Rhode Island CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Rhode Island

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

All, RIte Care/RIte Share

Who should we contact if we have any questions about your report?

4. Contact name:

Mark Kraics

5. Job title:

Deputy Medicaid Program Director

6. Email:

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7. Full mailing address:

Include city, state, and zip code.

3 West Road Virks Building Cranston, RI 02920

8. Phone number:

401-462-3516

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All Medicaid Expansion CHIP populations must be enrolled in Managed Care. All new enrollees may have a period of one (1) to eight (8) weeks in Fee for Service while waiting to get formally enrolled into their health plan of choice.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All separate CHIP populations must be enrolled in Managed Care. All new enrollees may have a period of one (1) to eight (8) weeks in Fee for Service while waiting to get formally enrolled into their health plan of choice.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ○ No
- ◉ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- (●) Yes
- ( ) No
- ( ) N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ( ) Yes
- (●) No
- ( ) N/A

16. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

As part of the Rhode Island's efforts to improve outcomes for birth parents and newborns, the State plans to seek approval from the Centers for Medicare and Medicaid Services (CMS) to update Rhode Island's Medicaid Expansion CHIP program to adopt the state plan option, provided by Sections 9812 and 9822 of the American Rescue Plan Act of 2021, to provide 12 months of continuous postpartum coverage to pregnant individuals enrolled in CHIP. The State plans to submit the SPA before 12/31/22 to obtain an effective date of October 1, 2022.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ○ Yes
- ◉ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ◉ Yes
- ○ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

As part of the Rhode Island's efforts to improve outcomes for birth parents and newborns, the State plans to seek approval of a Health Services Initiative (HSI) from the Centers for Medicare and Medicaid Services (CMS) to update Rhode Island's Separate CHIP program to provide 12 months of continuous postpartum coverage to the State's CHIP unborn population. The State plans to submit the HSI before 12/31/22 to obtain an effective date of October 1, 2022. The State also plans to elect the CHIPRA 214 option to provide coverage to lawfully residing pregnant people through a SPA submitted before 12/31/22.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ○ Yes
- ◉ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	32,059	31,376	-2.13%
Separate CHIP	1,915	2,602	35.875%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	6,000	2,000	2.6%	0.9%
2016	2,000	1,000	0.9%	0.4%
2017	3,000	1,000	1.3%	0.5%
2018	2,000	1,000	0.8%	0.6%
2019	3,000	1,000	1.3%	0.7%
2020	Not Available	Not Available	Not Available	Not Available
2021	2,000	1,000	1%	0.5%

Percent change between 2019 and 2021
-23.08%

1. What are some reasons why the number and/or percent of uninsured children has changed?

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ○ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ○ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- ◉ Yes

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  Yes. Currently, Rhode Island has the lowest uninsured rated in the United States.

- ○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Historically, contracting with community-based organization (CBOs) has been most effective.

4. Is there anything else you'd like to add about your outreach efforts?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ○ No
- ◉ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

We have a premium assistance program in which we require enrollment into ESI if the employer's insurance product is determined to be cost-effective by the State. One major issue with our program has and continues to be the inability to get health plan benefit information and rates from the employers since there is no requirement for employers to provide that information (unless they are also Medicaid-enrolled providers).

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ○ Yes
- ◉ No

3. Do you send renewal reminder notices to families?

(●) Yes

3a. How many notices do you send to families before disenrolling a child from the program?

2

3b. How many days before the end of the eligibility period did you send reminder notices to families?

15 minimum

( ) No

4. What else have you done to simplify the eligibility renewal process for families?

EOHHS is able to validate certain eligibility criteria to passively renew families.

5. Which retention strategies have you found to be most effective?

Streamlining processes in the administrative/application process. Improving the clarity of communications to families.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

EOHHS employs data analysts that query our integrated eligibility system and report metrics and measures of effectiveness.

