3. Special Provision: Pediatric and Family Engagement Exception

In cases where the Medicaid beneficiary is a minor (under 18 years old) or an individual requiring caregiver support due to developmental or medical needs, CHW engagement with family members or caregivers may be allowable, only if:

- The engagement is medically necessary and directly tied to a documented health condition;
- The service is authorized by a Licensed Practitioner of the Healing Arts (LPHA) licensed in Rhode Island;
- Documentation clearly demonstrates that the service benefited the Medicaid beneficiary, even if the interaction occurred with a parent, guardian, or other caregiver.

Family engagement activities must directly relate to advancing the beneficiary's documented medical goals or care plan and must not include general caregiver support, independent counseling, or social engagement services unrelated to medical necessity. Services must be properly authorized, documented, and supervised consistent with Medicaid program integrity standards.

This allowance is consistent with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements outlined in 42 U.S.C. § 1396d(r), which mandate Medicaid services to correct or ameliorate physical, emotional, or developmental conditions for eligible children. Additionally, CMS guidance permits caregiver-directed services when necessary for a Medicaid beneficiary's health outcomes.

4.4. Allowable Place of Service for CHW Services

CHW services may only be billed when delivered in appropriate, HIPAA-compliant settings that ensure privacy, support medical necessity, and meet documentation and referral standards as required under Medicaid regulations.

4.4.1. Allowable and Non-Allowable Settings for CHW Services

Allowable Settings:

- Clinical settings: Primary care clinics, outpatient behavioral health sites, federally qualified health centers (FQHCs), and other HIPAA-compliant medical offices.

- Community settings: Homeless shelters, libraries, and private offices within community-based organizations where HIPAA privacy can be ensured.

- Beneficiary's home: Apartments, transitional housing, or other temporary accommodations. ⚠ *Note: Beginning July 1, 2026, Electronic Visit Verification (EVV) is required for all CHW home visits, in accordance with Section 12006 of the 21st Century Cures Act. RI Medicaid will monitor EVV compliance through audit and claims oversight*.

- Virtual settings for Health System Navigation only: ⚠ Effective July 1, 2025, CHW services classified as Health System Navigation and Resource Coordination (H0038) may be delivered via synchronous telehealth, including audio-only communication. The following conditions must be met:
  - The beneficiary and CHW must both be located within the State of Rhode Island at the time of the service;
  - Services must be delivered in real time using a HIPAA-compliant platform;
  - The service must be authorized by an LPHA and clearly documented;
  - All required elements for telehealth documentation must be met, as outlined in Section 3.3.3.

  ⚠ Effective July 1, 2025, Telehealth is not permitted for Health Promotion and Coaching or Health Education and Training services.

Non-Allowable Settings:

- Schools: Including K-12 classrooms, colleges, universities, extracurricular settings.

- Beneficiary's Place of Work: Workplace-based services raise privacy and employment-related concerns.

- During Travel or Transit Time: Travel time is never billable. Time spent commuting, driving, riding along, or accompanying a beneficiary in a car, van, or bus is not reimbursable.

- 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.

- 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.

- Correctional, Detention or Carceral Settings: Services delivered within jails, prisons, or detention centers are not eligible unless under a specific waiver. CHW services are suspended during incarceration and are not eligible for Medicaid reimbursement.

- 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.

- Settings and Services Already Covered by Another Medicaid-Designated Program: Programs, such as PACE centers or managed long-term care institutional settings where care coordination is already embedded in bundled rates. CHWs may render services under these alternative locations, but they cannot be billed independently through the bundled rates.

- Virtual Settings Without Documentation: CHW services delivered via phone or telehealth must meet strict documentation, medical necessity, and LPHA referral standards to be eligible for reimbursement. Telehealth is permitted only for Health System Navigation and Resource Coordination (H0038); Health Promotion and Coaching and Health Education and Training must be delivered in person. Anonymous, drop-in, or asynchronous telehealth (e.g., texting, video recordings) and group services via telehealth are not reimbursable.

All CHW services must be delivered in settings that ensure compliance with HIPAA privacy standards and Medicaid documentation requirements.

5. Rhode Island Medicaid CHW Certification Requirements

To be eligible for Medicaid reimbursement, CHW Services must be provided by individuals who are certified by the Rhode Island Certification Board (RICB) and are enrolled with Rhode Island Medicaid in accordance with program rules. CHWs must also meet all credentialing and compliance requirements established by EOHHS and any applicable rules and regulations for managed care organizations (MCOs) or delegated entities if EOHHS moves CHW services as an benefit under MCOs.

Failure to comply with certification or enrollment requirements will result in the CHW being ineligible to deliver or bill for CHW Services under the Rhode Island Medicaid Program.

Failure to meet certification or enrollment requirements will result in ineligibility to deliver or bill for CHW Services and may subject the CHW or provider organization to recoupments, disallowances, or audit findings.

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.

⚠️ *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.

5.2. Organizational CHW Providers

5.2.1. Provider Responsibilities

Organizations such as primary care providers, behavioral health agencies, community-based organizations, and hospitals that enroll with RI Medicaid can submit claims for CHW Services rendered by certified CHW staff.

Organizational CHW providers must:

- Ensure all CHWs are fully certified or enrolled in a valid transitional certification plan (through October 1, 2025);
- Prevent billing for uncertified or ineligible CHWs;
- Ensure CHWs operate within their authorized scope;
- Maintain up-to-date certification records for all CHWs;
- Make records available upon request by EOHHS, the Fiscal Intermediary (FI), MCOs, or delegated entities.

Non-compliance may result in disallowances, recoupments, or audit findings.

5.2.2. Maintenance of Certification and Medicaid Enrollment

CHWs must:

- Maintain an active, valid RICB certification;
- Complete credential renewals as required by RICB;
- Notify the provider, FI, or MCO if their certification lapses or is revoked.

Organizational providers must:

- Immediately suspend billing for any CHW who loses certification;
- Remove ineligible CHWs from billing rosters;
- Cooperate with certification and enrollment audits.

5.2.3. CHWs Affiliation Requirements (⚠ Effective October 1, 2025)

⚠ 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.

CHWs without an affiliated Medicaid provider after this date will be disenrolled and deemed ineligible to deliver CHW services under the Rhode Island Medicaid program.

This affiliation requirement promotes clinical accountability, enhances integration within managed care delivery systems, and strengthens oversight to ensure the delivery of high-quality CHW Services.

6. Provider Enrollment Requirements

To be eligible for Medicaid reimbursement, all Community Health Workers (CHWs) must be actively enrolled with the Rhode Island Medicaid Program in accordance with federal and state guidelines. As required under Section 5005(b)(2) of the 21st Century Cures Act (Pub. L. 114-255), all providers—including CHWs—must be screened and enrolled by the State Medicaid Agency (SMA) regardless of whether claims are billed under Fee-for-Service (FFS) or managed care.

This enrollment requirement also applies to current Medicaid-enrolled providers who intend to begin offering CHW services. A separate enrollment under the CHW provider type is required.

Organizations are not required to be certified but must ensure that all CHW staff meet RICB certification, criminal background check, and enrollment requirements.

6.1. Key Provider Enrollment Compliance Deadlines for CHWs

Requirement	Deadline	Applies To
RICB Certification (Newly Enrolled CHWs)	May 19, 2025	All CHWs providing billable services must be fully certified by the RICB unless under the approved transition certification status.
Criminal Background Check (BCI)	May 23, 2025	All CHWs (new or revalidating).
RICB Certification Transitional Deadline	October 1, 2025	All CHWs enrolled under transitional status must have full certification from RICB. Must have enrolled by May 19, 2025 under this category.
National Provider Identifier (NPI)	October 1, 2025	All CHWs (must apply directly, no placeholder NPIs)
CHW Group Affiliation Requirement	October 1, 2025	CHWs must be under a Medicaid-enrolled and approved entity

6.2. National Provider Identifier (NPI) Requirement

CHWs must obtain a valid NPI through the National Plan and Provider Enumeration System (NPPES). NPIs are free and required for Medicaid CHW providers under federal law.

To apply:

- Visit: https://nppes.cms.hhs.gov
- Select “Apply for an NPI”
- Choose “Individual Provider”
- Use the taxonomy code: 172V00000X (Community Health Worker)

CHWs must also ensure that any changes to their name, practice location, or contact information are promptly updated in the NPPES system to maintain Medicaid enrollment compliance.

