MILLIMAN REPORT

2025 Social and human service programs review: Accountability standards v1.2

Rhode Island, Office of the Health Insurance Commissioner

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Revision History

Version	Publication Date	Revision
1.0	May 26, 2023	• Initial Publication
1.1	August 31, 2023	• Added Medicaid managed care contract requirements for network adequacy, provider payment, quality assurance and reporting, and value-based purchasing • Added information on the contracting and oversight process utilized by DCYF to procure services for children, youth, and families • Added Child and Family Services Review outcomes
1.2	December 27, 2024	• Updated list of State Directed Payments in Figure 4 • Updated NCQA ratings for 2024 • Updated DCYF Council on Accreditation progress • Noted the publication of CMS final rules impacting access and managed care regulations • Updated the Appendix to include Ticket to Work

Background

Milliman, Inc. (Milliman) has been retained by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) to conduct a comprehensive review of all social and human service programs having a contract with or licensed by the state, inclusive of the State of Rhode Island Executive Office of Health and Human Services (EOHHS) and the state agencies under its purview. This review is required by State of Rhode Island General Laws (RIGL) § 42-14.5-3(t). This statute requires nine assessments covering various rate and programmatic elements of the social and human service programs, with a final assessment being a culmination of the prior nine assessments. Social and human service programs include services in the following subject areas: social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult/adolescent day services, vocational, employment and training, and aging. As a whole, this series of reports may be used as one set of resources to provide education and insight into current Rhode Island social and human service programs' provider reimbursement and programmatic structure.

The first iteration of the Social and Human Service Programs Review was completed in 2023, culminating in the publication of the final report on September 1, 2023. The mandated public meeting subsequently took place on September 22, 2023.[1] This report is part of the 2025 cycle of the review, which is scheduled to conclude with the release of the final report by September 1, 2025, followed by a public meeting in September 2025. The update to programmatic reports is limited to significant program changes noted in the revision history. Benchmark data was not updated.

The rate recommendations included in the final September 1, 2023, report were focused on the Medicaid program. The recommended rates were largely adopted and funded by the State of Rhode Island with an effective date of October 1, 2024, and applied to both the Medicaid FFS and managed care programs. The status of the rate implementation (along with other rate initiatives) is available on the EOHHS website.[2]

This report addresses RIGL § 42-14.5-3 task 5: "an assessment and detailed reporting on accountability standards for services for all social and human service programs."[3] This report provides an overview of the points of oversight for social and human services, providing a summary of the different accountability structures that exist for programs at the state and federal level.

[1] The reports and meeting material for the Social and Human Service Programs Review is available at https://ohic.ri.gov/regulatory-review/social-and-human-service-programs-review.

[2] For more information see https://eohhs.ri.gov/FY25-Medicaid-Rates

[3] The Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight, R.I. Gen. Laws § 42-14.5-3 (2022). http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-3.HTM

Executive Summary

This report details the current accountability standards (see definition per RIGL § 42-14.5-2.1, below) for programs that provide social and human services to the state of Rhode Island. The Executive Office of Health and Human Services (EOHHS) is the lead agency for social services in Rhode Island, overseeing the Department of Human Services (DHS), Department of Children, Youth and Families (DCYF), the Department of Health (DOH), and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). For each in-scope program, this report documents the state and federal levels of oversight, providing a description of high-level reporting requirements, formal advisory groups, and state code citations. This report also provides information regarding specific Rhode Island Medicaid managed care contracting details, highlighting contract requirements for network adequacy, provider payment, quality assurance and reporting, and value-based purchasing. Additionally, this report provides information on the contracting and oversight process utilized by DCYF to procure services for children, youth, and families in Rhode Island, as well as a summary of outcomes identified in the latest Child and Family Services Review.[4]

Programs that are considered in-scope for this report are those that offer a social or human service falling under the directive of (RIGL) § 42-14.5-3(t) which include social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult/adolescent day services, vocational, employment and training, and aging programs. Programs include those that are operated by the state directly or under contract, using policy and procedures established by the state and provide a direct service to an individual. Some programs that are limited to medical services only and are not targeting one of the social or human service areas listed in RIGL § 42-14.5-3(t) are not in scope for this report. Programs inventoried for this report are listed in Figure 1 with the agency which provides program oversight.

As defined by the Rhode Island legislature in RIGL § 42-14.5-2.1:

"Accountability standards means measures including service processes, client and population outcomes, practice standard compliance and fiscal integrity of social and human service providers on the individual contractual level and service type for all state contacts of the state or any subdivision or agency to include, but not limited to, the department of children, youth and families (DCYF), the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid. This may include mandatory reporting, consolidated, standardized reporting, audits regardless of organizational tax status and accountability dashboards of aforementioned state departments or subdivisions that are regularly shared with public."

4 Child and Family Services Reviews Statewide Assessment Instrument. (2018, April 9). Children's Bureau. https://dcyf.ri.gov/sites/g/files/xkgbur416/files/documents/data-evaluation/rhodeisland_2018_cfsr_sa_final.pdf

Below is a list of the programs reviewed in this report.

FIGURE 1: PROGRAM INVENTORY FOR ACCOUNTABILITY ANALYSIS

Executive Office of Health and Human Services (EOHHS)	
• Medicaid 1115 Demonstration Waiver	• Medicaid State Plan Services
• CEDAR Family Services Center	• Rhode Island Early Intervention
Department of Human Services (DHS)	
• The Sherlock Plan	• Katie Beckett Program
• Children's Health Insurance Plan	• Head Start
• Ombudsman Program	• Adult Protective Services
• Rhode Island Pharmaceutical Assistance to Elders Program	• Vocational Rehabilitation & Vocational Rehabilitation for the Blind
• Independent Living and Social Services	• Disability Determination Services
• Business Enterprise Program	• Adaptive Telephone Equipment Loan Program
• Rhode Island Works	• SSI Enhanced Assisted Living Program
• Ticket to Work	
Department of Children, Youth, & Families (DCYF)	
• Family First Prevention Services	• Family Care Community Partnership
• Youth Diversion Programming	• Wayward Disobedient Programs
• Child Protective Services	• Foster Care Licensing
• Rhode Island Training School (RITS)	• Community Services and Behavioral Health
Department of Health (DOH)	
• Nurse Family Partnership	• First Connections
• Lead Poisoning Prevention	• State Tobacco Quitline/RI Nicotine Helpline
• Plans of Safe Care	
Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)	
• Eleanor Slater Hospital and RI State Psychiatric Hospital	• Projects for Assistance in Transition from Homelessness (PATH)
• Access to Independence	

Overview of Accountability Mechanisms

As a basic function of government, all state government programs must be accountable for the services they provide. This accountability assures that the programs achieve their stated intent (per the applicable statutes and regulations) and typically involves oversight by departments within the state (either within the same agency, or sometimes also involving review by other parts of state government or the legislature). In the case of EOHHS, many of its social and human services programs receive funding from a federal government agency (rather than, or alongside state funding) and as such, the federal agency sets additional standards the program must follow as a condition of funding (and in some cases, as a condition of operation). This federal oversight defines many features for the regulatory environment under which the programs must operate. Federal regulations can direct some or all aspects of a program, frequently including criteria such as eligibility standards, required services, and allowable expenditures. Federal regulations sometimes also dictate standards for service provider enrollment, oversight, and payment activities. To assure that state programs are in compliance with federal regulations, federal agencies frequently require state programs to provide regular reports on program activities and can conduct audits of the state programs that they fund or regulate. This report provides a summary of the methods of federal oversight for each program area selected for review under this report, organized by department within EOHHS.

In addition to federal oversight, state programs also must comply with the state statutes and regulations that enable the program at the state level. State requirements under the Rhode Island Code of Regulations (RICR) may, depending on the program, direct eligibility standards, provider standards, reporting requirements, and state funding sources. RICR sometimes also requires oversight or advisory committees to conduct oversight functions regarding agency or program work. Many state programs have specific reports that must be provided to the state General Assembly on a regular basis. This report provides a summary of the state administrative regulations that apply to in- scope programs.

A variety of state staff handle day-to-day management for each program and, to the extent the program utilizes providers or contractors to deliver services under the program, a part of the state staff's role is to assure accountability of these providers and contractors. In this role, state staff provide direct monitoring of contracted activities and may assess damages or other formal consequences when contract standards are not met. There are also state staff who receive reporting (from state systems or from providers/contractors, or both) and are tasked with analyzing the reports and other data to inform assessment of program administration, service delivery, and outcomes. Because legislative, federal, or other external reports may be required for these programs, staff will then package this data into external reports for public sharing or other levels of review outside the department. Phase 1 of this report focused on the external points of accountability that oversee the state administration of programs. Phase 2 of this report adds detail on state contracting process and oversight by EOHHS and DCYF.

It is worth noting that many social services are delivered by health professionals with licensure requirements that are set by the Rhode Island Center for Professional Boards and Licensing. While out of scope for this report, these licensing agencies also conduct oversight of individual providers by establishing and monitoring compliance with licensure requirements, safety and other operational standards, and scope of practice parameters that a professional or provider entity in the state must follow. If these standards are not met, the licensing agency conducts disciplinary actions when needed (up to and including removal of licensure/authority to operate) and may communicate with other state programs regarding these actions, as needed.

Accountability by Department

Each department in scope for this review has specific points of accountability. Some departments are overseen exclusively by one federal oversight agency, while others have diverse programs and are overseen by several federal agencies. Some programs are subject to multiple levels of oversight and accountability, while others have little formal oversight outside of the state agency responsible for the program. The differing levels of accountability can be driven by statute or other authority which enables the program, the level of risk should services not be appropriately provided, the size of the program or budget, and the number of individuals served. In the following sections, this report summarizes each department's purpose, programs, and accountability structure.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

The EOHHS is the lead agency for social services in Rhode Island, overseeing the Department of Human Services, Department of Children, Youth and Families, the Department of Health, and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. Federal requirements stipulate that a single state agency must be designed to administer the Medicaid program for each state; EOHHS serves that role for Rhode Island.[5] The mission of EOHHS is "to ensure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders."[6]

In administering the state's Medicaid program, EOHHS is overseen by the Centers for Medicare and Medicaid Services (CMS), which is part of the United States Department of Health and Human Services (HHS). A primary source of accountability to CMS is the Medicaid State Plan. Each state Medicaid program must be governed by a formally documented state plan, which is "an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs…[that] gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities."[7] The Rhode Island Medicaid State Plan documents who is eligible for services, what services are covered, how services are delivered, how providers are enrolled, and the administrative processes. When a state wants to make a change to any program or administrative element covered by the state plan document, it must go through a public notice and comment process before submitting to CMS for consideration. After submission of a State Plan Amendment, CMS can determine whether the plan continues to meet federal requirements and authorize federal expenditures. Once an amendment is submitted, CMS has 90 days to make a decision, otherwise the proposed change automatically goes into effect. Once approved, changes can take effect retroactively to the first day of the quarter in which the state submitted the amendment. Once approved, an amendment does not expire, but a state can change it through a subsequent amendment.

