OHIC Social and Human Service Program Review: 2025 Update to Report #7: Access to Programs

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Executive Summary

In August 2023, Milliman Inc published a report titled, *Report 7 - Social and Human Service Programs Review: Access to Programs* ("Report 7") on behalf of the State of Rhode Island's Office of the Health Insurance Commissioner (OHIC).[1] This was the seventh assessment out of nine required by State of Rhode Island General Laws (RIGL) § 42-14.5-3(t) covering various rate and programmatic elements of the social and human service programs.

Faulkner Consulting Group (FCG) supported the original access assessment and has been contracted by Milliman Inc. to deliver the 2025 update to *Report 7 - Social and Human Services Programs Review: Access to Programs,* for OHIC to submit to the legislature by April 1, 2025.[2]

Qualitative research conducted as part of Report 7 suggested substantive barriers to access across most service categories included in the study. In most cases, this assessment was constrained by the availability of consistently defined, centrally tracked data to measure access. As shown in the exhibit below, only three of the eighteen service categories had data available to track access to those services over time, whereas ten services had either no data available or data was highly limited.

Starting point: Report 7 (2023) resulted in the following assessment of access

Exhibit 1. Report 7 Assessment of Services

			Access Barriers *Qualitative Status*	Quantitative Data Availability
Adult Behavioral Health	1	Counseling, psychotherapy	Highly Limited	Highly Limited
	2	Intensive outpatient (including MH + SUD)	Highly Limited	**Unavailable**
	3	Mobile crisis	Highly Limited	Undetermined
	4	Residential mental health	Highly Limited	Highly Limited
	5	Residential SUD treatment	Highly Limited	Somewhat Limited
Children's Behavioral Health	6	Counseling, psychotherapy	Highly Limited	Highly Limited
	7	Enhanced Intensive OP (MH & SUD including DCYF)	Highly Limited	Highly Limited
	8	Mobile crisis	Somewhat Limited	Generally Available
	9	Residential mental health	Highly Limited	Highly Limited
	10	Residential SUD treatment	Highly Limited	Undetermined
Home & Community Based (HCBS)	11	Adult day	Somewhat Limited	Highly Limited
	12	Assisted living	Highly Limited	Highly Limited
	13	Private Duty Nursing (PDN)	Highly Limited	Highly Limited
	14	Personal Care	Highly Limited	Generally Available
IDD Services	15	I/DD services for children & adults	Highly Limited	Highly Limited
Other	16	Early intervention services (children under 3)	Somewhat Limited	Generally Available
	17	Traumatic brain injury (TBI) day services	**Unavailable**	Undetermined
	18	Non-emergency medical transportation (NEMT)	Somewhat Limited	Somewhat Limited

[1] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[2] This report will use "Report 7" for short when referring back to the 2023 report.

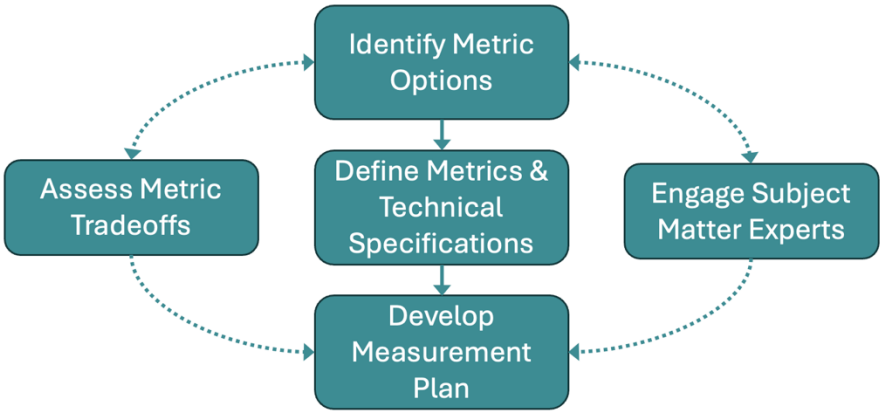
To update Report 7 (2023) in the 2025 biennial cycle, OHIC selected three services categorized as having "highly limited" quantitative data for further assessment:[3]

1. Residential Mental Health for Adults[4]
2. Assisted Living Services
3. Intellectual/Developmental Disability Services for Adults

One or two metrics of access are recommended for each service type. Each metric is accompanied by an assessment of its strengths and weaknesses within the Rhode Island context, and a measurement plan with action steps for data collection and reporting processes**.** Key tasks included (1) identifying and defining access metrics, (2) assessing measurement opportunities and barriers, and (3) developing actionable recommendations with data collection and reporting plans.

Methodology: For each of these three service areas FCG conducted an iterative, five step process to document a set of metrics, as shown in Exhibit 2 below.

Exhibit 2. Methodology – Iterative Five Step Process



FCG used this process to identify, evaluate, and finalize actionable metrics to enhance access measurement for the three service areas of focus. The process began with an assessment of Rhode Island's current data landscape, as outlined in Report 7 (2023),[5] and supplemented by research of publicly available information to identify viable metric options. Where relevant stewarded measures or national/state benchmarks were available they were included, and where none were available, Rhode Island-specific metrics were proposed to ensure relevance and feasibility. FCG created a shortlist of potential metrics based on these evaluations.

FCG then engaged subject matter experts (SMEs) to refine the shortlisted metrics and measurement plans. This included reviewing existing data collection systems, identifying reporting processes, and addressing barriers to implementation. Based on SME feedback, the options were further narrowed to one or two optimal or feasible

[3] The scope of this report has been limited to three of the 18 services assessed in Report 7 (2023) due to resource constraints.
[4] Note, for the purposes of defining and recommending service-specific access metrics, Residential Mental Health for Adults has been refined to include three Mental Health Psychiatric Rehabilitative Residences (MHPRR) settings. Additional information on these settings is available in the Methodology section of this report.
[5] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

metrics for each service type. To guide policymakers in understanding the strengths and weaknesses of these metrics, FCG developed criteria to assess tradeoffs between optimization and feasibility.

Finally, the recommendations were finalized by conducting an additional review with SMEs to validate the metrics and associated measurement plans. FCG outlined actionable steps for data collection and reporting to operationalize these metrics effectively. This comprehensive methodology ensures the selected metrics are robust, contextually appropriate, and designed to improve access measurement in Rhode Island.

Through this iterative research process, leveraging extensive local SME engagement, the team assessed access barriers and opportunities, and selected the "best possible" measures of access for each service, as listed in Exhibit 3, below.

Findings: Key Access Barriers and Opportunities

- **Residential Mental Health:** Improving provider response and assessment processing time was identified as a key opportunity to improve access to Mental Health Psychiatric Rehabilitative Residences (MHPRR). Without understanding time from application approval to referral for provider interview and time from referral to placement, it is challenging to identify potential staff shortages or system limitations that delay provider processing time. Provider capacity was also identified as a key access barrier to MHPRR services. By reporting average time on waitlists by level of need (e.g., MHPRR setting), the state could better quantify the type of provider capacity needed to reduce wait time for clients.
- **Assisted Living:** Several barriers identified as contributing to limited access to assisted living services relate to limited capacity available for Medicaid recipients. While Rhode Island has data on the share of Assisted Living Residences (ALRs) that are Medicaid enrolled and potential unit capacity by residence through licensure data, the state cannot determine how many beds at any point in time are filled with a Medicaid participant, nor do they know whether a vacant bed will be filled by a Medicaid participant or whether the ALR will choose to fill it with a privately paying individual. Stakeholders noted that some providers may only accept private pay individuals that are in the processes of spending down and will eventually be transitioned to Medicaid as their sole payer.[6] Without data on cross-payer capacity and residence availability to Medicaid recipients by licensure type (special care/dementia, limited health services) and geography, it is challenging to understand which type of ALR capacity is needed and where to improve access.
- **Intellectual and Developmental Disability (I/DD) Services for Adults:** Report 7 (2023) highlights several barriers as contributing to limited access to DD specific waiver services, many of which point to fragmented systems.[7] For example, different service delivery systems can lead to confusion and potential inequities in access. By monitoring timely access to assessment and service by service delivery system (e.g., fee for service vs managed care) the state will be able to quantify these challenges and propose targeted interventions.

[6] Executive Office of Health and Human Service Email to Jessica Brown. (February 4, 2025)
[7] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

Exhibit 3. Recommended Access Measures [8]

Residential Mental Health for Adults
Metric #1: MHPRR Placement Processing Timeline • **Sub-measure #1A:** Average number of days from application approval to BHDDH referral for initial evaluation interview by provider • **Sub-measure #1B:** Average number of days from BHDDH referral to provider denial • **Sub-measure #1C:** Average number of days from BHDDH referral to MHPRR placement
Metric #2: Average time on waiting list: Average number of days on waiting list
Assisted Living Services [9]
Metric #3: Rhode Island ALR Capacity Index • **Sub-measure #3A:** Bed capacity: total staffed, filled, available per State-Licensed Assisted Living Residence • **Sub-measure #3B:** Share of residences accepting Medicaid clients (moment in time indicator) • **Sub-measure #3C:** Total staffed ALR beds per 1000 adults age 75+
Intellectual/Developmental Disability Services for Adults
Metric #4: Time to I/DD Assessment & Service • **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment • **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider • **Sub-measure #4C**: Share of individuals who received supplemental funding through an S109[10]
Metric #5: I/DD Service Capacity & Delivery • **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist by DD specific waiver service • **Sub-measure #5B:** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services

Each of these metrics is supported by a set of **Technical Specifications** including recommended measurement period, numerator/denominator definitions, exclusions, proposed metric stratifications, and metric limitations. This report also specifies a recommended **Measurement Plan** for each metric, including the primary data reporter, data collection method, lead agency for data monitoring, and a public reporting method.

These five measures were identified and assessed as "best possible" based on the following criteria:

1. **Aligned with Service Opportunities**– Does the measure directly address the access barriers identified in Report 7 (2023)?
2. **Actionable** – Is a steward/national or state benchmark be available for this service? Is the measure used by other states? Is the measure comprehensive, or does it require multiple data caveats or supplemental data to interpret access?
3. **Technical feasibility –** Is the data for this measure already being collected? Is the data collection process automated? Is there an existing standardized reporting process that can be leveraged?
4. **Ease of implementation -** Can the measure be implemented with little to no additional burden on providers? On State staff? Would an investment be required to implement the measure?

[8] Note, Metric #2 is the recommended measure requiring calculation. For all other metrics, only sub-measures require calculation, and the metric is used as a title to represent the scope.
[9] Note, based on input from subject matter experts, only one Assisted Living access metric was identified as a viable option, as opposed to two identified for the other services. Additional ALR metrics have been included in the Findings section of this report for future consideration.
[10] Note S109 funding is also referred to as "L9"

The results of this assessment are summarized in the exhibit below.

Exhibit 4. Summary Assessment of Recommended Measures

Assessment Key: Indicator of alignment with Domain Criteria[11]		Optimal Alignment		Moderate Alignment	Limited Alignment	
		Residential MH		ALR Services	I/DD Services	
Domain	Domain Criteria	#1	#2	#3	#4	#5
1. Aligned with Service Opportunities	1.1. Metric Addresses Access Barriers					
	1.2. Advances Health Equity					
2. Actionable	2.1. Steward, State/ National Benchmark					
	2.2. Used by Other States					
	2.3. Minimal Measure Limitations					
3. Technical Feasibility	3.1. Data/System Availability					
	3.2. Existing Reporting Processes					
4. Ease of Implementation	4.1. Provider Admin Burden					
	4.2. State Admin Burden					
	4.3. Investment Required					

Key Learnings from this Assessment

- No measure received a perfect score, in that all had tradeoffs across the four criteria and all had some limitations.
- All measures were carefully selected to align with the barriers and opportunities identified for each included service. Access barriers were identified in Report 7 (2023) and further specified in this assessment.[12]
- There were very few instances of available data stewards or well-defined national benchmarks. Most recommended metrics were tailored from relevant stewards or benchmarks to suit each service area within the Rhode Island context.
- Most measures had an available technical starting point – either an existing data collection mechanism or reporting process.
- New/additional administrative resources will likely be required to support the reporting and analysis for these recommended measures.

Several external and evolving factors, including shifting federal and state priorities, may impact the implementation and sustainability of the proposed access metrics. Resource constraints may require a phased

[11] These categories are further defined in Exhibit 9 later in the Report.
[12] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

approach to data collection and reporting. Nonetheless, ongoing state initiatives, such as implementation of Wellsky, the State's LTSS case management system, the EOHHS Data Ecosystem, and the Health Care System Planning initiative, present opportunities to enhance efficiency and support the integration of access metrics across service areas.

Next Steps

This report recommends specific access metrics and measurement plans for implementation of these metrics. If adopted/approved by Rhode Island leaders, relevant agencies would need to be assigned specific responsibilities for reporting and monitoring access measurements. These agencies would need to establish workflows and allocate resources to implement these metrics.

While this report focuses on just three of the 18 service categories evaluated in Report 7 (2023),[13] the approach demonstrated here could be applied to the other 15 service areas. This would allow for a complete assessment of quantitative access metrics across all services examined in Report 7 (2023), along with implementation plans for each.

After reporting begins and additional measures are established across a broader set of service categories, a monitoring dashboard could be created to track access changes and improvements that occur as the rate recommendations developed through State of Rhode Island General Laws (RIGL) § 42-14.5-3(t) covering various rate and programmatic elements of the social and human service programs take effect.

It's important to note that these recommendations are based on available data, subject matter expertise, and professional analysis as of submission. If implementing agencies adopt and tailor data collection and reporting processes for these recommendations, they should account for any changes to underlying assumptions or operations that may have occurred since this report was drafted.

[13] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

Background

In August 2023, Milliman Inc published a report titled, *Report 7 - Social and Human Service Programs Review: Access to Programs* on behalf of the State of Rhode Island's Office of the Health Insurance Commissioner (OHIC).[14] This was the seventh assessment out of nine required by State of Rhode Island General Laws (RIGL) § 42-14.5-3(t) covering various rate and programmatic elements of the social and human service programs.

