MILLIMAN CLIENT REPORT

Social and Human Service Programs Review: Access to programs

Rhode Island, Office of the Health Insurance Commissioner

August 31, 2023

Jason Clarkson, FSA, MAAA
Principal and Consulting Actuary

Natalie Angel, MA
Senior Healthcare Consultant

Barbara Culley, MPA, NHA
Senior Healthcare Consultant

Jeremy Hoffman, JD
Healthcare Consultant

Milliman

Table of contents

BACKGROUND **3**

EXECUTIVE SUMMARY **4**

FINDINGS 13

BEHAVIORAL HEALTH SERVICES: BACKGROUND AND CONTEXT 13

COUNSELING AND PSYCHOTHERAPY 19

INTENSIVE OUTPATIENT: ADULTS (Including MH and SUD) 23

INTENSIVE OUTPATIENT AND SUD OUTPATIENT: CHILDREN (Including DCYF) 26

MOBILE CRISIS 31

RESIDENTIAL MENTAL HEALTH 33

RESIDENTIAL SUD TREATMENT 38

HOME AND COMMUNITY BASED SERVICES (HCBS) 43

ADULT DAY 44

ASSISTED LIVING 47

PRIVATE DUTY NURSING (PDN) 52

PERSONAL CARE 55

INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD) 58

OTHER SERVICES 63

EARLY INTERVENTION SERVICES 63

TRAUMATIC BRAIN INJURY (TBI) DAY SERVICES 69

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) 72

LIMITATIONS **77**

APPENDIX A **78**

APPENDIX B **81**

APPENDIX C **82**

APPENDIX D **82**

APPENDIX E **82**

APPENDIX F **82**

Background

Milliman, Inc. (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 review is required by State of Rhode Island General Laws (RIGL) § 42-14.5-3(t). This statute requires nine assessments covering various rate and programmatic elements of the social and human service programs, with a final assessment being a culmination of the prior nine assessments. 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. As a whole, this series of reports may be used as one set of resources to provide education and insight into current Rhode Island social and human service programs' provider reimbursement and programmatic structure.

The assessments were completed in two phases with the first phase published in May 2023, and second phase published by September 1, 2023. The first phase included the nine assessments with a limited scope of services. The second phase is cumulative encompassing all information presented in the first phase reports with any applicable updates and additional programs or services reviewed. The second phase will conclude with a 10th report, published by OHIC, which will contain recommended provider reimbursement rate adjustments and other findings from the review.

This final report addresses RIGL § 42-14.5-3(t) task 7: "an assessment and reporting on access to social and human service programs, to include any waitlists and length of time on waitlists, in each service category" and includes findings from both the first phase (Phase 1) and the second phase (Phase 2).

The purpose of this report is to provide baseline information regarding the services in Rhode Island that have state-maintained waitlists and identify other types of services where access issues may be present. In Phase 1 of reporting, state-maintained waitlists were identified, and the processes of their maintenance were described. Additionally, potential services with access issues were identified through interviews with a broad array of stakeholders. The services identified for further research and the proposed methodology was introduced. In Phase 2 of this report, the identified services were assessed using the proposed methodology. The findings of that assessment are documented in this final report.

Executive summary

Milliman has developed this final report which builds on the access information that was presented in Phase 1 reporting. In Phase 1, state-maintained waiting lists were identified, and the maintenance processes were described. Additionally, a methodology for evaluating access issues for an identified set of services was proposed. In this report, that methodology is further explained and the findings of the evaluation are presented. For this report, Milliman contracted with Faulkner Consulting Group (FCG) to conduct Phase 2 research to assess the state of access to social and human services provided by the State of Rhode Island and identify potential root causes or drivers of access observations for selected services.

We 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 based on industry knowledge and provider experience.

Overall, 18 total services were assessed as part of Phase 2. These services were selected through stakeholder input designed to identify services with possible access challenges. Many EOHHS programs and services fell outside of this selection process and the access assessment presented in this report is not intended to be representative of all services provided through human and social service programs in Rhode Island. The services assessed fell into four domains: adult behavioral health services, child and adolescent behavioral health services, home and community-based services (HCBS), and other services. The complete list of services that were analyzed as part of Phase 2 is listed in Figure 1. Please note that the focus of rate reviews is the Medicaid fee-for-service program, not managed care organizations (MCOs). However, in this report on access, services offered through the MCOs are included in some analysis and many stakeholders for this report mentioned MCOs in their comments.

FIGURE 1: PHASE 2 SERVICES EVALUATED FOR POTENTIAL ACCESS BARRIERS

Child and Adolescent Behavioral Health	Adult Behavioral Health
▪ Counseling and Psychotherapy ▪ Intensive Outpatient, incl. Mental Health (MH) and Substance Use Disorder (SUD), and Department of Children, Youth, and Families (DCYF) ▪ Mobile Crisis ▪ Residential Mental Health ▪ Residential SUD Treatment	▪ Counseling and Psychotherapy ▪ Intensive Outpatient, incl. Mental Health (MH) and Substance Use Disorder (SUD) ▪ Mobile Crisis ▪ Residential Mental Health ▪ Residential SUD Treatment
Home and Community Based Services (HCBS)	**Other**
▪ Personal Care and Homemaker ▪ Private Duty Nursing (PDN) ▪ Adult Day Services ▪ Assisted Living ▪ Intellectual/Developmental Disability (I/DD) Services	▪ Early Intervention (EI) ▪ Traumatic Brain Injury (TBI) Day Services ▪ Non-Emergency medical Transportation (NEMT)

As part of the process to prepare this report, representatives from over 30 stakeholder groups were interviewed, including provider groups, state government, and members of the Social and Human Service Programs Review Advisory Council. Both qualitative and quantitative data, when available, were analyzed and incorporated into the findings. Due to data limitations, access observations are significantly informed by stakeholders' opinions. Given this limitation in available data, we understand that there are inherent challenges in relying primarily on subjective anecdotal information.

At the highest level, it appears that many of the evaluated services may have opportunities for improvement in access. Access limitations are perceived by interested parties as driven by provider capacity, geographic barriers, and reimbursement barriers. Other reports completed for the broader mandated analysis provide a data-driven review of provider reimbursement rates. For some services, we identified specific service limitations, eligibility constraints, and/or public policy challenges that also contributed to barriers to access. Several of the services assessed did not have enough information or data regarding equity barriers to comment on it; however, when information was

obtainable, we identified potential disparities in service access. A summary of the level of access identified through stakeholder interviews and analysis of limited available data is provided in Figure 2.

FIGURE 2: PHASE 2 SUMMARY OF ACCESS FINDINGS

Unavailable	Highly Limited	Somewhat Limited	Generally Available
▪ TBI Day	▪ Adult Counseling/Psychotherapy ▪ Adult Intensive Outpatient ▪ Adult Residential Mental Health ▪ Adult Residential SUD ▪ Child Counseling/Psychotherapy ▪ Child Intensive Outpatient ▪ Child Residential Mental Health ▪ Assisted Living ▪ Private Duty Nursing ▪ Personal Care ▪ I/DD Services ▪ Mobile Crisis* ▪ Residential SUD Services for Children	▪ Children's Mobile Crisis ▪ Adult Day ▪ Early Intervention ▪ Non-Emergency Medical Transportation	

** CMS has recently provided a definition of mobile crisis. States are working toward meeting the new definition and expanding the service option. Currently, mobile crisis services are delivered in facilities, e.g., the Emergency Department.*

Consistent criteria were used to categorize each service type as well as the availability of data to support the review. Each service has then been color-coded as red, orange, yellow or green. Grey was used to color-code those items for which data was unavailable or not applicable. The criteria used for high-level categorization of the findings from the stakeholder interviews and review of available data are described in Figure 3. The preponderance of the information related to informal waitlists used to develop these categorizations is primarily based on stakeholder input. Informal waitlists are independently maintained by each provider with no standard processes or data aggregation to allow for more quantitative analysis. In many cases, providers do not maintain wait lists, further compounding the challenge in objective analysis.

FIGURE 3: ACCESS AND DATA CLASSIFICATION DEFINITIONS

Legend	Qualitative Status of Access Barriers	Status of Available Quantitative Data
Unavailable	Service not offered in state Consistently reported findings	Access data not centrally tracked or Services inconsistently defined
Highly Limited	Highly limited access Consistently reported findings	Access data not centrally tracked or Services inconsistently defined
Somewhat Limited	Limited access within specific subcategories or populations and/or Access constraints inconsistently reported	Access data centrally tracked or Services consistently defined or Specific/narrow data limitations
Generally Available	No access limitations identified	Access data centrally tracked or Services consistently defined or No/few data limitations
Undetermined	Data not available or not applicable	Data not available or not applicable

Using this system of analysis, a more detailed analysis is provided below. **As part of Phase 2, the following observations are made with reliance on primarily qualitative input:**

- **13 out of the 18 services evaluated were found to have highly limited access,** with the contributing factors most cited for constraining access being **limitations in provider capacity/network barriers, geographic barriers, and reimbursement barriers.**
- **One service, TBI Day, was found to be unavailable in RI,** where the service was effectively not available in the state.
  - Based on the Governor's Permanent Advisory Commission on TBI Annual Report, and further confirmed by qualitative stakeholder interviews conducted for this study, TBI Day Services do not exist in Rhode Island, and both stakeholders and the Governor's Report noted that this lack of availability is a high priority concern.[1]
- **Four services (22%) were found to have somewhat limited access only within specific subcategories or populations**– Mobile Crisis for children, Adult Day, Early Intervention, and Non-Emergency Medical Transportation.
- **No services evaluated were found to be generally available without barriers to access.** This is likely attributable to the process used to select the services that were assessed. Stakeholder input was designed to identify those services with the most significant perceived barriers. EOHHS programs and services that were not identified as having potential access issues by multiple stakeholders were not evaluated.

Data Limitations

In most cases, this assessment was constrained by the availability of consistently defined, centrally tracked access data. For example:

- **Only three of the evaluated services (17%) have access data that is both consistently defined and centrally tracked** with few limitations. These are Mobile Crisis for children, Personal Care, and Early Intervention.

[1] Rhode Island Governor's Permanent Advisory Committee on Traumatic Brain Injury. Annual Report (2023).

- **Centralized tracking was limited, as half of the services evaluated (50%) had no centralized tracking** of access-related measures, such as members awaiting/pending referrals, average time to referral, or average time to appointment. This was most notable for home and community-based services, where four of the five services evaluated did not have centralized tracking of access-related measures: Private Duty Nursing, Adult Day, Assisted Living, and I/DD services.
- **Definitional issues substantively impeded access assessment for three of the evaluated services (17%):** For Outpatient BH services (for both adults and children), the continuum of care, service names, and the definitions varied significantly by department (DCYF, Executive Office of Health and Human Services - EOHHS, Department of Behavioral Healthcare, Developmental Disabilities & Hospitals – BHDDH) and naming conventions were inconsistently applied between managed care and fee-for-service (FFS).

Given these limitations, our assessment supplemented centrally available quantitative access data with qualitative interviews and stakeholder discussions. Qualitative interviews centered around service providers in each of the targeted service categories to understand provider-specific perceptions of barriers to access as well as to identify any specific access data maintained by these providers. There are two considerations regarding this approach:

- Consumer perspectives are not directly represented in the analysis. When available and provided, feedback from interviewees about their understanding of consumer perspectives was incorporated as appropriate. Consumer perception is an important factor in assessing access as regulatory standards may be set at a more rigorous level than what the general consumer finds acceptable.
- Stakeholders interviewed provided individual responses based on their own experience, which may include biases – conscious or unconscious – that we evaluate for concurrence in the associated analysis. The interviews were thoroughly conducted and included probing questions to understand stakeholders' responses, but the qualitative data collected and used throughout this report remains subjective.

Report Structure

This report provides a discussion of access, waitlists, and barriers to access for various healthcare services and describes selected programs that fall into informal or formal waitlist categories. Additionally, the criteria used for prioritizing the waitlists are indicated, where processes or formal practices exist. Each program section further discusses the primary and contributing factors that resulted in the summary assessment of the access status for the programs selected for this report. The report presents information in the following order:

- Formal waitlists by program
- Informal waitlists by program
- Access dimensions used to evaluate barriers to access
- Access and data evaluation matrix and definition
- Findings by program
- Each program is organized to include the following information:
  - Program Name
  - Access analysis summary chart
  - Service definition
  - Current Status (further defined where appropriate by age, e.g., adult/youth)
  - Data status
- Findings:
  - Provider capacity/network barriers
  - Geographic barriers
  - Public policy barriers
  - Service limitations barriers
  - Equity barriers
  - Reimbursement barriers
  - Eligibility barriers

The appendices provide additional graphic representation of the data discussed in the program sections for further reference and visualization.

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 is required to 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 or otherwise qualify for prioritized access.

Regarding the programs that were reviewed in Phase 1 of this report, Figure 4 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.

FIGURE 4: 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 maintained. As of March 2023, no one is on a waitlist for entry into services.[2]
Behavioral Health Group Home	Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	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.[3]
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.[4]

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

The following sections provide a more detailed discussion of the waitlist process for each of these programs.

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.[5]

- **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."[6]

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

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

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

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

[6] Ibid.

- **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."[7]

- **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."[8]

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 the Figure above, 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 Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (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.[9] 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 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[10]

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

1. 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
2. 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[11]

HEAD START

The Head Start collaboration office is run by the Department of Human Services; however, the majority of the program's 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.[12] One location does not have a waitlist.

[7] Ibid.
[8] Ibid.
[9] Olmstead v. L.C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/case.pdf
[10] 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, (September 28, 2022).
[11] Ibid.
[12] Department of Human Services Email to Molly McCloskey. (March 28, 2023).

OTHER NOTED SERVICES OF INTEREST (INFORMAL WAITLISTS)

Stakeholders interviewed for this report identified a number of additional services that may have access issues as indicated by 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 deemed appropriate. The providers are able to target individuals for receipt of services according to their own policies and procedures.

Figure 5 summarizes the services that were identified in Phase 1 as likely to have access issues and which may have 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). In the process of Phase 2 research, refinements to this original list of services were made. Service definitions were clarified in the behavioral health area that reduced the number of services listed. Under the home care and HCBS services section, Medicaid Management and Administration was removed. The findings in each section clarify the services that were part of Phase 2 access research.

FIGURE 5. SERVICES WITH ACCESS ISSUES, AS IDENTIFIED IN PHASE 1

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 ▪ Mental Health Outpatient ▪ SUD Outpatient ▪ Residential Mental 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 Mental Health ▪ Residential SUD Treatment

METHOD

In order to review Rhode Islanders' ability to access the services included in this evaluation, FCG and Milliman developed an access definition and approach for the Phase 2 analysis which was grounded in the framework for analysis of access developed by the National Academy of Medicine (NAM), formerly known as the Institute of Medicine.[13] 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. For the purposes of this study, we adapted NAM's definition of access as "the timely use of services to achieve the best possible outcomes." NAM identifies four categories of barriers to access that we used for this analysis: structural, financial, personal, and cultural. We further refined these categories to reflect types of barriers to access that might be anticipated in Rhode Island, and after incorporating feedback from the Social and Human Service Programs Review Advisory Council and state subject matter experts (SMEs), used the following categories (Figure 6) for this analysis.

We evaluated each of the identified services against the seven dimensions of access defined in Figure 6.

[13] 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/

FIGURE 6: DEFINITION OF ACCESS DIMENSIONS

Access Dimension	Definition
Provider Capacity/Network Barriers	Assess capacity of providers to meet needs, network sufficiency, network limitations
Service Limitations	Review benefit definition for barriers to access for each service, such as benefit limits and service exclusions
Geographic Barriers	Barriers related to location-based gaps in access to services, and transportation-related challenges to accessing care
Equity Barriers	Access related issues associated with dimensions including but not limited to culture, race, language, deaf and hard of hearing, blind and visually impaired, LGBTQ+, and other demographic characteristics, including income
Public Policy Barriers	Access issues related to statutory or regulatory constraints, administrative requirements that may make providers reluctant to provide services or create delays in accessing care
Reimbursement Barriers	Provider reimbursement related barriers to offering services
Eligibility Barriers	Assessment of eligibility issues including if members who need services are in fact eligible, timeliness of eligibility determination, and eligibility process challenges

Our research approach included both qualitative and quantitative data collection where available and analysis to gather relevant data and develop insights on access. We conducted primary research and data collection, as well as leveraged prior work conducted by the Faulker Consulting Group (FCG) as a starting point. Through this process, we further refined the combinations of services and access dimensions to provide a clear picture of access without duplicating work completed under other tasks of this study.

Quantitative research included 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 evaluated how each waitlist is managed and identified any process opportunities that may improve wait times.

Qualitative research included conducting interviews with Advisory Council members, community stakeholders, and subject matter experts to collect their feedback regarding the seven dimensions of access for the four service categories of focus. We collaborated with OHIC and the Social and Human Service Programs Review Advisory Council to identify and confirm that the appropriate stakeholders and SMEs were included. Qualitative interviews centered around service providers in each of the targeted service categories to understand provider-specific experiences with perceived barriers to access as well as to identify any specific access data maintained by these providers. We caution users of this report to consider the limitations of this approach, in particular:

- Consumer perspectives are not directly represented in the analysis. When available and provided, feedback from interviewees about their understanding of consumer perspectives was incorporated.
- Stakeholders interviewed provided individual responses based on their own experience, which may include biases – conscious or unconscious – that are considered and evaluated in the associated analysis. The interviews were thoroughly conducted and included probing questions to understand stakeholders' responses, but the qualitative data collected and used throughout this report remains subjective.

To further inform our analysis, where available, we grounded our Rhode Island-specific findings by comparing the local landscape to access considerations nationally and across the region. For instance, we looked 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. As part of our analysis, we leveraged work already conducted to provide initial data for this analysis, including the following:

1. 2020-2021 Rhode Island Behavioral Health System Review Final Report (BH System Report):

For the child and adolescent behavioral health and adult behavioral health service categories, we leveraged the research and analysis conducted as part of the Rhode Island Behavioral Health System Review Final Report,

completed in July 2021.[14] 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. Findings from relevant tasks from other social and human service programs reports:

Any relevant contractual barriers, eligibility barriers, or waitlist data identified in other tasks during this project were reviewed for relevant information to inform this report.

[14] Faulkner Consulting Group and Health Management Associates (July 2021). *Rhode Island Behavioral Health System Review Technical Assistance*. https://eohhs.ri.gov/initiatives/behavioral-health-system-review

Findings

BEHAVIORAL HEALTH SERVICES: BACKGROUND AND CONTEXT

Nationwide there has been an ongoing behavioral health workforce shortage coupled with increasing need of behavioral health services.[15] A 2023 issue brief developed by Kaiser Family Foundation noted that *"behavioral health conditions are most prevalent in Medicaid enrollees and, on average, only 36% of psychiatrists are accepting new Medicaid patients."*[15]

OHIC has been charged with conducting a comprehensive review of all social and human service programs contracted with or licensed by the state. As part of this review, several services within the Behavioral Health (BH) continuum of care were requested to be reviewed by stakeholders, including those related to Adult Mental Health, Adult Substance Use Disorder, and Children's Behavioral Health System Service.

As there was a BH System Report conducted in 2020-2021, Faulkner Consulting Group and Milliman incorporated relevant findings from that review into this access study in tandem with updated quantitative data and qualitative feedback from community stakeholders.

While qualitative interviews focused on each of the distinct BH services, feedback from community stakeholders may be relevant across services and apply to the broader BH service continuum of care.

The complete list of Adult and Children's Behavioral Health services analyzed as part of Phase 2 is listed below in Figure 7.

FIGURE 7: BEHAVIORAL HEALTH SERVICES REVIEWED IN PHASE 2

Child and Adolescent Behavioral Health	Adult Behavioral Health
▪ Counseling and Psychotherapy ▪ Enhanced/Intensive Outpatient (MH and SUD), including DCYF ▪ Mobile Crisis ▪ Residential MH ▪ Residential SUD Treatment	▪ Counseling and Psychotherapy ▪ Intensive Outpatient (MH and SUD) ▪ Mobile Crisis ▪ Residential MH ▪ Residential SUD Treatment

[15] Kaiser Family Foundation (KFF). (January 10, 2023). *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs.* https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/

Figure 8 provides a summary of the findings for Adult Behavioral Health Services that were assessed for access. The overall results indicate that services were consistently reported to be highly limited. The contributing factor of limited access for 4 of the 5 services for adults was provider capacity with service limitations also being noted as a contributing factor for 4 of the 5 services. The data available was also limited for most service categories.

FIGURE 8: ADULT BEHAVIORAL HEALTH SERVICES

		Adult Behavioral Health Services				
Access Category		**Counseling/ Psychotherapy**	**Intensive Outpatient (including Mental Health and Substance Use Disorder)**	**Mobile Crisis**	**Residential Mental Health**	**Residential Substance Use Disorder**
Overall Access		Highly Limited	Highly Limited	Highly Limited	Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor	-	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	Contributing Factor	-	-	Contributing Factor
	Public Policy Barriers	-	-	-	-	-
	Services Limitations Barriers	-	Contributing Factor	Contributing Factor	Contributing Factor	Contributing Factor
	Equity Barriers	Contributing Factor	Contributing Factor	-	Undetermined	-
	Reimbursement Barriers	-	Contributing Factor	-	-	-
	Eligibility Barriers	-	-	-	-	-
Data Status		Highly Limited	Unavailable	Undetermined	Highly Limited	Somewhat Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Figure 9 provides a summary of the findings for Children's Behavioral Health Services that were assessed for access. DCYF is responsible for maintaining all children's behavioral health services; the agency does so in partnership with Medicaid as the primary payor for many of these services. The overall results were mixed with services being identified as somewhat limited or highly limited in overall access. The contributing factor for 4 of the 5 services for children was provider capacity as reported by stakeholders and review of available data. There is also a lack of residential substance use disorder treatment for children in Rhode Island. Service limitations are also being noted as a contributing factor for 2 of the 5 services.

FIGURE 9: CHILDREN'S BEHAVIORAL HEALTH SERVICES

		Children's Behavioral Health Services				
Access Category		**Counseling/ Psychotherapy**	**Enhanced/ Intensive Outpatient (including Mental Health and Substance Use Disorder), including DCYF**	**Mobile Crisis**	**Residential Mental Health**	**Residential Substance Use Disorder**
Overall Access		Highly Limited	Highly Limited	Somewhat Limited	Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor	-	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	Contributing Factor	-	-	-
	Public Policy Barriers	-	Contributing Factor	-	-	-
	Services Limitations Barriers	Undetermined	Contributing Factor	Contributing Factor	-	-
	Equity Barriers	Contributing Factor	Contributing Factor		Undetermined	-
	Reimbursement Barriers	-	-	-	-	-
	Eligibility Barriers	-	-	-	-	-
Data Status		Highly Limited	Highly Limited	Generally Available	Highly Limited	Undetermined

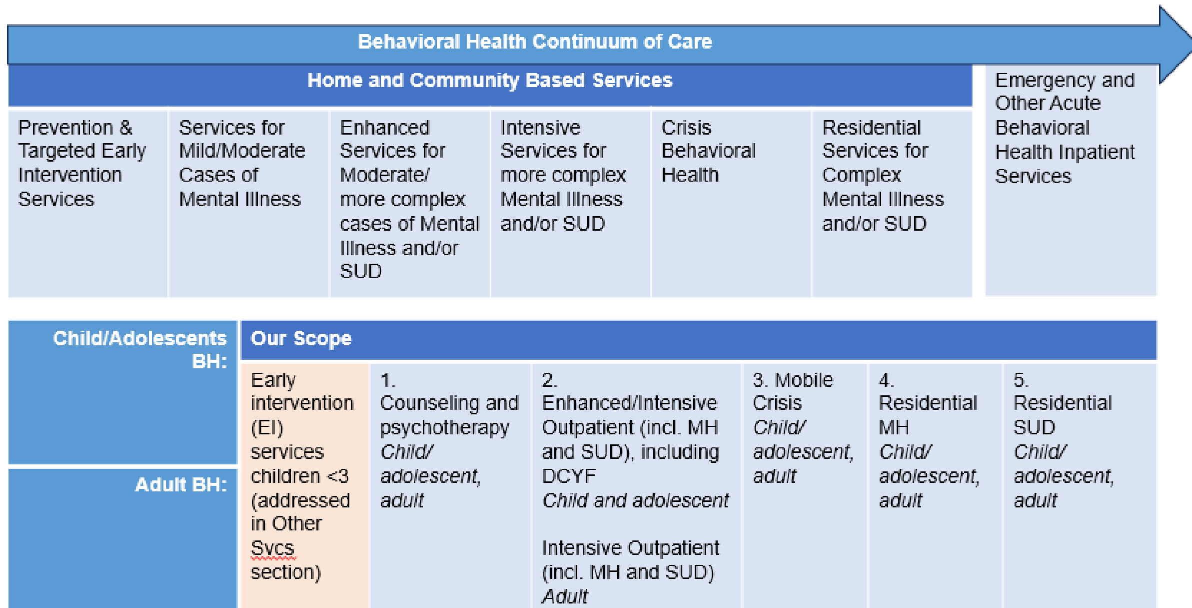
Note that the dash indicates this access dimension was not identified as an issue in the research.

Three contextual notes regarding this assessment:

1. Scope of Assessment within the Behavioral Health Continuum of Care

Our assessment of these behavioral health services is organized in accordance with the Behavioral Health Continuum of Care [16] and; as such, we aligned each service listed above within the appropriate service category as shown in Figure 10 below.

