Report to the Centers for Medicare and Medicaid Services

Annual Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2015 – December 31, 2015

Submitted by the Rhode Island Executive Office of Health and Human Services (EOHHS)

August 2016

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Annual Report Demonstration Reporting

Period: DY 7 January 1, 2015 – December 31, 2015

II. Introduction

The Rhode Island Medicaid Reform Act of 2008 (R.I.G.L §42-12.4) directed the state to apply for a global demonstration project under the authority of section 1115(a) of Title XI of the Social Security Act (the Act) to restructure the state's Medicaid program to establish a "sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value- based purchasing to maximize available service options" and "a results-oriented system of coordinated care."

Toward this end, Rhode Island's Comprehensive demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure that beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of: 1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

With those four exceptions, all Medicaid funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration or otherwise, are subject to the requirements of the demonstration. Rhode Island's previous section 1115 demonstration programs, RIte Care and RIte Share, were subsumed under this demonstration, in addition to the state's previous section 1915(b) Dental Waiver and the state's previous section 1915(c) home and community-based services (HCBS) waivers. The state's title XIX state plan as approved; its title XXI state plan, as approved; and this Medicaid section 1115 demonstration entitled "Rhode Island Comprehensive Demonstration," will continue to operate concurrently for the demonstration period.

The Rhode Island Comprehensive demonstration includes the following distinct components:

a. The Managed Care component provides Medicaid state plan benefits as well as supplemental benefits as identified in Attachment A of the Standard Terms and Conditions (STCs) to most recipients eligible under the Medicaid state plan, including the new adult group effective January 1, 2014. Benefits are provided through comprehensive mandatory managed care delivery systems. The amount, duration and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.

b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid eligibility under RIte Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL. Section X of the STCs details the requirements.

c. The RIte Share premium assistance component enrolls individuals who are eligible for Medicaid/CHIP, and who are employees or dependents of an employee of an employer that offers a "qualified" plan into the Employer Sponsored Insurance (ESI) coverage.

d. Effective through December 31, 2013, the Rhody Health Partners component provides Medicaid state plan and demonstration benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance. Effective November 1, 2013, the Rhody Health Options and Connect Care Choice Community Partners component expanded to all qualified aged, blind, and disabled beneficiaries whether they have other health insurance or not. Effective January 1, 2014, the New Adult Group began enrollment in Rhody Health Partners. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.

e. The Connect Care Choice component provides Medicaid state plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.

f. The Home and Community-Based Service component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.

g. The RIte Smiles Program is a managed dental benefit program for Medicaid eligible children born after May 1, 2000.

h. Rhody Health Options is a managed care delivery system for Medicaid only and Medicare Medicaid eligibles that integrates acute and primary care and long term care services and supports.

i. Connect Care Choice Community Partners is an optional delivery system for Adult, Blind and Disabled Medicaid and Medicare Medicaid eligibles that utilizes a community health team and a Coordinating Care Entity to integrate Medicaid benefits.

On December 23, 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes changes to support the state's implementation of the

Affordable Care Act (including coverage of the new adult group for adults with incomes at or below 133 percent of the FPL), the expansion of the state's home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model. The Comprehensive demonstration renewal commenced with effectives date of January 1, 2014.

III. Enrollment Information

Complete the following table that outlines all enrollment activity under the demonstration. Indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by placing "0" in the appropriate cell.

Note: *Enrollment counts should be participant counts, not participant months.*

Population Groups (as hard coded in the CMS-64)	Number of Current Enrollees (to date)* 03/31/15	Number of Enrollees That Lost Eligibility in 03/31/15**	Number of Current Enrollees (to date)* 06/30/15	Number of Enrollees That Lost Eligibility in 06/30/15**	Number of Current Enrollees (to date)* 09/30/15	Number of Enrollees That Lost Eligibility in 09/30/15**	Number of Current Enrollees (to date)* 12/31/15	Number of Enrollees That Lost Eligibility in 12/31/15**
Budget Population 1: ABD no TPL	19,496	1,016	18,407	1,180	17,040	1,288	15,123	1,413
Budget Population 2: ABD TPL	27,767	389	28,785	514	29,900	395	31,079	444
Budget Population 3: RIte Care	124,087	4,728	123,955	4,795	124,441	2,167	123,386	1,463
Budget Population 4: CSHCN	12,332	237	12,253	357	12,155	380	12,036	395
Budget Population 5: EFP	116	21	94	35	128	2	224	4
Budget Population 6: Pregnant Expansion	48	6	36	13	33	2	40	2
Budget Population 7: CHIP Children	25,536	983	25,111	1,134	27,174	460	29,033	549
Budget Population 8: Substitute care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 9: CSHCN Alt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 10: Elders 65 and over	1,453	88	1,487	96	1,515	113	1,507	114
Budget Population 11, 12, 13: 217-like group	3,490	68	3,524	82	3,611	69	3,632	91
Budget Population 14: BCCTP	130	11	117	10	113	10	117	7
Budget Population 15: AD Risk for LTC	2,913	2	2,968	1	3,007	1	3,059	0
Budget Population 16: Adult Mental Unins	12,028	0	12,028	0	12,028	0	12,027	1
Budget Population 17: Youth Risk Medic	2,649	173	2,717	222	2,774	207	2,820	185
Budget Population 18: HIV	259	76	259	113	281	37	286	45
Budget Population 19: AD Non-working	0	0	0	0	0	0	0	50
Budget Population 20: Alzheimer adults	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 21: Beckett aged out	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 22: New Adult Group	62,473	2,829	64,049	1,769	64,865	2,987	65,741	1,370

*Current Enrollees:
Number of current enrollees in the eligibility system as of the last day of the month in the quarter on the basis of Medicaid eligibility.

**Number of Enrollees That Lost Eligibility in the Current Quarter:
Number of enrollees no longer in the eligibility system as of the last day of the month in the quarter on the basis of Medicaid eligibility.

IV. "New"-to-"Continuing" Ratio

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the each quarter in DY 7 January 1, 2015 – December 31, 2015:

Quarter 1: 0.017 (8/453) at the close of the quarter
Quarter 2: 0.044 (20/448) at the close of the quarter
Quarter 3: 0.058 (26/448) at the close of the quarter
Quarter 4: 0.036 (17/462) at the close of the quarter

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during each quarter of DY7 2015 (by category or by type) with an annual total of special purchases expenditures of $15,983.94.

Quarter 1 2015	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	3	Over the counter medicines		$ 586.90
	12	Acupuncture		$ 1,125.00
	20	Massage Therapy		$ 1,215.00
	2	Service Dog Training		$ 185.00
	3	Strength Training/URI		$ 16.00
	1	Supplies, non-medical		$ 107.00
	1	Reiki		$ 60.00
	10	Laundry		$ 682.00
	CUMULATIVE TOTAL			**$ 3,976.90**

Quarter 2 2015	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	2	Over the counter medicines		$ 562.06
	15	Acupuncture		$ 1,125.00
	9	Massage Therapy		$ 615.00
	3	Service Dog Training		$ 277.50
	1	Supplies, non-medical		$ 107.00
	3	Fitness Training		$ 40.00
	20	Laundry		$ 812.80
	CUMULATIVE TOTAL			**$ 3,539.36**

Quarter 3 2015	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	3	Over the counter medicines		$ 838.40
	15	Acupuncture		$ 1,125.00
	9	Massage Therapy		$ 615.00
	3	Service Dog Training		$ 277.50
	1	Fitness Training		$ 48.00
	17	Laundry		$ 587.00

	CUMULATIVE TOTAL	**$ 3,490.90**

Quarter 4 2015	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	3	Over the counter medicines		$ 667.89
	1	RIPTIX	Transportation	$ 60.00
	15	Acupuncture		$ 1,125.00
	15	Massage Therapy		$ 877.50
	4	Service Dog Training		$ 370.00
	3	Fitness Training		$ 144.00
	2	Support Stockings		$ 214.00
	1	Diabetes Nurse	Diabetes Education	$ 65.00
	1	Medical Alert		$ 49.99
	15	Laundry		$ 566.00
	1	Abdominal Binder		$ 29.50
	1	Scooter		$ 807.90
	CUMULATIVE TOTAL			**$ 4,976.78**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the quarters during DY7 January 1, 2015 – December 31, 2015.

