Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Final Report

Submitted to the

Rhode Island Senate

September 1, 2022

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SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

Members

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District 28 – Cranston, Providence

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District 12 – Little Compton, Middletown, Newport, Tiverton

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THE SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

INTRODUCTION

The Rhode Island Senate has consistently prioritized improving the health and human services landscape in the state and has long championed initiatives to improve service delivery and access. At the end of the 2021 legislative session, Senate Bill No. 0985 was passed to create *The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island* (the commission). As the name of the commission suggests, the commission's charge is to review and make recommendations on how to most efficiently and effectively administer health and human services in Rhode Island.

The commission is chaired by Senator Joshua Miller, and includes members Senator Louis DiPalma, Senator Jessica de la Cruz, and eight additional members with relevant expertise and experience with the Executive Office of Health and Human Services (EOHHS) and the four departments it manages (sub-agencies): the Departments of Children, Youth and Families (DCYF), Health (DOH), Human Services (DHS), and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

Between October 2021 and August 2022, the commission met nine times to study EOHHS and its sub-agencies. Meetings included testimony from EOHHS, its sub-agencies, out-of-state experts, commission members, and community stakeholders. Meeting topics included: EOHHS history; EOHHS structure; RI's Medicaid program; behavioral health services; developmental disability services; state hospitals; and health and human services state agency structures in other states. All meeting materials can be found on the Rhode Island General Assembly website.

The structure and functions of the Executive Office of Health and Human Services have not been thoroughly examined since its inception in 2005. Over the past 17 years, the health and human services landscape in Rhode Island has changed greatly. The commission acknowledges that there remains a need for a strong, efficient executive office that focuses on alignment and coordination, quality improvement, and sub-agency support; it also recognizes that EOHHS has some unique responsibilities not easily replicated by individual agencies, including oversight of, and compliance with, federal consent decree requirements.

The commission closely evaluated EOHHS and its sub-agencies and learned about the strengths and weaknesses of the current structure. The commission's recommendations aim to address some of the weaknesses within EOHHS, but also build on the existing strengths, including the EOHHS data ecosystem, centralization of financial services, and various media campaigns. By leveraging inter-agency coordination displayed by these existing strengths, the commission believes that EOHHS and its sub-agencies can successfully implement the commission's recommendations.

The commission's intent is that the recommendations outlined herein are executed in an expeditious manner with the least possible disruptions to services. Many of the recommendations involve major structural changes within EOHHS and its sub-agencies. The commission recognizes the challenges

associated with such changes and believes that appropriate planning is necessary for success, including realistic timelines and strong inter-agency collaboration. Additionally, the commission acknowledges the vital role of the Department of Administration (DOA) in the implementation of these recommendations. DOA has the necessary expertise to successfully restructure state agencies – knowledge and experience in the areas of compensation, hiring practices, personnel, budgets, and contracting will be crucial. An EOHHS restructuring plan without DOA leadership and involvement could face major implementation setbacks. The commission calls upon DOA to be an active participant in the execution of these recommendations.

The commission's recommendations aim to improve the efficiency and effectiveness of health and human services administration in Rhode Island. They are a result of expert testimony and thorough discussion among the knowledgeable and experienced commission members. These recommendations are *not* a negative reflection on the hard-working employees within EOHHS and its sub-agencies, but instead are intended to support employees in their important mission-driven work. As noted throughout this document, many of the recommendations will require legislation for implementation, and it is expected that more detailed legislative proposals will result from the work of the commission.

BACKGROUND

The Executive Office of Health and Human Services was created via Executive Order in 2005 and was codified in statute during the 2006 legislative session. According to Jane Hayward's presentation submitted to the commission on October 25, 2021, the creation of EOHHS resulted from a "business approach to government" and was considered a "fiscal fitness initiative" with the intention of consolidating "like functions across the Executive Branch to achieve increased efficiency as well as coordinate policy agenda and direction." [1]

EOHHS is administered by the Secretary of Health and Human Services, who is "responsible to the Governor for supervising the Executive Office of Health and Human Services and for managing and providing strategic leadership and direction to the four [health and human services] departments."[2] EOHHS is intended to be a "consumer-centered system of publicly-financed state administered health and human services that supports access to high-quality services, protects the safety of the State's most vulnerable citizens, and ensures the efficient use of all available resources by the four departments."[3]

Under Rhode Island General Law § 42-7.2-2., EOHHS is charged with leading the state's four health and human services departments in order to:

1. "Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting, and financing";
2. "Design strategies and implement best practices that foster service access, consumer safety, and positive outcomes";
3. "Maximize and leverage funds from all available public and private sources, including federal financial participation, grants, and awards";

[1]Jane Hayward: PowerPoint Presentation on October 25, 2021, slide 3. https://www.rilegislature.gov/commissions/HHS/commdocs/2021.10.27%20JH%20Hisotry%20HHS.PDF
[2]Rhode Island General Law § 42-7.2-4. http://webserver.rilegislature.gov//Statutes/TITLE42/42-7.2/42-7.2-4.htm
[3]Rhode Island General Law § 42-7.2-1. http://webserver.rilegislature.gov//Statutes/TITLE42/42-7.2/42-7.2-1.htm

4. "Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments"; and
5. "Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf," and other duties pursuant to § 42-7.2-2.

RECOMMENDATION TO REORGANIZE THE RHODE ISLAND MEDICAID PROGRAM

Recommendation 1: Create a Medicaid Department within EOHHS and elevate the role of Medicaid Director, requiring Advice and Consent by the Senate. This would put the Medicaid Director on the same level as the other sub-agency directors within EOHHS. Currently, EOHHS and Medicaid are intertwined, which complicates Medicaid's work with other departments. A dedicated Medicaid Department would be less influenced by competing priorities within the executive office. It would allow EOHHS to focus more attention and resources on streamlining centralized services, as well as carrying out a coordination and oversight role. Additionally, Medicaid's large budget, which is nearly one-third of the state's budget, warrants holding the Medicaid Director directly accountable to the Governor and the General Assembly.[4]

The commission heard multiple experts discuss the idea of creating a Medicaid Department – the topic was thoroughly debated and potential opportunities and challenges were explored. During the February 2nd meeting of the commission, Gretchen Hammer of the Public Leadership Group and former Medicaid Director in Colorado, spoke to the commission about trends in how health and human services agencies are structured nationwide. Ms. Hammer reported that typically, states with smaller populations have highly integrated health and human services functions – likely due to the size of state government, and because the population is receiving services from multiple programs at the same time. She further reported that 74% of Medicaid agencies in the United States are subdivisions within a larger HHS structure. However, within those larger HHS structures, Medicaid most often operates as an independent division with directors who are peers with directors in other divisions (e.g. the director of the department of human services). In contrast, currently in Rhode Island, Medicaid is embedded within the Executive Office of Health and Human Services "as an infrastructure program that is supporting everything," which differs from how other states tend to operate. Ms. Hammer stated: "I do think that there is some nuance in the things that you all are considering in that structure … there is a strong precedence for an integrated health and human services model, but that there may be opportunities for you to consider an independent or more defined department or division for your Medicaid program to clarify." Furthermore, during the same meeting, Linda Katz, Co-Founder and Policy Director of the Economic Progress Institute and a longtime advocate in Rhode Island, recommended making the Medicaid Director an independent position who would be responsible for all the duties related to Medicaid set forth in Rhode Island General Law § 42-7.2-5. Ultimately, based on expert testimony and much discussion, the majority of commission members recommend creating a separate Medicaid Department operating under EOHHS as the other sub-agencies currently do.

This recommendation would require legislation to create a new department. The legislation would charge the Medicaid Director with ensuring that the use of Medicaid funds meets federal rules. The Medicaid Department would provide expertise and policy support to the other sub-agencies to maximize federal

[4]Rhode Island Medicaid Expenditure Report, SFY 2019: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-05/RIMedicaidExpenditureReport_SFY19.pdf#page=5.

dollars for the Medicaid-eligible populations they serve. Legislation would shift Medicaid resources, staff, and authority from the executive office to the new department. The legislation would also outline an organizational structure and other essential guardrails to ensure clear lines of communication and coordination between Medicaid and the other EOHHS agencies. This would include Medicaid staff who would act as liaisons to the other sub-agencies and support those agencies' initiatives to improve services for their constituents.

RECOMMENDATIONS TO REORGANIZE THE DEPARTMENT OF BEHAVIORAL HEATLH, DEVELOPMENTAL DISABILITIES & HOSPITALS

Recommendation 2: Remove Hospitals from the Department of Behavioral Health, Developmental Disabilities and Hospitals and create a Department of Hospitals. This would allow for more targeted expertise in the leadership of the new Department of Hospitals – hospital management is a distinct skillset from other types of departmental management and should be treated as such. In recent years, Eleanor Slater Hospital has had a number of federal compliance and licensing issues that have negatively affected the entire department. The commission believes that a Department of Hospitals would benefit from experienced leadership that can focus solely on hospital management.

The Department of Hospitals would be a department within EOHHS, like DOH and DHS, and would include Eleanor Slater Hospital (on two campuses), the RI Veterans Home, and the new RI Psychiatric Hospital that was established in the fiscal year 2023 budget. The commission recommends that private-sector salaries be evaluated and used as a reference point when setting the salaries for leadership roles within the Department of Hospitals so that the state can recruit and retain experienced professionals to run the new department. *Creating a new Department of Hospitals would require legislation to shift BHDDH hospital programs and the RI Veterans Home to the new department.*

The commission also recommends that EOHHS explore whether it would be beneficial to make the Department of Hospitals a quasi-public agency. Status as a quasi-public agency would allow the department to respond to issues and opportunities faster and more efficiently than a comparable state agency while also maintaining a degree of oversight and accountability to the state.

In a memo sent from EOHHS to the commission on August 2, 2022, EOHHS expresses agreement with the commission's recommendation to remove hospitals from BHDDH and states, "we do believe the hospitals may benefit as a quasi-public agency."

Additionally, removing hospitals from the Department of Behavioral Health, Developmental Disabilities and Hospitals would enable the new BHDD to focus more closely on its remaining two divisions: behavioral health and developmental disabilities.

Recommendation 3: Add children's behavioral health (BH) and children's developmental disabilities (DD) to the charge of BHDD within a timeframe as recommended by EOHHS and other stakeholders. The commission recommends that this transfer occur contingent upon the recommendation to remove hospitals from BHDDH. As stated above, removing hospitals from BHDDH would allow the department to focus on BH and DD, therefore creating bandwidth to take on children's BH and DD. *Legislation would be required to shift the responsibility of overseeing the state's BH and DD systems of care from DCYF to BHDDH.*

Adding children's BH and DD programs to BHDD would promote an integrated continuum of care and would improve the youth to adult services transition process. Currently, the Department of Children Youth and Families (DCYF) is charged with overseeing the statewide system of care for children and youth requiring behavioral health services, including those children who are involved with the department due to abuse or neglect. According to EOHHS, "in calendar year 2021, there were 110,125 children with any Medicaid claim. Of those, 29,950 (27%) had at least one Medicaid claim for a behavioral health service. And of the 110,215 children, 15,533 (14%) are involved in DCYF. The number of children in calendar year 2021 who are involved with DCYF and have a behavioral health Medicaid claim is 6,853 (6%)." Therefore, the proportion of non-DCYF-involved children on Medicaid with a behavioral health claim is higher than the proportion of DCYF-involved children with a behavioral health claim. Additionally, it was anecdotally reported to the commission that families who are not involved with DCYF due to abuse or neglect are hesitant to engage with the department for purposes strictly related to BH or DD, which hinders access to such services. For these reasons, having both youth and adult services fall under one department would make services accessible without reference to whether the child's guardian is a family or the state, thus increasing access to services.

A memo from the Rhode Island Coalition for Children and Families to the commission aptly explains:

> "Children's behavioral health policy, programming, data collection, and resourcing currently are situated in multiple governmental departments and private sector organizations and insurers. DCYF has statutory responsibility for children with serious emotional disturbance, BHDDH has responsibility for youth substance use, RIDOH has oversight of family visiting programs, RIDE has oversight of school programming, DHS has oversight of early care and education, EOHHS/Medicaid and OHIC has program, policy, and insurance oversight responsibility, and community-based organizations and hospitals are the primary providers of services, and youth and families are the beneficiaries of service. These groups are all key stakeholders in the children's behavioral health system."

The commission recognizes that the timing of this recommendations is crucial – moving children's BH and DD from DCYF to BHDD is a large undertaking that will require strong leadership and inter-agency cooperation. Executing this recommendation at an inappropriate time could impede service delivery, which is counter to the commission's goals. Therefore, the commission further recommends that EOHHS convene all aforementioned stakeholders to review and recommend a transition plan for moving children's BH and DD to BHDD. The stakeholders' plan should include an appropriate and justified timeline for this transition and recommend a leadership and administrative structure within BHDD to oversee a comprehensive children's behavioral health system. The plan should establish a process for design, implementation, and resourcing of such a structure and system. The commission recommends that this stakeholder group provide a report to the General Assembly by January 1, 2023.

RECOMMENDATIONS TO REALIGN THE SCOPE AND AUTHORITY OF EOHHS

Recommendation 4: Strengthen accountability by giving the EOHHS Secretary authority to make recommendations to the Governor regarding appointment and removal of the agency directors. The Governor would be required to give due consideration to the recommendations of the EOHHS Secretary regarding the appointment and removal of directors of the agencies that report to EOHHS. This would give the Secretary an official role in the selection process of those directors who will be held accountable to the Secretary, to help form an effective and efficient team. The authority regarding removal

recommendations would give the Secretary a role in addressing accountability issues to ensure success of the EOHHS team.

The Secretary of Massachusetts's Executive Office of Health and Human Services, Marylou Sudders, presented to the commission during the February 16th meeting. Secretary Sudders made it clear that her ability to recommend, evaluate, and remove agency directors is an important tool that allows her to hold directors accountable, and strengthens her authority and effectiveness as a leader. The commission gave strong consideration to Secretary Sudders' testimony and the Massachusetts model of agency appointments and accountability, surfacing both the strengths of such a reporting structure as well as the constitutional and practical questions if such a model were to be recommended for Rhode Island. Ultimately, Secretary Sudders' testimony and insight informed the commission's recommendation to give the Secretary the authority to make recommendations to the Governor regarding the appointment and removal of the sub-agency directors. *Legislation would be required to accomplish this recommendation.*

Recommendation 5: Create a stakeholder group to ensure appropriate input for the rate review process that was included in the 2023 budget to hold the Office of the Health Insurance Commissioner (OHIC) accountable through public meetings, ensuring that the process is transparent. The fiscal year 2023 budget allocates $1.5 million to OHIC to "conduct a comprehensive analysis of all state licensed and contracted social and human service providers, to include review of rates, eligibility, utilization, and accountability standards pursuant to Rhode Island General Law, Section 42-14.5-3(t)." The new law requires OHIC to conduct public meetings to allow stakeholders the opportunity to ask questions and provide comment. The new law also requires consultation with EOHHS. Though the law requires that public meetings be held, the commission recommends that a formal stakeholder group also be created. *This recommendation could be accomplished through executive action; legislation would not be required.*

Additionally, commission members expressed a need for tracking community access to social and human services programs provided by the state and by state-contracted providers. The new law will require "an assessment and reporting on access to social and human service programs, to include any wait lists and length of time on wait lists, in each service category." The commission supports this provision, which can be used to hold the Secretary accountable for improving access to services in the community.

Recommendation 6: Create a Health and Human Services Cabinet, which the Secretary would be held accountable for convening, in order to achieve certain outcomes that would be reported to the legislature on a regular basis. The cabinet would be required to regularly hold public meetings, which would increase transparency and improve accountability between member-agencies and to the public. The commission recognizes that to be successful, the cabinet needs to be appropriately resourced and staffed. This cabinet would be a similar model to the Children's Cabinet and *would be established in statute.*

The Health and Human Services Cabinet would work to strengthen cross-agency alignment, effectively use data, and ultimately coordinate policies and programs that advance equity, eliminate disparities, and improve population level outcomes. The commission recommends that the cabinet include all agencies within EOHHS (BHDDH, DCYF, DHS, and DOH), the new agencies proposed to be created in this document, OHIC, HealthSource Rhode Island, the Secretary of Housing, the Department of Education, the Department of Corrections, Department of Labor and Training, the Department of Administration, and community provider agencies. The recommended composition represents agencies that work directly in health and human services along with agencies that work in areas related to the social determinants of

health, enabling the cabinet to work towards administering health and human services in a holistic manner.

Additionally, the commission recommends that the Health and Human Services Cabinet have a formal relationship with a higher education partner that would provide staff support and research capabilities to the cabinet.

Recommendation 7: Increase the salary of the Secretary of EOHHS, and the salaries of the directors of agencies that report to EOHHS, in order to support recruitment and retention. In recent history, it has been challenging to recruit a secretary and directors – as is evident by the current leadership vacancies within EOHHS and its sub-agencies. It is extremely important for agencies to have strong leadership in place to promote stability in the HHS agencies.

The Secretary oversees the largest state budget, and programs under EOHHS affect a large portion of the Rhode Island population. The commission recommends that a salary increase be based on comparable leadership positions within state government, including the Secretary of Commerce and the Health Insurance Commissioner. The new salary should also be competitive with comparable roles in the region. *A salary increase would need be included in the state budget.*

The fiscal year 2023 budget allows the Department of Administration to propose salary increases for agency directors to the General Assembly by October 30, 2022. The commission recommends significant increases to the salaries of the Secretary of EOHHS, in addition to increases for the directors of the agencies within in EOHHS. The work of these agencies is complex and should be compensated accordingly to attract skilled candidates.

Together with sufficient provider rates, appropriate compensation structures within EOHHS will support leadership continuity, talent acquisition, and overall workforce stabilization across the health and human services ecosystem in Rhode Island.

OTHER RECOMMENDATIONS

Recommendation 8: Include the Department of Children, Youth and Families in the biannual Caseload Estimating Conference (CEC). The CEC is an open public meeting held each May and November to forecast caseloads to provide for a more stable and accurate method of financial planning and budgeting. The Governor's budget is required to include the estimates determined by the CEC in the executive budget, and the General Assembly must make appropriations in accordance with the estimates.[5] Currently, certain programs within BHDDH, DHS, and EOHHS are included in the CEC. The commission recommends that DCYF be included in the CEC to improve the department's financial planning and budgeting process. *Legislation would be required to include DCYF in the CEC.*

The commission further recommends that caseload estimates inform staffing levels within EOHHS, its sub-agencies, and within the community agencies who provide state-contracted health and human services to Rhode Islanders. The commission specifically acknowledges a need for more attorneys within EOHHS. An appropriate number of attorneys assigned to EOHHS and each sub-agency should be determined based on scope of work, including caseloads *and* the specific fluctuating legal needs of a department at any given time (e.g. managing federal court oversight of a department). The commission heard that it is beneficial

[5] Rhode Island General Law § 35-17. http://webserver.rilegislature.gov//Statutes/TITLE35/35-17/INDEX.htm

for EOHHS to employ a “law firm” model and deploy attorneys to each department based on the current legal needs of a department at any given time. The commission also heard that certain agencies have lost attorneys to other agencies based on higher pay and less demanding workloads. The commission recommends that EOHHS appropriately staff each agency to meet legal needs, and that EOHHS conduct a wage analysis to ensure that the compensation structure does not lead to agencies competing among each other for attorneys.