FIGURE 10: SCOPE OF ACCESS ASSESSMENT WITHIN THE BEHAVIORAL HEALTH CONTINUUM OF CARE[16]



2. Leveraging the 2020-2021 Rhode Island Behavioral Health System Review

As there was a BH System Review conducted in 2020-2021, Faulkner Consulting Group and Milliman incorporated relevant findings from that review into this access study in tandem with updated quantitative data and qualitative feedback from community stakeholders. The Rhode Island Behavioral Health System Review Technical Assistance Report identified a range of major gaps and shortages in the Behavioral Health Continuum of Care.[14] To address these gaps, the study recommended the implementation of Certified Community Behavioral Health Centers (CCBHCs) and Mobile Crisis.[14] Implementation of these programs is underway, with a targeted effective date of February 1, 2024.

3. Considering Overall Behavioral Health Provider Capacity

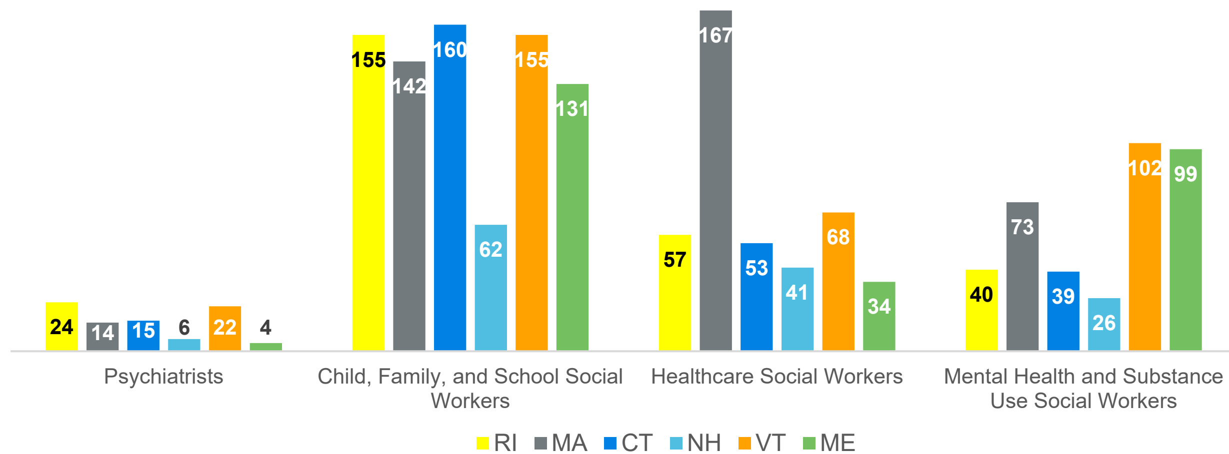
Access to the specific behavioral health services included in this assessment may be impacted by the national behavioral health workforce shortage.[17] To understand workforce capacity in Rhode Island and states within the region, we reviewed state by state Bureau of Labor Statistics behavioral health workforce data and other national studies to identify relevant gaps or trends in capacity.

Figure 11 shows that a state-by-state comparison suggests a different mix of workforce professionals in Rhode Island compared to bordering states. Specifically, Rhode Island has more psychiatrists on a per capita basis [24 psychiatrists per 100,000 residents versus 14 in Massachusetts (MA) and 15 in Connecticut (CT)]. Additionally, Massachusetts has nearly three times the number of social workers per 100,000 population as compared to Rhode Island (167 healthcare social workers per 100,000 people in MA versus 57 in RI).

[16] Presentation from Rhode Island Children's Behavioral Health System of Care at RI Department of Children, Youth and Families (DCYF). (March 2019).

[17] Understanding the U.S. Behavioral Health Workforce Shortage, (May 2023). The Commonwealth Fund. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage

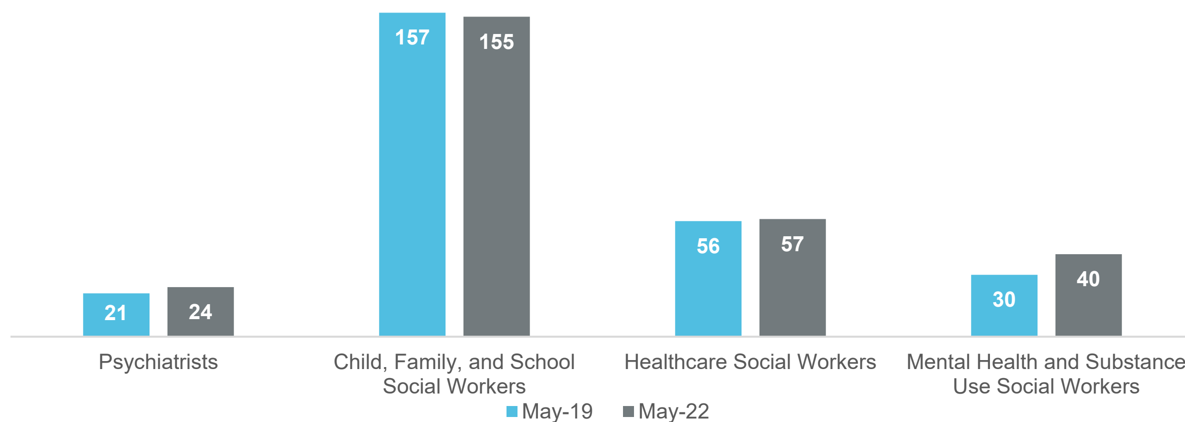
FIGURE 11: GENERAL BEHAVIORAL HEALTH SERVICES PROVIDERS PER 100,000 POPULATION: RI, MA, CT, NH, VT & ME, MAY 2022* [18]



*Health Care Professionals was defined using BLS codes 29-1223, 21-1021, 21-1022. 21-1023.

The overall number of BH professionals has increased in Rhode Island by about 5%, from 264 per 100,000 residents in May 2019 to 276 per 100,000 residents in May 2022. As shown in Figure 12, psychiatrists and mental health and substance abuse social workers are driving this increase; the number of child and family social workers and healthcare social workers remained flat (less than 2% change in both categories).

FIGURE 12: GENERAL BEHAVIORAL HEALTH SERVICES PROVIDERS PER 100,000 POPULATION IN RI: MAY 2019 VS. MAY 2022[18]



A Kaiser Family Foundation (KFF) analysis of mental health care shortages supported the finding that Rhode Island has more psychiatrists per capita than many states in Centers for Medicare and Medicaid Services (CMS) Region 1. In that study, the percent of met need was identified for each state with an identified health care professional shortage area (HPSA). "Percent of need met is defined as the ratio of psychiatrists to the number needed to eliminate

[18] Bureau of Labor Statistics (BLS). Occupational Employment and Wage Statistics. *Population data from US 2022 Census*. https://www.bls.gov/oes/tables.htm

the HPSA designation."[19] Mental health shortage areas are primarily based upon the number of psychiatrists compared to the population. Figure 13 compares the percentage of need met in Rhode Island with other states. Based on that research, Rhode Island is outperforming all states in CMS Region 1 with capacity that can meet nearly 62% of the need for care. The estimated number of new practitioners needed to meet the remaining care needs is 15 additional psychiatrists. However, this study did not take into consideration the practice profile of psychiatrists to determine if they will accept Medicaid covered individuals.

FIGURE 13: MENTAL HEALTH CARE HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA), SEPTEMBER 2022[20]

State	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Rhode Island	61.9%	15
Connecticut	19.0%	84
Massachusetts	33.0%	19
Maine	19.7%	31
New Hampshire	51.1%	5
Vermont	N/A	N/A

Despite these quantitative findings, stakeholders suggested that a substantive shortage of behavioral health providers remains in Rhode Island, which in turn limits service and visit availability across the continuum of behavioral health care. Stakeholders generally attributed this discrepancy to a combination of three factors: (1) many RI licensed professionals are choosing to work in bordering states due to differences in pay/reimbursement rates; (2) many community-based providers are shifting to private pay only and not accepting insurance; and (3) demand for behavioral health services is continuing to increase. More research is needed to verify these interested party perceptions.

[19] Kaiser Family Foundation (KFF). *Mental Health in Rhode Island.* https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/rhode-island

[20] Kaiser Family Foundation (KFF). (March 20, 2023). *Mental Health and Substance Use State Fact Sheets.* https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/

COUNSELING AND PSYCHOTHERAPY

FIGURE 14: ACCESS ANALYSIS FOR COUNSELING AND PSYCHOTHERAPY

Access Category		Counseling/ Psychotherapy: Adult	Counseling/ Psychotherapy: Children
Overall Access		Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	Contributing Factor
	Public Policy Barriers	-	-
	Services Limitations Barriers	-	-
	Equity Barriers	Contributing Factor	Contributing Factor
	Reimbursement Barriers	-	-
	Eligibility Barriers	-	-
Data Status		Highly Limited	Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

This category is broadly intended to assess all services for **mild/moderate** cases of mental illness. For purposes of this analysis, we more narrowly defined this service as counseling/psychotherapy only, including the following claims codes: 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90867, 90868, 90869, 90870, 90889, 90899, H0004, H0036, H0037, H2000, H2015, H2016. These codes were selected as they were consistently applied for adults and children, with analysis distinguishing utilization by age (adult versus youth). Integrated Health Home (IHH) and Assertive Community Treatment (ACT) bundled payments were excluded from this analysis.[21]

Current Status of Counseling and Psychotherapy Services in Rhode Island

The Rhode Island BH System Report performed in 2020-2021 described access to counseling and other professional services in the community as mixed.[14]

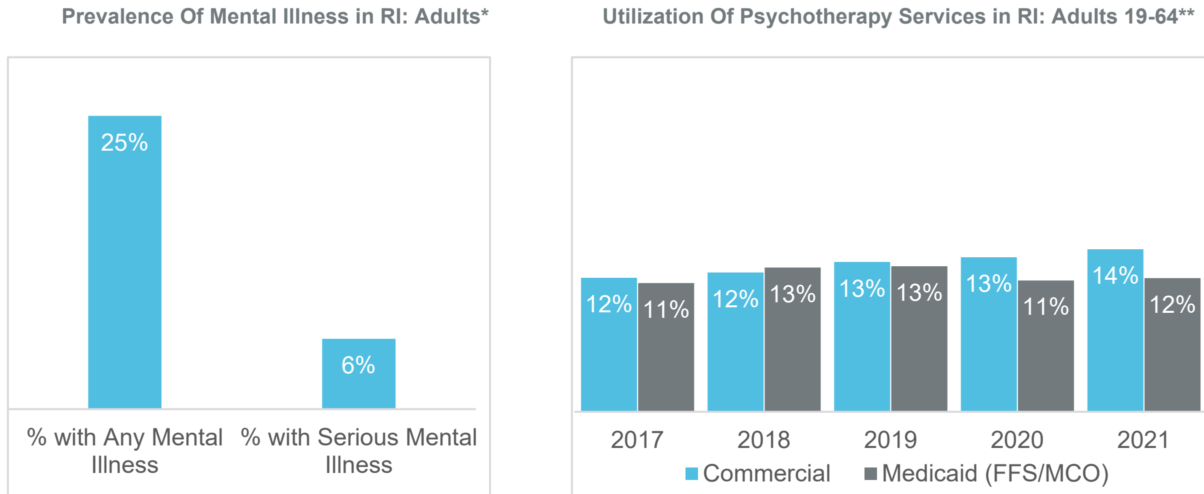
Updated data analysis and qualitative interviews resulted in an overall access score of highly limited indicating that there was highly limited access and that access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity is the contributing factor of this classification across both adults and children; geography is a contributing factor for both adults and children, and equity is a contributing factor for children.

A comparison of mental illness prevalence to psychotherapy utilization rates from Rhode Island claims and the All-Payer Claims Database (APCD) suggest that there is a need for psychotherapy services among both adults and children that is not supported by comparable service utilization rates, as shown in Figures 15 and 16. Specifically:

For Adults: In 2021, one in four (25%) Rhode Islanders over age 18 reported experiencing any mental illness in the past year[22], while 12% of Medicaid enrolled individuals and 14% of commercially enrolled individuals ages 19-64 utilized psychotherapy services.

[21] Several of these codes are primarily utilized by managed care organizations and are not billed through FFS. As such they are not part of the broader rate recommendations.
[22] Substance Abuse Mental Health Services Administration (SAMHSA). 2021 National Survey of Drug Use and Health (NSDUH) Releases (samhsa.gov)

FIGURES 15 AND 16: PREVALENCE OF MENTAL ILLNESS AND UTILIZATION OF PSYCHOTHERAPY SERVICES in RI: Adults [23,24]

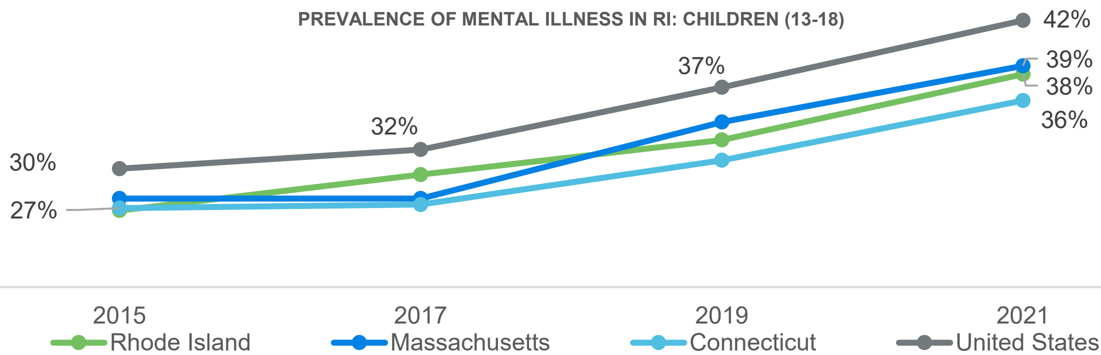


*Share of RI Adults with a claim indicating any mental illness, of any severity, in the past year.

**Actual utilization of psychotherapy services is likely to be understated among Medicaid adults because for those adults enrolled in a health home the service may be part of a bundled rate and therefore not separately identifiable using standard CPT procedure codes. In addition, counts may be understated as the APCD does not include private pay (which would not generate a claim).

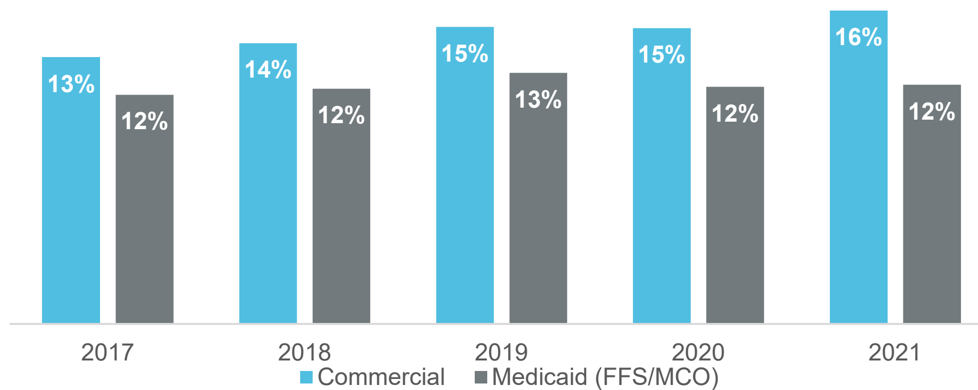
Youth and Adolescent: As shown in Figure 17, the prevalence of self-reported mental illness among RI youth is growing. 38% of RI high schoolers surveyed said that they felt sad or hopeless almost every day for 2+ weeks, up from 27% in 2015. Additionally, an average of 12% of Medicaid enrolled individuals 3-18 years of age utilized psychotherapy services, as shown in Figure 18.

FIGURE 17: % OF HIGH SCHOOLERS WHO FELT SAD OR HOPELESS ALMOST EVERY DAY FOR 2 OR MORE WEEKS IN THE PAST YEAR, 2015 - 2021 [25]



[23] Substance Abuse Mental Health Services Administration (SAMHSA).2021 National Survey of Drug Use and Health (NSDUH) Releases (samhsa.gov)
[24] All-Payer Claims Database (APCD). (June 2023). *BH Utilization Report*.
[25] Centers for Disease Control and Prevention (CDC). *1991-2021 High School Youth Risk Behavior Survey Data*. https://nccd.cdc.gov/youthonline/App/Default.aspx

FIGURE 18: PERCENT OF MEDICAID VS. COMMERCIAL ENROLLED INDIVIDUALS, AGES 3-18, WHO UTILIZED PSYCHOTHERAPY SERVICES IN THE PAST YEAR, 2017-2021[24]



Data Status

Data status for counseling and psychotherapy services was classified as highly limited, as Rhode Island does not currently have a centralized system for collecting and reporting on access to counseling and psychotherapy services, in particular waitlists and data regarding provider availability to accept new clients. FCG has created a definition of services from which to report on these services, which can be consistently applied to both Medicaid and All Payor datasets. However, the definitions should be further tested and confirmed with payors and providers prior to utilizing this methodology to support access analyses on an ongoing basis.

Findings

Provider Capacity/ Network Barriers

As described earlier, analysis from the Bureau of Labor Statistics indicates that the number of BH professionals per 100,000 people is rising in the state; however, stakeholders anecdotally indicated their perception that there still appears to be a lack of available providers which, in turn, limits service and visit availability. Stakeholders generally attributed this discrepancy to a combination of three factors: (1) many RI licensed professionals are choosing to work in bordering states due to differences in pay/reimbursement rates; (2) many are shifting to private pay and not accepting insurance; and (3) demand for behavioral health services is continuing to increase.

Geographic Barriers

Stakeholders noted that there may be geographic barriers for individuals who live outside of the Providence metropolitan area. One stakeholder cited geographic challenges for both children's and adult services across the state, in particular "*those areas with smaller populations (Tiverton, Little Compton, South County between Westerly and Wakefield).*"

Public Policy Barriers

No public policy barriers were identified by stakeholders. One stakeholder noted that there is no prior authorization or PCP referral needed to access these services.

Service Limitations Barriers

No service limitations barriers were identified by stakeholders.

Equity Barriers

Utilization among commercially insured youth is growing each year, while utilization for Medicaid youth has remained consistent. The data also shows a difference in utilization of psychotherapy services for Medicaid enrolled adults vs. Commercial enrolled adults. As noted in Figure 16 above, adults 19-64 with commercial coverage were 1.2 times more likely to utilize psychotherapy services compared to Medicaid enrollees (14% vs 12% respectively). This may be an indication of income equity barriers to care. Further research is needed to understand the variance.

In addition, stakeholders cited significant barriers for individuals who do not speak English as their primary language, noting that individuals typically feel more comfortable with a provider who can speak their preferred language rather than having to rely on translations or an interpreter. One provider cited that the waiting list for someone waiting for a

BH provider who speaks Spanish is significantly longer than that for one who speaks English: "*If I call and say I need help for my mom who is in your panel and who only speaks Spanish – it usually takes about a year for a Spanish-speaking provider for BH. There are not a lot out there and those that have Spanish-speaking providers are at capacity. So, the waitlist is usually 1 year and onwards. English speaking is faster and usually takes about 30 days and onwards, but it also depends on the client and their location*." There are also reported concerns for the availability of clinicians who are able to use sign language or find available sign language interpreters.

Reimbursement Barriers

No reimbursement barriers were identified by stakeholders.

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

INTENSIVE OUTPATIENT: ADULTS (Including MH and SUD)

FIGURE 19: ACCESS ANALYSIS FOR INTENSIVE OUTPATIENT: ADULTS (INCLUDING MH AND SUD)

Access Category		Intensive Outpatient and SUD Outpatient: Adult
	Overall Access	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	-
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	-
	Data Status	Unavailable

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

This category is broadly intended to assess all services for moderate/more complex cases of mental illness among adults, including crisis services. For purposes of this analysis, we have included four service groups[26]:

- **Mental Health Intensive OP**: Intensive Outpatient Psychiatric Services, per diem (CPT Code S9480).
- **SUD Intensive OP:** Alcohol and/or drug services; intensive outpatient, including assessment, counseling, crisis intervention (CPT Code H0015:HF).
- **Other/Unknown Intensive OP:** Outpatient claims with a revenue code of 0760 or 0761 (Specialty Services – General Classification/ Specialty Services – Treatment Room). These codes are typically used by health plans and are not distinguishable between MH or SUD claims.
- **Crisis Intervention:** The FFS program uses Crisis Intervention Service (H2011, per 15 minutes) while MCOs use Crisis Intervention Mental Health Services (S9485, per diem). Mobile Crisis services are addressed in a separate section of this report.

Two definitional notes:

- There appears to be an overlap in the service groups listed above. Where providers offer both MH and SUD services, place of service and/or provider type may not give a clear indication of which service is being provided under a non-specific code for individuals with both MH and SUD diagnoses. Additionally, individual health plans may have different billing specifications for the use of procedure codes and/or revenue codes. As such, we cannot clearly distinguish between MH and SUD service utilization or between Intensive Outpatient Services and Crisis Intervention Service utilization.
- This assessment does not include Integrated Home Health (IHH), Assertive Community Treatment (ACT) program services, or Opioid Treatment Program (OTP) service codes, all of which have a health home component that supports Medicaid's Serious Persistent Mental Illness/Serious Mental Illness (SPMI/SMI) and SUD populations. These programs are provided on a bundled payment basis by Medicaid and serve approximately 11,500 Medicaid eligibles with SMI/SPMI or SUD-related diagnoses (1,400 ACT, 7,100 IHH, and 3,000 OTP). The assessment, however, would include any utilization of the specific intensive outpatient and crisis intervention services codes separately billed for these populations.

Current Status of Intensive Outpatient Services for Adults (including MH and SUD) in Rhode Island

The Rhode Island BH System Report identified a lack of capacity for intensive outpatient care and services in the community, which can lead to unnecessary utilization of more restrictive and more expensive levels of care (i.e., emergency department visits or inpatient care), and longer length of stay for inpatient care.[14]

Updated data analysis and qualitative interviews performed for this report confirmed this assessment, with an overall access score of highly limited access, with consistently reported anecdotal findings. Provider capacity/network and service limitations were contributing factors of access limitations; public policy, equity considerations and geographic limitations were contributing factors.

[26] Several of these codes are primarily utilized by managed care organizations and are not billed through FFS. As such they are not part of the broader rate recommendations.

The number of distinct users of Intensive Outpatient and SUD Outpatient Services among Medicaid enrolled adults declined by 11% between 2020 and 2022, from 7,004 in 2020 to 6,200 in 2022.[27] From a need perspective, the number of RI Medicaid adult members with a primary SUD diagnosis increased from 15,799 to 16,448 (4%) between 2020 and 2022.[28]

Data Status

Data status for Intensive Outpatient MH and SUD services for adults is classified as unavailable. There does not appear to be any centralized system for collecting and reporting on access to Outpatient MH and SUD services. Stakeholders indicated that each provider or agency maintains their own individual tracking system or Electronic Health Record (EHR). Additionally, there appear to be significant variations in the service definitions and nomenclature for these services across state agencies, providers, and payors, making it difficult to measure and report on access.

Findings

Provider Capacity/Network Barriers

Stakeholders noted the ability to recruit, hire, and retain staff as a challenge. Providers cited payment rates as a driving factor as they stated that current rates do not allow them to compete with payment rates provided by RI hospitals or with facilities in Massachusetts and Connecticut. One provider noted that their experience with staff exit interviews showed about 90% cited payment as the reason for leaving. One provider stated that since the COVID-19 pandemic, they have struggled to attract individuals to apply for open positions at all levels – clinical, medical, and non-direct care.

- A stakeholder also highlighted a shift in their workforce, citing losses of more experienced staff members. *"We used to have a really nice balance in my first 24 years of working here. 65-70% of seasoned workers and the rest entry level and interns. They could be mentored. Now it's flipped."*

One stakeholder noted many providers do not feel they have the skill set or training to address the needs of I/DD patients.

Geographic Barriers

Stakeholders cited both geographic factors and transportation as barriers to access, specifically noting the northwestern and southwestern parts of the state and that public transportation is not available in these areas.

Public Policy Barriers

No public policy barriers were identified by stakeholders.

Service Limitations Barriers

Stakeholders noted that insurance benefits are not flexible enough to meet patient needs for OP MH and SUD services – they are typically time-limited, include service level qualifications that restrict access, and are not flexible enough to meet changing client needs. As one stakeholder described, *"For some services, benefits may cut off after 3-6 months…for other services you may need to see someone multiple times a week to qualify, otherwise you have to take them out of that category and put in a lower category".* Another identified that the authorizations provided by managed care organizations (MCOs) sometimes only permit delivery of fewer services than what the individual needs. Note that providers did not discuss appeal and grievance processes in relation to these challenges.

One stakeholder noted that the new Certified Community Behavioral Health Clinic (CCBHC) program will include a broader array of services and should reduce/eliminate these service limitations for individuals who seek services at participating CCBHCs.

Equity Barriers

Across most programs, stakeholders noted a wide gap between private pay individuals versus those seeking coverage through insurance. This reality is due to the growing practice of behavioral health providers moving to a private pay system and refusing to bill insurance. This means individuals wishing to use their healthcare coverage for payment must work with their insurance company to be reimbursed for the out-of-pocket expense, which may create

[27] FCG retrieved from the RI Medicaid Claims Database in July 2023. Methodological Note: Distinct users of Intensive OP or Crisis Intervention are identified as individuals who used any of the services coded as IOP or crisis intervention – removing duplicates of individuals who used more than one service.

[28] FCG retrieved from the RI Medicaid Claims Database (June 2023).

an economic equity concern. For example, one stated "*If I have the resources, I find a therapist, and take care of it; if I have to go through insurance, it's a whole different ball game…"*

Reimbursement Barriers

As described in more detail in the "provider capacity" section above, providers noted payment rates as a challenge to retaining sufficient staff to meet the demand for access. Stakeholders specifically cited payment as a significant barrier for outpatient SUD services, with one provider stating that agencies have not had a rate increase in over 16 years.

