



Responses to Public Comments: Community Health Workers

Public Comment Period: May 9, 2025 through June 10, 2025

| Category | Nature of the Comments | EOHHS' Response |
|---|--|---|
| Daily/Monthly Unit Limitations (12) | The proposed two-hour daily cap is incompatible with evidence-based programs (which often require 2.5+ hours per session) and acute situations requiring extended CHW involvement. Suggested alternatives included weekly or higher daily limits. | The two-hour daily limit is informed by national best practices adopted by other state Medicaid programs. Requests for additional time may be submitted for prior authorization when clinically appropriate. |
| Objections to LPHA prescription/order requirement (9) | Commenters opposed requiring CHW services to be prescribed or ordered by a licensed practitioner, citing administrative burdens, access delays, and clinical workflow disruption. Many suggested standing orders as a more flexible alternative. | The requirement for a licensed practitioner's order is consistent with federal requirements and ensures necessary oversight by a licensed practitioner healing of the arts (LPHA). Standing orders do not provide sufficient clinical evaluation to determine whether a beneficiary's condition is improving or worsening, which is critical to ensuring appropriate and effective CHW services. |
| Concern about elimination of non-direct services (7) | Concern that disallowing reimbursement for non-direct services (e.g., collateral services like contacting providers or researching resources) would undermine CHWs' ability to coordinate care, especially for clients with complex social needs. Recommended retaining collateral services with appropriate safeguards. | Given the high risk of inappropriate billing when services are rendered without the presence of the Medicaid beneficiary, EOHHS has determined that maintaining the program integrity of the CHW benefit requires that all CHW services must be delivered in the presence of a covered beneficiary. This approach ensures that services are verifiable, appropriately individualized, and directly tied to the needs of the person receiving Medicaid benefits. |
| Support for reimbursement of CHWs working toward certification (6) | Commenters emphasized that CHWs often gain experience while training, and disallowing reimbursement during this period would create a hiring and workforce pipeline barrier. Proposed a limited window (e.g., 6-18 months) for provisional billing. | To ensure Medicaid funds support qualified services, the proposed CHW State Plan Amendment requires CHWs to be fully certified before billing which is consistent with other Medicaid provider types. This standard promotes quality, equity and accountability by ensuring all billed services meet the same credentialing criteria. |
| Call for stakeholder consultation / delayed implementation (6) | Commenters urged EOHHS to delay implementation of key provisions (especially LPHA referral requirement) until January 2026 to allow time for workflow updates, training, and stakeholder input. Many called for structured stakeholder engagement moving forward. | EOHHS has engaged stakeholders throughout the development of the CHW program and remains committed in engaging partners on this Medicaid benefit. However, delaying implementation could jeopardize CMS approval of the benefit in Rhode Island, federal financial participation by CMS to Rhode Island Medicaid as these requirements are necessary to ensure compliance with federal Medicaid law and program integrity standards. |

| Category | Nature of the Comments | EOHHS' Response |
|--|---|--|
| <p>Need to preserve or restore national CHW definitions</p> <p>(5)</p> | <p>Respondents objected to revised CHW definitions that removed “social” aspects of care, stating that it does not recognize the full scope of services provided by CHWs.</p> | <p>The CHW definition in the proposed State Plan Amendment is tailored to meet federal State Plan requirements while recognizing the critical role CHWs play in addressing related social needs as allowable under CMS rules.</p> |
| <p>Request to limiting services to post-diagnosis only</p> <p>(1)</p> | <p>Concerns raised about restricting CHW services to post-diagnosis scenarios, arguing that CHWs are most effective when providing preventive and upstream interventions that address social determinants of health.</p> | <p>CHW services are a preventive Medicaid benefit and may include early prevention when a condition, or risk factor, is identified by an LPHA. The requirement for LPHA documentation ensures appropriate clinical oversight and authorization in alignment with federal Medicaid standards. The documentation requirement does not change the underlying medical necessity criteria for CHW services.</p> |
| <p>Requests for increased or clarified group size/class duration</p> <p>(1)</p> | <p>Some commenters noted that group size caps (e.g., 8 participants) conflict with fidelity standards that require higher numbers (e.g., 12–15). They asked for clarification or increases in group size and session length limits.</p> | <p>The proposed CHW State Plan Amendment establishes group size and duration limits based on the definitions within the applicable CPT codes, as well as national best practices, to support quality and economy of services delivered to Medicaid beneficiaries.</p> |
| <p>Technical concern: CHW services billed in 30-minute increments instead of 15</p> <p>(1)</p> | <p>Commenters asked EOHHS to confirm whether the group education reimbursement rate would be adjusted proportionally to reflect the change from 15-minute to 30-minute units.</p> | <p>Yes, the proposed billing structure uses 30-minute units for session-based CHW Services, and reimbursement rates will be adjusted proportionally to reflect this change. Final rates will be published in the Medicaid fee schedule.</p> |
| <p>Request for CHW advisory group</p> <p>(1)</p> | <p>Commenter requested partnership with CHW Providers and recommended a CHW advisory group.</p> | <p>EOHHS appreciates this recommendation and recognizes the importance of meaningful collaboration with CHW providers and stakeholders. While the establishment of a formal CHW advisory group is beyond the scope of this State Plan Amendment, EOHHS remains committed to engaging CHW providers and stakeholders through existing advisory bodies, public forums, and periodic stakeholder engagement meetings. Additionally, should CHW services transition into managed care organizations (MCOs), there will be further opportunities for stakeholder engagement and advisory participation through MCOs’ provider governance structures, advisory committees, and community forums. We encourage CHW providers to actively participate in these opportunities to provide valuable input into policy and programmatic decisions.</p> |