ADDENDUM

SENATE RESOLUTIONS

MEETING AGENDAS, PRESENTATIONS, AND CAPITOL TV RECORDINGS

October 27, 2021:	Agenda, Presentations, and Capitol TV Recording
November 16, 2021:	Agenda, Presentation, and Capitol TV Recording
November 30, 2021:	Agenda, Presentation, and Capitol TV Recording
December 16, 2021:	Agenda, Presentation, and Capitol TV Recording
January 20, 2022:	Agenda, Presentation, and Capitol TV Recording
February 2, 2022:	Agenda, Presentations, and Capitol TV Recording
February 16, 2022:	Agenda, Presentations, and Capitol TV Recording
March 2, 2022	Agenda and Capitol TV Recording
August 3, 2022:	Agenda and Capitol TV Recording

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

S E N A T E R E S O L U T I O N

CREATING A SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

Introduced By: Senator Louis P. DiPalma

Date Introduced: June 27, 2021

Referred To: Senate Health & Human Services

WHEREAS, The Executive Office of Health and Human Services (EOHHS) was established in state law in 2006 to serve as the principal agency of the executive branch of state government to manage the State's four health and human services departments: the Departments of Children, Youth and Families (DCYF), Health (RIDOH), and Human Services (DHS), and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); and

WHEREAS, The Executive Office of Health and Human Services (EOHHS) is administered by the Secretary of Health and Human Services who is responsible to the Governor for supervising EOHHS and for managing and providing strategic leadership and direction to the four health and human services departments; and

WHEREAS, EOHHS is intended to be a consumer-centered system of publicly-financed state administered health and human services that supports access to high-quality services, protects the safety of the State's most vulnerable citizens, and ensures the efficient use of all available resources by the four departments responsible for the health and human services programs serving all Rhode Islanders and providing direct assistance and support services individuals and families; and

WHEREAS, EOHHS was charged with leading the four (4) departments in order to:

(1) Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting, and financing;

(2) Design strategies and implement best practices that foster service access, consumer safety, and positive outcomes;

(3) Maximize and leverage funds from all available public and private sources, including federal financial participation, grants, and awards;

(4) Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments; and

(5) Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf, and other duties pursuant to § 42-7.2-2; and

WHEREAS, The health and human services landscape has changed greatly since 2006; now, therefore be it

RESOLVED, That a special legislative commission be and the same is hereby created consisting of not more than eleven (11) members: three (3) of whom shall be members of the Senate, not more than two (2) from the same political party, to be appointed by the President of the Senate; and not more than eight (8) of whom shall be members with relevant expertise and experience as providers, partners and/or stakeholders of the Executive Office of Health and Human Services, the Medical Assistance (Medicaid) Program, the Department of Children, Youth and Families, the Department of Human Services, the Department of Health, and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, to be appointed by the President of the Senate.

In lieu of any appointment of a member of the legislature to a legislative study commission, the appointing authority may appoint a member of the general public to serve in place of a legislator, provided that the Senate President or the Minority Leader of the political party that is entitled to the appointment consents to the appointment of the member of the general public.

The purpose of said commission shall be to review and make recommendations on how to most efficiently and effectively administer health and human services in the state of Rhode Island.

Forthwith upon passage of this resolution, the members of the commission shall meet at the call of the President of the Senate, who shall appoint a Chair of the commission. Vacancies in said commission shall be filled in like manner as the original appointment.

A quorum of the commission shall consist of a majority of its membership, and the membership of said commission shall receive no compensation for their services.

All departments and agencies of the state, shall furnish such advice and information,

documentary or otherwise, to said commission and its agents as is deemed necessary or desirable by the commission to facilitate the purposes of this resolution.

The Joint Committee on Legislative Services is hereby authorized and directed to provide suitable quarters for said commission; and be it further

RESOLVED, That the commission shall report its findings and recommendations to the President of the Senate on or before March 1, 2022, and said commission shall expire on July 1, 2022.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

S E N A T E R E S O L U T I O N

CREATING A SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

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This resolution would create a not more than eleven (11) member special legislative commission whose purpose it would be to review and make recommendations on how to most efficiently and effectively administer health and human services in the state of Rhode Island, and who would report back to the Senate no later than March 1, 2022, and whose life would expire on July 1, 2022.

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2022

S E N A T E R E S O L U T I O N

EXTENDING THE REPORTING AND EXPIRATION DATES OF THE SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

Introduced By: Senator Joshua Miller

Date Introduced: June 09, 2022

Referred To: Placed on the Senate Consent Calendar

RESOLVED, That the special legislative commission created by resolution No. 338 passed by the Senate at its January session, A.D. 2021, and approved July 1, 2021, entitled "Senate Resolution Creating a Special Legislative Commission To Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island" is hereby authorized to continue its study and make a report to the Rhode Island Senate on or before September 1, 2022, and said commission shall expire on January 1, 2023; and be it further

RESOLVED, That the time for reporting authorized by resolution No. 338 passed by the Senate at its January session, A.D. 2021, and approved July 1, 2021, be and the same is hereby rescinded.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

S E N A T E R E S O L U T I O N

EXTENDING THE REPORTING AND EXPIRATION DATES OF THE SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

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This resolution would extend the reporting and expiration dates of the special legislative commission to review and make recommendations regarding the efficient and effective administration of Health and Human Services programs in the State of Rhode Island, from July 1, 2022, to September 1, 2022, and said commission would expire on January 1, 2023.

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Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Notice of Meeting

DATE: Wednesday, October 27, 2021

TIME: 3:00 PM – 5:00 PM

PLACE: Senate Lounge – State House

Agenda:

I. Opening remarks

II. Presentation by Jane Hayward
President and CEO, Rhode Island Health Center Association

III. Roundtable discussion

IV. Presentation by National Conference of State Legislatures

V. Roundtable discussion

VI. Next meeting date(s)

VII. Public comment

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

History of Health and Human Service Organization in Rhode Island State Government

Jane Hayward, President & CEO
Rhode Island Health Center Association
October 25, 2021

History of Health and Human Service Organization
Rhode Island State Government
1935-1970

Boards & Commissions

- Department of Public Welfare 1935-1939
- Department of Social Welfare 1939 –1970

Decentralization of Services

- Department of Social and Rehabilitative Services,
- Department of Mental Health, Developmental Disabilities, and Hospitals;
- Department of Children Youth and Families,
- Department of Corrections

Call for Business Approach to Government

December 1, 2005, Executive Order

- Governor Carcieri created the **Executive Office of Health and Human Services (EOHHS)**
- Codified in statute in the 2006 General Assembly session

Intent

- Fiscal Fitness Initiative
- Desire to consolidate like functions across the Executive Branch to achieve increased efficiency as well as coordinate policy agenda and direction.
- Initial discussions focused on creating Secretariats for Health and Human Services, Transportation and Public Safety
- Health and Human Services consolidation was the only consolidation to move forward at that time.

Structure
EOHHS

Patterned after similar structure in the states of Virginia and Massachusetts
Umbrella structure
Designed for interdepartmental policy coordination and the consolidation of administrative support functions i.e., budget and finance, legal, human resource, information technology
Centralize the single state agency authority for Medicaid
Secretary has limited authority over departments
Departmental Directors continued to be appointed by the Governor with advice and consent of the Senate
Statutory authority and framework for the respective departments remained intact

Initial Implementation Priorities

EOHHS Structure cont.

- Initial staff of the Executive Office was under 10 FTEs
- Creation of collaboration model among the Office and the Departments
- Designating the Office as the single state agency for Medicaid

Long Term Opportunity

- Reorganize by functional areas i.e., behavioral health, long term care services and supports
- Cradle to grave continuum of services

Limitations of the Model

Dependent on the engagement and commitment of the Governor to support the structure

Ongoing framework of statutory authority remains in the respective departments

Vulnerable to resistance to change and the efforts and energy employed to retain the status quo

Health and Human Services Agencies: Trends in Organization and Governance

Emily Blanford, Program Principal, NCSL Health Program

October 27, 2021

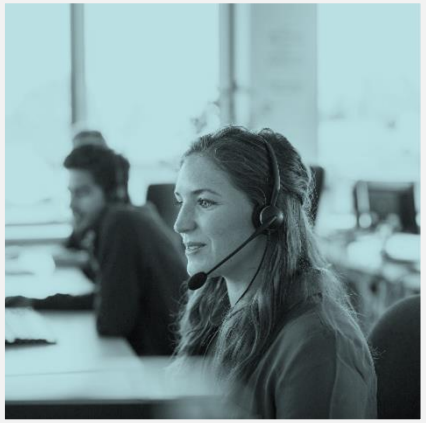
How NCSL Strengthens Legislatures

Policy Research

NCSL provides trusted, nonpartisan policy research and analysis

Connections

NCSL links legislators and staff with each other and with experts



Training

NCSL delivers training tailored specifically for legislators and staff

State Voice in D.C.

NCSL represents and advocates on behalf of states on Capitol Hill

Meetings

NCSL meetings facilitate information exchange and policy discussions

Agency Types

Umbrella

- Sometimes called “superagency”
- Responsible for a variety of services including public health activities, Medicaid, public assistance, long-term care and mental/behavioral health and substance use services

Standalone

- Standalone agencies are responsible for one area of health and typically report directly to the governor or governing board
- Examples include agencies solely responsible for administration of the Medicaid program or solely responsible for public health

Public Health Agencies

- Organization
  - 30 agencies are standalone agencies
  - In 20 agencies, public health is a division or unit within an umbrella agency
- Governance
  - 66% of State Health Officials (SHOs) were appointed by the Governor
  - 14% of SHOs were appointed by an umbrella agency secretary
  - 10% of SHOs were appointed by a board or commission

Source: Association of State and Territorial Officials (ASTHO)"Profile of State and Territorial Health", 2017 and 2019

Medicaid Agencies

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- Organization
  - 10 agencies are standalone Medicaid agencies
  - In 35 agencies, Medicaid is a division or sub-division of an umbrella agency
- Governance
  - In 29 agencies, the Medicaid Director reports to a cabinet-level leader (for example, secretary of health)
  - In 7 agencies, the Medicaid Director reports directly to the Governor
  - In one agency, the Medicaid Director reports to a board of directors

Source: National Association of Medicaid Directors (NAMD), "Seventh Annual Medicaid Operations Survey"

State Examples and Trends

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Umbrella Agencies

- **Texas** enacted SB 200 (2014) and SB 208 (2014), which led to the consolidation of five health and human services agencies into two: the Human Services Commission and the Department of State health Services
- **Kansas** in 2011, Governor Brownback signed Executive Reorganization Order No. 38 to consolidate agencies

Behavioral Health

- **Washington** enacted HB 1388 (2017) to transfer the oversight of provision of behavioral health services to from the Department of Health and Social Services to the Health Care Authority
- **Arizona** consolidated physical and behavioral health agencies in 2015

Umbrella Agencies Recent Legislation

- Utah enacted HB 365 (2021) to consolidate the Department of Health and the Department of Human Services into a single state agency
- North Dakota enacted HB 1247 (2021) to merge the Departments of Health and Human Services

Emily Blanford

Program Principal
NCSL Health Program

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Reach out anytime!

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The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 1 – 10.28.2021

http://ritv.devosvideo.com/show?video=d60602b7e460&apg=ed687894

Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

NOTICE OF MEETING

DATE: Tuesday, November 16, 2021
TIME: 3:00 PM – 5:00 PM
PLACE: Senate Lounge - State House

Agenda:

I. Opening remarks

II. Presentation by the Executive Office of Health and Human Services

a. The mission, function, and organizational structure of the Central Management Division

III. Roundtable discussion

IV. Public Comment

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

POSTED: FRIDAY, NOVEMBER 12, 2021, 3:05 P.M.

Executive Office of Health & Human Services

HHS Commission Presentation
November 16, 2021

RHODE ISLAND

Introduction to EOHHS

EOHHS is an umbrella organization and the Single State Authority for Medicaid in Rhode Island.

Our core functions support the agencies under the HHS umbrella:

- BHDDH
- DCYF
- RIDOH
- DHS
- Office of Healthy Aging
- Office of Veterans Services

EOHHS's Priorities

Our mission: Ensure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders. We accomplish our mission by:

ONE

Preserving and improving ***access*** to quality, cost-effective healthcare

TWO

Shifting systems and investments to prevention, value, choice, and ***equity***

THREE

Curbing the opioid epidemic, addressing addiction, and ***improving*** mental health services

FOUR

Promoting efficient, effective and ***fair*** delivery of services

EOHHS's Guiding Principles

CHOICE

- **Full Choice for Individuals and Families**

- Every resident that we engage must be given the right to choose and influence what they receive. Options must exist.
- Whole person
- Respect and dignity

RACE EQUITY

- **Race Equity**

- We must ask ourselves every time we create a policy, procedure, practice or implement a plan "What role if any is race play in the decisions we make? Is this equitable? Is this fair?"
- We must ask ourselves every time we create/fill a position or look to promote "What role if any is race playing in our decision making?" Recruitment, retention, and promotion of people of color must be priority.

ENGAGEMENT

- **Community Engagement**

- We need to intentionally have community at the table from the onset and throughout. We must ensure that the community voice is heard and respected. Balance power.
- We must ask the community what they need before we act and not assume we know what is best or do what works best for government.
- We must engage community using a racial equity lens.

EOHHS Central Management Core Functions

These core functions help support the HHS agencies under our umbrella:

- Budget and Finance
- Data Management and Analysis
- Legal Division and Appeals Office
- Performance Management
- Policy Development and Analysis
- Public/Legislative Affairs

Our aims are to promote efficiencies, interagency coordination & alignment, collaboration, and accountability through performance management.

What's Working (1 of 3)

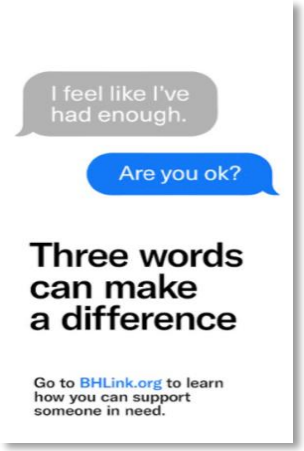
Using data to drive action, and inform policy and decision making. Examples include:

- State Data Ecosystem - Data and Evaluation Planning Processes
- Carrying Out the Evidence Update for the Governor's Overdose Prevention and Intervention Task Force
- Long Term Supports & Services Policy Development
- Behavioral Health System Transformation Planning Across the Lifespan
- Creating COVID-19 Data Dashboards

What's Working (2 of 3)

Public Affairs – interagency coordination of communication efforts with those we serve, our partners and stakeholders, and the RI General Assembly

- Communications and Legislative Coordination
- COVID-19 Equity Council Support
- Media Campaigns
  - Behavioral Health
  - Birth to 5 - Pre-K, Child Care, etc.
  - Medication Lock Up
  - Overdose Prevention
  - Safe Sleep
  - Substance Exposed Newborns



What's Working (3 of 3)

Public/private interagency policy alignment

- Long Term Services & Supports
- Behavioral Health System Transformation Planning Across the Lifespan
- Workforce Stabilization
- Telemedicine
- Race Equity Work
- Health System Transformation (e.g., State Innovation Model Test Grant, Integration of Physical and Behavioral Health, Hospital Capacity Planning, Health Information Technology, Accountable Entities)

EOHHS's Management of HHS Agencies

- One on One Meetings with Directors for oversight and direction
- PULSE Performance Management Meetings with Agencies
- Bi-Weekly Directors' Meetings, with all Health Cabinet Members
- CFO Monthly Group Meetings and One on Ones with the EOHHS CFO
- Executive Counsel Meetings and One on Ones with EOHHS Executive Legal Counsel
- Coordinated Race Equity Work Across the Secretariat
- Public Affairs Weekly Meetings during General Assembly Session
- Staff Deployment To HHS Agencies When Needed

Challenges With Current EOHHS Structure

Hybrid systems can lead to silos and fractured systems of care

- Resource Needs
- Responsibility and Accountability but Lack of Authority
- Reporting Structure
- Centralization of Public Affairs Staff
- Lack of Adequate Support Staff for Attorneys
- Department-Centric Policy:
    - Behavioral Health Data Sharing
    - Facility and Professional Licensure regulations not integrated with workforce planning and development

Mechanisms for Feedback

- Community engagement is one of the key EOHHS principles and we all prioritize and carry that out individually and within our structures, in a variety of ways:
    - Our Leadership Team at EOHHS holds ongoing discussions with community and residents
    - We hold regular formal meetings with community partners through public Steering Committees, Task Forces, and Work Groups
    - We participate in other agencies' meetings, structures, and coalitions – those we lead and organize and those we engage with organized by others
- We recruit and welcome Community Co-Chairs on key initiative workgroups

Top Recommendations for a Stronger, More Efficient Secretariat

- Maintain EOHHS as the single state authority for Medicaid
- Implement recommendations from EOHHS-wide Program Operational Review (currently underway)
- Maximize the Secretariat's work on equity and racial justice to build even stronger, more efficient, family- and community-centered services
- Formalizing the Health Cabinet, through alignment with EOHHS
- Legislative changes
- Resources

APPENDIX

RHODE ISLAND

EOHHS's Statutory Role (42-7.2-5)

Oversight, coordination, and cohesive direction of state-administered health and human services and in ensuring the laws are faithfully executed

Coordinate the administration and financing of healthcare benefits, human services, and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX of the U.S. Social Security Act.

Implement service organization and delivery reforms that facilitate service integration, increase value, and improve quality and health outcomes.

Resolve administrative, jurisdictional, operational, program, or policy conflicts among departments and their executive staffs and make necessary recommendations to the governor.

Ensure continued progress toward **improving the quality, the economy, the accountability and the efficiency of state-administered health and human services**

Prepare and integrate comprehensive budgets for the health and human services departments and any other functions and duties assigned to the office.

Utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development.

Establishment of an integrated approach to **interdepartmental information and data management** that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to a **consumer-centered integrated system** of state administered health and human services.

At the direction of the governor or the general assembly**, conduct independent reviews** of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.

Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda.

Employ such personnel and contract for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.

Assume responsibility for **complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records,** in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

Hold the director of each health and human services **department accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of their agencies.**

EOHHS Priorities 2021 – 2023

Race, Equity, and Community Engagement

COVID-19 Response – COVID Equity Council

Core functions: Policy, Planning & Strategy; Performance Management; Data Analytics; Finances, HR, Legal; Public Affairs and Medicaid Program

Preserve and Improve Access to Quality, Cost-Effective Healthcare

Leads: EOHHS/Medicaid, RIDOH, DHS & OHIC

Health System Transformation
- MCO Re-Procurement
- Hospital + healthcare re-orientation
- Investments in primary care and Accountable Entities
- Early Intervention, Home Based Therapeutics, Family Home Visiting, Pediatric Care and Children's System of Care

Investments in social determinants & health equity
- HEZ expansion + Blue Meridian new grant
- AE/HEZ & Equity alignment
- Community Resource Platform and Rhode to Equity

Health Information Technology

Shift Systems and Investments to Prevention, Value, Choice, and Equity

Lead: EOHHS/Medicaid, DCYF and BHDDH

Long-Term Care Resiliency & Rebalancing
- Workforce and Provider Transformation Investments
- Self Directed / IP Model Expansion
- No-Wrong Door
- Nursing Home Repurposing
- Safe Staffing Implementation

DCYF Child Welfare Reform
- Update operational and practice model
- Expand Foster & Adoptive Capacity
- Reimaging of the Training School & Creation of Alternatives

DDD Consent Decree Exit
- Reinvestment in employment and integrated day programming

Curb the Opioid Epidemic, Address Addiction, and Improve Mental Health

Lead: EOHHS/Medicaid RIDOH & BHDDH

Behavioral Health & Substance Use Epidemic Planning
- More strategic dollar allocations + financial mapping
- Launch targeted campaign to address stigma amongst communities of color, indigenous communities and other marginalized communities
- Complete OD evidence refresh and implement recommendations + expand focus to substance addiction
- BH Planning + expanding focus to mental health more broadly and statewide system impact;
- Development of CCBHC practice and rate model

Community Engagement

Below is a sample of the many ways that EOHHS engages community in our work.