Faulkner Consulting Group (FCG) supported the original access assessment and has been contracted by Milliman Inc. to deliver the 2025 update to *Report 7 - Social and Human Services Programs Review: Access to Programs,* referred to as "Report 7", for OHIC to submit to the legislature by April 1, 2025.

Qualitative research conducted as part of Report 7 (2023) suggested substantive barriers to access across most service categories included in the study. In most cases, this assessment was constrained by the availability of consistently defined, centrally tracked data to measure access. As shown in the exhibit below, only three of the eighteen service categories had data available to track access to those services over time, whereas ten services had either no data available or data was highly limited.

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Exhibit 5. Report 7 Assessment of Services

			Access Barriers *Qualitative Status*	Quantitative Data Availability
Adult Behavioral Health	1	Counseling, psychotherapy	Highly Limited	Highly Limited
	2	Intensive outpatient (including MH + SUD)	Highly Limited	**Unavailable**
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[14] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

Objective: Recognizing significant gaps in quantitative data and the need for reliable, standardized reporting to inform capacity assessments and evaluate the impact of rate recommendations on service access, this project builds on existing findings with the goal of improving Rhode Island's data collection and reporting processes for access metrics.

To update Report 7 (2023) in the 2025 biennial cycle, OHIC selected three services categorized as having "highly limited" quantitative data for further assessment:[15]

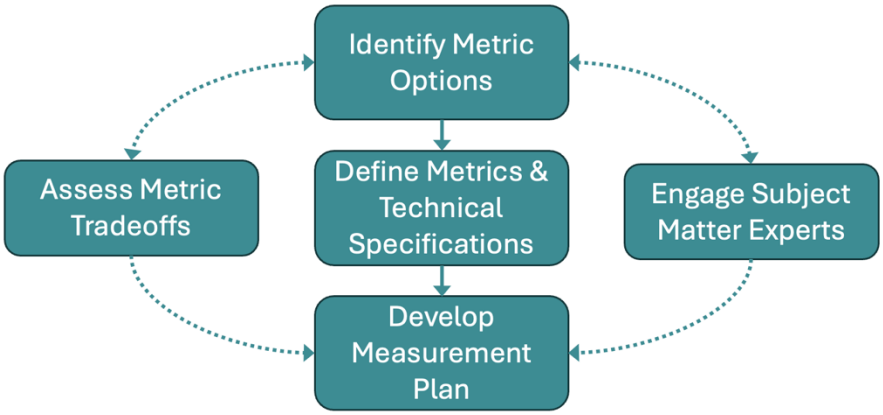
1. Residential Mental Health for Adults
2. Assisted Living Services
3. Intellectual/Developmental Disability Services for Adults

One or two measures of access are recommended for each service type. Each measure is accompanied by an assessment of the metrics strengths and weaknesses within the Rhode Island context, and a measurement plan with action steps for data collection and reporting processes**.** Key tasks included (1) identifying and defining access metrics, (2) assessing measurement opportunities and barriers, and (3) developing actionable recommendations with data collection and reporting plans.

Methodology

For each of these three service areas FCG conducted an iterative, five step process to document a set of metrics, as shown in Exhibit 6 below.

Exhibit 6. Methodology



The team continuously refined the metrics considered, definitions and technical specifications based on input from subject matter experts and iterative assessment of metric tradeoffs.

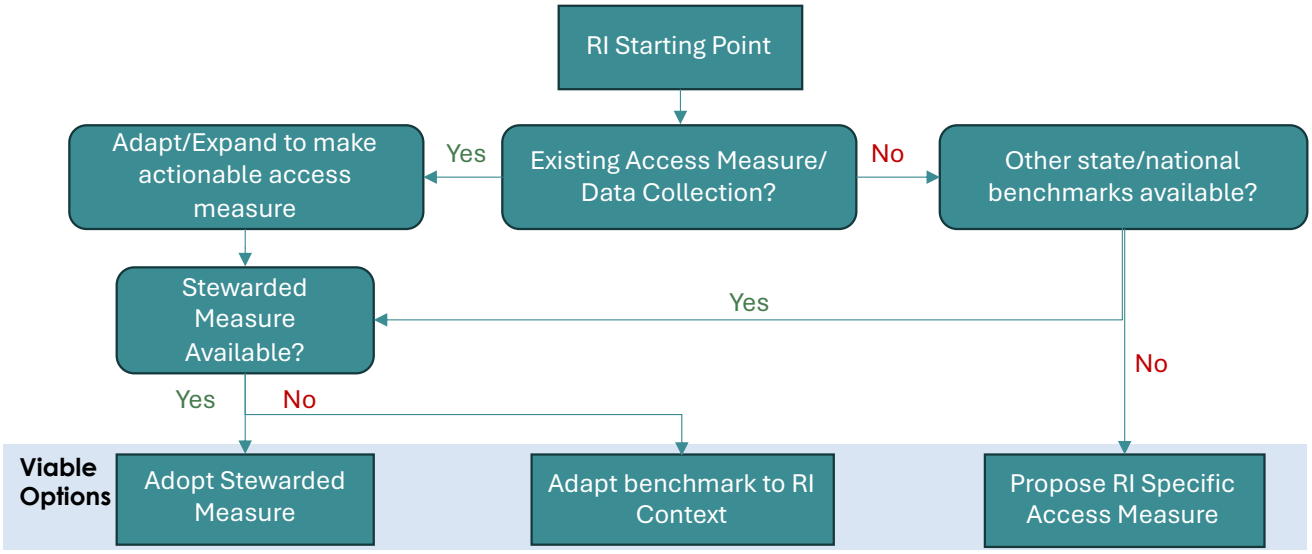
1. Identify Metric Options

For the purposes of this report, we began by identifying a suite of viable metric options for each service. We assessed the "Rhode Island Starting Point" for each service based on Report 7 (2023) findings, and publicly available information. From this research, possible metrics were classified as either a stewarded measure

[15] The scope of this report has been limited to three of the 18 services assessed in Report 7 (2023) due to resource constraints.

available for Rhode Island to implement, or a state/national benchmark available to adapt to the Rhode Island context, or, if neither were available, a Rhode Island-specific access measure.

Exhibit 7. Metric Option Identification



2. Engage Subject Matter Experts

FCG brought forward a short list of viable options to assess with subject matter experts (SMEs). Through this process, we further defined existing data collection and reporting processes, identified relevant systems in use and plans for new systems to be implemented, and ruled out or refined metric/measurement plan options based on SME input. From these findings, we narrowed metric options to one (1) to two (2) measures for each service that are optimal and/or feasible.

Exhibit 8. Subject Matter Experts Engaged

Service	Subject Matter Experts
Residential Mental Health	**Jamie Goulet,** Director, Data Unit, BHDDH
	Christine Emond, Director of Interdepartmental Services, BHDDH
	Tom Martin, Director, Division of Behavioral Healthcare, BHDDH*
Assisted Living	**Jim Nyberg**, Public Consulting Group (former ED of LeadingAge RI)
	Maureen Maigret, Advocate
	Karen Statser, Program Director MFP, EOHHS*
I/DD	**Kevin Savage,** Director, Division of Developmental Disabilities, BHDDH*
	Carrie Miranda, Executive Director, Looking Upwards
Cross-cutting HCBS (Assisted Living & I/DD)	**Amy Hulberg**, Medicaid Policy Director, EOHHS
	Sophie Asah, Chief of Strategic Planning, Monitoring and Evaluation, EOHHS
	Patricia Arruda, Interdepartmental Medicaid Project Manager, EOHHS*

**Subject matter expert identified to conduct final review of metrics and measurement plans*

3. *Define Metrics & Technical Specification*

Service Definitions for Access Measures

Starting with the findings in Report 7 (2023), FCG narrowed the scope of services for the purposes of this report to focus on specific service types or settings identified as particularly difficult to access.[16] Definitions for this report are:

Residential Mental Health for Adults is defined to include three Mental Health Psychiatric Rehabilitative Residences (MHPRR) settings. These MHPRR settings are defined below according to the States BHO Rules and Regulations and are overseen by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH).[17]

1. **Mental Health Psychiatric Rehabilitative Residence (Basic MHPRR):** a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing
2. **Specialized Mental Health Psychiatric Rehabilitative Residence (Specialized MHPRR):** a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing for populations with complex co-occurring conditions in which the clients receive a wide range of care management, co-occurring treatment of substance use and mental health, psychiatric rehabilitation and individual care services.
3. **Enhanced Mental Health Psychiatric Rehabilitative Residence (E-MHPRR):** congregate licensed residential program with no more than nine (9) beds that provides 24/7 services to individuals who meet the admission and eligibility criteria.[18] [19]

Assisted Living Services are broadly defined as those received while residing in a State Licensed Assisted Living Residence (ALR). The Rhode Island Medicaid program covers assisted living in ALRs that are certified to provide long-term services and support (LTSS) services, also referred to as Medicaid-enrolled residences.[20] Report 7 (2023) highlights access to placement in ALRs as a primary concern, specifically for individuals receiving Medicaid.[21] Therefore, the access metrics recommended for Assisted Living are focused on measuring access to placement in a residence.

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[16] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[17] Rules and Regulations for Behavioral Healthcare Organizations. 212-RICR-10-10-01 (2023). https://rules.sos.ri.gov/Regulations/part/212-10-10-01?reg_id=12974

[18] Ibid.

[19] Additional MHPRR-related settings included in the BHO rules and regulations include Supportive Mental Health Psychiatric Rehabilitative Residence Apartments and On-site Supportive Psychiatric Rehabilitative Apartments. These settings follow HUD rules and regulations and providers identify clients and make referrals. Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Jessica Brown. (February 18, 2025).

[20] Rhode Island's 1115 Waiver defines Assisted Living HCBS as: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility; but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

[21] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

Intellectual and Developmental Disability Services for Adults are defined as HCBS waiver services available to BHDDH eligible I/DD adults, aged 18 and older. The following service types are available:

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

Technical Specifications

To promote streamlined implementation and reporting of the recommended access measures, each of the following components have been defined for of each measure:

- Measurement Period
- Denominator
- Numerator
- Exclusions
- Proposed measure stratifications & variables needed
- Measure Limitations

4. Assess Metric Tradeoffs

Assessment criteria were developed to identify strengths and weaknesses of final metric options to give policy makers a tool to understand the tradeoffs between optimizing a measure and relative feasibility.

We confirmed and finalized recommendations by identifying one or two experts for each service to complete a final review of metrics and measurement plans.

5. Develop Measurement Plan & Action Steps

FCG documented a measurement plan for each metric to specify the potential data collection approach and reporting responsibilities, with substantive input from SMEs. Measurement plans identify the primary data reporter, the data collection method, the lead agency for data monitoring, the public reporting method, and whether the measure is payer-specific (e.g., measuring access for Medicaid recipients only) or cross-payer.

Additionally, each measurement plan is supplemented by a short description of action steps, including the data collection and public reporting processes. In most cases the numerator and denominator show the calculation required and how the measurement plan would work if/when implemented.

Exhibit 9. Metric Assessment Criteria

Domain	Domain Criteria	Optimal Alignment	Moderate Alignment	Limited Alignment
	1.1. Metric Addresses Access Barriers	Addresses access barriers identified in Report 7 - Social and	Partially addresses access barriers identified	Does not address access barriers identified

Domain	Domain Criteria	Optimal Alignment	Moderate Alignment	Limited Alignment
1. Aligned with Service opportunities		Human Service Programs Review: Access to Programs (2023)		
	1.2. Advances Health Equity	Metric enables identification of service-specific access disparities in need of additional resources	Metric enables identification of access disparities	Metric does not allow for identification of access disparities
2. Actionable	2.1. Steward or State/ National Benchmark	Stewarded measure	Stewarded or state/ national benchmark adapted to RI context	No steward available / No state or national benchmark
	2.2. Used by Other States	Used by 2+ other states	Used by one other state	No evidence measure is used by another state
	2.3. Minimal Measure Limitations [22]	Comprehensive measure of access, with limited additional data needed for context	Comprehensive measure, requires contextual data	Narrow measure, requires multiple additional measures / data caveats to interpret access
3. Technical Feasibility	3.1. Data/System Availability	All data for recommended measure is being collected, system is in place to collect data	Portion of data available or some systems are in place to collect data, additional data needed	No existing data available or system in place to collect data for recommended measure
	3.2. Existing Reporting Processes	Existing public platform for reporting of relevant data	Existing platform for reporting data, additional resources needed to make data publicly available	No existing platform, resources needed to formalize regular public reporting process
4. Ease of Implementation	4.1. Provider Admin Burden	No additional burden	Some additional burden	New reporting process required
	4.2. State Admin Burden	No additional burden	Some additional burden	New reporting process required
	4.3. Investment Required	No additional investment required	Small investment anticipated	Larger investment anticipated

[22] Measure limitations outside of small sample limitations inherent to Rhode Island's population size.

Findings

Residential Mental Health for Adults

Introduction and Context

In 2023, Report 7 to the legislature identified overall access and access data for Residential Mental Health (RMH) Services, specifically Mental Health Psychiatric Rehabilitative Residences (MHPRR), also known as Group Homes, as highly limited.[23] Key factors contributing to limited access were provider capacity and network barriers. See below the status of RMH data per Report 7 (2023), [24] followed by an update based on research and interviews conducted over the course of this project.

Data Status from Report 7: Social and Human Service Programs Review: Access to Programs (2023)
Highly Limited

- Services are consistently defined but access data is not centrally tracked
- RI has a centralized database (RI Behavioral Health Open Beds (BHOB)) that tracks and monitors behavioral health services capacity however the database does not include mental health residential beds (MHPRR).
- BHDDH tracks mental health residential beds separately.

2025 update to "Data Status" based on recent learnings:

- Licensed behavioral healthcare organizations (BHOs) are required to submit all of their behavioral healthcare clients' admission, discharge and event data into the State's Behavioral Health On-Line Database (BHOLD).[25] This database is considered an adequate centralized data source for eligibility, admissions, discharges, demographics, and diagnoses.[26]
- A monthly report is submitted to the Governor's Behavioral Health Council tracking the MHPRR waiting list (compiled using data from BHOLD).
- The MHPRR wait lists are tracked manually by the Behavioral Health Division of BHDDH and this is the most accurate source for waitlist data. Tom Martin, Director of BH Division at BHDDH, and his team review client cases every two (2) weeks to manage the waiting list (e.g., to track referrals, denials, and placements).