6.3. Enrollment on the RI Medicaid Healthcare Portal

CHWs must enroll through the RI Medicaid Healthcare Provider Portal:
https://www.riproviderportal.org

6.3.1. Enrollment Process through September 2025:

Until September 2025, CHWs enrolling with Medicaid must use the following configuration:

- Provider Type: RI Medicaid Provider – Billing Claims Directly to RI Medicaid
- Enrollment Type: “Atypical” ⚠️ Effective through June 30, 2025, CHWs enrolling under the "Atypical" category are not required to submit a taxonomy code. The taxonomy code requirement specific to CHWs will begin on July 1, 2025.
- Required Uploads:
  - W-9 Form
  - Documentation of CHW certification or transitional status

The “Atypical” enrollment type will no longer be accepted for new CHW applicants after this date.

Note: CHW NPI is strongly recommended prior to October 1, 2025, but not required until that date. Effective October 1, 2025, CHW providers must be affiliated with a Medicaid-enrolled billing provider group that holds a valid Type 2 NPI. Individual CHWs must be enrolled under a Type 1 NPI.

6.3.2. ⚠️ *Enrollment Transition Effective October 1, 2025:*

By October 1, 2025, all CHW enrollments must use the dedicated "CHW" enrollment type in the Medicaid Provider Portal. The "Atypical" enrollment type will no longer be accepted for CHW enrollments after this date.

The Medicaid FI will update the portal functionality by September 2025 to support this new enrollment type and additional compliance requirements as described in Section 6.3.3.

6.3.3. 🔁 *Mandatory Re-Enrollment Required by October 1, 2025:*

⚠️ All CHWs who were enrolled under the "Atypical" category must submit a new CHW enrollment application to the Medicaid Fiscal Intermediary by October 1, 2025, to continue delivering or billing for Medicaid CHW services.

This re-enrollment must include:

- A valid CHW certification issued by the Rhode Island Certification Board (RICB);
- A completed BCI (Bureau of Criminal Identification) background check;
- An active National Provider Identifier (NPI) registered with the National Plan and Provider Enumeration System (NPPES);
- A signed Affiliation Attestation linking the CHW to a Medicaid-enrolled provider organization.

All CHWs must obtain and have an active National Provider Identifier (NPI) prior to submitting their re-enrollment applications, which are required to be submitted by October 1, 2025. Failure to have these prerequisites completed before October 1, 2025, will result in delays or denials of enrollment. See Section 6.4 for more details regarding this requirement.

6.3.4. Attestation Requirement for Organizational Affiliation Requirements

Individuals previously enrolled as "Atypical" providers cannot re-enroll solely by applying and attestation on their own behalf. Instead, the Medicaid-enrolled provider organization must submit the enrollment application on behalf of the individual CHW, including a signed Affiliation Attestation confirming the linkage between the CHW and the organization. Organizations seeking to add additional CHWs must utilize the designated paper application process: Adding Members to Existing Group Enrollment Application. Provider organizations are responsible for submitting the signed Affiliation Attestation as part of the CHW group enrollment process. The FI will verify that each CHW listed on the enrollment form has a valid attestation on file with the organization. The FI does not directly collect the attestations; this is the responsibility of the enrolling organization.

6.4. Criminal Background Check (BCI) Requirements

⚠️ 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.

6.4.1. How to Obtain a BCI?

CHWs must obtain their BCI report from the Rhode Island Office of the Attorney General or a state-authorized vendor:

- Website: https://riag.ri.gov
- Submission: Online or in person with a valid photo ID
- Fee: ~$5–$20 (subject to change)

6.5. **Good Moral Character Review Process**

Community Health Workers (CHWs) play a trusted role in the delivery of Medicaid-funded services. To safeguard beneficiary wellbeing while supporting equitable access to workforce opportunities, EOHHS may allow applicants with certain non-disqualifying offenses to undergo a Good Moral Character (GMC) Review Process.

This process is intended for individuals who:

- Have older, non-violent, or relevant misdemeanor or felony charges;
- Have demonstrated evidence of rehabilitation, compliance with legal obligations, and/or community service;
- Are not subject to automatic disqualification as outlined in Section 6.5.1.

6.5.1. Rhode Island CHW BCI Disqualification Matrix and Good Moral Character Qualifications

The following table describes whether a CHW with an offense on their BCI is eligible to enroll as a CHW in the RI Medicaid Program:

Offense Type	Mandatory Disqualification	Conditional or Time-Limited Bar	Notes
Abuse, neglect, or exploitation	Yes	–	Permanent exclusion; no waiver allowed
Felony conviction involving violence	Yes	–	Includes homicide, sexual assault, or exploitation
Health care fraud or Medicaid abuse	Yes	–	Permanent ban from all U.S. healthcare programs
Pending felony charges	Yes	Temporary hold on enrollment	Enrollment paused until legal resolution; final determination based on disposition
Felony theft or property crimes (non-violent)	No	Yes – 5 years post-conviction	GMC review possible; must show rehabilitation and no recurring behavior
Felony drug possession/sales	No	Yes – 5 years post-conviction	GMC review possible with proof of rehabilitation and no new offenses
Misdemeanor domestic violence	No	Yes – 5 years	May require clinical supervision or monitoring
Misdemeanor theft or property crimes (non-violent)	No	Yes – 3 years post-resolution	Case-by-case review; must show no recurring incidents
DUI or motor vehicle violations	No	Case-by-case	May be allowed if unrelated to direct service delivery

EOHHS reserves the right to review all background information on a case-by-case basis, including evidence of rehabilitation, time since offense, and nature of CHW duties. Such review will be consistent to the Good Moral Character Review Process described in Section 6.5.1.

6.5.2. Good Moral Character Review Process

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This process is intended for individuals who:

- Have older, non-violent, or relevant misdemeanor or felony charges;
- Have demonstrated evidence of rehabilitation, compliance with legal obligations, and/or community service;
- Are not subject to automatic disqualification as outlined in Section 6.5.

6.5.3. Eligibility for Review

An individual may request a GMC Review if:

- The disqualifying offense occurred more than three (3) years prior,
- The individual has no new offenses since resolution; and,
- The offense is listed as "conditionally allowed" in the BCI Disqualification Matrix (Section 6.5).

6.5.4. Required Documentation

Applicants must submit the following materials for GMC Review:

- A personal statement explaining the offense, rehabilitation steps, and personal growth;
- Two (2) letters of reference, including one from a professional (employer, educator, mentor);
- Proof of completion of probation, restitution, or other court-ordered conditions (if applicable);
- Certificates of training, employment history, or community involvement.

6.5.5. Review Panel and Decision Process

Reviews are conducted by a designated EOHHS panel review body.

A decision is rendered within thirty (30) calendar days of submission, or an explanation is provided if delayed.

Applicants may be:

- Approved for Enrollment, with or without supervision conditions;
- Denied with a written explanation. Applicants may file an appeal of the decision within thirty (30) calendar days.

If no appeal is filed, a new review request may be submitted after twelve (12) months from the date of the denial.

6.5.6. Limitation

Individuals convicted of abuse, neglect, or exploitation, health care fraud, or violent felonies remain ineligible and are not eligible for GMC review.

EOHHS reserves the right to revoke approval if new disqualifying information emerges.

6.5.7. Final Authority

EOHHS' decision regarding good moral character is final and is based on:

- Protection of Medicaid beneficiaries;
- Integrity of the CHW workforce; and
- Compliance with state and federal oversight requirements.

6.6. Trading Partner Enrollment with the Fiscal Intermediary (FI)

CHWs and affiliated CHW organizations are required to obtain a Trading Partner Number (TPID) only if they intend to bill Medicaid services under the Fee-for-Service (FFS) model. Organizations billing exclusively through Managed Care Organizations (MCOs) are not required to obtain a TPID. All billing, prior authorization, and reimbursement activities must be managed at the organizational level, and individual CHWs are no longer required or permitted to hold or use a TPID.

Steps:

1. Visit: https://www.riproviderportal.org/hcp/provider/Home/TradingPartnerEnrollment
2. Click “Click Here to Enroll”
3. Complete all required fields: Name, Tax ID/SSN, Contact Info, Provider Type: Community Health Worker
4. Select X12 transactions: 837P (Professional), 999 Acknowledgment
5. Accept the Trading Partner Agreement
6. Save the tracking number and submit
7. After completing enrollment, providers must register their Trading Partner Number on the RI Provider Portal to submit claims. For step-by-step instructions, visit: https://eohhs.ri.gov/providers-partners/billing-and-claims

6.7. Provider Application Fees

EOHHS requires CHW provider organizations to pay application fees as part of the Medicaid enrollment process. Application fees are established in accordance with federal and state regulations to cover the cost of provider screening, enrollment verification, and program integrity measures. Updated fee schedules and specific guidance on acceptable forms of payment will be made available on the Rhode Island Medicaid website prior to the new enrollment period starting July 1, 2025. Providers are responsible for regularly checking for updates and ensuring compliance with all fee-related requirements before submitting their enrollment applications. Failure to submit the required fees will result in enrollment delays or denials.