Innovative Activities

Reinventing Medicaid

Governor Gina Raimondo issued Executive Order 15-08 in early 2015 charging the Secretary of Health and Human Services to convene a Working Group to study and make recommendations on how to Reinvent Medicaid. Governor Raimondo understood that the old Medicaid model was unsustainable, as it relied heavily on volume-based payment structures and did not include sufficient incentives for the delivery of cost-effective, quality health care. To this end Governor Raimondo appointed the Working Group to Reinvent Medicaid with two main charges: to submit a report on or about April 30, 2015, of its findings and recommendations for consideration in the Fiscal Year 2016 budget; and to submit recommendations, no later than July 1, 2015, for a plan for a multi-year transformation of the Medicaid program and all state publicly financed health care in Rhode Island.

Executive Order 15-08 further directed that "the Working Group's meetings shall be public meetings and shall be held in various locations throughout Rhode Island." In compliance with this directive, the Working Group met on four occasions and convened town hall-style meetings across Rhode Island. Approximately 400 Rhode Islanders attended these town hall-style meetings, details of which are outlined in the Outreach Activities section that follows. With these reports, strong partnership from the General Assembly, and working with leaders in the healthcare, business and labor communities, Rhode Island passed the Reinventing Medicaid Act of 2015. The Act identified key initiatives that provide a better coordination of mental and physical health, a better coordination of care through Rhode Island's managed care organizations and provider partnerships; a continued emphasis to shift service delivery away from institutional care and toward community-based services, and better enforcement of Medicaid rules to protect against waste and fraud.

In the year since, the state has been implementing these initiatives and others that are projected to save approximately $75 million in state Medicaid spending this year without cutting eligibility and without reducing benefits. In the out years, the savings associated with these initiatives are projected to be even larger relative to projected costs without Reinventing Medicaid.

Healthcare Innovation

Building on the successful efforts to reinvent Medicaid and shift Rhode Island's publicly funded healthcare system to pay for value instead of volume, Governor Raimondo launched a public effort to spark innovation across the entire healthcare industry, eliminate waste from the system, and hold down the cost of healthcare. In Executive Order 15-13, Governor Raimondo creating the Working Group for Healthcare Innovation. This publicly meeting group was comprised of a varied membership of healthcare professionals, patient advocates, business leaders and others to examine and recommend improvements across the state's entire healthcare system. The

Working Group's challenge was to build on this promising foundation laid by the efforts to Reinvent Medicaid. It became clear that there is an opportunity to transform Rhode Island's healthcare system, and in doing so achieve the Triple Aim: improve the health of those served, enhance the quality of care, lower per-capita costs. The Secretary of Health and Human Services was tasked with chairing this group and leading these efforts.

The Working Group, which met on four occasions with two public listening sessions and six subgroup meetings detailed in the Outreach Activities section to follow, devised four recommendations for Governor Raimondo to consider as means to moving Rhode Island's healthcare system forward: To create an Office of Health Policy to set statewide health policy goals and oversee effective implementation; to hold the system accountable for cost and quality, and increase transparency through a spending target; to expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs; and to align policies around alternative payment models, population health, health information technology and other priorities.

State Innovation Model

Rhode Island was awarded a State Innovation Model (SIM) Test grant in 2013 by the Centers for Medicare and Medicaid Services. In July of 2014 Rhode Island applied for the second round of SIM awards in order to test its model design. As a part of Round Two, Rhode Island has received a $20 million award to test its health care payment and service delivery reform model over the next four years.

The governance model for SIM Round Two includes the following:

> ***Healthy Rhode Island Steering Committee*:** This Steering Committee is the governing body of SIM Round Two. The Committee is composed of state officials, hospitals, long-term care providers, behavioral health practitioners, health insurers, primary care practice organizations, advocates, and consumers. This Committee is setting the strategic direction and policy goals of SIM Round Two.
>
> ***Contractual support*:** EOHHS intends to enter into a competitive bid process for: 1) project management, 2) evaluation and monitoring, and 3) data management /analytics contractual support.
>
> ***Internal working group of state staff*:** SIM Round Two is a collaborative effort that includes staff representation from the following state agencies: Office of the Governor, Office of the Lt. Governor, EOHHS, Department of Health (DOH), Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), Office of the Health Insurance Commissioner (OHIC), Department of Administration (HealthSourceRI and the State Employee Health Plan).

A project director for SIM was brought on board in late 2015. The steering committee meets on a regular basis and has decided that to reach the goal of improving Population Health (which

includes both physical and behavioral health; behavioral health always includes mental health and substance use disorders), there need to be investments in the people – providers and patients – who must adapt to a new system. The SIM Steering Committee has chosen to make investments in three major buckets of work with the intent of having a measurable impact on Population Health and the reform of Rhode Island's healthcare system. These three buckets are: investing in Rhode Island's Provider Workforce/Practice Transformation; patient empowerment; and increasing data capability and expertise. Given these decisions SIM staff are beginning the processes that will allow funding to flow to these projects. The SIM project will continue its work on transformation opportunities as a result of this grant opportunity and will work with community stakeholder along the way to achieve these goals.

Integrated Care Initiative – Phase 2

The Integrated Care Initiative- Phase 2 is designed to coordinate both Medicare and Medicaid benefits into one, integrated delivery system for eligible members. The ICI Phase 2 is a partnership between the Centers for Medicare and Medicaid Services (CMS) and the State of Rhode Island. CMS issued a press release on July 30, 2015 announcing the Memorandum of Understanding between the State and CMS. A three way contract is now pending between the state, Neighborhood Health Plan and CMS. Understanding that this work will involve consumers with key needs, a vigorous stakeholder process has been underway, building upon the contiguous updates given at the Executive Office of Health and Human Service's Task Force meetings. As the work moves forward, an effort is under way to create a formal Integrated Care Initiative Implementation Council, comprised of 51% consumers, 49% advocates, providers and interested parties designed to mimic similar successful stakeholder bodies in nearby states.

Outreach Activities

Rhode Island has continued to execute the State's comprehensive communications strategy to inform stakeholders about the 1115 Demonstration Waiver. In addition, efforts have increased to inform stakeholders about all aforementioned innovation activities with the intent to keep all processes strong with effective, and open, feedback.

- Convened ten meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (formerly named 1115 Waiver Task Force) in 2015 on January 26, February 23, March 23, May 18, June 22, August 24, September 28, October 26, November 23 and December 14, 2015

- Updated the EOHHS website information on the Integrated Care Initiative Phase 2

- Updated the EOHHS website on State Innovation Model Grant Activities

- Updated the EOHHS website on new initiatives

- Convened seven meetings of the Reinventing Medicaid Working Group on March 2, April 6, April 22, April 30, May 27, June 24 and July 8, 2015

- Convened four Town Hall style meetings to hear direct from the public on the topic of Reinventing Medicaid on March 16, March 18, March 23 and April 1, 2015

- Convened four meetings of the Working Group for Healthcare Innovation on August 19, October 7, November 4, and December 1, 2015

- Convened two Listening Session meeting to hear direct from the public on the topic of Healthcare Innovation on September 15 and October 13, 2015

- Convened four meeting of providers, physicians, specialists, nurse practioners and interested parties with the Secretary of EOHHS to encourage feedback and input from providers on September 29, October 27 and December 9, 2015

- Convened twelve meetings focused on State Innovation Model efforts, with varying working groups and committees on September 9, October 15, December 10, 2015

- As an effort to devote more time to the topic, branched off the EOHHS Task Force and convened four meetings focused on the Integrated Care Initiative Phase 2 work on October 10 and November 16, 2015

- Conducted the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on March 3, September 9 and December 02, 2015

- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs

- Conducted numerous community and provider trainings on the Integrated Care Initiative

- Continued refinements to the EOHHS website and partnerships with the Governor's office to improve communications and transparency

- Posted the following reports to the EOHHS websites:

    - Long Term Care Transition Report, January – December 2014
    - 1115 Demonstration Waiver Quarterly Report January –March 2014, March 2015
    - Sherlock Plan Report, March, May and September 2015
    - Rhode Island Annual Medicaid Expenditure Report (SFY2014), June 2015

- Monitoring Quality and Access in RIte Care & Rhody Health Partners, October 2015

- Posted Monthly Provider Updates in January- December 2015
- Posted public notice on rule, regulations and procedures for EOHHS

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the quarters in DY7 January 1, 2015 –December 31, 2015.

Reinventing Medicaid Act of 2015

After years of Medicaid growth that was crowding out investment in education, infrastructure and skills training, Governor Raimondo and Secretary Roberts led a successful effort to Reinvent Medicaid. The packages of progressive, sustainable reforms goes beyond straight cuts and drive the system to pay for outcomes and value, not volume:

- 34+ initiatives achieve $70 million in immediate state savings without cutting eligibility.
- Creates Rhode Island's first incentive model for hospitals and nursing homes that rewards providers for achieving better outcomes.
- After nearly a decade of talking about "rebalancing" long term care, state finally makes meaningful investments in home- and community-based services like assisted living and adult day.
- Long-term recommendations from Working Group to Reinvent Medicaid set ambitious goal to tie 80 percent of all Medicaid payments to a quality measure by 2018.

