



Together for Children. Families. Communities.

April 7, 2026

The Honorable Louis P. DiPalma
Senate Finance Committee
Room 211
State House
Providence, RI 02903

Dear Chairman DiPalma, Vice Chairs Ciccone and Felag, Secretary Acosta and Honorable Members of the Senate Finance Committee,

Thank you for the opportunity to submit testimony. On behalf of the Rhode Island Coalition for Children and Families, I would like to focus on several critical issues that we believe are not fully addressed in the proposed FY2027 budget for the Rhode Island Department of Children, Youth and Families (DCYF).

Our concerns fall into two main areas:

1. Risks to the availability and stability of child welfare and children's behavioral health community-based services due to System Medicaid Transformation
2. Infrastructure resources needed to comply with the State's children's behavioral health consent decree.

Risks to Children, Families, and the Programs that Serve Them During Medicaid Transformation

1. Adequate Service Rates

Just two years ago, DCYF implemented updated service rates that were finally sufficient to support providers delivering home- and community-based services. As a result, providers were able to nearly double available services—from approximately **900 service slots to about 1,700** for children and families.

Based on the most recent rates received by members, we conducted a risk assessment asking providers how the most recently reported rates would affect their ability to continue operating programs. Providers were asked to estimate whether they could continue services as they are today, would need to reduce program quality, or would eventually be forced to close.

Of the 70 programs surveyed, only 21 expected no impact. Eleven programs, including eight residential programs, report they would close immediately if the rates are not adjusted to reflect the true cost of providing services. Twenty-three programs say they would need to reduce service quality to stay within budget, and fourteen report they would likely close within one to two years.

In other words, more than two-thirds of the programs surveyed expect significant harm under the current rate structure. These are many of the same programs the state recently worked to expand in order to meet the needs of children and families.

As a result of advocacy, the rates are being increased slightly for administration and specific program inputs. These new administrative rates are barely adequate, undercompensate residential providers, and still do not adequately represent the real costs to members of running these programs. Moving forward with a payment structure that does not reflect real operating costs risks undoing this progress and reducing access to critical services across the state.

If programs close or reduce capacity, families will face longer waitlists and fewer options for care.

2. Reduced Flexibility for Families

Children's behavioral health services frequently require flexible, individualized supports that do not always fit neatly into Medicaid rate structures.

A system that relies too heavily on Medicaid funding may reduce the ability of DCYF and providers to offer flexible, clinical and non-clinical family supports and prevention and stabilization services tailored to each child's needs.

For this reason, **sufficient General Revenue and other flexible funding sources remain essential**. These funds allow DCYF and providers to respond quickly to the needs of youth and families when services fall outside traditional Medicaid reimbursement. In addition, changes in federal claiming methodology is expected to jeopardize nearly **\$20 million in Revenue from Medicaid**, further necessitating additional funding.

Without flexible resources, there is a real risk that certain specialized or innovative services will be reduced or eliminated.

3. Implementation Challenges

Transitioning to a new Medicaid billing environment is complex and costly for community-based agencies. Providers are facing significant new requirements, including:

- Upgrading billing and data systems
- Training staff on Medicaid documentation and compliance
- Managing new administrative and reporting requirements

These costs are substantial, and providers are currently absorbing them without additional support. One member indicates that the hard costs already having an Electronic Health Record are estimated to be \$145,000-\$200,000. This does not include administrative oversight or quality assurance.

Data from a recent readiness assessment conducted with DCYF indicates that **14 of the 24 participating programs reported they were only partially prepared—or not prepared at all—for full Medicaid implementation**.

Even programs that report being prepared often have not previously billed Medicaid at this scale or managed complex dual-billing structures, which creates additional risk during implementation.

Providers have been working closely with the state since Spring of 2024 and asking for information to guide their investments. Their questions have been pushed off to “Phase II” and are only now being considered but still with no plan for investment. While being extremely cooperative in providing data and feedback, we have made repeated requests for assistance that have been ignored. There seems to be a fundamental lack of understanding of what this takes at the provider level and the cost-benefit analysis that providers have to make in moving forward. For years, members have subsidized the costs of state services, but the environment has changed and this is no longer an option as our members’ testimony will report. As a result, we have submitted additional legislation for Medicaid Transformation.

Consent Decree Implementation

Finally, Rhode Island is working to comply with the federal consent decree governing the children’s behavioral health system. Meeting these requirements will require targeted investments that are not fully reflected in the current budget proposal.

Key needs include:

- **Funding for a comprehensive statewide needs assessment of children’s behavioral health services**
- **Infrastructure within DCYF to implement the consent decree, including:**
 - Executive Director of CBH and Medical Director
 - Independent Access and Entry Point
 - Independent Intensive Care Coordination
 - Full MRSS and crisis response capacity

These services will likely support not only children involved with DCYF, but also the broader Medicaid population and children covered by private insurance, making them critical system-wide investments.

Rhode Island has made important commitments to improving the children’s behavioral health system. However, successful reform requires careful attention to funding, implementation timelines, and the stability of the community providers who deliver these services every day. As you consider the FY2027 budget, we urge policymakers to ensure:

- Adequate and sustainable service rates with administrative rates of 25-30%
- Consider funding sources that allow providers to more flexibly meet child and family needs
- Create a Medicaid Transformation Fund for \$5M or up to \$200,000 per impacted provider
- Funding for the infrastructure required to meet consent decree obligations

Thank you for your continued commitment to Rhode Island’s children and families.

Respectfully,

A handwritten signature in black ink, appearing to read "Tanja Kubas-Meyer". The signature is fluid and cursive, with a long horizontal stroke at the end.

Tanja Kubas-Meyer
Executive Director