Recommended Metrics [27]

Exhibit 10. Residential Mental Health Metric Methodology

RI Starting Point	**Yes**, existing data collection and MHPRR waitlist and discharge reporting to Governors Council on Behavioral Health (not publicly available)

[23] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.
[24] Ibid.
[25] Reporting Requirements | State of Rhode Island Dept. of Behavioral Healthcare, Developmental Disabilities, and Hospitals.
[26] Interviews with Jamie/Thomas Martin
[27] Additional measures were explored but not recommended. These measures are organized by service in Appendix B with a brief explanation of why they were not pursued.

Stewarded Measure Available	**No,** there are no nationally stewarded measures specific to residential mental health access	
Relevant Benchmark or Stewarded Measure (to be adapted to RI Context)	**Relevant Steward:** • **CCBHC I-SERV:** The I-SERV measure calculates the average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure. The I-SERV measure is comprised of three sub-measures of time until provision of: (1) initial evaluation, (2) initial clinical services, and (3) crisis services.[28] **Relevant State/National Benchmark:** • **Time from referral to treatment (RTT)** is a similar measure referenced in several international studies for various types of healthcare services.[29] [30] [31] [32]	**Relevant State/National Benchmark:** • **Average wait time to placement** was recently used in an assessment completed by Massachusetts DMH to recommend 500 group home living placements be built.[33] Additionally, in a study to address the shortage of inpatient BH beds in Los Angeles, CA a key recommendation was to develop a dashboard with bed capacity, utilization trends, and wait time by level of care, as this was identified as an oversight data gap.[34]
	Relevant stewarded measure adapted to RI Context: I-SERV sub-measures 1, 2	**State/National Benchmark adapted to RI Context: Average wait time**
Metric	**Metric #1: MHPRR Placement Processing Timeline** **Sub-measure #1A:** Average number of days from application approval to BHDDH referral for initial evaluation interview by provider[35] **Sub-measure #1B:** Average number of days from BHDDH referral to provider denial[36] **Sub-measure #1C:** Average number of days from BHDDH referral to MHPRR placement	**Metric #2: Average time on MHPRR waiting list** Average number of days on waiting list

[28] Substance Abuse and Mental Health Services Administration: *Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual*. Substance Abuse and Mental Health Services Administration, 2024.
[29] (2024). Waiting times for elective (non-urgent) treatment: referral to treatment (RTT). *The King's Fund*.
[30] Hayes, H., Meacock, R., Stokes, J., & Sutton, M. (2024). The effect of local hospital waiting times on GP referrals for suspected cancer. *PloS one*, *19*(5), e0294061.
[31] Waldrop, T. (2019). The Truth on Wait Times in Universal Coverage Systems. *The Center for American Progress*.
[32] Lewis, A.K., Harding, K.E., Snowdon, D.A. *et al.* (2018). Reducing wait time from referral to first visit for community outpatient services may contribute to better health outcomes: a systematic review. *BMC Health Serv Res* 18, 869
[33] Walsh, K.E., & Doyle, B. (2023). Strategies to Reduce Wait Times and Enhance Access to Behavioral Health Services. *Massachusetts Department of Mental Health*.
[34] Wong, L.H. (2024). ESTABLISHING A ROADMAP TO ADDRESS THE MENTAL HEALTH BED SHORTAGE (ITEM NO. 41-D, AGENDA OF JANUARY 24, 2023). County of Los Angeles Department of Mental Health.
[35] At the time of application approval the client is placed on the MHPRR waiting list. BHDDH referral occurs when an MHPRR bed becomes available, and the next client on the waiting list is referred to the provider for evaluation prior to placement.
[36] Providers may issue a denial if they deem the client is not an appropriate match for the facility. The alternative to denial is placement.

Access Barriers and Opportunities	• Improving provider response and assessment processing time was identified through interviews as a goal to improve access to MHPRR services • Without an understanding of time from application submission to interview and to placement it is challenging to identify potential staff shortages or system limitations that are delaying provider processing time.	• Provider capacity was identified in Report 7 (2023) and through interviews as key access barrier to MHPRR services.[37] • By reporting average time on waitlists by level of need (e.g., MHPRR setting) and gender, in particular, the state could better quantify the type of provider capacity needed to reduce wait time for clients.
Key Metric Distinctions	• Adapted from stewarded measure with technical specifications • Sources data from a single existing automated data collection system without reliance on manual updates • Captures provider processing time between BHDDH referral and denial or placement, not captured by Metric #2	• Benchmarked measure, generally used in access assessments • Sources data from existing BHDDH maintained MHPRR waiting lists

Technical Specifications

Below are the technical specifications for the Residential Mental Health metrics, specific to evaluating MHPRR access.

Exhibit 11. Residential Mental Health Metrics – Technical Specifications

Metric	**Metric #1: MHPRR Placement Processing Timeline** **Sub-measure #1A:** Average number of days from application approval to BHDDH referral for initial evaluation interview by provider [38] **Sub-measure #1B:** Average number of days from BHDDH referral to provider denial [39] **Sub-measure #1C:** Average number of days from BHDDH referral to MHPRR placement	**Metric #2: Average time on MHPRR waiting list** Average number of days on waiting list
Measurement Period	**Year / Annual Reporting**	**Quarter / Quarterly Reporting & Annual Reporting**

[37] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[38] At the time of application approval the client is placed on the MHPRR waiting list. BHDDH referral occurs when an MHPRR bed becomes available, and the next client on the waiting list is referred to the provider for evaluation prior to placement.

[39] Providers may issue a denial if they deem the client is not an appropriate match for the facility. The alternative to denial is placement.

Denominator	**Sub-measure #1A & #1C**: Sum of clients who submitted an approved MHPRR application during the Measurement Year [40] **Sub-measure #1B:** Sum of clients who submitted an approved MHPRR application during the Measurement Year and were issued a denial by a provider	**Metric #2:** Sum of clients who received placement into an MHPRR during the quarter (placement: moved into MHPRR)
Numerator	**Sub-measure #1A:** Among the denominator population, the total number of days between application approval and BHDDH referral to provider for the initial evaluation interview **Sub-measure #1B:** Among the denominator population, the total number of days between BHDDH referral and provider denial **Sub-measure #1C:** Among the denominator population, the total number of days between application approval and MHPRR placement	**Metric #2:** Among the denominator population, the total number of days between being added to and removed from the waitlist (e.g., approved application to placement)
Exclusions [41]	**Sub-measures #1A - #1C**: Cases where a referral from BHDDH was not issued **Sub-measure #1C:** Cases where placement did not occur during the measurement period	

Proposed Metric Stratifications [42]	• Required stratifications:
	  • By setting (before placement)
	  • By DYCF referral for youth in transition[43]
	  • By provider
	  • Level of care needed (e.g., MHPRR, Specialized MHPRR)[44]
	  • By new vs returning client[45]
	  Race/Ethnicity/Language
	  • Gender
	• Required stratification for sub-measure #1C
	  • By denial issued (Yes/No)
		• Required stratifications:
		  • By setting (before placement)
		  • By provider
		  • Level of care needed (e.g., MHPRR, Specialized MHPRR, Enhanced-MHPRR)
		  • Gender
		• Recommended stratifications, as available:
		  • Medicaid Only or Dually Eligible for Medicaid and Medicare

[40] Note, the Measurement Period for the denominator, as defined by the technical specifications for the I-SERV measure, is the Measurement Year, excluding the final month of that year, and including the 6 months preceding the Measurement Year. The Measurement Period for the numerator is the 12-month Measurement Year.
[41] It is recommended BHDDH caveat reporting of this measure with the number of excluded cases and the average number of days these clients have been waiting for placement.
[42] Challenges reporting certain recommended measure stratifications may arise as a result of small sample size. Reporting may require certain groups of data be aggregated to avoid HIPAA violation.
[43] It is recommended youth in transition be reported separately from other applicants to identify any disparities in timely access. See Metric #1 Metric Limitations for additional information on referrals and applications from DCYF.
[44] Enhanced Mental Health Psychiatric Rehabilitative Residence (E-MHPRR) would not be captured by Metric #1 because the BHOLD system is not yet capturing data for these settings.
[45] Returning clients are defined as those who were discharged from an MHPRR within the year prior to the relevant application submission.

	• Recommended stratifications, as available: • Medicaid Only or Dually Eligible for Medicaid and Medicare	• Race/Ethnicity/Language[46] (not currently available)
Metric Limitations	Public reporting of these metrics should caveat the following: • There is necessary prioritization among individuals waiting for services to comply with the federal Olmstead decision, which found that unjustified segregation of people with disabilities is a form of unlawful discrimination.[47] Therefore, certain individuals in highly restrictive settings prior to placement will necessarily have shorter wait times than others. BHDDHs priority policy, as documented in Report 7 (2023), is available in Appendix A for reference.[48] • In addition to necessary prioritization as referenced above, there are also "best fit" placement considerations, meaning BHDDH and providers need to consider the appropriate milieu for each client, which can further delay placement.[49] [50] • Current data collection does not permit identification of cases where timely access is delayed due to client choice.	
	Additional caveats to publicly reporting Metric #1: • The BHOLD system does not currently capture client data for Enhanced-MHPRRs (E-MHPRRs), the setting designed for clients with the highest intensity need. Therefore, time from referral to placement is not available for individual's seeking services in these settings. • Referrals and applications from DCYF for youth in transition to adult services are often submitted early (e.g., 6 months prior to the clients 21st birthday) and BHDDH processes these applications with the aim of making a referral in advance of the clients 21st birthday, as it is challenging to identify the appropriate placement for youth this age. To account for this complication, it is recommended BHDDH report DCYF referrals separately from other referrals on Metric #1, specifically sub-measure 1A (time from application submission to evaluation interview).	Additional caveats to publicly reporting Metric #2: • BHDDH monitors waiting lists for Basic MHPRR, Specialized MHPRR, and Enhanced-MHPRR settings. Waiting lists for On-Site Supportive Psychiatric Rehabilitative Apartments and Supportive MHPRR Apartments are managed by the Department of Housing and Urban Development (HUD), therefore BHDDH will need to caveat access reporting to note this limitation.[51] [52] • Additionally, BHDDH manually tracks waiting lists for Enhanced-MHPRRs independently of other settings (e.g., does not receive manual reports from E-MHPRRs providers on their waitlist), therefore incorporating wait times for these services may require additional analysis by BHDDH.

[46] Race, ethnicity, and language data are not available using the current waiting list management system. Martin, T. (2025, January 31). Personal communication.
[47] Olmstead v. L.C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/case.pdf
[48] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.
[49] Goulet, J., Emond, C. (2025, January 09). Personal communication.
[50] Martin, T. (2025, January 14). Personal communication.
[51] Goulet, J. (2025, January 09). Personal communication.
[52] Martin, T. (2025, January 14). Personal communication.

Measurement Plans

Exhibit 12. Residential Mental Health - Measurement Plans

Metric	**Metric #1: MHPRR Placement Processing Timeline** **Sub-measure #1A:** Average number of days from application approval to BHDDH referral for initial evaluation interview by provider [53] **Sub-measure #1B:** Average number of days from BHDDH referral to provider denial [54] **Sub-measure #1C:** Average number of days from BHDDH referral to MHPRR placement	**Metric #2: Average time on MHPRR waiting list** Average number of days on waiting list
Primary data reporter	• BH Division, BHDDH (date of application approval and referral) • MHPRR Providers (date of denial and placement)	• BH Division, BHDDH maintains waiting list for Basic MHPRR, Specialized MHPRR, and E-MHPRRs
Data collection method	**Data Collection Method**: • BHDDH documents date of application approval and referral in BHOLD • Provider documents date of denial and placement in BHOLD • BHDDH pulls records from BHOLD to assess time between key metric dates	**Data Collection Method:** • BHDDH conducts analysis of waiting list data to identify those who received placement during the reporting period and assesses time between waitlist entry and exit dates for this population.
Lead agency *for data monitoring & public reporting method*	**Lead Agency:** BHDDH, Division of Behavioral Health **Data Reporting:** existing process via update to Governors Council on Behavioral Health; additional reporting recommended to BHDDH website	**Lead Agency:** BHDDH, Division of Behavioral Health **Data Reporting:** existing process via monthly update to Governors Council on Behavioral Health; additional reporting recommended to BHDDH website
Single or cross-payer	Cross Payer – Medicaid, Dual, Other	Cross Payer – Medicaid, Dual, Other

Recommended metrics for Residential Mental Health services are similarly aimed at monitoring average time to placement, however, Metric #1 captures provider processing time by distinctly identifying time from BHDDH referral to provider denial and to placement, whereas Metric #2 more directly builds off existing waiting list reporting to the Governors' Council on Behavioral Health by calculating average time on these waiting lists. Below is an assessment of each measure against the assessment criteria defined in our Methodology section, considering the Rhode Island barriers and opportunities identified through SME interviews and research.

[53] At the time of application approval the client is placed on the MHPRR waiting list. BHDDH referral occurs when an MHPRR bed becomes available, and the next client on the waiting list is referred to the provider for evaluation prior to placement.
[54] Providers may issue a denial if they deem the client is not an appropriate match for the facility. The alternative to denial is placement.

Assessment Criteria

Exhibit 13. Residential Mental Health Assessment Criteria

Domain	Domain Criteria	Metric #1: MHPRR Placement Processing Timeline	Metric #2: Average time on MHPRR waiting list
1. Aligned with Service Opportunities	1.1. Metric Addresses Access Barriers		
	1.2. Advances Health Equity		
2. Actionable	2.1. Steward or State/ National Benchmark		
	2.2. Used by Other States	*undetermined*	
	2.3. Minimal Measure Limitations		
3. Technical Feasibility	3.1. Data/System Availability		
	3.2. Existing Reporting Processes		
4. Ease of Implementation	4.1. Provider Admin Burden		
	4.2. State Admin Burden		
	4.3. Investment Required		

Assessment Criteria – Explained (Metric #1)

Metric #1: MHPRR Placement Processing Timeline

Sub-measure #1A: Average number of days from application approval to BHDDH referral for initial evaluation interview by provider[55]

Sub-measure #1B: Average number of days from BHDDH referral to provider denial[56]

Sub-measure #1C: Average number of days from BHDDH referral to MHPRR placement

[55] At the time of application approval the client is placed on the MHPRR waiting list. BHDDH referral occurs when an MHPRR bed becomes available, and the next client on the waiting list is referred to the provider for evaluation prior to placement.