The Reinventing Medicaid initiatives focus on:

- better coordination of mental and physical healthcare;
- better coordination of care through our managed care organizations and new provider partnerships;
- a continued emphasis to shift service delivery away from institutional care and toward community-based services; and
- better enforcement, through new electronic monitoring programs, of Medicaid rules to protect against waste and fraud

The Reinventing Medicaid Initiatives implementation required the following activities: a review of the federal and state authority; policy; systems; financing/rate setting; contracts; communications and stakeholder engagement. The following is a compilation of the Reinventing Medicaid initiatives which collectively sets forth a pathway to meaningful transformation of the delivery of services funded under Medicaid.

- Align with federal and commercial value-based purchasing targets: 50% by 2018
- Pilot coordinated care program
- Scale up community health reams
- Hospital incentive program
- Nursing home incentive program
- Reduce or eliminate NICU policy adjuster to DRG rate
- Pay GME funding
- Rate-setting for lab (across FFS and MCO)
- Improve personal choice program administration
- Eliminate automatic hospital rate increase and adjust rate by -2.5%

- Delay October 1 nursing home payment bump
- Fund automatic impatient and outpatient UPL supplemental payments through license fee
- Enhance Medicare identification
- Enhance residency verifications
- Redesign Medically needy program to reduce churn and improve care coordination
- Streamlined eligibility-only use ABD for over 65 or need 3 month retro
- Evaluate structural barriers to HCBS in our eligibility rules and other state policies
- Align criteria for "highest need "level of care with MA and CT: applicants need 3 or more ADLs to qualify
- Implement expedited eligibility for long-term services and supports
- Develop a bundled payment model for maternity and childbirth, including NICU
- Develop a state policy around Telehealth services under Medicaid
- Ensure Medicaid pharmacy purchase "best price" drugs (including a single PDL)
- Align commercial insurance mandates : EI cap, ABA cap
- Ensure agency-wide consistency in payment rates and eligibility determination of certain high cost services (homecare services, CEDARR direct services, residential services)
- Redesign CEDARR services. Program, transition to community health team approach
- Move out-of-plan services for children with special healthcare needs into managed care
- Redesign Connect Care Choice Program: transition to CHT approach
- Assess hospice payment to ensure the state is paying for value
- Home stabilization initiative for targeted populations, including DCYF children, adults and youth experiencing or at risk of homelessness, elders returning to the community for a nursing home
- Change payment structure to support expansion of assisted living
- Increase participation in PACE
- Implement Adult Supportive Care Residence
- Increase estate recoveries
- Electronic Visit Verification
- Enhanced verification for payment of HCBS
- Enhancement and automation of patient share collection (HCBS and DD)
- Predictive modeling
- Enhanced Fraud Prevention contract with additional vendor to screen eligibility (RFI)
- Performance efficiencies and administrative simplification
- Coordinate veterans with VA for eligible veterans
- Identify alternate (lower-cost) settings for appropriate Eleanor Slater Hospital residents
- Fund STOP program for chronic inebriation
- Convert RICLAS group home to private sector
- Closure of group homes (Southwick and Rogler)
- Private laundry service at Eleanor Slater Hospital
- Consolidation of Food Services between ACI and Eleanor Slater Hospital
- Coordinated care management of SPMI

Working Group for Healthcare Innovation

Building on the successful Reinventing Medicaid reforms, Governor Raimondo directed Secretary Roberts to lead an ambitious effort to spark innovation across the entire healthcare system. The Working Group for Healthcare Innovation proposed a series of actions to provide Rhode Island families and businesses with more predictability in their healthcare spending:

- Create an Office of Health Policy to better coordinate health policy decisions that affect all Rhode Islanders.
- Establish the framework for a spending target that aligns the growth of healthcare spending with the growth of the overall economy.
- Additional recommendations included:
    - establish population health goals to support healthier communities;
    - expand the state's analytic capabilities;
    - increase use of health information technology; and
    - heighten the focus on alternative payment models to drive better care at more sustainable costs.

Health Equity Zones

Health begins where we live, learn, work and play. Governor Raimondo has championed the Department of Health's Health Equity Zone initiative because it's an innovative approach that helps everyone have a fair chance at good health, no matter their zip code. The Health Equity Zones were established in 11 RI regions with the goals outlined below:

- Build healthier communities through local partnerships to prevent chronic diseases, improve birth outcomes, and improve social and environmental conditions.
- Root strategies in science and evidence-based practice.
- Set a national model of innovation and collaboration that other states can turn to.

Turnaround Efforts at DCYF and Eleanor Slater Hospital

Governor Raimondo inherited significant administrative and managerial challenges at DCYF and Eleanor Slater Hospital and ordered an immediate overhaul of both agencies in July of 2015. Change is hard and often requires new perspective. Over the last six months, both agencies have taken significant steps to address operational challenges and achieve better results for some of the most vulnerable children and patients in the state.

Department of Children, Youth and Families

- Nationally-respected leaders partnering with DCYF to reform placement processes and build additional capacity to provide kids and families with the right care, at the right time and in the right setting.
- Governor Raimondo included additional funding in the FY16 budget for foster care. For first time since 2009, Rhode Island earned recognition through the federal Adoptions Incentive Program for efforts to place children in permanent foster and adoptive homes.

- Since taking office, Raimondo administration has launched a comprehensive review of all contracts over $1 million and scaled back other contracts as the agency builds capacity to consolidate services with better performance management.

Eleanor Slater Hospital

- Recruited and hired nationally-respected chief medical officer and developed a robust recruitment strategy to fill other key managerial and clinical leadership positions.
- Commenced developing academic medical training programs and links with Brown University's Alpert School of Medicine.
- Collaborated with an interim management team to develop a more responsive executive staffing structure and improve the hospital's operational efficiency, clinical quality, risk management and patient services.

Overdose Prevention and Intervention Task Force

Addiction and overdose are claiming lives, destroying families and limiting opportunity for too many Rhode Islanders. Governor Raimondo's Overdose Prevention and Intervention Task Force developed a strategic, evidence-based plan to reduce opioid overdose by one-third within three years. The plan recommended:

- Developing a system to provide Medication-Assisted Treatment everywhere opioid users are found, including the medical and criminal justice systems, drug treatment programs and in the community.
- Making a sustainable source of naloxone, which can save lives by reversing the effects of an overdose, available for communities, first responders and people at risk of overdose.
- Establishing a prescriber program and system-level efforts to reduce unsafe combinations of prescribed medications.
- Facilitating a large-scale expansion of peer recovery coaches to support long-term addiction recovery.

Key Health and Human Services Accolades

- RIte Care ranked as the nation's top Medicaid program for children and families.
- State's uninsured rate falls to 5 percent, one of the lowest in the U.S.
- America's Health Rankings list Rhode Island as the 14th healthiest state in the U.S., number one in immunizations for teens, and among the top six states for health policy.

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island has been established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall goal is to improve care for Rhode Island's elder and people with disabilities to improve quality of care; maximize the ability of members to live safely in their homes and communities; improve continuity of care across settings and promote a system that is person-centered and helps members attain or maintain personal health goals. Rhode Island is implementing the ICI in two phases. Phase 1 commenced

in November 2013 with the enrollment of eligible individuals into managed care for their Medicaid funded services, including long-term services and supports (LTSS). Phase 2 is expected to start in the Spring of 2016. Phase 2 will be a partnership between the Rhode Island Medicaid program, CMS and a managed care organization under the Financial Alignment Demonstration opportunity. Activities conducted during the reporting quarters in DY7 January 1, 2015 – December 31, 2015 are outlined below.