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

INTENSIVE OUTPATIENT AND SUD OUTPATIENT: CHILDREN (Including DCYF)

FIGURE 20: ACCESS ANALYSIS FOR INTENSIVE OUTPATIENT AND SUD OUTPATIENT: CHILDREN (INCLUDING DCYF)

Access Category		Intensive Outpatient and SUD Outpatient: Children
Overall Access		Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	-
Data Status		Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

This category is broadly intended to assess all services for moderate/more complex cases of mental illness among children, including crisis services.

DCYF is responsible for maintaining all children's behavioral health services; the agency does so in partnership with Medicaid as the primary payor for many of these services.

For purposes of analysis, this study focused on Medicaid funded intensive outpatient children's services, specifically:

- **Intensive Outpatient Treatment (IOP):** A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for MH and/or SUD.
- **Enhanced Outpatient services (EOS) were excluded from this report and analysis.** Enhanced outpatient services are home/community based clinical services provided by a team of specialized licensed therapists and case managers. Some examples of EOS clinical specialists include providers with expertise in the treatment of Developmental Disabilities, Sexual Abuse, and Post Traumatic Stress Disorder.

State staff estimate that there are approximately thirty (30) home based intensive outpatient services (evidence based, evidence informed services), provided by about fifteen (15) providers. These Medicaid funded services are primarily billed through the following four service groups:[29]

- **Mental Health Intensive OP**: Intensive Outpatient Psychiatric Services, per diem (CPT Code S9480).
- **SUD Intensive OP:** Alcohol and/or drug services; intensive outpatient, including assessment, counseling, crisis intervention (CPT Code H0015).
- **Other/Unknown Intensive OP:** Outpatient claims with a revenue code of 0760 or 0761 (Specialty Services - General Classification/ Specialty Services – Treatment Room). These codes are typically used by health plans and are not distinguishable between MH or SUD claims.
- **Crisis Intervention:** Crisis Intervention Service (H2011, per 15 minutes) or Crisis Intervention Mental Health Services (S9485, per diem). Mobile Crisis services are addressed in a separate section of this report.

There appears to be a substantive overlap in the service groups listed above. Additionally, individual health plans may have different protocols for the use of particular codes. As such, we cannot clearly distinguish between MH and SUD service utilization or between Intensive Outpatient Services and Crisis Service utilization.

[29] Several of these codes are primarily utilized by managed care organizations and are not billed through FFS. As such they are not part of the broader rate recommendations.

Current Status of Intensive Outpatient Services (including MH and SUD) for Children in Rhode Island

The Rhode Island BH System Report identified that, within Rhode Island, there was a lack of capacity for outpatient care and services for children in the community, which may lead to unnecessary utilization of more restrictive and more expensive levels of care (e.g., emergency department visits, inpatient care) and longer length of stay for inpatient care.[14]

Updated data analysis (Figure 20) and qualitative interviews appear to confirm this assessment, with highly limited access overall, with consistently reported findings. Provider capacity/network, service limitations, public policy, equity considerations and geographic limitations were contributing factors.

The number of distinct users of Intensive Outpatient and SUD Outpatient Services among Medicaid enrolled children ranged from 920 to 1,045 between 2020 and 2022.[30]

In addition to these distinct users of services, DCYF tracks the number of children "pending" placement for intensive outpatient services. As of June 2023, there were 323 children awaiting placement. Current DCYF systems do not track the length of time that these children are pending services (Figure 21).

FIGURE 21: COUNTS OF PENDING DCYF REFERRALS FOR SERVICES, BY PROVIDER AND SERVICE [31]

Provider	Services	Count of Individuals Awaiting Services
ARI	Teen Focus	10
Boys Town	Visitation	15
Child & Family	Family Centered Treatment (FCT); Functional Family Treatment (FFP); Family Stabilization Program (FSP)	4
Children's Friend	Project Connect	14
Children's Museum	Visitation	4
Communities for People	Enhanced Family Support Services (EFSS); FCT	9
Community Care Alliance	Integrated Permanency – Intensive Family Preservation (IFP) Intensive Family Preservation for Parents with Development Delays (IFP-DD); IRVPNE; IRVPNE DD; Visitation; Visitation DD	17
Day One	Commercial Sexual Exploitation of Children Mentoring (CSEC Mentoring); Trauma Treatment, Evaluation, Assessment, and Management (TTEAM)	10
Familias Unidas	Familias Unidas	2
Family Service of RI	Safe Care; Trauma Systems Therapy (TST); Trauma Systems Therapy Community Health Team (TST CHT); Visitation	37
Groden	Family Preservation Program (FPP); Patient and Family Empowerment Program (PFEP)	10
Key	EFSS; Positive Parenting Program (Triple P)	11
North American Family Institute (NAFI)	Multi-Systemic Therapy (MST); Multi-Systemic Therapy for Problem Sexual Behavior (MST PSB); Parenting with Love and Limits (PLL) Home; Parenting with Love and Limits (PLL) Placement	21
Parent Support Network	Parent Support Network (PSN)	44
Strong African American Families (SAAF)	SAAF	1
St. Mary's	Supporting Adoptive and Foster Families Everywhere (SAAFE); Stabilization, Assessment, and Rapid Re-Integration Program (STARR)	4

[30] FCG retrieved from the RI Medicaid Claims Database in July 2023. Methodological note: Distinct users of Intensive OP or Crisis Intervention are identified as individuals who used any one of the four categories of services – removing duplicates of individuals who used more than one service.

[31] FCG received via DCYF (July 2023).

Provider	Services	Count of Individuals Awaiting Services
The Providence Center	Multi-Systemic Therapy (MST); Teen Assertive Community Treatment (TACT)	2
Tides	Functional Family Therapy (FFT); Modified Outreach & Tracking (O&T); Preserving Families Network (PFN); PFN Lite, YTC	73
Youth Advocate Programs (YAP)	YAP	35
Total		**323**

Local trends in Medicaid children's diagnoses suggest that the need for some BH services may be growing:

- A recent (March 2022) study performed by RI EOHHS assessed a myriad of indicators of youth behavioral health needs, including youth suicide ideation and attempts among adolescents between 2016 and 2021.[32] The study noted a particular increase in youth suicide ideation and attempts among adolescent females, with a 35% increase in suicide ideation and a 302% increase in suicide attempts between 2016 and 2021.[33]
- The number of children aged 18 and under that are enrolled in Medicaid and have had a primary diagnosis for treatment of a SUD ranged from 451 to 560 between 2020 and 2022. Given that the underlying incidence rate in a year is less than 0.5% (with the rate of incidence being 1.0% among teenagers 14-18), statistically, there is no discernible trend in the annual count of children with an SUD diagnosis (using a chi-squared test).

Data Status

Data status for Outpatient MH and SUD services for adults and children is classified as highly limited. Stakeholders indicated that each provider or agency maintains their own individual tracking system or electronic health record (EHR). There is some centralized tracking of individuals pending/awaiting Outpatient BH services though DCYF; however, DCYF systems constraints limit the Agency's ability to monitor the length of time members are pending. Additionally, there appear to be variations in the service definitions and nomenclature for these services across state agencies, providers, and payors, making it difficult to measure and report on access.

Findings

Provider Capacity/Network Barriers

Stakeholders noted recruiting, hiring, and retaining staff as a significant challenge. Providers also cited payment rates as a driving factor as they state that the current rates do not allow them to compete with payment rates provided by RI hospitals or with facilities in Massachusetts and Connecticut.

Stakeholders noted a particular gap in youth and adolescent service capacity and tended to cite payment rates as a dominant constraint.

One provider noted that their agency previously had a strong adolescent program, but no longer provides this service as they were unable to sustain it with the current funding and payment rates. The Rhode Island Coalition for Children and Families (RICCF) surveyed outpatient community based behavioral health providers serving children and families across 23 outpatient programs in the spring of 2023, supporting all populations (Medicaid, Commercial, self-pay). While the results of this survey are not yet published, RICCF leadership noted findings will include declines in capacity over the past year, provider vacancy rates over 20%, and wait times of up to one year for some services.

Geographic Barriers

The same geographic barriers were noted for children as for adults. Stakeholders cited both geographic and transportation as barriers to access, specifically noting the northwestern and southwestern parts of the state and that public transportation is not available in these areas.

[32] Rhode Island Executive Office of Health and Human Services (EOHHS). (March 2022). *Rhode Island Behavioral Health System of Care Plan for Children and Youth*. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-03/RI%20Behavioral%20Health%20System%20of%20Care%20Plan%20for%20Children%20and%20Youth.pdf

[33] The study noted lower use of services for behavioral health needs for boys "who may express behavioral need differently, have different cultural context for acknowledging and seeking support for the need, or who may have genuinely different prevalence."

Public Policy Barriers

Stakeholders noted that there was a structural, regulatory gap regarding the allowable range of clinician types that is exacerbating provider capacity limits.

- *"Clinician options in the behavioral health space are not clear – so you have uncredentialed clinicians and then you have clinicians with master's degrees – and there is not a lot in between – that creates a gap."*
- *"There hasn't [sic] been any efforts to address the supply of clinicians and/or the prohibitions against other clinician types – that all needs a lot of work."*

Stakeholders also noted particular service challenges that are attributed to DCYF being the state agency responsible for this service delivery. This situation can lead to two different types of challenges. First, it may be perceived by some families and providers that only DCYF-involved children are eligible for some or all services. Second, families may be hesitant to seek help through these providers because they fear that someone may take custody of their child or they will become part of DCYF oversight actions.

Some stakeholders articulated that any child was eligible to receive the expanded array of intensive DCYF services with a referral. Other participants indicated that seeking a referral for DCYF services creates a barrier to access for children and families.

- DCYF staff indicated that there are multiple pathways to these services which can be accessed if the child is not part of the DCYF system and that half of Family Care Community Partnership (FCCP) recipients have had no involvement with the department. According to DCYF, patients can go to FCCPs to get access to DCYF services where the FCCP fills out a brief needs assessment that gets sent to DCYF to determine eligibility, but the client does not go to a DCYF case worker. One example includes DCYF contracts with Tides Family Services who can provide services to non-DCYF involved families. The intent is to provide services to avoid families becoming DCYF involved. DCYF stakeholders noted there is a messaging issue as families tend to think they have to be involved with DCYF to receive services which is incorrect, but not widely understood. *"For the "average kid", [I'm] unsure where doctors would send someone who needs help – maybe a psych on staff, a CCBHC."* Stakeholders also noted their perception that there are issues with capacity and said, *"The plans can't offer the same models of service because of capacity."*

Service Limitations Barriers

- Stakeholders noted some of the same service limitations for children as adults – noting that insurance benefits are perceived as not flexible enough to meet patient needs for OP MH and SUD services, typically time limited, include service level qualifications that restrict access, *"Going from 1-2 outpatient visits per week to 2-3 times a week – now you are enhanced – it's an insurance designation – and this designation is typically not flexible enough to allow providers to meet the needs of the population. What if I decide this week that you need 4 visits – but next week you need only 1?"*

Some stakeholders noted that since children's intensive behavioral health services are offered through managed care, the plans have the authority to offer a more flexible service model to support the needs of individual patients; but this has not happened.

- *"Most evidence-based practices of intensive outpatient therapy are intended to be for a three-to-six-month period, then you move to a different level of service…yet we have had kids in these services for years…kids are stuck in those services."*

Some stakeholders also noted that the service array offered through managed care has not evolved to keep up with the evolution of evidence-based practices:

- *"Managed care has not expanded their service array to include a different set of Evidence Based Practices. [The state] says "here is a list of providers, a list of services that are evidence based, go negotiate with them; you can create these services, you can expand your service array; but instead they are static."*

Equity Barriers

Stakeholders noted the same equity considerations for adults and children, citing a combination of internal, familial, and community stigma which can impact whether an individual seeks out services, disproportionately impacting some cultures more significantly than others.

Stakeholders also cited gaps between private pay individuals versus those seeking coverage through Medicaid coverage, noting the shift to private pay by providers, limiting access to service by those covered by insurance, Medicaid, and/or Medicare. Further research is needed to determine if there are income equity barriers to care.

Reimbursement Barriers

Similar to adults, stakeholders noted reimbursement barriers predominantly focused on payment rates, which tie back to provider capacity. One stakeholder commented, *"The numbers increased so dramatically because of the need, but we don't have a margin to be able to give away services. We have to make payroll."*

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

MOBILE CRISIS

FIGURE 22: ACCESS ANALYSIS FOR MOBILE CRISIS

Access Category		Mobile Crisis: Adult	Mobile Crisis: Children
Overall Access		Highly Limited	Somewhat Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	-	-
	Geographic Barriers	-	Contributing Factor
	Public Policy Barriers	-	-
	Service Limitations Barriers	Contributing Factor	Contributing Factor
	Equity Barriers	-	-
	Reimbursement Barriers	-	-
	Eligibility Barriers	-	-
Data Status		Undetermined	Generally Available

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Mobile Crisis is a mental health service which provides the community with immediate response emergency mental health evaluations. Evaluations can be requested by hospital emergency rooms, community providers, families, jails, nursing homes, police, or emergency medical services (EMS). These services are available on a 24-hour basis.

The Substance Abuse and Mental Health Services Administration (SAMHSA)[34] defines Minimum Expectations to Operate a Mobile Crisis Team Services. According to these guidelines, mobile crisis team services must: (1) Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation; (2) Respond where the person is (home, work, park, etc.), and not restrict services to select locations within the region or particular days/times; and (3) Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

Current Status of Mobile Crisis Services in Rhode Island

The current status of mobile crisis services varies for adults as compared to youth programs.

- **Adults:** The Rhode Island BH System Report identified adult mobile crisis services as a major gap in the behavioral health continuum of care for adults.[35] There is currently not a mobile crisis program for adults in Rhode Island that meets the CMS definition of Mobile Crisis. This program is noted as highly limited. However, there are crisis services for adults in Rhode Island. "BH Link is a behavioral health facility designed to provide immediate assistance to a person in crisis by providing innovative crisis intervention services and connecting people to ongoing treatment and care."[36] For adults, after hours crisis calls are typically sent to an answering service which then calls an on-call clinician (typically staffed at an emergency department). These after-hours crisis calls are tracked and monitored by BHDDH.
- **Youth:** The Rhode Island BH System Report identified youth mobile crisis services as a "Moderate Shortage."[14] Recent data appears to confirm this assessment, as overall access was classified as somewhat limited, indicating that there was limited access within specific subcategories or populations and access constraints were inconsistently reported.

Data Status

The current status of data for mobile crisis services varies for adults as compared to youth programs.

- **Adults:** Crisis services offered through CMHCs in Rhode Island do not meet the new CMS service definition of Mobile Crisis. Crisis services and services currently deemed to be mobile crisis are billed using the same codes and therefore data for mobile crisis cannot be separated from other crisis services. This data distinction is necessary to complete quantitative analysis of the two types of crisis services, which is the driver for the overall assessment of the data.
- **Youth:** For children's mobile crisis, overall data/reporting status was classified as generally available, indicating that access data is centrally tracked, services were consistently defined and there were no/few

[34] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *National Guidelines for Behavioral Health Crisis Care.* www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[35] Faulkner Consulting Group and Health Management Associates (July 2021). *Rhode Island Behavioral Health System Review Technical Assistance.* https://eohhs.ri.gov/initiatives/behavioral-health-system-review

[36] BH Link https://www.bhlink.org/about

data limitations. For children's mobile crisis, DCYF currently maintains a database that monitors mobile crisis utilization for children and this data is consistently defined and measured across providers. Additional utilization monitoring is completed by BHDDH.[37]

Findings

Provider Capacity/ Network Barriers

There are no mobile crisis teams operating in Rhode Island for adults that meet the new CMS definition. Current crisis services are generally provided in facility settings.

Geographic Barriers

Stakeholders cited that geography is not typically a barrier to access (for children). Adult mobile crisis teams are not active throughout the state, facility-based services could represent a geographic barrier for adults.

Public Policy Barriers

Stakeholders did not cite any public policy barriers to mobile crisis services, with MCOs noting that neither prior authorization nor PCP referrals were needed in order to access crisis services.

Service Limitations Barriers

Adults: Mobile Crisis, as defined by CMS, is not a service offered in Rhode Island, thus there is a service limitation barrier.

Children: Rhode Island's Children's Mobile Crisis Response (CMCR) pilot program began in 2020 with the intent of supporting mental health crises for youth and adolescents in the state.

Rhode Island is in the process of implementing a Certified Community Behavioral Health Clinic (CCBHC) program which is designed to provide a comprehensive array of mental health and substance use disorder services, inclusive of crisis mental health services (24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization). The CCBHC program is scheduled to begin in February 2024. Pending the Centers for Medicare and Medicaid (CMS) approval, these services will be incorporated into the Medicaid state plan and funded through the CCBHC Prospective Payment System (PPS-2) beginning in February 2024. Over time, it is expected that the CMCR pilot will be integrated into the CCBHC model and program structure.

Equity Barriers

No equity barriers were identified by stakeholders.

Reimbursement Barriers

No reimbursement barriers were identified by stakeholders.

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

[37] Goulet, Jamie. Document review. Received from Molly McCloskey. 29 Aug 2023.

RESIDENTIAL MENTAL HEALTH

FIGURE 23: ACCESS ANALYSIS FOR RESIDENTIAL MENTAL HEALTH

Access Category		Residential Mental Health: Adult	Residential Mental Health: Children
Overall Access		Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor
	Geographic Barriers	-	-
	Public Policy Barriers	-	-
	Service Limitations Barriers	Contributing Factor	Contributing Factor
	Equity Barriers	N/A	N/A
	Reimbursement Barriers	-	-
	Eligibility Barriers	-	-
Data Status		Highly Limited	Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Residential Mental Health services are identified as professional claims with one of the following Healthcare Common Procedure Coding System/ Current Procedural Terminology (HCPCS/CPT) procedure codes: H0010, H0011, H0018, H0019 or an Inpatient Claims with a Revenue Code of 1003, 1002, 0116, 0126, 0136, 0146, or 0156. For purposes of this report, if primary diagnosis is in the F10 through F19 range (excluding F17 for tobacco), utilization is denoted as for Substance Use, otherwise, it is denoted as Mental Health.

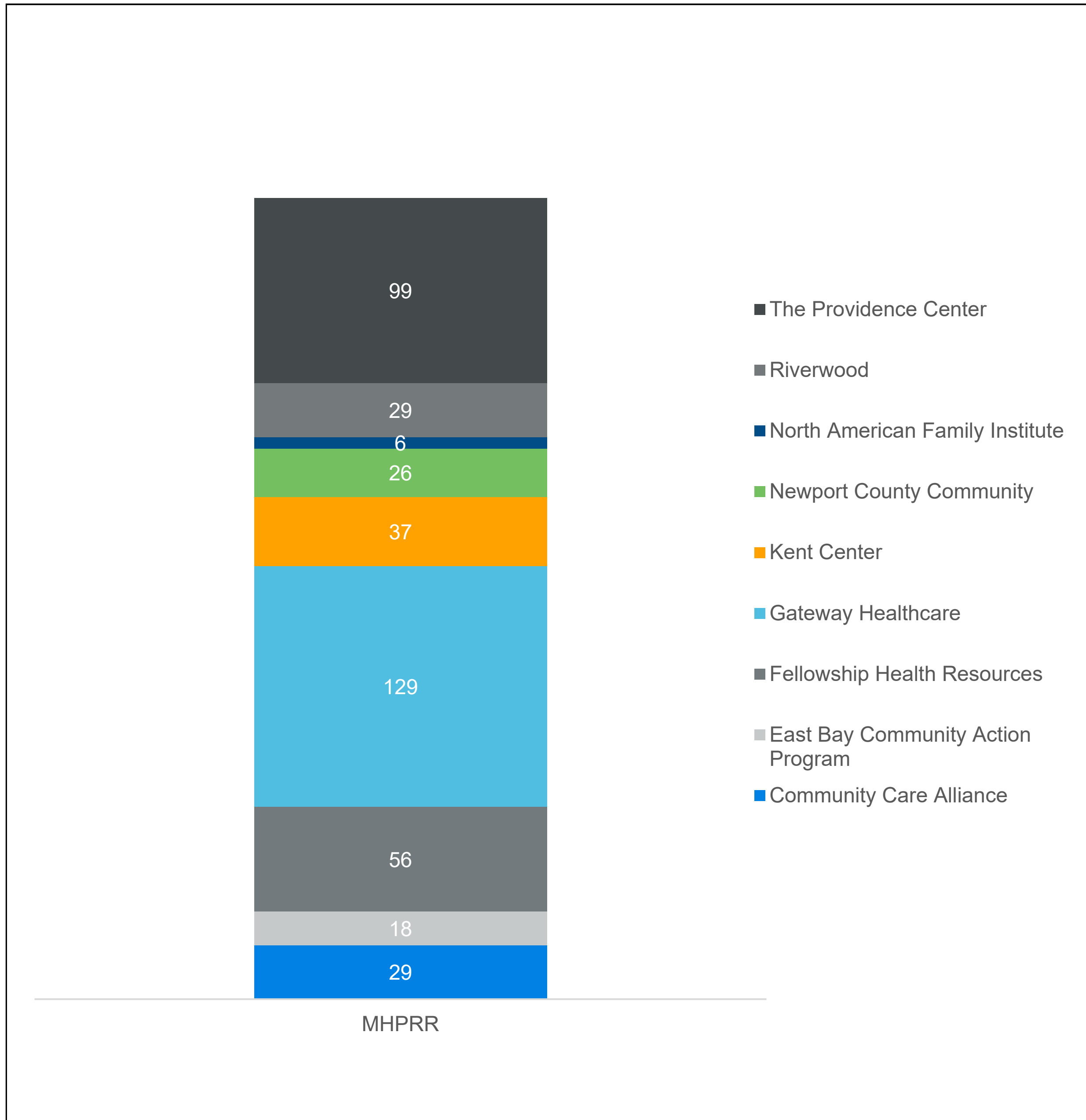
Current Status of Residential Mental Health Services in Rhode Island

The current status of residential mental health services varies for adults as compared to youth services.

- **Adults**: Overall access was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. The contributing factors identified were provider capacity, service limitations and geographic barriers. The Rhode Island BH System Report identified "significant shortages" in residential MH services for adults.[14] The study noted that between August and December 2020, there were 55 to 108 people respectively waiting for residential services.[14]

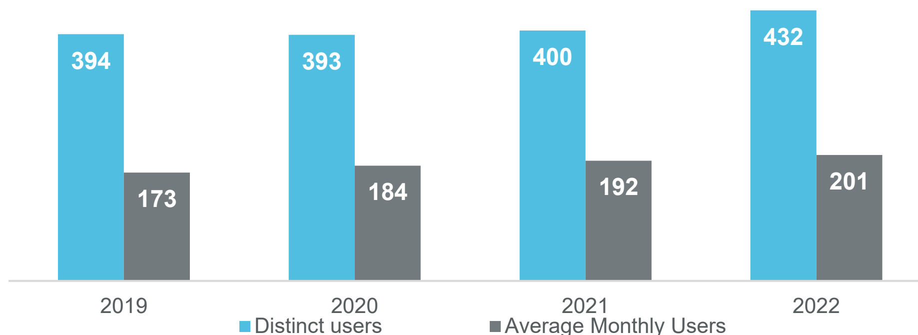
  In 2020, Rhode Island had 386 group home beds as seen in Figure 24. The implementation of Open Beds has added transparency to the process of finding residential treatment. Since the Rhode Island BH System Report was published, the number of beds has grown to 429 beds in 2023.[14] Additionally, in early August 2023, there were 46 people waiting for residential services.

FIGURE 24: GROUP HOME [MENTAL HEALTH PSYCHIATRIC REHAB RESIDENCES (MHPRR)] BEDS BY FACILITY, RHODE ISLAND, 2023[14]



Data shown in Figure 25 Indicate that even with additional beds and greater transparency, there are still waitlists for these services. Data indicates there were 201 monthly users in 2022 and 432 distinct annual users that year. Although the number of adult Medicaid beneficiaries accessing residential MH services has increased from 394 in 2019 to 432 in 2022, the utilization rate has been flat/unchanged at 0.9% (utilization rate calculated as a percentage of the Medicaid beneficiaries with a primary MH diagnosis accessing services).[28]

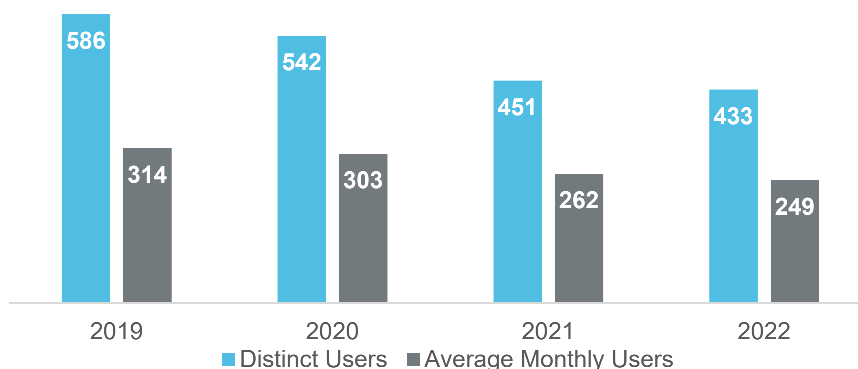
FIGURE 25: ADULT MEDICAID BENEFICIARIES ACCESSING RESIDENTIAL MH SERVICES STATEWIDE, 2019-2022[38]



- **Children**: Overall access was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity and service limitations were identified as contributing factors. The Rhode Island BH System Report identified "significant shortages" in residential MH services for children/youth and major gaps in Youth Residential Treatment for Eating Disorders.[14] The study noted that between May-Dec 2020, there were between 5 and 31 children and adolescents waiting for residential services.[14]

  Recent data shown in Figure 26 identifies a decline in the number of youth Medicaid beneficiaries accessing residential MH services between 2019 and 2022. The utilization rate has also declined over the same period (utilization defined as the percentage of the Medicaid beneficiaries with a primary MH diagnosis accessing services), as shown in Figure 26. Without further data on the other potential factors, including access to alternative programs and comparison with typical teen population need for residential services, conclusions on access are unclear, but may benefit from additional analysis to understand demand.

