Medicaid Billing for Community Health Worker (CHW) Services in Rhode Island

Complete Evaluation Report

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Background

The American Public Health Association defines a Community Health Worker (CHW) as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." (APHA 2021) There is an increasing body of literature that documents the contribution CHWs make to improving patient health. (e.g., World Health Organization, 2020; Dunklee, 2021; Scott 2018; Sklar et al., 2017; Lewin et al., 2010), and how states use Medicaid reimbursement to fund CHWs. (e.g., ASTHO, 2021; FamiliesUSA, 2016; Rhode Island Executive Office of Health and Human Services, March 2022) Additionally, it is well-documented how CHW expansion is happening across the country.

It is less clear how organizations approach Medicaid billing for CHW services, develop necessary processes to implement Medicaid billing, and view the adequacy of reimbursement for covering non-billable aspects of CHW services, including administrative and infrastructure costs, and CHW training, supervision, and documentation activities. (Medicaid and CHIP Payment Access Commission, March 2022)

In 2021, the Rhode Island Department of Health (RIDOH) received a Centers for Disease Control and Prevention (CDC) Community Health Worker grant (CCR DP21-2109) to support the growth, sustainability, and innovation of Rhode Island's CHW workforce. On July 1, 2022, CHWs' work became a Medicaid reimbursable service in Rhode Island.

In 2023, the Care Transformation Collaborative of RI (CTC-RI), via funds from a CDC CCR DP21-2109 grant, contracted with Mardia Coleman, MS, and Roberta E. Goldman, PhD, to conduct a qualitative evaluation study of how a selected subset of organizations utilizing CHWs, as well as selected independent CHWs, approach and implement Medicaid billing for CHW services. The evaluation study's goal was to learn about: organizations' experiences with Medicaid CHW billing, factors that facilitate success and should be maintained or enhanced, challenges organizations encounter, and recommendations for changes EOHHS and RIDOH can make to further support existing and new organizations in their adoption of Medicaid CHW billing.

Research Questions for the Evaluation Study

1. Literature review: What do we know, and still need to know, about how organizations that have implemented Medicaid billing for CHW services have done so?
2. How have grant program sites in RI prepared for and implemented Medicaid billing for CHW services?
3. How does having Medicaid reimbursement of CHW services in RI impact organizational approaches to CHW services, in general?
4. What barriers and facilitators have organizations in RI encountered when enrolling with Medicaid as a CHW provider, obtaining certification for their CHWs, and implementing billing procedures?
5. What is the organizational context of providing and billing for CHW services in RI?
   - How do organizations understand which tasks are billable to Medicaid, and how fully do they perceive themselves to be billing for eligible services? What barriers prevent organizations from maximizing revenue for billable services? What facilitates billing?

Methods

Methods overview

Methods used for this evaluation were a literature review about CHW billing in other US states; a review of documents related to RI-specific CHW Medicaid billing requirements and processes; a purposive sample (Kuzel, 1999) of qualitative interviews with key informants to provide context and knowledge about CHW Medicaid billing in RI and elsewhere (n=9); and a purposive sample of 16 qualitative interviews with employees of two medical organizations (n=6) and three community-based organizations (n=6) that utilize CHWs, and independent CHWs in RI (n=4).

*Table 1: Interview Participants' Work Setting Type and Role**

CHW Employment Setting	Director/ Administrator/ Supervisor	Billing/ Revenue Cycle	CHW
Medical practice, FQHC	1	1	2
Medical practice, hospital system	1	1	
CBO	2	1	
CBO	1	1	
CBO	1		
Independent CHW			4
Total N=16	6	4	6

**Some interviewees held multiple roles, such as CHW supervisor and billing oversight, or billing entry and CHW. We listed interviewees' role as the primary role for which they were being interviewed.*

Separate, but related, qualitative interview guides with mostly open-ended questions were developed for key informants, people working in medical settings, people working in CBOs, and independent CHWs. (As an example, see Appendix 3 for the CBO CHW interview guide.) Interviews were conducted and recorded via Zoom and were 60 to 90 minutes long. Recordings were professionally transcribed.

Qualitative data were analyzed using the "immersion/crystallization" (Borkan, 2022) method entailing individually reading the transcripts and taking analytic notes which were sorted by topic and supplemented with illustrative quotes. Findings were iteratively discussed by the evaluators to explore divergent perspectives and to arrive at a final interpretation.

Format of this report

For each content area, a brief presentation of findings is followed by recommendations that arose from data analysis. The term 'organization' is used to include both medical and community-based organizations, unless otherwise noted.

Findings and Recommendations

Technical assistance, manuals and providing billing updates

Gainwell Technologies customer support and technical assistance

Gainwell Technologies (Gainwell) is the company responsible for claims management for Rhode Island's Medicaid program. Gainwell provides Medicaid enrollees free billing software, Provider Electronic Solutions (PES) to those enrolling in Medicaid billing who do not have their own billing software.

For the Medicaid CHW program, in addition to its ongoing support staff, Gainwell added a dedicated position to manage CHW billing needs. People with billing questions may interact with the general customer support staff or be elevated to the dedicated staff person.

All interviewees found Gainwell's customer support personnel to be readily available and extremely helpful. CBOs and independent CHWs reported the dedicated Gainwell staff spent at least one and a half hours going over billing procedures with them in an initial, individual session. Some interviewees mentioned they would have found accessing support easier if there were extended support hours available beyond typical 'business' hours.

All interviewees reported making additional calls to Gainwell to get billing procedures clarified or to get help with the billing process. When Gainwell customer service personnel or the dedicated staff did not know the answer to a billing software or process question, the question was elevated to Amy Katzen, Director of Policy and Strategy for Rhode Island's Medicaid program. Ms. Katzen also made her direct line available for one-to-one consultations.