Phase 1 of the ICI

- Mailed ICI enrollment letters to 6,851 new eligible beneficiaries from January 1, 2015 – December 31, 2015
- Enrolled 21,920 eligible beneficiaries in the ICI as of December 31, 2015
- Conducted ICI trainings for stakeholders including consumers, advocates and providers
- Presented at the Lt. Governor's Long Term Care Coordinating Council meetings in February, March, April, May, June, September, October, November and December of 2015
- Continued readiness reviews and operational oversight of the ICI contracted vendors
- Monitored the Enrollment Help Line activities
- Processed enrollment opt-out requests and mailed confirmation of ICI program opt-out
- Provided guidance to providers regarding enrollment opt-out procedures and billing procedures
- Identified and resolved systems issues
- Identified issues with patient liability
- Continued to develop the Medicare Data Use Agreement application
- Refined reporting templates for the ICI initiative
- Planned the sunset of Connect Care Choice Community Partners and transitioned members to the managed care organization
- Prepared amendments to the contracts related to the Reinventing Medicaid initiatives

Phase 2 of the ICI

- Continued to negotiate the Memorandum of Understanding (MOU) for the three-way contract under the Financial Alignment Demonstration
- Executed the MOU in July 2015
- Continued to analyze data for the Phase 2 rate development and continued the rate negotiation with CMS
- Developed the procurement document for the CMS Ombudsman Grant for Phase 2
- Provided information to internal and external stakeholder on the Phase 2 ICI initiative
- Established the ICI Implementation Council
- Continued to negotiate the terms of three-way contract for the Financial Alignment Demonstration with CMS

- Developed the proposal for the enhanced ADRC/SHIP funding available to states participating in the Financial Alignment Demonstration
- Participated in the Center for Health Care Strategies initiative, Implementing New Systems of Care for Dually Eligible Enrollees, known as INSIDE, made possible by The SCAN Foundation and The Commonwealth Fund
- Finalized the systems modifications needed to support the Financial Alignment Demonstration
- Continued the planning for the call center operation requirements under the Financial Alignment Demonstration
- Continued the development of the marketing and member materials for the Financial Alignment Demonstration
- Conducted readiness review activities with CMS and NHPRI

Health Reform/New Adult Group (Medicaid Expansion)

On January 1, 2014, enrollment under Health Reform through HealthSource RI into a Qualified Health Plan (QHP) and the Medicaid New Adult Group became effective. Individual and families could apply online or by phone, in-person, or by mail. The Health Source RI Contact Center staff, the Navigator Program (with 140 individuals available to assist), Department of Human Services Field Staff and EOHHS/Medicaid staff have been assisting clients with the enrollment process since October 1, 2013. The activities conducted are outlined below.

- Continued on-going enrollment
- As of December 31 2015, enrollment in Medicaid through HealthSource RI was 65,741
- Continued oversight of the managed care organizations
- Continued systems modifications to support enrollment of the New Adult Group
- Monitored enrollment of newborns into Medicaid and QHPs
- Worked with customer service staff from the state and HealthSource RI to resolve enrollment issues

Patient Centered Medical Home/High Utilizers Strategy

Rhode Island's Care Transformation Collaborative (CTC), formerly known as Patient Chronic Care Sustainability Initiative (CSI-RI), brings together key health care stakeholders, including Medicaid, to promote care for patients with chronic illness through the patient-centered medical home model. CTC's mission is to lead the transformation of primary care in Rhode Island. CTC brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care. A pilot has been developed to address barriers to CTC practice sites success in meeting utilization targets for all cause hospitalization and all cause emergency use through the use of a Community Health Team. This effort aligns with Medicaid high utilizers' strategy. Additionally, the PCMH-Kids initiative, an all-payer medical home demonstration project for children and their families,

identified a cohort of practices to participate in the PCMH-Kids practice transformation collaborative. During the reporting quarters, the following activities have occurred.

- Monitored the intensive care management strategies focused on patients who are identified as high risk/high cost/high impact in a targeted geographic region
- Analyzed data to identify high utilizers for the Reinventing Medicaid initiatives
- Implemented the strategy to define high utilizers, establish "real time" patient registry of high risk patients to generate lists of high risk patients with "impactable" high cost conditions
- Continued to explore opportunities to align efforts with current*care,* the statewide Health Information Exchange
- Participated in the PCMH-Kids initiative design and development

Medicaid Adult Quality Grant

Rhode Island received a Medicaid Adult Quality Grant in December 2013. Funding under this grant was to assist states with the implementation of the twenty-six (26) Medicaid Adult Core Set Measures. Grantees were required to implement two quality improvement projects tied to one of the Medicaid Adult Core Set Measures and maintain implementation of the Quality Improvement Projects (QIPs) over the two-year grant period. The following work has been achieved on the quality improvement projects.

- Released a mini-bid in April 2015 to solicit entities who could provide us with three products:
  1) a review of our current data analytic infrastructure and development of a modernization/integration plan;
  2) a comprehensive assessment of the data warehouse and capability gaps; and
  3) assistance in developing and implementing data models or cubes (using either MMIS or warehouse) that would allow grant staff to more readily calculate quality measures across time (years), programs, plans, and populations.

- Planned to construct simplified (i.e., integrated across Medicaid delivery systems) data extracts/sets that are specifically designed to more readily support quality measurement analytics.
- Attended a weekly Analytics and Evaluation Meeting to review data files and develop and share standard tools and methodologies for analytics that support the Medicaid program in general.
- The AMQ team also lent its expertise to statewide efforts such as the SIM Model Test Grant awarded to Rhode Island in December 2014
- Convened interface with the Center for Medicare and Medicaid Innovation (CMMI)
- Organized the goals and deliverables of the SIM State Working Group
- Participated on Rhode Island's newly created All Payer Claims Database (APCD).
- Engaged a vendor, DataStat Inc., to conduct a CAHPS® survey with Rhode Island Fee-

For-Service Medicaid recipients to assess customer satisfaction and further quality measurement.

- Monitored the following QIP activities:

Transitions of Care QIP with Health Centric Advisors

- Convened EOHHS, commercial and Medicaid plans, and OHIC to align expectations around Safe Transitions Best Practice. Met with DOH to discuss alignment with other statewide initiatives and regulations.
- Conducted three (in a series of five) chart audits in participating practice sites to assess information sharing.
- Conducted five (in a series of seven) Micro-Session Webinars to explore current processes and review audit results with participating hospitals and practices.
- Facilitated two Learning Sessions for participating hospitals and practices and broader stakeholders to explore hospital to community provider communication and review results of chart audits and lessons learned from micro-sessions.

Antidepressant Medication Management QIP with University of Rhode Island College of Pharmacy

- Developed algorithms to identify eligible AMM population and identify high volume providers, calculated rates of adherence for MC vs FFS populations, as well as for high volume providers for CY2013 and baseline period.
- Reached out to stakeholders including staff from the Medicaid Connect Care Choice program, Health Plan directors, the Care Transformation Collaborative of RI, the RI Healthcare Advisory Board, to discuss experiences with this QIP and identify opportunities for alignment and spread, and participated in the new England Comparative Effectiveness Public Advisory Council conference on integrating behavioral health into primary care.
- Distributed intervention materials (provider-specific feedback on adherence rates, information regarding prescribing practices, and patient education) and conducted site visits.

Electronic Health Record (EHR) Initiative with Brown University School of Public Health

- Completed qualitative interviews with providers/nurses/ medical assistants at all three participating clinics, to investigate patient flow and clinical staff use of EHRs.
- Worked with participating clinical sites to generate datasets of Medicaid patients meeting certain criteria, including diagnosis and treatment data, for comparison with EOHHS-generated lists.
- Conducted detailed comparisons of clinical sites' EHR-based patient data and EOHHS' claims-based patient data, to identify concordance/discordance in diagnoses and treatments.

- Developed an appropriate sampling scheme, and selected cases for EHR chart review, to analyze discordance of site vs. state data.
- Developed and tested a secure data collection interface to enable capture of EHR chart information, to analyze discordance of site vs. state data.
- Continued meeting on a bi-weekly basis with EOHHS staff and clinic team members, to discuss results, project methodology, and next steps.
- Calculated HgA1c and LDL rates from all three practice sites and compared them to claims-based rates calculated by the state.
- Began the qualitative analysis stage: Brown currently is conducting chart audit analyses from each site to identify sources of variance in measurement reporting and inter-rater reliability on each measure.
- Performed additional analyses assessing our attribution/assignment methodology and its impact on measurement calculation.

Money Follows the Person Demonstration Grant

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011 to rebalance care from an institutional setting to a qualified community based setting of care. Rhode Island has made strides in the rebalancing effort and the activities accomplished are outlined below.