[56] Providers may issue a denial if they deem the client is not an appropriate match for the facility. The alternative to denial is placement.

Exhibit 14. Residential Mental Health Metric #1 Explained

Domain	Domain Criteria		Metric #1: MHPRR Placement Processing Timeline
1. Aligned with Service Opportunities	**1.1. Metric Addresses Access Barriers** [57]		• Improving provider response and assessment processing time was identified through interviews as a goal to improve access to MHPRR services – by reporting time from BHDDH referral to provider denial or to client placement, BHDDH will have insight into how provider processing time varies by MHPRR setting and by provider. This data could promote identification of provider best practices with respect to application/waitlist administration and processing, as well as identification of staff shortages or system limitations that are delaying processing time.[58]
	1.2. Advances Health Equity		• Data stratified by factors such as age, race, ethnicity, language, and in particular gender and level of need will enable BHDDH to identify potential differences in access between populations and key capacity gaps. Stratified data can also inform the design and adoption of quality improvement initiatives that address the drivers of disparities experienced by underserved populations.[59]
2. Actionable	**2.1. Steward or State/ National Benchmark**		• Metric #1 is an adaptation of the CMS stewarded measure for CCBHCs, I-SERV sub-measures 1 and 2. This measure required alterations to make sense in the context of Rhode Island residential mental health, but working off of existing technical specifications allowed for a comprehensive measure definition to be recommended. • Time from referral to treatment (RTT) is a similar measure referenced in several international studies for various types of healthcare services.[60] [61] [62] [63]
	2.2. Used by Other States		• Undetermined – given the specificity of this measure in how it has been adapted to the RI process, it's unclear if other states report it, however, states generally report average time to service for residential services. See examples noted for Metric #2.

[57] Note, in addition to the access barriers identified for residential mental health services in Report 7, access concerns highlighted in interviews have also been considered in the assessment of RMH Metric #1
[58] Martin, T. (2025, January 14). Personal communication.
[59] Tsai, D. (2024). Home and Community-Based Services (HCBS) Quality Measure Set (QMS) Reporting Requirements for Money Follows the Person (MFP) Demonstration Grant Recipients. *Center for Medicare and Medicaid Services*.
[60] (2024). Waiting times for elective (non-urgent) treatment: referral to treatment (RTT). *The King's Fund*.
[61] Hayes, H., Meacock, R., Stokes, J., & Sutton, M. (2024). The effect of local hospital waiting times on GP referrals for suspected cancer. *PloS one*, *19*(5), e0294061.
[62] Waldrop, T. (2019). The Truth on Wait Times in Universal Coverage Systems. *The Center for American Progress*.
[63] Lewis, A.K., Harding, K.E., Snowdon, D.A. *et al.* (2018). Reducing wait time from referral to first visit for community outpatient services may contribute to better health outcomes: a systematic review. *BMC Health Serv Res* 18, 869

Domain	Domain Criteria		Metric #1: MHPRR Placement Processing Timeline
	2.3. Minimal Measure Limitations		Publicly accessible data should caveat the following: • The BHOLD system does not currently capture client data for Enhanced-MHPRRs (E-MHPRRs), the setting designed for clients with the highest intensity need. Therefore, time from referral to placement is not available for individual's seeking services in these settings. • Referrals and applications from DCYF for youth in transition to adult services are often submitted early (e.g., 6 months prior to the clients 21st birthday) and BHDDH processes these applications with the aim of making a referral in advance of the clients 21st birthday, as it is challenging to identify the appropriate placement for youth this age. To account for this complication, it is recommended BHDDH report DCYF referrals separately from other referrals on Metric #1, specifically sub-measure 1A (time from application submission to evaluation interview).[64] • There is necessary prioritization among individuals waiting for services to comply with the federal Olmstead decision, which found that unjustified segregation of people with disabilities is a form of unlawful discrimination.[65] Therefore, certain individuals in highly restrictive settings prior to placement will necessarily have shorter wait times than others. BHDDHs priority policy, as documented in Report 7 (2023), is available in Appendix A for reference.[66] • In addition to necessary prioritization as referenced above, there are also "best fit" placement considerations, meaning BHDDH and providers need to consider the appropriate milieu for each client, which can further delay placement.[67] [68] • Current data collection does not permit identification of cases where timely access is delayed due to client choice.
3. Technical Feasibility	**3.1. Data/ System Availability**		• Source of all data needed for metric (application approval, BHDDH referral, denial, and placement date, as well as population details/measure stratifications): Behavioral Health On-Line Database (BHOLD) – required reporting from all BH licensed providers, automated for most MHPRRs. BHOLD is a robust enrollment-based data source.
	3.2. Existing Reporting Processes		• Standing monthly report to Governors Council on Behavioral Health (not publicly available) – reports 1) aggregate # on waitlist, monthly trend beginning July 2024, 2) monthly

[64] Martin, T. (2025, January 31). Personal communication.
[65] Olmstead v. L.C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/case.pdf
[66] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.
[67] Goulet, J., Emond, C., (2025, January 09). Personal communication.
[68] Martin, T. (2025, January 14). Personal communication.

Domain	Domain Criteria		Metric #1: MHPRR Placement Processing Timeline
			discharges from MHPRR group homes, and 3) number of clients awaiting medically and behaviorally intensive E-MHPRRs • Recommended public reporting would require additional processing to translate Governors' Council data to page on BHDDHs website and to add annual reporting on Metric #1
4. Ease of Implementation	**4.1. Provider Admin Burden**		• Given existing data/system availability and reporting - implementation of measure/measurement plan will not put additional administrative burden on providers
	4.2. State Admin Burden		• Given existing data/system availability and reporting - implementation of measure/measurement plan should require minimal coordination between Division of BH and Data/IT Unit at BHDDH
	4.3. Investment Required		• Investment could be needed to maintain publicly accessible reporting on BHDDH website

Measurement Plan Action Steps - Metric #1 [69]

Action Steps:

Metric #1: MHPRR Placement Processing Timeline

Sub-measure #1A: Average number of days from application approval to BHDDH referral for initial evaluation interview by provider [70]

Sub-measure #1B: Average number of days from BHDDH referral to provider denial [71]

Sub-measure #1C: Average number of days from BHDDH referral to MHPRR placement

Data Collection Process:

1. BHDDH, Division of Behavioral Health documents the date of MHPRR application approval in BHOLD, and adds the individual to the MHPRR waiting list - **Clock "start" date (sub-measure #1A)**
2. When an open bed becomes available BHDDH refers the next individual on the waiting list to the provider for an evaluation interview to ensure MHPRR placement in the providers residence is clinically appropriate – **Referral is clock "end" date (sub-measure #1A), clock "start" date (sub-measures #1B, #1C)**
3. The provider issues a denial if they deem the client is not an appropriate match for the facility – **Clock "end" date (sub-measure #1B)**
4. If the provider deems the setting is clinically appropriate for the applicant and the applicant agrees, they provide BHDDH with a tentative placement date

[69] Proposed action steps are intended to provide color to measurement plans and are a simplified representation of the workflow expected to report each metric.

[70] At the time of application approval the client is placed on the MHPRR waiting list. BHDDH referral occurs when an MHPRR bed becomes available, and the next client on the waiting list is referred to the provider for evaluation prior to placement.

[71] Providers may issue a denial if they deem the client is not an appropriate match for the facility. The alternative to denial is placement.

5. When the individual is moved into an MHPRR facility, the provider documents the official date of placement - **Clock "end" date (sub-measure #1C)**

Data Reporting Process:

6. BHDDH pulls data from BHOLD, identifying all individuals who submitted an approved MHPRR application during the measurement period e.g., the "eligible population", identifying those who were issued a denial (for sub-measure #1B)
7. BHDDH extracts date of referral, date of denial for those who were issued a denial, and date of MHPRR placement for the eligible population to calculate total number of days between key dates for each metric.
8. BHDDH calculates measures as (sum of days from event start to end for the eligible population) / (sum of eligible population)[72]
   Calculates distinct results for:
   a. Required stratifications:
      i. By setting (before placement)
      ii. By DYCF referral for youth in transition [73]
      iii. By provider
      iv. Level of care needed (e.g., Basic MHPRR, Specialized MHPRR)[74]
      v. By new vs returning client [75]
      vi. Race/Ethnicity/Language
      vii. Gender
   b. Required stratification for sub-measure #1C:
      i. By denial issued (Yes/No)
   c. Recommended stratifications, as available:
      i. Medicaid Only or Dually Eligible for Medicaid and Medicare
9. BHDDH reports data annually to Governors Council on Behavioral Health and forwards Council update to Data Unit to report to BHDDH website

Assessment Criteria – Explained (Metric #2)

Exhibit 15. Residential Mental Health Metric #2 Explained

Domain	Domain Criteria		Metric #2: Average time on MHPRR waiting list
1. Aligned with Service Opportunities	**1.1. Metric Addresses Access Barriers**		• Provider capacity was identified in Report 7 (2023) and through interviews as key access barrier to MHPRR services – by reporting average time on waitlists by level of need (e.g., MHPRR setting) and gender, in particular, the state should be able to better

[72] Please refer to Exhibit 11 for this metrics technical specifications where the measurement period and eligible population for both the numerator and denominator of each sub-measure are defined.
[73] If time to service data for DCYF referrals are reported in aggregate with other referrals, results will show significantly longer wait times. See Metric #1 Metric Limitations for additional information on referrals and applications from DCYF.
[74] Enhanced Mental Health Psychiatric Rehabilitative Residence (E-MHPRR) would not be captured by Metric #1 because the BHOLD system is not yet capturing data for these settings.
[75] Returning clients are defined as those who were discharged from an MHPRR within the year prior to the relevant application submission.

Domain	Domain Criteria		Metric #2: Average time on MHPRR waiting list
			quantify the type of provider capacity needed to reduce wait time for clients.[76] [77] [78]
	1.2. Advances Health Equity		• Data stratified by factors such as race, ethnicity, and gender will enable BHDDH to identify potential differences in access between populations and to identify key capacity gaps. Stratified data can also inform the design and adoption of quality improvement initiatives that address the drivers of disparities experienced by underserved populations.[79]
2. Actionable	**2.1. Steward or State/ National Benchmark**		• Average time on waiting list is a state/national benchmark that is commonly used to measure access across settings • Metric #2 is an un-stewarded measure, meaning there are not technical specifications published for states to adhere to (e.g., exact calculation, reporting period, and other factors) making direct comparison across states more challenging
	2.2. Used by Other States		• Average wait time to placement was recently used in Massachusetts assessment to recommend an additional 500 group home living placements be built, among other studies.[80] • In a study to address the shortage of BH beds in Los Angeles, CA a key recommendation was to develop a dashboard with bed capacity, utilization trends, and wait time by level of care, as this was identified as an oversight data gap.[81]
	2.3. Minimal Measure Limitations		Publicly accessible data should caveat the following: • BHDDH monitors waiting lists for Basic MHPRR, Specialized MHPRR, and Enhanced-MHPRRs. Waiting lists for Supportive MHPRR Apartments are managed by the Department of Housing and Urban Development (HUD), therefore BHDDH would need to caveat access reporting to note this limitation.[82] • Additionally, BHDDH manually tracks waiting lists for Enhanced-MHPRRs independently, therefore incorporating wait times for these services may require additional analysis by BHDDH.

[76] Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Molly McCloskey. (May 17, 2023).
[77] New York State Office of Mental Health. Inpatient Bed Capacity.
[78] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.
[79] Tsai, D. (2024). Home and Community-Based Services (HCBS) Quality Measure Set (QMS) Reporting Requirements for Money Follows the Person (MFP) Demonstration Grant Recipients. *Center for Medicare and Medicaid Services*.
[80] Walsh, K.E., & Doyle, B. (2023). Strategies to Reduce Wait Times and Enhance Access to Behavioral Health Services. *Massachusetts Department of Mental Health*.
[81] Wong, L.H. (2024). ESTABLISHING A ROADMAP TO ADDRESS THE MENTAL HEALTH BED SHORTAGE (ITEM NO. 41-D, AGENDA OF JANUARY 24, 2023). County of Los Angeles Department of Mental Health.
[82] Rules and Regulations for Behavioral Healthcare Organizations. 212-RICR-10-10-01 (2023). https://rules.sos.ri.gov/Regulations/part/212-10-10-01?reg_id=12974

Domain	Domain Criteria		Metric #2: Average time on MHPRR waiting list
			• There is necessary prioritization among individuals waiting for services to comply with the federal Olmstead decision, which found that unjustified segregation of people with disabilities is a form of unlawful discrimination.[83] Therefore, certain individuals in highly restrictive settings prior to placement will necessarily have shorter wait times than others. BHDDHs priority policy, as documented in Report 7 (2023), is available in Appendix A for reference. • In addition to necessary prioritization as referenced above, there are also "best fit" placement considerations, meaning BHDDH and providers need to consider the appropriate milieu for each client, which can further delay placement.[84] [85] • Current data collection does not permit identification of cases where timely access is delayed due to client choice.
3. Technical Feasibility	**3.1. Data/ System Availability**		• Source of wait time for Basic MHPRR, Specialized MHPRR, and Enhanced MHPRR: Division of BH, BHDDH managed Waiting List[86]
	3.2. Existing Reporting Processes		• Standing monthly report to Governors Council on Behavioral Health – reports 1) aggregate # on waitlist, monthly trend beginning July 2024, 2) monthly discharges from MHPRR group homes and 3) number of clients awaiting medically and behaviorally intensive E-MHPRRs • Additional recommended reporting would require administrative resources to make Gov Council data publicly accessible.
4. Ease of Implementation	**4.1. Provider Admin Burden**		• Given existing data/system availability and reporting - implementation of measure/measurement plan will not put additional administrative burden on providers
	4.2. State Admin Burden		• Given existing data/system availability and reporting - implementation of measure/measurement plan should require minimal coordination between Division of BH and Data/IT Unit at BHDDH
	4.3. Investment Required		• Investment could be needed to maintain publicly accessible reporting on BHDDH website

[83] Olmstead v. L.C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/case.pdf
[84] Goulet, J., Emond, C., (2025, January 09). Personal communication.
[85] Martin, T. (2025, February 24). Personal communication.
[86] Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Molly McCloskey. (May 17, 2023).

