MILLIMAN CLIENT REPORT

Social and human service programs review: Access to programs

Rhode Island, Office of the Health Insurance Commissioner

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Background

Milliman has been retained by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) to conduct a comprehensive review of all social and human service programs having a contract with or licensed by the state, inclusive of the State of Rhode Island Executive Office of Health and Human Services (EOHHS) and the state agencies under its purview. This comprehensive review is required by State of Rhode Island General Laws (RIGL) § 42-14.5-3(t). This statute requires 10 assessments covering various rate and programmatic elements of the social and human service programs, with the 10th assessment being a culmination of the prior nine assessments that will result in recommended rate adjustments. For purposes of this review, social and human service programs include services in the following subject areas: social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult/adolescent day services, vocational, employment and training, and aging.

The assessments will be completed in two phases, with Phase One published in May 2023 and Phase Two published by September 1, 2023. The first phase will include the first nine assessments with a limited scope of services. The second phase will include updates of the first nine assessments with additional services as well as the 10th report. Milliman is currently working with OHIC to determine the breadth of services that may be included in each assessment in Phase One and Phase Two of the social and human service programs review.

This Phase One report addresses RIGL § 42-14.5-3(t) task 7: “an assessment and detailed reporting on access to social and human service programs, to include any waitlists and length of time on waitlists, in each service category.”[1]

Executive Summary

EOHHS holds responsibility for a variety of social and human service programs that encompass a wide array of benefits, including medical care, behavioral health treatment, specialized services for individuals with a developmental disability, services for the aging, food assistance, and child welfare services. The mission of the Executive Office of Health and Human Services is “to ensure access to high-quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders.”[2] This Phase One report provides an overview of the access to social and human services in Rhode Island. The definitions of access used in this report are provided below.

In meetings with stakeholders, lack of access to services was identified by stakeholders to be a concern in Rhode Island. Stakeholders identified specific service areas that they believe have access concerns. Those concerns are detailed later in this report. Various studies suggest that access issues may have cost implications when individuals eventually seek services in a more expensive setting.[3, 4] Nationally, the Centers for Medicaid and Medicare Services (CMS), the federal agency that oversees state Medicaid programs, released a notice of proposed rulemaking on April 27, 2023.[5] The proposed rule would strengthen the Medicaid program’s focus on access to care. Among the proposed requirements in the draft rule are national standards for maximum wait times for some services and a requirement for states to publish wait lists for home care services.[6]

Programs often have a variety of mechanisms for monitoring access to their programs. In the Medicaid program, CMS requires state programs to provide reporting on network adequacy and access. The network adequacy and

[1] The Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight, R.I. Gen. Laws § 42-14.5-3 (2022). Retrieved from: http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-3.HTM
[2] Executive Office of Health and Human Services. (n.d.). https://eohhs.ri.gov/
[3] Sansano, T. (2022). *Average costs by state and room type*. Consumer Affairs. Retrieved from: https://www.consumeraffairs.com/health/nursing-home-costs.html
[4] *Behavioral Health: Research on Health Care Costs of Untreated Conditions is Limited*. (2019, October 10). U.S. GAO. Retrieved from: https://www.gao.gov/products/gao-19-274
[5] Centers for Medicare and Medicaid Services (April 27, 2023). *Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking.* Retrieved from: https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking-0
[6] Axios. (n.d.). *Worker pay, wait list transparency would be revealed under new Biden Administration Medicaid proposal*. Retrieved from: https://apple.news/AI-MtJPmfShmKCOImLLio_w

access to care reports are designed to provide CMS with an analysis and assurance that members are able to adequately receive necessary services. However, pending the proposed federal rules noted above, there is no national standard for network adequacy. Instead, states are allowed to establish their own quantitative network adequacy standards. These standards are often based on the time or distance it would take an individual to reach a particular type of provider. A related metric of minimum provider-to-enrollee ratio[7] may be used by plans as an adequacy metric that serves as a proxy to represent access. Federal law requires Medicaid managed care plans to assure that they have provider capacity to serve expected enrollment in their service area and maintain a sufficient number, mix, and geographic distribution of providers.[8] These reports help states and CMS identify geographic regions that may not have a sufficient number of providers or specialty services for the surrounding population.