Manual and presentation

While all interviewees found the technical support manuals, *RI Medicaid, Community Health Workers, Versions 1 and 2,* and the related PowerPoint slides (*Community Health Worker Service: Training, February 24, 2022*) helpful, all interviewees would like to see these materials revised to be more user friendly, and some want the materials written in less technical language. Most interviewees felt the materials would have benefited from user input and usability testing before being finalized. They also would like to have how-to videos to supplement the written manuals or to be embedded within the manuals. Some suggested the manual be offered in formats that accommodate multiple learning styles. As one CHW explained: *"I'm more of a listener. I can learn when you're telling me. When I read stuff, I can't always comprehend it exactly the way it's written."*

Technical assistance regarding collateral services

Few interviewees reported having contacted Gainwell for technical assistance regarding collateral services, despite having many questions about this category of activity. Rather, they billed only for collateral services for which they were sure there was no ambiguity, e.g., scheduling appointments or coordinating services.

Interviewees want the manual to include clear, unambiguous guidelines and examples about eligible and ineligible collateral services. Many stated a separate document just about collateral services would be helpful, and some would like the revised RI guidelines to have a link to a collateral services training video that supports the written material.

Obtaining billing information updates

As with any new program, there were, and will continue to be, changes in billing decisions. While Gainwell sends out emails regarding billing changes, there does not appear to be an easily accessible, centralized source that provides Medicaid CHW billing information updates. Some noted they obtain information updates informally from others. This occasionally led to misunderstanding of a guideline and then misinformation being shared with others.

The monthly EOHHS Provider Update is another source of CHW billing information. However, it did not appear to be widely accessed, nor does the Provider Update offer CHW billing updates or other billing related information on a monthly basis.

Other sources of technical assistance or information

Some interviewees asked CHWARI for information about CHW billing. Some also referenced one or more national CHW videos that showed CHWs conducting activities that may not be Medicaid reimbursable in Rhode Island. As noted earlier, CHWs, CHW supervisors and others involved in Medicaid billing share information with each other.

Peer-to-peer technical assistance mentoring

Some interviewees said they could benefit from mentoring or technical assistance from another organization that has experience, particularly around EHR modifications and setting up documentation systems. This type of consultation could help organizations save time and effort. One healthcare organization interviewee suggested this, and also offered to be part of a mentoring group.

Technical assistance recommendations:

1. RIDOH/EOHHS: Recognize Gainwell for providing excellent customer service.
2. Gainwell: Consider providing at least one evening a week and/or Saturday morning customer service time block to expand access to technical assistance.
3. EOHHS and Gainwell: Update the billing manual and related PowerPoint presentations. Improvements could include the following:
    a. Incorporate user input and user testing from each user group (e.g., independent CHWs, CBOs, healthcare organizations) in the next version(s) of the manual and related PowerPoint slides.
    b. Incorporate "how-to" videos for key areas such as downloading the PES software, entering claims correctly and other areas identified through user input.
    c. Incorporate detailed information about what constitutes collateral services, either in a standalone document or as a separate section within the manual. Create a companion training video that shows examples of what are and are not reimbursable collateral services.
    d. Add a section to the manual regarding the challenges that could be faced modifying an EHR to report claims to billing software.
    e. Add a section to the manual and PowerPoint slides regarding federal requirements for collection, storage, and transmittal of protected health information, and how to meet those requirements (e.g., locked cabinets for paper records, encrypted email, password protected computer folders). Consider adding HIPAA security modules, such as those offered on the HealthIT.gov website: https://www.healthit.gov/topic/privacy-security-and-hipaa/health-it-privacy-and-security-resources-providers
    f. Provide links to free reading software to aid manual and PowerPoint slide set users who would benefit from listening to the materials rather than reading them.
4. EOHHS and Gainwell: Create a web-based resource that provides current billing information and updates that can be easily accessed. Additionally, send a weekly or monthly bulletin that provides updates and more detail about areas of billing confusion to all who have enrolled for Medicaid CHW billing. Provide a sign-up feature to receive bulletins.
5. CHWARI, EOHHS or Gainwell: Help facilitate, promote, and support a peer-to-peer technical assistance workgroup.
6. Consider creating an online community space specific to RI CHWs, similar to the nationally-focused online community hosted and moderated by the envision team.

Preparing for Medicaid CHW billing

Enrolling as a Medicaid CHW provider and trading partner

Most interviewees reported enrolling as a Medicaid CHW provider was an easy process. Some independent CHWs described problems downloading PES software, problems gathering the documentation needed to register, and one had minor problems enrolling as a Trading Partner. (All business entities that will exchange electronic data with the RI Medicaid Program must enroll as a Trading Partner with EOHHS and Gainwell.) Most problems were related to inexperience with computer technology. Organizations and independent CHWs who experienced issues asserted that Gainwell's technical assistance was very helpful.

EHR and billing software modifications

Gainwell provides billing software, the PES, to those who do not already have billing software compatible with the Medicaid billing system. The PES appears to meet the needs of some CBOs and all the independent CHWs. One large CBO downloaded the PES software, then made a substantial financial investment in an All-Payer claims management system. The new updated claims management system allows the organization to bill Medicaid and payers for other programs. Healthcare organizations modified their existing EHR and billing processes to accommodate Medicaid billing and did not use the PES software.

As noted by a healthcare interviewee, *"Getting the billing systems ready for CHW Medicaid billing can be a daunting task."* For one healthcare organization, making EHR modifications entailed about three months of meetings and roughly 40 hours of IT and professional staff time.

One interviewee offered it would be helpful if EOHHS/RIDOH had a start-up fund to which organizations could apply for assistance. This fund would help cover costs needed to make EHR, care management software or billing system upgrades or modifications.

The issues with EHR modifications depend on the EHR product used by the organization and how those modifications interface with their billing system. Some issues interviewees shared include getting the billing system to accept CHWs as healthcare providers; getting the EHR to recognize a secondary insurance; getting the EHR modified so data uploads correctly to the billing system; being more specific regarding time spent and units of service; and having to add a T code for billing purposes. One healthcare organization (with a different EHR product) created a new CHW template based on behavioral health telemedicine to accommodate CHW billing. Their EHR modifications were relatively straightforward. While the template required some tweaking, the overall process was not time consuming.