7. Is there anything else you'd like to add that wasn't already covered?

No

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

397

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

<11

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

387

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

109

4. How many applicants were denied CHIP coverage for other reasons?

0

5. Did you have any limitations in collecting these data?

Rhode Island's Integrated Eligibility system has limitations in tagging denials and terminations as CHIP so numbers reported may be an under-representation of all applicants. System enhancements planned for FY 2022 to improve CHIP reporting were postponed due to higher priority PHE Unwinding preparations.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	2.52%
Denied for eligibility reasons	97.48%
Denials for other reasons	0%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

35270

2. Of the eligible children, how many were then screened for redetermination?

5170

3. How many children were retained in CHIP after redetermination?

5170

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

0

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

0

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

0

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Renewal activity continued to focus on cases pre-determined to auto-renew. The only individuals disenrolled during the PHE (Public Health Emergency) were identified outside of the renewal process resulting in '0' disenrolled children through redetermination.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	100%
Children disenrolled after redetermination	0%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

80995

2. Of the eligible children, how many were then screened for redetermination?

13621

3. How many children were retained in Medicaid after redetermination?

13621

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

0

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

0

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

0

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting these data?

Renewal activity continued to focus on cases pre-determined to auto-renew. The only individuals disenrolled during the PHE (Public Health Emergency) were identified outside of the renewal process resulting in '0' disenrolled children through redetermination.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	100%
Children disenrolled after redetermination	0%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
161	0	0	0

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
174	0	0	0

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	0

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	0

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	0

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	0

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1448	482	594	372

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1411	452	556	353

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11		<11	<11

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
36	30	37	18

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- ○ Yes
- ◉ No

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [ ] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [x] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- (●) Yes
- ( ) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

Full Medicaid Benefits. Any medically necessary service covered by Medicaid but not covered by ESI (e.g. certain services for Children with Special Healthcare Needs would be provided as Medicaid fee-for-service.

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- ( ) Yes
- (●) No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2022?

752

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 262

9. What's the average monthly contribution the employer pays towards coverage of a child?

$

10. What's the average monthly contribution the employee pays towards coverage of a child?

$ 0

Table: Coverage breakdown

Child

State	Employer	Employee
262		0

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at		Ends at
$	→	$

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at		Ends at
$	→	$

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at		Ends at
	→	

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

Administrative barriers continue to exist especially related to getting information from employers.

15. What challenges did you experience with your premium assistance program in FFY 2022?

Employers not responding to requests for summary of benefits and rates.

16. What accomplishments did you experience with your premium assistance program in FFY 2022?

N/A

17. Is there anything else you'd like to add that wasn't already covered?

RI is interested in how other states with premium assistance programs are doing and whether this continues to be a viable option given the increase in the costs of commercial coverage.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

EOHHS Office of Program Integrity (PI) recognizes areas of vulnerabilities that adversely affect program integrity. PI has protocols and procedures in place to detect and deter fraud, waste and abuse, increase accountability and transparency. PI uses sophisticated data mining and modeling techniques to identify unusual patterns of purchasing and billing by third parties, holds provider agencies accountable for building and maintaining systems to prevent improper billing, utilizes administrative tools such as payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. PI shares that information with the Managed Care Organizations (MCOs) during monthly meetings with MCO SIU unit and, more broadly, with the AG's office and MCO at the MFCU meeting.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

◉ Yes

5a. What safeguards and procedures do the Managed Care plans have in place?