7. Provider Billing and Reimbursement Requirements

To be eligible for Medicaid reimbursement, Community Health Worker (CHW) services must be properly authorized, medically necessary, and billed in compliance with the Rhode Island Executive Office of Health and Human Services (EOHHS) regulations and guidelines, the Social Security Act § 1902(a)(27), 42 C.F.R. Part 455, and applicable Rhode Island state laws including R.I. Gen. Laws § 42-7.2.

This section outlines current billing policies, transition timelines for updated codes, service limits, and ethical and operational expectations. All claims must reflect services actually provided, accurately documented, and submitted in accordance with Medicaid integrity rules to prevent fraud, waste, and abuse.

In accordance with these laws and regulations, CHW providers must:

- Social Security Act § 1902(a)(27): Maintain and disclose records of services furnished under Medicaid upon request.
- 42 C.F.R. § 455.2: Adhere to federal definitions and prohibitions on fraud, waste, and abuse in Medicaid programs.
- 42 C.F.R. Part 455, Subpart E: Complete provider enrollment, screening, and comply with disclosure requirements.
- R.I. Gen. Laws § 42-7.2: Comply with oversight, audit, and integrity activities conducted by EOHHS in Rhode Island.

Violations of these requirements may result in recoupment, penalties, provider disenrollment, civil liability under the False Claims Act, and/or criminal prosecution through the Rhode Island Office Medicaid Program Integrity (PI) and/or Rhode Island Attorney General Medicaid Fraud Control Unit (MFCU).

⚠️ **Disclaimer**: This CHW Program Manual is intended for informational purposes only and does not constitute legal, billing, or compliance advice. It does not replace the need for providers and organizations to consult with qualified billing, legal, or Medicaid compliance professionals. **Providers are responsible for ensuring that all claims submitted to the Rhode Island Medicaid Program meet applicable state and federal requirements, including documentation, coding, and medical necessity standards. Errors, omissions, or reliance solely on this document may result in claim denials, audits, or recovery actions.**

7.1. Beneficiary Eligibility Verification

CHWs must verify a beneficiary's Medicaid eligibility on *each* date of service using the Rhode Island Medicaid Healthcare Portal (HCP), available 24/7.

As of May 19, 2025, reimbursement is limited to services that:

- Are delivered in real-time to the Medicaid beneficiary;
- Are medically necessary, based on a Licensed Practitioner of the Healing Arts (LPHA) referral;
- Are clearly documented and linked to an appropriate diagnosis.

7.1.1. Important Beneficiary Eligibility Verification Compliance Requirements

As a reminder, the following are important that CHW and organizational billing provider follow to ensure appropriate billing compliance with Rhode Island Medicaid Program rules:

- Retroactive eligibility requests or backdating referrals are not allowed. CHWs and providers must verify a beneficiary's Medicaid eligibility before delivering any services.
- Services provided to individuals who are not actively enrolled in RI Medicaid at the time of service are not reimbursable, even if they become eligible later.
- All CHW services must be LPHA-authorized in advance.
- Administrative-only activities—including onboarding, orientation, eligibility screening, or general background intake—are not separately billable under the Medicaid CHW benefit, regardless of documentation.

These requirements support Rhode Island Medicaid's compliance with 42 C.F.R. § 447.45, 42 C.F.R. § 455.2, and state integrity standards, ensuring that CHW services are medically justified, properly authorized, and delivered to actively enrolled beneficiaries.

7.2. Timely Filing Guidelines

To receive Medicaid reimbursement for CHW services, providers must submit claims in accordance with timely filing policies established by EOHHS and federal Medicaid regulations.

Different timelines apply depending on the delivery model (FFS vs. MCO/delegated entity).

7.2.1. Filing Timeframe Requirements

The following table describes clean claims filing deadlines for CHW submission.

Delivery System	Claim Type	Submission Deadline	Citation
Fee-for-Service (FFS)	All CHW claims	Twelve (12) months from the date of service	42 C.F.R. § 447.45(d)
Managed Care	Clean claims	Ninety (90) calendar days from the date of service	42 C.F.R. § 438.602(g); EOHHS MCO Contracts

7.2.2. Definition of a Clean Claim

A clean claim, as defined by 42 C.F.R. § 447.45(b), is a claim that:

- Is submitted in the required format,
- Contains all necessary documentation,
- Is not subject to delay due to errors, incomplete data, or pending eligibility issues.

7.2.3. Denied Claims and Resubmission Policy

Claims denied for reasons other than timely filing may be resubmitted within 365 calendar days of the denial date regardless of delivery system (FFS/MCO/Delegated Entity).

Claims denied due to exceeding the timely filing window are not eligible for reimbursement unless the original submission was within the required timeframe and was delayed for an approved reason by the EOHHS, FI, MCO or delegated entity.

7.2.4. Timely Filing Compliance Requirements

To ensure compliance with Medicaid billing and program integrity standards, CHWs and organizational billing providers must follow these key requirements:

- Timely and accurate claim submission is required for all CHW services, including those billed under both FFS and Managed Care systems.

- Providers must maintain evidence of submission date, such as electronic confirmation or postal documentation, for audit purposes.

- Retroactive eligibility requests or backdated claims are not permitted. CHWs must verify beneficiary eligibility prior to delivering any services as described in Section 7.1.

- Claims submitted beyond the allowable timeframe, even if services were rendered, will not be reimbursed unless clearly justified and within federal or state-approved exceptions on a case-by-case basis.

- CHWs and provider organizations must understand and comply with the specific timely filing requirements of each MCO or delegated entity, as outlined in their contract or plan manual.

7.2.5. Legal and Policy References for Medicaid Billing and Claiming

This section aligns with the following federal and state regulations:

- 42 C.F.R. § 447.45 – Timely filing and claims payment standards for Medicaid
- 42 C.F.R. § 438.602(g) – Timely payment for managed care
- 42 C.F.R. § 455.2 – Definitions and scope of program integrity
- EOHHS Provider Manual and MCO Contract Requirements

7.3. Claims Submission Methods

7.3.1. Legal and Regulatory Authority Regarding Claim Submissions

For reference, CHW providers must comply with the following laws and regulations regarding claims submission.

- 42 C.F.R. § 447.45 – Timely Claims Payment: Requires that State Medicaid Agencies pay clean claims within specified timeframes and maintain a system for prompt adjudication.

- 42 C.F.R. § 433.32 – Mechanized Claims Processing System: Requires states to operate an automated claims processing system to ensure claims are submitted, tracked, and adjudicated efficiently and accurately.

- CMS State Medicaid Manual (Pub. 45), Chapters 1 & 3: Establishes standards for claims integrity, documentation, format, and electronic submission procedures.

- R.I. Gen. Laws § 42-7.2: Authorizes the Executive Office of Health and Human Services (EOHHS) to administer and enforce Medicaid billing, provider enrollment, and oversight procedures.

7.3.2. Claims Submission Options

Providers may submit CHW service claims using the following methods, subject to the requirements of the delivery system (Fee-for-Service or Managed Care):

A. Electronic Submission (Preferred):

CHW providers are strongly encouraged to submit claims electronically using HIPAA-compliant 837 Professional transaction formats.

- For Fee-for-Service (FFS) claims, the Rhode Island Executive Office of Health and Human Services (EOHHS) offers free access to Provider Electronic Solutions (PES) software, which includes built-in validation tools and is available through the EOHHS website.

- For Managed Care Organizations (MCOs) or delegated entities, CHWs must comply with the MCO's designated electronic claims submission processes and portal access rules. MCOs may not accept paper claims.

B. Paper Submission (FFS Only):

Paper claims may be submitted only for Fee-for-Service (FFS) claims and must follow CMS standards:

- Use the CMS-1500 professional claim form (version 02/12)

- Must be typed or filled using black ink (handwritten, altered, or highlighted forms will be rejected)

- Forms can be obtained from medical supply vendors

⚠️ Reminder: CHWs submitting claims under a managed care plan or delegated entity should confirm the submission method and format directly with the MCO. Paper submissions are not accepted by most MCOs.

7.3.3. Submission and Processing Guidelines

All claims must be complete, accurate, and compliant with Medicaid billing standards.