FIGURE 26: RESIDENTIAL MH UTILIZATION AMONG YOUTH MEDICAID BENEFICIARIES, STATEWIDE, 2019-2022[39]



Data Status

Overall, the data and reporting status for residential mental health services for both adults and youth was classified as highly limited, indicating that services are consistently defined but access data is not centrally tracked. Rhode Island does have a centralized database (RI BH Open Beds) that tracks and monitors mental health services

[38] FCG retrieved from the RI Medicaid Claims Database in June 2023

[39] *Ibid.*

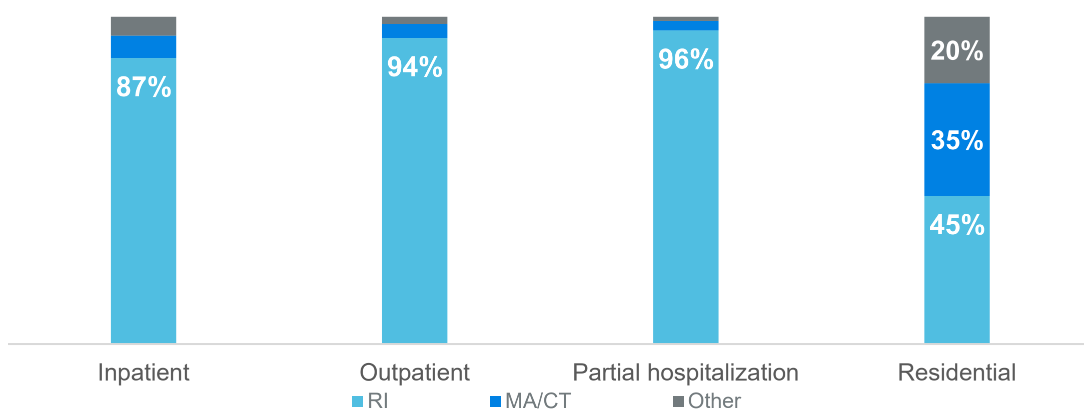
capacity, however that database does not include mental health residential beds (MHPRR). BHDDH tracks mental health residential beds separately.

Findings

Provider Capacity/ Network Barriers

While Medicaid data was not available, using the Rhode Island BH System Report on commercial or Medicare covered individuals as a proxy, 55% of Rhode Islanders obtain residential Mental Health care outside of the state I; including 35% who obtain residential Mental Health care in Massachusetts, or Connecticut (see Figure 27).[14] Top out-of-state residential MH facilities include The McLean Hospital (Massachusetts) and Northeast Behavioral Health (Massachusetts).[14]

FIGURE 27: DISTINCT USERS BY SERVICE TYPE FOR MH FACILITIES BY LOCATION, RI APCD, 2017-2019[40]



Providers cited challenges in ability to recruit, hire, and retain staff across both child and adolescent as well as adult services, noting that other employment opportunities may provide higher payment and more flexibility. One stakeholder commented:

> *"BHDDH is responsible for statewide residential placement. When a bed opens, we coordinate with the department of BHDDH to fill the bed as quickly as possible."*

Multiple stakeholders also noted that there is currently not an eating disorder residential treatment program in the state for either children or adults.

Geographic Barriers

Stakeholders cited that geography is not typically a barrier to access.

Public Policy Barriers

No public policy barriers were identified by stakeholders.

Service Limitations Barriers

No service limitations barriers were identified by stakeholders.

Equity Barriers

No equity barriers were identified by stakeholders.

Reimbursement Barriers

No reimbursement barriers were identified by stakeholders.

Eligibility Barriers

[40] RI APCD Data Pull, Freedman Healthcare, November 2020; only including commercial or Medicare-paid services. Substance use admissions has an average of 1,217 distinct patients per year, and mental health admissions has an average of 3,750 distinct patients per year.

No eligibility barriers were identified by stakeholders.

RESIDENTIAL SUD TREATMENT

FIGURE 28: ACCESS ANALYSIS FOR RESIDENTIAL SUD TREATMENT

Access Category		Residential SUD Treatment: Adult	Residential SUD Treatment: Children
Overall Access		Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	-
	Public Policy Barriers	-	-
	Service Limitations Barriers	Contributing Factor	-
	Equity Barriers	-	-
	Reimbursement Barriers	-	-
	Eligibility Barriers	-	-
Data Status		Somewhat Limited	Undetermined

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Residential SUD Treatment Programs are 24-hour supervised treatment programs designed to provide the necessary support and address the substance use treatment needs of individuals with substance use disorder. Covered services include detoxification, rehabilitation, mental health, childcare, and care coordination services when provided by qualified staff.

In Rhode Island, nine organizations have licensed substance use residential beds (AdCare, Bridgemark, Community Care Alliance, Galilee Mission, Gateway Healthcare, MAP BH, SSTARbirth, The Providence Center, and Zinnia Health).

Current Status of Residential SUD Treatment in Rhode Island

The coverage of residential substance use disorder treatment for adults (ages 19-64) in the Medicaid program is heavily influenced by federal regulations around the coverage of inpatient care for behavioral health services. The institutions for mental disease (IMD) exclusion prohibits the federal government from providing federal Medicaid funds to states for services provided to individuals who are patients in an IMD. Any inpatient setting with 16 or more beds that is primarily providing behavioral health treatment is an IMD. For the purposes of this regulation, substance use disorder treatment is considered a behavioral health treatment.[41]

Federal level policy changes have allowed coverage of these services using federal funds with certain limitations. In a State Medicaid Director letter from November 2018, CMS reaffirmed opportunities for state coverage of SUD treatment with limitations, “Medicaid managed care rules permit Federal Financial Participation (FFP) for monthly capitation payments to managed care plans for enrollees that are inpatients in a hospital providing psychiatric or SUD inpatient care or in a sub-acute psychiatric or SUD crisis residential setting that may qualify as IMDs when the stay is for no more than 15 days during the period of the monthly capitation payment and certain other conditions are met.”[42]

Additionally, Rhode Island has added coverage for SUD services into the global 1115 waiver. This allows for SUD treatment including short term residential and inpatient stays in IMDs. However, the state must aim for a statewide average length of stay of 30 days or less in residential treatment settings.[43]

The current status of residential SUD services varies for adults as compared to youth programs.

- **Adults**: Overall access was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. The Contributing Factors were provider capacity, service limitations, and geographic barriers as contributing factors.

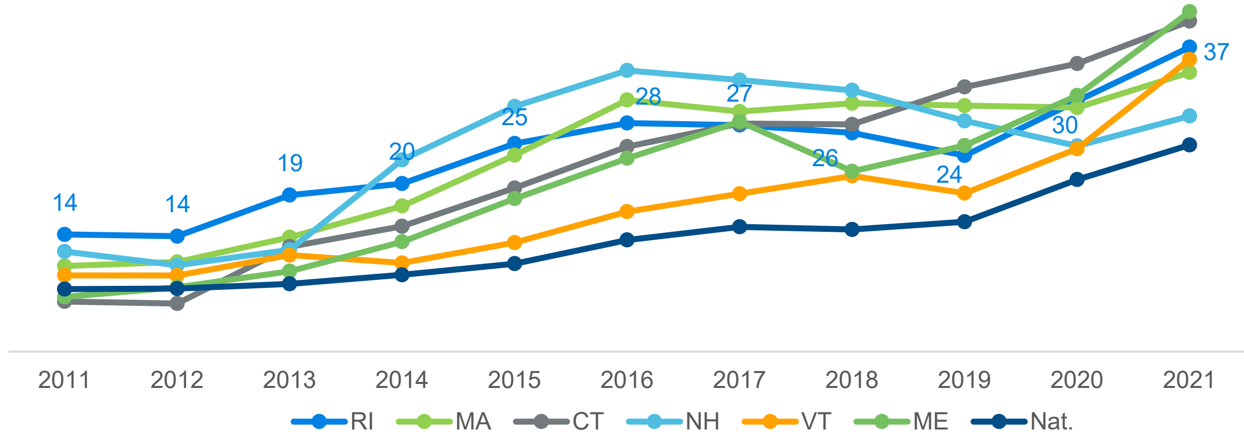
[41] Centers for Medicare and Medicaid Services (CMS). (November 13, 2018). *SMD # 18—011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.* https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

[42] Ibid.

[43] *Rhode Island Comprehensive Demonstration.* (2020, July 28). Medicaid. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

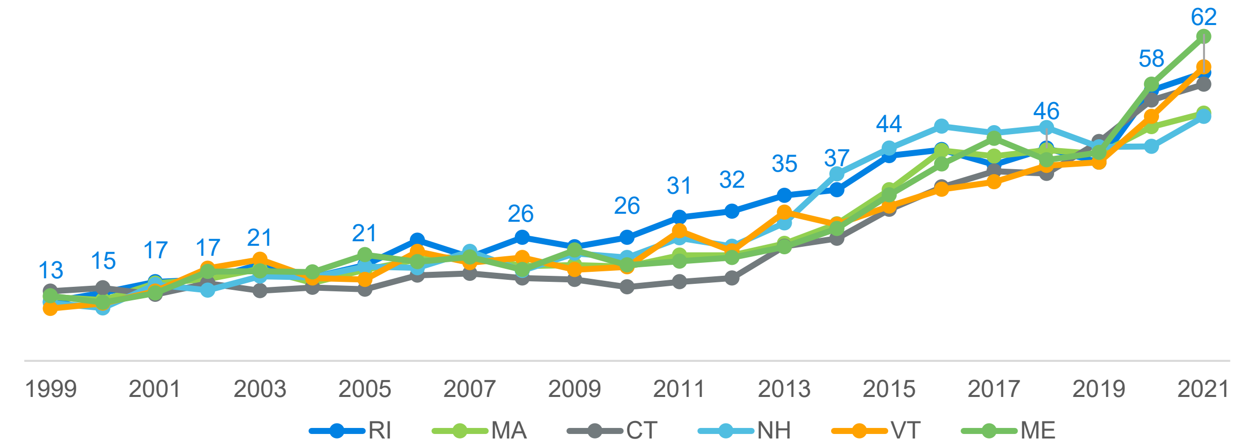
Since 2019, Rhode Island opioid overdose deaths have increased and are higher than the national average, as shown in Figure 29. Over the same period, alcohol- or drug-related cause of death incidence has also increased, as shown in Figure 30.

FIGURE 29: Opioid Overdose Deaths per 100,000 People, 2011-2021[44]



Note: N denotes that the data was normalized.

FIGURE 30 Alcohol- or Drug-Related Cause of Death per 100,000 People, 2011-2021[45]



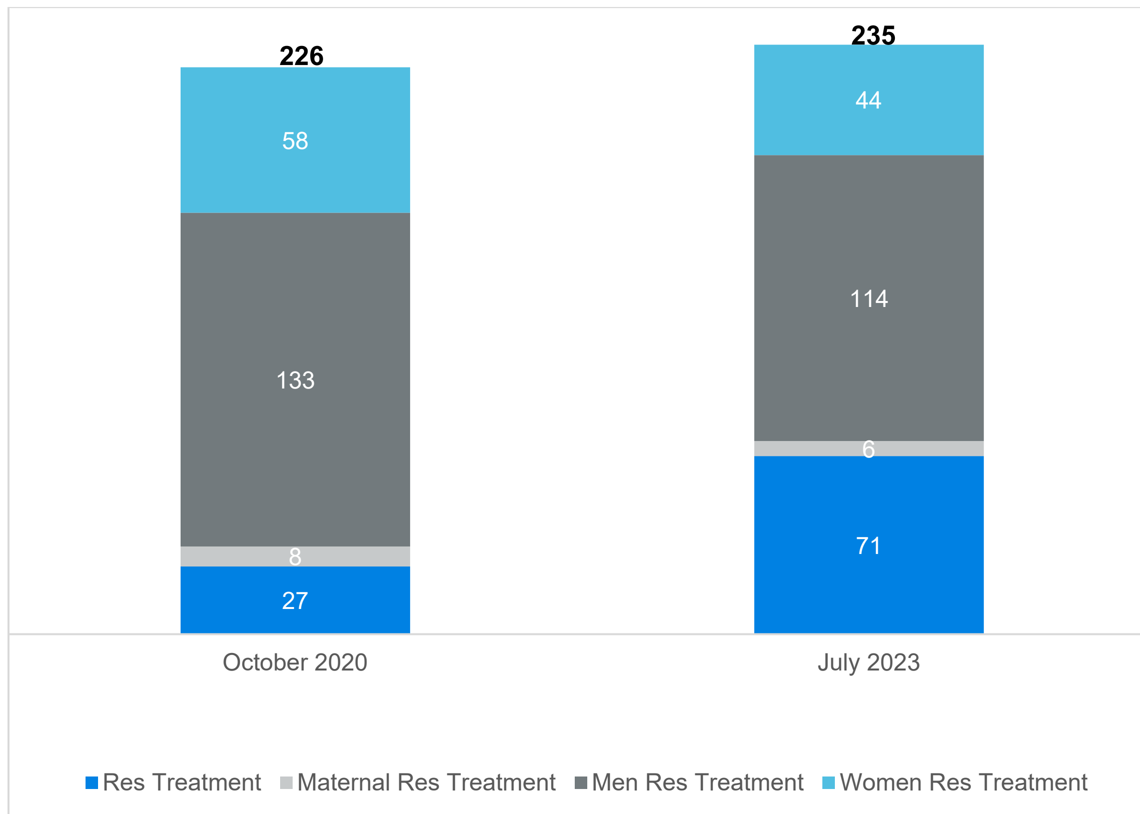
Note: N denotes that the data was normalized.

As shown in Figure 31, capacity for residential SUD in Rhode Island increased by approximately 4%, from 226 substance use disorder beds in October of 2020 to 235 beds in July of 2023.

[44] Kaiser Family Foundation (KFF). (2021). *State Health Facts*. https://www.kff.org/other/state-indicator/opioid-overdose-deaths/

[45] Centers for Disease Control and Prevention (CDC). (May 18, 2023). *Wide-ranging Online Data for Epidemiologic Research (WONDER)*. https://wonder.cdc.gov/.

FIGURE 31: TOTAL RI SUD RESIDENTIAL BEDS: OCTOBER 2020 VS JULY 2023[46]



The utilization rate for SUD residential services has been consistent over the past four years with between 12%-14% of Medicaid enrolled adults with a primary SUD diagnosis using residential treatment services. This ranged from a high of 14% (2,279 individuals) in 2019 to 12% (2,054 individuals) in 2022.[47]

- **Children:** Overall access to Children' Residential SUD services are classified as highly limited, as there is one (Emma Pendleton Bradley hospital) available in Rhode Island. There are five or fewer children accessed residential SUD treatment each year.

  There were mixed perspectives among stakeholders regarding the need for this service capacity in Rhode Island. On the one hand, some noted that many youths and adolescents may seek services out of state due to the limited availability of services. Other stakeholders offered a different perspective, noting that the state had received feedback from the community about the need for youth SUD residential treatment options, but indicated that when those services were available, they were not utilized. A residential SUD facility was previously opened to address the perceived growing need for SUD residential treatment, but the facility was closed within 6 months due to lack of utilization.

[46] Rhode Island Behavioral Health Open Beds. (October 2020; July 2023). https://www.ribhopenbeds.org/

[47] FCG retrieved from the RI Medicaid Claims Database in June 2023

Data Status

Overall, the data and reporting status was classified as somewhat limited for adults, indicating that access data is centrally tracked, services are consistently defined, but there are specific/narrow data limitations that limit access assessment.

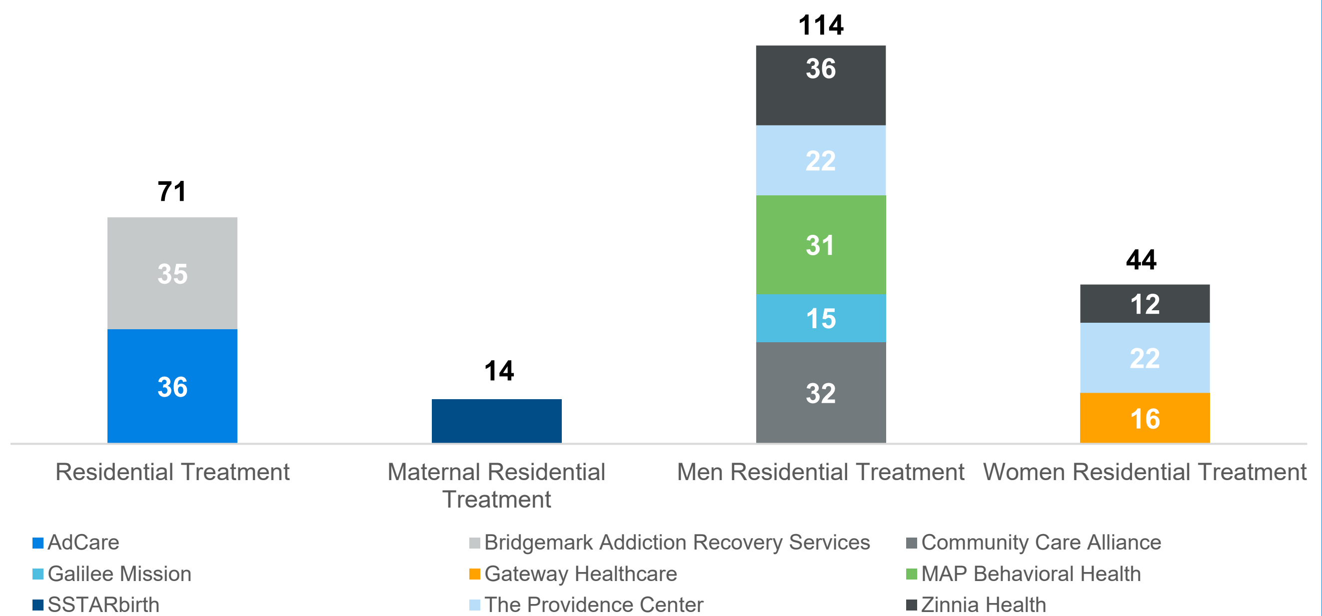
Rhode Island does have a centralized database (RI Open Beds) that tracks and monitors residential SUD services capacity, with consistent service definitions to support this reporting. Wait lists are measured as a point in time and are not tracked over time to assess the length of time people are waiting for access to services.

Findings

Provider Capacity / Network Barriers

There are a total of 235 SUD residential beds across nine providers of following types: Residential Treatment (71), Maternal Residential Treatment (6), Men's Residential treatment (114), Women's Residential Treatment (44) (see Figure 32).

FIGURE 32: RESIDENTIAL SUD BEDS BY BED TYPE AND FACILITY, RHODE ISLAND, JULY 2023[48]



Note: Two locations (St. Mary's Home for Children and Caritas House) are not captured.

As of July 27, 2023, there are 79 people waiting for residential services at these facilities, which is equal to approximately one third (34%) of the state's residential capacity on that day.[49]

Stakeholders cited challenges in hiring across all levels of staffing – clinical, medical, and non-direct care – and indicated that there are difficulties in getting people to apply for open positions. One stakeholder noted: *"We have enough [staff] to not break regulations but we're not where we'd like to be."*

Using the 2020-2021 Behavioral Health System Review commercial and Medicare data as a proxy for population need, 53% of Rhode Islanders requiring substance use residential services obtain those services in a state other than RI, MA, or CT (see Appendix D).[14]

[48] Rhode Island Behavioral Health Open Beds. (July 2023). https://www.ribhopenbeds.org/

[49] Rhode Island Behavioral Health Open Beds. (July 2023). https://www.ribhopenbeds.org/

Geographic Barriers

Stakeholders cited both geography and transportation as barriers to access, specifically noting the northwestern and southwestern parts of the state as challenging.

Public Policy Barriers

One provider indicated that there are challenges with the MCO and insurance company authorization processes to obtain a longer length of stay for clients who need additional residential support services. As the MCOs contract with the state, processes and expectations are embedded in the agreements.

Additionally, providers who do not accept uninsured individuals are not required to comply with the BDHHS waitlist reporting requirements.

Service Limitations Barriers

Stakeholders cited concerns regarding the length of time an individual can remain in a residential SUD facility, citing the 14-day limit as a barrier. As noted, federal regulations on the use of federal funds for in-patient behavioral health treatment are a limiting factor for this service.

Equity Barriers

No equity barriers were identified by stakeholders.

Reimbursement Barriers

No reimbursement barriers were identified by stakeholders.

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

HOME AND COMMUNITY BASED SERVICES (HCBS)

As defined by CMS, HCBS allow Medicaid beneficiaries to receive services in their own home or community rather than an institutional setting.[50] Rhode Island provides HCBS under the authority of the RI Comprehensive 1115 Medicaid Waiver Demonstration.[51]

Nationwide there has been an ongoing shortage of direct-care workers in the HCBS field. A 50-state survey conducted by the Kaiser Family Foundation in 2022 found that "all responding states were experiencing shortages of direct care workers in 2022", with 44 states indicating that at least one Medicaid HCBS provider had permanently closed.[52]

As part of Phase 2 of this Access Study, the HCBS services listed in Figure 33 were evaluated.

FIGURE 33: ACCESS ANALYSIS HOME AND COMMUNITY-BASED SERVICES

HCBS						
		Adult Day Services	Assisted Living	Private Duty Nursing (PDN)	Personal Care	I/DD
Overall Access		Somewhat Limited	Highly Limited	Highly Limited	Highly Limited	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	-	Contributing Factor	Contributing Factor	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	-	Contributing Factor	Contributing Factor	Contributing Factor
	Public Policy Barriers	-	Contributing Factor	Contributing Factor	Contributing Factor	Contributing Factor
	Service Limitations Barriers	Contributing Factor	-	Contributing Factor	-	Contributing Factor
	Equity Barriers	Contributing Factor	Contributing Factor	Contributing Factor	-	Contributing Factor
	Reimbursement Barriers	-	Contributing Factor	Contributing Factor	Contributing Factor	Contributing Factor
	Eligibility Barriers	-	Contributing Factor	-	-	Contributing Factor
Data Status		Highly Limited	Highly Limited	Highly Limited	Generally Available	Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

[50] Centers for Medicare and Medicaid Services (CMS). *Home and Community Based Services.* https://www.medicaid.gov/medicaid/home-community-based-services/index.html

[51] Rhode Island Executive Office of Health and Human Services (EOHHS). Home and Community Based Services Provider Reference Manual. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-06/HCBS%20Waiver%20V1.9_0.pdf

[52] Kaiser Family Foundation (KFF). (2022). *Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey.* https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/

ADULT DAY SERVICES

FIGURE 34: ACCESS ANALYSIS FOR ADULT DAY

Service		Adult Day Services
Overall Access		Somewhat Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	-
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	-
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	-
	Eligibility Barriers	-
Data Status		Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Adult Day Services are community-based services provided by state licensed Adult Day Centers that serve older adults who need supervision and health services during the daytime after which they return to their homes and caregivers at the end of the day.[53] Adult Day programs offer nursing care, therapies, and other services in a community setting.[53]

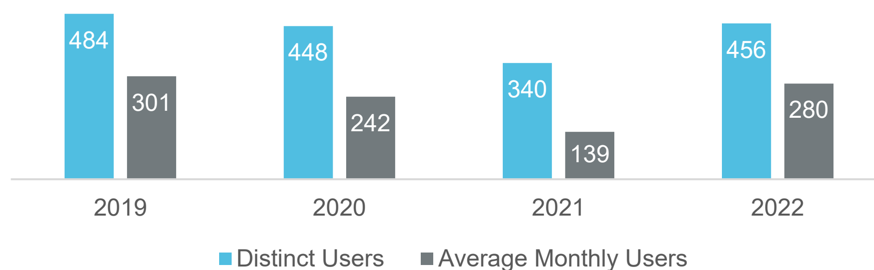
Current Status of Adult Day Services in Rhode Island

Overall, access to Adult Day Services was classified as somewhat limited, indicating that there was limited access within specific subcategories or populations and access constraints were inconsistently reported. Geographic barriers, service limitations and equity barriers were contributing factors.

Based on analysis of RI Medicaid Claims data as shown in Figure 35, utilization of services decreased during the COVID-19 pandemic from 301 average monthly users in 2019 to 139 average monthly users in 2021 likely impacted by public health policies on social distancing and stay at home orders. Utilization data for 2022 suggests that Adult Day services use has increased from 2021 to 2022, up to 280 average monthly users in 2022 but remains 7% below the pre-COVID levels of 2019.

Stakeholders discussed that awareness of adult day services may be an issue, noting that individuals are not necessarily aware of what Adult Day Services comprise and the availability of those services. Providers noted that they work closely with Community Action Agencies and conduct their own grassroots outreach and marketing to obtain referrals.

FIGURE 35: ADULT MEDICAID ELIGIBLES ACCESSING ADULT DAY SERVICES (STATEWIDE, 2019-2022)



[53] Rhode Island EOHHS. *Medicaid Managed Care Contracts & Policy/Guidance Documents.* https://eohhs.ri.gov/providers-partners/medicaid-managed-care

Data Status

Data for adult day services was classified as highly limited, as Rhode Island does not currently have a centralized system to track who is eligible for and awaiting adult day services.