Secretary's Visits – Health Equity Zones, Community Health Centers, Provider Roundtables, etc.

Children's System of Care Planning Teams – 8 Workgroups meeting monthly

Governor's Overdose Task Force, including 10 Public/Private Workgroups, which EOHHS members attend

Medicaid Community Engagement – Consumer Advisory Council, Accountable Entities Meetings, etc.

Participation in the Governor's Behavioral Health Council and Long-Term Care Coordinating Council

Health Information Technology Steering Committee – public/private committee from the HIT Statewide Roadmap and Implementation Plan

Proposed Workforce Planning Interagency Public/Private Committee

COVID-19 Equity Council

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 2 – 11.16.2021

http://ritv.devosvideo.com/show?video=d94e6b245e64&apg=ed687894

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

THIS IS A REVISED AGENDA

NOTICE OF MEETING

DATE: Tuesday, November 30, 2021
TIME: 3:00 P.M.- 5:00 P.M.
PLACE: Room 313 - State House

Agenda:

I. Opening remarks

II. Presentation by the Executive Office of Health and Human Services on the Rhode Island Medicaid Program

~~III. Presentation by Jeffrey A. Meyers~~
~~Director, Healthcare Strategy at Guidehouse~~

IV. Public comment

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

POSTED: WEDNESDAY, NOVEMBER 24, 2021, 3:45 P.M.
REVISED: TUESDAY, NOVEMBER 30, 2021, 12:55 P.M.

Medicaid Senate HHS Commission Presentation

November 30, 2021

RHODE ISLAND

Agenda

1. Medicaid Overview and Initiatives
2. Medicaid Rate Setting
3. Managed Care Re-Procurement

Medicaid Overview

RHODE ISLAND

Medicaid Overview - Authority

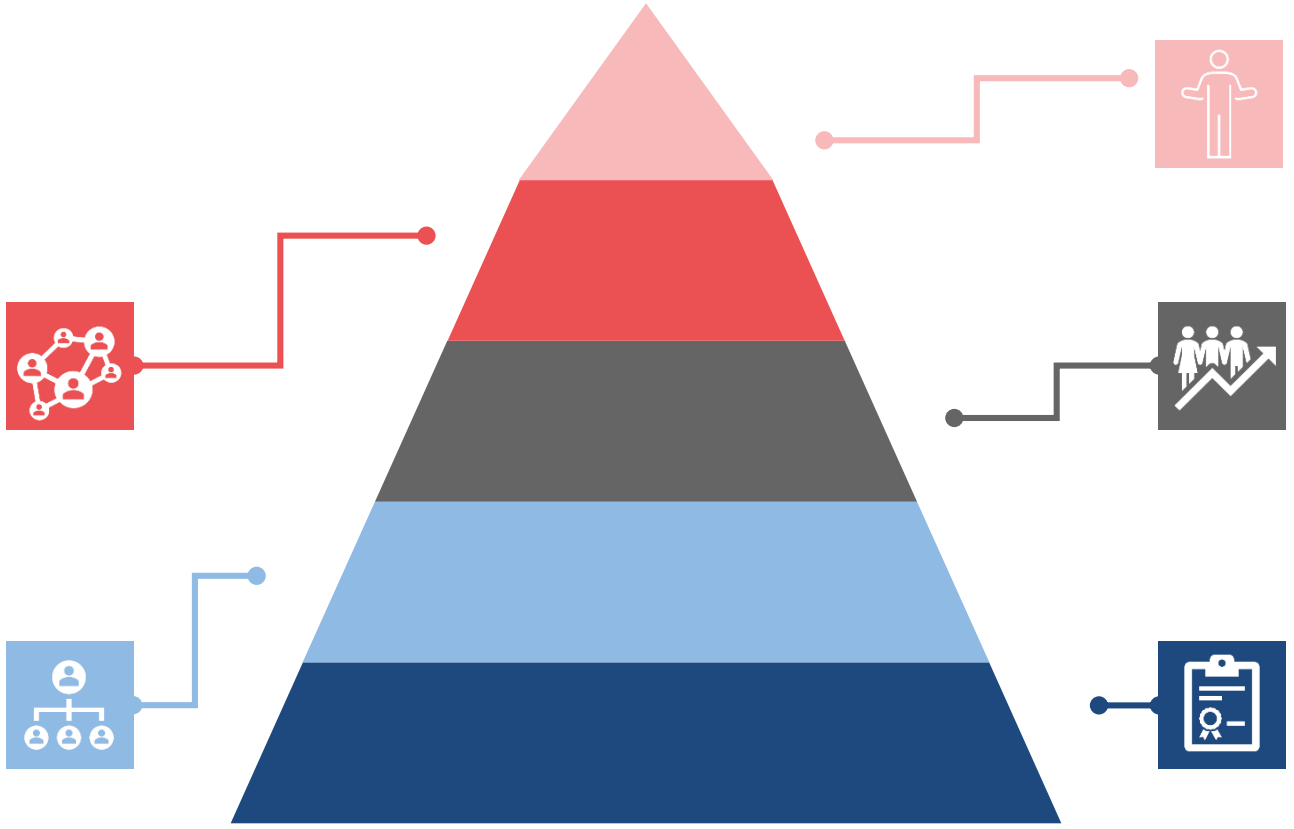
Medicaid is a state and federally funded health insurer for people exhibiting categorical or financial need. The Center for Medicare and Medicaid Services (CMS) relies on states to administer their own Medicaid programs.

Managed Care

35 states, including Rhode Island, contract with managed care plans to deliver Medicaid services on a capitated basis.

EOHHS

Rhode Island' s Executive Office of Health & Human Services (EOHHS) administers the state's Medicaid program.



Medicaid Enrollee

Medicaid is a member centric program to provide medical, long-term care behavioral health and rehab services.

Affordable Care Act

In 2012 the ACA made it an option for states to expand Medicaid eligibility, which Rhode Island chose to do in 2014.

Federal Authority

Title XIX of the Social Security Act authorizes Medicaid through State Plan and 1115 Waiver

RI Medicaid Today – Eligibility

RI Medicaid coverage is extended to the following groups, largely dependent on income. Rhode Island has chosen to expand eligibility beyond what is federally mandated.

Children & Families

- Parents with children under age 18 with income up to 133% of the Federal Poverty Level (FPL)
- Pregnant women with income up to 253% of the FPL
- Children up to age 19 with income up to 261% of the FPL

ACA Expansion

- Childless adults ages 19-64 with income up to 133% of the FPL

Elders and Adults with Disabilities

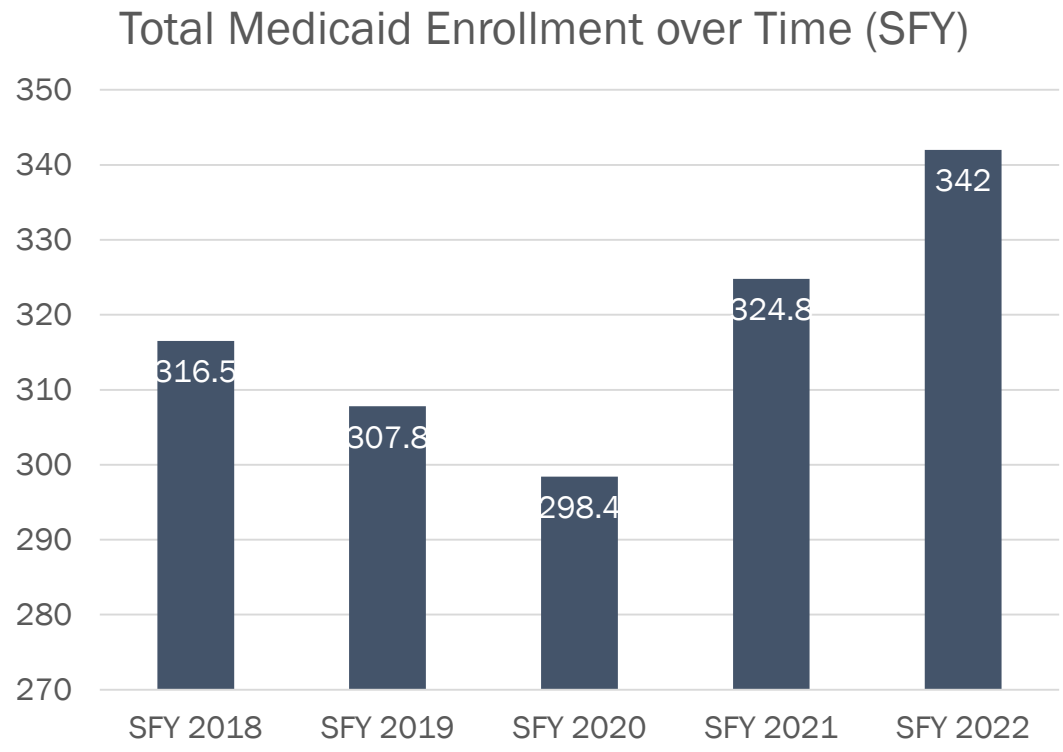
- Adults ages 65 and over with income up to 100% FPL and savings less than $4,000 (single person) or $6,000 (married couple)
- Adults receiving SSI

Special Populations (Children with Special Healthcare Needs, Substitute Care (DCYF), Extended Family Planning)

RI Medicaid Today - Enrollment

We cover ~342K Rhode Islanders in every city and town, including 55% of all children, 28% of adults and 12% of seniors in State. This represents a 15% increase over pre-pandemic levels.

Eligibility Category	Enrollment
Children and Families	174,099
Extended Family Planning	1,441
Child Welfare / DCYF	2,896
Children with Special Healthcare Needs	9,468
Expansion – Childless Adults	101,831
Aged, Blind, Disabled	27,765
Other	24,820



RI Medicaid Today – What We Cover

RI Medicaid must cover mandatory benefits per federal law, but may expand coverage to optional benefits. RI Medicaid coverage is generally considered comprehensive health insurance coverage. RI Medicaid has no cost shares or co-pays for these services.

Mandatory Benefits (All States Must Cover)

- Inpatient hospitalization
- Outpatient hospital services
- Primary care and physician services
- Lab and X Ray Services
- Home health services
- Nursing facility services
- Early and Periodic Screening, Diagnosis, and Treatment (Children's Services)
- Non-emergency medical transportation

Optional Benefits (RI Chooses to Cover)

- Prescription Drugs
- Case management and home stabilization
- Assisted Living
- Home care / personal care services
- Physical therapy and occupational therapy
- Dental services
- Optometry
- Behavioral health, psychology and substance abuse disorder
- Interpreter services

RI Medicaid Today – Managed Care Organizations

88% - or 296K members – are in one of three managed care organizations. Managed care organizations (MCOs) are responsible for cost, quality and access for their populations. MCOs receive a monthly payment from the state for each member that they take care of. Members can select their own MCO when they become eligible and change once a year.

Neighborhood Health Plan OF RHODE ISLAND™

- ~187K members as of October 2021
- Includes DCYF-Child Welfare population, exclusively.
- Also includes joint Medicaid / Medicare product called Integrity aka MMP

UnitedHealthcare®

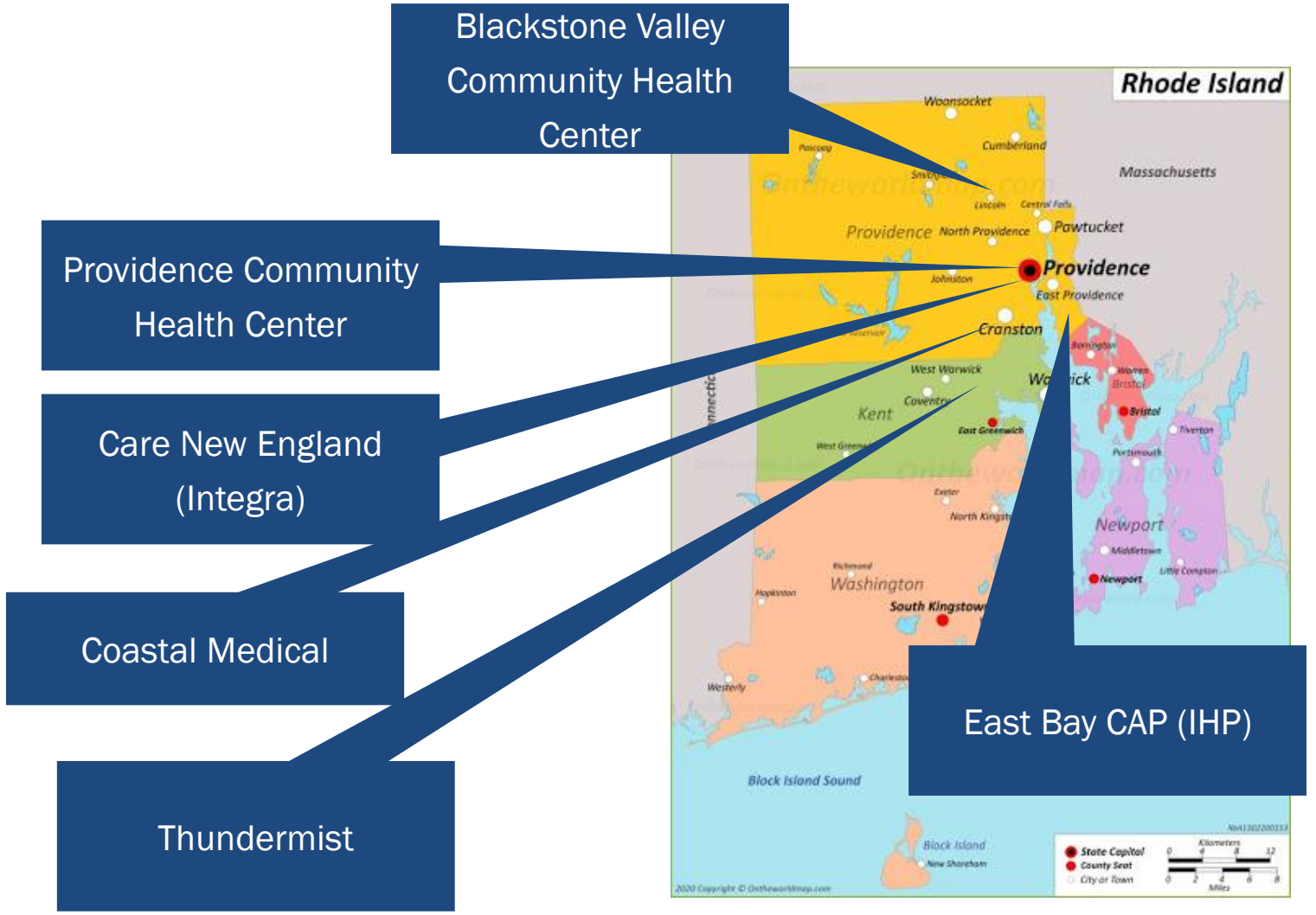
- ~97K members as of October 2021
- Includes primarily child and family, single adults and adult disabled population

TUFTS Health Plan

- ~17K members as of May 2021
- New entrant into the RI Medicaid program in 2016

RI Medicaid Today –Accountable Entities

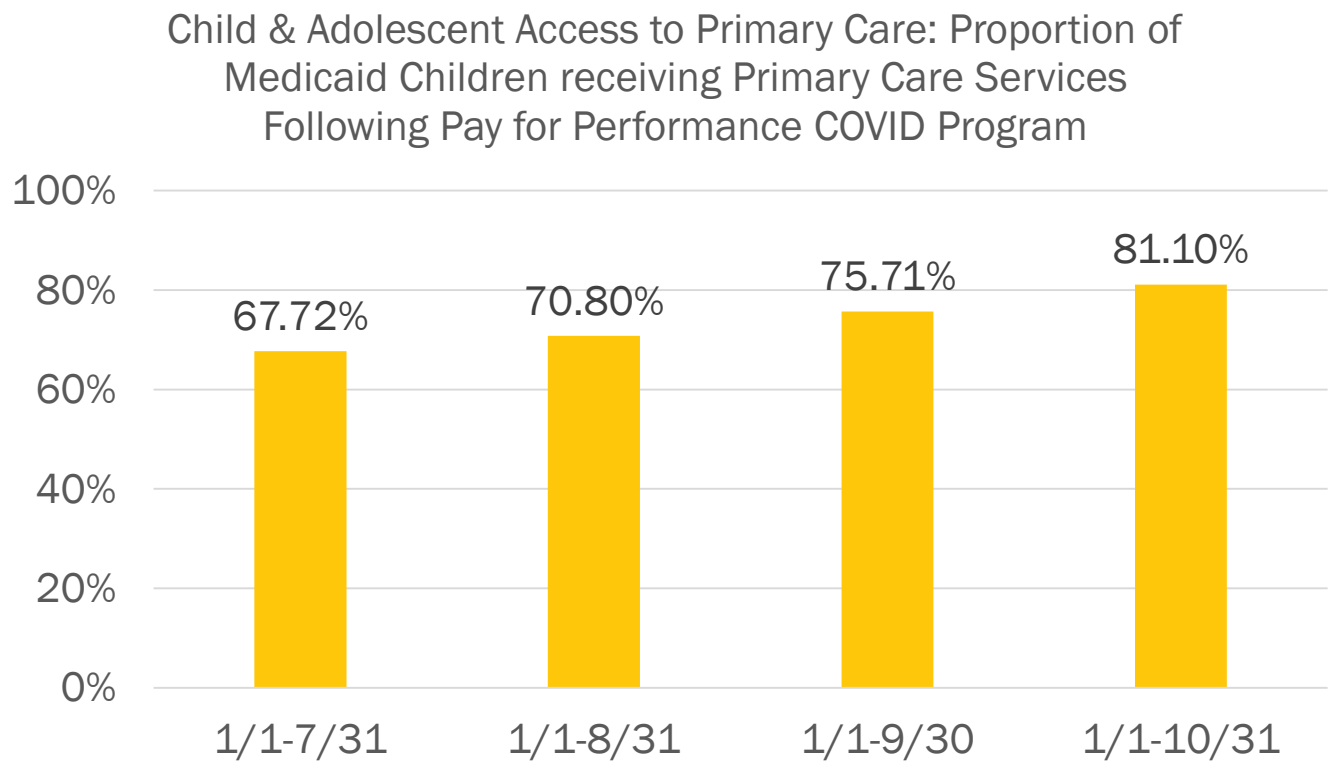
About to enter their fourth year, many Medicaid providers are organized as Accountable Entities. AEs are responsible for the primary and behavioral health care of their members. They work to make and keep their populations healthy, avoid hospitalizations and improve quality of care. These are the physicians and health care providers that most Medicaid members interact with. These AEs include health centers (PCHC, IHP, BVCHC), Hospitals (Integra/CNE, Prospect) and Primary Care (Coastal Medical).



RI Medicaid – Response to COVID-19

We were at the forefront of the COVID-19 response. We applied for ~80 emergency authorities and launched 18 financial programs with over $50M budgeted to ensure access to benefits.

