# Senate Finance Committee

## *FY2022 Proposed Budget Amendment- ARPA Funds*

10.27.21

## Background

- On October 7, 2021, Governor McKee submitted a requested budget amendment for FY2022 *(2021-H-6494)* that allows the use of $113 million in federal American Rescue Plan Act funds
- Proposal represents 10% of State Fiscal Recovery Funds available for Rhode Island
- Governor indicates it is a “down payment” on larger, longer-term investments
- Invests in business supports, child care and childhood health, and housing affordability and security

# Investment Summaries:
# Child Care and Childhood Health

## Child Care and Childhood Health

| Investment Category | Initiative | Cost |
|---|---|---|
| **Child Care and Childhood Health** | | **$38,500,000** |
| | Bonus pay to child care workers | $12,700,000 |
| | Employee bonus pay for DCYF providers | $12,500,000 |
| | Pediatric primary care performance pay and stabilization grants and enhanced health screenings | $7,500,000 |
| | Early intervention program stabilization and performance grants | $5,500,000 |
| | Child care provider startup grants | $300,000 |

## Child Care - $13.0 Million

**Proposal**

- $12.7 million to provide Pandemic Retention Bonuses to 75.0 percent of the state's child care workforce.
  - Eligible child care workers would be able to receive a $1,000 bonus, 2 times a year (every 6 months), for a maximum bonus of $2,000.
- $300,000 to provide start-up grants to 100 new Family Child Care providers.
  - Grants would be $2,000/provider.
- Proposal includes administrative costs of 4.0 percent of total budget for each initiative.

**Timeline / Recurrence**

- All funds anticipated to be expended in FY2022.

**Outcomes / Performance Metrics**

- Goal of Pandemic Retention Bonus is to increase the retention rate among early childhood educators.
- Goal of provider start-up grants is to increase the number of Family Child Care providers in the state. Specifically providers who care for CCAP eligible children.
  - Should also open up an additional 800 child care seats.

## DCYF Provider Workforce - $12.5 million

**Proposal**

- Provide hazard pay to address workforce crisis for DCYF-contracted service providers
  - Private, community-based providers (residential, group homes, etc.)… NOT state workers
- Staff who make under $75k per year eligible for an additional $25,000 over three years
  - Federal cap on premium pay, $25,000 per worker
  - Works out to $695/month
  - About 1,500 workers impacted
- DCYF will implement by increasing provider rates and requiring a pass-through to employees
- Extension of a similar but broader workforce stabilization program that was operated in 2020 and funded through CRF
- No suitable funding alternative

**Timeline / Recurrence**

- Effective upon contract negotiation
- Would be retroactive to July 1, 2021, so full-year impact captured
- Only funds the first year, FY2022, but further investments can be made in FY2023 and FY2024

**Outcomes / Performance Metrics**

- Goal is to ensure that DCYF's array of placements and direct services remain viable so vulnerable children and youth get the care they need
- Success measured by vacancy/turnover rates and bed availability

## Pediatric Health Care Recovery - $7.5 million

**Proposal**
- Incentive program to support pediatric providers and address pandemic's impact on access to infant/child health services
- Providers have voiced financial solvency concerns
- $6.0 million to provide stabilization grants to providers
  - Pay for performance program to incentivize recovery
  - Extension of a CRF provider relief program that operated in 2020 which, according to EOHHS, successfully increased screenings and vaccinations
- $1.5 million to implement socio-emotional and social determinants of health screenings to address new child behavioral healthcare needs that have surfaced
  - Implementation, training, and payment
- No suitable funding alternative

**Timeline / Recurrence**
- EOHHS says that they would be able to release applications within 3 months of funding approval
- One-time funds in FY2022, but further investments could be made

**Outcomes / Performance Metrics**
- Goal is to support access to care early in life to support long-term wellness
- Success measured by
  - Pediatric primary care encounters
  - Lead/behavioral health screenings
  - Vaccination rates