Interviewees across all billing types reported that having the Z codes and the T codes on different screens could mean that CHWs forget to add the T code. However, one organization reported an advantage of using the Z codes to bill was being able to more specifically capture the issues facing their patients (Z codes document social determinants of health, e.g., housing, food insecurity).

Additionally, billing for CHW services can be complicated because it is a new product that requires a change in thinking. For example, billing staff in some organizations initially kicked back claims for collateral services. Training the claims review staff to understand that billing for collateral services was allowable was an unexpected billing system issue.

Costs associated with EHR modifications

Interviewees noted there are start-up costs associated with preparing for CHW billing.

- Assessing the capacity of current billing systems
- Meetings to determine how to modify current billing and/or EHR software
- Purchasing additional software, if needed
- Creating data dictionaries and/or user manuals for staff training
- Training staff regarding data entry

Preparing for Medicaid CHW billing recommendations

1. Gainwell and EOHHS/RIDOH: Create a separate document that describes what activities individuals and organizations likely must undertake to prepare for Medicaid billing, and what barriers they likely will face, especially in regard to EHR modifications.
2. EOHHS/RIDOH: Provide a source for start-up funds to support organizations making these preparations and EHR modifications.
3. Gainwell: Continue to support organizations as they prepare for billing.
4. Gainwell and EOHHS: Support the creation of a technical support user group as described in the Technical Support recommendations.

Billing-related issues

Obtaining Medicaid numbers and verifying eligibility

Billing for CHW services relies on being able to access a client's Medicaid ID number. Interviewees asserted that often patients/clients do not know their RI Medicaid Anchor number. CHWs have encountered this situation with a new client/patient being served in a non-medical setting, such as a shelter or elder housing, with former clients or patients who qualify for retrospective billing, or when a patient has an MCO Medicaid plan and no longer can find their RI Medicaid Anchor card. (The MCO plan number cannot be used for Medicaid billing of CHW services).

In theory, obtaining the Medicaid number should not be difficult. Staff can call the Gainwell Help Desk or they can use the healthcare portal to retrieve a patient's or client's Medicaid number. However, both methods require obtaining at least the person's social security number. Using the portal requires the person's Social Security Number and last date of service. To call the Help Desk requires obtaining the person's Social Security Number, date of birth and the person's first and last name. All interviewees noted doing the background work to obtain this information is very time consuming.

Interviewees who experienced problems obtaining the Medicaid number uniformly felt, *"There should be a much easier way to get people's Anchor number."* Additionally, they asserted it would be much easier if the Medicaid billing system accepted the Medicaid MCO ID number for CHW billing.

Interviewees reported that patients and clients can be hesitant to provide their social security number or other personal information when the need is not clear to them, as is sometimes the case when they are attending free health education classes, or the organization is attempting retrospective billing.

Interviewees did claim that once they have the Medicaid ID number, verifying Medicaid eligibility is simple. No interviewees reported problems with this aspect of billing.

Obtaining recommendations for CHW services from a licensed professional of the healing arts

To bill Medicaid for CHW services for any individual Medicaid member, CHWs must obtain a recommendation for CHW services from a licensed practitioner of the healing arts. Interviewees relied almost exclusively on recommendations from medical providers, despite organizations having licensed

professionals on their staff, and independent CHWs enrolling or working with clients in settings that had licensed professionals of the healing arts onsite.

For healthcare organizations, medical providers within their system typically made recommendations that were documented in the patient's EHR.

CBOs and most independent CHWs contacted the client's medical provider, typically a primary care provider, to obtain a written service recommendation. When clients do not have a medical provider, one independent CHW helps the clients get affiliated with a medical provider and obtains the recommendation at that time. However, due to a misunderstanding, there was the perception by a small number of CHWs that when helping clients in non-medical settings, they do not have to get a recommendation. This misperception was later rectified.

It appeared only one organization interviewed has a process for standing orders. Overall, it appeared there is not a good understanding of standing orders, or if understood, interviewees are unsure how to implement standing orders in a systematic fashion for CHW services. Most interviewees feel having a provider write a patient-specific CHW service recommendation is easiest to do and the best practice.

Understanding and use of billing codes

Some interviewees believe that ICD-10 medical diagnosis codes must be collected for documentation purposes (not for billing purposes) for every client or patient to justify services even when the service recommendation relates to a SDOH Z code. To some extent this belief perpetuates the reliance on getting CHW service recommendations primarily from medical providers.

As noted earlier, some interviewees did not bill for collateral services because they thought it required a separate code.

Retrospective billing

Time spent tracking down clients to either get their Medicaid number and/or to determine an accurate number of units of service deters some organizations and some independent CHWs from retrospective billing. They determined it would cost them more in staff time to do the research necessary for retrospective billing than they would receive in reimbursement. Confusion about what activities are eligible for collateral time also deters organizations from retrospective billing. Some interviewees recognized their past CHW services documentation could not be used for retrospective billing because it did not include the amount of time spent providing services.

There also is confusion about the date to which the organization can retrospectively bill. While the manual states organizations can retrospectively bill going back to July 1, 2022, one organization said they were told they could retrospectively bill only to the date of their application, not to July 2022.

Retrospective billing for health education classes also is problematic as described in the next section.

Billing for health education classes

None of the interviewees reported having problems with the mechanics of billing for health education classes once they obtained the needed Medicaid ID numbers. However, almost all organizations reported health education reimbursement does not match the administrative costs for these classes.

Organizations that provide health education classes have found that many, and sometimes most or all, class participants do not have Medicaid as their insurance. Even when some attendees are Medicaid-insured there could be problems acquiring the Medicaid number since some people were concerned

about having to provide their Medicaid ID number for a class that was free to them, and other participants just did not know their ID number.