The Contracts with RI EOHHS for Medicaid Managed Care Services requires RI's three (3) MCOs and Dental Plan to have written Member and Provider Fraud, Waste and Abuse Policy and Procedures and Compliance Plan, submit quarterly Fraud and Abuse report. The MCOs are required establish and maintain internal controls which are designed and executed to prevent, detect, investigate, and report suspected Medicaid Fraud and Abuse that may be committed by network providers, non-network providers, vendors, subcontractors, employees, members, or other third parties with whom the Contractor contracts. EOHHS and its Office of Program Integrity may conduct audits at any time on the Contractor's formal fraud, waste and abuse program as well as any files as a result of claims audits. MCOs are required to educate its members about Medicaid fraud and abuse by including this subject matter in the contractor's member handbook. MCOs must submit copies of their Corporate Compliance Plan and associated documentation, as well as completed Ownership and Controlling Interest forms, to the RI EOHHS. The latter series of forms must be submitted for the MCO itself as well as subcontractors. EOHHS requires MCOs to issue an Explanation of Member Benefits (EOMB) notices, to complement the MCOs' fraud/waste/abuse detection/prevention functions. MCOS have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by 42 CFR 456.3, 456.4, and 456.23. The MCOs initiate an investigation of possible Medicaid fraud and abuse and are required to report any suspected cases of provider or vendor fraud and/or abuse to RI EOHHS and PI within five (5) business days following the close of an initial investigation. PI will vet suspected case(s) and will make a referral to the MFCU if warranted. Quarterly meeting with the three(3) MCOs and Dental Plan with representatives of EOHHS, the Rhode Island Department of the Attorney General's Medicaid Fraud Control Unit (MFCU), and the State's Fiscal Intermediary, are held providing attendees a forum to discuss open, closed and potential issues of fraud, waste and abuse in both managed care and FFS networks to evaluate if each is seeing similar activity. In addition to quarterly meetings, EOHHS and the Office of Program Integrity

(PI) hold a monthly call with each of the MCOs. Participants provide ongoing investigation status updates, share new leads and provide support and education to the MCO SIU/investigators. EOHHS instituted mandatory quarterly fraud and abuse investigation reporting in 2006 for all Medicaid participating MCOs. These reports are submitted by the MCOs to EOHHS' Office of Program Integrity (PI) and to the Rhode Island Department of the Attorney General's MFCU. In addition to the PI-MCO specific meetings, EOHHS Medicaid Managed Care Oversight Team conducts oversight meetings monthly with the MCOs. These monthly meetings are conducted separately with each MCO and the agendas for these meetings focus upon both standing and emerging issue

- ○ No
- ○ N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

0

7. How many cases have been found in favor of the beneficiary in FFY 2022?

0

8. How many cases related to provider credentialing were investigated in FFY 2022?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

0

10. How many cases related to provider billing were investigated in FFY 2022?

0

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

0

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

0

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

0

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

  15a. How do you provide oversight of the contractors?

  For questions 8, 9, 10, 11 & 14 - Our SURS unit is contracted out to Gainwell and reports to Program Integrity For questions 12 & 13 - Due to the CMS COVID-19 mitigation policies, we have not investigated fraud in the programs during FY2022. The answer to both questions would be none. We look forward to reinstituting investigations when the medical emergency ends.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ◉ No

17. Is there anything else you'd like to add that wasn't already covered?

Program Integrity does not target CHIP or provider credentialing in our investigations.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ○ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

We do not have children enrolled in a Separate CHIP program. The only members eligible under separate CHIP are higher income pregnant women and CHIP Unborns. As such this question regarding dental benefits for children under 19 is not relevant for Rhode Island's Separate CHIP program.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- ○ Yes
- ◉ No

Part 2: You didn't collect the CAHPS survey

Since you didn't collect the CAHPS survey, please complete Part 2.

1. Why didn't you collect the CAHPS survey?
Check all that apply.

- [ ] Entire population wasn't included in the survey
- [ ] Part of the population wasn't included in the survey
- [ ] Data wasn't available due to budget constraints
- [ ] Data wasn't available due to staff constraints
- [ ] Data wasn't consistent or accurate
- [ ] Data source wasn't easily accessible
- [ ] Data source wasn't easily accessible: requires medical records
- [ ] Data source wasn't easily accessible: requires data linkage that doesn't currently exist
- [ ] Data wasn't collected by a provider
- [ ] Sample size was too small (fewer than 30)
- [x] Other

2. Explain in more detail why you weren't able to collect the CAHPS survey.

It has been our policy in Rhode Island that our MCOs collect CAHPS surveys. Each MCO is contractually obligated to collect a CAHPS survey for their member population, and each MCO subsequently submits the survey results to Rhode Island EOHHS. We receive the survey results in either PDF or Excel format. EOHHS does not have access to the raw data. The CAHPS survey method is validated by our External Quality Review Organization (EQRO).