One indication that there may be an access-to-care issue for a particular service or program is the existence of a waitlist. When there is more demand for a service than capacity to provide that service, a waitlist may be created. In some cases, maintenance of a waitlist is mandated by program regulations, while other programs have informal lists that are maintained by individual providers. However, just knowing that a waitlist (or multiple waitlists) exists does not provide the complete picture. When there is not a well-defined or consistent process for maintaining a waitlist, there are limitations to what can be learned from simply looking at the number of individuals on the list.

To promote a fuller understanding of the extent of an access issue, it may be useful to add additional assessments of the size and scope of waitlists, and information on how long a person is likely to wait for services. Individuals on a waitlist may not be eligible for that service or may be receiving service through another provider. It may also be useful to stratify the report information to identify whether there are pockets of need, such as in certain geographic areas, or for certain groups of beneficiaries (e.g., certain racial or ethnic groups, or for individuals with certain conditions). In addition, it is important to understand the root cause(s) of access issues. It may be possible to identify particular drivers impacting the impaired service availability, which can then be addressed in a more targeted way. For instance, process barriers could exist that limit access, even though providers are available. The rates for one program may exceed the rates for another program, causing providers to make business decisions about the programs for which they will open up access.

In this Phase One report, we provide an overview of the waitlists maintained by the state and identify a list of services that are noted through stakeholder interviews as experiencing access issues. We then provide our planned methodology for Phase Two research that will assess the severity of access to services and identify the root cause or drivers of access issues. These findings will be utilized by OHIC to inform recommended rate adjustments for social and human service programs in the summer of 2023.

As part of the work to prepare this report, we spoke with over 30 stakeholders (including representatives from provider groups, state government, and the Social and Human Service Programs Review Advisory Council members). Additionally, we reviewed findings from previous stakeholdering conducted by EOHHS. The preliminary list of services in Rhode Island that have been noted by stakeholders as having access issues falls largely into two domains: behavioral health services and home and community-based services (HCBS). Challenges with access to these provider types are not unique to Rhode Island, as both service domains are experiencing provider shortages nationally. A nationwide trend of worsening mental health and an increase in substance use disorders has grown significantly since the beginning of the COVID-19 pandemic.[9] This increase in demand for behavioral health services unfortunately coincides with an already over-stretched behavioral health system, leaving many people living in areas with a shortage of providers.[10] A similar shortage currently exists with direct care workers who provide HCBS services, worsened in recent years by increasing wages in other sectors that are pulling individuals away from these

[7] KFF(February 3, 2022). *Network Adequacy Standards and Enforcement*. Retrieved from: https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/
[8] *42 CFR 438.207 -- Assurances of adequate capacity and services.* (n.d.). Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207
[9] The White House(2022). *Reducing the Economic Burden of Unmet Mental Health Needs*. Retrieved from: https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/
[10] USAFacts. (2021). *Over one-third of Americans live in areas lacking mental health professionals - USAFacts*. Retrieved from: https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-health-professionals/

jobs.[11] Direct care workers are in high demand, and a nationwide shortage has led many state and national organizations to work on innovative ways to attract people to the field. [12]

It is noted that Rhode Island has worked to address access issues in behavioral health by maintaining the Rhode Island Behavioral Health Open Beds website.[13] This web-based referral platform provides a centralized listing of behavioral health providers with inpatient services. Participating providers can update their own information to reflect their current capacity and indicate if they are currently experiencing a waitlist and how many people are on the waitlist. This allows other providers or individuals themselves to find available inpatient beds more quickly for an individual who is seeking inpatient care.

Furthermore, in 2022, Rhode Island implemented a set of new programs aimed at growing the number of HCBS providers in Rhode Island, i.e., the HCBS Workforce Recruitment and Retention programs.[14] This initiative dedicated $57 million in funding from the American Rescue Plan Act to increase compensation to direct service workers and to recruit new workers. The program also allocated more than $6 million for workforce training programs. The workforce training program invests in workers through training initiatives, hiring incentives, and higher education programs to incentivize pathways to licensure. These programs are designed to increase employee competencies, further career development, and increase the number of licensed professionals in Rhode Island to help address access issues impacted by staff shortages in fields that are in high demand.