Health classes at some organizations were not initially taught by CHWs, which made the classes ineligible for Medicaid reimbursement. This issue was resolved by organizations paying for their CHWs to be specifically trained to teach the classes. Additionally, many of the evidence-based health education classes require two instructors, each of whom must write notes for services provided to each of the Medicaid members in the class. These evidence-based trainings with smaller class sizes, even when attended fully by Medicaid insured patients, may not cover their costs through Medicaid CHW billing.

In sum, it is likely that for some organizations, Medicaid CHW billing for health education classes will not be cost effective. For others, it may supplement but not fully cover the costs incurred to provide health education classes.

Billing for collateral services

CHW collateral services are those services conducted on behalf of the client or patient at times when the CHW is not in direct contact with the client/patient. Not all states allow billing for collateral services, and Rhode Island, according to key informants, is among the most generous in its definition of what constitutes collateral services. Nonetheless, interviewees reported collateral services is the area for which they experience the most uncertainty around billing. Some interviewees from CBOs or independent CHWs had not even heard of the concept collateral services or had not seen the explanation in the manual. Others found the ambiguity in the description did not allow them to feel confident about billing for collateral time. At healthcare organizations, billing staff initially kicked back claims for collateral services because it was a new service area with which they were unfamiliar. Some do not bill because there is no dedicated code for collateral services. As one interviewee explained: *"I have quite a lot of it. It's just I don't know how to bill for it."*

During interviews, many shared questions they have about specific CHW tasks, and thought it likely they are underbilling for collateral services. One comment exemplifies interviewees' concerns: *"The only thing about collateral, probably a lot of people's problem with it, is that it's not extremely specific. So there's a lot of room to wonder if [a particular service] would be considered billable."*

Appendix 1 provides a list of services CHWs provide that interviewees are confused about in terms of whether these activities are billable collateral services.

Billing burden and claims review

Interviewees all described taking great effort to ensure their claims are appropriate and their billing is correct. Healthcare organizations and CBOs reported they review every CHW billing claim before submitting it, as they do for any Medicaid claim. However, because CHW Medicaid billing is new, it requires more supervisory or billing staff time to review these claims. CHWs can make errors entering the correct Z code or forget to enter the T code. Their service documentation, including time spent in units, also is reviewed. This requires repeated training to ensure CHWs correctly enter their claims.

The following quote captures the level of scrutiny provided at both healthcare and community organizations: *"We have billers who look at every claim, who look at every visit. And they actually do the coding, although the community health workers add a T code. But there's a billing person who looks at every claim and scrubs it and gets it ready to go out the door."* A healthcare provider explained that Medicaid CHW billing requires manual work to *"scrub the claims"* to ensure they are now billing Medicaid rather than a managed care Medicaid plan, and it requires creating a secondary claim when a patient has a Medicaid MCO plan.

Independent CHWs also carefully review their claims before submitting, and when questions arise, they contact Gainwell or Amy Katzen for clarification.

Billing-related issues recommendations

1. Gainwell and EOHHS: Determine if it is possible to make the retrieval of Medicaid numbers easier. This will support both CHW billing generally, and retrospective and health education class billing, in particular.
2. Gainwell and EOHHS: Consider if it is possible to modify the existing Gainwell billing software so that it is feasible to use the patient's Medicaid MCO number for CHW billing purposes.
3. Gainwell and EOHHS: Consider making concrete recommendations in the manuals and presentations that explain exactly how to obtain recommendations from other licensed practitioners of the healing arts, e.g., what a recommendation would look like, how to obtain the recommendation, and how to store the recommendation in the patient/client record.
4. Gainwell and EOHHS: See technical assistance section for recommendations for clarifying which collateral services are eligible for billing. Overall, ensure that any changes or updates are broadly shared with all CHW billers. Highlight on the website updates about billable CHW services in relation to collateral time.
5. EOHHS/RIDOH: If the monthly CHW strategy meetings are ongoing, consider using them as a forum to address questions about collateral services. Dedicate time during the monthly strategy meetings specifically for questions about collateral time (and other billing issues). If the strategy meetings have ceased, find other ways to effectively distribute this information, including in CHW-related newsletters.
6. EOHHS/RIDOH: Consider creating a specific billing code for collateral services.
7. Gainwell: Consider addressing one aspect of billing burden mentioned by interviewees by adding a "Help" function embedded in the Gainwell software, and a drop-down menu of Z codes so there is no need to type the codes in.

CHW services documentation

EHRs and documentation

EHRs, with or without modification, can be effective means for collecting and reporting the data needed to meet Medicaid billing requirements. The EHR can collect diagnostic data via ICD-10 codes. The EHR collects data regarding medical providers' treatment orders, services provided, as well as offers a communication mechanism between the healthcare-employed CHW and the medical provider. When configured to do so, the EHR also can collect the exact amount of time services were provided.

Key informants explained that in addition to healthcare-employed CHWs entering information in patients' EHR records, it can be a best practice for a CBO-employed or independent CHW to receive the patients' and the healthcare sites' permission to access the patients' EHR records, and to document their service provision directly into the records. However, among those interviewed for this study, this process is not yet occurring.

Documentation and oversight of documentation for CHW services

Interviewees asserted documentation procedures require initial and ongoing training, with an emphasis on being precise. Independent CHWs and some CBOs designed their own documentation formats, with some using paper-based documentation and others using Excel spreadsheets. One CBO uses case management software. CBOs and independent CHWs reported it would be helpful to have RIDOH or Gainwell provide care management or documentation templates they can use and tailor to fit their particular needs.

CHWs working in medical settings can document directly in the patient electronic record. Both in medical settings and CBOs, CHWs follow the documentation procedures outlined by their employers, and in all cases the documentation receives some level of scrutiny by a supervisor before claims are entered into the Gainwell software. Most interviewees asserted supervision of documentation and billing is time consuming, especially if the CHWs are confused about how to characterize their services or are incomplete or incorrect in their use of the documentation form. For group sessions led by CHWs, notes are documented by each CHW involved in the session, for each attending Medicaid member.