Measurement Plan Action Steps - Metric #2[87]

Action Steps: Metric #2: Average time on MHPRR waiting list

Data Collection Process:

1. BHDDH follows standard processes to evaluate an individual's MHPRR application and approves the application
2. The individual is placed on the MHPRR waiting list maintained by the BH Division - **Clock "start" date**
3. When the individual is taken off the waiting list and moved into an MHPRR facility, the official provider placement date is documented - **Clock "end" date**

Data Reporting Process:

4. BHDDH analyzes waiting list data to identify all individuals who were placed into an MHPRR during the measurement period (e.g., clock end date within the quarter)
5. BHDDH calculates the number of days from clock start to clock end date for the eligible population
6. BHDDH calculates measure as (sum of days on waiting list for the eligible population) / (sum of eligible population) = Avg number of days on waiting list
   Calculates distinct results for:
   a. Required stratifications:
      i. By setting (before placement)
      ii. By provider
      iii. Level of care needed (levels of MHPRRs, including E-MHPRRs)
      iv. Gender
   b. Recommended stratifications, as available:
      i. Medicaid Only or Dually Eligible for Medicaid and Medicare
      ii. Race/Ethnicity/Language (not currently available)[88]
7. BHDDH reports data to Governors Council on Behavioral Health and forwards Council update to Data Unit to report to BHDDH website.

[87] Proposed action steps are intended to provide color to measurement plans and are a simplified representation of the workflow expected to report each metric.
[88] Race, ethnicity, and language data are not available using the current waiting list management system.

Assisted Living Services

Introduction and Context

In 2023, Report 7 to the legislature identified overall access and access data for HCBS Assisted Living Services as highly limited. Key factors contributing to limited access were provider capacity and network barriers, public policy, equity, reimbursement, and eligibility barriers. See below the status of Assisted Living data per Report 7 (2023), [89] followed by an update based on research and interviews conducted over the course of this project.

Data Status from Report 7: Social and Human Service Programs Review: Access to Programs (2023)
Highly Limited

- No centralized system to track who is eligible for and awaiting services.
- RI does not have any centrally managed referral lists nor measures of wait times or length of referral processing time.

2025 update to "Data Status" based on recent learnings:

- HCBS access rule will require quarterly timely access and service utilization reporting, inclusive of Assisted Living Residence (ALR) services, by July 2027, however this reporting occurs at the agency level (e.g., EOHHS is 75% in compliance (share of authorized HCBS service hours provided))
- EOHHS currently receives quarterly reports on HCBS quality from its sister agencies (e.g., BHDDH, DCYF, OHA) and submits annual reports on these measures to CMS per their corrective action plan (CAP). This reporting is inclusive of a sample of ALR services, and the service utilization measure mentioned above.
- RIDOH makes data on licensed residences and total estimated bed capacity/special care unit capacity available on their licensure site
- MMIS provides data on Medicaid utilization of ALR services, often used as a measure of access.

Recommended Metric [90]

Exhibit 16. Assisted Living Metric Methodology

RI Starting Point	**No,** no existing access measures or public reporting. Relevant data collected includes: (1) data required by RIDOH for biennial licensure; (2) utilization data via claims in APCD and MMIS; and (3) referral and service plan data collected by case managers for Medicaid recipients
Stewarded Measure Available	**No**, there are no nationally stewarded measures specific to Assisted Living access
Relevant Benchmark or Stewarded Measure (to	**Relevant State/National Benchmark:** • **Bed capacity** - Benchmark used to develop sub-measure #3A

[89] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[90] Note, based on input from subject matter experts, only one Assisted Living access metric was identified as a viable option, as opposed to two identified for the other services. Additional ALR metrics for future consideration have been included below. Measures that were explored but not recommended are organized by service in Appendix B with a brief explanation of why they were not pursued.

be adapted to RI Context)	• The National center for Assisted Living reports on ALR capacity using licensed beds, nationally and by state.[91] • New York State publishes a monthly Bed Capacity Report for several inpatient and residential settings.[92] • **Beds per relevant population** – Benchmark used to develop sub-measure #3C. • The AARP Assisted Living Supply Indicator, defined as Licensed Assisted Living beds per 1000 adults age 75+, is reported on AARPs LTSS Scorecard for each state in the U.S. [93] This benchmark is also often used to assess nursing home capacity adequacy however the denominator population can range from age 65 to 85.[94] This is a helpful capacity adequacy benchmark to monitor and compare across states.

RI Specific Measure

Metric	**Metric #3: Rhode Island ALR Capacity Index** **Sub-measure #3A:** Bed capacity: total staffed, filled, available per State-Licensed Assisted Living Residence (cross-payer) **Sub-measure #3B:** Share of residences accepting Medicaid clients (moment in time indicator) **Sub-measure #3C:** Total staffed ALR beds per 1000 adults age 75+ (cross-payer)
Access Barriers and Opportunities	• Several barriers identified as contributing to limited access to assisted living services, center around limited capacity for Medicaid recipients. • While Rhode Island has data on the share of ALRs that are Medicaid enrolled and potential unit capacity by residence through licensure data, the state cannot determine how many beds at any point in time are filled with a Medicaid participant, nor do they know whether a vacant bed will be filled by a Medicaid participant or whether the ALR will choose to fill it with a privately paying individual.[95] • Stakeholders noted that some providers may only accept private pay individuals that are in the processes of spending down and will eventually be transitioned to Medicaid as their sole payer. [96] • Without data on cross-payer capacity and residence availability to Medicaid recipients by licensure type (special care/dementia, limited health services) and geography, it is challenging to understand which type of ALR capacity is needed and where. • Additionally, it would be helpful to shed light on the utilization rate of non-Medicaid-certified residences, to determine if they are able to fill their beds with commercial and private pay clients or if there is excess capacity not being utilized.

Other measures were proposed as potentially being helpful in tracking ALR access and unmet need for these services that were not able to be fully defined or vetted but may be worth considering. Measures include:

[91] American Health Care Association & National Center for Assisted Living. (2025). Facts & Figures.
[92] New York State Office of Mental Health. Inpatient Bed Capacity.
[93] AARP. (2023). Assisted Living Supply.
[94] AARP. (2023). Assisted Living Supply.
[95] Note, service utilization data on Medicaid recipients is available via claims data in Rhode Island's Medicaid Management Information System (MMIS).
[96] Executive Office of Health and Human Service Email to Jessica Brown. (February 4, 2025)

1. Number of clients entering an ALR with Medicaid as their sole payer and number of clients converting to Medicaid after entering as private pay.
    a. Some ALR providers suggest that there is a long wait to get clients approved for Medicaid after they have entered a residence, therefore it could be advantageous to track time from Medicaid application to Medicaid eligibility specifically for individuals already residing in an ALR.[97]
2. Share of Medicaid clients who are billing for assisted living services out of those whose person-centered plan (PCP) indicates assisted living as a planned service.
    a. This could potentially be collected from existing data sources (e.g., PCPs via Wellsky, billed services via MMIS)[98]
3. Number of Medicaid clients on a waiting list for ALR services/placement with the Department of Human Services.

Technical Specifications

Exhibit 17. Assisted Living Metrics – Technical Specifications

Metric	**Metric 3: Rhode Island ALR Capacity Index** **Sub-measure #3A:** Bed capacity: total staffed, filled, available per State-Licensed Assisted Living Residence (cross-payer) **Sub-measure #3B:** Share of residences accepting Medicaid clients (moment in time indicator) **Sub-measure #3C:** Total staffed ALR beds per 1000 adults age 75+ (cross-payer)
Measurement Period	**Monthly / Monthly & Annual Reporting**
Denominator	**Sub-measure #3B:** Total number of ALR residences **Sub-measure #3C**: Total RI residents aged 75 and older (cross-payers) *Sub-measure #3A does not require calculation*
Numerator	**Sub-measure #3B:** Number of ALRs that indicate they are open to accepting Medicaid clients at the time of the monthly report [99] **Sub-measure #3C:** Sum of staffed ALR beds in RI (sourced from sub-measure #1 responses) *Sub-measure #3A does not require calculation*
Exclusions	**N/A**
Proposed Metric Stratifications	**Stratifications for sub-measure #3A**: • By tier (A-C for Medicaid-enrolled residences) • By standard vs memory care unit • By zip code, geographic region or catchment area (state-specified regions) of the ALR [100] **Stratifications for sub-measure #3B**: • Accepting Medicaid clients (Y/N) by residence

[97] Ibid.
[98] Executive Office of Health and Human Service email to Jessica Brown. (February 4, 2025)
[99] Medicaid enrolled residences that are open to privately paying clients that plan to spend down to become Medicaid eligible, should not be counted as "accepting Medicaid clients" in the numerator of sub-measure #3B.
[100] Catchment areas are state-defined geographic regions developed to monitor access to behavioral health services for the implementation of CCBHCs. See Appendix C for a map of these regions.

Metric Limitations	• Sub-measure #3A (total capacity) and sub-measure #3B (accepting Medicaid patients) will enable a more accurate estimate of total ALR capacity and Medicaid capacity than is available today, however, we are still unable to estimate the number of beds available to Medicaid clients because Medicaid does not certify beds. In practice this means that some Medicaid enrolled ALRs fill nearly 100% of their beds with Medicaid clients whereas others may only accept a Medicaid client on occasion. • There may be challenges compelling reporting by providers. There will be a need for licensure and/or regulatory requirements to ensure reporting compliance for a comprehensive view of capacity from all providers. ALR Medicaid-certification standards would also need to be updated.

Measurement Plan

Exhibit 18. Assisted Living Measurement Plan

Metric	**Metric 3: Rhode Island ALR Capacity Index** **Sub-measure #3A:** Bed capacity: total staffed, filled, available per State-Licensed Assisted Living Residence (cross-payer) **Sub-measure #3B:** Share of residences accepting Medicaid clients (moment in time indicator) **Sub-measure #3C:** Total staffed ALR beds per 1000 adults age 75+ (cross-payer)
Primary data reporter	ALR Providers (sub-measures #3A - #3C)
Data collection method	**Data collection method:** • Providers respond to a survey before the end of each month where they report on sub-measures #3A & # 3B via Microsoft form/standard template or online database (similar to that used for Behavioral Health Open Beds) • EOHHS aggregates and analyzes ALR provider data[101] • Reporting agency collects local population data from the census bureau or a reliable alternate source to identify number of RI residents aged 75 or older.[102]
Lead agency *for data monitoring & public reporting method*	**Lead Agency:** EOHHS **Data Reporting**: Monthly update to publicly available dashboard recommended[103]
Single or cross-payer	Cross Payer

[101] Note, data collection and reporting on ALR measures could also be led by RIDOH. Responsibility to be determined at the preference of the two agencies.

[102] Note, while the U.S. Census Bureau does not directly provide population data at the exact zip code level, it does offer data for "Zip Code Tabulation Areas" (ZCTAs), which are generalized representations of zip code service areas, allowing you to access population data at a level closely approximating zip codes. Source: Bureau, U. C. (2023). ZIP Code Tabulation Areas (ZCTAs). Census.Gov.

[103] Reporting could be a component of HCBS Access Rule or Quality Measure Set reporting, if there are plans to make this data publicly available upon implementation in July 2027 and 2028, respectively.

Assessment Criteria

Below is summary of the recommended Assisted Living metric against the assessment criteria developed to identify strengths and weaknesses of each measure.

Metric #3: Rhode Island ALR Capacity Index

- **Sub-measure #3A:** Bed capacity: total staffed, filled, available per State-Licensed Assisted Living Residence (cross-payer)
- **Sub-measure #3B:** Share of residences accepting Medicaid clients (moment in time indicator)
- **Sub-measure #3C:** Total staffed ALR beds per 1000 adults age 75+ (cross-payer)

Exhibit 19. Assisted Living Assessment Criteria

Domain	Domain Criteria	**Metric #3: Rhode Island ALR Capacity Index**
1. Aligned with Service Opportunities	1.1. Metric Addresses Access Barriers	
	1.2. Advances Health Equity	
2. Actionable	2.1. Steward or State/ National Benchmark	
	2.2. Used by Other States	*undetermined*
	2.3. Minimal Measure Limitations	
3. Technical Feasibility	3.1. Data/System Availability	
	3.2. Existing Reporting Processes	
4. Ease of Implementation	4.1. Provider Admin Burden	
	4.2. State Admin Burden	
	4.3. Investment Required	

Assessment Criteria Explained – Metric #3

Exhibit 20. Assisted Living Metric #3 Explained

Domain	Domain Criteria		**Metric #3: Rhode Island ALR Capacity Index**
1. Aligned with Service Opportunities	**1.1. Metric Addresses Access Barriers**		• Several barriers identified as contributing to limited access to assisted living services, center around limited capacity for Medicaid recipients. While Rhode Island has data on the share of ALRs that are Medicaid certified and potential unit capacity by facility through licensure data, the state cannot determine how many beds at any point in time are filled with a Medicaid participant, nor do they know whether a vacant bed will be filled by a Medicaid participant or whether the ALR will choose to fill it with a privately paying individual. • Without data on cross-payer capacity and residence availability to Medicaid recipients by licensure type (special care/dementia,

			limited health services) and geography, it is challenging to understand which type of ALR capacity is needed and where. • Additionally, this metric would shed light on the utilization rate of non-Medicaid-certified residences, to determine if they are able to fill their beds with commercial and private pay clients or if there is excess capacity not being utilized.
	1.2. Advances Health Equity		• By reporting bed availability and Medicaid accessibility by geographic region and licensure type, Rhode Island will be able to better identify disparities in access by geography and identify locations where additional capacity is needed.