- Received 390 referrals for Nursing Home Transitions
- Transitioned 107 individuals to the community, of which sixty-three (63) individuals qualified under the MFP program.
- Continued to monitor the MFP activities under the managed care Integrated Care Initiative (ICI)
- Continued to directly manage the MFP activities in the Medicaid Fee For Service program
- Continued to develop relationships with housing authorities to improve capacity for community-based housing for individuals transitioning from nursing facilities. Successfully established housing preference's within the 811 demonstration program, Rhode Island Housing- Housing Choice Voucher Program and Charles gate Independent housing for long term stay nursing home residents
- Continued to convene MFP Steering Committee meetings, MFP Housing Sub-Group meetings
- Launched, in collaboration with a clinician from Butler hospital, a state wide Hoarding work group
- Received approval for the states MFP Sustainability Plan
- Received CMS's approval to use MFP rebalancing expenditures to fund a Housing Stabilization Pilot that provides a rental subsidy with a Housing Stabilization Manager to teach a set of skills associated with successful tenancy, Caregiver Guide reprint, obtained

a license to use the Homeless Management Information System (HMIS) in an effort to coordinate care for individuals transitioning out of NH who have a history of homelessness, and approval was received to fund the procurement of training curriculum for both clinical and non-clinical staff to carry out evidence based hoarding interventions and to develop a sustainable, community-based learning collaborative.

- Convened successful CMS site visit for the RI MFP program
- Participated in developing opportunities under the Reinventing Medicaid workgroups related to long term services and supports rebalancing and housing stabilization initiatives

Health Homes

Rhode Island continues to operate three programs under the Health Home opportunity. Activities conducted are outlined below.

- Continued the implementation and oversight of the Opioid Treatment Health Home SPA
- Implemented the Integrated Health Home Initiative for Behavioral Health as part of Reinventing Medicaid
- Continued to monitor the children's health home

Home and Community Base Services (HCBS) Final Rules

In January 2014, CMS published the HCBS final rules. Rhode Island has examined the final rules and has begun the planning of the requirements for implementation of the final rules. The activities that have occurred are outlined below.

- Convened internal and external stakeholder to develop a HCBS Transition Plan for compliance with the final rules
- Developed assessment tools and conducted a survey of HCBS providers compliance under the new HCBS guidelines
- Posted HCBS transition plan for public comments and convened public meetings
- Submitted HCBS Transition Plan to CMS on June 24, 2015
- Continued to develop plan for on-going monitoring of settings, work plan with milestones, on-going survey of settings, Department of Justice Consent Decree alignment with the HCBS Transition Plan and heightened scrutiny process
- Identified and reviewed regulatory and policy changes to support the HCBS final rules

Non-Emergency Medical Transportation

Effective May 1, 2014, the Executive Office of Health and Human Services implemented a new Non-Emergency Medical Transportation management broker contract. The vendor, LogistiCare, began coordinating transportation services for Medicaid beneficiaries and individuals over the age of 60 who do not have access to transportation for critical appointments and services. This change to the transportation system is for Non-Emergency Medical Transportation only**.** The broker provides member services, eligibility verification for transportation services, schedules

appointments with contracted transportation providers, quality assurance and monitoring and program reporting.

- Continued oversight and monitoring of LogistiCare contract activities and complaint issues with missed rides for appointment and transportation provider network capacity
- Eliminated bus pass option and implemented new process to authorize non-emergency medical transportation
- Continued to report to external committees and/or multi-agency groups including: the Alliance for Better Long Term Care and the Lt. Governor's Long Term Care Coordinating Council

Behavioral Health Delivery System Redesign

The Rhode Island General Assembly transferred all Medicaid-funded behavioral health services to EOHHS on July 1, 2014. EOHHS and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) began meeting to plan for the transition and re-design. EOHHS and BHDDH convened stakeholder input into the re-design of the current adult behavioral health benefit, with the goal of integrating the behavioral health benefits with the physical health benefits. EOHHS and BHDDH continued to develop the integration of physical and behavioral health system re-design to produce an equitable, evidence-based, cost-effective, efficient and flexible system that is responsive to the individual and family needs. The target implementation date for the behavioral health benefit package delivered in managed care was revised for January 1, 2016. In addition, as a result of the Reinventing Medicaid initiative, staff have developed the Behavioral Integrated Health Home to be coordinated with managed care in January 2016.

Transforming State LTSS Access Programs and Functions into a No Wrong Door System for All Populations and All Payers

EOHHS received grant funding to develop a three-year plan to design and implement a "No Wrong Door" (NWD) system to help all Rhode Islanders, regardless of age, disability, or income status access needed Long-Term Services and Supports (LTSS). The goal of this grant is to develop a statewide NWD system that provides timely and accurate information about LTSS to consumers. The objectives of the grant are to: Develop a planning document that will address the needs of those consumers who must inform and educate themselves about LTSS options for themselves or their loved ones. The grant will: (1) Involve all stakeholders in the planning process to ensure that the NWD system reflects the needs of the State and is utilized to its fullest capacity; (2) Develop a three-year plan that: a) results in streamed-lined, coordinated, and integrated access to LTSS during the intake, assessment, counseling and enrollment processes for all Rhode Islanders; and b) adheres to the principles of a person-centered options counseling approach for all consumers. Activities conducted during the quarter are outlined below.

- Issued a procurement and selected a contractor for the development of the three-year work plan for the NWD system
- Conducted an environmental scan of the LTSS access processes and opportunities

- Submitted the three-year work plan for RI's NWD system in September 2015 to the Administration for Community Living

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the DY 7 period January 1, 2015 – December 31, 2015.

Request Type	Description	Date Submitted	CMS Action	Date
SPA	Nursing Home Payment Methodology	06/13/2013	Pending	
SPA	Hospital Presumptive Eligibility	03/28/2014	Pending	
Cat II	Coordinated Care Pilot	11/16/2015	Withdrawn	02/09/2015
SPA	Change in the CEDARR benefit	12/02/2014	Withdrawn	01/20/2015
SPA	Outpatient Hospital Rate Reduction and Community Lab Rate Alignment	02/03/2015	Pending	
SPA	Home Equity Increase for LTC	02/24/2015	Approved	03/15/2015
SPA	Annual MNIL Update	02/24/2015	Approved	05/08/2015
SPA	State Supplemental Payments	02/24/2015	Approved	05/13/2015
SPA	Eliminate CHIP Premiums	03/09/2015	Approved	04/22/2015
SPA	Graduate Medical Education	06/15/2015	Denied	12/15/2015
SPA	Update Inpatient Hospital Payment Methodology	06/15/2015	Approved	11/03/2015
SPA	Supplemental Inpatient Hospital Payment	06/17/2015	Approved	10/14/2015
Cat II	Cortical Integrative Therapy	06/22/2015	Withdrawn	09/21/2015
SPA	Rate Reduction-Incontinence Supplies	06/30/2015	Approved	08/27/2015

Request Type	Description	Date Submitted	CMS Action	Date
SPA	Disproportionate Share Hospital Policy Change	09/09/2015	Pending	
Cat III	Cortical Integrative Therapy	09/22/2015	Pending	
SPA	Nursing Home Rate Cut and Delay 10/1 Payment Bump	09/22/2015	Approved	12/04/2015
Cat II	Personal Choice Rate Cut	10/22/2015	Pending	
Cat II	Level of Care Determination Policy	11/16/2015	Pending	
Cat II	STOP	11/16/2015	Pending	
Cat II	Coordinated Care Pilot	11/16/2015	Pending	
Cat II	Home Stabilization Initiative	11/16/2015	Pending	
Cat II	Peer Specialist	11/30/2015	Pending	
SPA	Reduce NICU Adjuster to DRG	12/2/2015	Pending	
SPA	Institute Level of Care Requirement for Adult Day Services	12/28/2015	Pending	
SPA	Inpatient Hospital Rate Reduction	12/31/2015	Pending	

VIII. Financial/Budget Neutrality Developments/Allotment Neutrality Developments/Issues

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the DY 7 quarters, or allotment neutrality and CMS-21 reporting for the DY 7 quarters. The Budget Neutrality Report is can be found in Attachment E-XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the DY7 January 1, 2015 – December 31, 2015. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

The summary of the consumer issues identified during DY7 January 1, 2015 – December 31, 2015 are outlined below.

Consumer Issues

RI EOHHS employs procedures to monitor consumer issues across both managed care[1] and primary care case management[2] delivery systems. The procedures include tracking, investigating and remediating consumer issues and enable the State to identify trends and take preventive action. The procedures differ slightly between the capitated managed care and the PCCM delivery system models.

All Health Plans continuously monitor member complaints to watch for trends or emerging consumer issues. A Summary of Informal Complaints report is submitted to RI EOHHS quarterly. These reports present consumer-reported issues grouped into seven (7) categories: access to care, quality of care, environment of care, health plan enrollment, billing issues, and transportation. The informal complaint reports are also presented each quarter in a face-to-face session with RI EOHHS by each Health Plan during the oversight and administration meetings that focus on Operations. Data is disaggregated according to Medicaid cohort, including Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, Rhody Health Options, and Rhody Health Expansion (ACA)[3].One Plan reported a decrease of 15% in the number of complaints from 2014 to 2015 while the other Plan reported an increase of 20%. Between the 2 plans there was a 6% decrease in the total number of informal complaints from 2014 to 2015. Both of the Plans reported that the majority of complaints were unsubstantiated and that the highest percentages of complaints were made by RIte Care members and the expansion population.