- *For Workers*: ~$20M in worker supports for congregate care and home care workers as "hazard pay" during COVID-19 to ensure that no-one during COVID was making less than $15 / hr.
- *For Pediatricians*: $7M in relief and rate supplements tied to improvements in Medicaid children receiving vaccinations and check-ups. Results show a 13 percentage point increase.
- *For Children's Services and EI Providers*: $5M in provider relief tied to re-opening plans to meet family's needs.
- *For Long-Term Service and Supports Providers*: $25M across 10 different programs to support providers and expand home and community-based options



RI Medicaid – Objectives and Select Initiatives

Objectives	Select Initiatives
Access to the right care at the right time	• Planning for PHE unwinding and re-starting Medicaid renewals and terminations • COVID-19 vaccine administration • Governor's Down payment Proposal on Early Intervention and Pediatrics • Monitoring BBB Bill for Postpartum Coverage Extension
Quality care	• Managed Care Re-procurement • NF Transformation
To pay for value, not volume	• HSTP Sustainability Plan • LTSS, HCBS and BH HSTP Investments
Improve population health	• Community Resource Platform, Participatory Budgeting and Rhode to Equity • Doula and Community Health Worker Budget Implementation
Rebalance the delivery system	• HCBS FMAP (ARPA) workforce investments, no wrong door, self-directed expansion, CCBHC infrastructure payments
Excellent service	• Fill vacancies within organization • MES/MMIS Modernization

Medicaid Rate Setting

Medicaid Rate Setting - Overview

There are three ways Medicaid rates are set or amended. These mechanisms do not include “blending” funding from other sources like grants that often go to Medicaid providers (e.g. BH SAHMSA grants)

- Managed Care Rate Setting Process
- Fee For Service Rate Setting
- Managed Care Directed Payments under 42 CFR Section 438.6(b) such as incentive payments, directed payments, quality withholds, value based purchasing, or minimum rates.

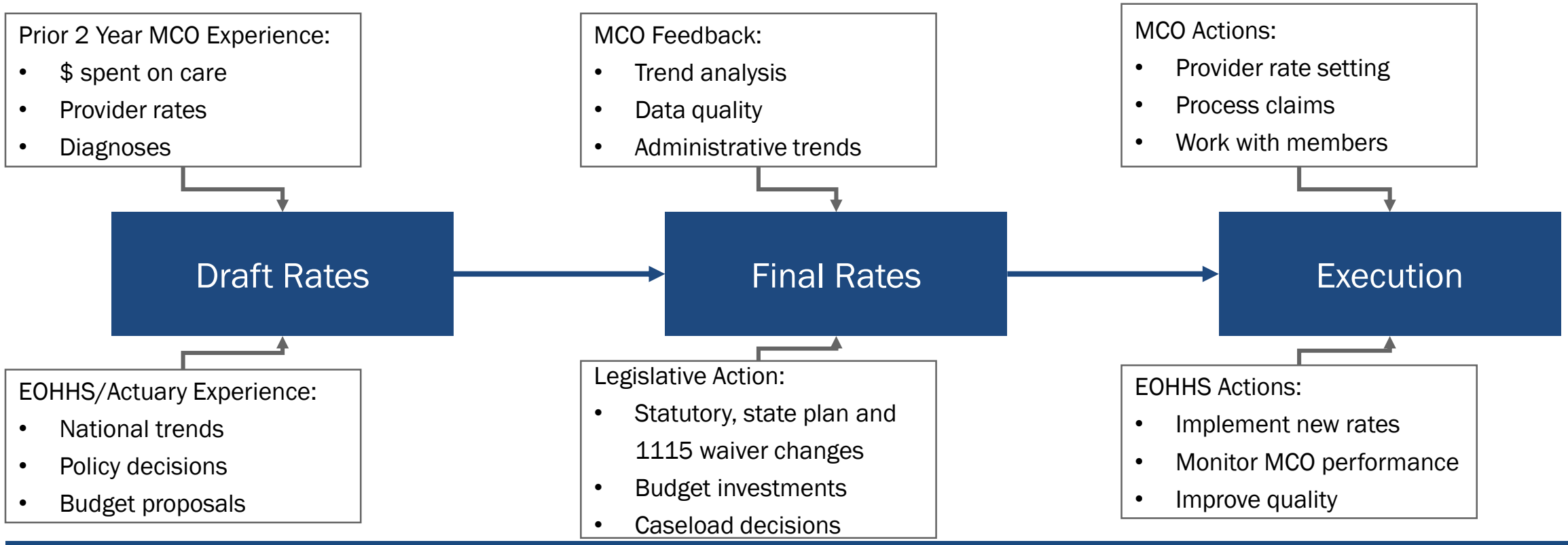
A Medicaid rate needs 1) a service or services in a bundle to be provided, 2) a price per service, 3) an eligible group of patients for that service, 4) eligible providers.

Moving Medicaid rates away from fee-for-service and towards quality linked payments, value-based payments or population-based payments is critical over time to increase quality and decrease cost trend.

All require inclusion in the Governor Recommended Budget and approval from the General Assembly. All require state plan/waiver, technology changes and policy guidance for implementation. Can take ~2 years from conception to full implementation of a new initiative.

Managed Care Rate Setting Detail

For our MCOs, EOHHS annually sets a per-member per month rate based on observed costs, State policy decision and national trends. These are adopted through the budget and caseload process. For example, an MCO covering a single female between ages 30-39 would get $536 per month from the state. That is the capitation rate. MCOs set their own rates with participating providers.



Managed Care Re-Procurement

EOHHS Medicaid Managed Care (MCO) Procurement: What We Heard

~9 Month Discovery Assessment and Planning Process

- **April 2021 Public Request for Information (RFI):** 19 responses from potential bidders, providers and stakeholders.
- **May 2021 Member Survey and Focus Groups:** Survey administered online and paper in 12 different languages receiving over 2300+ responses. Also held member focus group to learn about consumer experience and areas for improvement.
- **November 2020-Present, Cross-Agency Working Groups:** Feedback sessions with DCYF, DHS, DOC, RIDOH, BHDDH and HSRI to help address state-wide health goals.
- **Expert Interviews, National Reviews and Expert Policy Analysis:** Implement best practice and utilize other state examples to meet future program needs

Summary of What We Heard and Learned

"Support the integration of behavioral health care and primary care; Reform incentives and change the ways we pay for care; Implement payment reform to reduce unnecessary and low-value care; Implement quality improvement initiatives" – RI Foundation "Health in Rhode Island: A Long-Term Vision"

"I got general instructions [after hospital discharge] but they really didn't help me deal with the recovery process at all. I don't think they took the fact that I live alone and have no family/relatives into consideration. I could have used help." – Member Survey

"Allow providers close to the patient to provide care and service coordination." – RFI Responses

"MCOs can support AEs and other providers as they screen and intervene on member's social risk factors… Electronic tools, such as recording screening results in electronic health records (EHRs) and Community Resource Referral Platforms, will facilitate screening and intervention processes." – RFI Responses

"State should use an independent 'broker' to help members select and MCO and members should be encouraged to choose a primary care doctor." – RFI Responses

"We observed for many years the growing complexity of the MCO contract settlement process and the challenges facing EOHHS in ensuring the validity of the data supporting that process." – Dennis Hoyle, Auditor General, Letter Dated July 16, 2021

EOHHS Medicaid Managed Care (MCO) Procurement : What We'll Improve

RFP released in November 2021 for contracts to potentially take effect in July 2022. New contract will make the progress in the four key areas below, building on our values of choice, engagement and race equity:

1 Empower Members to Make Informed Choices

- Allow DCYF families to choose among all MCOs, not just one, for all DCYF families.
- Allow Medicaid LTSS members who were with an MCO prior to LTSS determination to stay in their MCO for acute and behavioral health needs to not interrupt benefits.
- Develop beneficiary support broker to provider counseling on member choice and options.

2 Improve Care Coordination and Management

- Allow providers to manage care coordination, if properly staffed and at a member's request.
- Require MCOs to ensure members have a centralized care plan, with responsible points of contact.
- MCOs must develop data sharing standards with AEs, and continue movement toward value-based payments

3 Advance Health Equity

- Require MCOs to ensure that community feedback reflects demographics of their membership.
- Require MCOs to obtain formal certifications in health equity.
- Require MCOs to report quality data by race and ethnicity.

4 Finance to Support Quality, Access and Budget Predictability

- Utilize risk mitigation to stop backstopping MCO losses, eliminate reconciliation payments and protect taxpayer dollars from MCO excess profits.
- Pay MCOs in full only if certain quality measures achieved.
- Liquidated damages for not meeting SLAs for data quality, member services, and access to care requirements.

More detailed information can be found at: 2023 Medicaid Managed Care Procurement Library | Executive Office of Health and Human Services (ri.gov). In particular, the EOHHS Managed Care Procurement Policy Presentation at the link above.

Any Questions?

RHODE ISLAND

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 3 – 11.30.2021

http://ritv.devosvideo.com/show?video=96e336d7abee&apg=ed687894

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Thursday, December 16, 2021
TIME: 11:00 A.M.- 1:00 P.M.
PLACE: Room 313 - State House

Agenda:

I. Opening remarks

II. Presentation on Behavioral Health by the Executive Office of Health and Human Services; Department of Children, Youth & Families; and Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

III. Presentation on the Delivery of Behavioral Health Services to Adults by Alexander Donoyan, MBA, LCDP, CEO, VICTA and Lisa Peterson, LMHC, LCDP, LCDS, MAC, COO, VICTA

IV. Presentation on the Delivery of Behavioral Health and Children's Services by Benedict F. Lessing, Jr., President/CEO of Community Care Alliance and Bridget Bennett, Vice President Family Well-Being and Permanency, Community Care Alliance

V. Public comment

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

POSTED: FRIDAY, DECEMBER 10, 2021, 2:35 P.M.

Executive Office of Health & Human Services

HHS Commission Presentation
December 16, 2021

RHODE ISLAND

EOHHS's Priorities

Our mission: Ensure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders. We accomplish our mission by:

ONE

Preserving and improving ***access*** to quality, cost-effective healthcare

TWO

Shifting systems and investments to prevention, value, choice, and ***equity***

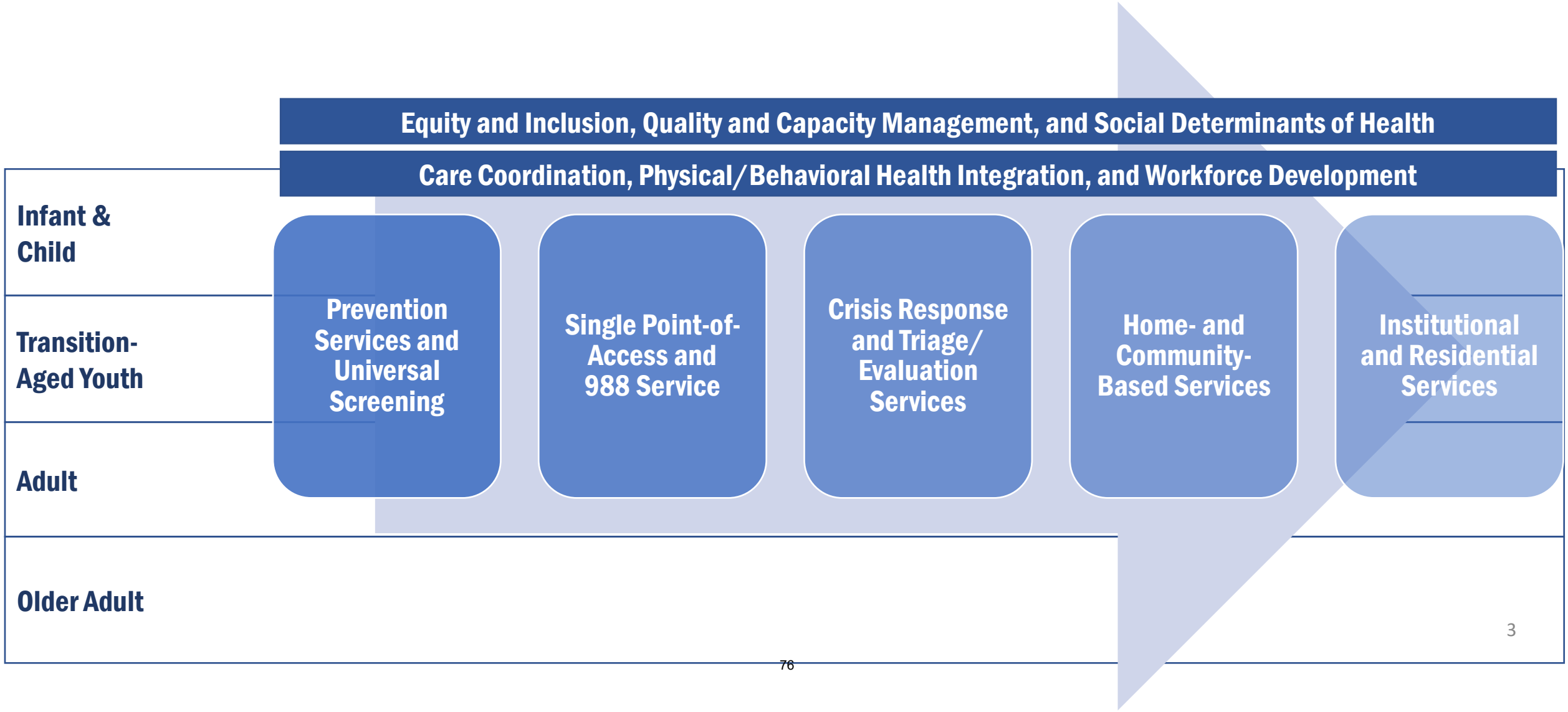
THREE

Curbing the opioid epidemic, addressing addiction, and ***improving*** mental health services

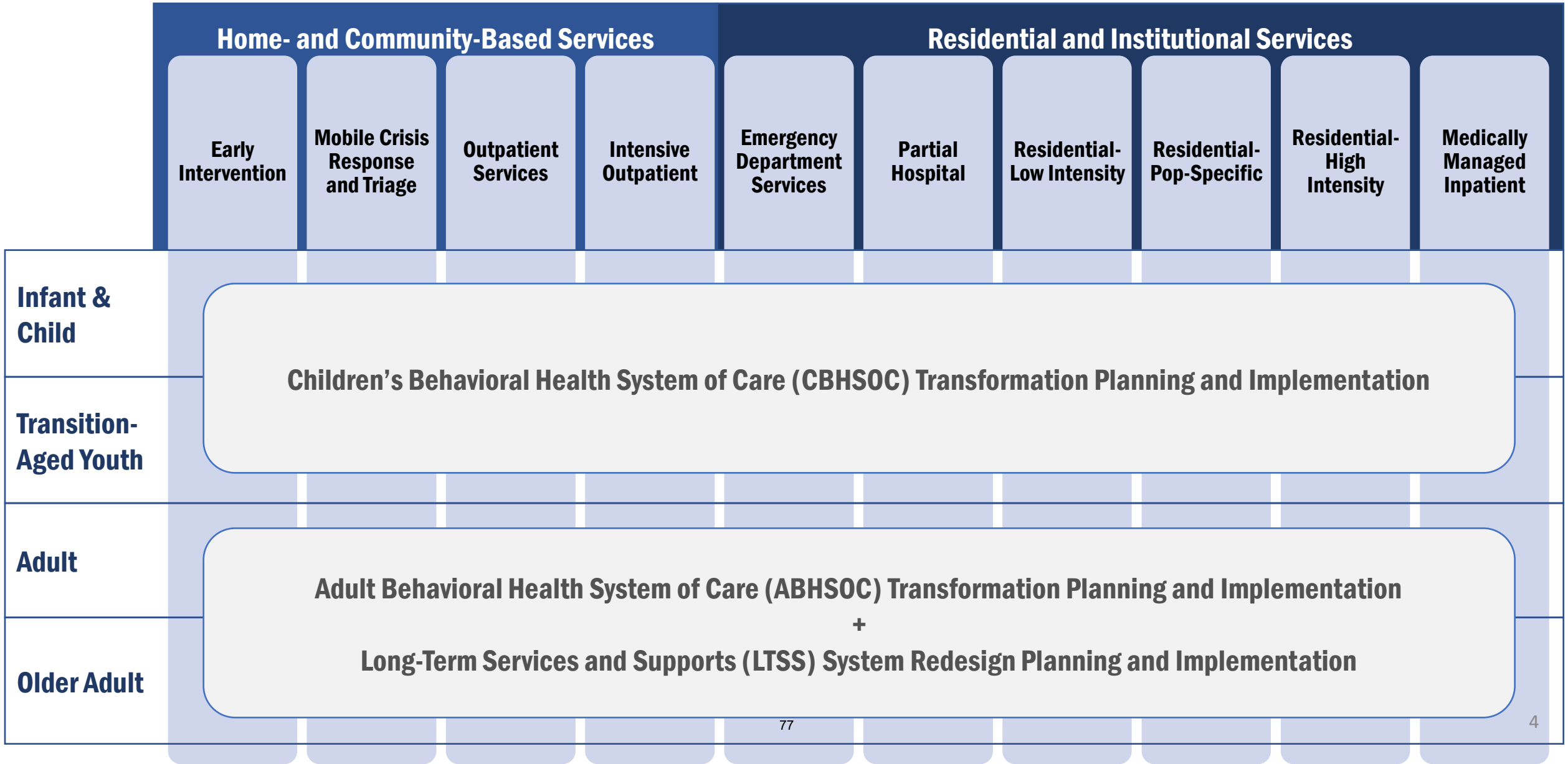
FOUR

Promoting efficient, effective and ***fair*** delivery of services

Rhode Island Vision of a Behavioral Health Continuum of Care



Comprehensive Behavioral Health Treatment Service Array



EOHHS's Overarching Vision for Behavioral Health System Transformation

We aim to create a structure that works for true continuums of care, which should create a seamless transition from infants to children and youth, to adults, and to geri/psych. This structure must ensure equitable provision of services and includes:

- A focus across the lifespan, from prenatal care, to infant mental health, all the way to geri/psych
- Rebalancing toward community services, and away from more restrictive services – the right services from the right entities at the right time, when they need it, including the integration of physical and behavioral health
- Investing in our workforce, which is in a particular crisis due to COVID
- Services that are culturally, linguistically, and developmentally appropriate – answering the question: what is the service that will help this particular person at this particular time.
- A reliance on data-based decision-making
- Investments in prevention
- A focus on peer services

System of Care Planning

Plan for Children and Youth

- Interagency Team planning since Fall of 2020
- Eight public/private workgroups since May 2021, resulting in the draft RI BH System of Care Plan for Children & Youth:
- Aligned this planning as much as possible with the BH System Review work
- Implementation Planning beginning in Winter 2021/22.

Adult BH System Transformation

- Behavioral Health System Review begun in Winter 2020, through contract with Faulkner Consulting Group and Health Management Associates.
- Planning included 35 Focus Groups or Interviews with key Rhode Island community leaders
- Implementation Planning on Certified Community BH Clinics and Mobile Crisis starting Summer 2021

Context

- COVID's impact on the system has been undeniable.
- The impact has been disparate, with more challenges for people of color and low-income people.
- Our data show the need for significant attention to and investments in the BH Systems across the lifespan, based on our principles and theories of change

Existing Children's Behavioral Health Structure in RI

There are multiple children/youth behavioral health program and funding responsibilities across State government.