Global 1115 Demonstration Waiver

Rhode Island has further chosen to deliver the majority of services under its Medicaid program using a type of federal program authority called a 1115 demonstration waiver. A waiver refers to the ability of a state to request to waive certain provisions of Medicaid law to give states additional flexibility to design programs.[8] Section 1115 demonstration waiver is a Medicaid waiver authorized under Section 1115 of the Social Security Act that gives the Secretary of HHS the authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program.[9] 1115 demonstration waivers must include oversight procedures that include public comment periods on any proposed amendments or renewals, independent quality reviews, independent evaluation reports, and regular reporting to CMS on both financial expenditures and program activities.

Programs covered by Rhode Island's global 1115 waiver include RIte Care, Rhody Health Partners, RIte Share, and the Children's Health Insurance Program (CHIP).[10] The format for waiver oversight activities for these

[5] 42 CFR Part 431 Subpart B -- Section 1115 Demonstrations. (n.d.). ecfr.gov/current/title-42/chapter-IV/subchapter-C/part- 430/subpart-B?toc=1
[6] About EOHHS. (n.d.). Executive Office of Health and Human Services. https://eohhs.ri.gov/about-eohhs
[7] Medicaid State Plan Amendments. (n.d.). Medicaid.gov. https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html
[8] About Section 1115 Demonstrations. (n.d.). Medicaid. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about- section-1115-demonstrations/index.html
[9] Ibid.
[10] Rhode Island Comprehensive Demonstration. (2020, June 28). Medicaid. https://www.medicaid.gov/Medicaid-CHIP-Program- Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

programs is outlined below:

- **Public notice and comment:** When a state would like to start, amend, or extend a waiver demonstration, it must provide public notice and allow at least 30 days for the public to provide comments on the proposal. In addition, two public meetings must be held for people to submit comments orally or in writing.[11]
- **Independent evaluation:** States with an 1115 demonstration waiver must contract with an independent evaluator to conduct rigorous evaluation activities.[12] CMS provides guidance on evaluation design development and must approve the final evaluation design. All evaluation reports are posted publicly.
- **Financial reporting:** In addition to the standard financial reporting required in the Medicaid program, 1115 demonstration waiver programs must submit regular budget neutrality reports.[13] Budget neutrality requires that the activities and services covered by the waiver cost no more than the federal government would have spent without the waiver program.
- **Program reporting:** Quarterly and annual programmatic reports document implementation and operational activities. This can include data trends, outcomes, program enrollment, monitoring, and communications. These are reviewed by the federal government and posted publicly on the CMS website.

In Rhode Island, the Medicaid program has been designed such that the vast majority of services are delivered through contracts with managed care organizations (MCOs). The next section of this report highlights the oversight CMS requires for states that opt to utilize managed care as a delivery system for Medicaid.

Medicaid Managed Care Contracting

States that contract with MCOs as the delivery system for some or all Medicaid services must go through several layers of oversight from the federal government including approval from CMS. States must apply for permission from the federal government to operate a Medicaid program under managed care by using one of the following federal authorities: Section 1932(s); 1915 (a) and (b) or section 1115.[14] Rhode Island operates its managed care programs through a Section 1115 waiver.

Regardless of what federal authority is utilized, CMS must review and approve draft contracts and capitation rates before a state can move forward with a contract. CMS reviews contracts to assure that members have adequate protections and appeal rights, that the state has proper oversight documented, and to assure that capitation rates are adequate to assure both provider participation in the program and prudent use of tax dollars. However, within these parameters, states still have a great deal of flexibility in how their Medicaid programs, and managed care programs, are operationalized.

In addition to ongoing federal reporting and program monitoring requirements, states are also required to ensure their Medicaid MCO contracts include a variety of mandatory topics or specific terms. For instance, states are required to document how MCOs must work with members and providers. Federal regulations mandate certain contractual requirements cover the following topics:

- **Member information**: What information must be in a member handbook and on the website, how MCOs must provide translation services, how quickly the call center answers calls, and what methods of communication with members can be utilized. This also includes what marketing materials and activities can be undertaken by the MCO.
- **Enrollment and disenrollment**: How members are eligible to be enrolled and what can cause a member to be disenrolled. These requirements must also detail timeliness for these processes and when they are applicable for each eligibility group.

[11] 42 CFR Part 431 Subpart G -- Section 1115 Demonstrations. (n.d.). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter- C/part-431/subpart-G
[12] 42 CFR Part 431 Subpart G -- Section 1115 Demonstrations. (n.d.). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-G[12]
[13] Ibid.
[14] *Managed Care Authorities.* (n.d.). https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html

- **Network adequacy**: How many providers of each type the MCO must have enrolled to serve members. This can include the maximum time a member must travel to obtain care or maximum length of wait time for an appointment. These requirements typically vary based upon type of provider.
- **Provider payment**: How quickly provider claims must be paid, how disputes must be adjudicated, and some services have directed payments that tell the MCO how much they must pay providers for specific services. Prompt payment requirements are also part of federal regulations.
- **Member rights and protections**: Responsibilities afforded to members including rights to appeal adverse actions, access to information regarding claims and coverages, and prevention from discrimination.
- **Delivery of services**: Guidelines and enforcement mechanisms for required services to be covered by the MCO and for reimbursement to members who receive out-of-network care in qualifying situations.
- **Program integrity**: Specific safeguards and procedures to prevent fraud, waste, or abuse of Medicaid services and funding. Program integrity standards apply in relation to both providers and members.
- **Quality standards**: Alignment with state quality strategy and annual assessments of quality and access to services for plan members.

States are not required to have special health programs or value-based purchasing arrangements. However, if they do choose to operate these programs, they must be documented in contracts.

- **Special programs**: Programs that target special population groups with the goal of incentivizing preventive care or treatment of chronic conditions.
- **Value based purchasing**: Specific performance metrics that must be achieved in order to receive full payment from the state.

MCO contract terms may vary by state or program and often vary in the level of specificity, but all contracts include a basic set of activities and specific requirements mandated by federal law. CMS provides states with a contract checklist to ensure that all federal requirements are included since the contracts are subject to CMS review and approval.[15] Some of these additional requirements include the ability to audit financial records, who may be an owner or subcontractor of an MCO, and several provisions regarding financing such as actuarial soundness and minimum medical loss ratios. In addition to written contract oversight, CMS also requires states to submit annual reports on managed care compliance. CMS requires multiple reports related to managed care financing and access to care. These mandated reports include:

- **Rate certifications:** Rate certification is the process by which CMS reviews Medicaid capitation payments to risk-based managed care plans to verify that the payments are actuarially sound, developed in accordance with generally accepted actuarial principles and practices, appropriate for the population and services, and certified by qualified actuaries."[16] The rate certification report is subject to CMS review and approval before the capitation rates can be implemented for the MCOs.
- **Medical loss ratio:** The medical loss ratio (MLR) is a component of the managed care capitation rate calculation meant to protect Medicaid from paying for excessive health plan administrative expenses or profits by ensuring that a sufficient percentage of the total capitation is spent on medical services or other specified plan benefits.[17] The MLR report shows CMS the percentage of revenue used for patient care at the contract level. States are not required to establish a minimum MLR. Under current regulations, CMS requires states that do set a minimum MLR to set a standard of at least 85%. Failure to meet a minimum MLR of 85% may result in sanctions and repayment of capitation funds to the state.[18]
- **Network adequacy/access to care:** The network adequacy and access to care reports are designed to provide CMS with an analysis and assurance that members can adequately receive necessary services. However, there is no national standard for network adequacy. Instead, states are allowed to

[15] *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval*. (2022). https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf
[15] *Managed care rate setting.* (2015, March 30). MACPAC. https://www.macpac.gov/subtopic/managed-care-rate-setting/
[17] *Medical Loss Ratio in Medicaid Managed Care.* (2022, January). MACPAC. https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issue-brief-January-2022.pdf
[18] Ibid.

establish their own quantitative network adequacy standard. These standards are often based on the time or distance to it would take an individual to reach a particular type of provider or a minimum provider-to-enrollee ratio.[19] Federal law requires Medicaid managed care plans to assure that they have capacity to serve expected enrollment in their service area and maintain a sufficient number, mix, and geographic distribution of providers.[20] These reports help states and CMS identify geographic regions that may not have a sufficient number of providers or specialty services for the surrounding population. New federal rules, noted below, establish additional standards for network adequacy.

- **External quality review:** External quality review (EQR) is an analysis and evaluation carried out by an external quality review organization (EQRO) that reviews Medicaid managed care plans. Federal regulations require states that contract with a MCO to ensure that a qualified EQRO conducts an annual review for each MCO.

MCOs must provide all covered services and follow member cost sharing rules that are determined by the state. They may not choose to cover fewer services or require member co-payments or premiums that were not established by the state. The plan may choose to cover services or offer additional benefits besides what is required by the state. Additionally, the plan is required to pay federally qualified health centers or rural health clinics no less than it pays other providers for the same services.

Finally, CMS mandates an annual managed care program report which provides an overview of each managed care program administered by the state.[21] The report must include information on specific topics including program enrollment and service area expansions, financial performance, encounter data reporting, grievances, appeals, and state fair hearings, availability, accessibility, and network adequacy, quality and performance measures, sanctions and corrective action plans, and beneficiary support system (BSS).

Rhode Island Care Contracts

In compliance with federal law (and state procurement requirements), EOHHS holds contracts with each of its Medicaid MCOs. While the state must comply with the general provisions noted above, there is flexibility within the framework for states to also include state-specific contract requirements. In 2023, Rhode Island contracts with Neighborhood Health Plan of Rhode Island, United Health Care of New England, and Tufts Health Public Plan to provide comprehensive health coverage in the Medicaid program. The contracts are publicly available and posted on the EOHHS website. This report provides information regarding Rhode Island contract provisions that the state utilizes to monitor MCO performance and accountability. These key contract components include network adequacy, provider payment, quality assurance and reporting, and value-based purchasing.

Network Adequacy: In Rhode Island, the contract requirements that address network adequacy are based upon travel time and distance as well as wait time for appointments. For time and distance, the contractor must ensure that every member has access to a provider office located within the lesser of the relevant time or distance standard. Figure 2 details the time and distance standard by provider type. The contract allows EOHHS to grant exceptions to the time and distance standards.

FIGURE 2: TRAVEL TIME IN MCO CONTRACTS[22]

Provider Type	Time and Distance Standard
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home

[19] *Network Adequacy Standards and Enforcement*. (2022, February 3). KFF. https://www.kff.org/health-reform/issue-brief/network- adequacy-standards-and-enforcement/
[20] *42 CFR 438.207 -- Assurances of adequate capacity and services.* (n.d.). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207
[21] *42 CFR 438.66 -- State monitoring requirements.* (n.d.). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part- 438/subpart-B/section-438.66
[22] MCO contract 2.09.02 (UHC 2017-15, Effective Amended July 1, 2024 FINAL)

Provider Type	Time and Distance Standard
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home

Additional contract provisions that address network adequacy are standards requiring the MCO to have the capacity to provide certain services within a given timeframe. For most services, this is measured by the maximum time an individual must wait for an appointment. Figure 3 documents the specific types of care that have a standard for the maximum wait time to obtain that service.