In addition to two Health Plans, there is one dental plan that administers the RIte Smiles program to children born on or after May1, 2000. They monitor informal complaints as well and have seen a 33% drop in the number of informal complaints from 2014 compared to 2015.

RI EOHHS utilizes Summary of Informal Complaints reports and participation in internal Health Plan committees and State oversight and administration meetings to identify consumer issue trends and develop strategies to prevent future occurrence. We also look to find new ways to

[1] The State's capitated managed care programs are: RIte Care, RIte Care for Children with Special Health Care Needs, RIte Care for Children in Substitute Care, Rhody Health Partners, RIte Smiles, Rhody Health Options, and Rhody Health Expansion.

[2] The State's PPCM programs are Connect Care Choice and Connect Care Choice Community Partners.

[3] The Rhody Health Expansion (RHE) cohort became Medicaid eligible in conjunction with the implementation of the Affordable Care Act (ACA).

offer consumer protections as is demonstrated by our requiring the provision of the RI Office of Health Insurance Commissioner's consumer assistance contact line information on specified member communications. This offers our managed care members another avenue by which they may seek assistance in invoking their member rights or in voicing dissatisfaction with the Health Plans' processes.

The State continues to require NHPRI and UHCP-RI to maintain National Committee for Quality Assurance (NCQA) accreditation and adhere to the NCQA's standards that pertain to members' rights and responsibilities. Adherence to this standard dictates that Health Plans:

- Educate members about their right to make a complaint and about the difference between a complaint and an appeal, and about the Plan's process for remediation; and

- Develop and implement an internal process for the tracking, investigation and remediation of complaints.

The State also participates in two advisory groups, the long-standing Consumer Advisory Committee (CAC) and the Integrated Care Initiative's CAC (ICI-CAC), now known as the ICI Implementation Advisory Council. CAC stakeholders include individuals who are enrolled in RIte Care, and representatives of advocacy groups, health plans, the Department of Human Services and EOHHS. The CMS Regional Officer participates in these meetings, as her schedule permits. The CAC met 5 times during CY 2015

January meeting agenda:
- RIte Care Renewals
- Transportation Update
- Enrollment

March meeting agenda:
- RIte Care Renewals
- RIte Share Renewals
- Enrollment

May meeting agenda:
- RIte Care Renewals
- RIte Share Renewals
- Enrollment

September meeting agenda:
- RIte Care Renewals
- RIte Share Renewals
- Enrollment
- Re-invent Medicaid Update

November meeting agenda:

- Re-invent Medicaid Update
- General Medicaid Update
- Enrollment

The ICI Implementation Advisory Council includes individuals who are Medicaid-enrolled and receive Long-term Services and Supports in Phase One of RI's Integrated Care Initiative and representatives of Health Plans and community groups. The group was restructured in the fall to be more of a consumer lead group and met twice in the last part of 2015.

October meeting agenda:

- Role of the Integrated Care Initiative Implementation Advisory Council
- Timeline for Implementation
- Consumer Assistance
    a. Enrollment Line
    b. Ombudsman
    c. ADRC SHIP Counselors
- Outreach, Education & Training
- Public Comment

November meeting agenda:

- Update on Redesign of Connect Care Choice Community Partners
- Medicare-Medicaid Plan Integrated Appeals Process
- Contract Update
- Public Comment

The EOHHS Transportation Broker, Logisticare, reported on transportation related complaints. The number of transportation complaints has decreased over the DY 7 2015, while number of transportation reservations increased. The following charts reflect the number of complaints compared to the increased transportation reservation and the top five complaint areas.

NEMT Analysis	DY 7 Q1	DY 7 Q2	DY 7 Q3	DY 7 Q4	DY 7 Total
All NEMT & Elderly Complaints	1,219	3,291	3,051	4,530	12,091
All NEMAT & Elderly Trip Reservations	276,804	356,085	427,929	471,898	1,532,716
Complaint Performance	0.44%	0.92%	0.71%	0.96%	0.79%

Top 5 Complaint Areas	DY 7 Q1	DY 7 Q2	DY 7 Q3	DY 7 Q4	DY 7 Total
Rider No Show	1	1,237	967	2,258	4,463
Transportation Provider Late	525	790	796	902	3013
Complaint about Rider	27	67	74	287	455
Transportation Provider General Complaint	242	407	309	266	1,224
Transportation Provider No Show	309	581	605	276	1,771

X. Marketplace Subsidy Program Participation

Complete the following table that displays enrollment and cost information pertaining to the Marketplace Subsidy Program. Include a summary and explanation of any trends discovered.

The following chart identifies the marketplace subside program participation during the DCY7 January 1, 2015 – December 31, 2015.

2015 Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Actual Costs
January	95	15	$ 42.61	$ 4,048.00
February	61	-34	$ 46.02	$ 2,807.00
March	155	94	$ 42.57	$ 6,599.00
April	181	26	$ 43.00	$ 7,783.00
May	224	43	$ 43.24	$ 9,686.00
June	203	-21	$ 43.89	$ 8,909.00
July	260	57	$ 42.31	$ 11,001.00
August	230	-30	$ 41.63	$ 9,574.00
September	249	19	$ 41.36	$ 10,298.00
October	251	2	$ 42.41	$ 10,645.00
November	229	-22	$ 41.93	$ 9,601.00
December	251	22	$ 41.22	$ 10,346.00
Total				$ 101,297.00

Summary of Marketplace Activities for the DY 7 January 1, 2015 – December 31, 2015

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 142% and 179% of the Federal Poverty Level (FPL), who are not Medicaid eligible themselves, can apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HeathSource RI Contact Center, online at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Application_for_State_Assistance_Program.pdf, or can be requested by calling the RIte Care InfoLine at (401) 462-5300. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI. Based off a list of families previously enrolled in Medicaid and who met the Premium Assistance Program's FPL guidelines, EOHHS was able to identify and contact potential members. Along with letter generation, a notice was also posted on the EOHHS website.

All potential Premium Assistance members who have submitted an application are confirmed with a monthly report provided by Deloitte. The report lists individuals who meet the income and

Medicaid-related provisions governing the RI Affordable Health Care Coverage Assistance Program (AHCCA). Along with these requirements, a Premium Assistance applicant must also be confirmed in the report as having paid (on-time) for their Silver Plan in order to be eligible for reimbursement.

As of December 2014, the monthly report has been automated and is available in UHIP. The report is run on the 27th of the previous month, and aims to ensure that potentially eligible members have *fully* paid for next month's Silver Plan coverage by the due date specified by their insurer. Within Deloitte's January and February 2015 reports, as many as 5,153 individuals had been identified as potentially eligible for future enrollment. The Premium Assistance Program contacted this group of potential applicants via mail, which led to a substantial increase in the program's enrollment.

The following chart identifies that Marketplace Subsidy Program and Childless Adult QHP enrollment trends during DY7 January 1, 2015 - December 31, 2015.

2015 Month	**Number of Childless Adults Enrolled in a QHP**	**% Change in QHP Enrollment of Childless Adults from Previous Month**	**Number of Marketplace Subsidy Enrollees**	**% Change in Marketplace Subsidy Enrollment from Previous Month**
January	3674		95	
February	4283	17%	61	-36%
March	5158	20%	155	154%
April	5297	3%	181	17%
May	5324	1%	224	24%
June	5337	0%	203	-9%
July	5334	0%	260	28%
August	5362	1%	230	-12%
September	5298	-1%	249	8%
October	5325	1%	251	1%
November	5345	0%	229	-9%
December	5155	-4%	251	10%

Enrollment trends for Marketplace Subsidy are highly variable from month to month, with changes in enrollment ranging from a decrease of 12% to an increase of 28%. Conversely, the QHP monthly enrollment trends are rather steady, with changes in enrollment ranging from a decrease of 4% to an increase of 3%. The variability in Marketplace Subsidy enrollment may be attributed to members losing eligibility due to tardy or insufficient premium payments. The State recommends the continuation of the Marketplace Subsidy program. This program assists parents/caretakers who are low income with premium payments to ensure they have access to and can afford health insurance.

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in the quarters in DY7.

The following report is represents the major evaluation, quality assurance and monitoring during the reporting quarters in DY7 January 1, 2015 – December 31, 2015.