- **DCYF** has statutory authority over children's behavioral health for all Rhode Island children (not only those legally involved with the Department).
- **EOHHS/Medicaid** serves as a large State funding source of behavioral health services for children in the state, serving 1/3 of Rhode Island's children.
- **BHDDH** has authority over substance abuse services for youth and transitional services for youth with behavioral health conditions entering adulthood.
- **RIDOH** also is engaged in prevention services for children and young parents, including suicide prevention and a range of Family Home Visiting services.
- **RIDE** has Early Childhood Services and behavioral health services in three school districts through the Project AWARE grant.
- **OHIC** has oversight of commercial insurance's array of children's behavioral health services.

Presentations:
Department of Children, Youth, and Families
&
Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

RHODE ISLAND

Department of Children, Youth, and Families

RHODE ISLAND

Division of Community Services & Behavioral Health

DCYF's Division of Community Services & Behavioral Health is responsible for developing a continuum of care for children's behavioral health services that supports children to live in family settings.

OPERATIONAL FUNCTIONS

- Residential Placement
- Utilization Management
- Level of Need
- Medicaid Management
- Family Navigation
- Home-Based Services

Strengths and Recent Activities

- **Family First Prevention Planning.** The Family Prevention Services Act of 2018 is landmark federal legislation that offers a major opportunity for jurisdictions to strengthen prevention services by allowing IV-E reimbursement for mental health services, substance use treatment, and in-home parenting skill training for children and youth determined to be at imminent risk of foster care and their parents and/or kin caregivers. DCYF collaborated with stakeholders to design and finalize its 5-year Family First Prevention Plan, submitted in September 2021.

- **Establishment of a robust home-based services array and greatly expanded Medicaid claiming to pay for it.** This has greatly contributed to far more families remaining together safely and fewer children needing congregate care.

- **Expansion of Family Care Community Partnerships.** These community-based programs serve as primary resources for families across the state who need access to housing assistance, family counseling, child care, early development programs, and other family support services.

- **Providing access to DCYF behavioral health services for families without relinquishing parental custody.**

Children's BH Challenges and Opportunities

CHALLENGES

1. Higher behavioral health acuity for children
2. Too many children in psychiatric hospitals
3. Confusion among families on how to access effective behavioral health services
4. Difficulty in accessing intensive, family-focused home-based interventions
5. Difficulty in connecting with culturally and linguistically appropriate services
6. Rate structure for behavioral health services

OPPORTUNITY:
Children's BH System of Care

Led by EOHHS, State agencies are working to design and implement a System of Care that includes:

- Mobile crisis response to prevent hospitalizations and serious incidents
- A streamlined access point to BH services for any child, regardless of health insurance
- Expanded access to FCCP services as an evidence-based wraparound service
- Expanded access to DCYF's robust array of evidence-based and evidence-informed, family-focused children's BH services.
- Expanded residential treatment options through Psychiatric Residential Treatment Facilities (PRTFs)

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

RHODE ISLAND

Behavioral Health Division at BHDDH - Overview

What does the Behavioral Health Division at BHDDH do?

- The BH Division is responsible for administering key federal grants that support behavioral healthcare services, facilitating timely access to behavioral healthcare by working directly with individuals and their families, providers, and other state agencies, and planning with other state agencies for the future provision of behavioral health services. The Division works closely with other BHDDH Divisions to support these key functions.

How is the division organized?

The Division has a Director and four teams that cover its main operational functions

- Tom Martin: Acting Director of the Behavioral Health Division
- Four teams: Treatment, Prevention & Recovery, Program Development, and Grants, Contracts & Operations
- BHDDH also supports behavioral healthcare activities through its other divisions (Central Mgmt., DDD, ESH)

Touchpoints from BHDDH to other State agencies

- BHDDH and EOHHS support each other in several areas of behavioral health planning and services:
  - Coordinating behavioral healthcare services between individuals with service needs, providers, managed care/Medicaid, and BHDDH Quality Management/Licensing
  - Planning for service expansions or improvements that cut across multiple departments/authorities
  - Sustaining programs funded initially with BHDDH grants from the federal government

- BHDDH also works closely with RIDOH and EOHHS on the development and implementation of programs and services to end Rhode Island's overdose crisis. These three agencies work closely to manage the Governor's Overdose Task Force and the implementation of the Task Force's strategic plan

- Through Eleanor Slater Hospital, BHDDH works closely with RIDOC to treat patients experiencing behavioral health challenges through forensic admissions to the State hospital

Strategies and Recent Activities

- Focus on behavioral health crisis services: alternatives to the criminal justice system and diversion into treatment, funded through federal grants
- Reducing barriers to treatment: expanding access to medication assisted treatment, expanding substance use residential services, working with Medicaid to build more services that expand and strengthen the BH continuum of care
- Emphasis on recovery in programming: through cooperation with providers, focus on the outcomes that support recovery, like housing, employment, and community, understanding that all individuals will have different treatment journeys and explore different recovery pathways
- Continuing to integrate data into our analysis of the behavioral health system and using data to drive improvements: at the end of the day, we need to know that our services are working and helping the people we are charged to protect

Current Challenges

CHALLENGES

- Limited service availability exacerbated by pandemic—too many people skewing to high-acuity settings and getting stuck in EDs
- Workforce challenges—all levels of BH system: rates of pay may be lower in RI than in neighboring states
- Complicated system that is historically underfunded
- Racial and ethnic disparities in accessing care
- Lack of clinicians with cultural/linguistic competency for diverse populations
- Limited access to actionable data

HOW WE'RE ADDRESSING THE CHALLENGES

1. BHDDH is working with EOHHS and DCYF to develop the largest community mental health system investment in recent memory
   - Proposing to create a CCBHC model for Rhode Island that will significantly expand who can get community mental health services
   - Developing a statewide mobile crisis system that will seamlessly connect people experiencing behavioral health crisis with needed ongoing care while diverting from hospitals and the criminal justice system
2. Using federal funding to give money to providers for recruitment/retention bonuses and student loan forgiveness

Questions & Answers

RHODE ISLAND

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 4 – 12.16.2021

http://ritv.devosvideo.com/show?video=4c9bf353bd35&apg=ed687894

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Thursday, January 20, 2022
TIME: 2:00 P.M.- 4:00 P.M.
PLACE: via WebEx

Agenda:

I. Opening remarks

II. Presentation on development disabilities services by the Department of Children, Youth & Families; and Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

III. Presentation by Carrie Miranda, Executive Director, Looking Upwards

IV. Presentation by Linda Ward, Executive Director, Opportunities Unlimited

V. Presentation on state hospitals by the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

VI. Presentation by Karen Hazard, Laborers' International Union of North America Local 808

VII. Presentation by Cynthia Lussier, President, State of Rhode Island United Nurses & Allied Local 5019

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

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POSTED: FRIDAY, JANUARY 14, 2022, 4:13 P.M.

EOHHS Senate Commission Briefing

Briefing on Developmental Disabilities Division & Eleanor Slater Hospital by BHDDH and DCYF – January 20, 2022

RHODE ISLAND

BHDDH Developmental Disabilities Division

Division Overview

Division Director: Kevin Savage

BHDDH Developmental Disabilities Division: Overview

The Division of Developmental Disabilities is responsible for planning, funding and overseeing a community system of services and supports for adults with developmental disabilities.

- The Division funds a statewide network of community services and supports for Rhode Islanders living with intellectual and significant developmental disabilities. These services are available through community provider agencies. Individuals and families may also receive self-directed services.
- Ensures access to available resources in response to the unique needs of each person receiving services.
- Supports opportunities for meaningful roles in the community for people living with developmental disabilities. This includes opportunities for jobs at competitive wages.
- Works to achieve the terms of a 2014 federal consent decree and provide integrated employment and day services for individuals living with developmental disabilities.
- Supports person-centered planning. This type of planning helps each person receiving services create a service plan matched to their unique interests and goals.
- Promotes human rights and protect the health and safety of individuals living with developmental disabilities. We do this in part through quality improvement initiatives and the licensing and oversight of service providers.

BHDDH Developmental Disabilities Division: Services

The Developmental Disabilities Division oversees services provided both through licensed, independent organizations and through the state-run Rhode Island Community Living and Supports (RICLAS) system.

- **Residential Services:** Funding and assistance in obtaining residential services, including:
  - Shared Living Arrangements (SLAs): supports life in an individual or family in a home-like setting.
  - Congregate Living/Group Homes:
    - Rhode Island Community Living and Supports (RICLAS): State-administered group home network.
  - Equipment/home modifications
- **Employment Services:** Funding and assistance for services and supports to help individuals connect with employment opportunities.
- **Day/Community Activities:** Daytime supportive activities for eligible individuals.
- **Self-Directed Services:** Funding and assistance with individuals who make their own choices regarding goals, schedule/activities, and supporting providers.
- **Other Supports:** Including transportation, emergency services, and support coordination.

Service needs are identified by the Support Intensity Scale (SIS). Individual and family input are vital to the process.

BHDDH Developmental Disabilities Division: Key Statistics

Overall, the Division supports services for approximately 4,000 adults with intellectual/developmental disabilities.

Key statistics regarding the Division are:

- FY22 Enacted Budget: $336,685,992 AF ($145,293,304 GR)
- Licensed Service Providers: 36
- Total Congregate Living Sites: 294 Group Homes
- RICLAS: 109 residents; 21 facilities (19 Group Homes; 2 Apartments)
- Total Employees (as of 01/07/22): 244.6 FTEs
  - RICLAS: 193.6 (excludes 16 FTEs on leave or W/C)
  - Division Staff: 51

Photo: Chris works at The Groden Center, an I/DD provider.

DCYF Developmental Disabilities: Overview

DCYF is responsible for ensuring services and supports for children and youth with developmental disabilities, and supporting successful transitions to the adult system, when needed.

DCYF STAFFING AND STRUCTURE

- **CSBH Family Navigation Unit:** Helps parents or caregivers with children with developmental disabilities access services and residential treatment without relinquishing parental rights.
- **BHDDH Liaison:** Supports planning for youth in DCYF group care who are transitioning to BHDDH adult group care.
- **Family Service Units (FSU):** Within DCYF's child welfare division, a dedicated unit specializes in working with children with developmental disabilities.
- **Family Care Community Partnerships:** Connects families to community-based, DD wraparound supports, when needed.

KEY STATISTICS

- 81 children in DD-specific residential treatment
- Children with developmental disabilities per unit
  - 27 in CSBH Family Navigation unit
  - 86 in FSU DD unit (not all are in residential treatment)
- 25-30 young adults transition each year to BHDDH
- Staffing: 3 caseworkers in CSBH, 5 in FSU DD unit

DCYF & BHDDH: Coordinating Youth and Adult Services

DCYF administers I/DD services for youth, and BHDDH administers I/DD services for adults. Transitioning between the youth and adult systems requires careful and advanced planning.

- **Apply:** Recommended that the application process be initiated two months prior to 17th birthday. Confirmation of application is sent to families after receipt, and completed applications reviewed within 30 days.
- **Assess:** Complete Supports Intensity Scale (SIS-A) is a standardized, nationally validated assessment tool that helps determine the supports an individual needs. Trained workers spend time with the youth/young adult and complete the assessment in partnership with people who know the individual well (including family and teachers).
- **Select:** Eligible young adults and their families are connected to a DD social caseworker at BHDDH who will help to select future services and support.
- **Plan:** Eligible individuals meet with providers to develop an Individual Service Plan (ISP), detailing long- and short-term goals. This plan is submitted to BHDDH's DD Division for approval and is modified as needed.

Eleanor Slater Hospital

Division Overview

Interim CEO: Rick Charest, Director, BHDDH

Eleanor Slater Hospital: Overview

Eleanor Slater Hospital (ESH) is operated by BHDDH and treats patients with acute and long-term medical illnesses, as well as patients with mental health conditions.

- Eleanor Slater Hospital provides long-term acute and post-acute hospital level of care to patients with complex medical and psychiatric needs.
- The Hospital is led by an executive team that includes the following roles with respective teams critical to hospital operations:
  - Chief Executive Officer
  - Chief Medical Officer
  - Chief Nursing Officer
  - Chief Financial/Operations Officer
  - Chief Quality Officer.
- Eleanor Slater Hospital has four facilities in two locations – a Cranston Campus and a Zambarano Campus.
  - Pastore Campus (Cranston): the Adolf Meyer and Benton Buildings provide psychiatric services, while the Regan Building provides psychiatric and medical services.
  - Zambarano Campus (Burrillville): the one hospital facility on the Zambarano campus, the Beazley Building, focuses on medical services.

Eleanor Slater Hospital: Services

Eleanor Slater Hospital is licensed as an Acute Care Hospital - and is designated as a Long-Term Acute Care Hospital (LTACH) by CMS. ESH services include:

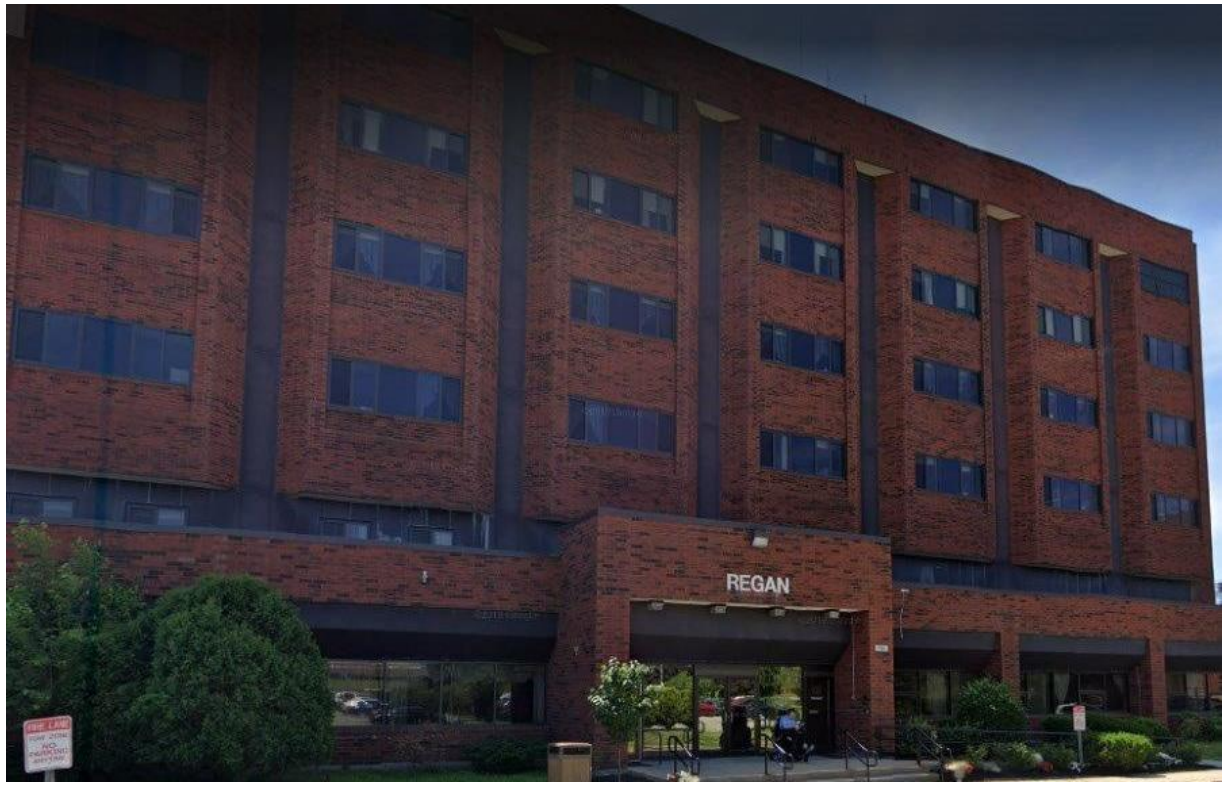
- Comprehensive Mental Health Services:
  - **Forensic Services:** Psychiatric care for individuals involved in the criminal justice system, including specialized services transfers from RIDOC.
  - **Civil Psychiatric Services:** Psychiatric care for individuals without a current criminal proceeding or sentence, often including geriatric/psychiatric services and co-occurring behavioral health and developmental disabilities.
  - **Forensic Outpatient Clinic:** Care coordination and case management for individuals with a forensic finding who are not remanded to ESH custody.
- **Ventilator Care:** Treatment and care for individuals in need of ventilator support.
- **Acute Brain Injury Care:** Treatment and supportive services for people who have experienced a traumatic brain injury (TBI).
- **Physical, Occupational, Recreational, Speech and Respiratory Therapies:** Eleanor Slater Hospital provides these services for patients who need these therapies in addition to treatment for other medical or behavioral conditions.

Eleanor Slater Hospital: Key Statistics

The Hospital's current census (as of 12/31/2021) was 215 patients.

Key statistics regarding ESH are:

- FY22 Enacted Budget: $118,283,372 AF ($115,970,100 GR)
  - This assumes $2,003,522 in federal billing; federal billing expected to be higher: +$11,800,000
- Labor: Employees belonging to 8 unions
- Total Employees (as of 01/07/22):
  - 583.4 FTEs (excludes 48 FTEs on leave or W/C)
  - Between 80-100 contractors who work regularly for ESH at any given time



The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 5 – 01.20.2022

http://ritv.devosvideo.com/show?video=f645cfa8fbcd

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Wednesday, February 2, 2022
TIME: 2:00 P.M.- 4:00 P.M.
PLACE: Virtual Meeting via WebEx

Agenda:

I. Opening remarks

II. Presentation on Cash Assistance (RI Works, GPA, and SSI Supplement), CCAP, Medicaid for seniors and people with disabilities, and RI Bridges (UHIP) update by the Department Human Services

III. Presentation by Linda Katz, J.D., Co-Founder and Policy Director, Economic Progress Institute

IV. Data brief by The Executive Office of Health and Human Services

V. Presentation by Gretchen Hammer, Public Leadership Consulting Group

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

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It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

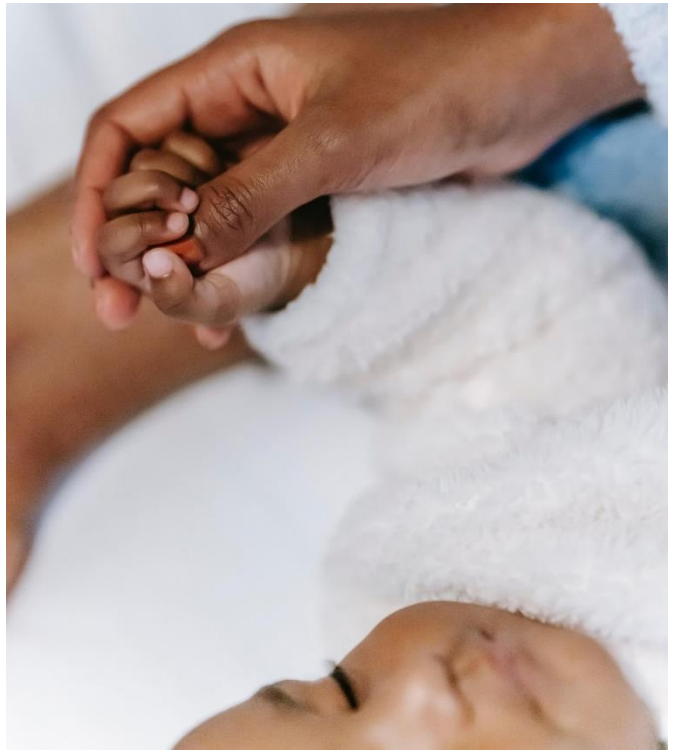
POSTED: FRIDAY, JANUARY 28, 2022, 4:06 P.M.