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- ○ Yes
- ◉ No

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them

are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Reduce the number of uninsured children under age 19 by .5%. Data source is: ACS survey data in Table HI05_ACS

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Children under age 19 with no insurance according to the ACS survey.

4. Numerator (total number)

5697

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total children under age 19 in the ACS survey.

6. Denominator (total number)

227045

Computed: 2.51%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The number of uninsured children under age 19 in the State of Rhode Island in 2019 was 1.8% (margin of error of .7%). While the goal was to reduce the number of uninsured children by .5%, the number of uninsured children under age 19 increased by .7% (1.8% - 2.5%) according to the 2021 ACS Survey. There was no data reported in the ACS survey for 2020 due to the COVID-19 public health emergency. Therefore, we can only compare 2021 to 2019 data for this measure. It is also difficult to estimate the impact of the public health emergency on the number of uninsured children in Rhode Island.

10. What are you doing to continually make progress towards your goal?

Rhode Island has implemented strategies that allow families and children to access eligibility and enrollment seamlessly and in a variety of settings. In addition, Rhode Island has worked to ensure that its systems operate seamlessly to ensure swift enrollment. Newborns are automatically deemed eligible and enrolled. Rhode Island's managed care entities and providers work together to ensure that families and children are aware of qualifying criteria and are assisted with enrolling. Rhode Island will also be working to maintain enrollment during the anticipated public health emergency "unwinding" period in 2023.

11. Anything else you'd like to tell us about this goal?

Yes. The State of Rhode Island Plans to keep this goal in future years. We may adjust the % target based on the opportunities for improvement, and the results of the 2023 public health emergency "unwinding". The denominator of total children under age 19 increased significantly between 2019 (211,974) and 2021 (227,045), a 7% increase in the age group population. This may account for some of the increase in the number of uninsured children in the age group.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access to care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ◉ Discontinued goal

2a. Why was this goal discontinued?

Increase access goal was discontinued in 2020 because the HEDIS Measure for "Children and Adolescents' Access to Primary Care Practitioners (CAP)", was retired by NCQA in 2020. Therefore, there is no 2020 or 2021 data available to assess performance for this measure.

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

/

End
mm/yyyy

/

8. Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase the use of preventative care for children in Rhode Island.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

Meet the 75th Quality Compass percentile for HEDIS Childhood Immunization Status (CIS-Combo 10)

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

4. Numerator (total number)

3293

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Total number of children included in CHIP and Medicaid (Title XIX).

6. Denominator (total number)

5532

Computed: 59.53%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, there was an increase in the total rate of 1.23% from 2020-2021. The goal was surpassed by meeting the XXth Quality Compass percentile regional benchmark (East North Central All LOB's; Average).

10. What are you doing to continually make progress towards your goal?

RI continues to promote collaboration between providers, payors, and members, to increase access to care and ultimately preventive care. We believe that this effort along with a focus on risk identification, targeted care coordination, and oversight has contributed to RI's success on this goal.

11. Anything else you'd like to tell us about this goal?

Yes, RI plans to keep this goal in future years. We may adjust the percentile target based on performance and opportunity for improvement.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Maintain immunization status for adolescents.

1. Briefly describe your goal as it relates to this objective.

Meet the 75th Quality Compass percentile for HEDIS Adolescent Immunizations (IMA Combo 1)

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

4. Numerator (total number)

4622

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Adolescents who turned age 13 during 2021 included in CHIP and Medicaid (Title XIX)

6. Denominator (total number)

5526

Computed: 83.64%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

There was a decrease in the total performance of 3.34% (86.98%-83.64%) from 2020-2021. The performance of 83.64 percent was in the Quality Compass 50th percentile. Therefore, the goal of meeting the 75th percentile Quality Compass regional benchmark (East North Central All LOB's; Average) was not met.

10. What are you doing to continually make progress towards your goal?

RI's approach to collaboration between members, their providers, and payors has been key to ensuring that families and children are engaged in care. There has been a targeted effort across all of our programs to include a focus on adolescence. This is evident in RI's demonstrations, our updated CHIP SPA, and our MCO contracts. We will continue to keep this focus. The COVID-19 pandemic continued to affect performance on immunization measures during 2021.