Advice from one interviewee to others planning to bill Medicaid for CHW services illustrates the importance of good documentation: *"Ultimately, the documentation is your source of truth. …What are the problems you're trying to address with the patient? And then from there, what did you do? And then last, being very clear about time. That way you can feel extremely comfortable with the number of units that you're billing for these services."*

There was concern from one key informant and an interviewee about the lack of consistency in service documentation across organizations and CHWs, and the variation in how documentation is entered into the client/patient record. Such wide variation will make it difficult to do any statewide analysis of the effectiveness of CHW services.

CHW service documentation recommendations:

1. EOHHS/RIDOH: Consider establishing uniformity in what CHW data are collected through patient records and what the format should be for those data. When establishing a more uniform data set, consider what data from EOHHS/RIDOH or other internal or external researchers will be needed to measure CHW service effectiveness.
2. Gainwell and EOHHS/RIDOH: Provide service documentation templates that include the above data set and that can be used or adapted by any organization or independent CHW. These templates can help standardize data collection. Healthcare organizations can provide some examples of well-designed CHW service documentation templates.
3. Gainwell and EOHHS: As noted earlier, ensure all Medicaid CHW service billers understand and can conform with HIPAA PHI requirements.

CHW experience

CHW certification and experience

Across all interviewees and organizations, there is a universal expectation that all CHWs will be certified well within the required 18-month timeframe. Interviewed CHWs have years of experience working as a CHW or in a similar role. Many have lived experience which gives them additional insight into patients' or clients' needs.

CHWs received their certification training either from the organization for which they worked or from an external training site such as CHWARI or Rhode Island College. Some interviewees reported that while the training is free of cost, the hours that trainings are offered can be problematic because there are limited opportunities for weekend or evening classes.

CHW experience recommendations

1. EOHHS/RIDOH: Consider advocating with organizations that provide CHW certification training to expand CHW training opportunities to include some evening and/or weekend classes. This will accommodate those who work fulltime within traditional workhours.

Independent CHWs

Independent CHWs as a business model

Medicaid CHW billing allows independent CHWs an opportunity to provide needed CHW services to underserved community members both within and outside the usual nine-to-five workday. Independent CHWs have the flexibility to do outreach and provide services during evenings and weekends, and in underserved community locations where people congregate whose health may greatly benefit from receiving CHW services.

Independent CHWs serve a range of clients—including older adults and others living in public housing, people with behavioral health disorders, families and individuals with unstable living conditions, and people with substantial learning or physical disabilities. When going into settings such as shelters or elder housing, some independent CHWs serve clients *regardless of their insurance status*, however they do endeavor to fulfill requirements necessary to bill for eligible services for Medicaid members.

Independent CHWs are small business owners. They like having their own business—they have the autonomy to focus on those whose needs best match their skills and professional and lived experience. Having their own business gives them more autonomy over their schedule, caseloads, and income.

Under the current system, it is possible for independent CHWs to earn more than if they were to be employed by healthcare or CBO organizations. However, overall earnings depend on how much unreimbursed time is spent working with non-Medicaid insured clients, and also if they understand and fully bill for collateral services. For instance, one independent CHW who was not billing for collateral services, and who provides services to non-Medicaid clients, calculated that with all of their work and costs factored in for a typical time period, their earnings came to about $15.00 per hour. Those independent CHWs not billing for collateral services felt their business sustainability will improve once they fully understand what is allowable to bill.

Supporting Independent CHWs

Independent CHWs vary in their experience as small business owners. Some had previously had their own businesses; for others, this is their first time working as an independent contractor. As independent CHWs do not have access to an IT Help Desk, they are very appreciative of Gainwell’s support. Their technology systems are not as up to date as those used by larger organizations. It is unclear to what extent the independent CHWs (or CBOs) have firewalls or secure email systems, or if those technology features are required by RIDOH for the transmittal of patient data between the CHW and the patient or the patient’s provider.

Independent CHWs suggested they would benefit from mentoring or technical assistance from a small business association or a local Chamber of Commerce in areas such as business and health insurance, tax implications of having a business, creating a business plan overall and one that helps them calculate a sustainable caseload, and guidance around business development and marketing.

Regarding professional support when dealing with emotionally draining situations, all claimed their many years of lived and professional experience and other external supports allow them to deal effectively with their clients. They access many of the trainings offered by CHWARI and other professional groups and find these trainings very helpful. However, they would also like to have access to trainings targeted specifically to their needs as independent CHWs. They would appreciate having an independent CHW trade or other organization where they could share ideas and experiences.

Independent CHW recommendations:

1. The Alliance for Community Health Worker Employers is getting established in RI for support and professional development. There are independent CHWs who are licensed business entities and/or who employ other CHWs to provide services to a caseload of clients; all are small business owners. The Alliance should consider inviting independent CHWs into their network. This could serve as a source of peer support until an independent CHW group is developed.
2. EOHHS/RIDOH: See Documentation Recommendations regarding creating sample templates for time spent, documentation of services, and other record keeping.
3. CHWARI or other organizations that provide CHW trainings: These organizations can enhance existing trainings to include more information on documentation and HIPAA requirements regarding safeguarding protected health information, particularly for those working in a home office setting.
4. CHWARI: CHWARI was a primary source for CHWs to learn about the opportunity to become an independent CHW. In addition to providing information about this opportunity, CHWARI could support prospective independent CHWs by offering optional, online training modules that address what is involved in becoming an independent CHW, and providing information about organizations that offer small business development support such as the Rhode Island Small Business Development Center, the Rhode Island Small Business Coalition and the RI Department of State Business Services Division.
5. CHWARI: CHWARI could also develop and distribute a small business owner manual that provides basic information regarding setting up and managing one's own business and/or provide a resource list of books and guides regarding small business management.