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## Early Intervention Recovery - $5.5 million

**Proposal**
- Incentive program to support early intervention providers to promote access and engagement for young children with developmental needs
  - Currently, 4 of 9 EI providers are not taking new referrals
- $4.5 million to provide stabilization grants to providers
  - Help reopen referrals and enhance outreach
  - Extension of a CRF provider relief program
- $1.0 million in pay-for-performance bonus opportunities
  - Potential for providers to receive bonuses based on specific metrics, including reducing turnover and increasing enrollment to pre-pandemic levels
- Providers required to commit to 80% in-person visit target
- No suitable funding alternative

**Timeline / Recurrence**
- Expected program guidance within three months of funding approval
- One-time funds in FY2022, but further investments could be made

**Outcomes / Performance Metrics**
- Goal is to address concerns early in life and support long-term health/success for children with developmental needs
- Success measured by
  - Early intervention encounters
  - Referral to participation rate

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## Child Care Investments

The Governor recommends $13.0 million for:

- Pandemic Retention Bonuses for the state's childcare workforce.
- Start-up grants for new family child care providers.

### FISCAL IMPACT AND TIMELINE

#### *Fiscal Impact*

The Governor proposes using $13.0 million from the State Fiscal Recovery Funds to support investments in child care. The tables below outline how the total amounts were derived.

| Pandemic Retention Bonuses | |
|---|---|
| Max. # of Eligible Workers | 8,200 |
| Assume 75% apply | 6,150 |
| Max. Bonus per Year | $2,000 |
| Total Bonuses | $12,300,000 |
| Fiscal Intermediary Funds | $400,000 |
| **Total** | **$12,700,000** |

| Famild Child Care Start-Up Grants | |
|---|---|
| Participants | 100 |
| Grant Amount | $2,000 |
| Total Grants | $200,000 |
| Fiscal Intermediary Funds | $100,000 |
| **Total** | **$300,000** |

#### *Timeline*

The Governor's proposal states the Pandemic Retention Bonus will be implemented by the end of Fall 2021. The first round of awards would be launched 3-4 months later and the second round 8-9 months. It is possible this initiative crosses over into FY2023 in which case the funding would need to be shifted. The proposal is for one-time incentive bonuses for child care workers and does not require additional funding beyond what is proposed.

The Governor's proposal would also launch the Family Child Care Start-Up Grants in Fall 2021. It is not clear how long it will take from the time a provider receives the grant to the time they are a fully functional child care facility. This is a one-time start-up grant that does not require additional funding beyond FY2022. However, if the program is successful the Governor does recommend continuing the program in FY2023 and FY2024 which would require additional funds beyond what is included in the Governor's proposal.

### ANALYSIS AND BACKGROUND

#### *Pandemic Retention Bonuses*

The Department of Human Services (DHS) states that child care providers, both center- and family-based, are suffering from high turnover and trouble retaining experienced staff. Providers are not able to open at full capacity due to staffing shortages, resulting in fewer child care spaces for parents who require child care to continue their employment.

Early childhood education is a unique field in that it is a high-skill, low-wage industry. As wages in other jobs increase workers chose to move to another higher paying field. Early childhood educators also work daily with children who are not yet eligible for the COVID-19 vaccine, resulting in a higher risk of possible exposure. According to the DHS 2021 Market Rate Survey, the highest average hourly rate for a lead teacher is $17.42.

Child care providers also struggle with the ability to pay their workers more as it would often require them to increase their tuition rates. The 75$^{th}$ percentile weekly cost for full time infant child care in a center is $289/week, or $1,252/month.

*Analyst Note: Federal Guidance establishes the 75th percentile (of market rates) as the benchmark for equal access.*

The Governor's proposal would provide a $1,000 bonus, twice a year for a total of $2,000, to eligible child care workers. The Administration estimates that 75.0 percent of eligible workers will apply resulting in 6,150 workers receiving the bonus. The goal of the Pandemic Retention Bonuses is to retain and adequately compensate existing staff.