2. Actionable	**2.1. Steward or State/ National Benchmark**		• Metric #3 is built using several benchmarks related to residential/inpatient capacity that have been adapted to the RI context, including:
			  • Bed counts (sub-measure #3A) – ALR capacity is often reported using licensed beds as the benchmark, however, this metric can overstate capacity because it does not account for day-to-day changes in staffed beds due to staffing shortages, for example. The National center for Assisted Living reports on AL capacity using licensed beds, nationally and by state[104]
			  • Share of residences that are Medicaid certified (sub-measure #3B) – Medicaid access to ALR services is often measured by the ratio of Medicaid enrolled residences out of total residences.
			  • Population-to-bed ratios (sub-measure #3C) – ALR supply adequacy is measured by AARP on its LTSS Scorecard as beds per 1000 individuals age 75+ this benchmark is also often used to assess nursing home capacity adequacy however the denominator population can range from age 65 to 85.[105]

	2.2. Used by Other States		• Undetermined - Research suggests limited state specific reporting/data on assisted living access
	2.3. Minimal Measure Limitations		• Sub-measure #3A (total capacity) and sub-measure #3B (accepting Medicaid patients) will enable a more accurate estimate of total ALR capacity and Medicaid capacity than is available today, however, we are still unable to estimate the number of beds available to Medicaid clients because Medicaid does not certify beds. • Note, there may be challenges compelling reporting by providers. There will be a need for licensure and/or regulatory requirements to ensure reporting compliance for a comprehensive view of capacity from all providers. ALR Medicaid-certification standards would also need to be updated.

[104] American Health Care Association & National Center for Assisted Living. (2025). Facts & Figures.
[105] AARP. (2023). Assisted Living Supply.

			• Sub-measure #3C focuses on population-to-provider capacity for clients ages 75+, however, another area of concern is availability of appropriate Assisted Living care for younger adults. This measure would need to be adapted to better understand capacity for clients under 75 years old.
3. Technical Feasibility	**3.1. Data/System Availability**		• Data for Metric #3 is currently not being collected by providers, nor is there a data sharing system in place for any type of standardized reporting. • There is no plan for Elders and Adults with Disabilities (EAD) providers, including ALRs, to have access to the States LTSS case management system, therefore a manual reporting processes would need to be put into place, whether this be accomplished via a standard template using Microsoft forms, for example, or an online portal, similar to how providers report bed availability and waiting lists to Behavioral Health Open Beds (BHOB).[106] [107]
	3.2. Existing Reporting Processes		• EOHHS is currently submitting annual reports on a limited set of HCBS quality measures to CMS, inclusive of a sample ALR services– therefore there is some provider participation in standardized reporting of a service utilization measure (e.g., share of HCBS hours being provided, of those specified in the service plan), however data is aggregated at the agency level for reporting so ALR specific utilization is not available. • Licensure data is publicly available on the RI Department of Health (RIDOH) website – there are no other sources of publicly available data, nor existing processes for standardized reporting.
4. Ease of Implementation	**4.1. Provider Admin Burden**		• Providers would need to participate in a new reporting process for the state to access the data for this metric • Depending on the data collection system implemented, providers may need to partake in technical assistance training
	4.2. State Admin Burden		• The state would need to develop new reporting processes and systems to collect these data from providers. • Providers may require technical assistance support from the state • Staff capacity will be needed for data cleaning, analysis, reporting, oversight and system maintenance. • To enforce reporting compliance, regulations and certification standards would require updating. • Additionally, staff capacity will be needed to ensure that providers are submitting accurate information monthly, reaching out to the providers with issues.
	4.3. Investment Required		• Investment will be required for state staff time associated with administrative tasks identified in 4.2 above, technology/systems changes, and public reporting.

[106] Hulberg, A., Asah, S., Arruda, P. (2025, January 09). Personal Communication.
[107] Goulet, J. (2025, January 09). Personal Communication.

Measurement Plan Action Steps - Metric #3 [108]

Action Steps: Metric #3: Rhode Island ALR Capacity Index

Sub-measure #3A: Bed capacity: total staffed, filled, available per facility
Sub-measure #3B: Share of residences accepting Medicaid clients
Sub-measure #3C: Total staffed ALR beds per 1000 adults age 75+

Data Collection Process:

1. Once a month, providers log into a state-run portal to record facility-specific data on:
    a. Moment in time bed capacity (total staffed, filled, and available beds)
        i. Filled beds by tier (A-C for Medicaid enrolled residences)
        ii. Filled and available by standard vs memory care unit (all residences)
    b. Yes/No – is the facility accepting Medicaid clients into their available beds at the time of reporting.[109] [110]

*Note, during the first month of data collection, it's recommended the State ask Medicaid enrolled providers to indicate if they **ever** admit Medicaid applicants, as some Medicaid enrolled residences may only admit private-pay individuals that are in the process of spending down.*

Data Reporting Process:

2. Following monthly submission from all licensed providers, EOHHS will:
    a. Conduct a quality check of all provider data[111]
    b. Pull population data from the census bureau or a reliable alternate source to identify number of RI residents aged 75 or older and calculate sub-measure #3C as (total staffed beds) / (total RI population ages 75+) X 1000 = # of beds per 1,000 potentially eligible individuals[112]
        i. By geographic region, or catchment area[113]
    c. Aggregate sub-measure #3A across residences to report total staffed beds (filled and available) by unit type, and total filled beds by tier:

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[108] Proposed action steps are intended to provide color to measurement plans and are a simplified representation of the workflow expected to report each metric.
[109] Ideally providers would report moment-in-time data on the same day each month, however upon review of these action steps, EOHHS flagged the unlikelihood of having a system capable of handling this user traffic. Therefore, as long as all residences are reporting once a month, this data can still be used as an indicator of access. If the state had interest in using this reporting as a service tool for clients, more frequent data collection would be required.
[110] If a Medicaid enrolled ALR accepts Medicaid clients but does not have any available beds at the time of reporting, they would answer no to this question.
[111] This could include a comparison of staffed beds to total beds as reported by RIDOH to identify variances between real-time capacity and licensed capacity (as an indication of staffing shortages and/or other concerns)
[112] Note, while the U.S. Census Bureau does not directly provide population data at the exact zip code level, it does offer data for "Zip Code Tabulation Areas" (ZCTAs), which are generalized representations of zip code service areas, allowing you to access population data at a level closely approximating zip codes. Source: Bureau, U. C. (2023). ZIP Code Tabulation Areas (ZCTAs). Census.Gov.
[113] Note zip codes do not perfectly align with catchment areas which has caused challenges with reporting on behavioral health measures required by the CCBHC program. However, the EOHHS data team has new mapping software that would make collecting the most granular data (address) possible and geolocating to catchment areas a better approach then identifying via zip code alone. The appropriate geographic unit of analysis should be determined by EOHHS.

i. Statewide
ii. By accepting Medicaid applicants (Y/N)
iii. By zip code, geographic region, or catchment area

d. Report sub-measures #3A-#3C publicly on EOHHS website.

Data Compliance and Monitoring:

To facilitate compliance, the State could consider tying data compliance to licensure. Absent compliance monitoring and enforcement for all providers (Medicaid-enrolled and non), there is a high likelihood of non-compliance, which will limit the States ability to track ALR capacity comprehensively. FCG recommends against tying reporting requirements to Medicaid certification as to not make the certification more burdensome and further dissuade providers from serving Medicaid clients.

Intellectual and Developmental Disability (I/DD) Services for Adults

Introduction and Context

In 2023, Report 7 to the legislature identified overall access and access data for HCBS – I/DD Services as **highly limited.** Key factors contributing to limited access were provider capacity and network barriers, geography, public policy, and service limitation barriers. See below the status of I/DD data per Report 7 (2023), [114] followed by an update based on research and interviews conducted over the course of this project.

Data Status from Report 7: Social and Human Service Programs Review: Access to Programs (2023)
Highly Limited

- Services are consistently defined but there is no centralized system to track who is eligible for and awaiting services.
- BHDDH established a case management software system specific to the adult population.
- Providers maintain their own referral system or waitlist - they can't see each other's referrals
- Innate challenges to data tracking, as most individuals do not have a specific I/DD diagnosis within the range of the BHDDH I/DD eligibility criteria.

2025 update to "Data Status" based on recent learnings:

- BHDDH provides quarterly consent decree report updates on various initiatives including specific I/DD services
- HCBS access rule will require timely access (time from HCBS approval to service) and service utilization (% of authorized HCBS hours provided) reporting, inclusive of adult I/DD waiver services (July 2027)
- EOHHS currently receives quarterly reports on HCBS quality from its sister agencies (e.g., BHDDH, DCYF, OHA) and submits annual reports on these measures to CMS per their corrective action plan. This reporting includes a sample of adult I/DD services, and the service utilization measure mentioned above.
- BHDDH currently uses the Therap system for both case management and incident management. The agency is in the process of transitioning to Wellsky for case management and plans to have the system fully implemented by July 1, 2025.

Recommended Metrics [115]

Exhibit 21. I/DD Services Metric Methodology

RI Starting Point	**Yes,** existing data collection and quarterly public reporting via the Consent Decree Quarterly Report. Relevant data collected includes: (1) utilization data via claims in APCD and MMIS; (2) referral and service plan data collected by case managers for Medicaid recipients; and

[114] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[115] Additional measures were explored but not recommended. These measures are organized by service in Appendix B with a brief explanation of why they were not pursued.

	(3) data collected as part of consent decree monitoring (e.g., court monitor in-person surveys on quality of life, progress of Conflict Free Case Management (CFCM) implementation, new and annual reassessments, and more)[116]	
Stewarded Measure Available	**Mixed,** there are several stewarded I/DD Services access measures, however, they are largely designed to measure quality of life and community integration more broadly (e.g., AARP Community Integration indicators; NASDDDS, Advancing States, HSRI, and NCI-IDD stewarded measures in the HCBS Quality Measure Set (required reporting per HCBS access rule)) as opposed to access to specific types of services	
Relevant Benchmark or Stewarded Measure (to be adapted to RI Context)	**Relevant Steward:** • CMS Timely Access: HCBS Access Rule Measure (tech specs not yet published) – benchmark for sub-measure #4B **Relevant State/National Benchmark:** • Maine HCBS Access Measures Dashboard, Office of Aging and Disability Services - publicly reported for individuals with I/DD and TBI – benchmark for sub-measure #4A, #4C [117]	**Relevant Steward:** • CMS Service Utilization: HCBS Access Rule Measure[118] – currently reported at an agency level, using tech specs provided in the Rhode Island Comprehensive Section 1115 Demonstration HCBS Performance Measures (Sept 2024) – benchmark for sub-measure #5B **Relevant State/National Benchmark:** • Maine HCBS Access Measures Dashboard, Office of Aging and Disability Services - publicly reported for individuals with I/DD and TBI– benchmark for sub-measure #5A
	Relevant stewarded measure adapted to RI Context: Timely Access **State/National Benchmark adapted to RI Context: Average time to completed medical eligibility assessment**	**Relevant stewarded measure adapted to RI Context: Service Utilization** **State/National Benchmark adapted to RI Context: Average wait time**
Metric	**Metric #4: Time to I/DD Assessment & Service** **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment (SIS-A) **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider **Sub-measure #4C**: Share of individuals who received supplemental funding through an S109	**Metric #5: I/DD Service Capacity & Delivery** **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist for each DD specific waiver service (as applicable) **Sub-measure #5B:** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services
Access Barriers and Opportunities	• Report 7 (2023) highlights several barriers as contributing to limited access to I/DD community waiver services, many of	• By monitoring both sub-measure #5A (total/new enrollment and waitlist) and sub-measure #5B (share of service plan

[116] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2024). Consent Decree Status Reports.
[117] State of Maine Department of Health and Human Services. (2024). HCBS Access Measures.
[118] Ibid.

	which point to fragmented systems, such as different service delivery systems which lead to confusion and inequalities in access.[119] • By monitoring timely access to assessment and service by service delivery system (e.g., fee for service vs managed care) the state will be able to quantify these challenges and propose targeted interventions. • Additionally, interviews pointed to discrepancies in the SIS-A assessment outcomes that can lead to challenges with underservice. The S109 is a source of funding for individuals that apply to supplement their SIS-A funding level.[120] [121] By tracking time to service for clients who receive S109, the state will have a better understanding of how supplemental funding may impact timely access to services.[122] • I/DD Metric #4 will identify differences in time to service based on SIS-A funding level, S109 supplemental funding, as well as demographics such as gender and age.	hours provided) by service type, the state will have a comprehensive view of where additional provider capacity is needed and where the state is unable to meet the needs of Rhode Island residents.
Key Metric Distinctions	• Tracks timely access to services • Captures administrative processing time between referral and assessment, adding transparency to the onboarding process for new clients • Utilizes existing data collection and systems available	• Provides added transparency into service-specific capacity gaps, where there are waitlists and fewer service plan hours are being fulfilled. • Metrics #4 and #5 are complimentary

[119] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

[120] Note, several processes have been implemented to identify client needs early on in the assessment process and to reduce the administrative burden of having to request supplemental funding later in a client's case. In the quarterly consent decree report BHDDH documents the number of clients who go through their three-step assessment process. Through this process, clients automatically receive an Additional Needs and Supports Questionnaire (ANSQ) following a SIS-A assessment. The ANSQ identifies clients in need of S109 supplemental funding. Additional information on this process is available in the Quarterly Consent Decree Report

[121] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2024). Consent Decree Status Reports.

[122] It may be beneficial to also track time from initial SIS-A to S109 approval.