Impact of Medicaid reimbursement for community health worker services

Some key informants and some interviewees noted that for grant funded CHW services, or for contracted CHW services, CHWs provide the services they deem clients/patients need, without considering time spent in units of service. Their view is that once community organizations bill Medicaid for CHW services in a fee-for-service format, these organizations effectively become medical service organizations, and must consider productivity measures as well as client/patient needs. This can have an impact on the culture of service at an organization, introducing pressure to increase service hours or numbers and types of clients/patients served. This was supported by interviewees who expressed

concern that thinking in quarter hour increments is incompatible with the mission and charge of *community* health workers since working in units of service changes the nature of service provision. They said their CHWs were accustomed to providing the care needed, and making calculations to the minute can undermine that mindset. "*Like if they're out in the community and they're just thinking in units, it is counterintuitive to the work they're doing.*"

In another example of the impact of Medicaid billing, a mission-driven CBO with a specific focus of service worried Medicaid CHW billing could mean their organization would have to address their clients' broad social needs, not just the issue historically addressed by their organization, creating a possibly unwelcome expansion of their mission and necessity to expand their areas of expertise. *"We are mission-driven, not client-driven. …If we continue down this path, are we still being true to who we are as an organization, or are we now trying to be more of a different kind of entity?"*

Recommendations regarding impact of Medicaid reimbursement for community health worker services:

1. EOHHS: EOHHS should reconsider the fee-for-service payment model and reimbursement rates once they have collected sufficient data to inform appropriate changes.
2. EOHHS: Ensure that any restructuring provides a sustainable reimbursement rate for each of the three billing categories—new, individual and group—and continues to support a broad range of services. A sustainable rate should consider the totality of administrative costs (e.g., time spent verifying eligibility, obtaining service recommendations, CHW wage increases and career ladders, and time spent ensuring claims data are entered correctly).
3. EOHHS/RIDOH: It is important to keep in mind that any alternate payment model should include methods for contracting with CBOs and independent CHWs.

Medicaid reimbursement and CHW service sustainability

Medicaid billing supplements existing revenue

To enable an organization or an independent CHW to provide a sustainable program or set of CHW services, costs must be covered and CHWs must earn a living wage.

All organizations in this evaluation study reported that Medicaid billing will supplement, but not fully replace, existing funding sources such as grants or philanthropy. Some interviewees did anticipate Medicaid CHW billing will give them more financial stability by providing a stable source of revenue that can enhance grant or philanthropic funding. As one CBO interviewee noted, *"Medicaid is our best funder right now because you put your Medicaid billing in, and two weeks later you have a check."* Others were finding their volume of Medicaid CHW billing does not cover the costs of providing the service and billing for it.

Perceptions of Rhode Island CHW Medicaid billing rates

Interviewees in all categories of CHW-related work had strong opinions about the CHW Medicaid reimbursement rates in Rhode Island. Organizations asserted the rates are too low to sustain the business of providing quality services. In contrast, two independent CHWs felt the rate either is sufficient or will be sufficient once they fully understand billing for collateral services.

Issues interviewees raised include:

- The static rate does not address pay increases associated with career advancement (e.g., taking on supervisory or other additional responsibilities), does not recognize some organizations pay a

differential rate for CHWs with specialized skills, and does not reflect a pay differential for CHWs who work with difficult caseloads and require more supervision, logistical support, or emotional support.

- Reliability in pay increases can lead to a more stable workforce. One CHW who works for an organization that gives predictable pay raises expressed what all employers would be happy to hear: *"This is actually where I'm going to be retiring from [years from now]. It took me this long to find the career that was for me. I wish I'd found it earlier!"*
- The rate does not cover all expenses involved in providing CHW services (e.g., paying for certification and recertification; time for training and supervision; emotional support of CHWs who work in emotionally complex circumstances; billing and other administrative tasks).
- The increased rate for the first visit does not adequately compensate for the comprehensive nature of intake visits which, as one interviewee explained, *"can be overwhelming".*
- Two employers calculated that at the current billing rate, CHWs need six billable hours/day to cover costs of providing CHW services. They deemed this to be unfeasible due to all the uncompensated time required in doing the work of a CHW.
- As noted earlier, the group rate is not deemed by interview participants to afford sustainability.

Impact of tracking CHW services in quarter hour increments or units of service

While some CBO interviewees felt that tracking services in quarter hour increments is antithetical to their mission (as described above), and some previously did not document time spent, instead focusing on the *types* of services provided, no interviewees expressed actual difficulty in billing for CHW services in quarter hour increments. And some in medical settings noted this is how they have always tracked their CHW time, even before Medicaid billing. Most understood the allowable calculation for rounding up or down to report in quarter hour units. And almost all interviewees reported they or their staff now document their services by noting time started and time ended, either in their EHR or in their notes.

Interviewees appreciated that there is no cap on the number of quarter hour units permitted per day, and recognized they may be underbilling due to confusion about collateral time. At least one organization had the perception that the rate of reimbursement per unit has been kept low to accommodate the possibility of billing 96 units per day. This misconception prompted their suggestion, *"That since claims for any individual Medicaid member are typically far less than 96 units/day, RI Medicaid should reduce the maximum allowable daily units, which would then allow Medicaid to increase the rate paid for each quarter hour."* These interviewees were explaining their perceptions. EOHHS has confirmed that the two issues are not linked, and the rate would not increase should the maximum billable hours/day be decreased.

Alternate payment models

Interviewees believed the way to make CHW services more sustainable is to incorporate CHW services into alternate payment models such as bundled payments or value-based contracting. Some interviewees asserted a flat monthly rate for CHW services for Medicaid members would be preferable to billing in quarter hour increments, as this would allow them to focus entirely on the patients'/clients' needs, and less on time documentation. They warned, however, that this would only be preferable if the rate was sufficiently high to cover all costs inherent in providing the services.

Medicaid reimbursement and CHW service sustainability recommendations:

1. EOHHS: Reconsider the fee-for-service payment model and reimbursement rates once they have collected sufficient data to inform appropriate changes. Ensure that any restructuring continues to support a broad range of services and provides a sustainable reimbursement rate.
2. EOHHS: It is important to keep in mind that any alternate payment model should include methods for contracting with CBOs and independent CHWs and/or continue fee-for-service billing.