Claims must include all required fields, including:

- Beneficiary's Medicaid ID
- Diagnosis (ICD-10) code assigned by a Licensed Practitioner of the Healing Arts (LPHA)
- Procedure code and any applicable modifiers
- Rendering provider's NPI (National Provider Identifier), consistent with the CHW enrolled in the Medicaid system
- Referring provider's NPI
- Supporting documentation as required by the Medicaid Fiscal Intermediary (FI) or Managed Care Organization (MCO)

⚠️ Beginning October 1, 2025, all CHWs must include their individual NPI on claims submitted to Medicaid. Claims without an active rendering NPI will be denied.

Email, fax, or non-secure uploads are not accepted for claims submission.

CHW providers must retain copies of all submitted claims (electronic or paper) and related documentation for a minimum of ten (10) years, in accordance with Medicaid recordkeeping and audit requirements.

7.4. Claim Documentation and Required Fields

To ensure compliance with Rhode Island Medicaid Program requirements and federal billing integrity standards, all CHW service claims must include complete and accurate information as outlined below. Claims lacking any required documentation may be flagged for review or denied.

7.4.1. Required Claim Elements

Each CHW claim must include the following:

- Beneficiary's Medicaid ID (Anchor Card):
  - The unique Medicaid identification number assigned to the beneficiary. CHWs must verify and input this number on each claim.
- ICD-10 Diagnosis Code(s):
  - Must be assigned by a Licensed Practitioner of the Healing Arts (LPHA);

- Must be medically necessary and current;
- Must be directly linked to the CHW service delivered;
- Z-codes (e.g., Z55–Z65) may only be used as secondary diagnoses. Claims listing Z-codes as the primary diagnosis will be denied.

- Procedure Code and Applicable Modifiers (See Section 7.5 for details):
  - Must correspond to the specific CHW service delivered (e.g., H0038, S9445, S9446);
  - Modifiers (e.g., "HQ" for group sessions) must match the setting and service structure;
  - Include the date of service and the start and end time or session duration.
- Rendering and Ordering/Referring NPO:
  - The CHW who performed the service must be identified on the claim using their individual National Provider Identifier (NPI);
  - Claims must also include the NPI of the LPHA who issued the referral or order;
  - The LPHA must be enrolled with the State Medicaid Agency either as a billing provider or as an OPR-only provider, in accordance with 42 C.F.R. § 455.410.
  - ⚠️ Claims must include the Ordering/Referring LPHA's NPI (enrolled with RI Medicaid) beginning July 1, 2025, and, beginning October 1, 2025, the CHW's individual NPI as the rendering provider.
- Supporting Documentation (Required by FI or MCO):
  - Must include any documents requested by the Fiscal Intermediary (FI) or Managed Care Organization (MCO), such as:
  - Copy of the LPHA referral;
  - Attendance logs for group sessions;
  - Clinical documentation supporting medical necessity;
  - All supporting documentation must align with the service billed.

7.4.2. Diagnosis Code Alignment Requirements

To be billable under Medicaid:

- The CHW service must address a condition or risk documented in the ICD-10 diagnosis code used.
- The LPHA referral and diagnosis code must be congruent with the CHW intervention.

- For example, Health Coaching tied to diabetes must cite an E-series (e.g., E11.9) diagnosis and Health System Navigation related to asthma care must cite a J45-series diagnosis.
- Diagnosis must not be vague or general (e.g., "unspecified condition").
- Failure to demonstrate clinical alignment between the LPHA referral, diagnosis, and billed CHW activity may result in claim recoupment or denial during audit.

7.4.3. Regulatory References and Compliance Standards for Claiming Standards

The following are relevant regulatory and compliance standards that CHW billing providers should familiarize themselves with:

- 42 C.F.R. § 455.2 – Defines fraud, waste, and abuse in Medicaid billing.
- 42 C.F.R. § 440.130(c) – Specifies that preventive services must be recommended by a physician or other licensed practitioner.
- 42 C.F.R. § 431.107 – Requires Medicaid providers to maintain records supporting services billed.
- R.I. Gen. Laws § 40-8 – Governs the administration and oversight of Rhode Island's Medicaid program.
- R.I. Gen. Laws § 42-7.2 – Grants EOHHS the authority to enforce provider compliance, including billing standards and audit procedures.

7.4.4. Important Notes and Reminder Regarding Claims Submission

CHW providers must adhere to the following standards to ensure claims are accepted, audit-ready, and compliant with Medicaid requirements:

- Link all claims to a current, active LPHA referral that is valid and supports medical necessity for the CHW service delivered.
- Ensure the diagnosis code is clinically appropriate and consistent with the CHW service, service category, and LPHA documentation.
- Conduct a pre-submission review of all claims for accuracy in procedure codes, modifiers, service dates, and required identifiers (e.g., CHW NPI, LPHA NPI) to avoid processing delays or denials.
- Maintain all documentation—including LPHA referrals, progress notes, session logs, and supporting records—for no fewer than ten (10) years, in

accordance with 42 C.F.R. § 431.107 and the RI Medicaid Provider Agreement.

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).

7.5.2. Unit-Based vs. Session-Based Billing

CHW services are billed either in 15-minute units or per-session depending on the procedure code. For session-based codes, the duration must be no less than 25 minutes to count as a full session. Time may not be rounded up. The table below explains the differences and appropriate unit code conversions:

Billing Type	Codes	Definition	Limits
Unit-Based	H0038 (T1016 until 6/30/25)	1 unit = 15 minutes	Max 8 units/day, 48 units/month
Session-Based	S9445, S9446	1 session = 30 minutes (must be ≥25 min)	Max 4 sessions/day, 24/month

Note: All T1016 codes for CHW Services will sunset on June 30, 2025. Use H0038, S9445, or S9446 starting July 1, 2025.

Sessions for S9445, S9446 must be at a minimum 25 minutes to bill for one (1) session. Time may not be rounded or combined across beneficiaries.

7.5.3. Claim Submission and Modifier Requirements

All CHW claims must include:

- U3 Modifier: ⚠ Effective May 19, 2025, the U3 modifier for a new enhanced beneficiary rate shall not be allowed to be billed for CHW services.
- 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.
- OPR NPI: ⚠ Effective July 1, 2025, NPI of the LPHA who authorized the CHW service must be enrolled as a billing or OPR-only provider.
- Session Modifiers: ⚠ Effective July 1, 2025, the following modifiers must be on all CHW claims:
  - U2 = Health Promotion & Coaching
  - U4 = Health Education & Training
  - None = Health System Navigation (H0038)
- Rendering CHW NPI: ⚠ Effective October 1, 2025, the rendering CHW NPI must be on the claim.

7.5.4. Billing Transition Timeline

Effective Date	Change Description
May 19, 2025	• Daily service limit of 2 hours per beneficiary enforced (Prior authorization required for additional hours) • U3 Modifier sunsets (no more enhanced rate for new patients) • Collateral services and multidisciplinary billing sunset
July 1, 2025	• Monthly service limit of 12 hours per beneficiary (Prior authorization required for additional hours) • Z-codes no longer allowed as primary diagnoses • New session-based billing codes with modifiers go into effect (See Section 7.6) • Group service limits and participant caps enforced (<8 beneficiaries) • T1016-based codes sunset • Ordering NPI required on all CHW claims
October 1, 2025	• Rendering NPI required on all CHW claims

7.5.5. Prior Authorization (PA) for Exceeding Daily and Monthly Limits

⚠️ Effective May 19, 2025, Prior Authorization (PA) requests for Community Health Worker (CHW) services exceeding the standard daily (2 hours or 120 minutes) and monthly (12 hours or 720 minutes) service limits, must follow the PA process administered by Gainwell, the EOHHS Fiscal Intermediary (FI). Please note the monthly limit is effective July 1, 2025.

A prior authorization is not required by for services less than 2 hours per day or more than 12 hours per month.

Providers must submit PA requests using the standardized Rhode Island Medical Assistance Prior Authorization Form, available here:

https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-04/pa_form_2025.pdf

Prior Authorization | Executive Office of Health and Human Services

Providers submitting PA requests must ensure the following documentation is clearly provided:

- Beneficiary name and Medicaid ID.
- Requested dates and total units/sessions.
- Member's current Medicaid eligibility status.
- Valid Licensed Practitioner of the Healing Arts (LPHA) referral explicitly linked to a clinical diagnosis.
- A detailed clinical rationale if requesting services exceeding the standard daily (2 hours) or monthly (12 hours) limits, clearly detailing:
    - Why standard limits are insufficient.
    - Why CHW services represent the most cost-effective option.
    - Linkage to a treatment plan or discharge support.
- A signed Certificate of Medical Necessity form.
- Documentation aligning service modality with billing code requirements.
- Documentation that increased hours is alignment to rendering evidence-based curriculum that has been reviewed and approved by EOHHS or requests EOHHS evidence-based curriculum for consideration under the PA.