In FY2021, DHS implemented one round of Child Care Stabilization Grants utilizing $18.4 million from the Consolidated Appropriations Act funding. A total of 769 providers, 94.0 percent of total eligible child care providers, received funding. Through this Grant, child care centers were eligible to receive $4,500 per classroom per month, and family child care providers were eligible to receive $1,500 per provider per month. The FY2022 Budget as Enacted includes an additional $57.3 million in American Rescue Plan Act funding to support another round of Child Care Stabilization Grants, set to begin in late October 2021.

Funding from Child Care Stabilization Grants can be used to support equipment and supplies needed to respond to COVID-19, mental health supports to children and employees, personal protective equipment, rent or mortgage obligations, as well as personnel costs including premium or hazard pay, costs for employee recruitment and retention and staff bonuses. The average spot bonus provided to workers through the first round of Child Care Stabilization Grants was $716.

### *Family Child Care Start-Up Grants*

DHS states that the number of Family Child Care (FCC) home providers has decreased by about 100 as a result of the COVID-19 pandemic. FCC providers are often older individuals who care for a smaller number of children in their home. Many of these individuals retired due to the pandemic and ongoing safety concerns. FCC providers also often invest their own money up front in order to start their business, which can be a barrier to some who cannot afford the start-up costs.

The Governor's proposal would provide $2,000 start-up grants to 100 new FCC providers. This would also include technical assistance to ensure they are able to operate high quality programs able to serve the states CCAP population. If 100 new providers were able to open this could create an additional 800 child care seats.

FCC providers were also eligible for the Child Care Stabilization Grants discussed above and were able to receive an additional $1,500 per provider per month under the first round of grants. A second round of grants is anticipated to open at the end of October 2021. Under this grant FCC providers would be eligible for a monthly amount of $2,000 per provider.

## OUTCOMES

### *Equity*

According to the 2019 Workforce Needs Assessment conducted by DHS, the early child care workforce is approximately 90.0 percent woman. More than half of Family Child Care Providers are women of color. Both the Pandemic Retention Bonus and the Family Child Care Start-Up Grants would increase compensation for this workforce.

A lack of child care also causes women to leave the workforce as they are the primary care takers of young children. Creating additional child care seats will allow women to re-enter the workforce.

### *Performance Metrics*

**Pandemic Retention Bonuses:** To the extent that Pandemic Retention Bonuses retain existing staff, the Governor's proposal includes the following performance metrics:

- Number of applicants to the program
- Number of applicants eligible for the first and second round of benefit allocations

- Percentage of applicants in each job position (lead teacher, assistant, etc.)
- Rate of retention among early childhood educators.

This information will be used to identify if the initiative is successful and any changes needed to increase potential future participation in the program.

**Family Child Care Start-Up Grants:** Success of this program will be measured by the following performance metrics:

- Number of new FCC providers who open as a result of the start-up grants
- Number of providers who open who are 3, 4, or 5 star programs as measured by BrightStars by 2024
- Percentage of providers who resume full enrollment/utilization of programs by 2024.

## DCYF Provider Workforce Stabilization

The Governor recommends $12.5 million in State Fiscal Recovery Funds (SFRF) to provide premium pay for child welfare staff at private, community-based providers that contract with the Department of Children, Youth, and Families (DCYF). According to the Administration:

- Child welfare providers are facing a staffing shortage that affects DCYF's placement options. Since the start of the COVID-19 pandemic, the Department has seen a reduction in available beds for youth because short-staffed providers are limiting capacity. This, in turn, impacts access to critical services.
- Under this proposal, workers making less than $75,000 per year would be eligible for a bonus of up to $25,000 spread over three years. The bonuses would be paid monthly, totaling approximately $695 per worker per month. These are not State workers.
- A $12.5 million appropriation would support pay increases for an estimated 1,500 workers in **FY2022 only**. The amount includes retroactive increases to July 1, 2021. Additional appropriations of $12.5 million per year would be required if the program continues in FY2023 and FY2024.
- The Governor's proposed amendment appropriates $12.5 million to DCYF and includes proviso language requiring that the funding be used to support workforce stabilization supplemental wage payments to eligible direct care and supporting care staff of contracted service providers.