Programs and Services of Interest

In this report, we provide an overview of the formal waitlists maintained by health and human service programs in Rhode Island as well as provide an initial inventory of services that have been identified by stakeholders and the Social and Human Service Programs Review Advisory Council as anecdotally experiencing access issues (e.g., informal waitlists).

FORMAL WAITLISTS

For the purposes of this report, we have defined a formal waitlist maintained for a health and human services program as one that has some level of oversight by a state agency. This type of waitlist is a list of interested and qualified beneficiaries who would like to receive services but cannot because the program is at full capacity. Formal waitlists are typically mandated by federal or state statute or regulation and may have required parameters for how the list is to be maintained as well as updated based on new circumstances. When needed services are not currently available, beneficiaries are placed on the list and targeted for receipt of services as directed by the regulations of that waitlist. In some instances, the program must allocate services as they become available, in sequential order of when a person signed up (i.e., first come, first served). In other instances, the program may be required to apply factors for priority targeting to address those individuals who are in more urgent need of services.

For the programs that are the subject of this report, Table 1 identifies the program areas/services that have a formal waitlist with some level of state oversight. This list was developed through research of the state administrative code and discussions with state staff. A discussion of informal waitlists may be found later in this report.

Table 1. Programs/Services with a Formal Waitlist

Program	Department with Oversight	Waitlist Information
Vocational Rehabilitation Services	Department of Human Services (DHS), Office of Rehabilitative Services	Vocational Rehabilitation has state authority to maintain an order of selection through 218-50-00 R.I. Code R.§1.8. When needed, a waitlist is

[11] Taggart, E., & Fox-Grage, W. (2023). *State Strategies to Support Family and Professional Caregivers*. NASHP. Retrieved from: https://nashp.org/state-strategies-to-support-family-and-professional-caregivers/
[12] Scales, K. (2021). *It Is Time to Resolve the Direct Care Workforce Crisis in Long-Term Care*. Gerontologist, *61*(4), 497–504. Retrieved from: https://doi.org/10.1093/geront/gnaa116
[13] *Rhode Island Behavioral Health Open Beds - Available Beds*. (n.d.). Retrieved from: https://www.ribhopenbeds.org/
[14] Executive Office of Health and Human Services. *HCBS Workforce Recruitment and Retention.* (n.d.). Retrieved from: https://eohhs.ri.gov/initiatives/hcbs-workforce-recruitment-and-retention

		maintained. As of March 2023, no one is on a waitlist for entry into services.[15]
Behavior Health Group Home	Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)	The state has the authority to maintain a waitlist through 212-RICR-10-10 for BH Group Home placement. The state must use priority placement criteria documented in state policy. As of April 2023, 61 individuals were on a waitlist for placement.[16]
Head Start	Department of Human Services (DHS)*	The seven Head Start providers in Rhode Island each maintain their own waitlist for services. As of November 2022, six head start locations reported a waitlist for services with approximately 430 children and families on those lists.[17]

*DHS operates the head start collaboration office under federal guidance but does not control funding or maintain a centralized waitlist.

A more detailed discussion of the waitlist process for each of these programs follows.

VOCATIONAL REHABILITATION SERVICES

Vocational rehabilitation services are provided by the Rhode Island Office of Rehabilitative Services (ORS). The ORS is directed by 218-50-00 R.I. Code R.§1.8 to maintain an order of selection for vocational rehabilitation services when the program is not able to assist everyone who is eligible and seeking service. The order of selection places all individuals on a waitlist into one of three priority categories as described below.[18]

- **Priority Category I** individuals will be given first priority for movement from the waitlist into services. Category I is comprised of those with the most significant disabilities. Category I is defined as "a consumer who has a most significant disability if a mental or physical impairment exists that seriously limits four or more functional capacities in terms of an employment outcome and whose vocational rehabilitation requires multiple services over an extended period of time."[19]
- **Priority Category II** is comprised of consumers with a significant disability defined as "a mental or physical impairment exists that seriously limits two or three functional capacities in terms of an employment outcome and whose vocational rehabilitation requires multiple services over an extended period of time."[20]
- **Priority Category III** is comprised of "other eligible consumers who have a disability that seriously limits one functional capacity in terms of an employment outcome and requires two or more services over an extended period of time."[21]

When there is a waitlist and order of selection in place, the waitlist is to be maintained and published on the ORS website. As noted in Table 1, there is no one currently on the waitlist for entry into this program.