Quality Assurance and monitoring of the State's Medicaid-participating Health Plans

On a monthly basis, the RI EOHHS leads oversight and administration meetings with the State's three (3) Medicaid participating Plans, NHPRI, UHC Dental, and UHCP-RI. These monthly meetings are conducted separately with each Health Plan; agenda items focus upon both standing areas of focus as well as emerging items. Each of the following content areas is addressed on a cyclic, quarterly basis: a) Medicaid managed care operations (January/April/July/October); b) Quality improvement, compliance, and program integrity (March/June/September/December); & c) Medicaid managed care financial performance (February/May/August/November).

Specific to quality improvement, compliance, and program integrity, the following areas of focus were addressed during the cycle of oversight and administration meetings that were conducted during CY 2015:

Operations:

- Presentation of quarterly reporting and analytic trending of informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care.
- Specific to Rhody Health Options, NHPRI's Managed Long Term Services and Supports program, a presentation of the current reporting framework, inclusive of what indicators are tracked, trended, and the action steps taken by the Health Plan to improve identified areas of opportunity.
- Specific to Rhody Health Options, NHPRI's Managed Long Term Services and Supports program, a presentation on NHPRIs Nursing Home Transitions program and collaboration with the State's Money Follows the Person program.
- Presentation on the Health Plan analysis of Polypharmacy utilization by special need populations such as children with special health care needs and foster care (substitute care).
- Presentation on the Health Plans provider complaint monitoring and analytic trending.

Quality& Compliance:

- Presentation on the Health Plan integration and oversight of HIV case management and quality improvement efforts.
- Specific to Rhody Health Options, NHPRI's Managed Long Term Services and Supports program, a presentation on NHPRIs Nursing Home Quality Measures and Beneficiary Protection.
- Specific to Rhody Health Options, NHPRI's Managed Long Term Services and Supports program, a presentation of their proposed LTSS provider audit framework.

- United Health Care Dental, presented the RIte Smiles, annual geo access survey results, clinical case review on a select sample of orthodontic cases and on their required annual QIPs. The QIPs for UHC Dental align with the CMS Oral Health Strategy and are specific to preventative dental visits and sealants.
- Health Plan's response to the annual External Quality Review findings.
- Presentation of Health Plan's annual quality improvement projects (QIPS). In calendar year 2015, the Health Plans conducted QIPs on the following topics: Developmental Screening in the First Three Years of Life, Use of Imaging for Lower Back Pain, Follow-Up After Hospitalization for Mental Illness and Postpartum Care (NHPRI) and Anti-depressant Medication Management (UHCP-RI).

All three Health Plans (NHPRI, UHCP-RI, and UHC Dental) participate in quarterly Program Integrity meetings with the Rhode Island Executive Office of Health and Human Services and the Rhode Island Attorney General's Medicaid Fraud and Control Unit (MFCU) to discuss the status of open investigations from quarterly Fraud and Abuse reporting.

Section 1115 Waiver Quality and Evaluation Work Group

Rhode Island's Section 1115 Quality and Evaluation Work Group, which includes Medicaid enterprise-wide representation, was established in 2009 and was responsible for the development of the 1115 Waiver's initial draft *Evaluation Design*. This work group has met regularly since the implementation of the Demonstration Waiver to analyze the findings from on-going quality monitoring activities that span the areas of focus as delineated in the Waiver's Special Terms and Conditions, STC # 123 (*State Must Separately Evaluate Components of the Demonstration*).

The following table outlines the areas of focus that were addressed during in DY 7 January 1, 2015 – December 31, 2015 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	**AGENDA**
1/9/15	Communities of Care Program Evaluation
2/6/15	Nursing Home Transition and Money Follow the Program Quality Update
3/6/15	Overview of Adult Quality Grant and Medicaid Quality Strategy
12/2/15	Quality of Care for Medicaid Managed Care: Does the Type of Plan make a Difference?

In 2015, Rhode Island Medicaid decided to evaluate the purpose and function of the 1115 Waiver Quality & Evaluation work group. At the time, the Medicaid program decided to transition these meetings to focus specifically on quality measurement and how it can be used to help inform Medicaid programs across the delivery system. This modified approach would include the development and use of performance measures to assess quality, and the role of applied research. The discussion included the ability to ensure the right people and stakeholders are at the table and engaged, especially given the numerous competing priorities.

Also, in 2015, Rhode Island Medicaid decided to integrate the standing Child and Family Health Quality Improvement Committee into the newly formed Medicaid Quality and Evaluation

workgroup meeting, formerly known as the 1115 Waiver Quality and Evaluation meeting. The integration of these two committees created a forum for the discussion of quality and evaluation activities across the Medicaid delivery system.

Development of a Draft Evaluation Design for the Section 1115 Demonstration

In concert with the development of the proposed Section 1115 Comprehensive Quality Strategy, the EOHHS has analyzed the draft Evaluation Design which was submitted to CMS in July 2009. Based on the synthesis of feedback that the EOHHS has received from stakeholders in response to the proposed Section 1115 Comprehensive Quality Strategy, further modifications to the draft Evaluation Design were made. The RI Evaluation Design Strategy was submitted to CMS in the Fall of CY2015.

The *Evaluation Design* included a discussion of goals and objectives that apply more broadly to the Medicaid program as a whole, as well as a brief foray into a set of research questions that will drive evaluation of care for target populations. Since then we have begun efforts to both align our evaluation plan with related efforts within Rhode Island, as well as start the tedious task of identifying and accessing the data sources and operationalization of metrics required for our evaluation.

Staff involved in the 1115 Demonstration Evaluation Design overlap with those engaged in Rhode Island's State Innovation Model grant's analytic development and evaluation activities, including the establishment of core measure sets to be used across all payers in value-based payment contracting. We hope to leverage some of these measures in our Demonstration Evaluation efforts as they evolve.

More recently work has begun to assess the impact of the approximately 40 Reinventing Medicaid initiatives developed under the direction of Governor Raimondo upon her taking office in January of 2015. The evaluation of those initiatives, which essentially are important enhancements within the Demonstration, will be important building blocks for our more global Demonstration evaluation.

And finally, at the foundation of any good evaluation lies the breadth and quality of the data sources used to inform that evaluation. Thus far, the bulk of our efforts regarding our Evaluation Strategy have been towards infrastructure development and training. As an example, a considerable amount of time over the past year has been spent assessing and improving the quality of our managed care/encounter data set (that transitioned to an 837 structure in July of 2013), developing infrastructure to integrate that data with the Fee For Service claims data, and establishing standard methods of both categorizing and querying the information therein.

Another important source of evaluation data, Rhode Island's All Payer Claims Database (HealthFacts RI), although in its early stages of operation, now has a small group of power users (which include representation from Medicaid). HealthFacts RI will provide not only extra dimensions to our Medicaid data that will help inform our Demonstration evaluation (such as 3M groupers such as APR-DRGS, EAPGs, CRGs, and PFEs), but also will enable us to compare

access, cost, and quality of care with payers outside of Medicaid. Additional staff who will assist in the Demonstration evaluation are expected to begin training in the next several months.

Attachment J: FQHC Annual Report

Beginning in 2014, as part of each annual report, the state must collect and report data on the use of the payments for uninsured populations to FQHCs, (payments described in STC 81). The state must report on the costs associated with these individuals by provider, as outlined in Attachment J. In the report, the state must include information about the uninsured people being served by FQHCs including, but not limited to the following:

- The number of FQHC uninsured encounters
- Costs of FQHC uninsured encounters
- Number of uninsured people in the state
- General description of who the uninsured are, such as individuals who are difficult to enroll due to homelessness, individuals who report finding coverage cost prohibitive as the reason for lack of coverage, etc.

As indicated in section XIV of the STCs, the state assures that the payments made to FQHCs do not exceed the cost of delivering services to the uninsured. The state must report annually data associated with the services and costs delivered by the FQHCs to any uninsured individuals following the chart below. The methodology for the encounter rate is defined in the Medicaid State plan.

In 2015, there were 49,591 uninsured individuals in Rhode Island. The remaining group of uninsured is comprised primarily of 1) individuals who are difficult to enroll due to homelessness, 2) undocumented individuals and families, or 3) individuals who find coverage cost prohibitive or who refuse to pay monthly premiums, however small, as they are still able to receive services on a sliding fee scale even without coverage. The FQHCs used the funds to support activities to increase coverage and improve care to their uninsured populations. These activities include the following:

- Partnered with the health insurance exchange to engage uninsured residents at various events.
- Social Workers provided outreach activities to increase the community's awareness of available health care services to uninsured/low income populations at schools, faith based organizations, social service centers, and community case management programs.
- Outreach to patients that have been recently assigned to a PCP at the FQHC but have not received care from the provider.
- Development of distinct referral mechanisms in order to identify at-risk individuals and provide immediate access to care.