### FISCAL IMPACT AND TIMELINE

#### *Fiscal Impact*

The proposed amendment includes $12.5 million in FY2022 based on an estimated $695 monthly bonus for 1,500 eligible workers across 37 provider organizations. For a full-time hourly employee working 40 hours per week, this bonus equates to a raise of $4.00 per hour. The American Rescue Plan Act (ARPA) limits the amount of allowable premium pay to $25,000 per worker. The Governor's proposal assumes the maximum payment, but spreads this amount over three years.

*Analyst Note: The General Assembly added 91.0 new FTE positions and approximately $10.0 million from general revenues for frontline DCYF staff in FY2022. As of October 22, 2021, it appears that these positions have not been filled. This will likely result in a general revenue surplus that could be repurposed to enhance provider rates for the purposes of premium pay in the current year.*

#### *Timeline*

The $12.5 million figure accounts for a full year impact for FY2022, meaning that the wage increase would be retroactive to July 1, 2021. No rationale is given for why a retention bonus would be retroactive.

The full program would require additional investments in FY2022 and FY2023. U.S. Treasury guidance indicates that "premium pay may be provided retrospectively for work performed at any time since the start of the COVID-19 public health emergency, where those workers have yet to be compensated adequately for work previously performed."

DCYF will effectuate the supplemental wage payments by amending current agreements with provider organizations to allow for a temporary rate increase which must be passed through to eligible staff. DCYF reports that this will happen quickly upon funding approval. DCYF also anticipates that services and bed availability will begin stabilizing immediately once pay increases take effect, with noticeable improvements in child and youth outcomes within a year.

## ANALYSIS AND BACKGROUND

The Department of Children, Youth, and Families (DCYF) contracts with an array of community-based providers to provide essential placements and services for vulnerable children and youth in Rhode Island. These contracts have not been substantially renegotiated since 2016, and rates have been held constant over the last five years. Provider rates directly translate to staff wages; thus, wages have either remained constant, or have been increased and resulted in an operating deficit for providers.

At the same time, DCYF has been working to maximize placement options to ensure that children and youth get the appropriate level of care. The Department has made progress in recent years to rebalance its service array to meet children's needs, for example by investing in foster care to reduce its reliance on group homes and other, more restrictive out-of-home care options.

According to DCYF, current staffing shortages are at a crisis level, which jeopardizes the progress DCYF has made in rebalancing its service array. A recent report from the Rhode Island Coalition for Children and Families (RICCF), which represents many provider organizations in the State, indicated an industry average vacancy rate of 31.0 percent. This has forced some providers to limit their capacity or close to new referrals, which has already compromised the availability and quality of care provided to abused and traumatized children. According to DCYF, 25.0 percent of youth in congregate care experienced a negative placement change as a result of the pandemic. In the long term, this could result in youth with complex mental health conditions being discharged from congregate care placements against court orders, or children remaining in psychiatric hospitals past medical necessity or being place out-of-State due to the lack of other options. An immediate intervention could help ensure that DCYF does not lose progress and children and youth continue to receive the services they need in the appropriate setting. The Department anticipates that, by offering premium pay for staff, it will be able to stabilize placement options by incentivizing existing workers to stay as well as attracting and recruiting new staff. This will also enable the Department to work through a longer-term solution.