BEHAVIORAL HEALTH GROUP HOME SERVICES

Behavioral health group home services, a type of Mental Health Rehabilitative Residence, are overseen by the Rhode Island BHDDH. Under Rhode Island Code of Regulations Section 212-RICR-10-10, BHDDH is given authority to maintain a waitlist for group home placement. However, the regulations do not document the order of selection or priority process for placement. The code does require that the state use priority placement criteria as documented in state policy. In addition to the Rhode Island regulatory requirements, states are also expected to follow the terms of the federal Olmstead decision, which found that unjustified segregation of people with disabilities is a form of unlawful discrimination.[22] The BHDDH priority policy complies with the requirements of the Olmstead decision and includes a process to confirm that an individual is interviewed to determine that the placement is clinically appropriate prior to admission. The process of being added to the group home services waitlist begins when an application for Mental Health Rehabilitative Residence (MHPRR) services is submitted and deemed complete. The targeting priority policy

[15] Department of Human Services Email to Molly McCloskey. (March 24, 2023).

[16] Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Molly McCloskey. (May 17, 2023).

[17] Department of Human Services Email to Molly McCloskey. (March 28, 2023).

[18] Vocational Rehabilitation Program Regulations. 218-RICR-50-00-1. (2022). https://rules.sos.ri.gov/regulations/Part/218-50-00-1

[19] Ibid.

[20] Ibid.

[21] Ibid.

[22] Olmstead v. L.C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/case.pdf

creates two categories, those individuals who have been waiting for placement for less than 30 days from the application approval date and those who have been waiting more than 30 days.

For those on the waitlist who have been waiting for less than 30 days, the prioritization is as follows:

1. Forensic inpatients
2. Eleanor Slater Hospital patients
3. Acute inpatient psychiatric hospital patients
4. Youth who are transitioning from the Department of Children, Youth and Families (DCYF) system of care to the adult MHPRR system of care
5. Applicants who are being released or paroled from the Department of Corrections (DOC)
6. Applicants who are currently being treated in a Behavioral Health Stabilization Unit
7. Applicants who currently reside in a supervised apartment setting (also MHPRR) but require a higher level of care
8. Applicants who are being treated by a Community Mental Health Organization (CMHO) as an outpatient, with multiple inpatient psychiatric admissions, thus demonstrating the need for a higher level of care to remain safely in the community[23]

For those on the waitlist who have been waiting for more than 30 days:

- Any client who is currently placed in a setting listed in items 1-7 above, will be reviewed for placement in an appropriate milieu that meets the needs of the client
- Any applicant being treated by a CMHO as an outpatient or living in the community and treated by a provider and meets level of care criteria, will continue to be reviewed based on the priority list[24]

HEAD START

The Head Start collaboration office is run by the Department of Human Services; however, the majority of its funding comes from the federal government. If needed, each of the seven Head Start providers in Rhode Island maintains its own waitlist for services. There is not a centralized, state-maintained list. The state is made aware of the number of individuals waiting for service but does not direct the placement of individuals into service. As of November 2022, six Head Start locations reported a waitlist for services with approximately 430 children and families on those lists.[25] One location does not have a waitlist.

OTHER NOTED SERVICES OF INTEREST (INFORMAL WAITLISTS)

In addition, stakeholders interviewed for this report identified a number of additional services that may have access issues due to the existence of self-maintained waitlists for individual providers (e.g., informal waitlists). These lists are not regulated by state or federal rules, and each provider has discretion to maintain these lists as it deems appropriate. The providers are able to target individuals for receipt of services according to their own policies and procedures.

Milliman conducted 12 interview sessions with more than 30 individuals representing a broad array of advocacy and provider groups, state staff, and Social and Human Service Programs Review Advisory Council members. Through those interview sessions, conducted in February and March of 2023, a listing of programs with possible access issues was identified.