The FI evaluates these requests against specific criteria outlined in the Rhode Island Medicaid CHW Program Manual, which includes medical necessity requirements, scope of CHW services, and clinical appropriateness standards. PA requests should be exceptional rather than routine; high-utilization cases may require referral to LTSS or other more appropriate Medicaid services.

Appeals Process: Appeals following Gainwell's denial of CHW Prior Authorization requests will be directed to the EOHHS Medical Director. Appeal decisions rendered by the EOHHS Medical Director are final and communicated within seventy-two (72) hours of receipt.

Transition to Managed Care: Upon the transition of CHW services into managed care, all CHW-related PA submissions must adhere strictly to each Managed Care Organization's (MCO) specific prior authorization processes and criteria. MCOs are responsible for establishing internal processes to ensure these standards are met, maintaining integrity, clinical appropriateness, and cost-effectiveness of CHW services.

Managed Care Organizations will maintain records of all PA requests, approvals, denials, appeals, and associated documentation. Regular auditing and compliance monitoring are required to support program integrity and adherence to the PA requirements.

Delivery System	Urgent	Standard	Regulatory Authority
FFS (Gainwell)	72 hours	7 calendar days	CMS Interoperability Final Rule (CMS-0057-F); 42 C.F.R. § 438.210 (applicable to Medicaid FFS 1/1/2027)
MCO / Delegated Entity	72 hours	14 calendar days	42 C.F.R. § 438.210(d): MCOs may extend by 14 additional days if in the enrollee's interest or if requested.

7.6.CHW Billing Code Matrix

Effective billing requires correct use of procedure codes and modifiers to reflect the type of CHW service delivered. Modifier requirements differ between the current (sunsetting) and new (effective July 1, 2025) code sets:

A. **Current Codes (T1016 series) See Table A Below**: Modifiers must be applied to distinguish between new patients, group sessions, and specific service types.
U3 = New patient (sunsetting May 19, 2025)
HQ = Group session
None = Standard case management

B. **New Codes (S9445, S9446, H0038 – effective July 1, 2025) See Table B Below:** The procedure codes themselves, with applicable modifiers, fully describe the service type and setting.

A. Table A: Current (Sunsetting) Codes (Valid Until June 30, 2025)

Procedure Code	Modifier	Description	Unit	Valid Until
T1016	None	Established patient case management	15 min	June 30, 2025
T1016	U3	New patient enhanced service	15 min	May 19, 2025
T1016	HQ	Group session	15 min	June 30, 2025
T1016	None	Collateral Services	15 min	May 19, 2025
T1016	None	Multidisciplinary care planning	15 min	May 19, 2025

B. Table B: New Billing Codes (Effective July 1, 2025)

⚠ Code structure reflects service type and setting. The use of modifiers U2 and U4 is required when billing session-based codes S9445 and S9446. No modifier is required for H0038.

Code	Setting	Service Type	Modifier	Unit Type	Limits	Notes
S9445	Individual	Health Promotion & Coaching	U2	'30-minute session (≥25 min)	Max 4 Sessions/day, 24/month	In-person only; tailored, evidence-based
S9446	Group	Health Promotion & Coaching	U2	'30-minute session (≥25 min)	Max 4 Sessions/day, 24/month	Max 8 participants; in-person only
S9445	Individual	Health Education & Training	U4	'30-minute session (≥25 min)	Max 4 Sessions/day, 24/month	In-person only; evidence-based curriculum
S9446	Group	Health Education & Training	U4	'30-minute session (≥25 min)	Max 4 Sessions/day, 24/month	Max 8 participants; in-person only
H0038	Individual	Health System Navigation	N/A	15-minute unit	Max 8 Units/day, 48/month	Telehealth allowed; group not permitted

7.7. Payment Method and Rate Policy

This section outlines how CHW services are reimbursed under Rhode Island Medicaid, whether through Fee-for-Service (FFS) or Managed Care Organizations (MCOs), and the ethical and legal standards that apply.

7.7.1. Fee-for-Service (FFS) Medicaid Reimbursement

- Payment Method: All reimbursement is issued through Electronic Funds Transfer (EFT).
- Rate Determination: Reimbursement rates are established and published by the Rhode Island Executive Office of Health and Human Services (EOHHS) and are available at: https://eohhs.ri.gov
- Rate Enforcement: Rates under FFS may not be altered, increased, or supplemented by providers.

7.7.2. Managed Care Organization (MCO) Reimbursement

Variable Rates: MCOs may establish their own reimbursement rates for CHW services, in accordance with 42 C.F.R. § 438.602(e), which allows managed care plans to pay different rates than the State Plan Fee-for-Service (FFS) rate, so long as all covered services remain actuarially sound and consistent with federal access and quality requirements.

FFS Rate as a Benchmark: Although MCOs may pay variable rates, the FFS rate often serves as the State's base Medicaid rate floor and may inform capitation development and minimum reimbursement standards.

Provider Responsibility: CHW providers billing through an MCO must:

- Understand MCO-specific claim formats, codes, and modifier requirements;
- Adhere to MCO-specific service authorization requirements;
- Follow MCO timely filing deadlines, typically within 90 calendar days of the service date;
- Maintain medical necessity, LPHA referral documentation, and alignment with core Medicaid program rules for each service billed.

Providers should refer to the individual MCO's provider manual for detailed billing and service delivery requirements. Services must not duplicate those provided through LTSS, care coordination, or value-based program incentives embedded in the MCO's benefit design.

7.7.3. Private Pay Prohibition (FFS and MCO)

CHW services that are reimbursable through Medicaid may not be billed to beneficiaries under any circumstances, regardless of whether the service is billed through FFS or MCO. This includes:

- Charging cash or co-pays for CHW sessions
- Requesting private pay for "enhanced" navigation or group education
- Sliding scale charges, membership fees, or out-of-pocket support payments

Such actions are prohibited under state and federal laws, specifically:

- 42 C.F.R. § 447.15 – Providers must accept Medicaid payment as payment in full
- 42 C.F.R. § 438.106(c) – Prohibits beneficiary cost-sharing for MCO-covered services
- Social Security Act § 1902(a)(25) – Medicaid is the payer of last resort

7.7.4. Billing Integrity Practices and Compliance Safeguards for Billing CHW Services

To maintain program integrity, CHW providers must adopt the following safeguards for Billing Medicaid covered CHW Services:

Billing Separation:

- Do not combine multiple CHW services into a single session unless explicitly allowed
- Each billed encounter must represent one distinct service, be medically necessary, and be linked to the appropriate billing code and LPHA referral

Auditing and Oversight:

- Organizations must conduct regular internal audits of CHW claims
- Annual training on CHW billing is strongly recommended for CHWs, supervisors, and billing staff

Documentation Consistency:

- All billed services must include LPHA referral, diagnosis linkage, service type, start and end time, and session content

Overpayment Identification and Reporting:

Under 42 U.S.C. § 1320a-7k(d) and 42 C.F.R. § 433.312, all Medicaid providers must report and return any identified overpayments within sixty (60) days of discovery, or by the date the corresponding cost report

is due, whichever is earlier. This requirement applies to both Fee-for-Service (FFS) and Managed Care delivery systems.

- For FFS, overpayments must be reported and returned to the Medicaid Fiscal Intermediary (Gainwell Technologies) in accordance with State procedures.

- For Managed Care, overpayments must be reported to the applicable MCO or delegated entity, in accordance with plan policy. MCOs are separately responsible for returning overpayments to the State per 42 C.F.R. § 438.608(d).

Failure to return known overpayments within the required timeframe may be considered a false claim and may result in civil, administrative, or criminal penalties under federal and state law.

Regulatory Oversight:

- EOHHS, Medicaid Fiscal Intermediary (FI), and MCOs may audit, suspend, or recoup noncompliant claims under 42 C.F.R. § 433.32 – Mechanized Claims Processing Systems and CMS State Medicaid Manual, Pub. 45 – Claims integrity, duplication, service separation

7.8. Documentation Requirements

All Community Health Worker (CHW) services billed to Medicaid must be supported by complete, accurate, and contemporaneous documentation. Records must clearly demonstrate that services:

- Were medically necessary and ordered by a Licensed Practitioner of the Healing Arts (LPHA);
- Were delivered directly to a Medicaid-eligible beneficiary on the documented date;
- Complied with Rhode Island Medicaid billing policies and all applicable federal documentation standards.