Factor Findings

Provider Capacity / Network Barriers

In general, stakeholders did not express concern about overall provider capacity for Adult Day services.

Geographic Barriers

Lack of geographic proximity to programs and associated transportation challenges were cited as the primary barrier to accessing Adult Day centers in parts of Rhode Island, according to stakeholders.

See Appendix E which shows the percentage of Medicaid and Medicare dual eligible individuals utilizing Adult Day services stratified by individuals' city or town of residence (excluding cities/towns where less than 20 dual eligible individuals are utilizing Adult Day services). The average utilization rate was 3.2% of the dual eligible population in a city or town was utilizing Adult Day services. These data demonstrate geographic variation in utilization, from 6.3% utilization in Barrington and 5.2% in Providence to 1.4% utilization for residents of East Providence and Bristol. The dual eligible population in an area was used as a proxy for the senior population who might utilize the services.[54]

Consistent with these data, stakeholders cited that there is a high concentration of Adult Day providers in the Providence, Central Falls, and Pawtucket communities but also acknowledged geographic disparities within the state.

Stakeholders identified transportation as the top issue impacting access to Adult Day services.

- Stakeholders commented *"I truly believe transportation is a big issue. We have people [at our Adult Day center] from everywhere. They don't really say 'no' if they are in an outlying area."*
- Another stakeholder commented on the difficulty in accessing transportation services historically, saying *"Unless we know they live in an area where we can get transportation, we just opt for family bringing them or something else because they don't have a lot of vendors. MTM [the Medicaid transportation broker] has been working on things, but it has been a problem."*

Public Policy Barriers

No public policy barriers were identified by stakeholders.

Service Limitations Barriers

Stakeholders identified that there are some Service Limitations Barriers that prevent individuals from engaging in Adult Day. For an individual who is found eligible for Home Care hours, stakeholders shared their understanding that engaging in Adult Day services may disqualify the individual for Home Care eligibility. There are instances where Adult Day could act as a supplement to Home Care services, and stakeholders expressed that considering these services as complimentary would improve access and coordination of care for individuals utilizing Adult Day.

> *"Occasionally there is an issue with people that are deemed homebound because they've just had a hospitalization, and then they are not able to come to Adult Day – to return to the program even though it's a supportive environment. They are getting home care and they would lose that benefit, like nursing care in the home, following some type of an issue. They could potentially lose that benefit along with therapy services because they came to Adult Day."*

Equity Barriers

Stakeholders noted adult day facilities that are specialized for various populations including those with memory and mobility disorders and have mechanisms to support individuals who speak other languages such as Spanish, Russian, Chinese, and Hmong. However, providers did indicate that they see a trend of younger clients that tend to have different needs than their traditional population. This sometimes results in challenges for providers to meet the needs of all clients concurrently.

Reimbursement Barriers

No reimbursement barriers were identified by stakeholders.

[54] Medicare-Medicaid Enrollee State Profile (cms.gov) Medicare-Medicaid Enrollee State Profile (cms.gov)

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

ASSISTED LIVING

FIGURE 36: ACCESS ANALYSIS FOR ASSISTED LIVING

Service		Assisted Living
	Overall Access	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	-
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	-
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	Contributing Factor
	Data Status	Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

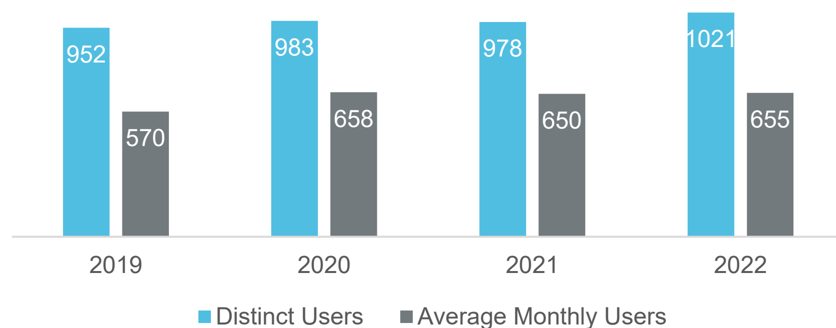
The RI Medicaid program covers assisted living services in State-licensed Assisted Living Residences (ALRs) that are certified to participate in the long-term services and support (LTSS) program.[55] Covered services include on-site, 24-hour personal care assistance, homemaker and chore services, medication management, therapeutic, social and recreational activities, and health-related transportation.[56] The amount of these services a person is eligible to receive may differ based on the scope of their needs.[57]

Current Status of Assisted Living Services in Rhode Island

Overall, access to Assisted Living services was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity, public policy, equity, reimbursement, and eligibility barriers are contributing factors.

Analysis of RI claims data, as shown in Figure 37, reflects that average monthly users of Medicaid Assisted Living services increased by 15% from 2019 to 2022, with most of the increase occurring between 2019 and 2020. Total unique users increased by 7% from 2019 to 2022.

FIGURE 37: DISTINCT ADULT MEDICAID (MEDICAID ONLY AND DUAL ELIGIBLE) USERS ACCESSING ASSISTED LIVING SERVICES (STATEWIDE, 2019-2022)*[58]



*Counts include both Medicaid and Dual Eligible Beneficiaries

[55] Rhode Island Executive Office of Health and Human Services (EOHHS). *Rhode Island Medicaid Assisted Living Fact Sheet.* https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-02/eohhs-38747-nwd-flyers_medicaid-for-assisted-living_85x11.pdf

[56] Ibid

[57] Ibid

[58] FCG retrieved from the RI Medicaid Claims Database in June 2023.

Stakeholders interviewed rated access to Medicaid assisted living services as poor, citing the decreasing number of assisted living facilities combined with the growing demand for services and subsequent waitlists for services. One stakeholder cited that the smaller facilities that had traditionally provided services to individuals that no other agency would serve have closed, further exacerbating access challenges.

Data Status

Data for assisted living services was classified as highly limited, as Rhode Island does not currently have a centralized system to track who is eligible for and awaiting assisted living services. Rhode Island does not have any centrally managed referral lists nor measures of wait times or length of referral processing time.

Findings

Provider Capacity / Network Barriers

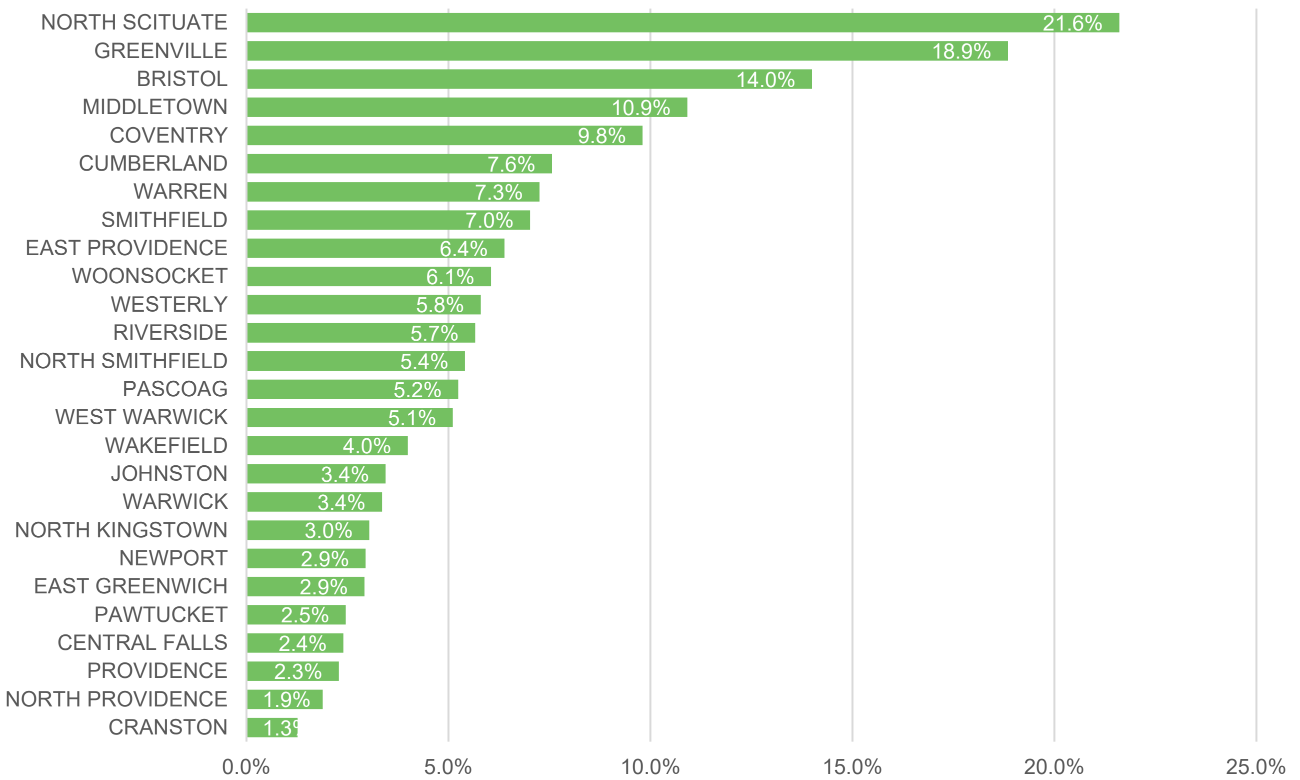
As part of the qualitative interviews, stakeholders noted that assisted living facilities that accept Medicaid are operating at full capacity and reported significant wait times for individuals seeking services. One noted that their wait list has an average of 50 Medicaid-eligible individuals with availability approximately 1 to 1.5 years wait. Stakeholders also cited ongoing challenges and barriers related to access to specialized assisted living for memory care for individuals with dementia.

- One stakeholder noted that lack of Medicaid Assisted Living Dementia units can result in individuals being placed in a nursing home dementia unit. *"One of the biggest arguments that we've been going back and forth with the state is: I have people that physically are fine. They don't need a memory care unit in a nursing home. When you walk in there, those people are more declined, and my people are still walking and talking. They are just trying to take off. Unfortunately, because there are no Medicaid Assisted Living Dementia Units, these people end up going to a nursing home in a dementia unit*."
- Stakeholders noted that both insufficient memory care supports in assisted living and limited availability of non-emergency medical transportation have led to Medicaid members utilizing higher levels of care than necessary (e.g., nursing homes). This qualitative finding is supported by the data in Figure 39, whereby in 2019 the state had a higher nursing facility utilization relative to assisted living utilization as compared to other states and national benchmarks, with a ratio of Medicaid Nursing Facility Residents to Medicaid Assisted Living Residents of 10.90, almost double the national average ratio of 5.53.

Geographic Barriers

Figure 38 represents the percentage of dual eligible adults aged 65+ utilizing assisted living services stratified by city/town (excluding cities/towns where less than 20 dual eligible individuals are accessing assisted living services). An average of 6.4% of adults aged 65+ utilized assisted living services.

FIGURE 38: % OF INDIVIDUALS AGE 65+ ACCESSING ASSISTED LIVING SERVICES, BY TOWN, 2019-2022*[59]



*Excludes towns where less than 20 dual eligible individuals are utilizing assisted living services.

Geography does not appear to be a major barrier to access to assisted living services, with a few exceptions noted by stakeholders:

- Among Medicaid members eligible for assisted living services but not currently enrolled, stakeholders reported there may be an insufficient supply of assisted living facilities with open Medicaid beds in some parts of the state.
- One stakeholder commented: *"If you live on Aquidneck Island, there is one assisted living facility that takes Medicaid, so if they are full, then there would be a waiting list unless you wanted to leave the island."*

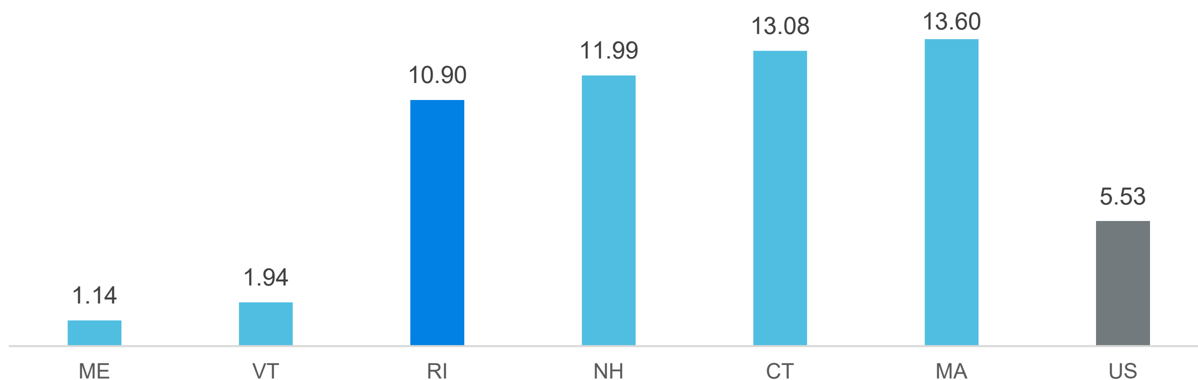
Public Policy Barriers

Several public policy barriers and opportunities were noted by stakeholders:

- **Administrative burden:** Stakeholders cited administrative burdens in application and eligibility determination that impact access to services for individuals with Medicaid coverage. One stakeholder noted the difficulties in ensuring that all appropriate documentation is completed, verified, and submitted to the state. The individual cited that the state's review process to determine eligibility has increased significantly, which impacts payments to an agency for services rendered to the individual being processed, as described in more detail in the Eligibility Barriers section below.
- **Licensure:** The Limited Health Services Level of Licensure was cited as a potential barrier, noting that if an individual needs memory care or the limited health services level of care, access is more difficult as there are fewer providers that have that level of licensure.

[59] FCG retrieved from the RI Medicaid Claims Database in June 2023

FIGURE 39: RATIO OF MEDICAID NURSING FACILITY RESIDENTS TO MEDICAID ASSISTED LIVING RESIDENTS, AS COMPARED TO NATIONAL BENCHMARKS, 2019[60,61]



- **Dementia Care:** Providers noted that the Tier 3 designation was intended to take the need for increasing access to specialized services for memory care into account by paying a higher rate, but stakeholders reported that specializing in memory care is still primarily private pay due to the intensive staffing requirements and corresponding higher costs associated with Tier 3 designation (see additional detail in Reimbursement Barriers, below).
  - As one provider described, *"because there are no Medicaid Assisted Living Dementia Units, [Medicaid members] end up going to a nursing home in a dementia unit where the state is paying over $200/day for them when they really don't need to be there."*
  - A stakeholder noted that the ability to get clients approved for the enhanced rate is very difficult.
- **Transportation:** Among Medicaid members currently residing in Assisted Living, providers noted that they sometimes experience difficulties in accessing transportation to get current Medicaid enrolled assisted living residents to appropriate medical services off-site (e.g., primary care, specialty care). For example, one provider cited experiences in which residents, who are older and qualify for nursing home levels of care, were dropped off at the wrong location or not picked up at all. In other instances, agencies had to pay for a cab or have staff take patients to medical appointments. Providers noted that these transportation challenges result in some Medicaid members choosing a more restrictive setting – nursing facilities – to ensure that they will have adequate access to needed medical care.

Service Limitations Barriers

No service limitations barriers were identified by stakeholders.

Equity Barriers

One stakeholder noted that providers who take commercial and self-pay patients may have available capacity but see Medicaid requirements as being prohibitive to serving Medicaid patients.

Stakeholders did note that there have been strides in better serving the LGBTQ+ community in assisted living facilities throughout Rhode Island. One highlighted that Rhode Island Assisted Living Association (RIALA) has offered trainings and support to advance LGBTQ+ inclusivity in Assisted Living facilities.

Another stakeholder noted that, when an individual is no longer able to remain in their facility because they need a higher level of care related to things like dementia where they need a Tier 3 facility, it may be difficult to find a place to send Medicaid members, especially for men. This stakeholder noted that male beds are often very hard to locate.

Reimbursement Barriers

Stakeholders noted that beginning in 2020, and finalized in 2021, Rhode Island conducted a comprehensive rate reform for assisted living, which resulted in a three-tiered system and created incentives for providers to serve more

[60] American Health Care Association and National Center of Assisted Living (AHCANCAL). *Assisted Living Facts and Figures.* https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx

[61] Kaiser Family Foundation (KFF). (2022). *State Health Facts – Residents in Certified Nursing Facilities.* https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Medicaid beneficiaries. One stakeholder cited that, even with the rate reform, the average cost per person per day still exceeded the daily rate providers were receiving. One provider cited that their daily rates are between $69 and $80 per person per day depending on whether a resident was a Tier 1 or Tier 2, whereas the average cost is reported anecdotally as approximately $150-$170 per person per day.

In terms of the ability to provide competitive compensation to caregivers, several stakeholders noted that they often cannot compete with the salary rates paid by hospitals, other states, or larger companies. This can result in challenges hiring and retaining staff.

- One stakeholder commented, *"When you look at an RN going to an org that has 700 Nursing Homes and they are offering $40k more to walk in, that's a whole other salary. Or they go to the hospital, forget it. They'll pay you $60/hour. Staffing is difficult*."
- Another stakeholder commented, *"You can't compete – my nurse is leaving to make $40k more somewhere else. We're not-for-profit. Medicaid - we don't have ability to pay people like that and so it's harder to find qualified candidates because everyone out there is paying them $15 more than what we can pay them. It's hard."*

Eligibility Barriers

Some stakeholders indicated that they are seeing the number of denials increase and that it adds a lot of administrative burden for them to have to continually appeal those decisions.

- One provider noted that their staff supports this process for Medicaid members, describing the process as, first "*there is a list of documentation that we need to get from the family. Then we have to send Third Party verification and that always takes time. You have to chase it. You are constantly chasing paperwork. And then once we have all that information together, we give it to the Case Worker. The Case Worker sits down with the family member or the resident, gets them to sign everything, and then it gets shipped off to the state. That's where the hold up starts. A lot of the contacts we had are gone. Before, if you applied for somebody to go on in the middle of August, they would be on September 1. Now it's taking them months to get on."*
- Another stakeholder noted, *"they have to technically be in the building for us to apply for them to go on the waiver – because they are Medicaid. So, we have to make sure we look into the whole situation before they come in, making sure that they don't have any hidden assets, have a house, any IRAs, too much money in the bank. If they have a little bit too much money in the bank, then typically they can come in and spend down. And when they get down to a certain amount, then we apply. But once it gets there, I don't know what is going on. People are getting denied all the time. And now they're getting switched from Medicaid to Neighborhood and then Neighborhood back to Medicaid. And we don't get notified so we're billing Medicaid, but the person is on Neighborhood for a month, and it's a mess."*

PRIVATE DUTY NURSING (PDN)

FIGURE 40: ACCESS ANALYSIS FOR PDN

	Service	PDN
	Overall Access	Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	-
	Data Status	Highly Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

PDN services refers to nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.[53] These services are provided: (1) by a registered nurse or a licensed practical nurse; (2) under the direction of the beneficiary's physician; and (3) to a beneficiary in one or more of the following locations at the option of the State: (1) his or her own home; (2) a hospital; or (3) a skilled nursing facility.[53]

Definitional Note: Stakeholders provided feedback about the importance of understanding the differences between skilled nursing care at home and private duty nursing and how those services differ from other personal care services. This area of the report focuses specifically on private duty nursing. Note that personal care is included in the scope of this report and the definition can be found under Service Definition in the Personal Care section.

Skilled nursing care is intended for clients who need care for a finite period of time while recovering from a specific disease or illness (e.g., frequent visits for wound care), while private duty nursing is typically intended to provide care for adult or pediatric clients who need long-term care (e.g., patient with long-term, complex medical equipment that requires monitoring and intervention). Nurses providing this care typically have similar training and credentials. Both private duty nurses and skilled care nurses may be certified as Licensed Practical Nurses (LPN) or Registered Nurses (RN), and both can provide one-to-one care in their clients' homes.

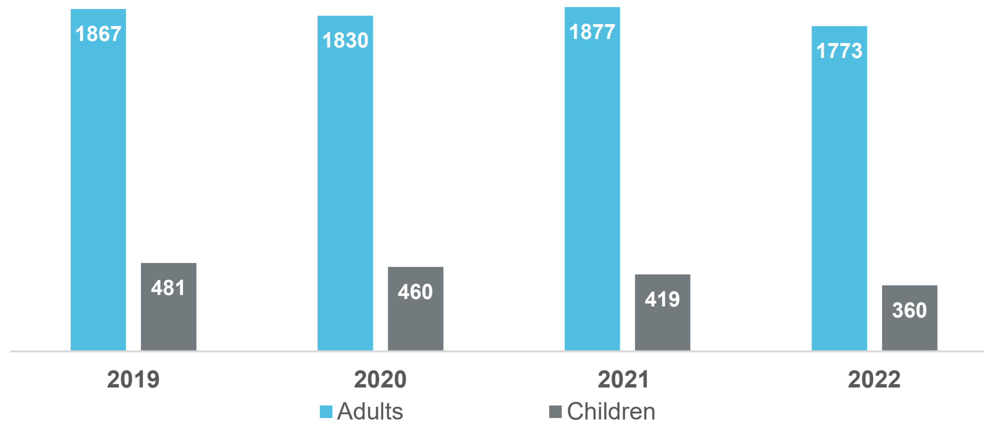
Current Status of Private Duty Nursing Services in Rhode Island

Overall, access to PDN services was classified as highly limited, indicating that there was highly limited access, and access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity, geography, public policy, service limitations, equity, and reimbursement barriers are all contributing factors of this classification.

Since 2019, there has been a decline in annual distinct users of PDN services of 5% for adults and 25% for children, as shown in Figure 41. Stakeholders have noted that limited provider capacity seems to have resulted in extended wait times for individuals seeking services.

- One agency stated that they have between 20-30 Medicaid patients waiting for services (skilled and non-skilled) at any given time, with some on the waiting list for over a year.
- A second agency stated they have 29 pediatric and adult referrals that go back to September 2022, noting that they check in on the referral to verify they are still waiting for services.

FIGURE 41: ANNUAL DISTINCT USERS (MEDICAID ONLY) OF PRIVATE DUTY NURSING, STATEWIDE, 2019-2022[62]



Data Status

Data for PDN services was classified as highly limited, as Rhode Island does not currently have a centralized system to track who is eligible for and awaiting PDN services; however, services are clearly defined for reporting purposes. There does not appear to be any centralized mechanism with the state for tracking PDN capacity and/or referral timelines.

Findings

Provider Capacity / Network Barriers

Stakeholders cited significant staffing capacity issues and attributed the inability to hire and retain staff to current reimbursement rates. One provider cited that they have lost ~50% of their staff since the COVID-19 pandemic to other industries and self-employment models that have more flexibility and better wages and benefits.

Geographic Barriers

Stakeholders noted that areas outside Providence are the most challenging to staff, especially more rural communities in Rhode Island. Agencies noted that it is often harder to find nurses who will travel to more remote and rural parts of the state, as they receive the same reimbursement rate regardless of where a patient lives and where the provider is located. *"There are no incentives for someone to travel to, for example, Newport or Middletown as there is no rate differential in Medicaid."*

Public Policy Barriers

Similar to Personal Care services, stakeholders cited administrative burdens – especially obtaining authorization approval – as an access barrier, as providers must have up-to-date authorizations to begin service provision or to continue service provision.

Some providers noted that there is an inconsistency between Medicaid fee-for-service and the MCOs in terms of authorizations, reauthorizations, and the number of hours that clients can receive. This inconsistency appears to impact a provider's ability to provide services and obtain timely payment.

Service Limitations Barriers

Service limitations with PDN that may create access barriers for Medicaid members were noted as generally relating to the limitations on the number of approved hours of nursing. Some stakeholders noted that at least one MCO is cutting hours for their clients. "*A nurse may be working with a client for 40 hours per week then [the new] assessment shows they only need 24 hours per week. That nurse may take another client. So now that original client went from 40 to 0, not 40 to 24.*"

[62] FCG retrieved from the RI Medicaid Claims Database in June 2023

Another stakeholder cited the following challenge related to service limitations of hours approved for private duty nursing: *"We'll get a call asking if we can service a client that is approved for 40 hours. We send out our nurse to do the assessment and in talking with our staff member, they say they know they are approved for 40 hours but only want 20. We go back and say to the social worker that they only want 20. Nothing happens, they still stay in the 40 hours approved. But it's because their patient is not needing it*." While this example does not directly impact the individual member's access to care, this example is highlighted to indicate that a measure of total hours approved as compared to total hours utilized by patients may not accurately measure the need for access to PDN services.

One stakeholder identified that MCOs have up to 14 days to provide authorization but that FFS authorization can come within 5-7 days on average.

Equity Barriers

A stakeholder identified that they struggled to find providers who have language capacities other than Spanish/ English/ Portuguese, which may pose an access barrier for individuals needing services in languages other than those three languages.

Reimbursement Barriers

Stakeholders noted that there is currently not a rate floor for PDN services, so MCOs could potentially pay below FFS rates for services. They shared that RI has a COLA for FFS rates so rates will be adjusted every year, and they hope that MCOs are following suit. Every agency has negotiated with MCOs separately for those increases.

Multiple providers also noted their inability to compete with the salary rates provided by hospitals, nursing homes, and schools, both within RI and its surrounding states. Providers stated that while there was a PDN rate increase in 2018, Rhode Island PDN rates were still $15-$20/hour lower than MA. Stakeholders commented:

- *"Our biggest struggle is that we can't pay what nurses want to make. We're losing them to LTCHs, hospitals, Nursing Homes, and schools. The biggest piece is that RI is so small, you can drive to MA and MA is paying $10 more per hour. We've had nurses leave and go to MA. It's literally the same job and they get paid more money."*
- *"Even when we are able to hire nurses, it's hard to retain them. If they work here for 6 months or a year, then they want a raise and we can't provide that since we're not getting a raise from Medicaid, so our hands are tied. And we end up losing them*."