11. Anything else you'd like to tell us about this goal?

Yes, RI plans to keep this goal in future years. We may adjust the percentile target based on performance and opportunity for improvement.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 92,966,921	**$** 100,000,000	**$** 105,000,000

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 7,695,000	**$** 8,000,000	**$** 8,500,000

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	92966921	100000000	105000000
Fee for Service	7695000	8000000	8500000
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	100661921	108000000	113500000

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 0	**$** 0	**$** 0

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 800,000	**$** 810,000	**$** 825,000

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	0	0	0
General administration	800000	810000	825000
Contractors and brokers			
Claims processing			
Outreach and marketing			
Health Services Initiatives (HSI)			
Other administrative costs			
Total administrative costs	800000	810000	825000
10% administrative cap	11184657.89	12000000	12611111.11

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	101461921	108810000	114325000
eFMAP	68.42	67.77	68.42
Federal share	69420246.35	73740537	78221165
State share	32041674.65	35069463	36103835

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 29,124	**$** 30,000	**$** 31,000

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 245	**$** 260	**$** 275

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	245	260	275

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 2,258	**$** 2,250	**$** 2,250

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 262	**$** 275	**$** 290

	FFY 2022	**FFY 2023**	**FFY 2024**
PMPM cost	262	275	290

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

Operationally, Rhode Island does not treat its CHIP-eligible members differently from its regular Medicaid children. In general, for MAGI-based eligibility groups (inc. CHIP children) enrollment in managed care is mandatory except in instances where the member has employer-sponsored insurance and Rhode Island is providing just wrap-around services or if the member has requested not to be enrolled in managed care. As such, most children are only temporarily enrolled in FFS upon first gaining Medicaid/CHIP eligibility; but these may include high cost services if, for example, a hospitalization is what prompted a members' enrollment. Total FFS amounts reflects all FFS transactions on a paid basis as reported on Rhode Island's CMS 64/21. The calculated PMPM is inclusive of all managed care payments made on behalf of children under the age of 19, including capitated payments for the major medical and other capitated payments such as dental and transportation. Pharmacy rebates collected by the State, NICU benefits paid on a FFS basis (as it is a carved out benefit), or any risk share related recoupments/payments are not included in calculation of managed care PMPM.

2. Optional: Attach any additional documents here.

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

There were no significant fiscal or political impacts to the CHIP program during the reporting period.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The most significant challenge facing the program was the continued presence the COVID-19 pandemic and the impact on access to care for CHIP members. EOHHS directed MCOs to coordinate with pediatricians and children's providers to ensure children had access to all services, to include COVID-19 vaccinations for eligible age groups; childhood immunizations, well-visits and lead screenings.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

EOHHS has continued to build on the success of the active contract management (ACM) strategy to drive success and impart change with all health plans. RI Medicaid prioritized immunizations to be included in the ACM performance review strategies with MCOs, (inclusive of lead screening). RI Medicaid continues to make strides in this area. In keeping with the effort to address the ongoing needs of children during the pandemic, RI moved forward with rate increases for Early Intervention (EI) and Home-based therapeutic services (HBTS) for children. The hope is that the increase in rates impacts work force and ultimately impacts access to necessary care for children

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

The most significant change made to the CHIP program in FFY 2022 was done at a policy level. RI Medicaid saw a gap in access to Medicaid for presumably eligible children. This gap impacted public health and the mission to ensure entitlements are utilized. To address this, EOHHS initiated a change in eligibility by updating the State Plan and seek approval from the Centers for Medicare and Medicaid Services (CMS) to provide Medicaid coverage for children, until they reach nineteen years of age, whose family income levels are up to two hundred fifty percent of the federal poverty level regardless of immigration status. With this modification, RI expects that the uninsured rate will be impacted positively.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

Rhode Island Medicaid continues to engage all health and human service agencies to ensure that all eligible children are covered by Medicaid but also to ensure that all children have access to the appropriate services they need to thrive.

6. Optional: Attach any additional documents here.

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