In accordance with 42 C.F.R. §§ 431.107(b), 440.130(c), and 455.20, CHW providers must maintain documentation sufficient to disclose:

- The extent and scope of each CHW service delivered;
- The identity of the CHW and beneficiary;
- The date, duration, and service type;
- The associated diagnosis, LPHA referral, and linkage to medical necessity;
- Compliance with HIPAA and Medicaid audit standards.

Records must be maintained for no fewer than ten (10) years and must be made available upon request to:

- The Rhode Island Executive Office of Health and Human Services (EOHHS);
- The Medicaid Fiscal Intermediary (FI);
- Managed Care Organizations (MCOs);
- EOHHS Delegated entities;
- Rhode Island Attorney General (e.g., MFCU);
- Rhode Island Auditor General; or,
- Federal oversight authorities (e.g., OIG, CMS).

7.8.1. Required Documentation Elements

The following documentation must be maintained by the CHW or the CHW billing provider:

- Beneficiary's Full Name and Medicaid ID
- Date of Service
- Start Time and End Time
- Service Category (e.g., Health Promotion & Coaching, Health Education & Training, Health System Navigation)
- Procedure Code and Applicable Modifiers
- Name and Credentials of the CHW Delivering the Service
- Linkage to Diagnosis
- LPHA Authorizations
- Service Description / Narrative
- Participant-Specific Notes (for Group Sessions)

⚠️ **Z Codes are not acceptable as a primary diagnosis for billing purposes effective July 1, 2025.**

7.8.2. Special Documentation Requirements

The following documentation standards apply to ensure CHW services meet Medicaid program integrity, audit, and billing requirements.

Group Sessions: A shared group note may summarize curriculum or shared content. However, individualized documentation is required for each participant and must include:

- The beneficiary's engagement and participation;

- The health condition addressed;

- A valid and specific LPHA referral or order; and
- The start and end time for the session.

➤ Refer to Section 7.9.2 for additional group documentation requirements.

Telehealth Services: Telehealth is permitted only for Health System Navigation and Resource Coordination (H0038). Documentation must include:

- The mode of communication used (e.g., phone, secure video);
- The physical location of the CHW and the beneficiary (both must be in Rhode Island per 42 U.S.C. § 1396a(a)(1));
- The date and time of the session;
- Confirmation that the interaction was live and synchronous;
- A valid LPHA referral linked to a diagnosis; and
- All other CHW documentation elements listed in Section 7.8.1.

⚠️ Text messages, voicemails, asynchronous check-ins, or pre-recorded content are not billable.

➤ See full telehealth compliance policy in Section 3.3.3.

Home Visits (EVV Compliance Starting July 1, 2026): Beginning 1, 2026, all CHW home visits must comply with Electronic Visit Verification (EVV) as required under 42 U.S.C. § 1396b(l). Documentation must include:

- Verified start and end times through the EVV system;
- CHW and beneficiary location data (GPS or address);
- An EVV audit or confirmation ID;
- All applicable CHW service details and LPHA referral.

➤ See EVV policy and home setting requirements in Sections 4.1 and 4.4.

7.8.3. Record Retention Requirements

CHW providers must retain complete, accurate, and accessible records for all Medicaid-billed services for ten (10) years from the date of service in accordance with state and federal law. This retention requirement is necessary for post-payment audit, appeals, overpayment investigations, and program integrity enforcement.

Legal and Regulatory Authority:

- R.I. Gen. Laws § 42-7.2 – Oversight and audit authority of EOHHS.
- 42 C.F.R. § 431.107 – Maintenance of records to disclose services and allow audits.
- 42 C.F.R. § 433.312 – Medicaid overpayment identification and repayment tracking.
- 42 U.S.C. § 1320a-7k(d) – 60-day rule for reporting and returning Medicaid overpayments.

Record Requirements Must Support:

- Verification of medical necessity, LPHA authorization, and CHW scope of practice;
- Documentation of date, time, location, and mode of delivery (in-person or telehealth);
- Clear diagnosis linkage and clinical justification;
- All applicable billing codes and modifiers;
- Compliance with CHW-specific limits and authorization thresholds;
- Electronic Visit Verification (EVV) (if applicable for home-based services);
- Compliance with telehealth documentation (see Section 3.3.3).

Record Access Requirements:
Records must be made available upon request to:

- EOHHS
- Medicaid Fiscal Intermediary (FI)
- Managed Care Organizations (MCOs)
- Delegated oversight entities
- Federal Medicaid auditors or regulators

⚠️ Failure to maintain or produce records may result in payment recoupment, program suspension, or referral to the Medicaid Fraud Control Unit (MFCU).

Recommended Practices:

- Providers are encouraged to adopt electronic health record (EHR) tools or standardized Medicaid documentation templates that ensure:
    - Real-time documentation;

- Session-specific tracking;
- Consistent diagnosis and referral linkage.

7.9. Group Settings and Size Requirements

Community Health Worker (CHW) services under the Rhode Island Medicaid Program must be personalized, medically necessary, and interactive. While group-based service delivery is permitted for certain service types, it is subject to strict documentation and participation requirements to preserve the individual focus of CHW services.

⚠️ Effective July 1, 2025, the following group session requirements and limitations will be enforced:

7.9.1. Group Session Limitations

- Maximum Group Size: No more than eight (8) Medicaid beneficiaries may participate in a group session conducted by a single CHW.

- Session Format: Group sessions must be interactive, structured, and delivered in real-time by the CHW. Didactic or lecture-style formats do not qualify.

- Permitted Service Types: Group settings are only allowable for:
  - Health Promotion and Coaching (S9446)
  - Health Education and Training (S9446)

  - Non-Permitted Services in Groups: Group billing is not allowable for:
    - Health System Navigation (H0038)
    - Session Duration: Each group session equals 1/2 hour. A maximum of 4 group sessions per day and 24 sessions per month, per beneficiary is allowed.

7.9.2. Documentation Requirements for Group Sessions

Each participant must have:

- An active LPHA referral specifically authorizing the group service.
- An individualized record entry summarizing:
  - The participant's condition;
  - Their engagement in the session; and,

- How the service aligned with the authorized goal or diagnosis.

General group summary is permitted to document shared content or curriculum, but it must be supplemented by individualized documentation.

7.9.3. Prohibited Group Formats

- Open Enrollment or Drop-In Groups: CHW group services may only be billed for participants who have an active, documented referral from a licensed practitioner of the healing arts (LPHA). Open enrollment or drop-in formats without LPHA referral are not reimbursable.

- Large-Scale Public Classes or Workshops: Events such as community wellness fairs, public cooking demos, fitness classes, or educational sessions with undefined attendees cannot be billed as CHW group services.

- Non-Interactive or Passive Formats: Watching pre-recorded videos, receiving flyers, or sitting through non-participatory presentations do not qualify.

7.9.4. Group Compliance and Oversight

CHW organizations are responsible for:

- Ensuring all group sessions meet billing criteria and documentation standards.
- Auditing group service claims to verify compliance with participant caps and session structure.
- Preventing misuse of the group billing code (S9446).

Noncompliance may result in recoupment of funds, claim denials, or audit findings by the Medicaid Fiscal Intermediary (FI), EOHHS, or managed care entities.

8. Ethical Billing, Fraud, Waste, Abuse Prevention

8.1. **Fraud, Waste and Abuse Prevention**

To maintain the integrity of the Rhode Island Medicaid Program, all Community Health Worker (CHW) providers and their affiliated organizations must adhere to rigorous standards of ethical billing, documentation, and service delivery. This includes full compliance with applicable federal and state fraud prevention laws, participation in mandatory training, and cooperation with oversight and audit reviews.

A provider engaged in fraudulent, abusive, or otherwise noncompliant billing practices may be subject to:

- Recoupment of overpayments;
- Suspension or termination of the provider agreement;
- Exclusion from federal or state health care programs; and
- Referral to the Medicaid Fraud Control Unit (MFCU) within the Rhode Island Office of the Attorney General for potential criminal prosecution.

Relevant authorities include:

- 42 C.F.R. § 455.2 – Definitions of fraud, waste, and abuse in Medicaid billing;
- 42 C.F.R. § 455.17 – Mandatory reporting of suspected fraud by providers;
- 42 C.F.R. § 433.32 – Medicaid mechanized claims processing program integrity standards;
- Social Security Act § 1902(a)(27) – Provider record maintenance and disclosure requirements;
- R.I. Gen. Laws § 42-7.2 – EOHHS program integrity and Medicaid oversight authority.