Providers shared that there used to be shift modifiers for the FFS reimbursement rate but those were eliminated in 2018 as part of legislature rate increase. There are no incentives for nights or weekends, which means that a nurse is paid the same rate regardless of the time of day or night they are working. They noted that, with the removal of those modifiers, they have seen issues with staffing. "*Why would nurses want to take night shift when they make the same amount of money for more convenient options?*" They also noted the lack of an acuity modifier.

Eligibility Barriers

No eligibility barriers were identified by stakeholders.

PERSONAL CARE

FIGURE 42: ACCESS ANALYSIS FOR PERSONAL CARE

Service		Personal Care
Overall Access		Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	-
	Equity Barriers	-
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	-
Data Status		Generally Available

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Personal Care services are a subcomponent of home care services covered by Medicaid for individuals who need assistance with the activities of daily living so they can remain in their own or someone else's home in the community. Personal care services may include assisting the client with personal hygiene, dressing, feeding, transfer, and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs, e.g., making the client's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the member also needs personal care services.

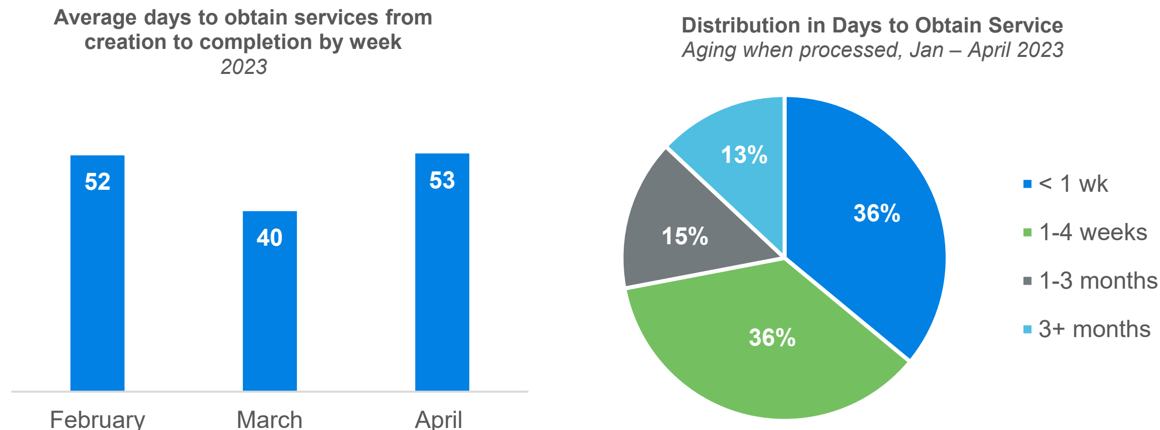
This study focused on agency-based services for personal care and homemaking and did not assess access to non-agency based personal care services, such as the Independent Provider (IP) and Personal Choice Programs. Stakeholders noted that the IP program may be underutilized and may be an area for further study.

Current Status of Personal Care Services in Rhode Island

Overall, access to agency-based personal care services was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity, geography, public policy and reimbursement barriers are the contributing factors of this classification.

Based on data from the RI Home Care Provider Referral Portal, the total time that individuals waited before they received services ranged from 13 to 99 days, with an average of approximately 48 days as shown in Figure 43.

FIGURE 43: WAIT TIMES (FFS): AVERAGE AND DISTRIBUTION[63]



Also shown in Figure 43, 36% of individuals needing personal care services were able to obtain services in under one week from processing (when the referral is accepted for service by the provider). For 28% of individuals, it took one month or longer to obtain services.[64]

Data Status

Overall data/reporting status was classified as generally available, indicating that access data is centrally tracked, services were consistently defined and there were no/few data limitations. EOHHS operates and maintains a Home Care Provider Referral Portal which outlines information about individuals approved for home care services. The state updates the portal monthly.

Findings

Provider Capacity / Network Barriers

Stakeholders frequently cited staffing as a challenge, noting difficulties in being able compete with hospitals and nursing facilities within Rhode Island, as well as those in surrounding states, all of which pay higher salary rates. Providers commented on their challenges in being able to recruit, hire, and retain staff and attributed this primarily due to reimbursement rates.

Geographic Barriers

Stakeholders noted that there is a lack of caregivers in the more rural communities in the state, citing Westerly and Northern RI. They also noted that there is a lack of these services in the East Bay. Many reiterated that statewide agencies exist, but there are not enough caregivers to provide sufficient services in these communities.

Referral data from the state's portal reporting average referral timelines by town confirms this geographic barrier. In the table below (Figure 44), we summarized the towns with the highest and lowest average referral timelines. Note the range of timelines by town and the longer wait times are in locations furthest from the Providence metro area.

[63] Rhode Island Executive Office of Health and Human Services (EOHHS). *Home Care Provider Referral Portal*. https://eohhs.ri.gov/reference-center/home-care-provider-referral-portal

[64] Ibid

FIGURE 44: COMPARISON OF AVERAGE WAIT TIMES (FFS*): BY TOWN, AS OF MAY 2023[63]

LONGEST WAITS**	SHORTEST WAITS**
1. 591 DAYS – 02813 (CHARLESTOWN)	**1.** 3 DAYS – 02910 (CRANSTON)
2. 453 DAYS – 02835 (JAMESTOWN)	**2.** 7 DAYS – 02921 (CRANSTON)
3. 380 DAYS – 02878 (TIVERTON)	**3.** 18 DAYS – 02903 (PROVIDENCE)
4. 369 DAYS – 02879 (WAKEFIELD)	**4.** 24 DAYS – 02865 (LINCOLN)
5. 328 DAYS – 02840 (NEWPORT)	**5.** 30 DAYS – 02907 (PROVIDENCE)

* FFS accounts for roughly 50% of home care services; via MMIS CHPROD analysis, July 1, 2018 - December 21, 2019 (18-Month)
** Data segmented by zip code may have small sample size.

Public Policy Barriers

Stakeholders frequently cited administrative burdens as a barrier. In particular, many noted authorization approval as an access barrier as providers are unable to provide services until appropriate documentation is signed and completed by the physician and insurer. One provider noted that they have multiple staff members whose time is spent following up with MCOs and physicians and doing authorizations so that their agency can receive payment. One stakeholder cited wait times as long as 3 weeks before they received authorization.

Service Limitations Barriers

No service limitations barriers were identified by stakeholders.

Equity Barriers

No equity barriers were identified by stakeholders.

Reimbursement Barriers

One stakeholder indicated their perception that clients needing personal care services requiring a CNA typically wait longer than a client needing a skilled nurse because the reimbursement for CNAs is insufficient to attract staff. One stakeholder said that CNAs "*can go to Massachusetts, the hospitals, or the nursing homes and get paid a lot more than what we can pay them."* All personal care providers interviewed indicated that they all pay significantly more for CNAs than they did two years ago but highlighted that they are no longer competing with just each other. One stakeholder commented that they are *"competing with Burger King and McDonalds and Dunkin' Donuts. It's a lot easier to do those jobs than Home Care–some of these patients are challenging*."

Eligibility Barriers

Participants did not cite any specific eligibility barriers.

INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD)

FIGURE 45: ACCESS ANALYSIS FOR I/DD

Service		I/DD
Overall Access		Highly Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	Contributing Factor
Data Status		Highly Limited

Service Definition

I/DD is a population served by Medicaid that requires tailored and specialized services across all service categories. For the purposes of this study, we focused on understanding I/DD services at a population level for both children and adults.

These individuals can be classified in three basic categories of eligibility:

- **Katie Beckett Eligible Children[65]:** An eligibility category that allows individuals under the age of 19 who have long-term disabilities or complex medical needs to become eligible for Medicaid coverage.
- **BHDDH Eligible I/DD Adults[66]:** Individuals must be found clinically and financially eligible to receive BHDDH-funded services. This includes:
  - Being found eligible for DD-BHDDH services by meeting the definition of developmental disability, per RI State Law. (R.I. Gen. Laws § 40.1-21-4.3)
  - Being found eligible for Medicaid either through Supplemental Security Income (SSI) or the Department of Human Services.
- **I/DD diagnosed Adults and Children:** Medicaid eligible Rhode Islanders with an I/DD diagnosis that have not been determined eligible for expanded I/DD specific services. These are mostly children (89%). Stakeholders describe them as either not yet processed for Katie Beckett or presenting with less complex needs such that they have not required the enhanced services associated with Katie Beckett or BHDDH eligibility.

FIGURE 46: I/DD POPULATION OVERVIEW, MEDICAID AND DUAL ELIGIBLE BENEFICIARIES, STATEWIDE, 2019-2022[67]

	Avg. Monthly Eligible	%		Avg. Monthly Eligible	Children (<18)	Adults (18+)	% <18
Katie Beckett	862	5%		**Katie Beckett**	846	16	98%
BHDDH Client	3,705	20%		**BHDDH Client**	2	3,703	0.05%
Other I/DD*	13,637	75%		**Other I/DD**	12,170	1,467	89%
Total	**18,204**	**100%**		**Total**	**13,017**	**5,186**	**72%**

*Other I/DD represents those with a diagnoses within the fiscal year indicating client had a diagnoses specific to a developmental disability

[65] Rhode Island Executive Office of Health and Human Services (EOHHS). Katie Beckett. https://eohhs.ri.gov/Consumer/FamilieswithChildren/ChildrenwithSpecialNeeds/KatieBeckett.aspx

[66] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH). *Developmental Disabilities – Eligibility and Application*. https://bhddh.ri.gov/developmental-disabilities/eligibility-and-application

[67] FCG retrieved from the RI Medicaid Claims Database in July 2023.

Populations determined eligible for Katie Beckett and/or BHDDH I/DD services are eligible to receive a broader set of I/DD specific services, as illustrated in Figure 47.

FIGURE 47: I/DD SERVICE OVERVIEW

Katie Beckett Services[68]	BHDDH Services[69]
1. KIDS CONNECT 2. Personal Assistance Services and Supports (PASS) 3. Home Based Therapeutic Services (HBTS)	1. Supported Employment 2. Integrated Day Supports 3. Community-Based Supports 4. Respite 5. Residential Services 6. Transportation 7. Professional Services 8. Support Brokerage 9. Fiscal Intermediary Services

Current Status of I/DD Services in Rhode Island

Overall, access to services for the I/DD population was classified as highly limited and access constraints were consistently reported in the data and among stakeholders who participated in this study. Provider capacity, geography, public policy, service limitations, equity, reimbursement, and eligibility barriers are contributing factors of this classification.

Data Status

Data for I/DD services was classified as highly limited, as Rhode Island does not currently have a centralized system to track who is eligible for and awaiting I/DD services; however, services are clearly defined for the purposes of reporting. Stakeholders indicated that BHDDH established a case management software system but noted that it is specific to the adult population. There does not appear to be a system-wide centralized referral system. Each provider maintains their own referral system or waitlist, but they are unable to see each other's referrals.

One stakeholder described the limitations in the qualitative data provided, identifying the need for a centralized access database: *"What's notable about what we are telling you is that there is no mechanism for capturing this information in the state. We're detailing what some of the limitations are, but we can't quantify it in any way. So that's part of our challenge, there's no centralized referral system or quantifying 'this is how many people are eligible, they should be here, or they should there'. The MCOs don't report on any of these eligibility categories and who's accessing services and who is not, not just for I/DD but any services. So that's notable. We're telling you these problems exist but there is not clear clearinghouse for how we measure that."*

There are innate challenges to developing data for this population as most individuals do not have a specific I/DD diagnosis within the range of the BHDDH I/DD eligibility criteria.

Findings

Provider Capacity / Network Barriers

Stakeholders described a lack of specialized expertise in the field as well as a lack of education pathways to specialize in services for I/DD populations. One stakeholder said, "*there is no higher education that has taken this on as a field to do or a discipline to do internships/field work. They don't emphasize it. We are not one of those populations that have recognized the need to have an expertise."*

Stakeholders also cited staffing as a challenge, similar to other service categories described throughout this report. Providers noted difficulties in hiring and retaining both direct support staff, managerial staff, and clinical staff due to a combination of general occupational burnout and lower payment rates in comparison to RI hospitals, school departments, and bordering states. Examples of comments reflecting staffing and provider capacity constraints for I/DD providers include:

- *"I've lost staff at every level to Connecticut because they have better rates. It's chronic for us."*

[68] Rhode Island Executive Office of Health and Human Services (EOHHS). *Children With Special Needs.* https://eohhs.ri.gov/consumer/families-children/children-special-needs

[69] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH). *Services for Adults.* https://bhddh.ri.gov/services-adults

- *"We've heard clinicians say that, as they are exiting college/clinical degrees, they are being told not to accept anything below $80,000 per year. If you do the math, that's $38.46 per hour, which right now (for the degrees that people are paying for in college) is not unreasonable."*

Geographic Barriers

Stakeholders identified transportation as a challenge in accessing I/DD services for both individuals and providers, specifically citing South County, West Kingston, Hope Valley, Westerly, and Newport County as specific examples.

- *"Transportation issues – different pockets of the state can be very, very difficult for staff and individuals with I/DD to get out and about in the community.*
- *"South County is notorious for having transportation issues, even in Westerly which is a bit of a hub. Anywhere in South County is an issue. I think, other than maybe Providence, the whole state has issues."*

For providers, stakeholders cited reliance on staff's personal vehicles as the primary barrier. For example, *"For a lot of our programs, both adults and children, we are expecting staff to drive a lot – so they are doing services in the community. I have a lot of staff who have left because, essentially, they feel they are paying the agency because they continuously refuel their car, are putting mileage on their car."*

Public Policy Barriers

Stakeholders cited provider regulatory criteria as an access challenge to I/DD services. A stakeholder commented on the challenges providers face in meeting regulatory requirements combined with the increasing number of individuals and families for whom they provide services: *"Part of the capacity issue with clinicians that I hear a lot is that they feel morally and ethically they cannot keep up with regulatory requirements, specifically for children. We are bound by regulations for these programs and they feel because their caseloads are so high, because they can't find staff, there's a bit of an ethical dilemma that they are facing because they are trying do everything they can for the families, and the number of their caseloads sometimes prevents them from getting to every family's home within the regulated amount of time. So, it creates this uncomfortable feeling for that clinician who is holding a license and is responsible for being the clinician on record for the plan. Because of that capacity issue, because they are so overloaded with their caseload, they're struggling with that 'am I doing the right thing?' How do you determine which family is going to get that one visit you have left in your schedule."*

Stakeholders also cited several access challenges related to fragmentation between I/DD services covered and populations served by MCOs versus fee-for-service. A detailed discussion of these access barriers is included below under "eligibility".

Service Limitations Barriers

One stakeholder cited challenges for individuals transitioning from child to adult services, noting that their agency has seen an increase in the number of denials for waiver services for individuals between ages 21-22. Similarly, another stakeholder indicated that the resources available for individuals under 21 may not be available once they are transitioned into adult services. These limitations are further described in the eligibility section of this report.

Equity Barriers

Stakeholders noted that there are several populations with access challenges, including the deaf and hard of hearing, populations that speak languages other than English, and some individuals on the autism spectrum who do not qualify for I/DD services.

Reimbursement Barriers

As described above in the "provider capacity" and "geographic barriers" sections, stakeholders noted several concerns regarding adequacy of rate payment to compete with the market and to reflect the level of indirect time put in by the staff that is not billable and/or recognized when delivering home-based services. Additional supporting evidence of reimbursement barriers described by stakeholders include:

- As with several other service categories, stakeholders noted that they often cannot compete with RI hospital rates and rates in MA and that they can't pay clinicians competitive rates. A stakeholder shared "C*ompression of wages has had an impact on our ability to keep staff or keep staff motivated*".

Eligibility Barriers

The system of care for I/DD populations is fragmented across programs (Medicare-Medicaid dual eligible/Medicaid only), delivery systems (Managed care/Fee-for-service), and State Agencies (BHDDH/Medicaid), as shown in Figure 48 below.

- Most (90%) of the Katie Beckett children are in FFS; while a majority (59%) of the BHDDH adults are in managed care. Specialized services are carved out of managed care and covered through the FFS program for those in managed care. While the data indicates that nearly all of the Katie Beckett children are covered by a single streamlined FFS payor, because of the eligibility criteria for Katie Beckett, almost all of these children have other insurance (e.g., commercial insurance through their parents) so the FFS coverage is a wrap-around that must be coordinated with their other insurance. This situation can create issues with defining which payor is responsible for provided services and can cause confusion in care delivery.
- There are different agencies responsible for I/DD based on which subpopulation they fall into - BHDDH is responsible for I/DD adults; Medicaid is responsible for I/DD children. This creates additional access barriers for individuals transitioning from coverage through Medicaid to BHDDH as they age out of children's services.

FIGURE 48: I/DD SERVICE OVERVIEW – AVERAGE MONTHLY ELIGIBLE, 2019-2022[70]

	Program Mix				Delivery System Mix			
	Total	**Dual**	**Medicaid Only**	***% Dual***	**Total**	**FFS**	**MC**	**% MC**
Katie Beckett	862	3	859	0.4%	862	778	84	10%
BHDDH Client	3,705	2,503	1,202	68%	3,705	1,536	2,169	59%
Other I/DD*	13,637	310	13,327	2%	13,637	1,162	12,475	91%
Total	**18,204**	**2,816**	**15,388**	***15%***	**18,204**	**3,476**	**14,728**	***81%***

*Other I/DD represents those with a diagnosis within the fiscal year indicating client had a diagnosis for specific intellectual or developmental disability, primarily ICD-10 codes in the range F70-79 and F80-89. Such counts are understated for Duals due to lack of claims and/or detailed diagnoses on existing claims for clients where Medicare is the primary payer.

- This fragmentation can lead to access challenges at key transition points. Most notably, as children age out of Katie Beckett and into BHDDH I/DD programs for adults they often need to shift care managers, benefit plans, and can face gaps in coverage that impede access. One stakeholder shared, *"In the last 2-3 months, we have received lots of calls from those who have young adults who have transitioned [into the adult system] and are seeing an uptick in denial for waiver services. There are a lot of people out there who don't know who to call once they receive a denial. The appeal is a lengthy process."* Stakeholders noted that there are concerns around changes to the scope of covered services once someone ages out of children's services.
- Similarly, another stakeholder indicated that *"the resources and services available for individuals under 21 may not be available once they are transitioned into adult services."*
- This fragmentation in population coverage options is further exacerbated by the fact that the specialized I/DD services for children (Kids Connect, PASS, HBTS) are in-plan benefits covered through MCOs. While I/DD services for adults (supported employment, integrated day supports, community-based supports, respite and residential services) are out-of-plan benefits (fee-for-service only). This division of coverage responsibility can lead to gaps in coverage between fee-for-service and managed care.
  - One stakeholder noted the example of a dual eligible health plan enrolled individual receiving home-based services through the BHDDH I/DD program who had a fall resulting in surgery and requires either skilled nursing care or personal care services for a short period upon return from the hospital: *"Is that a Medicare or Medicaid covered benefit? Or will that be covered by Medicaid FFS as part of the BHDDH community-based supports?"*
  - *"From children's services to adult, no matter how much effort is really focusing on those families of kids transitioning to adult services, it never really quite sinks in and so it's not always a smooth transition – even if you are within the same agency."*

This fragmentation also creates challenges of multiple points of contact and a lack of clarity regarding the lead case manager supporting I/DD eligible individuals that can also lead to gaps in access. One stakeholder noted, *"What is the role of the health plan case manager? The I/DD program case manager? The AE case manager?"*

Stakeholders also noted concern regarding the gap in benefits for individuals with an I/DD diagnosis who are not or have not yet been determined eligible for either Katie Beckett or other specialized services for children or BHDDH specialized services for adults.

[70] FCG retrieved from the RI Medicaid Claims Database in July 2023.

- *"There are individuals on the autism spectrum who do not qualify for I/DD services but still need some of the supports that are included in the I/DD service offerings."* They indicated that these individuals are "falling out of the system" and that they could benefit from these services if eligible.
- Additionally, stakeholders cited instances where people in their 40s or 50s who were never formally diagnosed prior to turning 21 are now not eligible for services they need because of their age at diagnosis.

OTHER SERVICES

The table below summarizes overall access, contributing factors of access status, and data status for three additional services assessed: Early Intervention, TBI Day services, and Non-Emergency Medical Transportation.

FIGURE 49: ACCESS ANALYSIS FOR OTHER SERVICES

		Other Services		
Access Category		**EI**	**TBI Day**	**NEMT**
Overall Access		Somewhat Limited	Unavailable	Somewhat Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor	Contributing Factor	Contributing Factor
	Geographic Barriers	Contributing Factor	Contributing Factor	Contributing Factor
	Public Policy Barriers	-	Contributing Factor	-
	Service Limitations Barriers	-	Contributing Factor	-
	Equity Barriers	Contributing Factor	-	-
	Reimbursement Barriers	Contributing Factor	-	-
	Eligibility Barriers	-	Contributing Factor	-
Data Status		Generally Available	Undetermined	Somewhat Limited

Note that the dash indicates this access dimension was not identified as an issue in the research.

EARLY INTERVENTION SERVICES

FIGURE 50: ACCESS ANALYSIS FOR EI SERVICES

Service		EI
Overall Access		Somewhat Limited
Access Dimensions	Provider Capacity/ Network Barriers	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	-
	Service Limitations Barriers	-
	Equity Barriers	Contributing Factor
	Reimbursement Barriers	Contributing Factor
	Eligibility Barriers	-
Data Status		Generally Available

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

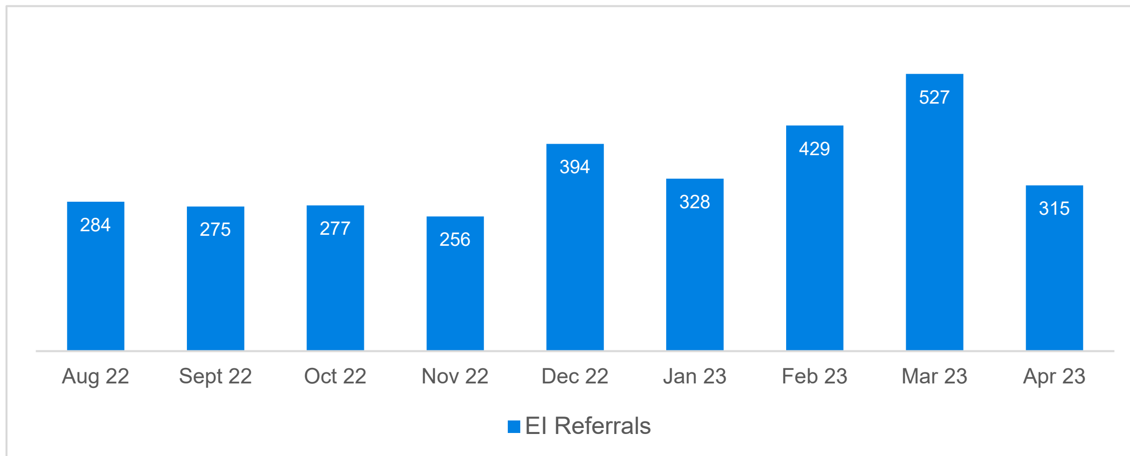
Rhode Island's Early Intervention (EI) Program is designed to support infants and toddlers under the age of 3 who have a developmental disability or delay in one or more areas.[71] EI services include an initial comprehensive evaluation, and then for those eligible, EI services include but are not limited to speech language services, occupational therapy (OT), and physical therapy (PT).[72]

Current status of EI services in Rhode Island

Overall access to EI services was classified as somewhat limited, indicating that there was limited access within specific subcategories or populations and access constraints were inconsistently reported.

Average monthly referrals to EI services increased from a monthly average of 297 in the last 5 months of 2022 to a monthly average of 400 in the first 4 months of 2023, as shown in Figure 51 below.

FIGURE 51: EARLY INTERVENTION REFERRALS FROM AUGUST 2022 TO APRIL 2023[73]



As described in detail below, contributing factors of rating EI services as “limited access” are provider capacity, geographic, equity, and reimbursement barriers.

[71] Rhode Island Executive Office of Health and Human Services (EOHHS). *Early Intervention Program.* https://eohhs.ri.gov/Consumer/FamilieswithChildren/EarlyIntervention.aspx

[72] Ibid

[73] Data retrieved from the RI State Early Intervention Data System (2021) via OHHS.

Data Status

Overall data/reporting status was classified as generally available, indicating that access data is centrally tracked, services were consistently defined and there were no/few data limitations. RI EOHHS maintains a central database of EI service eligibility and enrollment used for this study. There appears to be reasonable data and reporting associated with EI access and referral timelines, though there are agency-to-agency differences in processes and collection of data. Stakeholders described that reporting of referral timelines and management vary by agency, with some agencies removing individuals from their list when the agency can provide the full suite of EI services. Other agencies will begin the intake and service provision process but keep an individual on the waitlist if they are still awaiting openings in other service disciplines.