Rhode Island Department of Human Services Presentation for Senate Special Legislative Commission

To Review And Make Recommendations Regarding The Efficient And Effective Administration Of Health And Human Services Programs In The State Of Rhode Island. EOHHS Commission Hearing: February 2, 2022

Mission and Vision

DHS works hand-in-hand with community partners and resources throughout our great State to deliver critical benefits, supports and services to more than 300,000 families, adults, children, older adults, individuals with disabilities and veterans every year.



Vision

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.

Mission

DHS's programs and services are all designed to help families become strong, productive, healthy and independent; to help adults achieve their maximum potential; to ensure that children are safe, healthy, ready to learn, and able to reach their maximum potential; to honor, employ, and care for our state's veterans; and to assist elderly and persons with disabilities to enhance their quality of life, and to sustain their independence.

Guiding Principles

Right Service, Right Place

Effective triage is fundamental to serving customers as quickly as possible.

Champion "The Easy Way"

Customers should be rewarded for being proactive, coming prepared, and using preferred channels.

Prevention > Correction

Breaking the cycle of churn requires greater effort up front to avoid unnecessary closures.

Clear Message, Warm Voice

In every communication or interaction, customers should feel welcome, respected, and understood.

Keep Customers in the Loop

Make extraordinary efforts to let customers know the status of their case at any given time.

Inspire Confidence

Highlight when things go *well* in order to rebuild trust with employees and customers and build a culture of excellence.

Decide with Data

Use data to inform decisions and track progress toward department, program, and service level goals.

Commitment to Diversity, Equity & Inclusion Excellence

Acknowledge that systemic barriers exist and work together to eliminate them, promote change, show accountability, and embrace differences.

Support the Whole Family

Use a holistic, coordinated approach to ensure families have opportunities to achieve their goals and thrive.

DHS Overview

DHS delivers critical benefits, supports and services to more than 300,000 families, adults, children, older adults, individuals with disabilities and veterans every year. We are part of the solution to end poverty, food insecurity, and we make a lasting, positive impact on the State's health and future.

- **Number of Staff:** *1047*
- **Budget:** $742.3M (SFY 22 Enacted)
- **Composition:**
  - *Four sub-divisions:* Office of Child Support Services (OCSS); Office of Rehabilitative Services (ORS); Office of Healthy Aging (OHA); and Office of Veterans Affairs (VETS)
  - *Central Management:* Office of Constituent Affairs; Legal, Financial Management, Personnel, IT Systems & Support, Office of Performance Analytics and Continuous Improvement; Communications; Legislative Affairs; Policy, Training and Office of Child Care & Licensing
  - *Field Operations:* Nine office locations (7 customer facing; 4 administrative/back offices)

Overview of DHS Programs

RHODE ISLAND

DHS Benefit Programs Offered

DHS's benefit programs and services, collectively serve more than 300,000 Rhode Island families, adults, children, older Rhode Islanders, individuals with disabilities, and veterans each year. Each have their own eligibility requirements.

Child Care	General Public Assistance	Medicaid Programs
Energy Assistance	SSI State Supplemental Payment (SSP)	RI Works
Long Term Services Supports (LTSS)	Refugee Cash Assistance (RCA)	SNAP

DHS Cash Programs

The Rhode Island Works and General Public Assistance (GPA-Bridge) monthly cash payments and case management provides support to very low-income families and adults.

RI Works

Rhode Island's implementation of the federal Temporary Assistance to Needy Families (TANF) provides cash assistance and social services supports to put low-income Rhode Island families with children on a path to job security.

RI Works eligibility: Because it is a federal block grant program, most eligibility rules are determined by state statute.

Eligible applicants have:

*Very low-income (~50% federal poverty level (FPL)) *Minor aged children * Very low resources ($1,000)

* a 48-month lifetime time limit

RI Works 2021 Highlights

* Monthly benefit amounts increased in 2021 for the first time in 30+ years (household of 3 benefit $554 - $721 monthly)

* Annual $100 clothing allowance given for all children, not just school aged.

DHS Cash Programs

The programs described below provide monthly cash payments and case management supports to very low-income families and adults. DHS also administers Refugee Cash Assistance and the State Supplemental Payment (SSP).

GPA - Bridge

This state program provides a cash assistance loan to very low-income adults without children who are unable to work and pending a decision on a federal SSI application.

GPA - Bridge eligibility

This program is entirely state funded. Most eligibility criteria are set in statute with some regulatory flexibility.

Requirements include:

* Individual income limit $327 /month *Medicaid eligible *Disabled, unable to work

- Signed agreement for repayment when SSI is approved

GPA - Bridge 2021 Highlights

* Resource test increased from $400 to $3000 in alignment with SSI

DHS Nutrition Assistance

DHS works in partnership with other state agencies to coordinate responses to food insecurity through federal nutrition programs, coordinating access and promotion of SNAP, WIC (RIDOH), School Meals and Summer Meals (RIDE), Congregate Meals (OHA), Senior Farmers Market Vouchers (DEM).

Supplemental Nutrition Assistance Program (SNAP)

This federally funded, state administered program is often call the nation's first line of defense against hunger. SNAP provides a monthly food benefit to low-income individuals, families, seniors, and people with disabilities.

SNAP eligibility:

This federally regulated program allows limited state flexibilities. RI does pursue waiver opportunities when available. In addition to residency and citizenship/immigration requirements, eligibility is primarily based on a household's gross monthly income: 185% or 200% FPL (if older adult or disabled) - income threshold as compared to their household composition (household members who purchase and prepare food together)

SNAP 2021 Highlights

*Expanded SNAP access to some college students through public health emergency (PHE) flexibilities

*Increased community partnerships for outreach and application support

DHS Child Care Assistance

This work support for low-income parents helps defray the cost of quality child care allowing parents to fully participate in the economy. RI DHS also oversees the child care licensing unit for the State.

Child Care Assistance Program (CCAP)

CCAP offers subsidies to help low-income parents pay for high quality early childhood education and childcare to support their ability to work or participate in certain education and training programs. In addition to being available to low-income workers, it is also a work support to RI Works families and to young parents completing high school or a GED through the Teen Family Development program.

CCAP eligibility

There are federal requirements for program access and family affordability, but most CCAP eligibility rules are set in state statute.

Eligibility requires:

* An entry income limit of 180% FPL
* Parents must work at least 20 hours a week or participate in training program
* Child must be under age 13 unless with special need
* Cooperation with the Office of Child Support and Services

CCAP 2021 Highlights

* Pilot program authorized for college students to access CCAP
* Family co-pays capped at 7% of income
* ARPA funds allowed co-pays to be waived for families during some of the PHE

DHS Health Coverage Eligibility

An example of interagency collaboration with EOHHS, DHS determines the eligibility for Medicaid while OHHS administers the program and establishes its policies.

Modified Adjusted Gross Income (MAGI) Medicaid

Medical coverage available to low-income children, parents, caregivers, and adults. Those eligible for Medicaid have their choice of enrolling in a managed care plans.

MAGI Medicaid eligibility

Eligibility is based on income though income levels vary based on the age and relationship of applicant.

"Complex" Medicaid

A variety of Medicaid programs based on a “level of care” needed by the applicant. These include Elderly and Disabled (EAD), Katie Beckett, Long Term Services and Supports (LTSS), Sherlock, Chafee Kids programs.

"Complex" eligibility

Each of these programs have their own eligibility requirements that require a determination of need based on their level of need as well as income, resource, citizenship criteria.

DHS Cash Assistance Programs

Low-income families have been struggling for years, and COVID has exacerbated those struggles. DHS has responded to customer needs, but we recognize our customers require more resources to help bring them out of poverty - and DHS needs greater resources to provide appropriate access to Rhode Island's most vulnerable families.

- The current RIW statute restricts a family's ability to stabilize economically due to a low asset limit and small earned income disregard. We have an opportunity with the Governor's budget to **increase the resource limit from $1,000 to $5,000 and increase the earned income disregard from $170 to $300**. These changes can improve access for our customers, make things easier for DHS staff, and improve overall efficiency of the Department.
- RIW customers often face many challenges that require face-to-face assistance that was unavailable throughout COVID. **DHS has just opened its offices** and our reopening plan aims to address the challenges that we know our customers have been facing: limited access, long wait times and delayed application processing. The reopened offices will improve access to RI Works and their case management services.

DHS Operations Overview

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Key Operational Facts

- The RI Department of Human Services (DHS) customer facing regional offices are resuming in-person service.

- DHS hours of operation is 8:30 a.m. to 4 p.m. Monday through Friday, except holidays.

- DHS staff are available at each regional office to provide a range of services for all programs.

Key Operational Facts

- In addition to the services available at reopened regional sites, customers will continue to have access to:
  - The Call Center (1-855-697-4347) Hours: 8:30 AM - 3:00 PM
  - The Customer Portal (healthyrhode.ri.gov)
  - The HealthyRhode mobile app and text messaging
  - Community partners and vendors listed in the Customer Resource Guide available at dhs.ri.gov in English, Spanish and Portuguese.

- These resources offer different tools to the customer, including application assistance, application submission, checking benefits, uploading documents, seeing notices, conducting interviews, getting general and case-specific information.

Current DHS Regional Offices

Location	Office Type	Reopening Date
Woonsocket (219 Pond Street)	**Customer Facing** – All DHS Programs	January 4, 2022 (RIW Recertifications) January 18, 2022 (All Programs)
Pawtucket (249 Roosevelt St)	**Customer Facing** – All DHS Programs	November 1, 2022 (RIW Recertifications) January 18, 2022 (All Programs)
Warwick (195 Buttonwoods Ave)	**Customer Facing** – All DHS Programs	November 1, 2021 (RIW Recertifications) January 18, 2022 (All Programs)
South County Regional (4808 Tower Hill Road, Wakefield)	**Customer Facing** – All DHS Programs	November 1, 2021 (RIW Recertifications) January 18, 2022 (All Programs)
Newport Regional (31 John Clarke Rd, Middletown)	**Customer Facing** – All DHS Programs	November 1, 2021 (RIW Recertifications) January 18, 2022 (All Programs)
Providence, 1 Reservoir Ave.	**Customer Facing** - All DHS Programs	Facilities readiness date to be confirmed by DCAMM
Providence, 40 Fountain Street	**Customer Facing** - All DHS Programs	January 4, 2022 (RIW Recertifications) January 18, 2022 (All programs, limited service)

DHS Challenges and Opportunities

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Workforce

- DHS is experiencing workforce challenges like many other industries. We recognize that our staff are experiencing the impact of the pandemic which effects our overall staffing levels. To help our workforce cope with the impact of the pandemic, we have provided and will continue to offer Covid-19 workshops facilitated by our employee assistance program. In addition, DHS facilitates a weekly Health and Safety Committee with labor leadership to address questions and concerns.

- DHS recognizes that vacancies also has impacted our staffing levels. We have processed the documentation for the customer facing hiring. They are making their way through the system and will be posted. We are working on positions across all regional offices to ensure all Rhode Islanders have access to the benefits and services they need. EOHHS has helped us remove any barriers to filling these positions.

- DHS Call Center wait times are longer than acceptable, some factors impacting wait times are:
  - Recertifications waivers ended – we have worked with our federal partners and received a short extension
  - Shifting staff from teleworking to returning to the office
  - The need to increase staffing levels – working to fill positions
- DHS recognizes that our labor partners are critical to raising the concerns of our workforce and is committed to collaborating to find solutions.

Customer Relations

- Customers have different communication needs and preferences, and DHS has a plan for communication improvements, increasing self service and enhancing communication between workers and clients – which can greatly reduce the burden of wait times on the phones.
- We also have a plan for upgrading the phone systems for the call center, including improving self-service options and having better call return services.
- We are working with our Congressional Delegation, specifically Senator Whitehouse's office, to potentially make some waiver changes permanent.
- We continue to collaborate with EOHHS, federal and community partners to improve customer access and choice.
- We are working to streamline the DHS application, specifically for our older adults.
- Expansion of mobile app is on the horizon.

UHIP/RIBridges Update

RHODE ISLAND

RI Bridges (UHIP)

Project Summary	Overall Health*		
The Executive Office of Health & Human Services (EOHHS), the Department of Human Services (DHS) and HealthSource RI (HSRI), are charged with promoting health, nurturing quality of life and supporting our most vulnerable residents by preserving and improving access to quality health coverage and care as well as ensuring efficient, effective, and timely delivery of human services. The State's work on the RI Bridges system, also known as UHIP, serves approximately one third of the State and is the case management system that supports these efforts. Some of the key programs supported by RI Bridges include Medicaid, SNAP, CCAP, R.I. Works (RIW), LTSS, and General Public Assistance ("GPA") Program.	Scope	Schedule	Budget

Project Timeline

Phase	Phase 1 – Implementation of State Health Exchange	Phase 2 – Addition of Human Services Programs	Phase 2 – Stabilization of Integrated System	Phase 3 – Ongoing M&O and DDI (new dev.) for Certain Programs
End Date	October 2013	September 2016	2020	TBD*
Status	COMPLETED	COMPLETED	COMPLETED	IN-PROGRESS

Budget Snapshot*

Fiscal Year	FY2021	FY2022	FY2023	FY2024
Approximate Project Budget	$83m	$83m	$78m	TBD

Key Updates*

- Completed transition into new M&O contract (RFP & vendor selection completed in 2021) including implementation of new performance measures and executive reporting
- Implemented multiple system releases including enhancements and ongoing maintenance & operations changes; one notable enhancement enabled text message notifications for RIBridges customers

Risk/Issues/Decisions Needed

**Note: The RI Bridges program is managed by an executive committee (DHS director (chair), HSRI director, Medicaid director, IT Chief of Apps) and details on budget, status, risks/issues are provided via monthly executive reporting to the DOA director and EOHHS secretary.*

Questions and Discussion

Executive Office of Health & Human Services

HHS Commission Presentation on Data and Performance Management

RHODE ISLAND

Data Ecosystem

Analytics at EOHHS and the Data Ecosystem

People are not slices of data.

We are whole human beings, raised in families, rooted in communities, and bearing our history.

Because EOHHS uses data – qualitative and quantitative information – to support the people, families and communities we serve, our approach to data must reflect and encourage that complexity.

The Rhode Island Ecosystem is an analytic system that links data at the person and family level across state agencies to drive holistic improvements in human well-being.

It allows the state to ask and answer deep questions about what drives well-being. Through carefully governed, permissioned access to de-identified data, we empower state leaders, researchers, and community voices with the information they need to understand our connectedness.

Learn more: eohhs.ri.gov/initiatives/data-ecosystem

And explore HealthFacts RI Public Reports here.

Key project types:

(1) Curated integrated data sets provided to external requestors

(2) Team-led studies, evaluations, tool development

(3) Analytics or data support for internal use including performance management

Recent Ecosystem Projects + Impact

Project description	Agencies providing project guidance	Data sources for this project	Impact
Telehealth Analysis: Developed an interactive dashboard for state leadership and policy staff to learn about telehealth uptake, corresponding demographics, most frequent diagnoses and procedures.	Medicaid OHIC leadership	Medicaid All Payer Claims Database	The Ecosystem team worked closely with Medicaid policy staff to develop policy recommendations that informed the **state's telehealth bill** (2021-S 0004Baa, 2021-H 6032Aaa). The bill resulted in telemedicine coverage requirements for insurers and requires that all Medicaid programs cover telemedicine visits.
Overdose Evidence Update: Collaborated with a broad stakeholder group to evaluate the rates and characteristics of deaths from drug overdose before vs during COVID.	RIDOH BHDDH DLT RI Coalition to End Homelessness Medicaid Brown University	RIDOH Vitals Medicaid Claims DLT Wages, UI HMIS homelessness data	The analysis and corresponding recommendations were presented to the **Governor's Overdose Task Force** and published in a manuscript available on **JAMA Open Network**. The Ecosystem team and its analytic partners recommend that states establish **pilot overdose prevention sites** that is now **signed into law** in RI (2021-S 0016B, 2021-H 5245A). The analyses and recommendations continue to inform the Task Force.
Central Providence Opportunities: Ongoing efforts to develop meaningful baseline metrics that will allow long-term understanding of the impacts of place-based investments.	ONB Resident Advisory Council Rhode Island Foundation The Policy Lab	DHS program eligibility COVID testing, cases, and hospitalizations DLT wages, UI, job training	Beyond determining impact of the place-based investment in 02909 and 02908, the Ecosystem team is engaged in the CPO Scaling Working Group that will convene over the coming years to **develop optimal strategy and implementation of place-based investments.**

Security is a top priority of the EOHHS Data Ecosystem

Storage: All data provided by data providers is stored in SQL Server Databases housed in either the DoIT internal server farm or in the EOHHS Ecosystem VPN within DoIT's AWS (Amazon Web Services) Landing Zone. All data are first staged in files and databases on the validation server. From here, it is anonymized and linked to other data sets, then mapped to a reporting database (Eco_Analytics), also on the validation server. The data are then either loaded to a production SQL Server Database or securely transmitted for access by the data analysts licensed for a specific project. Some data sets are published to a Snowflake data warehouse, which also resides in AWS.

Network Security: All data reside in one of the following: the internal DoIT network, within DoIT's AWS Landing Zone, or within a Snowflake Data warehouse within AWS. Each of the environments follow DoIT security, firewalls, etc. Access to these databases is tightly managed using Active Directory groups and SQL Server roles. Access is only granted to those needing access to the specific data sets.

Data Transfers: Data transfers to the Data Ecosystem occur via one of the following methods: *i)* SFTP, *ii)* a secure shared folder only accessible to data sender and EOHHS technical staff, *iii)* or a direct database connection only accessible to EOHHS technical staff.

Compliance with Data Security Standards. EOHHS proceeds according to requirements contained in Federal Information Security Management (FISM) Act, National Institute of Standards and Technology (NIST) 800 series, including but not limited to Special Publication (SP) 800-39, Managing Information Risk. Furthermore, EOHHS is responsible for maintaining a secure environment compliant with the Security Rule, state policies, and other applicable law that supports the transmission of Confidential Data in compliance with the standards. EOHHS follows the specifics contained in (FISM) NIST SP800-47, Security Guide for Interconnecting Information Technology Systems and uses appropriate safeguards to prevent use or disclosure of Confidential Data other than as permitted by the IMOU, the (FISM), NIST SP800-47, and applicable law, including appropriate administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of that Confidential Data. Appropriate safeguards are those required by applicable law related to data security, including but not limited to (FISM) NIST SP800-53, Security and Privacy Controls for Federal Information Systems and Organizations.

EOHHS Performance Management

RHODE ISLAND

Performance Management Overview

Using data for internal and services delivery accountability across the Secretariat

Performance management is…

- A mechanism to check on effectiveness across agencies and cross-agency issues
- Part of agency work, not parallel or in addition to other continuous improvement processes
- Agency-led, tied to strategic priorities, and utilizes data to drive program changes
- Designed to strengthen the collective health and human service system by supporting agencies and making connections between bodies of interagency work

EOHHS Performance Management Process

EOHHS uses a process called PULSE. We start with a review of existing Performance, diagnose problems by Utilizing data, engage Leadership for strategic input, provide Supports to develop solutions, and finish with the Execution of recommended actions (PULSE).