Limitations

This study used purposive sampling to include healthcare organizations, independent CHWs and community-based organizations to ensure collection of a range of experiences regarding Medicaid CHW billing. The report findings may not reflect the experiences of other Rhode Island organizations and independent CHWs.

Based on the RI EOHHS Provider Search website, as of July 22, 2023, there were 40 organizations or individuals enrolled as Medicaid CHW providers. While this number continues to grow, it represents a small proportion of possible Medicaid CHW providers in the state. A limitation of this report is that no interviews were conducted with organizations or individual CHWs that chose not to enroll as Medicaid CHW providers.

Discussion

The purpose of this evaluation was to determine how the billing process unfolded in Rhode Island for those early adopter organizations and independent CHWs that enrolled as Medicaid CHW providers, and how billing processes could be improved. Because of the aim of the study, the report's findings lean more toward what needs improvement rather than success stories.

All interviewees were pleased with and grateful for Gainwell Technologies' customer support staff, including the person dedicated to CHW billing. Interviewees had recommendations to improve the written technical support materials provided by Gainwell and EOHHS. Almost all felt that supporting "how-to" videos would be helpful. If EOHHS and Gainwell invest in updating the technical support materials and in creating "how-to" videos, it will be important to do so in conjunction with user input and feedback. Many new Medicaid CHW providers will not have had previous experience with any form of Medicaid billing and may need more detailed orientation to the billing procedures.

Any updated materials should include specific information about what does and does not constitute collateral services. Additionally, Gainwell and EOHHS should consider creating a web-based source of information regarding all billing updates.

Community-based organizations and independent CHWs would like to have templates they can download to track patient encounter data. While not directly covered by this evaluation, it is likely community-based organizations and independent CHWs could benefit from easy to access and easy to understand training materials regarding HIPAA protections. For example, materials should explain requirements regarding storage of paper-based and electronic patient files and the transmittal of patient information to other providers.

Except for two independent CHWs, none of the interviewees assessed the Medicaid CHW rate as adequate to cover all the costs of providing CHW services. When EOHHS reviews the reimbursement rate and model, interviewees felt strongly that it be considered that the rate does not support the following: costs incurred in providing a career ladder and raises for CHWs; CHW supervision; training

regarding billing data entry; time for tracking down Medicaid Anchor numbers; setting up billing systems; and making EHR modifications.

To accommodate coverage of these necessary but non-direct service tasks, many interviewees recommended moving away from a fee-for-service model. Further, they believed changing to bundled payment models would help CHWs focus on service provision to patients and clients in need, rather than spending time deliberating whether a service can be categorized as collateral work or documenting the duration of each service in units of time. Additionally, to encourage new Medicaid CHW providers, EOHHS/RIDOH should consider providing start-up funds to cover the cost of EHR modifications, updates to existing billing software, and time spent setting up HIPAA compliant documentation systems.

Independent CHWs, an unanticipated addition to the RI Medicaid CHW workforce, can broaden the accessibility of CHW services by engaging clients at times and in locations often outside the scope of more traditional CHW providers. EOHHS, the Community Health Worker Alliance of Rhode Island, and the new Alliance for CHW organizations, should explore how to support this important workforce sector as it expands.

Conclusion

Rhode Island recognizes the importance of CHW services and supports services through Medicaid CHW billing. EOHHS and Gainwell have tried to make the enrollment and billing process easy to understand and easy to implement, and for the most part, they have succeeded. For instance, enrolling as a Medicaid provider and as a trading partner is considered by interviewees to be a straightforward process. Gainwell provides excellent customer service throughout the billing process. However, the user manual needs to be updated to be more informative and easy to understand.

The billing issues that interviewees described during qualitative data collection highlight the need for a Medicaid reimbursement rate that is sufficient to cover the cost of providing CHW services. No interviewee believed Medicaid reimbursement will replace other funding streams, but all anticipated that it can provide a stable source of revenue. Interviewees felt that moving to alternative payment methods would be an improvement over the fee-for-service model, but only if the rate is sufficient.

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Appendix 1: Questions interviewees have about billing for CHW services collateral time, and what constitutes legitimate collateral services

1. Providing home care and self-care activities on behalf of a client unable to do so on their own, in this case, due to substance use. Activities include shopping, cooking, self-care help, home maintenance.
    a. If eight hours are spent conducting these activities, is it appropriate to bill for the full eight hours?
    b. Which of these activities are billable and which are not?
2. When a client is in a crisis and calls the CHW, time on the phone talking down the client from the crisis state
3. Driving on behalf of a patient/client, for example, calling in, picking up and delivering a prescription. CHWs recognize that simply driving a client/patient somewhere is not billable unless teaching or health coaching is going on during the drive. But what about the cases where the client/patient is not in the car, and cannot do the health activity themself, such as picking up a medication?
4. Contacting medical providers about a CHW-provided service, coordinating care, providing updates
5. Finding job sites/opportunities for clients
6. Supervision when a particular Medicaid beneficiary case is being discussed. How would that be billed/documented?
7. What happens with the 5 minute phone call that are often needed on a patient's/client's behalf? Many of these brief calls may be necessary within a day, and the time adds up, but since no single call is long enough to bill for, a lot of time goes uncompensated.
8. Preparing applications for a patient that will have ongoing benefit eventual enrollment in the benefit. Is helping prepare the application billable? Is dropping the application off at the appropriate office billable?
9. Example of when a patient receives a medical procedure where it is required to have a support person on site, and/or who will drive them home, as for colonoscopies. Can all of this time, including the driving and waiting for the patient to have the procedure and recover from anesthesia, be billed?
10. When a CHW is with a hospitalized patient helping to sort out patient-related issues
11. Intake calls. Intake calls typically provide information about available resources, and how to access them, some case management, and attention to SDOH as appropriate. Since the Medicaid status or number is not known at the time of the intake call if a patient initiates the call, can this time be billed for retrospectively? Would this involve a standing order?
12. Community agencies and health care organizations may be providing the same or similar services to clients/patients. How does each entity you know who is providing services and what types of services to the same client/patient?