Table 2 summarizes the service listing that has been identified as likely to have access issues and which may be experiencing provider-maintained waiting lists. This likelihood of access issues and waitlists was the primary criteria used to select the four categories of focus for this work, those being: Child and Adolescent Behavioral Health; Adult Behavioral Health; Home Care and HCBS Services; and Other (which captures services that meet criteria but fall outside of the other categories). Phase Two research will be focused on gathering additional information and seeking to validate the potential access issues noted for these services.

[23] State of Rhode Island, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare, Policy and Procedure. MHPRR Application and Priority List Referral Process, 9-28-22.
[24] Ibid.
[25] Department of Human Services Email to Molly McCloskey. (March 28, 2023).

Table 2. Services With Access Issues, as Noted in Stakeholder Interviews

Child and Adolescent Behavioral Health	Home Care and HCBS Services
• Behavioral Health Preventive Care • Counseling and Diagnostics • Psychotherapy • Intensive Outpatient • Crisis Behavioral Health • Mobile Crisis • Behavioral Health Outpatient • SUD Outpatient • Residential Behavioral Health • Residential SUD Treatment	• Homemaker • Personal Care • Private Duty Nursing • Medication Management/Administration • Adult Day Services • Assisted Living • I/DD Services for Children
Other	**Adult Behavioral Health**
• Non-Emergency medical Transportation (NEMT) • TBI Day Services • Early Intervention	• Intensive Outpatient • Residential Behavioral Health • Residential SUD Treatment

Phase Two Methodology

Milliman and Faulkner Consulting Group, which is subcontracted to support this task, will provide an assessment that examines both the identification of access issues and exploration of the drivers of those access issues. Our approach to research and assessment is expressed below. The analysis will build upon previous research completed in Rhode Island in 2020-2021 that included review of access to behavioral health services.

ACCESS DEFINITION AND APPROACH

In Phase Two, we will ground our approach to analysis of access in the National Academy of Medicine (NAM), formerly known as Institute of Medicine, framework to evaluate Rhode Islanders' ability to access the services included in this evaluation.[26] NAM's framework was established by its Committee on Monitoring Access to Personal Health Care Services, including clinical expertise and broad perspectives on access to care nationwide. The NAM framework has been cited by several researchers and policymakers when evaluating healthcare access, including Healthy People 2030.[27]

For the purposes of this study, we will adapt the NAM's definition of access to "the timely use of services to achieve the best possible outcomes." NAM identifies four categories of barriers to access that we will use for this analysis: structural, financial, personal, and cultural. We will further refine these categories to reflect types of barriers to access anticipated in Rhode Island, those being: (1) eligibility barriers, (2) service limitations, (3) geographic barriers, (4) cultural barriers, (5) network/provider capacity barriers, (6) cost barriers, and (7) contractual barriers.[28]

We will evaluate each of the identified services against the seven dimensions of access from the NAM framework to tailor the evaluation methodology for each combination of service and dimensions of access (e.g., geographic, and cultural barriers for personal care). Through this process, we may refine combinations of services and access dimensions to provide a clear picture of access without duplicating work completed under other tasks of this study.

DATA COLLECTION

Our research approach will include both quantitative and qualitative data collection and analysis to gather relevant data and develop insights on access.

- **Quantitative research** will include utilizing data sources identified in other tasks of this project, identifying best practices and benchmarks as applicable, and conducting analysis of available data for waitlists, utilization trends, and relevant existing reports. In reviewing formal waitlists, we will evaluate how each waitlist is managed and identify any process opportunities that may improve wait times.

- **Qualitative research** will include conducting interviews with stakeholders and subject matter experts (SMEs) to collect their feedback regarding the seven dimensions of access for the four service categories of

[26] National Academies Press (US). (1993). *A Model for Monitoring Access*. Access to Health Care in America - NCBI Bookshelf. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK235891/
[27] *Access to Health Services - Healthy People 2030.* Health.gov. (n.d.). Retrieved from: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services
[28] National Academies Press (US). (1993). *A Model for Monitoring Access*. Access to Health Care in America - NCBI Bookshelf. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK235891/

focus. We will partner with OHIC and the Social and Human Services Program Review Advisory Council to identify and confirm the appropriate stakeholders and SMEs are included.