PRIMARY GOALS OF PULSE

1. Monitor and understand progress made on strategic initiatives using data, context, and expertise provided by the agencies
2. Escalate risks, issues, and questions as well as drive discussions, make decisions, and request resources
3. Develop strategic and coordinated solutions to problems flagged by agencies, EOHHS, and State leadership
4. Encourage continuous improvement through project management and performance management principles
5. Engage interagency team members to understand how they support the key priorities of the Secretariat and State leadership
6. Foster accountability for driving program performance using key metrics to meet objectives and maintain focus on key projects
7. Hold ourselves accountable for meeting milestones and demonstrating effective management and operations

EOHHS PULSE Check Meetings

WHAT IS A PULSE CHECK?

- Regularly scheduled meeting with EOHHS leadership and agency staff to review performance data in relation to key priorities, programs, projects, and progress on meeting established goals and objectives
- Point-in-time check-in during continued implementation
- Performance driven dialogues and not report outs
- A tool to help us be proactive, rather than reactive
- A means to identify areas requiring assistance, collaboration, and escalation

There is a standard cadence for PULSE meetings, typically every other month or quarterly, for the following agencies and interagency priorities:

EOHHS | **DHS** | **BHDDH**

RIDOH | **DCYF** | **LTSS**

OVERDOSE

Ecosystem Reference Slides

RHODE ISLAND

What data are included in the EOHHS Data Ecosystem?

Some of the data sources in the Ecosystem include:

- **Medicaid** claims, encounters, and enrollment
- **Department of Human Services** programs including: TANF, SNAP, CCAP, and SSI
- Child screening, immunization, and outreach program referral from the **Department of Health**
- Birth and death records
- COVID testing, case, and vaccine information
- Housing insecurity and homelessness data from the **RI Coalition to End Homelessness**
- Wages, income insurance, and job training from the **Department of Labor and Training**
- Developmental disabilities case management data from the **Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals**
- **Department of Corrections** incarceration data (data intake in February 2022)

Standalone, not linked to other sources:

- Medical and Pharmacy claims and enrollment data from the RI **All Payer Claims Database** (HealthFacts RI)

Data that EOHHS would like to add includes Housing data (eviction data via courts) and education data from pre-Kindergarten through college.

Legal framework

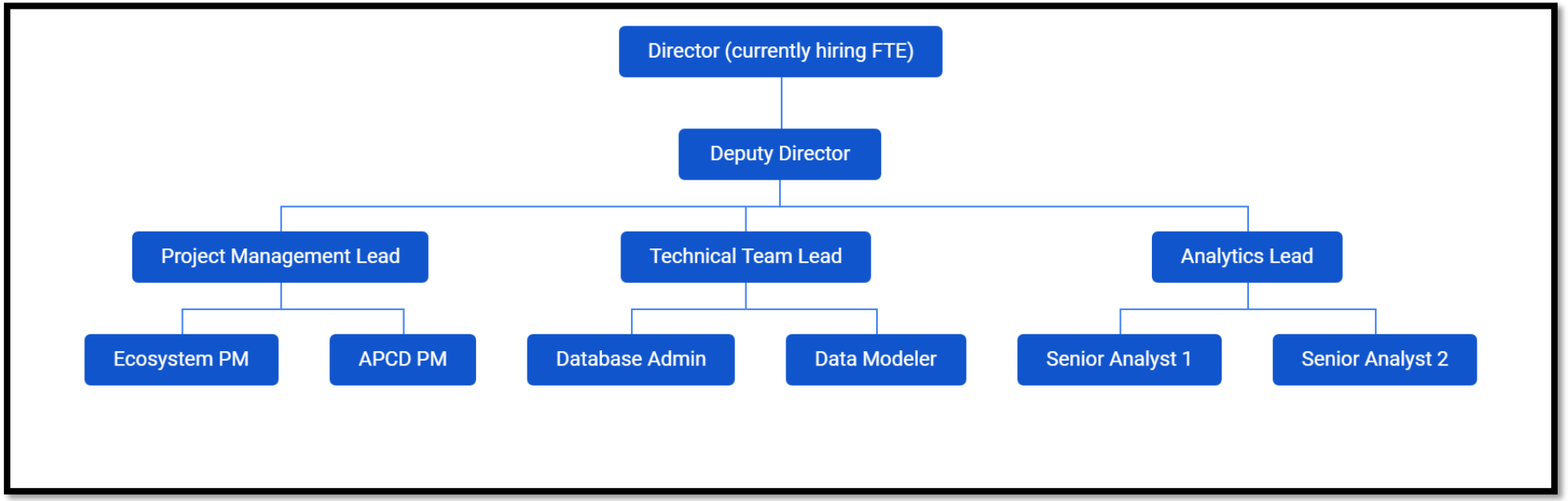
The following legal documents govern cross-agency collaboration and internal and external data access and use:

- The **Inter-Agency Memorandum of Understanding (IMOU)** documents the vision, mission, and governance process of the EOHHS Ecosystem.
- The **Data Sharing Agreement (DSA)** is a two-party agreement signed by each of the data providers and EOHHS that allows data to flow into the Ecosystem.
- The **Data License Request (DLR)** is completed by the Data Requester in coordination with the Ecosystem team. It is executed by all Data Stewards whose data are being requested. The DLR includes the Data Requester's credentials, project purpose, project methodology, a statement of benefit, and how the project will center racial justice. This document defines all data tables and data elements being requested for a project.
- The **Data Use License (DUL)** is a multi-party agreement signed by the Data Recipient and EOHHS. Importantly, it only allows for anonymized data to be released to Data Recipients. Additionally, Recipients are required to safeguard the data (security controls, re-disclosure restrictions, and cell suppression policy) and are accountable for unauthorized access, use, or disclosure (24 hour breach notification, and indemnification of the state).

Ecosystem's Governance Structure

- Executive Board
  - Ensures Ecosystem work aligns with state priorities; recommends large projects that represent 70% of Ecosystem resources; ensures Ecosystem sustainability and statewide support.
  - **Leadership:** EOHHS Secretary Womazetta Jones and Commissioner Patrick Tigue (OHIC) are vice-chairs.
  - **Membership:** Directors or designees from each of the contributing Data Providers of the Ecosystem; Governor's office; Department of IT; EOHHS Policy; EOHHS Legal.
  - **Meeting operations:** Quarterly meetings; Director facilitates.
- Data Stewards Group
  - Committee composed of representatives from each Data Provider with program and data expertise. One designated representative (Data Steward) from each Data Provider has decision-making authority over the use of their Confidential Data to approve use cases and projects.
  - **Meeting operations:** Monthly meetings that includes presentations on agency-led projects; Director, Deputy Director, and Project Manager co-facilitate.
- Ecosystem Team and Roles
  - Director, Deputy Director, Data Architect, project manager, technical staff, and analytic staff
  - Staff manage use access, permissions, security and project approval.
- Ecosystem Team and Roles
  - **System Oversight:** Take in data from partner agencies, clean it, model it and update on a monthly basis.
  - **Data Products:** Complete select centralized analytic work and support agencies in agency-led analysis on cross-agency data.

Ecosystem Staffing and Org Chart



Staffing model

- Currently includes one state FTE, the Director of Data and Analytics.
- Freedman Healthcare staff and contractors fill 8 of 9 current positions on the team.
- Takeaway: Fully interagency in approach but with limited dedicated FTEs.

Ecosystem Operating Costs and Funding

- Ecosystem Resources: A key challenge for the Data Ecosystem is ensuring staffing and resources – and in particular, additional FTEs.
- Annual operating costs for the Ecosystem and APCD are roughly $4M. The largest Ecosystem opportunity is its ability to receive CMS match of state general revenue for its costs that benefit Medicaid.
    - Currently, nearly all costs are considered Design, Development and Implementation and can be matched by CMS with a 90/10 federal match
    - Activities will eventually move to Maintenance and Operations, which will allow for a 75/25 federal match
    - In the future, the goal is that entire state portion (25% of costs) will come from license fees that the Ecosystem charges for its data

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 6 – 02.02.2022

http://ritv.devosvideo.com/show?video=61e2d0ce3a5a&apg=ed687894

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Wednesday, February 16, 2022
TIME: 2:00 P.M.- 4:00 P.M.
PLACE: Virtual Meeting via WebEx

Agenda:

I. Opening remarks

II. Presentation by Secretary Marylou Sudders, Massachusetts's Executive Office Health and Human Services

III. Presentation by John E Gage, President/CEO, Rhode Island Health Care Association

IV. Presentation by Secretary Womazetta Jones, Rhode Island's Executive Office of Health and Human Services

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

POSTED: FRIDAY, FEBRUARY 11, 2022, 1:57 P.M.

Executive Office of Health & Human Services

Massachusetts Executive Office of Health & Human Services Overview

Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

February 16, 2022

Agenda

1. MA EOHHS Overview
2. MA EOHHS Organizational Structure
3. MA EOHHS Mission and Critical Objectives
4. MA EOHHS Structure: Examples of Success

EOHHS Overview

In Massachusetts, the Executive Office of Health and Human Services (EOHHS) is the largest executive agency in Massachusetts state government, overseeing $25.7 billion (approximately 56%) of the state budget and 22,000 (out of 44,000) executive branch employees.

- The Secretary of EOHHS has executive oversight of twelve agencies in addition to Medicaid - agency leadership are recommended by the Secretary and formally appointed by the Governor. They report directly into the Secretary of EOHHS

1. MassHealth (Massachusetts Medicaid) – the Secretariat is the single state authority for Medicaid
2. Executive Office of Elder Affairs
3. Department of Veterans' Services (including two Soldiers' Homes)
4. Department of Public Health
5. Department of Mental Health
6. Department of Transitional Assistance
7. Department of Children and Families
8. Department of Youth Services
9. Office for Refugees and Immigrants
10. Department of Developmental Services
11. Massachusetts Rehabilitation Commission
12. Massachusetts Commission for the Blind
13. Massachusetts Commission for the Deaf and Hard of Hearing

Evolution of EOHHS Structure

MGL chapter 6A section 16, enacted in 2003, was the first significant restructuring of EOHHS and its agencies – change management took several years, and resulted in a stronger, more efficient, and centralized Secretariat.

- Key changes:
  - Agency leadership are recommended by the Secretary and appointed by the Governor. They report directly into the Secretary of EOHHS
    - Single point of accountability for clear decision making and efficiency
    - Ability to be nimble and proactive in response to emerging issues
  - EOHHS Centralized Functions
    - Facilities Management
    - Labor and Human Resources
    - Information Technology
  - Strong coordination
    - Budget and Finance
    - Cross agency initiatives and streamlined services
    - Legislative Affairs
    - Legal
    - Communications
    - Policymaking arm of Agencies to ensure the goals and priorities of the Administration are met

A person-centered approach, not an agency-centered approach

MA EOHHS Mission and Critical Objectives

MISSION

To provide effective leadership in the delivery of health and human services that promote health, resilience and independence to improve the quality of life for individuals, families and communities throughout the Commonwealth

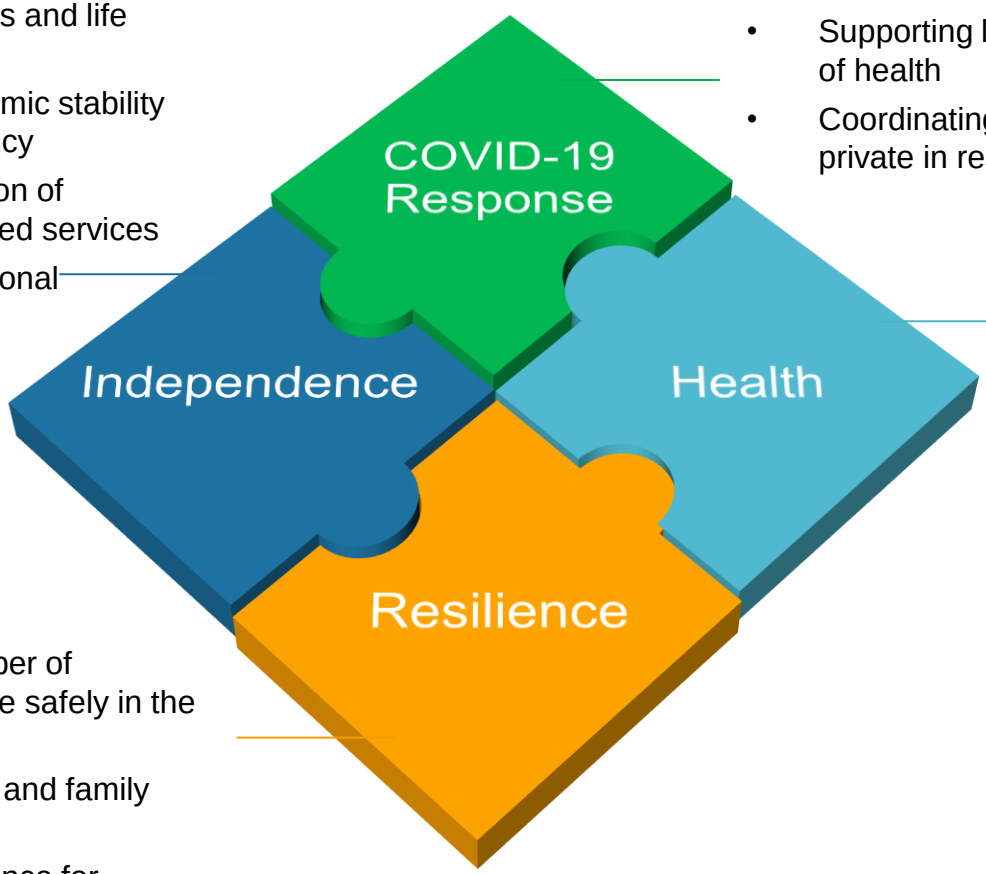
Objectives

To increase the number of individuals who live safely in the community
To ensure the long-term sustainability of the Medicaid program
To increase permanence for children the care or custody of child welfare
To address the opioid crisis
To decrease health disparities
To improve health care access and outcomes
To increase educational attainment for youth
To increase meaningful day opportunities, job skills and life skills training that lead to real jobs
To increase utilization of participant directed services

MA EOHHS Current Critical Objectives

- Directing COVID-19 Command Center
- Supporting local and regional boards of health
- Coordinating all sectors, public and private in responding to COVID-19

- Increase job skills and life skills training
- Increased economic stability and self sufficiency
- Increase utilization of participant directed services
- Increase educational attainment



- Front door access to behavioral health
- Investment in primary care
- Containing health care costs while creating pathways to affordable, quality, equitable healthcare

- Increase the number of individuals who live safely in the community
- Reduce individual and family homelessness
- Increase permanence for children in state care or custody

EOHHS Structure: Examples of Success

- **COVID Response:** The Massachusetts COVID Command Center led by the Secretary, involved multiple agencies managing pandemic activities
- **Medicaid:** Integrated MassHealth (Massachusetts Medicaid) within the Secretariat allows for deep collaboration on behalf of clients (e.g., Department of Mental Health or Department of Developmental Disability) given their shared membership
- **Roadmap for Behavioral Health Reform**: Collaboration across multiple agencies to develop the roadmap – an expanded access to treatment, more effective treatment, and improved health equity for individuals with mental illness, substance use disorders and co-occurring illnesses
- **Facilities Management**: Consolidated multiple agency leases and performed strategic partnerships at local level - multiple agencies have consolidated offices because they serve similar clients. Over two fiscal years, have saved ~5M in commercial lease costs
- **Human Resources**: Staffing is capped at a secretariat level as opposed to agency level, enabling the ability to flexibly manage staffing depending on need at any given time
- **Information Technology**: At height of pandemic, supported largely in-office workforce to a remote workforce by deploying over 18,000 devices in a systematic and streamlined way across the entire Commonwealth for individuals to be able to safely work from home when possible
- **Financial Management**: Effectively work with Governor's budget office to support agencies that have fluctuating and sometimes unpredictable caseload changes

APPENDIX

Excerpt MGL 6A Section 16

"The governor shall appoint a secretary of health and human services, who shall serve at the pleasure of the governor and shall act as the executive officer in all matters pertaining to the administration, management, operation, regulation, planning, fiscal and policy development functions and affairs of the departments, commissions, offices, boards, divisions and other agencies within the executive office.

The secretary shall have the authority to: (a) through the department of elder affairs and the division of medical assistance and other agencies within the executive office, as appropriate, operate and administer the programs of medical assistance and medical benefits under chapter 118E; provided, however, that the executive office under the direction of the secretary shall be the single state agency under section 1902(a)(5) of the Social Security Act, under Title XIX agency, for programs under titles IV(A), IV(B), IV(E), XX and XIX of the Social Security Act and for programs under the Rehabilitation Act; (b) establish certain rates of payment for health care services under section 13C of chapter 118E; (c) coordinate and supervise the administration of the executive office and its agencies to promote economy and efficiency and improve service delivery; (d) establish uniform regional and area boundaries for the agencies within the executive office; (e) establish uniform contracting and payment procedures for the executive office and its agencies; (f) develop and implement a management information system for the management of fiscal, client and program data necessary for the efficient administration of the agencies within the executive office; (g) pursuant to chapter 30A, make, amend and repeal rules and regulations for the management and administration of the executive office and agencies within the executive office, including regarding the sharing of data, including personal data, between and among the executive office and its agencies, subject to appropriate protections for the confidentiality of client data; (h) execute all instruments necessary for carrying out the business of the executive office and its agencies; (i) acquire, own, hold, dispose of, lease and encumber property in the name of the executive office and its agencies; (j) enter into agreements and transactions with federal, state and municipal agencies and other public institutions and private individuals, partnerships, firms, corporations, associations and other entities on behalf of the executive office or its agencies; (k) charge and collect fees, rentals and other charges as may be reasonable and necessary for carrying out the business of the executive office and its agencies; (l) apply for and accept funds, including grants, bequests, gifts and contributions on behalf of the commonwealth in accordance with section 6 of chapter 29B; and (m) serve as the executive and administrative head of each office, department, division, bureau, section, agency and other administrative unit within the executive office, except as specifically provided by law. The secretary may delegate any of the foregoing powers to an officer having charge of a department, office, division or other administrative unit within the executive office."

Full citation: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6A/Section16

Rhode Island Health Care Association

Special Legislative Commission Regarding the Efficient and Effective Administration of Health and Human Services In the State of Rhode Island

John E. Gage, MBA, NHA – President & CEO

February 16, 2022

EOHHS

- Created by the Rhode Island General Assembly in 2006
- Agency to serve as the umbrella organization for RI's healthcare and social services agencies
  - RIDOH
  - DHS
  - OHA
  - VETS
  - DCYF
  - BHDDH
- Agency also designated as the single State agency to administer the Medicaid program in RI.

EOHHS (CONTINUED)

- Agency Mission – "Assure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders."
- Agency Vision, Values & Priorities include the following:
  - Allocates public resources responsibly to ensure that all Rhode Islanders have the opportunity for a better future.
  - Assures service quality, program integrity and system accountability.
  - Fosters partnerships with providers, between the department and with the community.
  - Provides responsible financial stewardship.
  - Preserves and improves access to quality, cost-effective healthcare.

RIHCA'S PERSPECTIVE ON EOHHS

- EOHHS has not treated RI's nursing facilities as partners.
  - No real partnership exists.
  - Medicaid program has chronically underfunded nursing homes since the 2013 implementation of the price-based system of reimbursement.

- EOHHS has not assured access to high quality and cost-effective services.
  - Nursing homes are limiting admissions as a direct result of their inability to compete for staff in the current unprecedented and growing workforce shortage.
  - Vaccine mandates and the Minimum Staffing Statute passed last year are exacerbating this problem.
  - Nursing homes are closing – four just since the start of the Covid-19 pandemic.