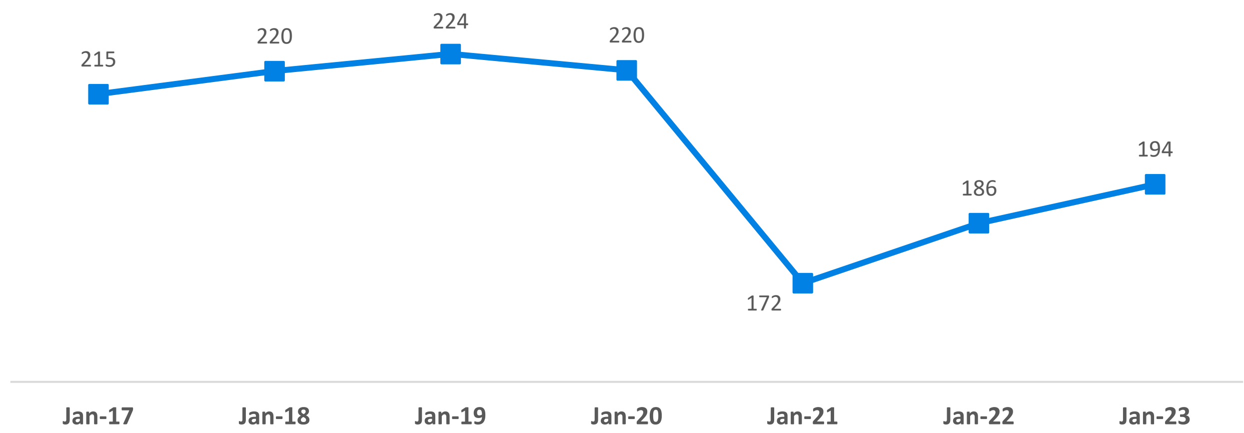
Findings

Provider Capacity / Network Barriers

Provider capacity is a contributing factor of access challenges to EI services. Stakeholders frequently noted workforce capacity challenges within EI, specifically citing increases in demand for speech and language therapy, occupational therapy, and physical therapy services. Even with the opening of independent occupational and physical therapy facilities, stakeholders noted that there are still significant waits in accessing these services.

Between 2019 and 2022, EI staffing declined, as shown in Figure 52, including a 22% drop during COVID in 2020. As of January 2023, staffing levels have increased to 88% of 2019 levels.

FIGURE 52: STAFFING BY # OF FTES – STATEWIDE 2017-2023[74]



Geographic Barriers

Geography is a contributing factor to access constraints for EI services. Stakeholders expressed concerns related to transportation to access EI services, as there are areas within RI that do not have busing or other easily available transportation to EI service providers. One stakeholder mentioned that a facility in Newport that previously provided PT, OT, and Speech Therapy has closed, making access on Aquidneck Island more challenging. Stakeholders also noted that some patients seek services in Massachusetts near the Rhode Island border, but still encounter wait lists as well as insurance challenges.

Public Policy Barriers

Stakeholders did not cite any specific public policy barriers to initial access. One stakeholder commented, "*Access from a policy viewpoint… is pretty open for families. Any family who has any concern for their child regardless of insurance can access EI services.*"

Service Limitations Barriers

No service limitations barriers were identified by stakeholders.

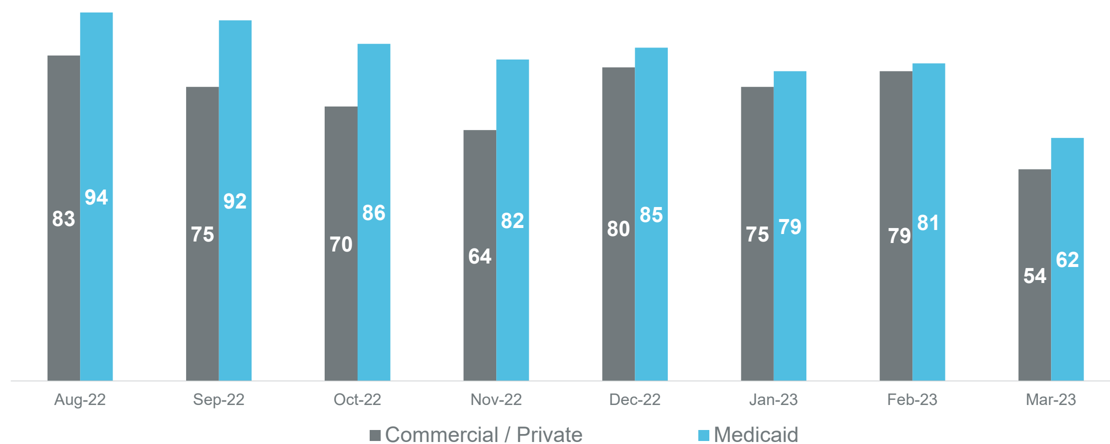
[74] Data retrieved from the RI State Early Intervention Data System (2021) via OHHS.

Equity Barriers

Both qualitative and quantitative analyses indicate discrepancies in access between Medicaid enrollees and individuals with commercial or private insurance, which may indicate an income equity challenge. Further research is necessary to validate this potential barrier.

- **Medicaid enrollees have longer wait times to enroll in EI services, waiting on average 10 days longer for services compared to commercially insured children (Figure 53).** Between August 2022 and March 2023, the average time to enrollment was 83 days for Medicaid enrollees and 73 days for privately insured children. Time to enrollment has decreased since August 2022 but remains longer than the program target of 45 days - 20% longer than program target for commercially insured children and 38% longer than program target for Medicaid enrollees.

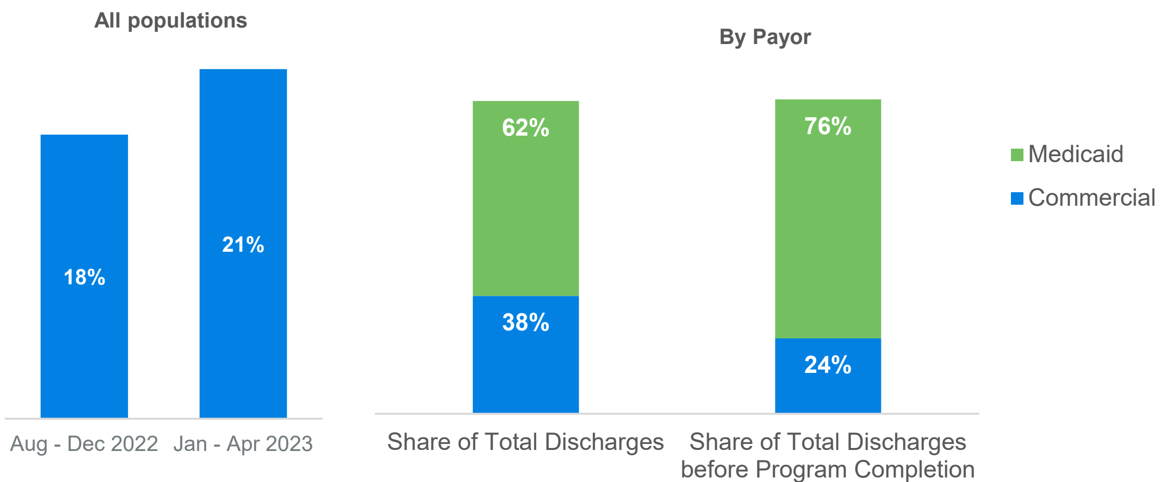
FIGURE 53: WAIT TIME TO ENROLLMENT - AVERAGE # DAYS FROM EI REFERRAL TO ENROLLMENT[75]



- **Medicaid children are less likely to complete evaluation for EI services once referred than privately insured children**. EI providers lose contact with 19% of Medicaid children who are referred to EI services before completing their evaluation compared to losing contact with 6% of commercially insured children who are referred for evaluation, see Appendix F for more information. Further analysis is needed to understand root causes for this variance.
- **Medicaid children are less likely to complete recommended EI services than privately insured children**. Stakeholders indicated that consistent outreach is needed to keep Medicaid EI enrollees engaged with the program. As shown in Figure 54, 21% of children enrolled in EI never completed services. Medicaid enrollees comprise 62% of total discharges and 76% of discharges before program completion.

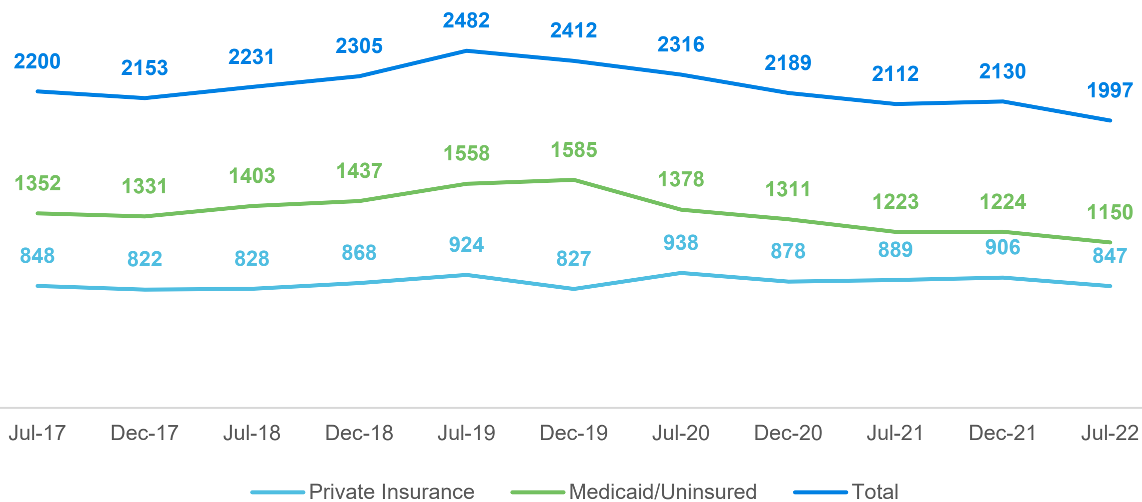
[75] Data retrieved from the RI State Early Intervention Data System (2021) via OHHS.

FIGURE 54: ENROLLED BUT NEVER COMPLETED - % OF CHILDREN 2022-2023[76]



- **As of July 2022, enrollment in EI programs among commercially insured has increased to at or above pre-COVID levels of December 2019, while Medicaid enrollment has declined and remains below pre-COVID rates.** As shown in Figure 55, the ratio of commercially insured to Medicaid for children accessing EI services was 0.74 in July of 2022 compared to a five year low of 0.59 in December 2019. Enrollment of commercially insured children during the initial COVID period (July 2020 as compared to December 2019) increased by 13% for commercially insured children while decreasing by 13% for Medicaid children and decreasing by 4% overall. Commercial enrollment has remained relatively flat since 2020, as Medicaid has largely driven the overall decline in service utilization since 2019.

FIGURE 55: INSURANCE OF CHILDREN ENROLLED IN EI – STATEWIDE, 2017-2022[77]



Some stakeholders noted that limited funding for outreach to Medicaid members referred to EI may pose an economic equity barrier for Medicaid enrollee engagement.

[76] Data retrieved from the RI State Early Intervention Data System (2021) via OHHS.
[77] Ibid

Reimbursement Barriers

Stakeholders expressed that insufficient reimbursement rates were seen as a significant barrier to delivering adequate access to EI services, noting that before 2022, there had not been a rate increase since 2002, which had led to a previous loss of 2 EI providers, leaving only 9 providers remaining in the state. Stakeholders acknowledge that the 45% rate increase in 2022 was critically important but perceive that it has not been sufficient to support agencies in hiring and retaining staff members, with many transitioning to other industries or choosing to work in other states with higher payment rates. Related findings include:

- **The 45% EI rate increase in 2022 was a one-time rate increase** and did not include an annual trend increase factor, without which the value of the increase will erode.
- **The rate increase did not include funding for an outreach component,** which many participants believe to be critical to successfully enrolling and retaining Medicaid eligible children.

Eligibility Barriers

Stakeholders did not cite any specific eligibility barriers to access. Stakeholders did note variability in experience and service continuity by school district when transitioning from EI services provided in the community for children under 3 years of age to similar services provided by school departments for children 3 years and older.

TRAUMATIC BRAIN INJURY (TBI) DAY SERVICES

FIGURE 56: ACCESS ANALYSIS FOR TRAUMATIC BRAIN INJURY (TBI) DAY SERVICES

Service		TBI Day Services
Overall Access		Unavailable
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	Contributing Factor
	Service Limitations Barriers	Contributing Factor
	Equity Barriers	-
	Reimbursement Barriers	-
	Eligibility Barriers	Contributing Factor
Data Status		Undetermined

Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

The Governor's Permanent Advisory Commission on Traumatic Brain Injury 2023 Annual Report[78] aligns the current availability of brain injury related services with a three-stage model continuum of care (Acute, Post-Acute, and Medical Supports).[56] The focus of this access assessment is narrowly related to TBI Day services, which, for the purposes of this report, includes both Outpatient and Day Treatment Services, as well as post-acute care provided less than 24/7 wherein those with a TBI can go to a certified facility and receive personalized services including nursing services and case management.[79]

From 2019 to 2022, there were 4,600 distinct children and 15,268 adults with a TBI diagnoses.[80]

Current Status of TBI Day Services In Rhode Island

Overall access to TBI Day services was classified as unavailable, indicating that there were consistently reported findings demonstrating that this service is not available in Rhode Island.

In March 2023, the Governor's Permanent Advisory Commission on Traumatic Brain Injury (the Commission) released its Annual Report, which assessed each service within the current continuum of care for brain injury, including day services.[81] As shown in Figure 57 below which is included in that report, both Outpatient & Day Treatment Services and post-acute care provided less than 24/7 are services that the Commission found to have poor availability.[1]

FIGURE 57: TRAUMATIC BRAIN INJURY CONTINUUM – POST ACUTE CONTINUUM

Post-Acute Care										
Comprehensive Inpatient Rehabilitation Hospital	Sub-Acute Rehabilitation (Specialized Beds)	Transitional Residential Treatment	Skilled Nursing Facility (Specialized Beds)	Long-term residential treatment (24/7 supervision)	**Less than 24/7**	**Outpatient & Day Treatment Services**	Specialized Concussion Treatment Centers	Specialized Mental Health Services	School	Vocational Rehabilitation
Adequate Availability	Improvement Needed	**Poor Availability**	Improvement Needed							

[78] *Report to the Governor and the General Assembly on all matters relating to Traumatic Brain Injury in Rhode Island*. Unpublished. 2023.

[79] Rhode Island Executive Office of Health and Human Services (EOHHS). *RI TBI Injury State Action Plan 2022-2026.* https://health.ri.gov/publications/stateplans/2022-2026TraumaticBrainInjury.pdf

[80] FCG retrieved from the RI Claims Database in June 2023; TBI diagnoses included in analysis are traumatic cerebral edema, diffuse TBI, focal TBI, epidural hemorrhage, traumatic subdural hemorrhage, traumatic subarachnoid hemorrhage, other specified intracranial injuries, unspecified intracranial injury, traumatic brain compression and herniation, personal history of TBI, and any intracranial injury diagnosis.

[81] ibid

The report found significant gaps in the availability of Step-Down/Less than 24-hour supervision services as well as Outpatient and Day Services, citing that "there are zero Brain Injury Day Treatment Program providers in Rhode Island."[82]

Our analysis confirmed that TBI day services are not available in Rhode Island, and that the contributing factors of the lack of access to these services for Rhode Islanders are provider capacity/network constraints, geography, public policy, service limitations and equity barriers are contributing factors.

Data Status

Overall data/reporting status was classified as "Undetermined". Given that there are no TBI day treatment providers in the state, there is therefore no centralized data/reporting on capacity and access to these services.

As part of the Governor's Permanent Advisory Commission on Traumatic Brain Injury, the state has been collecting hospital-level data, but referral lists and demand for access to TBI Day Services do not appear to be centrally tracked or monitored. Additionally, there do not appear to be standardized definitions for "less than 24x7" care to support data collection and reporting.

Findings

Provider Capacity / Network Barriers

Stakeholders frequently cited that TBI Day Services do not exist in Rhode Island, and there is not a sufficient workforce with knowledge of brain injury needs to support individuals with brain injuries. This is further supported by the Commission's finding that "*there is a very small selection of independent providers with specialized knowledge and skills to support mental health challenges of individuals with brain injury. These providers are either not able to accept new patients or have extensive waitlists."*[83] One stakeholder also noted the difficulty in finding neurologists who accept Medicaid coverage.

The lack of TBI day services has led individuals and their families to pursue several different alternative options for finding care which may not be optimal for what the individual needs. Those alternatives include:[84]

- Some individuals remain in their homes, sometimes without the care needed during the day, which may lead to further issues. As the Commission noted in its report, *"the absence of Day Treatment Programming is the primary complaint of current families who are unable to utilize respite programs and often struggle to return or maintain their employment because of their loved one's care needs."*[85]
- Other individuals may be served in a residential nursing facility which allows for more support but is often not the appropriate setting for the individual. There may be implications for staff who may not be trained in providing care for TBI patients who are often younger than the non-TBI nursing home residents. As the Commission's report concluded, "*The absence of providers at this part of the care continuum significantly contributes to the bottleneck of individuals stuck at the transitional and other residential 24-hour supervisory stages of the care continuum*."[86]
- Other adults and children must travel out of state to access services. Stakeholders estimated that at least 90% of the youth and adolescent population go out of state for TBI services, with many encountering care coordination challenges once they return to RI.

As one stakeholder commented, "C*urrently there are no adult day programs for individuals with brain injury in RI. There are a few adult day centers which take Medicaid, but they do not specialize in TBI. As far as day services, there are none."* Another stakeholder indicated that, in the past 6 months, they were aware of approximately 40 individuals who have needed Day Services but could not access them in Rhode Island.

Another stakeholder indicated that, "*We are lacking providers who are specialized in TBI. Many individuals with TBI go out of state. RI has a very small group home that has 3 locations and a total of 30 people. It is very limited in what it provides. We typically send individuals out of state to higher level care facilities because we do not have someone who treats neurobehavioral issues*."

[82] ibid

[83] Rhode Island Governor's Permanent Advisory Committee on Traumatic Brain Injury. Annual Report (2023).

[84] ibid

[85] ibid

[86] ibid

Geographic Barriers

By virtue of the lack of day services for people with TBI in Rhode Island, geography is a barrier to this service. Additionally, stakeholders identified transportation as a challenge for people with TBIs accessing services (e.g., adult day that do not specialize in TBI). Specifically:

- Individuals with RI Medicaid coverage qualify for transportation services provided by the state's Non-Emergency Medical Transportation (NEMT) vendor, MTM, Inc. One stakeholder stated that the state's NEMT vendor does not cross state lines and is not able to provide transportation services to individuals seeking services in other states due to Medicaid not providing reimbursement for out of state trips.[87] However, this is a misperception as there is a list of border communities where MTM is expected to provide rides that are considered in-network for Medicaid purposes as cited in the MTM 2023 Contract.[88] Stakeholder feedback indicates an opportunity for greater understanding about how transportation services can be used to support access issues for an individual needing to see a provider in one of those out of state locations.
- For those with TBIs who do not qualify for NEMT services, the RI RIde Program is available. Stakeholders cited constraints that the service must operate "within a 3/4-mile corridor on either side of a fixed route," thereby posing access implications for individuals who are more rural and live outside of the specified range and may then forgo services.[89]

Public Policy Barriers

Stakeholders highlighted current public policy limitations associated with TBI services, especially as they relate to creating more provider capacity. Advisory Commission members underscored that "*addressing this area is a high priority. BHDDH and EOHHS should provide funding mechanisms for day treatment programs and incentivize participation to increase providers, improving access and quality.*"[1] Similarly, the Commission emphasized that "*The state of Rhode Island has no providers of step-down/less than 24-hour supervision services nor does the state have regulations to guide the provision of this service*."[1]

Service Limitations Barriers

Stakeholders cited concerns with coverage limits for MRI, PT, OT services, and specifically cited the limit on the number of services that can occur per year per patient. One stakeholder described that MRIs for individuals with TBIs are typically capped at 1 per year, but stakeholders noted that individuals with TBI may require more scans. Stakeholders explained that typically the first MRI is paid by insurance; however, any subsequent MRIs would be paid for out of pocket by the patient. Further analysis may be useful to confirm specific authorization policies and procedures with each MCO to inform the prevalence of this service limitation.

Equity Barriers

No equity barriers were cited by stakeholders

Reimbursement Barriers

No reimbursement barriers were cited by stakeholders.

Eligibility Barriers

Stakeholders identified that there are some eligibility barriers that prevent individuals from accessing TBI Day Services. Stakeholders noted that referring to all brain injuries as "TBI" can be limiting as this definition leads to funding being focused on survivors of TBI. Those with Acquired Brain Injury (ABI) may not have the same access to services that TBI survivors have. As this study specifically focused on TBI, additional research may be warranted to gather data to validate and understand the breadth of access constraints for those with ABI.

[87] Rhode Island Executive Office of Health and Human Services (EOHHS). Contract Between State of Rhode Island EOHHS and Medical Transportation Management, Inc. for Transportation Brokerage Services (2023). (p. 340). https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-06/MTM%202023-00%20NEMT%20Contract_2023-04-28_fully%20executed_20230510.pdf

[88] Ibid

[89] RI Ride Paratransit Program. https://www.ripta.com/ride-paratransit-program/#

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

FIGURE 58: ACCESS ANALYSIS FOR NEMT

Service		NEMT
Overall Access		Somewhat Limited
Access Dimensions	**Provider Capacity/ Network Barriers**	Contributing Factor
	Geographic Barriers	Contributing Factor
	Public Policy Barriers	-
	Service Limitations Barriers	-
	Equity Barriers	-
	Reimbursement Barriers	-
	Eligibility Barriers	-
Data Status		Somewhat Limited

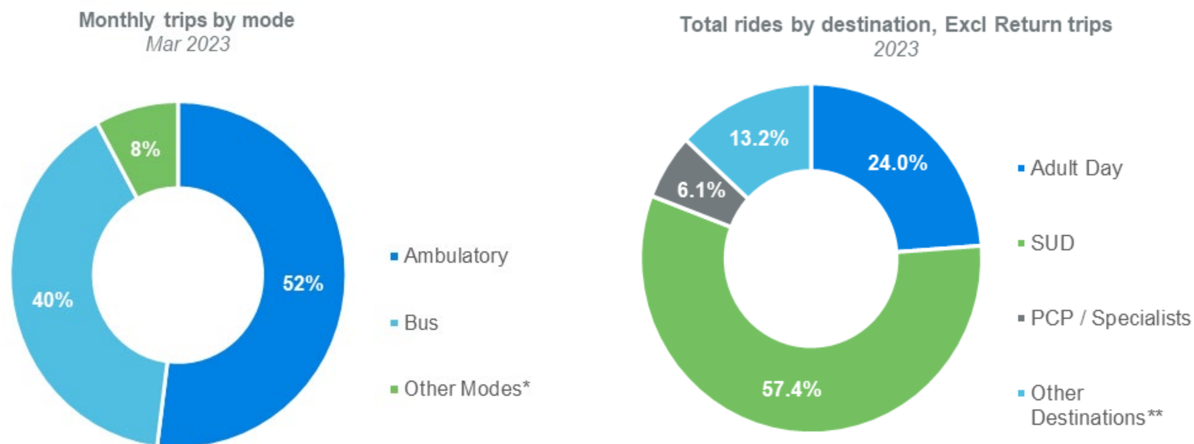
Note that the dash indicates this access dimension was not identified as an issue in the research.

Service Definition

Rhode Island's NEMT services are provided through its vendor, MTM. MTM coordinates with qualified transportation providers to provide rides to Medicaid members to and from Medicaid-covered service appointments when they are in need of transportation.[90]

For eligible Medicaid members, MTM provides transportation services through the following modes: ambulatory, bus, stretcher, and wheelchair. The most recent data indicates that 92% of monthly MTM trips are either ambulatory or bus transportation, as shown in Figure 59.[91] MTM also provides transportation to activities including SUD treatment (57% of transports), Adult Day (24% of transports), PCP/Specialist appointments (6% of transports), as well as other eligible destinations as needed.

FIGURE 59: TRANSPORTATION OVERVIEW[92]



* “Other modes” category includes stretcher, wheelchair, and ambulance (8%); mileage reimbursement; and ride share.
** “Other destinations” category includes BH (13.2%), cancer treatment, dialysis, and others.

[90] Rhode Island Executive Office of Health and Human Services (EOHHS). *Scheduling a Trip – Rhode Island’s Non-Emergency Medical Transportation Services.* https://eohhs.ri.gov/Consumer/TransportationServices.aspx

[91] Ibid

[92] Ibid

Current Status of NEMT Service in Rhode Island

Overall access to NEMT services was classified as somewhat limited, indicating that there was limited access within specific subcategories or populations and access constraints were inconsistently reported. Provider capacity and geography were identified as contributing factors of barriers to access to NEMT services.

There are discrepancies between findings from qualitative stakeholder interviews and the data provided by EOHHS about MTM services, with stakeholders identifying more significant access gaps than the data suggests.

Stakeholders suggested that some individuals may no longer attempt to seek services through MTM due to prior issues with securing a ride and that this would not be captured in the access data provided. One stakeholder commented, "*We receive a lot of data from NEMT, but it may not be reflective of what is happening. Community Health Workers (CHWs) see a lot of people who have given up and don't even try to access NEMT anymore. People are bypassing it all together because of bad experiences*."

Many stakeholders interviewed cited transportation issues as a critical limiting factor, if not the most limiting factor, where a regular, reliable source of transportation is a driver of access to services. There appear to be limitations in access among the services evaluated for this report in certain geographies within the state, and effort is required for agencies and providers to coordinate with MTM to ensure transportation services are available in a timely and consistent manner.

Data Status

Overall, the data and reporting status was classified as somewhat limited, indicating that access data is centrally tracked, services are consistently defined, but there are specific/narrow data limitations that limit access assessment, notably regarding geography.

