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March 19, 2026

The Honorable Susan R. Donovan, Chairwoman
House Committee on Health and Human Services
Room 101 – State House
Providence, RI 02903

RE: 2026 – H 7142– An Act Relating to Behavioral Healthcare, Developmental Disabilities and Hospitals – Certified Community Behavioral Health Clinics Accountability and Oversight Act

Dear Chairwoman Donovan:

The Executive Office of Health and Human Services (EOHHS) appreciates the opportunity to review proposed bill **H 7142** – An Act Relating to Behavioral Healthcare, Developmental Disabilities and Hospitals – Certified Community Behavioral Health Clinics Accountability and Oversight Act. While we welcome the ability to share data and information about the implementation of the CCBHC program, we note concerns about duplication of provider reporting and administrative functions found within this bill.

The State's CCBHCs are certified by EOHHS/Medicaid, but are formally evaluated and monitored on an ongoing basis by an interagency team, respecting the distinct authorities and subject matter expertise held by each of the following agencies: i) EOHHS as the convener of interagency initiatives and the State's Medicaid authority; ii) BHDDH as the State's substance use disorder (SUD) and adult mental health authority; and iii) DCYF as the State's children mental health authority. The Interagency Team has been the appropriate body to design and oversee the State's CCBHC program, with ongoing feedback from CCBHC providers and other key stakeholders.

EOHHS has been pleased to provide ongoing data about CCBHC performance to the General Assembly and will continue to do so without the creation of a special oversight committee. We recently published an Annual Report to quantify and publicly share some of the ways in which CCBHCs have helped to improve community access to behavioral health services, insights into the quality of care being provided by our CCBHCs, and trending performance data to drive continuous quality improvement and further program planning, in alignment with the core goals of this legislation. We will continue to produce these reports on an annual basis, incorporating additional data insights over time as the data becomes available.

Using established interagency data collection and analysis processes allows us to provide the General Assembly with insight into key metrics and measures. This approach avoids the development of duplicative data collection and reporting processes, reduces administrative burden on providers and the State, and enhances data quality and accuracy. For example:

- BHDDH already collects and analyzes financial data (e.g. balance sheets, income statements, cash flow statements, and receivable and payable aging) from the CCBHCs under their licensing authority to assess organizational financial health. The financial reporting requirements outlined in this legislation align with BHDDH's current analysis.

- EOHHS currently calculates and tracks CCBHC performance for the SAMHSA-required quality measures, leveraging data submitted by managed care organizations (MCOs) and clinics. For additional details, see: RI CCBHC Quality Manual.

- All of these activities are carried out with rigorous data collection, quality assurance, analysis, and data governance processes that ensure the accuracy of shared data and the protection of data in alignment with client privacy/PII laws; however, these processes require time and resources. Additionally, SAMHSA specifically regulates who can calculate certain measures.

EOHHS is open to discussing how to provide any data requested by the General Assembly. For instance, EOHHS is currently in the process of developing a standardized and robust analytic approach to evaluate additional performance metrics referenced in the proposed legislation, such as CCBHC utilization across demographic groups over time, with a focus on increasing access to, and meaningful engagement in services among high-need populations. We believe these metrics are best calculated by the State, rather than individual CCBHCs, to ensure a consistent analytic and reporting approach. We also note that it is difficult to quantify outcomes for mental health and substance use treatment, as treatment goals vary by each individual client.

EOHHS also notes that MRSS will be funded and clinically managed by the State, separate from the CCBHC program, beginning on October 1, 2026. Therefore, any reporting related to MRSS should be addressed separately from the CCBHC program.

With respect to reporting timelines, these are often driven by existing federal requirements. For example, quality measures that are required under the CCBHC Demonstration program are reported annually to EOHHS by October 31of the year following the measurement year. For instance, the quality measures for CY 2025 performance will be reported on October 31, 2026. Finally, regarding public hearings, EOHHS must ensure that any data shared is cleared for public release in accordance with established data governance and sharing protocols. This process may require additional data use agreements, as well as additional time and resources.

Sincerely,

Richard R. Charest, R.Ph., MBA
Secretary, Executive Office of Health and Human Services

Cc: Honorable Members of the House Committee on Health and Human Services
Honorable Julie A. Casimiro
Nicole McCarty, Esq., Chief Legal Counsel to the Speaker of the House