13. Advocacy work. It is assumed that attending IEP meetings at a child's school would be eligible, but what about going to the state house and advocating for services? Or is that an organizational responsibility, outside of CHW services?
14. When a CHW is on the phone with state/governmental agencies sourcing services or clarifying rules around services that will apply to many clients/patients, but not on the behalf of a specific client

Appendix 2: Other questions related to CHW Medicaid billing

- Should social service workers in a medical site get certified as CHWs because the services they provide are similar but they now do not bill for their time?
- If a CHW was already seeing the client before Medicaid billing started, then when the CHW sees the client for the first time that will be billed to Medicaid, can they use the higher rate of the first time code or not?
- If two CHWs are working on different aspects of need for the same patient, on the same day, if services are documented by both CHWs, should the organization add up the units between the two CHWs and bill for them all?
- Some would like advice on providing CHW services according to the Medicaid regualtions for documentation, while not "making it clinical." For example, as one CHW asked, "How can I ask a family that is in distress, in a nice way, that I would like to document all of this through Medicaid?"
- Some would like advice from EOHHS on exactly what is billable in terms of direct services and collateral work. They would like a concise listing of these, not a long manual.
- Some would like advice from EOHHS on how many hours in a day must be billable for sustainability.
- Some are concerned with the ethics of billing a client's Medicaid account without them knowing. If, for example, they receive the client's Medicaid number through their organization, and are now able to bill Medicaid for the CHW services, can they do this without explicitly letting the client know this is happening? (This might be mostly or only applicable in the case of retrospective billing.)

Appendix 3: Community-Based CHW Interview Guide

Background
Introductions: We are conducting an evaluation on behalf of the RIDOH to learn how the new Medicaid billing and reimbursement process is going for key stakeholders. As a CHW who has new reporting and documentation requirements, you can help us understand the impact Medicaid reimbursement has had on your organization, CHWs, and possibly, your clients or patients. 1. How long have you been a CHW? For this organization? 2. Briefly, how did you decide to become a CHW? Do you see being a CHW as an endpoint in your career or as part of a career path within this or another organization? As a career path to other professional roles, e.g., medical field, social services, managerial/management?
3. How many hours per week do you work as a CHW for this organization? 4. Do you provide CHW services for this organization, another organization, or a combination? 5. What are the demographics of or types of patients/clients do you typically serve (adult patients, families, teen moms, etc.)?
6. Is your organization currently billing Medicaid for your services? 7. If yes: About how long ago was it that your organization began Medicaid billing for CHW services? a. What did you think about this change to billing Medicaid for your services? b. What was your initial reaction to the changes Medicaid billing was likely to bring? 8. Were you aware of how your CHW position was funded prior to Medicaid reimbursement? How important is it to you to understand how your position is funded?
Medicaid billing and documenting hours
9. What changes have you experienced or noticed in your organization since the switch to Medicaid billing for CHW services? 10. What changes have you experienced in the specific tasks of your work or your workload since the switch to Medicaid billing for CHW services?
11. What challenges did you experience in learning or implementing any new documentation or billing procedures? 12. What helped you gain proficiency?
13. What types of activities or training helped you in becoming proficient in documenting your hours and billing? Which were the most helpful?
14. Tell us about your experience with documenting or tracking your hours in quarter hour increments. How does this track with how your work actually occurs? 15. How is documentation of 'collateral' work going – that is, for work on behalf of a patient/client but not when you're working directly with that person? 16. If applicable, what happens with billing or documenting your hours when a patient is seeing a health care provider and receiving CHW services at the same time?
17. Overall, how would describe the ease or difficulty with which you transitioned to Medicaid billing?
18. RIDOH allows up 96 units of service per day/client (a 24-hour day.) This helps the CHW account for collateral time, for instance, the time you may spend arranging for a particular patient's services, but you are not directly interacting with the patient. a. What are the benefits or drawbacks to this policy?
19. How much of a typical week are you traveling to see patients?

20. What are other responsibilities or job-related time commitments you have that are not Medicaid reimbursable? (staff meetings, trainings, supervision, travel, other). Over a week's time, what percent of your time do you think is spent in non-reimbursable activities? 21. Are you paid an hourly wage or a salary?
22. What advice would you give other organizations regarding how they prepare their CHWs to meet Medicaid billing requirements?
23. What advice do you have for other CHWs who will be having Medicaid billed for their work?
24. What advice would you give EOHHS regarding how to provide reimbursement for CHW activities?
Monitoring activities
25. How do you document the activities you perform on behalf of your clients/patients? a. How has documentation changed since your organization began Medicaid billing?
CHW certification
26. Have you received your CHW certification? How long ago?
27. How does your organization track CHW certification (or progress toward receiving CHW certification if CHW is not currently certified)?
28. What kinds of things might help or hinder someone from receiving certification? 18-month window to become certified? Training availability? Recertification every two years?
29. Do you know if your organization provides any reimbursement or recognition (monetary, comp time, pay increase, change in responsibilities) for CHW certification training; for achieving certification? a. Are there any penalties for not being certified?
CHW experience
You've already shared with us your experience regarding billing and documentation. We're wondering if Medicaid billing has had any impact on your relationships with your patients/clients. For instance:
30. Do you think that billing in quarter hour increments influences in any way your relationship with your client or patient?
31. Do you think having to keep track and be aware of your patient's or client's insurance status changes in any way your relationship with that client or patient?
32. How has Medicaid billing affected your ability to serve clients who are not Medicaid eligible?
Final recommendations and advice for other CBOs and for RIDOH/EOHHS
33. Some states that are implementing Medicaid billing are using the same model that RIDOH has adopted. But, a few states are taking a different approach to CHW reimbursement. It is still quite early in the new process, but we wonder if you have any thoughts or recommendations for EOHHS about how to improve funding mechanisms for CHW services?
34. Any other recommendations for CBOs? EOHHS? RIDOH? CHWARI?
35. Any other lessons learned?
36. Thank you for your time today!