FIGURE 3: APPOINTMENT AVAILABILITY IN MCO CONTRACTS[23]

Appointment	Access Standard
After Hours Care Telephone	Available 24 hours a day, 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within twenty-four (24) hours
Routine Care Appointment	Within thirty (30) calendar days
Physical Exam	Within 180 calendar days
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Appointment	Within 6 weeks
New Member Appointment	Within thirty (30) calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within ten (10) calendar days

On April 22, 2024 CMS released a final rule that is intended to improve access to care for all Medicaid members. The overall goal of the rule is to increase transparency and accountability, standardize data and monitoring, and create opportunities for State to promote active beneficiary engagement in their Medicaid programs, with the goal

[23] MCO contract 2.09.04 (UHC 2017-15, Effective Amended July 1, 2024 FINAL)

of improving access to care. This proposal impacts services delivered via fee-for-service, managed care, and self- directed care. Special focus is given to HCBS services. The provisions of the new rule are phased in over several years. Most access provisions must be implemented at the state level by July 2027.The full text of the rule can be found in the federal register.[24]

Provider Payment/Directed Payments: In a managed care contract, the obligation to pay providers is delegated to the MCO. Some states permit flexibility to the MCOs to set payment rates for their providers. Other states choose to direct their MCOs to pay providers according to specific rates or methods called "directed payments." This is permitted so long as those payments meet criteria established by the federal Medicaid program. There are three types of permissible Medicaid directed payments:

- Minimum or maximum fee schedule: Directing MCOs to pay providers at a particular rate compared to the state's fee-for-service rates or other rate schedule such as the Medicare fee schedule (e.g., no less than or no more than a specified rate schedule). These directives can apply to one service, a set of services, or all covered services
- Uniform rate increase: Directing MCOs to pay a uniform dollar or percentage increase above the base payment rates that have been negotiated by the MCO.
- Value Based Purchasing: Directing MCOs to implement VBP models such as pay for performance or shared savings programs.[25]

A state must submit its proposed directed payment plans to CMS for approval using a standard form called a preprint application. These arrangements are approved for no more than one year at a time and must be resubmitted for continued approval each year. However, in 2020, CMS updated its rules so that states no longer need to submit a preprint for approval of minimum fee schedules based on state plan rates.[26] Directed payment arrangements must be included in managed care contracts and rate certifications for CMS approval, and the state must demonstrate that they are actuarially sound. Managed Care contracts in Rhode Island currently have several directed payment provisions as listed in Figure 4. CMS released a final rule on April 22, 2024 that creates additional regulations for Medicaid directed payments. The regulations in this rule will be phased in over several years. States must be compliant with most portions of the rule by 2028. The full text of the rule can be found in the federal register at CMS-2439-F.[27]

FIGURE 4: CURRENT RHODE ISLAND STATE DIRECTED PAYMENTS

	Payment Requirement	Effective Date
Accountable Entity Program	MCOs that contract with AEs must remit payment for meeting state-specified total cost of care targets and meeting a common set of quality metrics	7/1/2024
Ambulance Rates	Pay no less than the Medicaid FFS Minimum Fee Schedule. No change over SFY 2024	7/1/2023
Ambulatory Dental Anesthesia Facility Fee	Pay no less than the Medicaid FFS Minimum Fee Schedule (% of Medicare) May use generic Code 41899 in lieu of G-Code	7/1/2024
Assisted Living Facility	Minimum fee schedule for assisted living services approved in Medicaid state plan	7/1/2024
Certified Community Behavioral Health Clinic (CCBHC)	Pay no less than the Medicaid CCBHC PPS fee schedule rate	10/1/2024
Children's Therapeutic & Respite	Pay no less than the Medicaid FFS Minimum Fee Schedule No change over SFY 2024	7/1/2023
Chiropractic Services	Pay no less than the Medicaid FFS Minimum Fee Schedule (% of Medicare)	7/1/2024
Care Transformation Collaborative PCMHC	$0.81 PMPM paid to the Care Transformation Collaborative for administration of the program, for each member attributed to providers that meet the OHIC definition of Patient-Centered	7/1/2024

[24] https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services
[25] Directed Payments in Medicaid Managed Care. (2022 June). MACPAC. https://www.macpac.gov/wp-content/uploads/2022/06/June-2022-Directed-Payments-Issue-Brief-FINAL.pdf
[26] 42 CFR 438.6—Special contract provisions related to payment. (2020). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438

[27] Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 F.R. 41002 (to be codified at 42 C.F.R. § 430, 438, and 457). https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf

	Payment Requirement	Effective Date
	Medical Home (PCMH). Administration includes such activities as: practice facilitation, technical assistance, coaching, and learning collaboratives to support practices in achieving the necessary requirements to become NCQA and OHIC recognized as a PCMH upon completion of the program. $3.00 PMPM paid to qualifying PCMHCs for attributed members	
Early Intervention	Pay no less than the FFS fee schedule. No change over SFY 2024	7/1/2023
Home Care Behavioral Health Certification Enhancement	Pay no less than FFS fee schedule	7/1/2022
Home Care Rates	Pay no less than the Medicaid FFS Minimum Fee Schedule	7/1/2024
Home Delivered Meals	Pay no less than the FFS fee schedule	7/1/2024
Hospital Inpatient and Outpatient Rates	Uniform percentage increase 3.1% Increase over 7/1/2023 rates -Includes Level IV Detox Services Contractor must follow payment methodology and state and federal requirements for the Hospital at Home Program. [R.I. Public Law 24419]	7/1/2024
Hospital Labor & Delivery	Pay no less than the FFS Minimum Fee Schedule. 3.3% Increase over 7/1/2023 rates	7/1/2024
Hospital Separate Payment Term	Following CMS approval of this separate payment term, EOHHS will issue quarterly payments to the MCOs outside of the capitation rates, to be paid to hospitals in Rhode Island pursuant to the preprint. The payment will be based upon a uniform percentage increase based upon the estimated difference between Medicaid and the average commercial rate (ACR), adjusted downwards for available funding. The first three quarters will be paid out in an amount equal to 100% of the quarterly value. The last quarter will be paid out at 80% of the quarterly value, with the balance distributed to plans with the final reconciliation for the fiscal year, which will be completed in October, allowing for three full months of claims run-out. The final reconciliation will tie payments to actual utilization during the rating period.	7/1/2024
Katie Beckett Case Management Only	Pay no less than the Medicaid FFS Minimum Fee Schedule (if not providing with MCO staff). No change over SFY 2024	7/1/2023
Nursing Home Increase	6.6% increase over July 1, 2024 rates	10/1/2024
OHIC Rate Review	Pay no less than FFS fee schedule for services subject to OHIC rate review	10/1/2024
Personal Care Shift Differential	Pay no less than the FY22 value of the differential; in FY22 the MCE was directed to increase shift differential modifier from FY21 levels by $0.19 per 15 minutes.	7/1/2022
Person-Centered Medical Home PMPM	$3.00 Per Member Per Month (PMPM) for each member attributed to providers that meet the OHIC definition of Patient-Centered Medical Home (PCMH)	7/1/2022
Pediatric E & M Services	Pay no less than the FFS fee schedule	7/1/2024
Shared Living	Minimum fee schedule for shared living services	7/1/2024

*Rates for Nursing facilities, inpatient hospitals and outpatient hospitals are set annually based on RI General Law.

Quality Assurance and Reporting: Rhode Island monitors quality assurance under its MCO contracts using several methods, including requiring industry accreditation and imposing a variety of reporting requirements. Major quality assurance activities are documented in the following section.

- National Committee for Quality Assurance: The State and EOHHS require the MCOs to meet National Committee for Quality Assurance (NCQA) standards. This includes making sure network providers meet certain quality standards in addition to all state and federal requirements for enrollment. Providers and MCOs are required to maintain minimum levels of accreditation in order to be enrolled and provide services for Rhode Island members. The MCOs are also required to report Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures to EOHHS.

  HEDIS measures are a set of national measures to compare MCOs across the nation and are developed by the NCQA. Since HEDIS is based on nationwide statistics, it allows EOHHS to evaluate the MCOs consistently across plans and understand national comparisons. The quality goal set by EOHHS is for all health plans to be between the 75th and 90th percentile for each HEDIS measure. The HEDIS

measures are broken down into categories and measure things such as preventative services, cancer screening rates, immunization rates, follow-up appointment utilization, and treatment utilization, among other categories.

CAHPS is a quality measurement based on consumer feedback. MCO members are surveyed annually to gauge services and care in order for the MCO to receive their NCQA accreditation.

- NCQA Plan Ratings: The 2024 Health Plan Ratings provide scores for the three Rhode Island health plans, United Healthcare, Neighborhood Health Plan, and Tufts Health Plan.[28] The Plan Ratings score the health plans in three categories: Consumer Satisfaction, Prevention, and Treatment. Consumer Satisfaction is based on member surveys on their plans care, services, and physician quality. Prevention is scored based on how well plans provide screenings, immunizations, and other preventive services. Finally, Treatment is scored based on how well a plan performs in treating chronic and acute conditions. On a scale of 0-5, with 0 being low performance and 5 being high performance, plans had varied overall scores with Tufts Health Plan at 3.5 overall, United Healthcare at 4.5 overall and Neighborhood Health Plan at 4.5 overall.

  Nationwide, NCQA determined ratings for 1,019 plans serving Medicare, Medicaid, Commercial and Exchange populations. In 2022, 36% of plans received a 3.5 rating, 26% of plans received a 4 rating and 7% of plans received a 4.5 rating. Less than 1% of plans earned an overall rating of 5.[29]

- CMS Scorecard: Rhode Island also submits reports from the MCOs to CMS as part of a voluntary federal survey used to create the CMS scorecard. The CMS scorecard was developed to increase public transparency about the programs' administration and outcomes. States and CMS can use the Scorecard to drive improvements in areas such as state and federal alignment, beneficiary health outcomes, and program administration. Overall, Rhode Island falls slightly below the median on the CMS scorecard.[30] For all adult measures, Rhode Island remains above the median for 7 of the 8 measures. Rhode Island falls into the lower quartile in one measure: Comprehensive Diabetes Care. For the Child Quality Measures, Rhode Island remains above the median in 6 of the 9 measures and never into the bottom quartile.

- External Quality Review (EQR): EQR is an analysis and evaluation carried out by an external quality review organization (EQRO) that reviews Medicaid managed care plans. The most recent EQR report for Rhode Island Medicaid was published in April 2024. The full report is available on the EOHHS website.[31] The EQR Report includes a review of the State's Medicaid quality strategy and makes recommendations to EOHHS for improvement. In the report, the EQRO vendor indicates that Rhode Island's quality strategy aligns with CMS requirements and provides a framework for MCOs. However, it provides a set of recommendations that the state should consider in working toward achieving strategic goals.