8.1.1. Training and Workforce Standards

Organizations employing CHWs must ensure that:

- All CHWs receive comprehensive initial and annual training on Medicaid billing, documentation standards, and program integrity rules;

  CHWs are competent in applying correct procedure codes, modifiers, and documenting medically necessary services in real time;

- Refresher trainings are conducted annually and must address:

    - Billing limits and duplication safeguards;
    - Documentation compliance and LPHA referral linkage;
    - Proper use of telehealth and electronic visit verification (EVV);
    - Fraud, Waste, and Abuse (FWA) prevention protocols.

Organizations may deliver this training internally or through approved external vendors, provided that the content aligns with EOHHS billing and program integrity expectations.

Organizations attest to the competency of CHWs to perform Medicaid-reimbursable functions in accordance with billing rules.

8.1.2. Internal Oversight and Program Integrity

Organizations must implement the following internal oversight practices:

- Internal audits of claims for unit accuracy and duplication;
- Verification of time-based billing compliance;
- Modifier application and claim integrity reviews;
- Review of LPHA referral validity and diagnosis coding accuracy; and,
- Ongoing internal education of CHW staff.

8.1.3. Ethical Use of Telehealth and Technology

Telehealth may only be used as authorized in this Manual (see Section 3.3.3) and is restricted to Health System Navigation services.

Providers must:

- Ensure live, synchronous HIPAA-compliant platforms are used;
- Record the location of both the CHW and beneficiary;
- Avoid “stacked” or overlapping billing; and
- Maintain full documentation of all remote encounters.

8.1.4. Service Duplication Safeguards

CHW services must not:

- Overlap with other Medicaid-covered roles (e.g., MCO case management, Peer Recovery, LTSS);

- Duplicate services paid under capitation or bundled payments;
- Be billed concurrently by multiple CHWs for the same activity or time period.

Each service must have:

- Distinct content, delivery, and documentation;
- An LPHA referral specific to the service provided.

8.1.5. Regulatory Oversight and Enforcement

EOHHS, the Medicaid Fiscal Intermediary (FI), and MCOs may:

- Conduct random or targeted audits;
- Deny or recoup noncompliant claims;
- Require corrective action plans; or
- Refer providers to enforcement entities.

Relevant federal and state regulations include:

- 42 C.F.R. § 433.312 – Overpayment identification and recovery;
- 42 C.F.R. § 455.2 & § 455.17 – Definitions and mandatory fraud reporting;
- 42 C.F.R. § 431.107 – Provider documentation responsibilities;
- R.I. Gen. Laws § 42-7.2 – State Medicaid program integrity oversight;
- Social Security Act § 1902(a)(27) – Maintenance and disclosure of provider records.

⚠ **Important Reminder**: CHW Providers may not charge Medicaid beneficiaries out-of-pocket ("private pay") for services reimbursable under Medicaid. This prohibition applies to both Fee-for-Service and Managed Care models. Violations may result in recoupment, administrative sanctions, suspension, and/or referral to the Medicaid Program Integrity Unit for further action.

8.1.6. Overpayment Identification and Whistleblower Protections

Under federal law:

- 42 U.S.C. § 1320a-7k(d) and 42 C.F.R. § 433.312 require providers to report and return any known overpayments to Medicaid within sixty (60) days of identification or the date any corresponding cost report is due, whichever is later.

- Failure to do so may result in liability under the federal False Claims Act (31 U.S.C. §§ 3729–3733).

- The Affordable Care Act (ACA) § 6402 provides whistleblower protections for employees or contractors who report suspected Medicaid fraud or abuse. Retaliation against individuals for good-faith reporting is strictly prohibited under federal and Rhode Island law.

8.1.7. Reporting Fraud, Waste, and Abuse (FWA)

If a CHW, supervisor, or billing entity becomes aware of improper billing practices, they must report it promptly to the EOHHS Program Integrity Unit.

Reports of suspected FWA may be submitted confidentially to:

- Tip Line: (401) 462-6009;
- Email: program.integrity@ohhs.ri.gov

Relevant requirements include:

- 42 C.F.R. § 455.17 – Mandatory reporting of suspected fraud;

8.1.8.*Anti-Abuse of Individual Billing Codes*

Organizations must monitor CHW claims to ensure services are not improperly billed as multiple individual sessions when group billing would be more appropriate.

Safeguards include:

- Regularly reviewing billing patterns to detect excessive individual session claims;
- Verifying that documentation supports the service format billed (individual vs. group);
- Providing targeted training to CHWs on appropriate use of group billing codes when medically appropriate and LPHA-authorized.

8.1.9. Mandatory Reporting of Abuse, Neglect, and Exploitation

Community Health Workers (CHWs) are mandatory reporters under Rhode Island law when they suspect abuse, neglect, or exploitation involving:

- Children (under age 18);

- Elders (age 60 and over);
- Adults with disabilities.

CHWs must comply with all mandated reporting laws, regardless of payer source or care setting. This includes compliance with:

- R.I. Gen. Laws § 40-11-3 – Mandatory reporting of child abuse and neglect;
- R.I. Gen. Laws § 42-66-8 – Mandatory reporting of elder abuse, neglect, or exploitation;
- R.I. Gen. Laws § 40.1-27-2 – Mandatory reporting of abuse or exploitation of adults with disabilities.

Where to Report:

- Children – DCYF Child Abuse Hotline: 1-800-RI-CHILD (1-800-742-4453)
- Elders – Adult Protective Services: (401) 462-0555
- Adults with Disabilities – BHDDH Protective Services: (401) 462-2629

⚠️ Reports must be made ***immediately*** upon suspicion.

Failure to report may result in penalties, administrative sanctions, or criminal prosecution under applicable federal and Rhode Island state law.

9. Compliance Calendar: Key Effective Dates for the CHW Program

This section outlines key compliance deadlines, implementation dates, and cross-references to sections of the Rhode Island Medicaid Community Health Worker (CHW) Program Manual where additional details can be found. All CHW providers and organizational billing entities must adhere to these dates to maintain Medicaid

🔁 Program Launch and Version Control

Compliance Item	Effective Date	Notes	Cross-Reference
CHW Manual v4.0 Effective	May 2025	Supersedes all previous CHW guidance	Section 1.1
CHW Manual v4.1	June 2025	Supersedes all previous CHW guidance	

⚠️ Service and Authorization Requirements

Requirement	Effective Date	Notes	Cross-Reference
Medical Necessity & LPHA Referral Required	May 19, 2025	Standing orders no longer allowed	Section 2.0
OPR NPI Must Be on All Claims	July 1, 2025	Required for LPHA authorizations	Section 7.5.3
CHW Rendering NPI Required	October 1, 2025	Required on all claims by CHWs	Section 7.5.3

💳 Billing Code and Modifier Changes

Requirement	Effective Date	Notes	Cross-Reference
U3 Modifier Sunsets	May 19, 2025	No enhanced rate for new patients	Section 7.5.4
Z-Codes Prohibited as Primary Diagnosis	July 1, 2025	Claims will be denied if used alone	Section 7.5.3
New Codes: H0038, S9445, S9446	July 1, 2025	T1016 code sunsets	Sections 7.5.2, 7.6
U2/U4 Modifiers Required	July 1, 2025	For all session-based codes	Section 7.5.3

⏱️ Service Limitations and Prior Authorizations

Requirement	Effective Date	Notes	Cross-Reference
2-Hour Daily Limit	May 19, 2025	Applies across all CHW codes	Section 7.5.1
12-Hour Monthly Limit	July 1, 2025	Applies across all CHW codes	Section 7.5.1
PA Required to Exceed Daily/Month Limits	May 19, 2025	Applies to both FFS and MCO	Section 7.5.5

👥 Group Session Requirements

Requirement	Effective Date	Notes	Cross-Reference
No Drop-In / Open Group Billing	May 19, 2025	LPHA referral required for each attendee	Section 7.9.3
Group Code Transition to S9446	July 1, 2025	Replaces T1016-HQ	Section 7.6
Max 8 Participants per Group	July 1, 2025	Strict size limit applies	Section 7.9.1

❌ Service Sunset

Service Sunset	Effective Date	Notes	Cross-Reference
Collateral Services	May 19, 2025	T1016 no longer billable	Section 3.4
Multidisciplinary Care Planning	May 19, 2025	T1016 no longer billable	Section 3.4

📜 Enrollment and Credentialing

Requirement	Effective Date	Notes	Cross-Reference
BCI Required	May 23, 2025	BCI Required for all new or reenrolled CHWs	Section 6.4
New CHW Enrollment Type Activated in Healthcare Portal	September 2025	"CHW" replaces "Atypical"	Section 6.3.2
Mandatory Re-Enrollment for CHW Providers	October 1, 2025	Application to FI with NPI and organizational affiliation	Section 6.3.3
Full RICB Certification Required	October 1, 2025	Transitional pathway closes	Section 5.1.2
CHW Group Affiliation Required	October 1, 2025	Individuals must be under billing group	Sections 5.2.3, 6.1
NPI Required for CHWs	October 1, 2025	Must be registered in NPPES	Section 6.2

🏠 Special Systems and Technology Compliance

Requirement	Effective Date	Notes	Cross-Reference
EVV Required for Home Visits	July 1, 2026	Federal compliance deadline	Sections 4.4.1, 7.8.2

Compliance Reminder

All CHWs, organizational billing providers, Managed Care Organizations (MCOs), and Fiscal Intermediary (FI) delegates are responsible for monitoring and implementing all compliance requirements outlined in this CHW Program Manual.