This initiative is related to a workforce stabilization loan program that was operated on a short-term basis during FY2020 using Coronavirus Relief Funds (CRF). The former program was administered by the Executive Office of Health and Human Services (EOHHS) and open to all direct care health and human services staff making less than $20 per hour. The bonus amount was based on the number of hours worked and was paid on a weekly basis. The program guidance utilized baseline payroll data from providers. The loan was provided, and then forgiven once providers demonstrated that the funds were passed through as wage increases. According to DCYF, "this was an effective tool to mitigate staffing crises and increase retention among the frontline workforce."

This proposal is an allowable SFRF use under two expenditure categories: services for hard-hit communities and families and premium pay for essential workers. The U.S. Treasury has identified families and children involved in the child welfare system as a disproportionately impacted community.

## OUTCOMES

### *Equity*

The proposal identifies the following equity components:

- **Population:** The benefit is only available to individuals making at or below the average median income in Rhode Island.
- **Awareness:** All contracted providers have equal access to the benefit and the benefit is the same across all providers.

- **Access and Distribution:** The wage increases will be handled by the providers and automatic for eligible employees; they need not apply individually for an increase.
- **Outcomes:** By increasing compensation, historically underpaid staff will be paid more competitively, which in turn will improve the level of services that the Department can provide.

***Performance Metrics***

The Department will track performance using the following metrics:

- Employee vacancy and turnover rates at provider agencies.
- Increased placement stability for children in congregate care.
- Decrease in high-need youth being served in congregate care, by supporting youth in foster care and at home instead.
- Decrease in the length of stay in psychiatric hospital settings.

## Pediatric Health Care Recovery

The Governor recommends $7.5 million in State Fiscal Recovery Funds (SFRF) to bolster pediatric health care providers that support children enrolled in the Medicaid program. According to the Administration:

- Since the onset of the COVID-19 pandemic, families and children have either deferred or struggled to access health care services and supports. The delay in receiving pediatric services has adversely affected child health outcomes and can have long-term consequences. Additionally, new challenges have surfaced in children's behavioral healthcare, due to new and worsening stressors presented by the pandemic.
- Pediatricians are uniquely positioned to identify developmental concerns, untreated trauma, and socio-emotional needs early and support families in engaging in services that put children on a path toward healthy development.
- Under this proposal, $6.0 million would be used for stabilization grants and a pay-for-performance program to offer financial assistance for pediatric providers affected by a decline in service utilization. An additional $1.5 million would be used to enhance socio-emotional and social determinants of health screenings to address new child behavioral healthcare needs that have surfaced during the pandemic.
- A $7.5 million appropriation would support the program in **FY2022 only**. Additional appropriations could be made in the future if desired.
- The Governor's proposed amendment appropriates $13.0 million to the Executive Office of Health and Human Services (EOHHS), which includes the $7.5 million for pediatrics plus $5.5 million in separate funding for an early intervention provider stabilization program. The amendment includes proviso language requiring that $7.5 million be used to support relief to pediatric providers in response to the decline in visitation and enrollment caused by the public health emergency.

### FISCAL IMPACT AND TIMELINE

#### *Fiscal Impact*

The proposed amendment includes $7.5 million in FY2022. This is the net of $6.0 million for stabilization grants and a pay-for-performance program, based on the final expenses for a previous iteration of the program that operated in FY2021. EOHHS expects to use the same guidelines as the former program and expects the same level of participation from providers. The remainder of the funding is to enhance behavioral health screenings. It is unclear how the $1.5 million expenditure estimate was derived.

This proposal is an allowable SFRF use under the public health expenditure category. The American Rescue Plan Act did not appropriate direct awards that could be used for this purpose. This objective could also be achieved using traditional funding (general revenue with a federal match).

#### *Timeline*

EOHHS will effectuate the program by establishing performance metrics, releasing guidance, opening and reviewing applications, and issuing payments based on provider responses. According to EOHHS, this will occur within three months of funding approval, with measurable outcomes soon after.

### ANALYSIS AND BACKGROUND

The Rhode Island Medicaid program provides comprehensive health care coverage for low-income families with children. Benefits include access to primary/preventative care, immunizations, mental health services,

early intervention, and more. According to EOHHS, over half of the Rhode Island population under age 19 is covered by Medicaid.