- Additional Reporting Requirements: EOHHS requires the MCOs to report several clinical data points to monitor quality. The measures and goals may change annually based on EOHHS priorities, but the goal is to collect data to review services and outcomes for members. Specifically, the availability of services, the quality of services received, the value and efficiency of services, and the effectiveness of services. Both clinical and nonclinical reporting allows EOHHS to monitor trends, implement programs to improve quality and outcomes, and plan or initiate programs to continue improvement or address areas of concern. Collecting service level data allows EOHHS to identify and address areas of concern for network adequacy, identify areas of underutilization or overutilization which can be used to set rates or determine marketing and educational initiatives, and analyze the quality of services received from members. These reports include:

  - Accountable Entity (AE) Quality Measure Report: The AE Quality Measure report is submitted annually and measures performance outcomes of each AE based on the Total Cost of Care requirements established by EOHHS. The report helps to measure overall quality and cost of integrated care through the AE program. EOHHS has started to share preliminary outcomes on select measures at EOHHS AE Stakeholder Meetings.[32]

[28] *NCQA Health Insurance Plan Ratings 2024*. (n.d.). National Committee for Quality Assurance. https://reportcards.ncqa.org/health-plans?dropdown-state=Rhode%20Island&filter-state=Rhode%20Island&filter-plan=Medicaid&pg=1

[29] *NCQA Report Cards.* (n.d.). National Committee for Quality Assurance. https://reportcards.ncqa.org/health-plans

[30] *Medicaid & CHIP in Rhode Island.* (n.d.). Medicaid. https://www.medicaid.gov/state-overviews/stateprofile.html?state=rhode- island

[31] Rhode Island Medicaid Managed Care Program All Medicaid Managed Care Plans 2022 External Quality Review Annual Technical Report. (2024 April). IPRO. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-04/RI%202022%20EQR%20ATR%20Aggregate_F2_4.29.24.pdf

[32] *Comprehensive Accountable Entities.* (n.d.). Rhode Island Executive Office of Health and Human Services. https://eohhs.ri.gov/initiatives/accountable-entities/comprehensive-aes

- Alternative Payment Methodology (APM) Report: The APM Report is an annual report that tracks alternative payment methodologies to determine if the payment arrangements improved quality as expected for the specific criteria established.
- Quality Plan and Evaluation (QPE): The QPE is an annual report used to track the progress of each quality improvement project that EOHHS implements.
- Quarterly Quality Improvement Plan Reports: Quality reports that analyze clinical and system issues within the health plan that may create barriers for service for Members. This report is then summarized into an annual report that is also submitted to EOHHS.[33]

Value-Based Purchasing: EOHHS has been working to increase the use of value-based alternative payment models under the Medicaid program through an initiative called the Health System Transformation Project. The preferred method being incentivized through MCO contract requirements is the growth in Accountable Entities (AE). An AE is an integrated provider organization that is responsible for the total cost of care and healthcare quality and outcomes of an attributed population.[34] The goal of this program, stated in the MCO contracts, is to transition "away from fee-for-service payment models through progressive development of value based Alternative Payment Models that incorporate total cost of care and quality performance for an attributed population."[35] The contract has both withholds and incentive payments to support the growth of AEs and other value-based purchasing programs. As a withhold, 0.5% of the monthly capitation payment is withheld and can be earned back by the MCO by meeting the

required threshold of payments that are made under an alternative payment method.[36] The threshold of payments has grown over the course of the contract. For the July 2019-June 2020 contract period, at least 50% of MCO payments to providers were required to be made through an alternative payment method (APM). An MCO could also earn the withhold if they achieved a 5% growth in the overall percentage of payments made through an APM from the previous contract period. These percentages increased in the July 2022-June 2023 contract period to at least 65% of MCO payments to providers made through an APM or a 10% growth from the previous contract period.[37]

The Medicaid Infrastructure Incentive Program, which is part of the Health System Transformation Project, provides funds to incentivize the establishment of AEs. Incentive payments are made to MCOs when they meet key functions of program development, implementation, and oversight of the AE initiative. An AE can also earn performance incentive payments from the MCO by attaining performance requirements that are established in their contract with the MCO. The details of performance requirements are documented in a requirements document developed by EOHHS for MCOs. The document "transitioning to alternative payment methodologies: requirements for Medicaid managed care Partners" is available on-line. The incentive pool total funding amount is derived from a per member per month amount multiplied by the number of attributed lives.

DEPARTMENT OF HUMAN SERVICES

DHS works with community partners "to deliver critical benefits, supports and services to more than 300,000 families, adults, children, older adults, individuals with disabilities and veterans every year."[38] DHS is established with the following mission: "As an agency committed to access and achievement, the vision for the Rhode Island Department of Human Services (DHS) is that all Rhode Islanders have the opportunity to thrive at home, work and in the community."[39] The department website also states: "More specifically, DHS strives to guarantee:

- Families are strong, productive, healthy, and independent.
- Adults are healthy and reach their maximum potential.
- Children are safe, healthy, ready to learn and reach their full potential.

[33] MCO Core Contract Reporting Calendar. (2021, October). Rhode Island Executive Office of Health and Human Services. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-11/11.5-cy22_mco_core_contract_reporting_calendar_2021-10-01-master-draft.pdf
[34] Ibid.
[35] Contract - 3.07
[36] Contract 2.01.01.01
[37] Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners. (2021, July 1). Rhode Island Executive Office of Health and Human Services. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-01/updated-transition- to-apm-december-2021.pdf (page 6).
[38] About Us. (n.d.). RI Department of Human Services. https://dhs.ri.gov/about-us
[39] Ibid.

- Child Care providers deliver high quality education services.
- Older Adults and Seniors and individuals with disabilities receive all necessary services to enhance their quality of life.
- Veterans are cared for and honored."[40]

DHS includes the following departments: the Office of Child Support Services, the Office of Healthy Aging, the Office of Rehabilitative Services, and the Office of Veterans Affairs.[41] This broad range of service areas under the purview of this department brings accountability from multiple sources.

At the federal level, components of DHS programs are overseen by regulators from the U.S. Department of Health and Human Services, including CMS, the Administration for Children and Families, and the Administration for Community Living. Other programs are overseen by the Department of Education, the Social Security Administration, and the Department of Justice. Programs reviewed under the Office of Rehabilitative Services determine medical eligibility for social security and Medicaid, assist individuals with disabilities in choosing, preparing for, obtaining, and retaining employment, and assist individuals with disabilities with living in the community. Vocational Rehabilitation services have federal oversight from the Department of Education. Disability determination services are distinct from other state operations in that their work is completely regulated by the Social Security Administration.

The Sherlock Plan and Katie Beckett program are overseen by DHS however, their main function is to provide a specific population with an eligibility pathway for Medicaid services. Much of the oversight and accountability for these programs comes through the 1115 wavier demonstration and CMS.

The Children's Health Insurance Program is also covered under the 1115 waiver program, but there are specific assurances and reporting to CMS that are distinct from Medicaid, which are done within the Department.

Programs under the Office of Healthy Aging provide advocacy and work to assure physical safety of older adults in Rhode Island. Their federal regulations come mainly from the Older American's Act.[42]

At the state level, several DHS programs have additional oversight bodies. For example, Vocational Rehabilitation is overseen by the Governor's Advisory Council for the Blind whereas the Office of Healthy Aging is overseen by the Advisory Commission on Aging and the Long-Term Care Coordinating Council.

DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

DCYF is the state child welfare, children's mental health and juvenile corrections services agency established with the following mission: "Our mission is to partner with families and communities to raise safe and healthy children and youth in a caring environment."[43]

DCYF includes the following program areas: Child Protective Services, Foster Care, The Division of Youth Development, Family Care Community Partnerships, The Family Service Units; and Community Service and Behavioral Health. DCYF also operates the Rhode Island Training School with federal oversight from the Department of Justice. The Rhode Island Training School (RITS) is a secure correctional program for male and female youth who are detained or sentenced to the facility by order of the Rhode Island Family Court. The RITS provides for the rehabilitation of youth through a comprehensive continuum of services provided in partnership with families, the community and DCYF. All youth incarcerated at the RITS receive educational services in accordance with their academic level or individual education plan.[44]

At the federal level, the work of DCYF is largely overseen by the Administration for Children and Families (ACF), part of the U.S. Department of Health and Human Services. The ACF promotes the economic and social well-being of families, children, individuals and communities through its variety of programs such as the Family and

[40] Ibid.
[41] *Programs and Services.* (n.d.). RI Department of Human Services. https://dhs.ri.gov/programs-and-services

[42] Public Law 114-144 Older Americans Act Reauthorization Act of 2016 (n.d.). https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25- 2020.pdf
[43] *About. (n.d.).* RI Department of Children, Youth & Families. https://dcyf.ri.gov/our-office
[44] *The Rhode Island Training School.* (n.d.). RI Department of Children, Youth & Families. https://dcyf.ri.gov/juvenile-corrective- services

Youth Services Bureau and the Office of Head Start. The ACF also operates the Family First Prevention program and approves state service plans in order to receive Title IV-E funds for mental health services, substance use treatment, and in-home parent skill-based programs for children and youth at risk of entering foster care. ACF accomplishes its oversight in part through several required reports, including those that detail a five-year plan that is tied to ongoing receipt of federal funding through the Family First Prevention Services Act. DCYF must provide expenditure reports that outline its planned and actual expenditures to the federal government. The state must also regularly provide data to several national databases including the U.S. Children's Bureau for the National Child Welfare report and the National Youth in Transition Database. In addition, the state must work with the Administration for Children and Families on a Child and Family Services Review State Assessment approximately every five years.[45] This federal review, also known as the Child and Family Services Review (CFSR), reviews the state's conformity with Title IV-B and IV-E regulations, determines what is happening to children and families who are involved in child welfare services, and assists states in achieving positive outcomes. The review includes two phases: a statewide assessment and an onsite review. The two phases help to determine substantial conformity in seven outcomes and seven systemic factors. States that score outside of conformity must develop a Program Improvement Plan (PIP) and participate in subsequent reviews.[46]

The seven systemic factors which are systems that the state should promote are:

1. The statewide information systems;
2. The case review system;
3. Quality assurance system;
4. Staff and provider training;
5. Service array and resource development;
6. Agency responsiveness to the community; and
7. Foster and adoptive parent licensing, recruitment, and retention.

Within the three domains of safety, permanency, and well-being, seven outcomes are also evaluated:

Safety

1. Children are, first and foremost, protected from abuse and neglect;
2. Children are safely maintained in their homes whenever possible and appropriate;

Permanency

3. Children have permanency and stability in their living situations;
4. The continuity of family and relationships and connections is preserved for children;

Well-Being

5. Families have enhanced capacity to provide for their children's needs;
6. Children receive appropriate services to meet their educational needs; and
7. Children receive adequate services to meet their physical and mental health needs.

Rhode Island underwent its last Child and Family Services Reviews (CFSRs) in 2018. During that review, the state was found not to be in substantial conformity with several identified outcomes and systemic factors. As a result, Rhode Island was required to create a Performance Improvement Plan (PIP). Being found to be out of substantial compliance was not unique to Rhode Island. In the CFSR review process, child welfare agencies in all states were found to be out of substantial compliance in some areas and were required to create a PIP.[47] More information about the process can be found at http://www.acf.hhs.gov/programs/cb.