Failure to meet compliance deadlines may result in:

- Claim denials or recoupments;
- Provider disenrollment;
- Administrative sanctions;
- Referral to the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit (MFCU).

APPENDIX A: Contact Information and Useful Tools

Access to Key Online Resources

- RI Medicaid Healthcare Portal (HCP): https://www.riproviderportal.org
- Healthcare Portal Resource Page: http://www.eohhs.ri.gov/ProvidersPartners/HealthcarePortal.aspx
- State Fiscal Year (SFY) Claims Payment and Processing Schedule: https://eohhs.ri.gov/providers-partners/billing-and-claims/payment-and-processing-schedule
- ICD-10 Diagnosis Code Lookup: https://www.icd10data.com
- Executive Office of Health and Human Services (EOHHS) Website: https://eohhs.ri.gov /
- National Plan and Provider Enumeration System (NPPES) — Apply for an NPI: https://nppes.cms.hhs.gov
- Rhode Island Attorney General – Background Check (BCI) Information: https://riag.ri.gov/BCI
- Medicaid Fraud, Waste, and Abuse (FWA) Reporting Tip Line:
    - Phone: (401) 462-6009
    - Email: program.integrity@ohhs.ri.gov

Provider Contact Information

- Provider Services (Gainwell Technologies): riproviderservices@gainwelltechnologies.com
- Provider Enrollment (Gainwell Technologies): rienrollment@gainwelltechnologies.com
- Customer Service Help Desk:
    - Phone: 401-784-8100 (Local)
    - Phone: 1-800-964-6211 (Toll Free)
    - Available Monday through Friday, 8:00 A.M. – 5:00 P.M. (EST)
- Contact for Claims Support:
    - Andrea Rohrer (Gainwell Technologies)
    - Email: Andrea.Rohrer@gainwelltechnologies.com
    - Phone: 469-897-4389

APPENDIX B: Glossary of Acronyms and Key Terms

APPENDIX B.1 – Key Terms

#	Acronym	Meaning
1	AE	Accountable Entity
2	ASTHO	Association of State and Territorial Health Officials
3	BCI	Bureau of Criminal Identification
4	BHDDH	Behavioral Healthcare, Developmental Disabilities, and Hospitals
5	CDC	Centers for Disease Control and Prevention
6	CHW	Community Health Worker
7	CFCM	Conflict-Free Case Management
8	CMS	Centers for Medicare & Medicaid Services
9	CPT	Current Procedural Terminology
10	DCYF	Department of Children, Youth and Families (Rhode Island)
11	EFT	Electronic Funds Transfer
12	EOHHS	Executive Office of Health and Human Services (Rhode Island)
13	EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Services
14	EVV	Electronic Visit Verification
15	FFS	Fee-For-Service
16	FI	Fiscal Intermediary
17	FQHC	Federally Qualified Health Center
18	FWA	Fraud, Waste, and Abuse
19	HCP	Healthcare Portal
20	HCPCS	Healthcare Common Procedure Coding System
21	HHS	U.S. Department of Health and Human Services
22	HRSA	Health Resources and Services Administration
23	HRSN	Health-Related Social Needs
24	ICD-10	International Classification of Diseases, 10th Revision
25	ICF	Intermediate Care Facility
26	LEA	Local Education Agency
27	LPHA	Licensed Practitioner of the Healing Arts
28	MAC	Medicaid Administrative Claiming
29	MCO	Managed Care Organization
30	MFCU	Medicaid Fraud Control Unit
31	MMIS	Medicaid Management Information System
32	NEMT	Non-Emergency Medical Transportation
33	NPI	National Provider Identifier
34	NPPES	National Plan and Provider Enumeration System
35	PACE	Program of All-Inclusive Care for the Elderly
36	PES	Provider Electronic Solutions
37	PI	Program Integrity (Office)
38	RICB	Rhode Island Certification Board

39	RIDOH	Rhode Island Department of Health
40	SMA	Single State Medicaid Agency
41	SPA	State Plan Amendment
43	TCM	Targeted Case Management

APPENDIX B.2 – Key Terms

#	Term	Definition
1	Beneficiary	An individual enrolled in Rhode Island Medicaid and eligible to receive covered services.
2	Clean Claim	A complete, accurate Medicaid claim with all required documentation and no pending eligibility or format issues (42 C.F.R. § 447.45(b)).
3	Collateral Services	Indirect coordination services that are sunset for CHW billing effective May 19, 2025.
4	Conflict-Free Case Management (CFCM)	Medicaid case management that ensures separation between service planning and service provision to prevent conflicts of interest.
5	Direct Clinical Knowledge	Verified awareness of a beneficiary's condition or treatment needs, obtained through licensure, documentation from a treating provider, or multidisciplinary team involvement.
6	Electronic Visit Verification (EVV)	A federally mandated system to electronically verify Medicaid-funded home services.
7	Good Moral Character (GMC) Review	An EOHHS review process for CHW applicants with past offenses to determine eligibility based on rehabilitation.
8	Group Session	An interactive service session conducted by a CHW for multiple Medicaid beneficiaries at once, subject to participant limits and documentation requirements.
9	Health Education and Training	Structured, evidence-based education delivered to a beneficiary addressing an LPHA-documented chronic condition or risk factor.
10	Health Promotion and Coaching	Direct coaching to help a beneficiary manage or reduce risks associated with diagnosed conditions, aligned with LPHA goals.
11	Health System Navigation and Resource Coordination	Direct assistance provided to a Medicaid beneficiary to access healthcare services and community supports.
12	Health-Related Social Needs (HRSN)	Social determinants that impact a beneficiary's health outcomes, including housing, food, transportation, and safety needs.
13	Inducement	A prohibited offer or gift intended to influence a Medicaid beneficiary's use of services or selection of a provider, in violation of federal or state anti-kickback statutes.
14	Licensed Practitioner of the Healing Arts (LPHA)	A Rhode Island-licensed clinician authorized to issue Medicaid referrals for CHW services.
15	Managed Care Contracted Delegated Entity	A subcontractor authorized by a Medicaid MCO to deliver or oversee specific healthcare services.

16	Marketing Materials	Any communication produced by or on behalf of a provider or MCO intended to influence enrollment, utilization, or perception of Medicaid services. Includes print, digital, broadcast, or verbal promotions. Subject to federal approval requirements (42 C.F.R. § 438.104).
17	Medicaid Fiscal Intermediary (FI)	The entity responsible for provider enrollment and Medicaid claims processing under contract with EOHHS (currently Gainwell Technologies).
18	Medicaid Fraud, Waste, and Abuse (FWA)	Improper actions resulting in unauthorized Medicaid benefits or unnecessary program costs.
19	Medical Necessity	A service required to diagnose, prevent, or treat a medical condition, consistent with accepted medical standards and Medicaid regulations (42 C.F.R. § 440.230).
20	Modifier	An additional claim code used to specify that a service was delivered in a modified way (e.g., group session).
21	Multidisciplinary Team Care	Collaboration between a CHW and a clinical care team to develop or coordinate a beneficiary's care plan; Medicaid billing sunsets May 19, 2025.
22	Rhode Island Certification Board (RICB)	The official credentialing body recognized by EOHHS to certify Community Health Workers (CHWs) for Medicaid billing eligibility.
23	Standing Order	A general, non-patient-specific authorization for services, prohibited for Medicaid CHW billing.
24	Trading Partner Agreement	A formal agreement with the Medicaid Fiscal Intermediary (FI) enabling electronic claim submissions and HIPAA compliance.
25	Transitional Certification	Temporary certification status for CHWs enrolled in an approved training program; valid until May 19, 2025, with full certification required by October 1, 2025.