Healthy child development is essential to future positive academic, social, and health outcomes. For example, EOHHS reports a causal relationship between access to health care and academic milestones, such as ability to read in the third grade. However, during the pandemic, families and children struggled to access services and providers voiced concerns about financial solvency. Continued delays in access to primary care, developmental supports, and behavioral health care services could have a significant long-term impact on child development in Rhode Island. The proposed pediatric provider relief programs are intended to help children catch up on critical preventative care such as vaccines and developmental screenings and engage in services to address the trauma of the pandemic. EOHHS also anticipates an increase in provider responsibilities as the COVID-19 vaccines are approved for and administered to younger age groups.

This initiative duplicates a pediatric provider stabilization program that operated during FY2021 using Coronavirus Relief Funds (CRF). This was a combination of two sub-programs: pediatric primary care relief and pediatric primary care rate supplement. According to EOHHS, the new program will use the same process as the CRF-funded stabilization program.

The relief sub-program, totaling $3.1 million, provided one-time grant payments to pediatric primary care providers to support system resiliency by keeping providers open and improving immunization rates following pandemic-related disruptions in care and practice cash flow. Awards were based on demonstrated financial shortfalls. The funding was issued based on providers' enrollment of Medicaid-covered children under age 18, not to exceed the amount of need demonstrated on the provider's application.

The relief sub-program was followed by a rate supplement sub-program, based on continued access issues due to social distancing and other business interruptions, limited transportation options, and general hesitancy to visit doctor's offices. EOHHS established a $3.0 million rate supplement program to bolster Medicaid rates for providers that met particular performance metrics (i.e. a pay-for-performance program). EOHHS established the metrics and provided monthly financial incentives for practices that demonstrated success. The metrics were based on primary care visits with Medicaid-insured children by age group and put providers on a pathway to see at least 70.0 percent of their Medicaid-insured patients by the end of CY2020. Participating providers increased visits from a baseline of 67.7 percent of patients seen by between January 1 and July 31, 2020, to 81.1 percent by October 31, 2020. By comparison, during all of CY2019, 75.2 percent of Medicaid-covered children had a primary care visit.

According to EOHHS, these CRF-funded pediatric provider programs "demonstrated significant success in increasing vaccination and screening rates in the pediatric population." However, since the CRF-funded programs have ended, providers have continued voicing financial solvency concerns and cite inadequacy of Medicaid reimbursement rates as a contributing factor. The Governor's proposal would fund another iteration of each component of the stabilization programs, at a total of $6.0 million.

In addition to a second round of the $6.0 million pediatric provider stabilization programs, the Governor's proposal adds $1.5 million to incorporate more rigorous behavioral healthcare screenings into primary care practices. The pandemic has impacted child development by inhibiting social interactions and increasing exposure to trauma and toxic stress. This program would be an extension of the pay-for-performance provider rate stabilization model noted above, where providers would receive separate financial incentives for meeting behavioral healthcare metrics. This would involve incentives for screenings for toxic stress and developmental, behavioral, and social-emotional needs as well as new referrals for follow-up treatment. A small amount of funding would be used to support practice facilitation, data support, and technical

assistance to implement new practice standards. There is no historical comparison for this initiative, and supporting documentation does not indicate how the $1.5 million estimate was derived.

This proposal is an allowable SFRF use under the public health expenditure category.

## OUTCOMES

### *Equity*

The proposal identifies the following equity components:

- **Population:** This program bolsters critical supports for low-income families with children that receive healthcare through Medicaid. In addition, there are racial and ethnic disparities in rates of children who receive immunizations and screenings in Rhode Island, driven by a disparate use of pediatric primary care services. The pandemic threatens to widen these disparities, and adds new concerns that can be addressed through these programs.
- **Awareness:** EOHHS will utilize its internal list of providers to communicate directly with pediatric providers. EOHHS reports that it has also worked with the American Association of Pediatrics and other stakeholders and will continue that engagement to publicize the program.
- **Access and Distribution:** Funding will be distributed based on the size of the practice so that it is proportional to the need.
- **Outcomes:** Closing gaps in visits, vaccinations, lead screenings, and referrals to other services will be targeted to Medicaid-covered children, who are disproportionately children of color.