The federal Children's Bureau (which is an office of the Administration for Children & Families) published a state-by- state performance guide on the latest round of CFSRs (round 3). Figure 5 shows the national indicators and where Rhode Island DCYF scored as a result of the review. The report showed that RI had mixed results, with

[45] *45 CFR 1355.33 -- Procedures for the review.* (n.d.). https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-G/part-1355/section-1355.33
[46] *Child and Family Services Reviews Statewide Assessment Instrument.* (2018, April 9). Children's Bureau. https://dcyf.ri.gov/sites/g/files/xkgbur416/files/documents/data-evaluation/rhodeisland_2018_cfsr_sa_final.pdf
[47] *Round 3 of the CFSRs.* (2022, December 15). Children's Bureau. https://www.acf.hhs.gov/cb/monitoring/child-family-services- reviews/round3#map_states_text_data

outcomes that were at or better than national performance for some measures but worse than national performance for others. Rhode Island performed better than national performance in placement stability. They performed at national standard for foster care re-entry. Rhode Island performed worse in maltreatment in foster care, recurrence of maltreatment in foster care, and all permanency measures. Based on the results of the round 3 CFSR, Rhode Island noted three strategic goals to improve DCYF:[48]

1. Improve overall consistency in investigations and safety and risk assessments.
2. Improve the service array of community-based and home-based services.
3. Improve face-to-face contact between the DCYF worker and the child. The next CFSRs (Round 4) is scheduled for FY 2022 through FY 2026.

The next round CFSRs (Round 4) is scheduled for FY 2022 through FY 2026.

FIGURE 5: SUMMARY OF RI RESULTS 2018 CFSR[49]

National Indicator	Rhode Island Round 3 Result
Maltreatment in Foster Care	Worse than national performance
Maltreatment Recurrence	Worse than national performance
Permanency within 12 months	Worse than national performance
Permanency 12-23 months	Worse than national performance
Permanency 24 months or longer	Worse than national performance
Placement stability	Better than national performance
Foster care re-entry	No different than national performance

Figure 6 shows how other CMS Region 1 states compare to Rhode Island. State performance is standardized and compared to national performance on set measures. Results are documented and rated as better than national performance, no different than national performance, or worse than national performance.

FIGURE 6: COMPARISON OF RI CFSR RESULTS WITH OTHER CMS REGION 1 STATES[50]

National Indicator	State	Results
Maltreatment in Foster Care	**Rhode Island**	**Worse than national performance**
	Connecticut	Better than national performance
	Maine	No different than national performance
	Massachusetts	Worse than national performance
	New Hampshire	Better than national performance
	Vermont	Better than national performance
Maltreatment Recurrence	**Rhode Island**	**Worse than national performance**
	Connecticut	Worse than national performance
	Maine	Worse than national performance
	Massachusetts	Worse than national performance
	New Hampshire	Better than national performance
	Vermont	No different than national performance
Permanency within 12 months	**Rhode Island**	**Worse than national performance**
	Connecticut	Worse than national performance
	Maine	Worse than national performance
	Massachusetts	No different than national performance
	New Hampshire	No different than national performance
	Vermont	Worse than national performance
Permanency 12-23 months	**Rhode Island**	**Worse than national performance**
	Connecticut	Worse than national performance
	Maine	Worse than national performance
	Massachusetts	Worse than national performance
	New Hampshire	Worse than national performance
	Vermont	No different than national performance
Permanency 24 months or longer	**Rhode Island**	**Worse than national performance**

[48] *Rhode Island Child and Family Service Review Round 3 Program Improvement Plan.* (2019, January 1). https://dcyf.ri.gov/sites/g/files/xkgbur416/files/documents/news/ri-cfsr-pip-2019.pdf
[49] *CFSR Round 3 Statewide Data Indicators Workbook*. (2021, July). Children's Bureau. CFSR Round 3 Statewide Data Indicators Workbook July 2021 (hhs.gov)
[50] Ibid.

National Indicator	State	Results
	Connecticut	Worse than national performance
	Maine	No different than national performance
	Massachusetts	Worse than national performance
	New Hampshire	No different than national performance
	Vermont	Better than national performance
Placement stability	**Rhode Island**	**Better than national performance**
	Connecticut	Better than national performance
	Maine	Better than national performance
	Massachusetts	Worse than national performance
	New Hampshire	No different than national performance
	Vermont	Worse than national performance
Foster care re-entry	**Rhode Island**	**No different than national performance**
	Connecticut	No different than national performance
	Maine	Worse than national performance
	Massachusetts	Worse than national performance
	New Hampshire	Worse than national performance
	Vermont	No different than national performance

Under the Family First Act, states are required to create a Title IV-E Prevention Service Plan. Each plan must be reviewed and approved by the US Children's Bureau.[51] Rhode Island's Title IV-E Prevention Services Plan was approved in 2022. States use this plan to provide a basic foundation for expanding and strengthening prevention services. DCYF is required to report to the Children's Bureau on the provision of services in the approved Title IV-E Prevention Plan, which should include information and data necessary to determine the performance measures.[52]

In order to comply with federal reporting requirements and to allow for state-directed performance assessment, the state's Office of Data Analytics, Evaluation, and Continuous Quality Improvement within DCYF evaluates the well- being of families and children in Rhode Island. The Office provides a robust offering of reporting on the public website located at https://dcyf.ri.gov/data-analytics. Available reports include the following areas:

- Juvenile Justice
- National Child Welfare Data and Reports
- Safety Data and Reports
- Permanency Data Analytic Reports
- Program Impacts, Outcomes, and Reports
- Child and Family Functional Assessment Reports
- National Youth in Transition Reports
- Prevention Program Reports
- Child and Family Services Review (CFSR)

At the state level, The Office of the Child Advocate serves as the oversight agency to the DCYF. The Office of the Child Advocate monitors the operations of each DCYF unit to ensure compliance with internal policies and protocols as well as state and federal law.[53] The mission of the Office of the Child Advocate is "to protect the legal rights of children in State care and to promote policies and practices which ensure that children are safe, that children have permanent and stable families, and that children in out of home placements have their physical, mental medical, educational, emotional and behavioral needs met."[54] Rhode Island state law requires DCYF to provide annual reports to the Governor and legislature on the topics of child protective services, foster care licensing, and children's behavioral health services.[55]

DCYF will soon be subject to additional accreditation standards. DCYF, at the direction of RIGL 42-72-5.3, is seeking to gain national human services accreditation by the Council on Accreditation (COA). The Council on

[51] *Title IV-E Prevention Program*. (n.d.). https://www.acf.hhs.gov/cb/title-iv-e-prevention-program
[52] Ibid.
[53] *About OCA. (n.d.). Rhode Island Office of Child Advocate.* http://www.child-advocate.ri.gov/about/
[54] Ibid.
[55] R.I. Gen. Laws § 42-73-2.1. Child Advocate Office. http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-73/INDEX.htm

Accreditation states that "accreditation provides a framework to manage resources, offer best practices, and strive for continuous improvement. This supports an organization's sustainability, encourages its growth, and helps it to achieve measurable results."[56] The process is a multi-year effort with a current estimate of achieving accreditation in early 2025. The COA site visit occurred in November 2024 and a decision regarding readiness for accreditation is pending. This would apply to the entire department rather than a single program. After receiving initial accreditation there is a reaccreditation process every four years that includes a self-study.

Provider Contracting Process

DCYF contractors join the program via a public procurement process. DCYF contracts with independent providers to deliver many of the services offered through their programs, including foster care, Family Care Community Partnerships (FCCP), and behavioral health services. Contracts with these providers must go through the public procurement process overseen by the Rhode Island Department of Administration. However, unlike services delivered by Medicaid contracted MCOs, these provider contracts are not reviewed by a federal oversight agency (the Administration for Children and Families). This creates a lower level of federal scrutiny on providers for child welfare services when compared to Medicaid managed care contracts (where there is both a state procurement process and CMS reviews the state's contracts prior to effectuation). Most states utilize a procurement process for services, however Rhode Island process, as described below, is less common.

In 2016, DCYF began utilizing a request for proposals (RFP) strategy known as "active contract management" that was developed by the Harvard Kennedy School.[57] The goal of active contract management is to use data and participant input to create a solution-oriented approach to government contracting. This new process resulted in a large number of contracts being procured at a single point in time and producing a common cycle for renewal for all of these providers. In the RFP process, DCYF issues a solicitation for services that are needed and providers respond with proposals on how they will provide the service, meet contractual requirements, and their rate for providing that service. This process allows for inherent variations in cost-based reporting since each provider may have different levels of expenses or different economies of scale. While this process does potentially allow for rates to support provider's individualized costs, it may create inefficiencies compared to using a standard fee schedule and does not necessarily encourage efficiencies or improved processes. In contrast, many states release an RFP for services with a rate per service already established, which providers must accept as a condition of contracting.

While this structure results in some contracting terms that are unique to each provider, the DCYF provider contracting process does allow for the application of certain standard terms that apply to all vendors. The standard contracting language incorporates boilerplate language on program requirements and requires the provider to make certain assurances for how it will do business with the state. The unique language in each contract is derived from the vendor's response to the RFP indicating how the provider will monitor its own program performance. This language includes key performance objectives and metrics developed by the vendor, which are then accepted by the state. One component of the boilerplate contract is an addendum regarding the active contract management process and formally notes that the scope of work proposed by the vendor shall define the key performance objectives that DCYF will apply. The active contract management process also requires that a provider must meet regularly with the department and comply with data collection and reporting as defined by the department.

Currently, however, the contracts do not specify detailed reporting requirements, specific data points, or reporting timelines, and lack performance withholds as well. The contracts also do not have provisions for liquidated damages as a contract enforcement mechanism. The absence of performance standards or penalties may limit the ability of DCYF to influence contractor performance. DCYF staff indicated that they have not terminated a contract with a provider based on performance since beginning use of the active contract management framework. DCYF staff also indicate that there is an overall shortage of willing providers, which further inhibits the agency's ability to influence provider performance.

DCYF must sometimes utilize out of state residential contracts due to a lack of capacity with in-state providers. When these placements occur, DCYF creates a single source contract and must agree to payment rates that match the other state's rate for the service.

[56] *Why Accreditation*. (2020, April 8). Council on Accreditation. https://coanet.org/why-accreditation/
[57] Active Contract Management: How Governments Can Collaborate More Effectively with Social Service Providers to Achieve Better Results. (n.d.). https://govlab.hks.harvard.edu/files/govlabs/files/active_contract_management_brief.pdf

DEPARTMENT OF HEALTH

DOH is established with the following mission: "prevent disease and protect and promote the health and safety of the people of Rhode Island."[58] In addition, DOH lists as its "leading priorities" that it will:

- "Address the socioeconomic and environmental determinants of health
- Eliminate health disparities and promote health equity
- Ensure access to quality health services for all Rhode Islanders, including the state's vulnerable populations"[59]

The Center for Professional Boards and Licensing within the DOH issues licenses for a broad array of professionals and facilities in the state.[60] Most medical providers and a number of those who provide social and human services are licensed by the DOH in Rhode Island. This includes home care providers, behavioral analysts, chemical dependency professionals, school-based health centers and social workers, just to name a few. The full list of licensee types can be found on the DOH website at: https://health.ri.gov/licenses/.