Exhibit 22. I/DD Services Metrics – Technical Specifications

Metric	**Metric #4: Time to I/DD Assessment & Service** **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment (SIS-A) **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider **Sub-measure #4C**: Share of individuals who received supplemental funding through an S109	**Metric #5: I/DD Service Capacity & Delivery** **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist for each DD specific waiver service (as applicable) **Sub-measure #5B:** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services
Measurement Period	**Quarterly / Quarterly & Annual Reporting**	**Quarterly / Quarterly & Annual Reporting**
Denominator	**Sub-measure #4A:** Total number of individuals with a completed SIS-A in the measurement period **Sub-measure #4B**: Total number of new clients who enrolled with an I/DD provider during the measurement period **Sub-measure #4C:** Total number of individuals with a completed SIS-A in the measurement period	**Sub-measure #5B:** sum of HCBS service hours authorized for I/DD participants seeking DD specific waiver services in the measurement period ***Sub-measure #5A*** *does not require calculation*
Numerator	**Sub-measure #4A:** Among the denominator population, the total number of days between referral and assessment **Sub-measure #4B:** Among the denominator population, the total number of days between referral and service **Sub-measure #4C:** Among the denominator population, the total number of individuals granted S109 supplemental funding	**Sub-measure #5B:** sum of HCBS service hours delivered for I/DD community waiver participants in the measurement period ***Sub-measure #5A*** *does not require calculation*
Exclusions	Cases where delay was due to beneficiary choice	Cases where delayed or cancelled service was due to beneficiary choice
Proposed Metric Stratifications	Stratifications for **all sub-measures**: • By Race/Ethnicity/Language • By catchment area (state-specific geographic regions) • By gender • By enrolled in managed care (Y/N) • By Age 18-21, 22-44, 45+ Stratifications for **sub-measure #4B**: • By SIS-A level of need (A-E)	• By enrolled in managed care (Y/N) • By Race/Ethnicity/Language • By catchment area (state-specific geographic regions) • By gender • By Age 18-21, 22-44, 45+ • By adult DD waiver service type By living arrangement (e.g., Group Home, Shared Living, Family Home, etc.) Note: Sub-

	• By received S109 (Y/N) • By adult DD waiver service type [123] Stratifications for **sub-measure #4C**: • By SIS-A level of need (A-E)	measure #5A waitlists should be reported by service type – additional stratifications are optional, can be reported as data is available if helpful for program tracking
Metric Limitations	• Public reporting for these services should be appropriately contextualized such that alongside access metrics there is data available on utilization, breadth of services, and interstate comparisons to provide a more complete picture of service delivery (e.g., AARP publishes publicly available interstate comparison data for several community integration indicators, such as Access to Housing Assistance for People with Disabilities) [124]	
	• Public reporting of this metric should caveat the following: Time to placement in residential settings is likely to have longer wait times than time to service for other types of DD specific waiver services for multiple reasons (e.g., capacity limitations, appropriate milieu considerations, clinical needs of clients, etc.)	• Public reporting of this metric should caveat the following: Any services that do not have a formal waitlist but may have clients waiting should be noted.

Measurement Plan

Exhibit 23. I/DD Services Measurement Plan

Metric	Metric #4: Time to I/DD Assessment & Service **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment (SIS-A) **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider **Sub-measure #4C**: Share of individuals who received supplemental funding through an S109	Metric #5: I/DD Service Capacity & Delivery **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist for each DD specific waiver service (as applicable) **Sub-measure #5B** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services
Primary Data Reporter	• Case Managers (date of referral, date of SIS-A assessments, S109 funding (Y/N)) • I/DD Providers (date of service/ enrollment)	• Case Managers (service plans) • I/DD Providers (enrollment, any provider specific waitlists, billed HCBS hours) • BHDDH, DD Division (state-maintained waitlists (e.g., group home/residential services)

[123] DD Specific Service types: Supported Employment, Integrated Day Supports, Community-Based Supports, Respite, Residential Services, Transportation, Professional Services, Support Brokerage, Fiscal Intermediary Services

[124] AARP. (2023). Access to Housing Assistance for People with Disabilities.

Data Collection Method	• Date of referral, SIS-A, authorization start date (e.g., initial service/enrollment with a provider), and S109 funding are documented in the Therap and Wellsky systems by case managers and providers. ○ Note, Wellsky is to be fully implemented as the case management system for adults with disabilities by July 1, 2025[125] • Data analyzed by BHDDH, Division of Developmental Disabilities (DDD)	• Enrollment, population details, and service plans via the Therap and case management systems • Waitlist data managed by BHDDH, DDD • Provider-specific waiting lists would need to be manually reported by providers[126] • BHDDH, DDD is in the process of implementing an internal process of reviewing service plans and utilization data for HCBS compliance. This process would be leveraged for data collection and reporting for Sub-measure #5B.[127]
Lead Agency *for data monitoring & public reporting method*	**Lead Agency:** BHDDH **Data Reporting**: existing process via quarterly uploaded report to BHDDH website	**Lead Agency:** BHDDH **Data Reporting:** existing process via quarterly uploaded report to BHDDH website
Single or Cross Payor	Medicaid or Dual Eligible	Medicaid or Dual Eligible

Assessment Criteria

Below is summary of the two recommended I/DD measures against the assessment criteria developed to identify strengths and weaknesses of each measure.

Metric #4: Time to I/DD Assessment & Service

- **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment (SIS-A)
- **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider
- **Sub-measure #4C:** Share of individuals who received supplemental funding through an S109

Metric #5: I/DD Service Capacity & Delivery

- **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist for each DD specific waiver service (as applicable)
- **Sub-measure #5B:** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services

[125] Executive Office of Health and Human Service Email to Jessica Brown. (February 4, 2025)
[126] Wellsky has the capacity for tracking waitlist but BHDDH, DD Division has not yet focused on implementing this functionality.
[127] Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Jessica Brown. (February 17, 2025).

Exhibit 24. I/DD Services Assessment Criteria

Domain	Domain Criteria	Metric #4: Time to I/DD Assessment & Service	Metric #5: I/DD Service Capacity & Delivery
1. Aligned with Service Opportunities	1.1. Metric Addresses Access Barriers		
	1.2. Advances Health Equity		
2. Actionable	2.1. Steward or State/ National Benchmark		
	2.2. Used by Other States		
	2.3. Minimal Measure Limitations		
3. Technical Feasibility	3.1. Data/System Availability		
	3.2. Existing Reporting Processes		
4. Ease of Implementation	4.1. Provider Admin Burden		
	4.2. State Admin Burden		
	4.3. Investment Required		

Assessment Criteria Explained – Metric #4

Exhibit 25. I/DD Metric #4 Explained

Domain	Domain Criteria		Metric #4: Time to Assessment & Service
1. Aligned with Service Opportunities	**1.1. Metric Addresses Access Barriers**		• Report 7 (2023) highlights several barriers as contributing to limited access to DD specific waiver services, many of which point to fragmented systems, such as different service delivery systems which lead to confusion and inequalities in access. By monitoring timely access to assessment and service by service delivery system (e.g., fee for service vs managed care) the state will be able to quantify these challenges and propose targeted interventions.[128] • Additionally, interviews pointed to challenges/discrepancies in the SIS-A assessment outcomes that can lead to challenges with underservice. I/DD Metric #4 will identify differences in time to

[128] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

			service based on SIS-A funding level, S109 supplemental funding, as well as demographics such as gender or age.
	1.2. Advances Health Equity		• Stratifications such as race, ethnicity, language, primary diagnosis, and level of need will enable BHDDH to identify potential differences in timely access between populations and to identify key capacity gaps, such as the need for additional multi-lingual providers, for example. Stratified data can also inform the design and adoption of quality improvement initiatives that address the drivers of disparities experienced by underserved populations.
2. Actionable	**2.1. Steward or State/ National Benchmark**		• Sub-measure #4A (time from referral to SIS-A) was developed based on Maine's reporting of average time to medical eligibility determination assessment and re-assessments.[129] • Sub-measure #4C (time from referral to service) was developed based on the CMS Timely Access: HCBS Access Rule Measure. • This measure does not have technical specification published however, based on the state's understanding of future reporting on this measure at the agency level, it has been adapted to drill further into the details of timely access by DD specific services by type.[130]
	2.2. Used by Other States		• Sub-measure #4A (time from referral to SIS-A) is publicly reported for individuals with I/DD and TBI by Maine's Office of Aging and Disability Services Maine in their HCBS Access Measures Dashboard.[131]

	2.3. Minimal Measure Limitations		• Public reporting of this metric should caveat the following:
			  • Reporting should be appropriately contextualized such that alongside access metrics there is data available on utilization, breadth of services, and interstate comparisons to provide a more complete picture of service delivery (e.g., AARP publishes publicly available interstate comparison data for several community integration indicators, such as Access to Housing Assistance for People with Disabilities) [132]
			  • Time to placement in residential settings is likely to have longer wait times than for other types of DD specific waiver services for multiple reasons (e.g., capacity limitations, appropriate milieu considerations, etc.)

3. Technical Feasibility	**3.1. Data/System Availability**		• Source of referral date: case management system via existing reporting from case managers and independent facilitators (IFs) for clients pursuing self-directed services • Source of SIS-A assessment date: case management system

[129] State of Maine Department of Health and Human Services. (2024). HCBS Access Measures.
[130] Executive Office of Health and Human Service Email to Jessica Brown. (January 24, 2025)
[131] State of Maine Department of Health and Human Services. (2024). HCBS Access Measures.
[132] AARP. (2023). Access to Housing Assistance for People with Disabilities.

			• Source of authorization start date (e.g., service/enrollment date): case management system via existing reporting from providers
	3.2. Existing Reporting Processes		• BHDDH publishes quarterly public reports as required per the Consent Decree, available on their website[133]
4. Ease of Implementation	**4.1. Provider Admin Burden**		• Given existing data/system availability and reporting - implementation of measure/measurement plan will not put additional administrative burden on providers
	4.2. State Admin Burden		• Given existing data/system availability and reporting - implementation of measure/measurement plan should require minimal coordination between the DD Division and Data/IT Unit at BHDDH
	4.3. Investment Required		• Investment could be needed to maintain publicly accessible reporting on BHDDH website, if the state opts to continue with quarterly reports that are uploaded to their website, it is unlikely to require additional investment • If additional interstate comparison data is displayed alongside measure, resources may be required to better define comparisons, conduct research, and create data visualizations for public posting.

Measurement Plan Action Steps - Metric #4 [134]

Metric #4: Time to I/DD Assessment & Service

- **Sub-measure #4A:** Average number of days from referral to initial Supports Intensity Scale – Adult assessment (SIS-A)
- **Sub-measure #4B:** Average number of days from referral to service/enrollment with an I/DD provider
- **Sub-measure #4C:** Share of individuals who received supplemental funding through an S109

Data Collection Process:

1. Client submits application with Developmental Disability Services and the DD Eligibility Review Committee reviews the application to determine eligibility within 30 days
2. An eligibility letter is sent to the client and the client is assigned to a case worker and referred for the SIS-A assessment - **Clock "start" date (time of referral)**
3. A case manager or trained provider completes the SIS-A with the client and family - **Clock "end" date (sub-measure #4A)**
4. The client is assigned a SIS-A tier based on the results of their assessment, which dictates the level of funding available for them to acquire DD specific services through BHDDH

[133] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2024). Consent Decree Status Reports.

[134] Proposed action steps are intended to provide color to measurement plans and are a simplified representation of the workflow expected to report each metric.

5. The client works with their case manager to go through the person-centered planning process, where they develop their service plan based on which services are best suited for the client.
6. The client schedules an appointment with a prospective provider, where the provider reviews the service plan and determines if they are able to fulfill the services outlined in the service plan given the SIS-A prescribed funding level[135]
7. The provider either accepts or denies enrollment of the client
    a. If accepted, the individual is enrolled with the service provider – this is referred to as the "authorization start date" - **Clock "end" date (sub-measure #4B)**
    b. If denied, the client may seek service from alternate providers and if unsuccessful or may apply for S109 supplemental funding **– S109 count (sub-measure #4C)**
        i. If S109 funding is granted the client repeats steps 6 and 7a.*

*Note, several processes have been implemented to identify client needs early on in the assessment process and to reduce the administrative burden of having to request supplemental funding later in a client's case. In the quarterly consent decree report BHDDH documents the number of clients who go through their three-step assessment process. Through this process, clients automatically receive an Additional Needs and Supports Questionnaire (ANSQ) following a SIS-A assessment. The ANSQ identifies clients in need of S109 supplemental funding. Additional information on this process is available in the Quarterly Consent Decree Report.[136]

Data Reporting Process:

8. BHDDH pulls data from the Therap and/or Wellsky case management systems on all clients who received an initial SIS-A or enrolled with a provider during the measurement period e.g., the "eligible population"
9. BHDDH extracts date of referral, initial SIS-A assessment (for sub-measure #4A), and authorization start date (for sub-measure #4B) from the Therap and/or Wellsky case management systems, for the eligible population to calculate total number of days between referral, assessment, and enrollment
10. BHDDH calculates **sub-measures #4A and #4B*** as (sum of days to event for the eligible population) / (sum of eligible population) = Avg number of days from referral to assessment and enrollment for new clients.
    Calculates distinct results:
    a. By Race/Ethnicity/Language
    b. By catchment area (state-specific geographic regions)
    c. By gender
    d. By enrolled in managed care (Y/N)
    e. By Age 18-21, 22-44, 45+
    *Note results for sub-measure #4B (time from referral to service) should also be calculated:
    a. By SIS-A level of need (A-E)
    b. By received S109 (Y/N)

[135] In the case of self-directed clients, an appointment would be scheduled with a Fiscal Intermediary or the client would be placed on a waitlist to meet with a Fiscal Intermediary. For these clients, enrollment with a Fiscal Intermediary does not necessarily equate to the service start date. Self-directed clients work with their Fiscal Intermediary to identify and employ the providers and resources requested by the client and this requires additional administrative time before the client is receiving their desired HCBS.
[136] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2024). Consent Decree Status Reports.

c. By adult DD waiver service type

Sub-measure #4C should be reported as (sum of clients who received S109 supplemental funding out of the eligible population)/ (sum of eligible population) in aggregate and by SIS-A level of need (A-E).

11. BHDDH makes data publicly available on a quarterly basis via their website, using a report document that is uploaded or a data dashboard.