### *Performance Metrics*

EOHHS will track performance using the following metrics:

- Health services delivered to Medicaid-covered children.
- Number of well-child visits.
- Number of vaccinations and vaccination rates.
- Number of lead screenings.
- Referrals to Early Intervention services.
- Participation rates of eligible families.
- Number of psychosocial-behavioral screenings.

## Early Intervention Recovery

The Governor recommends $5.5 million in State Fiscal Recovery Funds (SFRF) to bolster early intervention (EI) providers that support young children with developmental needs. According to the Administration:

- The pandemic has delayed child development and the State anticipates an increase in demand for behavioral healthcare and developmental supports. At the same time, providers face workforce shortages and financial solvency concerns. Four of the State's nine EI providers that provide such supports have stopped taking new referrals. This affects up to 75 children per week that may need services but cannot access them and can have long-term consequences for mental health and education.
- Under this proposal, the Medicaid program would allocate funding to providers to make up for losses incurred during the pandemic and help reopen referrals by enhancing outreach, rehiring and retaining staff, and expanding in-person delivery of services.
- A $5.5 million appropriation would support providers in **FY2022 only**. Additional appropriations could be made in the future if desired.
- The Governor's proposed amendment appropriates $13.0 million to the Executive Office of Health and Human Services (EOHHS), which includes the $5.5 million for early intervention plus $7.5 million in separate funding for a pediatric provider stabilization program. The amendment includes proviso language requiring that $5.5 million be allocated to early intervention providers in response to a decline in enrollment for early intervention, family home visiting, and screening programs.

### FISCAL IMPACT AND TIMELINE

#### *Fiscal Impact*

The proposed amendment includes $5.5 million in FY2022. This is the net of $4.5 million in stabilization grants for providers based on revenue losses in FY2021. The remaining $1.0 million would fund a pay-for-performance program under which providers receive bonuses for demonstrating improvement on a number of State-defined metrics.

This proposal is an allowable SFRF use under the public health expenditure category. The American Rescue Plan Act did not appropriate direct awards that could be used for this purpose. This objective could also be achieved using traditional funding (general revenue with a federal match).

#### *Timeline*

This program is based on a smaller-scale program that operated in FY2021 using Coronavirus Relief Funds (CRF). EOHHS expects to use similar guidelines as the former program, and will effectuate the program by releasing guidance, reviewing applications, and issuing payments based on provider responses. According to EOHHS, this will occur within three months of funding approval, with measurable outcomes soon after.

### ANALYSIS AND BACKGROUND

Early intervention (EI) programs serve children with special health care needs from birth through age three. These programs are federally required under the Individuals with Disabilities Education Act (IDEA). Providers connect children with developmental, cognitive, physical, medical, neurological, behavioral, and/or emotional conditions with specialized interventions, clinical treatments, and parent education designed to improve long-term outcomes. Early intervention is proven to reduce the need for special education services when children reach school age, according to the National Early Intervention

Longitudinal Study. EI programs serve over 4,000 children in Rhode Island annually, of whom approximately 60.0 percent are covered by Medicaid.

There are currently nine early intervention providers in the State: Children's Friend and Service, Community Care Alliance, Easter Seals, Family Service of RI, Groden Center, Looking Upwards, Meeting Street, Seven Hills RI, and J. Arthur Trudeau. As previously noted, four of these providers have stopped taking new referrals and are limiting capacity to current enrollees, leaving them unable to support the new demands that have surfaced during the pandemic.