At the Federal level, programs run by the Department of Health mostly fall under the oversight of Centers for Disease Control and Prevention (CDC). Health department programs that are in-scope for this report include those that fall under the umbrella of social and human services but exclude those that are medical only. For instance, the woman's cancer screening program provides breast and cervical cancer screening services and is thus being considered an out-of-scope medical program. Lead poisoning and the State Tobacco Quitline were identified as prevention services and are in scope for this report.

At the state level, the Center for Professional Boards and Licensing is required to follow a public notice process for any non-technical revision to a regulation.[61] The advanced notice of proposed rulemaking process allows the DOH to "gather information and solicit comments and recommendations from the public."[62] This process requires a minimum of 30 days for public comment. Public hearings may be scheduled on the proposed regulation within the 30-day comment period.[63]

Furthermore, the RI Department of Health is accredited by the Public Health Accreditation Board, which notes "Accreditation demonstrates the capacity of the public health department to deliver the three Core Functions of public health—assessment, policy development, and assurance—and the 10 Essential Public Health Services, which provide a fundamental framework for describing public health activities."[64] This accreditation process requires DOH to report on specific measures established within the 10 domains identified as Essential Public Health services and undergo a site visit to review and assess documentation. To maintain accreditation status, DOH must be reaccredited, by being evaluated against a set of national standards, every five years.[65]

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS

BHDDH is established with the following mission: "BHDDH guarantees high-quality, safe and accessible health care services for all individuals with differing intellectual/developmental abilities, mental health or substance use disorders, or who are in the care of facilities administered by BHDDH through an integrated healthcare landscape, in which all Rhode Islanders will thrive."[66]

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals provides services to Rhode Island residents with mental illness, substance use disorders, or developmental disabilities. The Department also operates two acute care state hospitals that serve these individuals.

A core function of the BHDDH is to oversee the Community Mental Health Services Block Grant (MHBG) and

[58] *Public Health Accreditation. (n.d.).* Rhode Island Department of Health. https://health.ri.gov/about/accreditation/
[59] *About Us. (n.d.).* Department of Health. https://health.ri.gov/about/
[60] *What we License. (n.d.).* Department of Health. https://health.ri.gov/licenses/
[61] *Regulations. (n.d.).* Department of Health. https://health.ri.gov/regulations/
[62] *Regulations. (n.d.)*. Department of Health. https://health.ri.gov/regulations/
[63] Ibid.
[64] Public Health Accreditation Board. (February 2022). *Policy for National Public Health Department Initial Accreditation*. https://phaboard.org/wp-content/uploads/Policy-for-Initial-Accreditation-Version-2022.pdf
[65] Ibid.
[66] *Department of Behavioral Healthcare, Developmental Disabilities & Hospitals.* (n.d.). Dept. of Behavioral Healthcare, Developmental Disabilities, and Hospitals. https://bhddh.ri.gov/about-us

Substance Abuse Prevention and Treatment Block Grant (SABG) awarded from the Substance Abuse and Mental Health Services Administration (SAMHSA) a part of the United States Department of Health and Human Services.[67] The Community Mental Health Services Block Grant is a federal program that makes funds available to states to provide comprehensive community mental health services.[68] State agencies that are awarded block grant funds must meet performance requirements established by SAMHSA that detail how funds are to be utilized, distributed and the monitoring of programs that are awarded funds.[69] The Substance Abuse Prevention and Treatment Block Grant, like the MHBG, are funds awarded to all states to "help plan, implement, and evaluate activities that prevent and treat substance abuse."[70] The state must adhere to the federal requirements for distribution and oversight of these federal funds. BHDDH guides strategic planning and oversight for prevention programs across the state and distribute prevention funds to programs.

Another core function of BHDDH is to provide licensure and oversight to providers within the state of Rhode Island with the goal of assuring quality service delivery. This includes "licenses for organizations that provide Behavioral Healthcare Services, Services for Persons with Intellectual/Developmental Disabilities, and Services for Persons with Cognitive Disabilities."[71] As such, they evaluate data and program outcomes for those populations with behavioral health needs or developmental disabilities. As noted in the report overview, this report will focus on external points of accountability and will not detail provider licensing activities.

BHDDH is also responsible for the operation of two state hospitals that provide residential treatment to individuals with the highest acuity behavioral health needs. These facilities have some oversight from the Governor's Council on Behavioral Health. This includes an annual report to the Governor and Legislature on the council's activities, performance, needs, plans for address healthcare needs, or other recommendations.[72] The Governor's Council of Behavioral Health was established by R.I. Gen. Laws § 40.1-29-5 with the directive to "advise the governor and general assembly on policies, goals, and operations of the behavioral health program, including the program areas of substance use disorder and mental health, and on other matters the director of behavioral healthcare, developmental disabilities and hospitals refer to it and to encourage public understanding and support of the behavioral health program.[73]

Method of Review for Accountability Inventory

To assess the landscape of how oversight is performed for each program, we performed a detailed document review for each in-scope program operated by departments within EOHHS as listed in Figure 1. Materials reviewed include state statutory and regulatory language, EOHHS website information, and various program materials as provided by EOHHS and department staff. In preparing this review, we identified several state web pages that were out of date; where possible, we worked with EOHHS staff to confirm the correct program information. However, to the extent that other inaccurate details are noted in the website information but were not flagged through these discussions, this may impact overall findings of the information reported here.

We developed detailed program summary tables (provided in Appendix 1) for each program to document the state agency responsible for the program and the department or office within the agency that provides direct oversight of the program, as well as the oversight mechanisms in place for each program. Figure 7 below provides an overview of the types of program information that may be found in each summary table.

Beyond listing the responsible state agency, each entry in the Appendix provides information about the federal governmental body that has oversight of the program, if applicable. For programs with federal oversight, required reporting is noted. At the state level, any known external state oversight, e.g., groups outside of the department who provide direct oversight, are listed. This could include advisory committees or councils that the state agency is required to provide with program reporting or for which the state must convene and participate in regular meetings. Any known reporting that is required by a state oversight body or state regulation is also listed. Any

[67] *Grants And Prevention Programs* (n.d.). Dept. of Behavioral Healthcare, Developmental Disabilities, and Hospitals. https://bhddh.ri.gov/prevention/grants-and-prevention-program
[68] *Community Mental Health Services Block Grant*. (n.d.). https://www.samhsa.gov/grants/block-grants/mhbg
[69] Ibid.
[70] Ibid.
[71] *BHDDH Quality Management Unit.* (n.d.). Dept. of Behavioral Healthcare, Developmental Disabilities, and Hospitals. https://bhddh.ri.gov/quality-management-report-suspected-abuse
[72] R.I. Gen. Laws § 40.1-29-5. Governor's Council on Behavioral Health. http://webserver.rilin.state.ri.us/Statutes/TITLE40.1/40.1- 29/40.1-29-5.htm
[73] R.I. Gen. Laws § 40.1-29-2. Governor's Council on Behavioral Health. http://webserver.rilin.state.ri.us/Statutes/TITLE40.1/40.1-29/40.1-29-2.htm

special considerations or additional information on oversight are also noted.

FIGURE 7. PROGRAM ACCOUNTABILITY SUMMARY

Program Description	A short description of the program that includes the main service(s) offered and the target eligible population for the program.
State Agency Responsible	The state agency with ultimate accountability for the program.
Department or Office Responsible	The department of state government that provides day to day operational oversight of the program.
Federal Oversight Body	The Federal department or agency that is responsible for oversight.
Required Federal Reporting	A summary of the type of reporting that is required by the federal government for the program.
External State Oversight	Any state entity, outside of the specific department that operates the program, that has an oversight or accountability role. This could be different agencies that perform oversight functions or advisory councils or committees.
State Required Reporting	Reporting that is required by a state regulation.
Special Considerations	Any additional points of interest or relevant details about overall accountability.

The summaries provide a concise listing of the multiple points of accountability that exist for Rhode Island's health and social service programs. The majority of programs have federal oversight that includes required program reports and, in some instances, independent evaluation. As noted previously, states must assure that they are meeting federal requirements in order to secure and maintain federal funding. At the state level, a variety of reporting requirements provide transparency on state programs and activities for interested stakeholders.

Summary

As illustrated across the services reviewed in this report, there are multiple layers to state program accountability that originate from federal government requirements, state general assembly requirements, and state administrative code. Programs – and their vendors and providers – can be held accountable for fiscal stewardship, transparency, programmatic operations and outcomes, member protections, provider protections, and contractual compliance. While a range of oversight tools are used by each program reviewed, not all programs fully utilize the potential set of tools to assure that accountability. The purpose of this report is to provide an educational summary of the points of accountability that exist for social and human service in Rhode Island. In addition, this report provides selected outcomes information for certain program areas, where publicly available.

Limitations

The information contained in this report has been prepared for the State of Rhode Island, Office of the Health Insurance Commissioner (OHIC) and their advisors. Milliman's work is prepared solely for the use and benefit of the OHIC in accordance with its statutory and regulatory requirements. Version 1.2 of this report has been limited to updates deemed substantial and significant at the request of the client and was not a complete revision or review of all EOHHS programs and departments. Milliman recognizes this report will be public record subject to disclosure to third parties, however, Milliman does not intend to benefit and assumes no duty or liability to any third parties who receive Milliman's work. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety.

The recommendations or analysis in this presentation do not constitute legal advice. We recommend that users of this material consult with their own legal counsel regarding interpretation of applicable laws, regulations, and requirements.

In preparing this information, we relied on information provided by EOHSS and the Departments under EOHHS oversight. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Ian McCulla is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

Appendix 1: Program Accountability Inventory

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Medicaid 1115 Demonstration Waiver

Program Description	Medicaid managed care program that provides health coverage to qualified Rhode Islanders through programs designed to address specific health needs. Programs that are operated under the waiver include RIte Care, Rhody Health Partners, RIte Share, Katie Beckett Program, The Sherlock Plan, and the Children's Health Insurance Program (CHIP)
State Agency Responsible	EOHHS
Department or Office Responsible	EOHHS - Medicaid Program
Federal Oversight Body	CMS
Required Federal Reporting	▪ External Quality Review Organization (EQRO) reports ▪ MCO reports ▪ State quality assurance monitoring and reporting ▪ General financial reporting requirements ▪ Eligibility and member enrollment reporting ▪ Budget neutrality reporting ▪ CMS Quarterly operations and annual evaluation reports
External State Oversight	▪ EOHHS Managed Care Oversight Team ▪ EOHHS Pharmacy Committee ▪ Medical Care Advisory Committee ▪ Governor direction and supervision for global waiver (R.I. Gen. Laws § 42-7.2-5) ▪ State Budget Office, House Representative and Senate Representative Caseload estimating conferences to anticipate needed resourced Legislature- R.I. Gen. Law § 35-17-1 (Rite Share)
State Required Reporting	▪ Work with the Care Transformation Collaborative of Rhode Island ▪ Annual reporting on the status of the global waiver to the legislature ▪ Annual reporting on which employer sponsored insurance plans qualify for Rite Share