Assessment Criteria Explained – Metric #5

Exhibit 26. I/DD Metric #5 Explained

Domain	Domain Criteria		Metric #5: I/DD Service Capacity & Delivery
1. Aligned with Service Opportunities	**1.1. Metric Addresses Access Barriers**		• By monitoring both sub-measure #5A (total/new enrollment and waitlist) and sub-measure #5B (share of service plan hours provided) by service type, the state will have a comprehensive view of where additional provider capacity is needed and where the state is unable to meet the needs of Rhode Island residents.
	1.2. Advances Health Equity		• Stratifying these data by race, ethnicity, language, age and specifically living arrangement, catchment area, BHDDH will be able to identify potential access disparities that otherwise would be difficult to quantify – allowing the state to implement policy that may alleviate barriers to access for currently underserved populations
2. Actionable	**2.1. Steward or State/ National Benchmark**		• Sub-measure #5B (share of service plan hours provided) was developed using the stewarded CMS Service Utilization: HCBS Access Rule Measure. This measure currently reported by RI EOHHS at an agency level, using tech specs provided in the Rhode Island Comprehensive Section 1115 Demonstration HCBS Performance Measures (Sept 2024). This measure has been adapted to address the access barriers specific to this set of services for this report.
	2.2. Used by Other States		• Sub-measure #5A (total/new enrollment and waitlist) is commonly reported by states at regular intervals, Maine includes this reporting on their HCBS access dashboard for Developmental Disability and Brain Injury Programs.

	2.3. Minimal Measure Limitations		• Public reporting of this metric should caveat the following:
			  • Reporting will need to be appropriately contextualized such that alongside access metrics there is data available on utilization, breadth of services, and interstate comparisons to provide a more complete picture of service delivery.
			  • There may be services that do not have a formal waitlist, not because there is no one waiting for the service – nuanced waitlist policy should be documented.

3. Technical Feasibility	**3.1. Data/System Availability**		• Source of total enrollment, new enrollment – Case Management System • Source of service-specific waitlist data: BHDDH, DDD maintains waiting lists for certain services however provider-specific waiting lists would need to be manually reported by providers[137] • BHDDH, DDD is in the process of implementing an internal process of reviewing service plans and utilization data for HCBS compliance. This process would be leveraged for data collection and reporting for sub-measure #5B.[138]
	3.2. Existing Reporting Processes		• Existing reporting via quarterly consent decree report[139]
4. Ease of Implementation	**4.1. Provider Admin Burden**		• Additional provider capacity would be required to report any provider specific waitlists
	4.2. State Admin Burden		• Given existing data/system availability and reporting - implementation of measure/measurement plan should require minimal coordination between the DD Division and Data/IT Unit at BHDDH. • The DD Division would need to develop a new process to collect provider specific waitlists, however, once Wellsky is fully implemented there may be an opportunity to leverage this system to automate waitlist tracking. For this reason, it is recommended BHDDH implement this measure in phases, beginning by only reporting state-maintained waiting lists for sub-measure 5A. • Additionally, program regulations may require updates related to additional provider reporting
	4.3. Investment Required		• Investment could be needed to maintain publicly accessible reporting on BHDDH website, if the state opts to continue with quarterly reports that are uploaded to their website, it is unlikely to require additional investment

Measurement Plan Action Steps - Metric #5 [140]

Action Steps: Metric #5: I/DD Service Capacity & Delivery

- **Sub-measure #5A:** Total enrollment, new enrollment, and number on waitlist for each DD specific waiver service (as applicable)

[137] Wellsky has the capacity for tracking waitlist but BHDDH, DD Division has not yet focused on implementing this functionality.
[138] Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Email to Jessica Brown. (February 17, 2025).
[139] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2024). Consent Decree Status Reports.
[140] Proposed action steps are intended to provide color to measurement plans and are a simplified representation of the workflow expected to report each metric.

- **Sub-measure #5B:** Share of authorized HCBS hours specified in the service plan that were provided to I/DD participants seeking DD specific waiver services

Data Collection Process:

Sub-measure #5A:

1. I/DD providers document newly enrolled clients in the case management system in line with existing standard process
2. I/DD providers manually report any provider specific waitlists to BHDDH by adult service type on a monthly basis

Sub-measure #5B:

1. As part of EOHHS annual HCBS quality measure reporting to CMS, EOHHS sister agencies submit quarterly reports to EOHHS and a sample of I/DD client service plans are selected to compare authorized hours to hours of utilization during the measurement period.
2. EOHHS sends the sampling of service plans to BHDDH

Data Reporting Process:

Sub-measure #5A:

3. BHDDH extracts the following data from the case management system:
    a. Point in time total enrollment
        i. By Race/Ethnicity/Language
        ii. By enrollment in managed care
        iii. By catchment area (state-specific geographic regions)
        iv. By Age 18-21, 22-44, 45+
        v. By adult DD specific waiver service type
    b. Total newly enrolled clients within the quarterly measurement period
        i. By adult DD specific waiver service type
4. BHDDH aggregates waitlist data reported by I/DD providers with internal BHDDH-maintained waitlists to report total estimated clients on waiting lists by service type.
5. BHDDH makes data publicly available on a quarterly basis via their website, using a report document that is uploaded or a data dashboard.

Sub-measure #5B:

3. BHDDH compares client utilization during the period to the sampling of service plans
4. BHDDH reports on the results of this comparison to EOHHS at an agency level (e.g., BHDDH is 85% in compliance) and makes data publicly available by service type on a quarterly basis via their website, using a report document that is uploaded or a data dashboard.

Key Learnings & Next Steps

This report represents a critical step toward addressing significant data gaps in access measurement for Residential Mental Health, Assisted Living, and Intellectual/Developmental Disability (I/DD) services in Rhode Island. By leveraging an iterative, data-driven approach and incorporating feedback from subject matter experts, the recommended access metrics and measurement plans provide actionable, context-specific tools to evaluate and improve access to essential services. These metrics were carefully designed to align with identified barriers, offer actionable insights, and be technically feasible for implementation within existing reporting infrastructures.

As identified in the Executive Summary, **Key Learnings from this Assessment** include:

- No measure received a perfect score, in that all had tradeoffs across the four criteria and all had some limitations.
- All measures were carefully selected to align with the barriers and opportunities identified for each included service. Access barriers were identified in Report 7 (2023) and further specified by subject matter experts in this assessment.[141]
- There were very few instances of available data stewards or well-defined national benchmarks. Most recommended metrics were tailored from relevant stewards or benchmarks to suit each service area within the Rhode Island context.
- Most measures had an available technical starting point – either an existing data collection mechanism or reporting process.
- New/additional administrative resources will likely be required to support the reporting and analysis for these recommended measures.

Several external and evolving factors, such as changing federal and state priorities, could significantly influence the implementation and sustainability of the proposed access metrics and measurement plans. Additionally, resource limitations may necessitate incremental implementation, making a phased approach to data collection and reporting a pragmatic choice. However, ongoing state initiatives offer opportunities for efficiency. For instance, Wellsky, the States LTSS case management system, once fully implemented, is expected to improve data collection and reporting processes. Similarly, the EOHHS Data Ecosystem may serve as a valuable cross-cutting resource for future reporting needs. Additionally, the Health Care System Planning initiative's exploration of centralized healthcare transparency and performance monitoring could provide a robust platform for integrating access metrics across diverse service areas.

Next Steps

If the recommended metrics and measurement plans included in this report were to be adopted/approved by Rhode Island leaders, relevant agencies would need to be assigned specific responsibilities for reporting and monitoring access measurements. Agencies would need to establish workflows and allocate resources to implement these metrics, including updating regulatory frameworks to ensure compliance.

Note, the recommendations contained herein are based on available data, subject matter expertise, and professional analysis available as of the time of submission. If agencies establish a process to implement these

[141] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

recommendations, they may also need to account for any changes to underlying assumptions or operations since the drafting of this report.

Additionally, it is recommended that this approach be extended to the remaining service categories identified in Report 7 (2023), enabling a comprehensive assessment of access across all areas of focus. Once reporting begins and additional measures are established for more service categories, a dashboard could be created to track access changes and improvements as rate recommendations under RIGL § 42-14.5-3(t) take effect.

Appendix

Appendix A. Report 7 (2023) – MHPRR Waiting List Prioritization Processes [142]

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]

[142] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner. Page 8.

Appendix B. Additional Access Measures Considered

Additional measures were explored but not recommended. These measures are organized by service below with a brief explanation of why they were not pursued.

Residential Mental Health Services

Measure: Bed availability and waiting list (moment in time/trend overtime) by MHPRR

In 2023, Report 7 identified Behavioral Health Open Beds (BHOB) as being used to track inpatient mental health beds and SUD residential beds by facility, therefore, adding MHPRR to the existing BHOB reporting platform was initially proposed.[143] Ultimately, this measure was not pursued based on the understanding that there is a substantive waiting list for placement into MHPRR and the waiting list is necessarily prioritized by BHDDH. Therefore, it would be misleading to show real time bed availability because all beds are in the processes of being filled as quickly as they can based on the waitlist management and prioritization process.

Assisted Living Services

Measure: Time to Placement - Average number of days from service authorization to placement in an Assisted Living Residence for Medicaid clients

Time to placement was not pursued because stakeholders raised concerns about the many reasons why Medicaid clients may be delayed in moving into a residence that are independent of system capacity or constraints within the States' control. Clients can be at varying stages of readiness to move when service authorization is provided and can set their own move in date. Due to the many confounding variables that influence time to placement, this measure is not recommended as an optimal measure of access for assisted living services.

I/DD Services

Measure: National Core Indicators® - Intellectual and Developmental Disabilities (NCI®-IDD) Surveys

According to the NCI website, Rhode Island had appeared to have discontinued administering the survey, with the last period being reporting as 2018-2019. Through interviews it was revealed that the Sherlock Center at Rhode Island College has been conducting the In-Person Adult survey in partnership with BHDDH for many years and had failed to reach the minimum reporting sample of 400 participants over the last 5 years. In addition to the In Person Adult survey, the Sherlock Center has plans to support BHDDH with the implementation of the NCI State of the Workforce Survey going forward. The state of the workforce survey had been implemented by the Consent Decree Court Monitor, and this will be transitioned to the Sherlock Center once the Consent Decree monitoring period has concluded in 2026.[144]

Measure: Average annual per person Medicaid waiver expenditure for I/DD Participants by Living Arrangement & Age

This measure was not pursued because it was determined to be too closely tied to reimbursement rates, could not independently measure access, and did not directly address access barriers identified in Report 7 (2023).[145]

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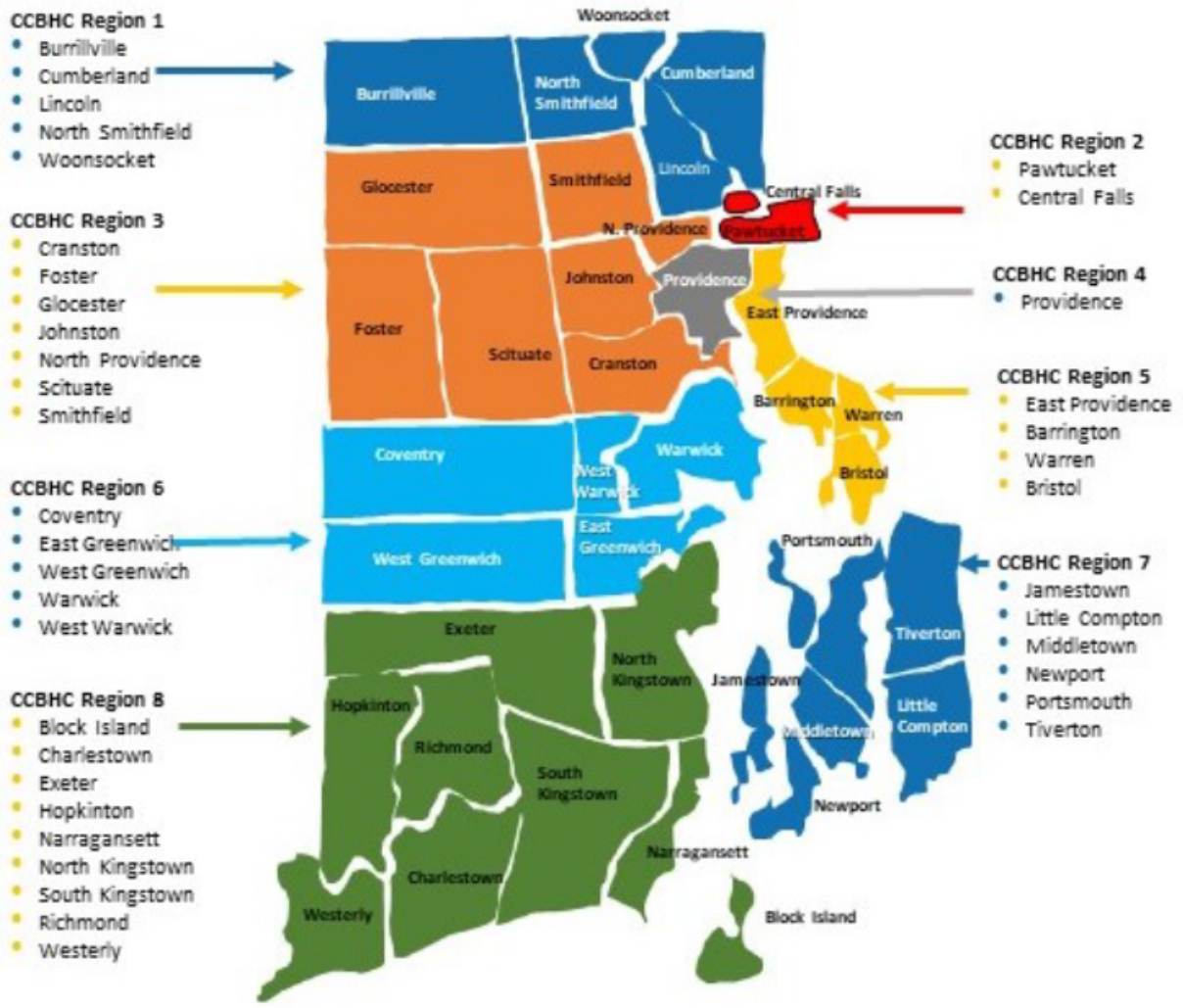
[143] Ibid.

[144] Sherlock Center, Rhode Island College Email to Jessica Brown. (January 29, 2025)

[145] Milliman Inc. (2023). Social and Human Service Programs Review: Access to programs (No. 7; Social and Human Service Programs Review). Rhode Island, Office of the Health Insurance Commissioner.

Appendix C. **Catchment Areas – Recommended Geographic Regions for Reporting** [146]

State of Rhode Island CCBHC Regions Section



[146] Certified Community Behavioral Health Clinics, State of Rhode Island Certification Guide. May 2024.