To further inform our analysis, we will ground our Rhode Island-specific findings by comparing the local circumstances to access considerations nationally and across the region.[29] We will look at aspects such as workforce shortages for behavioral health and direct care workers as well as issues that other states may be experiencing, such as cultural barriers to access for specific populations. Among other sources to be determined, three recent reports will provide initial data for this work:

1. **Rhode Island Behavioral Health System Review Final Report:** For the child and adolescent behavioral health and adult behavioral health service categories, we will leverage the research and analysis conducted as part of the Rhode Island Behavioral Health System Review Final Report,[30] completed in July 2021. The key themes and findings of the report were informed through a mixed-method approach conducted from September to December 2020, including qualitative work engaging stakeholders from both state agencies and the community, as well as a quantitative assessment of Rhode Island's behavioral health system. The report included an in-depth analysis of behavioral health services in Rhode Island that identified gaps in access and capacity to meet community need, insufficient workforce capacity, and disparities in health equity and race equity within the behavioral health system.

2. **Alternative payment model (APM) reporting**: We will evaluate reporting data being gathered for the Long-Term Services and Supports Alternative Payment Methodology (LTSS APM) Program,[31] as available (noting that first round of data will be for Q4-2022 and is expected to be available by early to mid-May 2023). Home care agency reporting will include two measures of access (service hours delivered versus approved, and consistent staff assignment) reported for all Medicaid members served by the agency.

3. **Findings from relevant tasks from other social and human service program reports**: Any relevant contractual barriers, eligibility barriers, or waitlist data identified in other tasks during this project will be reviewed for relevant information to inform this report.

ANALYSIS

We will evaluate the seven dimensions of access using a set of guiding questions, to the extent that this information is available. Those questions may include:

1. **Service limitations:** How is each service defined and what does each service provide to Medicaid members? Are there any utilization limits that might make access more difficult?
2. **Geographic barriers:** Are there geographic areas that are experiencing challenges with service availability? Do providers limit the total number of members who they are willing to serve? If yes, why are the numbers limited and how does that process work?
3. **Cultural barriers**: Are their specific barriers and cultural norms that impact the selection of providers for certain populations? How does healthcare literacy and disparity impact populations and access to providers? Does the provider network acknowledge and accommodate cultural norms?
4. **Network/provider capacity barriers:** Are there sufficient providers available? Are there any network limitations? For which provider types?
5. **Cost barriers:** Are there any cost-sharing requirements for members that might make access more difficult? Do providers limit services that are more costly for them to provide?
6. **Contractual barriers**: Are there any concerns raised related to provider/network contractual issues? Are there administrative requirements that may make providers reluctant to provide services?
7. **Eligibility barriers**: Are the members who need these services eligible to receive them? Is eligibility for services determined in a timely manner to allow access to services when needed? Are there other process challenges with the eligibility determination procedures?

As noted, the Phase Two report will be published by September 1, 2023, with work already underway.

[29] CMS region one includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.
[30] Faulkner Consulting Group and Health Management Associates (July 2021). *Rhode Island Behavioral Health System Review Technical Assistance*. Retrieved from: https://eohhs.ri.gov/initiatives/behavioral-health-system-review
[31] *LTSS APM Reporting* (November 2022). The Executive Office of Health and Human Services, State of Rhode Island. Retrieved from: https://eohhs.ri.gov/initiatives/accountable-entities/ltss-apm

Limitations

The information contained in this report has been prepared for the State of Rhode Island, Office of the Health Insurance Commissioner (OHIC) and its advisors. Milliman's work is prepared solely for the use and benefit of the OHIC in accordance with its statutory and regulatory requirements. Milliman recognizes this report will be public record subject to disclosure to third parties; however, Milliman does not intend to benefit and assumes no duty or liability to any third parties who receive Milliman's work. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety.

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

Faulkner Consulting Group is engaged as a subcontractor to Milliman on this project. Neither Faulkner's nor Milliman's work may be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third-party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

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

The services provided for this project were performed under the contract between Milliman and OHIC dated January 26, 2023.

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