Medicaid State Plan Services

Program Description	Traditional Medicaid health coverage for those not enrolled in managed care and the basis for Medicaid operational requirements in Rhode Island.
State Agency Responsible	EOHHS
Department or Office Responsible	EOHHS - Medicaid Program
Federal Oversight Body	CMS
Required Federal Reporting	State quality assurance monitoring and reporting General financial reporting requirements Eligibility and member enrollment reporting
External State Oversight	Regular reports to the Governor and make recommendations with respect to the state's health and human services agenda (R.I. Gen. Laws § 42-7.2-5) Medical Care Advisory Committee
State Required Reporting	Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda Annual Medicaid Expenditure Report- Medicaid expenditures outcomes, administrative costs, and utilization rates
Special Considerations	Routine reporting to CMS on all aspects of financing, service delivery, enrollment and program integrity. The Federal Government also operates routine reviews and audits of state data, including annual audits performed by the federal Office of the Auditor General. All services offered through traditional Medicaid must be fully documented in the Medicaid State Plan. This document is maintained by the state to assure compliance with Federal Medicaid participation requirements. Amendments to the state plan require a public notice process. The state plan documents eligibility requirements and processes, covered services, and program and financial administration. State plan documents are available on the EOHHS web stie at: https://eohhs.ri.gov/reference-center/medicaid-state-plan-scanned-pdf-version

Cedar Family Services Center

Program Description	Intensive care management and coordination for children and youth with special health care needs and their families.
State Agency Responsible	EOHHS
Department or Office Responsible	EOHHS
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	As a provider, CEDAR is required to report performance measures to EOHHS, at least annually. EOHHS reserves the right to request performance measures more frequently. Performance measures are operational goals that can result in incentive payments. For

Rhode Island Early Intervention

Program Description	Program to provide early diagnosis and treatment for a child who shows a delay in speech, physical ability, or social skills.
State Agency Responsible	EOHHS
Department or Office Responsible	EOHHS
Federal Oversight Body	U.S. Department of Education, Office of Special Education Programs
Required Federal Reporting	Annual Individuals with Disabilities Act (IDEA) performance report detailing annual compliance and performance outcomes such as measures on enrollment and outcomes for children served.
External State Oversight	All federal IDEA reports shall be submitted to the speaker of the house, president of the senate and the chairpersons of the appropriate house of representatives and senate oversight committees and the governor and the interagency coordinating council. (R.I. Gen. Laws § 23-13-22)
State Required Reporting	Annual Performance Report for IDEA detailing annual compliance and performance outcomes such as measures on enrollment and outcomes for children served.
Special Considerations	N/A

DEPARTMENT OF HUMAN SERVICES

The Sherlock Plan

Program Description	A Medicaid eligibility category for adults with disabilities who are actively employed and ages 65+.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS
Federal Oversight Body	CMS
Required Federal Reporting	Individuals enrolled are included in comprehensive Medicaid reporting.
External State Oversight	DHS shall report annually to the governor and chairpersons of the house and senate finance committees (R.I. Gen. Laws § 40-8.7-9).
State Required Reporting	Annual reporting on eight categories such as the number of beneficiaries, Medicaid claims, and demographics.
Special Considerations	This program provides eligibility for Medicaid services. Oversight of those services is generally provided through Medicaid program oversight activities.

Katie Beckett Program

Program Description	A Medicaid eligibility program for children under age 19 who have long term disabilities or complex medical needs, with the goal of providing care at home.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS
Federal Oversight Body	CMS
Required Federal Reporting	Individuals enrolled are included in comprehensive Medicaid reporting.
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	This program provides eligibility for Medicaid services. Oversight of those services is generally provided through Medicaid program oversight activities.

Children's Health Insurance Plan (CHIP)

Program Description	Health coverage for children up to age 19 and pregnant women with incomes above traditional Medicaid limits but within CHIP income guidelines.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS
Federal Oversight Body	CMS
Required Federal Reporting	Annual CHIP Reporting and 1115 reporting Quarterly CHIP reports
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	Individuals enrolled in the CHIP program are served through the 1115 waiver program. See 1115 Demonstration Waiver for additional oversight requirements.

Head Start

Program Description	Head Start programs offer services to children from birth to age 5 to support early learning and development, health, and family well-being.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS
Federal Oversight Body	HHS- Administration for Children and Families
Required Federal Reporting	Semi-annual reporting of ongoing oversight data to the governing body and policy council. Annual publication of community assessment Ongoing incident reporting within 7 days of any incidents affecting the health and safety of participants
External State Oversight	Head Start Collaboration Office- collaboration between state and local programs. Facilitate stakeholder input and discuss regional programming
State Required Reporting	N/A
Special Considerations	DHS Office of Child Care is the Head Start Collaboration Office while the majority of funding and oversight of providers comes from the Health and Human Services Administration.

Ombudsman Program

Program Description	Rhode Island's Long-Term Care Ombudsman advocates on behalf of residents in care facilities, listening to their concerns and taking action to protect their rights.
State Agency Responsible	Department of Human Services
Department or Office Responsible	Office of Healthy Aging
Federal Oversight Body	Department of Health and Human Services - Administration for Community Living- Assistant Secretary for Aging
Required Federal Reporting	Annual report on Office activities based on the Older American's Act
External State Oversight	Annual Report submitted to the governor, legislature, director of Department of Health, and Long-term Care Coordinating Council
State Required Reporting	Annual report on Office activities required by 218-RICR-40-00-1. The report shall include the information required by the Older Americans Act and contain analysis and recommendations for improving the program.
Special Considerations	N/A

Adult Protective Services

Program Description	Reporting entity for elder abuse and neglect cases in Rhode Island
State Agency Responsible	Department of Human Services
Department or Office Responsible	Office of Healthy Aging
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	R.I. Gen. Laws § 42-66-7 Advisory Commission on Aging- The commission shall meet at the call of the governor or the chairperson and shall make suggestions to and advise the governor or the director concerning the policies and problems confronting the aged and aging of the state.
State Required Reporting	N/A
Special Considerations	In 2019, the Attorney General created the Special Victims Unit to handle cases involving domestic violence, sexual assault, child abuse, child molestation and elder abuse.

Rhode Island Pharmaceutical Assistance to Elders Program

Program Description	Provides financial support to qualifying individuals to cover part of the cost of approved medications purchased under the deductible of a Part D plan.
State Agency Responsible	Department of Human Services
Department or Office Responsible	Office of Healthy Aging
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	Annual Report submitted to the governor, Budget Officer, Legislature, Board of Pharmacy (R.I. Gen. Laws § 42-66.2-9)
State Required Reporting	Annual Reports on the number of consumers eligible for the program, the number of consumers utilizing the program, the number of appeals, an outline of problems encountered in the administration of the program and suggested solutions to the problems, and any recommendations to enhance the program. Annual Report on the financial and utilization statistics as to drug use by therapeutic category, actuarial projections
Special Considerations	N/A

Vocational Rehabilitation and Vocational Rehabilitation for the Blind

Program Description	Program to assists individuals with disabilities, including individuals who are legally blind, in choosing, preparing for, obtaining, and maintaining employment.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	Department of Education
Required Federal Reporting	Annual Vocational Rehabilitation Financial Report Annual Vocational Rehabilitation Program/Cost Report
External State Oversight	Governor's Advisory Council for The Blind (R.I. Gen. Laws § 40-9-3) Authority to create reports and to report medical outcomes (R.I. Gen. Laws § 40-9-15 and 40-9-17)
State Required Reporting	Medical professionals and agencies that administer benefits to the blind shall report cases of blindness to the Department of Human Services and the Division of Motor Vehicles. The director of the Department of Human Services shall have the authority to publish data and issue statistical material that may be deemed in the public interest.
Special Considerations	N/A

Independent Living and Social Services

Program Description	Services that enable RI with visual impairments to maintain independent and self-sufficiency in the community.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	Department of Education- Rehabilitation Services Administration
Required Federal Reporting	Annual reporting RSA 7-OB
External State Oversight	Governor's Advisory Council for The Blind (R.I. Gen. Laws § 40-9-3) Authority to create reports and to report medical outcomes (R.I. Gen. Laws § 40-9-15 and 40-9-17)
State Required Reporting	The director of the Department of Human Services shall have the authority to publish data and issue statistical material that may be deemed in the public interest.
Special Considerations	N/A

Disability Determination Services

Program Description	Unit that determines medical eligibility of Rhode Island residents who are applying to Social Security Disability Insurance (SSDI) or Supplementary Security Income (SSI).
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	Social Security Administration (SSA)
Required Federal Reporting	Unavailable
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	The disability determination unit is part of state government, however, they work very closely under the oversight of the SSA. The standards for disability and methods for making a determination are set by the SSA for the federal programs. The state of Rhode Island uses the determinations made by this unit for Medicaid purposes and does not impose additional assessment.

Business Enterprises Program

Program Description	Program offering training and employment for qualified individuals who are legally blind.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	Department of Education- Rehabilitation Services Administration
Required Federal Reporting	Annual reporting of Vending Facility Program (RSA-15)
External State Oversight	Governor's Advisory Council for The Blind (R.I. Gen. Laws § 40-9-3)
State Required Reporting	N/A
Special Considerations	N/A

Adaptive Telephone Equipment Loan Program

Program Description	Program provides landline telephones and wireless devices on loan to Rhode Islanders who are deaf, hard of hearing, have a speech disability or neuromuscular condition that hinders their ability to use a standard telephone.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	Adaptive Telephone Equipment Loan Program Committee (R.I. Gen. Laws § 39-23-1)
State Required Reporting	Committee shall submit annual reports to the Legislature and advise the Department of Human Services on the program.
Special Considerations	N/A

RI Works

Program Description	A financial and employment assistance program for low-income families with dependent children. The program provides services tailored to the needs of the family in an effort to improve their employment situation.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	Health and Human Services (HHS)
Required Federal Reporting	Annual reporting on TANF recipients
External State Oversight	The director of the Department of Human Services shall report to the legislature (R.I. Gen. Laws § 40-5.2-27)
State Required Reporting	Annual report to the legislature on the impacts of families and how the program is expected to operate with current resources
Special Considerations	N/A

SSI Enhanced Assisted Living Program

Program Description	The program provides financial assistance to eligible individuals who are assessed and found to be in need of services provided in an Assisted Living Facility. The SSI Enhanced benefit allows for an increased Supplemental Security Income (SSI) payment to help cover the cost of room and board. To qualify, an individual must participate in an assessment and be considered an appropriate candidate for admission.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS
Federal Oversight Body	SSA- Must meet SSI standards for eligibility
Required Federal Reporting	Unavailable
External State Oversight	Unavailable
State Required Reporting	N/A
Special Considerations	N/A

Social Security Ticket to Work Program

Program Description	Program to assist individuals with disabilities, including individuals who are legally blind, in choosing, preparing for, obtaining, and maintaining employment. Limited to those individuals aged 16-64.
State Agency Responsible	EOHHS
Department or Office Responsible	DHS – Office of Rehabilitation Services
Federal Oversight Body	SSA- Must meet SSI standards for eligibility
Required Federal Reporting	Individuals enrolled are included in comprehensive Medicaid reporting.
External State Oversight	DHS shall report annually to the governor and chairpersons of the house and senate finance committees (R.I. Gen. Laws § 40-8.7-9).
State Required Reporting	Annual reporting on eight categories such as the number of beneficiaries, Medicaid claims, and demographics.
Special Considerations	This program provides eligibility for Medicaid services. Oversight of those services is generally provided through Medicaid program oversight activities.

DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES (DCYF)

Family First Prevention Services

Program Description	Program to support families and children to prevent need for entry into the foster care system.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	Health and Human Services - Administration for Children and Families
Required Federal Reporting	Semi-annual reporting requirement on foster care and pregnant and parenting youth. Title IV-E Prevention Services Plan See Child Protective Services section below
External State Oversight	Family First Advisory Team
State Required Reporting	N/A
Special Considerations	Title IV-E Prevention Services Plan DCYF office of data analytics, evaluation, and continuous quality improvement creates reporting on programs operated by DCYF. Many reports can be found on DCYF website at: https://dcyf.ri.gov/data-analytics

Family Care Community Partnerships

Program Description	Prevention resource to help families and communities raising children in a safe, healthy environment.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	N/A
State Required Reporting	The FCCP uniformly collects and reports child/family individual-level data elements on a quarterly and annual basis
Special Considerations	FCCPs are providers located throughout the state who provide services under contract for the DCYF. DCYF office of data analytics, evaluation, and continuous quality improvement creates reporting on programs operated by DCYF. Many reports can be found on DCYF website at: https://dcyf.ri.gov/data-analytics

Youth Diversion Programming

Program Description	Youth Diversion Programs are community-based programs for youth ages 9 to 17 years old who are not otherwise currently involved with DCYF.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	N/A
State Required Reporting	The FCCP uniformly collects and reports child/family individual-level data elements on a quarterly and annual basis
Special Considerations	FCCPs are providers located throughout the state who provide services under contract for the DCYF.

Wayward Disobedient Programs

Program Description	Wayward/Disobedient Programs (WDPs) are available to parents and guardians experiencing problems at home with their child(ren) 12 to 17 years of age.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	N/A
State Required Reporting	The FCCP uniformly collects and reports child/family individual-level data elements on a quarterly and annual basis
Special Considerations	FCCPs are providers located throughout the state who provide services under contract for the DCYF.

Child Protective Services

Program Description	Child Protective Services (CPS) is the investigative division of DCYF and includes the Department's abuse and neglect hotline. This division ensures each child and youth is protected from harm through the timely investigation of reports of child abuse and neglect.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	Health and Human Services (HHS), Administration for Children and Families (ACF)
Required Federal Reporting	The federal government requires each state's child welfare agency to create a five-year Child and Family Services Plan. The CFSP is directly tied to federal government funding. The State is required to report a variety of child welfare data to the federal government: Annual State Child Welfare Expenditure report: This report includes planned and actual expenditures for the state's child welfare programs, including prevention programs, child protective services, foster care, licensing, adoption assistance, and guardianship assistance and kinship navigator programs. Adoption and Foster Care Analysis and Reporting System (AFCARS): An AFCARS report is submitted annually by the State and contains case-level data about entries into and exits from foster care and children who were adopted from foster care. National Child Abuse and Neglect Data System (NCANDS): The State provides data annually on child abuse and neglect collected from reports to Children's Protective Services. Participation in NCANDS is voluntarily, however, all 50 states, the District of Columbia, and Puerto Rico participate. National Youth in Transition Database (NYTD): The State provides data semiannually about the services and expenditures related to independent living services provided to youth in foster care. This data is used to track state's use of independent living services and youth-level outcomes.

Foster Care Licensing

Program Description	Program responsible for the licensing, monitoring and enforcing regulations in all foster homes, residential facilities, and agencies who place children.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF
Federal Oversight Body	Health and Human Services (HHS), Administration for Children and Families (ACF)
Required Federal Reporting	See Child Protective Services section above.
External State Oversight	Annual report to the legislature (R.I. Gen. Laws § 42-72-36.3)
State Required Reporting	Annual report on foster care placement Annual report to the legislature showing progress in residential-care system reform and rebalancing to the finance committees of both the senate and the house of representatives. Additional state reports are not mandatory but can be created if in the public interest.
Special Considerations	ACF provides minimum guidelines that all states must meet, however they do not provide active oversight.

Rhode Island Training School (RITS)

Program Description	A secure correctional program for male and female youth who are detained and /or sentenced to the facility by order of the Rhode Island Family Court.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF – Juvenile Corrections
Federal Oversight Body	Department of Justice
Required Federal Reporting	Annual report of sexual abuse and/or sexual harassment within Rhode Island juvenile justice facilities covered under the federal prison rape elimination act (PREA).
External State Oversight	Office of the Child Advocate shall submit annual reports to the governor and the legislature (R.I. Gen. Laws § 42-73-6) Advisory committee to the office of the child advocate (R.I. Gen. Laws § 42-73-2.1)
State Required Reporting	Annual report by the Child Advocate Office detailing the work of the office and any recommendations for improvement. Annual report by DCYF director on the continuum of care for children in DCYF care and custody. Physical Restraint Report
Special Considerations	N/A

Community Services and Behavioral Health (CSBH)

Program Description	CSBH develops the continuum of care for children's behavioral health services.
State Agency Responsible	EOHHS
Department or Office Responsible	DCYF – Community Service and Behavioral Health
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	Annual reports to the legislature (R.I. Gen. Laws § 42-72-36.3)
State Required Reporting	Residential care reporting on reform and rebalancing required annual by April 1 to the finance committees of both the senate and the house of representatives.
Special Considerations	N/A

DEPARTMENT OF HEALTH

Nurse Family Partnership

Program Description	Program that provides resources to assist first time pregnant people with finding prenatal care, provides education to increase knowledge about pregnancy, labor and delivery, offers support around child growth and development, and links families with social services and community resources.
State Agency Responsible	EOHHS
Department or Office Responsible	Department of Health
Federal Oversight Body	HRSA
Required Federal Reporting	Maternal and Child Health Block Grant Annual Report
External State Oversight	N/A
State Required Reporting	The department of health shall issue an annual home-visiting report that outlines the components of the state's family home-visiting system that shall be made publicly available on the department's website (R.I. Gen. Laws § 23-13.7-2) Annual Maternal Child Health Program Reporting
Special Considerations	N/A

First Connections

Program Description	Home-visiting program that provides support and connections to assist pregnant people, families and caregivers of children up to age three.
State Agency Responsible	EOHHS
Department or Office Responsible	Department of Health
Federal Oversight Body	HRSA
Required Federal Reporting	Maternal and Child Health Block Grant Annual Report
External State Oversight	N/A
State Required Reporting	The department of health shall issue an annual home-visiting report that outlines the components of the state's family home-visiting system that shall be made publicly available on the department's website (R.I. Gen. Laws § 23-13.7-2) Annual Maternal Child Health Program Reporting
Special Considerations	N/A

Lead Poisoning Prevention

Program Description	Statewide program that works to identify and decrease environment lead hazards.
State Agency Responsible	Department of Health (DOH)
Department or Office Responsible	Centers for Disease Control and Prevention (CDC)
Federal Oversight Body	States funded by CDC and the Environmental Protection Agency (EPA) for childhood lead poisoning prevention and surveillance are required to report childhood lead data on a quarterly basis.
Required Federal Reporting	Annual report to legislature (R.I. Gen. Laws § 23-24.6-7) Interagency Coordinating Council on Environmental lead (R.I. Gen. Laws § 23-24.6-6)
External State Oversight	The department shall, at least annually, analyze and summarize all of the lead screening information provided by physicians, health care facilities, and laboratories and provide this information to all other local and state agencies involved with case management and lead hazard reduction. An analysis and summary of the data shall also be made available, at least annually, to the health care community, to the general assembly, and the general public. The Council shall report on or before March 1 of each year to the governor, speaker of the house and the president of the senate on both the progress of the comprehensive environmental lead program and recommendations for any needed changes in legislation.
State Required Reporting	N/A
Special Considerations	Department of Health (DOH)

State Tobacco Quitline / RI Nicotine Helpline

Program Description	Free service that connects people with nicotine dependency to multi-session live telephone counseling or web coaching, self-help tools, and referrals to other addiction treatment and cessation services.
State Agency Responsible	EOHHS
Department or Office Responsible	Department of Health (DOH)
Federal Oversight Body	Centers for Disease Control and Prevention (CDC)
Required Federal Reporting	RI Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, and Pregnancy Risk Assessment Monitoring System are used to report data to both the state and CDC. The federal cooperative agreement mandates annual reporting of Quitline specific performance measures, evaluation outcome measures and activities relating to Quitline operations. A report analyzing seven month follow up among tobacco users who used Quitline services must be submitted to CDC at least once during each 5-year funding period.
External State Oversight	N/A
State Required Reporting	RI Behavioral Risk Factor Surveillance System is used to report data to both the state and CDC RI Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, and Pregnancy Risk Assessment Monitoring System are used to report data to both the state and CDC. State Quitline Data is analyzed and findings shared with relevant department leadership, statewide coalition focused on tobacco work, and community partners for decision making purposes.
Special Considerations	CDC requires all states maintain a state specific Quitline. People anywhere in the United States can call their state Quitline by dialing 1-800-QUIT-NOW.

State Tobacco Quitline

Program Description	Process used by hospitals to identify infants born with substance exposure in order to provide support and treatment opportunities.
State Agency Responsible	EOHHS
Department or Office Responsible	Department of Health (DOH)
Federal Oversight Body	Administration for Children and Families
Required Federal Reporting	Child Abuse and Prevention Treatment Act requires annual reports
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	Federal law requires information on Plans of Safe Care (POSC) to be submitted to the DCYF for data tracking purposes and reported to the Administration for Children and Families. The Rhode Island DOH is responsible for collecting information on POSC from Rhode Island birthing hospitals and for aggregating and submitting these data to DCYF annually.

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELEMENTAL DISABILITIES, AND HOSPITALS (BHDD)

Elenor Slater Hospital & RI State Psychiatric Hospital

Program Description	State run facilities that provide residential inpatient treatment.
State Agency Responsible	EOHHS
Department or Office Responsible	BHDDH
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	Governor's Council on Behavioral Health (R.I. Gen. Laws § 40.1-29-5) BHDDH Quality Management Unit
State Required Reporting	Annual Report to the governor and Legislature on the council's activities, performance, needs, plans for address healthcare needs, or other recommendations
Special Considerations	N/A

Project for Assistance in Transition from Homelessness (PATH)

Program Description	Federal formulary grant funding directed to programs for individuals experiencing homelessness and serious mental illness.
State Agency Responsible	EOHHS
Department or Office Responsible	BHDDH
Federal Oversight Body	SAMHSA
Required Federal Reporting	Annual reporting of funding and expenditures
External State Oversight	N/A
State Required Reporting	N/A
Special Considerations	N/A

Access to Independence

Program Description	**Provides home modifications for individuals with intellectual or developmental disability to those who cannot obtain this service through a Medicaid waiver program.**
State Agency Responsible	EOHHS
Department or Office Responsible	BHDDH and RI Housing
Federal Oversight Body	N/A
Required Federal Reporting	N/A
External State Oversight	RI Housing
State Required Reporting	RI Housing completes inspections to verify the home modifications were completed and completed correctly according to the loan terms
Special Considerations	N/A