RIHCA'S PERSPECTIVE ON EOHHS (CONTINUED)

- EOHHS has not effectively managed the Medicaid program – across the healthcare continuum, but in a manner that disproportionately impacts nursing homes.
  - Nearly 75% of nursing home residents in RI are dependent on Medicaid to cover their cost of care.
  - Current Medicaid rates to nursing homes are based on 2011 actual allowable costs that were audited and then became the base "price" for Medicaid reimbursement to nursing homes in 2013.
  - Based on the Statute that established the Price-Based reimbursement model (Section 40-8-19) and the resulting Principles of Reimbursement, Medicaid was required to inflate the rates annually by the CMS SNF Market Basket Index and to conduct a rate review in FY 2016 and every 3 years thereafter to determine if the cost components used to establish the base rates were still appropriate.
  - EOHHS has not complied with either of these requirements.

RIHCA'S PERSPECTIVE ON EOHHS (CONTINUED)

- EOHHS has only applied the Annual Inflation Index as required in Statue and the Principles of Reimbursement in 2 of the past 10 years since the implementation of the Price-Based reimbursement methodology.

Actual Regulation Market Basket Updates											
Skilled Nursing Facility	**FY 12**	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**AVG**
CMS Market Basket Update	2.7	2.5	2.3	2.5	2.3	2.7	2.6	2.8	2.8	2.2	2.5
RI Nursing Facilities	**FY 12**	**FY 13**	**FY14**	**FY 15**	**FY16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**AVG**
RI Inflation Index Applied	0.0	0.0	0.0	0.0	2.3	1.5	1.0	1.0	2.4	2.2	1.0

CUMULATIVE IMPACT OF SEQUENTIAL INFLATION INDEX REIMBURSEMENT CUTS

- Reductions and elimination of the required index were driven by the budget process and Medicaid's seemingly endless efforts to find ways to reduce reimbursement.
- Nursing homes have not been treated like "partners" but as "cost-centers" to be cut.
- These sequential cuts in required reimbursement increases (1.0%/year rather than the average 2.5% CMS Index) have resulted in $250,000,000 in reduced reimbursement to nursing homes over the last 10 years - $50 million dollars last year alone.
- The unfunded mandate that is the Minimum Staffing Statute will effectively double this shortfall to a combined $100 million/year.
- This is not sustainable.
- Facilities have closed, and more will be forced out of business – disrupting the lives of hundreds of residents, families, and staff members.
- More locally owned and operated nursing homes will be sold to larger corporations with more efficiency and resources.

EOHHS NON-COMPLIANCE WITH RATE REVIEW (RE-BASE) SINCE FY 2016 THROUGH PRESENT

- EOHHS/Medicaid has ignored the rate review provisions of the Statute establishing the Price-Based System and the Principles of Reimbursement
  - Rate reviews in 2016, 2019 and 2022 have never been completed, to the best of our knowledge.
  - Base rates have never been updated since 2013 -using 2011 actual audited costs.

IMPACT OF COVID-19 ON NURSING HOMES RESIDENTS/OCCUPANCY & MEDICAID EXPENSE

- Nursing homes were the epicenter of the initial Covid-19 pandemic.
  - Total RI nursing home resident deaths since the start of the pandemic is 1,110
  - Nursing homes currently in a much better place for this latest wave of the pandemic
    - Highest vaccination rate of Nursing Home Staff in the country at 99.3%
    - Third highest vaccination rate of Nursing Home Residents in the country at 94.42%
  - Pre-COVID-19 nursing home occupancy was about 90%
  - The lowest occupancy was January 2021 when homes were at 70%
  - Currently, occupancy has recovered to 78.5%
- RI Medicaid Spend on Nursing Homes was approximately $76 Million less than appropriated in FY20 and FY21
- RIHCA feels strongly that that $76 Million needs to be redirected to nursing homes to enhance Workforce Stabilization Efforts – to retain and recruit workers and to shore up the nursing homes over the next 2 years

IMPACT OF COVID-19 ON NURSING HOMES STAFFING CRISIS

- Staffing has been dramatically impacted by COVID-19
  - November 2021 vacancy rates for Nursing Home positions was 20%
    - 1,920 Open Positions – 1,501 of which were clinical positions (RNs/LPNs/CNAs)
    - Vaccine mandate forced 400 +/- staff from RI nursing homes
    - Additional staff have left because of exhaustion, other career options, etc.
    - RIDOH estimates that the Minimum Staffing Mandate that was to have taken effect on January 1, 2022 would require a minimum of 475 additional staff at an estimated cost of $21.3 million in the first year of implementation.
    - Staffing mandate provided just $2.5 million in new reimbursement in year 1. (0.5% add-on scheduled for 10/1/2021 has yet to be implemented)
    - Unfunded mandate of $18.8 million in year 1 and will grow to $47 million/year in year 2 and beyond.

PREVIOUS COVID-19 RELIEF FUNDING FOR RI NURSING HOMES

- Medicaid funding during the Covid-19 pandemic has been limited to aone-time 10% rate add-on for just 3 months – 4/1/2020 – 6/30/2020.
- Many other States have provided enhanced rates for a much more extended time throughout this Public Health Emergency.
- COVID relief monies for nursing homes in RI, to date, have been one-time allocations of Federal monies through the CARES Act ($7 million) and Federal Provider Relief Funds.
- These one-time payments have certainly helped to bridge operations for a finite period, but what is needed is a sustainable funding stream to enable facilities to make meaningful pay rate changes that will enable nursing homes to compete in the current labor market.

RIHCA'S PROPOSALS FOR EOHHS TO MAKE EFFECTIVE CHANGES

- In the short-term, RIHCA proposes that EOHHS/Medicaid conduct an immediate review of the most recently available annual Medicaid Cost Report Data to determine the actual reimbursement shortfall and then work with the legislature and the nursing homes on a plan to close the gap
- What is needed is a Re-Array of Allowable Costs and a Re-Basing of the Price-Based Reimbursement model.
- In the longer-term, RIHCA Proposes that EOHHS partner with RI's nursing homes, together with the Governor and Legislature to ensure that nursing homes are reimbursed in accordance with applicable Statutes and the Principles of Reimbursement.
- RI demographics show that the 85+ population will double over the next 15 years.
  - All components of the LTC continuum will be over-run – home care, assisted living and nursing homes.
  - It is essential that we work collaboratively (EOHHS/State Government/Providers) to ensure the current and long-term viability of all aspects of the long-term care continuum, including nursing homes.

RIHCA – ADDITIONAL AREAS OF CONCERN RE: EOHHS

- Capitated contract with MTM, Inc. for Medicaid transportation services needs to be cancelled, and a new contract established with a suitable vendor that will truly be able to meet the needs of Medicaid Beneficiaries in RI
- Critical ambulance shortage must be addressed for those residents with a Certificate of Medical Necessity for the use of a stretcher/ambulance services – returning from the hospital, dialysis trips, etc.
- EOHHS needs to relent on its renewed efforts to "Passively Enroll" LTC Nursing Home Resident Medicaid Beneficiaries into NHPRI's Unity Plan
  - No savings to State as was the case with NHPRI several years ago
  - NHPRI receives Administrative Fees for "Case Managing" LTC nursing home residents while they require no case management, per se
  - NHPRI Rates of reimbursement are even lower than traditional Medicaid and Medicare

THANK YOU!

John E. Gage, MBA, NHA – President and CEO

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Rhode Island
Executive Office of Health and Human Services
Reflections and Recommendations:

February 16, 2022

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Research from Other States

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Overarching Findings from Research

- In our review of other states' Health and Human Services agencies, we focused on:
    - How their leadership was appointed
    - What functions were centralized
    - Who has responsibility for core functions

- Overall, we saw that organization by function, rather than population, was an effective way to carry out Secretariat activities – and that consolidation of core functions (i.e., finance, legal, budget, and public affairs) – is viewed as more efficient and a key to realizing savings.

Consolidated Functions in General Across States

Despite considerable variability across HHS consolidated structures in organization and design, most states centralize core administrative functions under their Secretaries or Commissioners. Excludes standalone agencies.

Function	Almost Always Centralized	Sometimes Centralized	Hardly Ever Centralized
Public Affairs and Outreach including legislation	X		
Legal & Regulation Services	Legal - X	Regulations - Tends to be shared when there is an umbrella model	
Policy Development and Planning	X		
Budget Development		Tends to be shared when there is an umbrella	
Budget Oversight	X		
Medicaid Finance	X		
Human Resources		X	
Quality Assurance		X	
LTSS		Tends to be shared when there is an umbrella model	
Program Administration			X
IT		X	
Performance Management		X	
Customer Services			X

Massachusetts

Massachusetts has a highly centralized administrative function within the Massachusetts' Executive Office of Health and Human Services. The Department is led by a Secretary, appointed by the Governor with Advice and Consent of the Legislature.

Centralized Administrative Services Under Secretary

- General Counsel
- Information Technology
- Civil Rights
- Fiscal Services
- Public Affairs
- Budget Analysis & Oversight

Responsibility for Core Functions

- The following agencies are under the umbrella of the Massachusetts EOHHS Secretariat: Public Health, Child Welfare, Medicaid, Temporary Assistance to Needy Families (TANF)/Nutrition, Developmental Disabilities, Behavioral Health/Substance Abuse.
- Elders/Aging needs are addressed within a separate Executive Office of Elder Affairs.
- Department Commissioner are appointed by the Governor, with the Secretary's recommendation. No legislative consent is required, except for the Secretary of Elder Affairs.
- Medicaid falls within EOHHS, with the Medicaid Director appointed by the Secretary with no advice and consent.

Connecticut

Connecticut is an example of a state with a highly centralized administrative function under the Connecticut Department of Social Services. The Department is led by a Commissioner, appointed by the Governor with Advice & Consent of the legislature.

Centralized Administrative Services Under Secretary

- Financial Management
- Constituent & Legislative Services
- Administrative Hearings
- Performance Management

Responsibility for Core Functions

- The following areas of work are divisions in the overall consolidated Connecticut Department of Social Services: Child Welfare, Elders/Aging, TANF/Nutrition, Developmental Disabilities, Behavioral Health/Substance Abuse.
- Public Health is a standalone agency, with its Commissioner appointed by the Governor.
- The Medicaid Director, along with other Agency Directors and Deputy Commissioners, are appointed by the Commissioner, with no legislative consent.

Maryland

Maryland's administrative function is also fairly centralized under the Department of Human Services and the Department of Health. Each Department is led by a Secretary.

Centralized Administrative Services Under Each Secretary

Both the Department of Human Services and the Department of Health have these centralized services:

- Budget and Finance
- Communications
- Employment and Equity
- Inspector General
- Information Technology

Responsibility for Core Functions

- The following are divisions in the Maryland Department of Human Services: Child Welfare, Elders/Aging, TANF/Nutrition.
- The following are divisions in the Maryland Department of Health: Medicaid, Developmental Disabilities, Behavioral Health/Substance Abuse .
- Deputy Secretaries are nominated by the Secretary, with appointment by the Governor. No legislative consent except for finance deputies in all agencies.
- The Medicaid Department is under the Deputy Secretary for Health Care Financing and Medicaid and is overseen by the Medicaid Deputy Director.

New Jersey

New Jersey centralizes administrative function under its Department of Human Services. The Department is led by a Commissioner, appointed by the Governor with Advice and Consent by the legislature.

Centralized Administrative Services Under Commissioner

- Administration and Operations
- Public Affairs, Legislation and Regulation
- Public Protection

Responsibility for Core Functions

- The following are divisions in the New Jersey Department of Human Services: Child Welfare, Elders/Aging, TANF/Nutrition, Medicaid, Developmental Disabilities, Behavioral Health/Substance Abuse.
- The Public Health Department has a standalone Commissioner, appointed by the Governor.
- The Medicaid Director is the Assistant Commissioner for the Division of Medical Assistance and Health Services within the Department of Human Services. The Medicaid Director is appointed by the Commissioner, without legislative consent.

Virginia

The Virginia Secretariat of Health and Human Resources was a model for RI EOHHS. The Secretariat is led by a Secretary, appointed by the Governor, with Advice and Consent by the legislature.

Centralized Administrative Services Under Commissioner

- Budget and Fiscal
- Management Review
- Public Relations
- Legal Counsel

Responsibility for Core Functions

- The following agencies are under the umbrella of the Virginia Secretariat: Public Health, Child Welfare, Elders/Aging, TANF/Nutrition, Medicaid, Developmental Disabilities, and Behavioral Health/Substance Abuse.
- Commissioners are recommended by the Secretary and appointed by the Governor. By law, they answer to the Secretary rather than to the Governor. No legislative consent of Commissioners.
- The Medicaid Director is a civil servant selected by the Secretary.

Rhode Island EOHHS Statutory Authority

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Key Components of RI EOHHS's Statutory Role (42-7.2-5)

- **Oversight, coordination, and cohesive direction** of state-administered health and human services and in ensuring the laws are faithfully executed
- **Coordinate the administration and financing of healthcare benefits, human services, and programs** including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX of the U.S. Social Security Act.
- **Serve as the governor's chief advisory and liaison to federal policy makers on Medicaid reform issues** as well as the principal point of contact in the state on any such related matter.
- **Implement service organization and delivery reforms** that facilitate service integration, increase value, and improve quality and health outcomes.
- **Resolve administrative, jurisdictional, operational, program, or policy conflicts** among departments and their executive staffs and make necessary recommendations to the governor.
- Ensure continued progress toward **improving the quality, the economy, the accountability and the efficiency of state-administered health and human services**
- **Prepare and integrate comprehensive budgets** for the health and human services departments and any other functions and duties assigned to the office.
- **Utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development.**

Key Components of RI EOHHS's Statutory Role (42-7.2-5)

- Establishment of an integrated approach to **interdepartmental information and data management** that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to a **consumer-centered integrated system** of state administered health and human services.
- At the direction of the governor or the general assembly**, conduct independent reviews** of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.
- **Provide regular and timely reports to the governor** and make recommendations with respect to the state's health and human services agenda.
- **Employ such personnel and contract** for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.
- Assume responsibility for **complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records,** in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.
- Hold the director of each health and human services **department accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of their agencies.**

Value of the Rhode Island EOHHS' Role and Functional Areas of Work

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What's Working (1 of 5)

Hands-on Support for EOHHS Agencies. Examples include:

- COVID Response:
  - Medicaid support for providers' adaptation to pandemic needs and for wage stabilization
  - Hospital Capacity Planning with interagency partners
  - Creating and staffing the first iteration of the Equity Council
- Leadership Support for EOHHS Agencies – Deployment of key staff when necessary: BHDDH, DHS, and RIDOH
- Centralization of financial services, with EOHHS CFO supporting other agencies' financial planning and oversight

What's Working (2 of 5)

Using data to drive action and inform policy and decision making. Examples include:

- Data Ecosystem support for EOHHS and Member Agency Data and Evaluation Planning Processes
- Completing the Evidence Update for the Governor's Overdose Prevention and Intervention Task Force
- Long Term Supports & Services Policy Development
- Creating COVID-19 Data Dashboards
- PULSE Project Management with all EOHHS Agencies

What's Working (3 of 5)

Public Affairs – interagency coordination of communication efforts with those we serve, our partners and stakeholders, and the RI General Assembly

- Communications and Legislative Coordination
- COVID-19 Equity Council Support
- Media Campaigns
  - Behavioral Health
  - Birth to 5 - Pre-K, Child Care, etc.
  - Medication Lock Up
  - Overdose Prevention
  - Safe Sleep
  - Substance Exposed Newborns

What's Working (4 of 5)

Public/private interagency policy alignment

- Long Term Services & Supports Modernization – and Rebalancing Medicaid toward Home and Community-Based Services

- Behavioral Health System Transformation Planning Across the Lifespan
  - Development of Certified Community Behavioral Health Clinics within Medicaid
  - Creation of the Behavioral Health System of Care Plan for Children & Youth

- Telemedicine – Medicaid supported immediate transformation for providers to telemedicine and supported the legislative effort to codify those changes into law.

- Maximizing Race Equity – Supporting agencies to create Race Equity strategic and operational plans

What's Working (5 of 5)

Public/private interagency policy alignment , continued

- Health System Transformation (e.g., Integration of Physical and Behavioral Health, Hospital Capacity Planning, Health Information Technology, Accountable Entities)

- Support for aligned Health Information Technology, to serve Medicaid providers and members and the commercial market:
  - Creation of the Health Information Technology (HIT) Roadmap and the EOHHS HIT Steering Committee
  - Completion of the Electronic Health Record Incentive Program, increasing EHR adoption among physicians from 68% in 2009 to 93% in 2021, with $35M in investments

Recommendations for Strengthening Rhode Island EOHHS Core Functions

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Reminder: EOHHS Central Management Core Functions

These core functions help support the HHS agencies under our umbrella:

- Serving as the Single State Agency for Medicaid
- Budget and Finance
- Data Management and Analysis
- Legal Division and Appeals Office
- Performance Management
- Policy Development and Analysis
- Public/Legislative Affairs

Our aims are to promote efficiencies, interagency coordination & alignment, collaboration, and accountability through performance management.

Centralization of EOHHS Core Functions

EOHHS has centralized some core functions but can do more under our current statute. These additional changes will strengthen EOHHS and our agencies. Here are our 2022-23 plans:

- Complete the centralization of EOHHS Finance
- Fully centralize
  - Public Affairs (communication and legislative work)
  - Data
  - Policy
- Maximize the Secretariat's work on race, equity and racial justice to build more responsive and efficient, family- and community-centered services

Additional Recommendations

- Resource EOHHS for proactive support for health and human services, rather than reactive problem-solving – particularly as we recover from the pandemic

- Work with the Governor's Office and the General Assembly to assess and align the legal authority of RI EOHHS and its member agencies to inform any additional structural changes

- Give EOHHS Secretariat the structural authority to propose EOHHS Agency Directors, for the Governor to nominate Directors, and the Senate to approve Directors through Advice and Consent

Questions & Answers

RHODE ISLAND

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 7 – 02.16.2022

https://ritv.devosvideo.com/show?video=282d06df682d&apg=e433d7db

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Wednesday, March 2, 2022
TIME: 2:00 P.M.- 4:00 P.M.
PLACE: Virtual Meeting via WebEx

Agenda:

I. Opening remarks

II. Commission member discussion

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

It will also be live streamed at https://www.rilegislature.gov/CapTV/Pages/default.aspx

POSTED: FRIDAY, FEBRUARY 25, 2022, 2:27 P.M.

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 8 – 03.02.2022

https://ritv.devosvideo.com/show?video=cd8f40c26917&apg=e433d7db

SPECIAL LEGISLATIVE COMMISSION TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE EFFICIENT AND EFFECTIVE ADMINISTRATION OF HEALTH AND HUMAN SERVICES PROGRAMS IN THE STATE OF RHODE ISLAND

NOTICE OF MEETING

DATE: Wednesday, August 3 2022
TIME: 2:00 P.M.- 4:00 P.M.
PLACE: Room 313 - State House

Agenda:

I. Opening remarks

II. Commission member discussion of draft recommendations

Please contact Molly McCloskey at mmccloskey@rilegislature.gov with any questions.

The meeting will be televised on Capitol Television, which can be seen on Cox Channels 15, and 61, in high definition on Cox Channel 1061, on Full Channel on Channel 15 and on Channel 34 by Verizon subscribers.

POSTED: FRIDAY, JULY 29, 2022, 4:10 P.M.

The Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island

Meeting 9 – 08.03.2022

https://ritv.devosvideo.com/show?video=7ac63cf34bc0&apg=e433d7db