MTM provides regular reporting across key measures of access statewide to EOHHS, and EOHHS tracks this performance via a standardized dashboard. There are two important limitations to this dashboard:

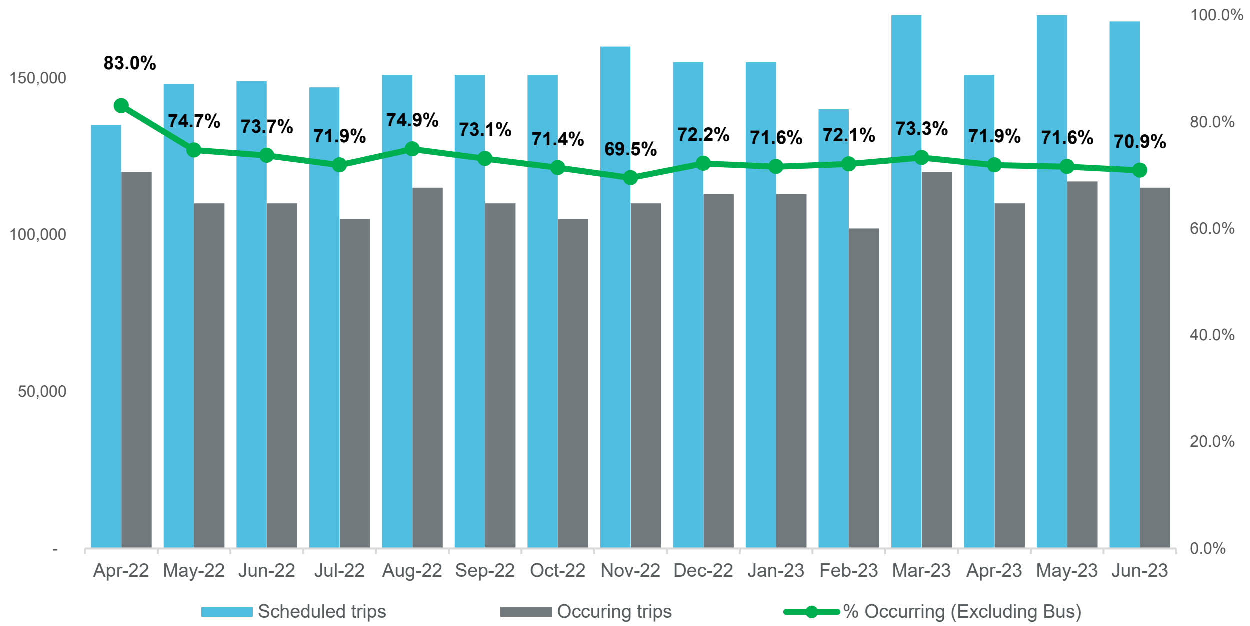
- The MTM team was not able to provide the data broken down by geography. Based on the consistent feedback from stakeholders indicating that there are certain geographical areas in the state where transportation is very limited, this would be an area to consider incorporating into the dashboard as an access and equity consideration, and;
- Some data may be absent as stakeholders reported that they are aware of individuals who no longer request transportation, even if they are in need of it, because of negative past experiences.

Findings

Provider Capacity / Network Barriers

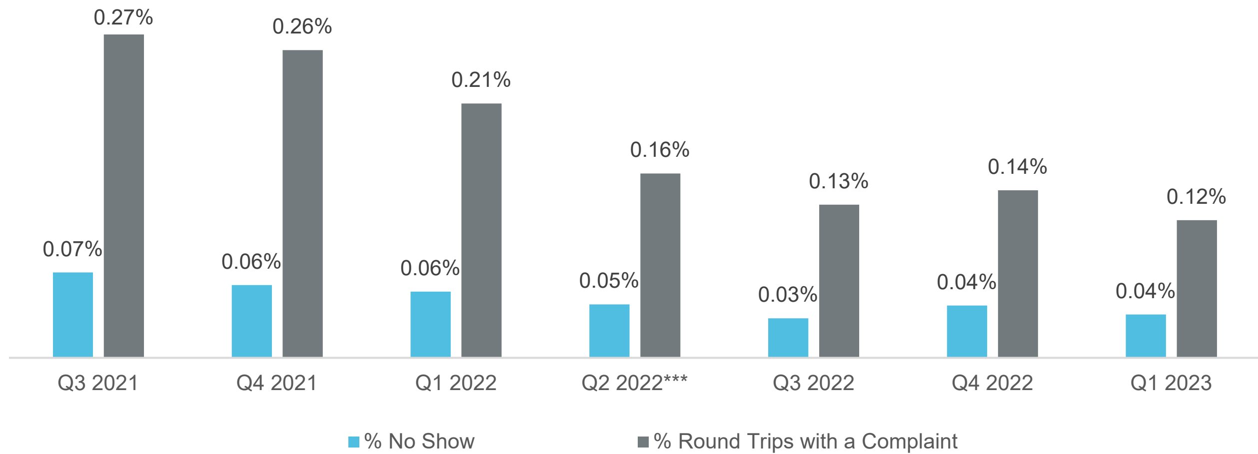
As shown in Figure 60, data provided by MTM to EOHHS indicates that MTM provides 175,000-201,000 trips per month and that approximately 70% of monthly scheduled trips are completed/occur.

FIGURE 60: SCHEDULED AND OCCURRING TRIPS BY MONTH (EXCLUDING BUS TRIPS)[93]



Additionally, since Q1 2022, less than a quarter of a percent (≤0.21%) of all trips have complaints filed associated with that trip, with percentages declining over time. No-show drivers were reported in 0.04% of trips as of Q1 2023, reflecting 85 rides. 270 (0.12%) total rides received a complaint in Q1 2023. (Figure 61)

FIGURE 61: ACCESS FINDINGS: COMPLAINTS AND NO SHOWS – 2021 - 2023[94]



***June 2022 excluded due to lack of No-Show data.

[93] State of Rhode Island MTM Oversight Report. (July 20, 2023).

[94] State of Rhode Island MTM Oversight Report. (April 25, 2023).

In contrast, stakeholders from interviews across a variety of services cited transportation as a key barrier to access based on patient experiences with the service. Stakeholders cited anecdotal instances in which MTM transportation providers did not pick up patients and/or drop them off at the incorrect location. In some cases, agencies opted to have a staff member transport patients to medical appointments or pay out of pocket for a cab, Uber, or Lyft to provide transportation services, due to vendor transportation issues and concerns. One stakeholder shared an instance where MTM was short of drivers so utilized a ride-share service to transport an individual with dementia. The individual requested to be dropped off at a different location rather than the intended location. The provider grew concerned that the individual had not arrived on time and called to redirect the driver to the appropriate location. These situations have reportedly led to patients to elect not to utilize the service. This anecdotal information is contrary to the data as presented in Figures 60 and 61. Further analysis would help to understand the existence and extent of challenges as compared to data presented in this report.

The agencies that reported the most success utilizing NEMT services noted that they have dedicated time to establishing a relationship with MTM and/or had a staff member whose time was focused on transportation coordination. One stakeholder commented: "*MTM is the big umbrella, and they hire different providers. It's a big, messy system, but somehow it works well. It creates a lot of stress, but it exists and I'm thankful for that*."

Geographic Barriers

Stakeholders across service areas frequently cited geography as a barrier in accessing transportation services for Rhode Islanders, especially for those who live in communities where transportation vendor availability is limited or completely unavailable.

Stakeholders cited examples such as Aquidneck Island, South County, and Jamestown as being among the most challenging locations for securing reliable transportation services; some stakeholders also mentioned rural areas in the northern and western parts of the state can also be challenging for transportation access.

Public Policy Barriers

Stakeholders did not cite specific barriers related to public policy.

Service Limitations Barriers

Stakeholders did not cite specific barriers related to service limitations.

Equity Barriers

Although not formally assessed as part of this study, stakeholders noted that there is a lack of wheelchair and stretcher accessibility in the state, estimating that they thought there were 1-2 vans in Rhode Island that can support individuals who have additional mobility needs. Data was not available to confirm this anecdotal information. Further research is necessary to independently confirm the stakeholders' perceptions.

Reimbursement Barriers

Participants did not cite any specific reimbursement barriers.

Eligibility Barriers

Participants did not cite any specific eligibility barriers.

Summary

This report presents the results of analysis of the state of access to services for selected programs, including description of identified state-maintained waiting lists, maintenance processes and informal waitlists. Services selected for review were identified primarily through stakeholder engagement and limited available data. These services were categorized into four domains: adult behavioral health services, child and adolescent behavioral health services, home and community-based services (HCBS), and other services.

Analysis indicates that many of the evaluated services may have opportunities for improving access to services. Selected categories of access barriers were ranked based on stakeholder input and available data.

As a significant portion of the evaluated services did not have data for quantitative analysis, further research may be warranted to validate stakeholder perceptions, understand root causes, and/or determine the value of establishing standardized data reporting for service access monitoring and evaluation. Additionally, consumer perspectives were not included in the stakeholder process and research into client experience and perspectives and insights may also inform further conclusions on access.

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 EOHHS 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.

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.

APPENDIX A

LIST OF INTERVIEWEES

All qualitative stakeholder interviews were conducted between May 21, 2023 – July 6, 2023

Access Study Services / Interview Session	Agency / Organization	Interview Date(s)
Access Study Methodology	Advisory Committee Member Organizations	May 22, 2023 June 1, 2023 (2 sessions) June 15, 2023 June 21, 2023
Data Review	State SMEs Group	June 7, 2023
Adult BH	State SMEs Group	May 31, 2023 June 2, 2023
	Newport County Community Mental Health Care	June 26, 2023
	Oasis Wellness and Recovery Center	June 26, 2023
	Community Care RI	June 26, 2023
	Family Service of Rhode Island (FSRI)	June 26, 2023
	National Alliance on Mental Illness (NAMI) RI	June 26, 2023
Child and Adolescent BH	State SMEs Group	May 31, 2023 June 2, 2023 June 15, 2023
	Rhode Island Coalition for Children and Families	June 26, 2023
	Family Service of Rhode Island (FSRI)	June 26, 2023
	Looking Upwards	June 26, 2023
	Newport County Community Mental Health Care	June 26, 2023
	Oasis Wellness and Recovery Center	June 26, 2023
	Community Care RI	June 26, 2023
	National Alliance on Mental Illness (NAMI) RI	June 26, 2023
Private Duty Nursing and Personal Care	State SMEs Group	May 31, 2023
	BAYADA Home Health Care	June 29, 2023
	Hearts for Home Care	June 29, 2023

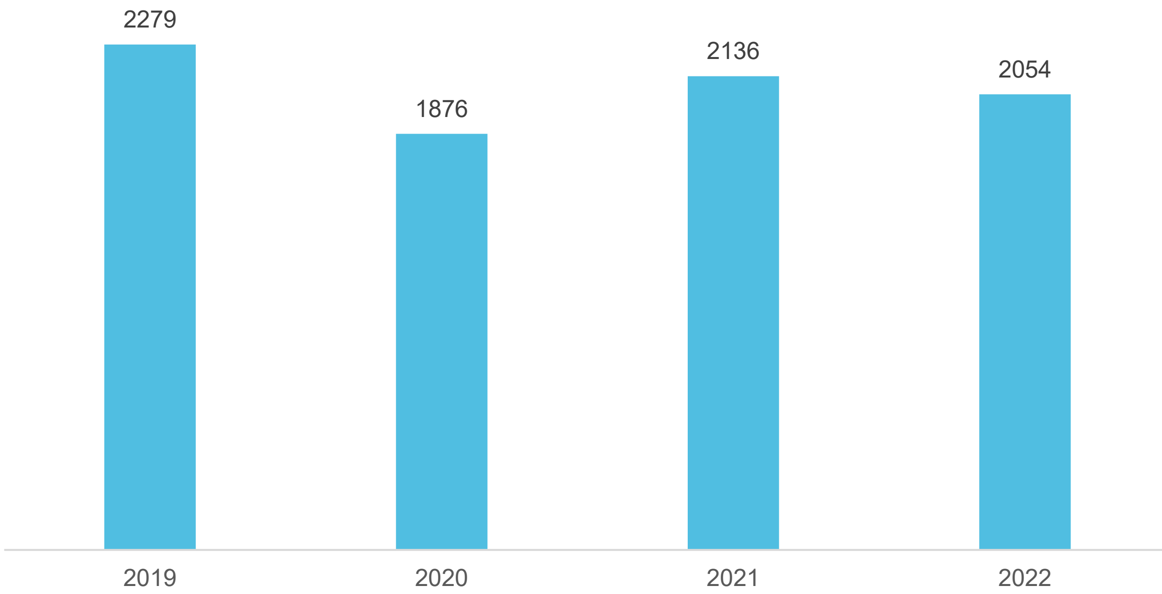
Access Study Services / Interview Session	Agency / Organization	Interview Date(s)
	Maxim Healthcare Group	June 29, 2023
	Home Health Care and Hospice Care Rhode Island	June 29, 2023
	Homecare Advantage	June 29, 2023
Assisted Living	State SMEs Group	May 31, 2023
	LeadingAge RI	June 29, 2023
	Rhode Island Assisted Living Association (RIALA)	June 29, 2023
	St. Elizabeth	June 29, 2023
Adult Day Care	State SMEs Group	May 31, 2023
	LeadingAge RI	June 23, 2023
	St. Elizabeth	June 23, 2023
	Hope Alzheimer's Center	June 26, 2023
Intellectual/Developmental Disability	State SMEs Group	May 31, 2023
	Looking Upwards	June 21, 2023
	Community Provider Network of Rhode Island (CPNRI)	June 21, 2023
	Seven Hills Rhode Island	June 21, 2023
	Frank Olean Center	June 21, 2023
	West Bay RI	June 21, 2023
Early Intervention	Family Service of Rhode Island (FSRI)	June 26, 2023
	Looking Upwards	June 26, 2023
Traumatic Brain Injury	State SMEs Group	May 31, 2023
	Rhode Island Department of Health (RIDOH)	June 26, 2023
	Brain Injury Association of Rhode Island (BIARI)	June 26, 2023
	Sargent Rehabilitation Center	June 26, 2023
	RI Elder Info	June 26, 2023
	Ocean State Center for Independent Living (OSCIL)	June 26, 2023
Substance Use Disorder	State SMEs Group	May 31, 2023 June 2, 2023 June 16, 2023

Access Study Services / Interview Session	Agency / Organization	Interview Date(s)
	The Sentinel Group, LLC	June 27, 2023 July 6, 2023
	AdCare	July 6, 2023
	CODAC	July 6, 2023
Managed Care Organization	Rhode Island Office of the Health Insurance Commissioner (OHIC)	June 27, 2023
	Rhode Island Executive Office of Health and Human Services (OHHS)	June 27, 2023
	Neighborhood Health Plan	June 27, 2023
	United Healthcare	June 27, 2023
	Tufts Health Plan	June 27, 2023
Overall Services Access	Rhode Island Parent Information Network (RIPIN)	June 30, 2023
HCBS Services	AgeFriendly RI	June 30, 2023

APPENDIX B

DISTINCT MEDICAID (MEDICAID ONLY) BENEFICIARIES ACCESSING RESIDENTIAL SUD TREATMENT, STATEWIDE, 2019-2022[95]

Adults

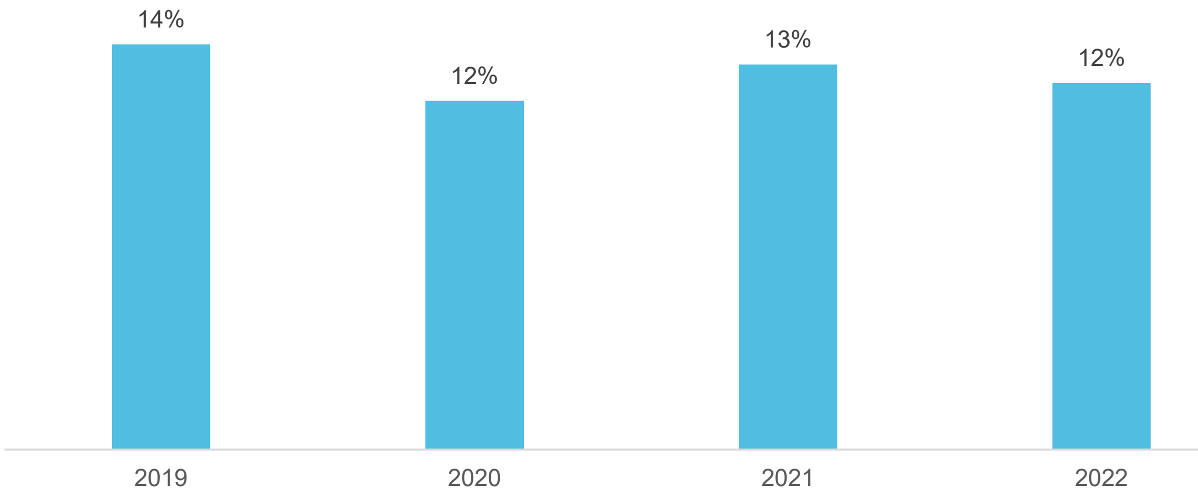


[95] FCG retrieved from the RI Medicaid Claims Database in July 2023.

APPENDIX C

MEDICAID (MEDICAID ONLY) BENEFICIARIES WITH A SUD PRIMARY DX ACCESSING RESIDENTIAL SUD TREATMENT, STATEWIDE, 2019-2022[96]

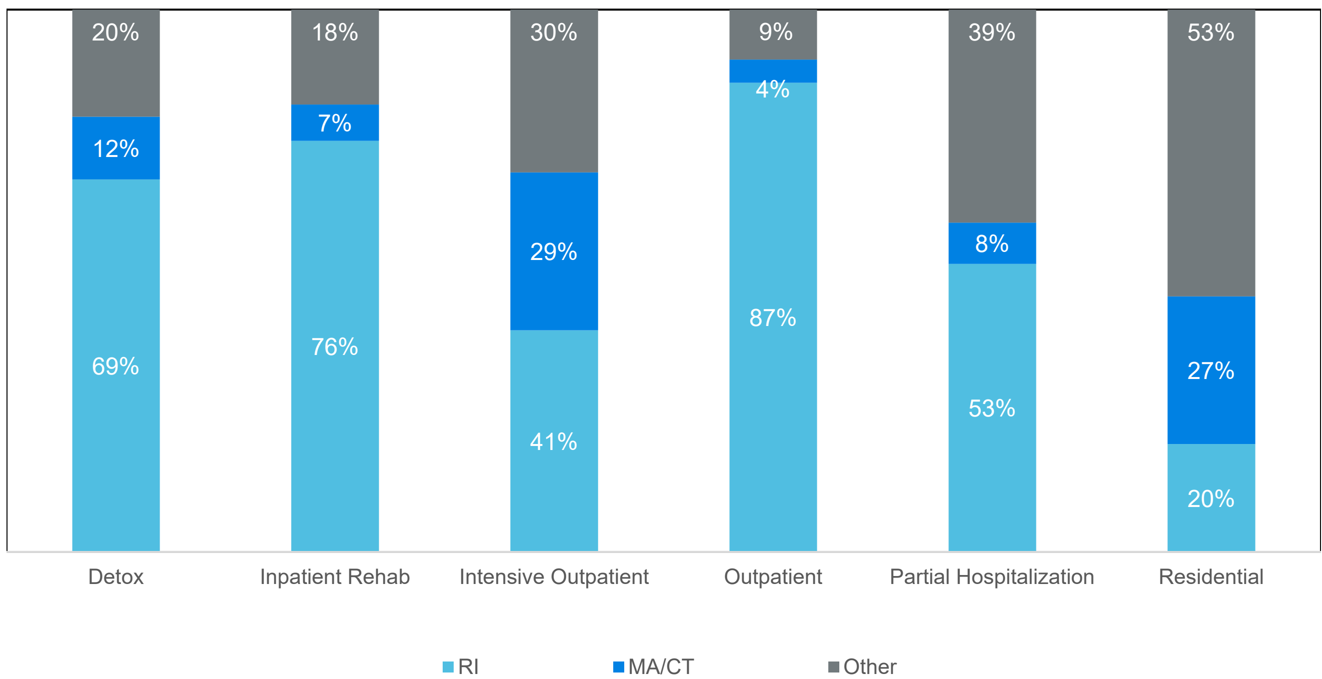
Adults



[96] FCG retrieved from the RI Medicaid Claims Database in July 2023.

APPENDIX D

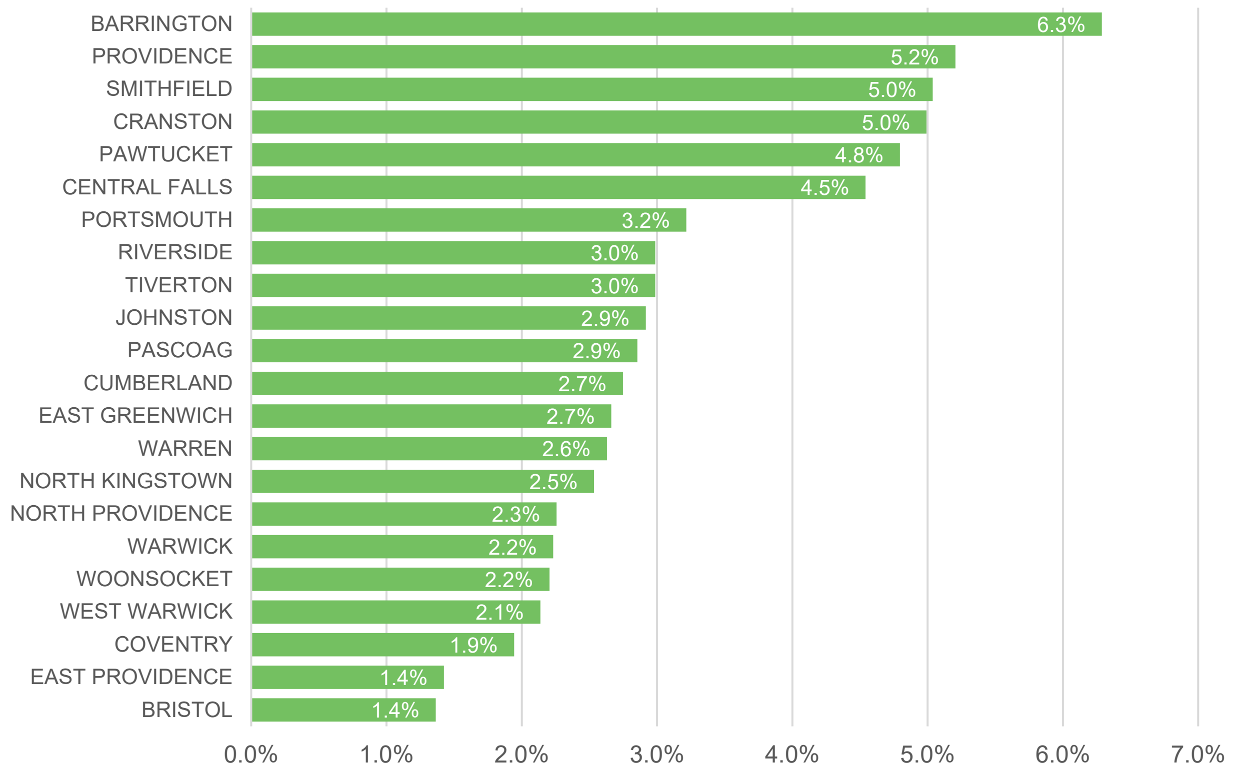
DISTINCT RI USERS BY SERVICE TYPE FOR SUD FACILITIES BY LOCATION, RI APCD, 2017-2019[97]



[97] RI APCD Data Pull, Freedman Healthcare, November 2020; only including commercial or Medicare-paid services. Substance use admissions has an average of 1,217 distinct patients per year, and mental health admissions has an average of 3,750 distinct patients per year. Note: "Commercial" refers to fully insured only. APCD Data excludes those insured by hospital confinement, disability income, accident-only claims, long-term care, Medicare supplement, limited benefit health insurance, specified disease indemnity, and other limited benefit policies. Data is also excluded from the following sources: commercial insurance plans with fewer than 3,000 covered lives in RI; dental insurance; federal programs including TRICARE, FEHBP< DVA, and the Indian Health Service; payments made out-of-pocket; and non-claims-related payments.

APPENDIX E

SHARE (%) OF MEDICAID/MEDICARE DUAL ELIGIBLE INDIVIDUALS ACCESSING ADULT DAY SERVICES (STATEWIDE, 2019-2022)*[98]

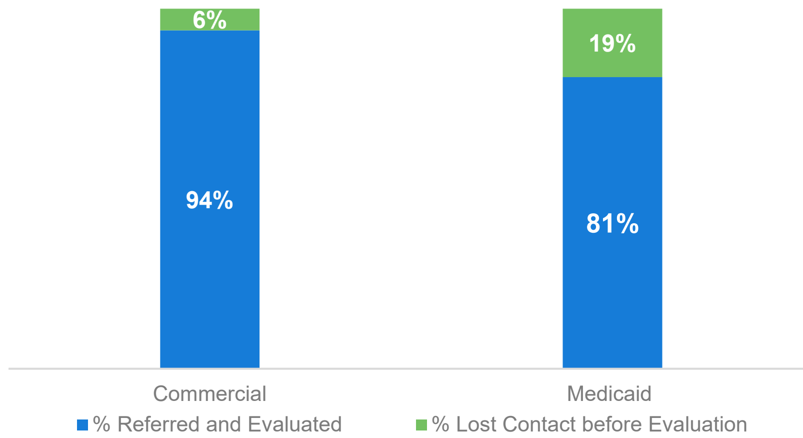


*Excludes cities/towns where less than 20 dual eligible individuals are utilizing adult day services.

[98] FCG retrieved from the RI Medicaid Claims Database in July 2023.

APPENDIX F

LOST CONTACT BY PROVIDER BEFORE ENROLLMENT IN EI SERVICES - % OF CHILDREN, AUGUST 2022 – APRIL 2023[99]



[99] Data retrieved from the RI State Early Intervention Data System (2021) via OHHS