The COVID-19 pandemic challenged Rhode Island's early intervention system. Medicaid claims declined by 7.4 percent in FY2020 compared to FY2019, and an additional 6.0 percent in FY2021 compared to FY2020. Enrollment declined 13.3 percent over the same two-year period. According to EOHHS, this is not due to a reductions in need, but barriers to access. Many children who should have been referred to early intervention programs were missed in 2020 due to the disconnection from traditional family supports, such as child care. Additionally, many children who should have received services in 2020 never began or successfully completed the program because of business interruptions. Providers have experienced high levels of staff turnover. According to EOHHS, almost a fifth of all staff leave every six months, which challenges the ability to provide consistent experiences for families and dedicate staff time towards outreach and engagement.

The Governor's proposal seeks to stabilize providers by establishing a grant relief program as well as a supplemental pay-for-performance bonus. In order to be eligible for the funding, providers will need to rebalance their service delivery to ensure that more visits occur in person, with providers committing to 80.0 percent in-person visits.

The proposed amendment assumes $4.5 million in stabilization grants, based on demonstrated FY2021 losses plus a rate supplement. According to EOHHS, providers experienced a $3.3 million revenue loss in FY2021. The grants will backfill this loss, which will then be supplemented by an additional 30.0 percent rate increase to account for the increased cost of service delivery and historically low Medicaid reimbursement rate. The additional funding could be used to pay for staff recruitment and retention efforts, outreach and engagement, professional development, or facility investments.

The remainder of the $5.5 million appropriation, or $1.0 million, would be used for pay-for-performance bonus allocations. Under this sub-program, providers would receive allocations, in addition to the stabilization grants, if they demonstrate improvement on the following metrics: recovering the referral pipeline to 2019 numbers; reducing staff turnover; increasing the rate of referrals reaching an eligibility evaluation appointment; increasing the number of families choosing to enroll in an individualized family service plan (IFSP); reducing the rate of families exiting the program due to lost contact; reducing disparities in performance metrics for families with Medicaid coverage and families of color; and improving in Early Intervention National Child Outcome #1: Positive Social Emotional Skills.

This program is based on a smaller-scale provider relief program that operated in FY2021 which provided $2.2 million in stabilization grants to early intervention providers. According to EOHHS, this program demonstrated improvement in outcomes, including an increase in referrals and enrollments. However, it addressed a smaller portion of provider losses and did not increase capacity to pre-pandemic levels. Further, capacity has declined since the termination of the first program in December 2020. For example, staff capacity increased from 77.0 percent in June 2020 to 85.0 percent in January 2021, but is currently at 73.1 percent capacity.

This proposal is designed to work in tandem with the Pediatric Health Care Recovery initiative, where pediatric providers would be incentivized to enhance screenings and refer children to EI programs, and EI

providers would be able to increase their capacity to serve these new referrals. Both are allowable SFRF uses under the public health expenditure category.

## OUTCOMES

### *Equity*

The proposal identifies the following equity components:

- **Population:** Low-income children and children of color disproportionately struggle to engage with and complete EI programs. According to EOHHS, a higher proportion of Medicaid beneficiaries and a higher proportion of families of color who are referred to early intervention are not screened because of lost contact. Bolstering services and increasing outreach will seek to close these gaps.
- **Awareness:** EOHHS will utilize its internal list of providers and communicate directly with them to ensure participation.
- **Access and Distribution:** Funding will be distributed based on demonstrated need so that it is proportional, and all practices will have the opportunity to engage in pay for performance supports.
- **Outcomes:** Closing gaps in access to early intervention will improve long-term outcomes. Funding will be targeted to Medicaid-covered children, who are disproportionately children of color.

### *Performance Metrics*

EOHHS will track performance using the following metrics:

- Decreasing staff turnover.
- Increasing rate of in-person service delivery.
- Increasing the percentage of referrals that convert to program enrollment.
- Decreasing the percentage of families that dis-enroll before meeting child outcomes.