Attachment J: List of FQHCs

FQHC	Medical Encounter Rate[4]	Uninsured Encounters	Overall Uninsured Cost
Blackstone Valley Community Health Care Inc.	$ 194.04	10,821	$ 2,099,706.84
Comprehensive Community Action Program	$ 203.47	7,978	$ 1,623,283.66
East Bay Community Action Program	$ 202.66	7,619	$ 1,544,066.54
WellOne	$ 170.76	3,386	$ 582,087.26
Providence Community Health Centers	$ 184.00	17,127	$ 3,151,368.00
Thundermist Health Center	$ 153.30	23,412	$ 3,589,059.60
Tri-Town Community Action Agency	$ 153.25	1,036	$ 177,591.12
Wood River Health Services	$ 179.26	5,462	$ 979,118.12

[4] FQHCs operate on varying fiscal years. Therefore the Medical Encounter Rates for each FQHC change at different points during the calendar year. The Medical Encounter Rate reported here and utilized in the above calculations are those rates which were in effect as of December 31, 2015.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 6 2014 YTD	DY 7 1st Qtr. CY 2015	DY 7 2nd Qtr. CY 2015	DY 7 3rd Qtr. CY 2015	DY 7 4th Qtr. CY 2015	DY 7 2015 YTD
ABD Adults No TPL	$ 549,082,463	$ 135,170,019	$ 125,906,541	$ 129,747,088	$ 120,516,983	$ 511,340,631
ABD Adults TPL	$ 1,081,111,664	$ 288,281,089	$ 294,603,773	$ 293,226,679	$ 297,320,232	$ 1,173,431,773
RIte Care	$ 777,080,793	$ 212,815,125	$ 211,937,633	$ 215,424,608	$ 216,042,492	$ 856,219,858
CSHCN	$ 388,266,894	$ 103,838,680	$ 103,124,052	$ 103,053,436	$ 101,963,133	$ 411,979,301
TOTAL	**$ 2,795,541,814**	**$ 740,104,913**	**$ 735,571,999**	**$ 741,451,812**	**$ 735,842,840**	**$ 2,952,971,564**

With Waiver Total Expenditures

Medicaid Populations	DY 6 2014 YTD	DY 7 1st Qtr. CY 2015	DY 7 2nd Qtr. CY 2015	DY 7 3rd Qtr. CY 2015	DY 7 4th Qtr. CY 2015	DY 7 2015 YTD
ABD Adults No TPL	$ 411,236,474	$ 97,689,817	$ 83,507,087	$ 115,840,574	$ 99,400,059	$ 396,437,538
ABD Adults TPL	$ 732,046,454	$ 174,657,347	$ 161,660,616	$ 209,062,522	$ 188,988,347	$ 734,368,832
RIte Care	$ 461,963,029	$ 128,561,629	$ 143,700,247	$ 162,932,309	$ 119,204,073	$ 554,398,258
CSHCN	$ 175,942,556	$ 45,550,569	$ 49,505,131	$ 55,696,718	$ 48,228,714	$ 198,981,132
Excess Spending: Hypotheticals	$ 31,145,557	$ (48,146,448)	$ (46,607,899)	$ (11,022,816)	$ (48,217,706)	$ (153,994,868)
CNOM Services	$ 13,794,518	$ 2,436,576	$ 3,261,455	$ 2,660,490	$ 1,649,464	$ 10,007,986
TOTAL	**$ 1,826,128,588**	**$ 400,749,490**	**$ 395,026,638**	**$ 535,169,797**	**$ 409,252,952**	**$ 1,740,198,877**
Favorable / (Unfavorable) Variance	$ 969,413,227	$ 339,355,423	$ 340,545,361	$ 206,282,014	$ 326,589,888	$ 1,212,772,686
Budget Neutrality Variance (DY 1 - 5)						
Cumulative Bud. Neut. Variance	**$ 3,756,374,377**	**$ 4,095,729,800**	**$ 4,436,275,161**	**$ 4,642,557,175**	**$ 4,969,147,063**	**$ 4,969,147,063**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2014 YTD	1st Qtr. 2015	2nd Qtr. 2015	3rd Qtr. 2015	4th Qtr. 2015	2015 YTD
217-like Group	$ 149,939,393	$ 38,844,000	$ 38,851,470	$ 39,968,235	$ 40,296,915	$ 157,960,620
Low-Income Adults (Expansion)	$ 440,412,112	$ 150,121,263	$ 154,020,411	$ 157,720,374	$ 155,269,179	$ 617,131,227
Family Planning Group	$ 46,171	$ 6,011	$ 5,040	$ 6,699	$ 11,658	$ 29,409
TOTAL	**$ 590,397,676**	**$ 188,971,274**	**$ 192,876,921**	**$ 197,695,308**	**$ 195,577,752**	**$ 775,121,256**

With-Waiver Total Exp.	2014 YTD	1st Qtr. 2015	2nd Qtr. 2015	3rd Qtr. 2015	4th Qtr. 2015	2015 YTD
217-like Group	$ 163,527,102	$ 40,398,485	$ 44,373,129	$ 43,143,371	$ 44,360,337	$ 172,275,322
Low-Income Adults (Expansion)	$ 457,942,487	$ 100,416,307	$ 101,891,866	$ 143,521,658	$ 102,988,786	$ 448,818,617
Family Planning Group	$ 73,644	$ 10,034	$ 4,027	$ 7,464	$ 10,923	$ 32,448
TOTAL	**$ 621,543,233**	**$ 140,824,826**	**$ 146,269,022**	**$ 186,672,493**	**$ 147,360,046**	**$ 621,126,387**

Excess Spending	2014 YTD	1st Qtr. 2015	2nd Qtr. 2015	3rd Qtr. 2015	4th Qtr. 2015	2015 YTD
217-like Group	$ 13,587,709	$ 1,554,485	$ 5,521,659	$ 3,175,136	$ 4,063,422	$ 14,314,702
Low-Income Adults (Expansion)	$ 17,530,375	$ (49,704,956)	$ (52,128,545)	$ (14,198,716)	$ (52,280,393)	$ (168,312,610)
Family Planning Group	$ 27,473	$ 4,023	$ (1,013)	$ 765	$ (735)	$ 3,039
TOTAL	**$ 31,145,557**	**$ (48,146,448)**	**$ (46,607,899)**	**$ (11,022,816)**	**$ (48,217,706)**	**$ (153,994,868)**

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 6 2014 YTD	DY 7 1st Qtr. CY 2015	DY 7 2nd Qtr. CY 2015	DY 7 3rd Qtr. CY 2015	DY 7 4th Qtr. CY 2015	DY 7 2015 YTD
ABD Adults No TPL	205,847	48,605	45,274	46,655	43,336	183,870
ABD Adults TPL	358,498	91,691	93,702	93,264	94,566	373,223
RIte Care	1,706,932	444,309	442,477	449,757	451,047	1,787,590
CSHCN	144,379	36,762	36,509	36,484	36,098	145,853
217-like Group	41,317	10,400	10,402	10,701	10,789	42,292
Low-Income Adult Group	569,744	184,651	189,447	193,998	190,983	759,079
Family Planning Group	2,401	297	249	331	576	1,453

Without Waiver PMPMs	DY 6 2014 YTD	DY 7 1st Qtr. CY 2015	DY 7 2nd Qtr. CY 2015	DY 7 3rd Qtr. CY 2015	DY 7 4th Qtr. CY 2015	DY 7 2015 YTD
ABD Adults No TPL	$ 2,667	$ 2,781	$ 2,781	$ 2,781	$ 2,781	$ 2,781
ABD Adults TPL	$ 3,016	$ 3,144	$ 3,144	$ 3,144	$ 3,144	$ 3,144
RIte Care	$ 455	$ 479	$ 479	$ 479	$ 479	$ 479
CSHCN	$ 2,689	$ 2,825	$ 2,825	$ 2,825	$ 2,825	$ 2,825
217-like Group	$ 3,629	$ 3,735	$ 3,735	$ 3,735	$ 3,735	$ 3,735
Low-Income Adult Group	$ 773	$ 813	$ 813	$ 813	$ 813	$ 813
Family Planning Group	$ 19	$ 20	$ 20	$ 20	$ 20	$ 20

Without Waiver Expendtures	DY 6 2014 YTD	DY 7 1st Qtr. CY 2015	DY 7 2nd Qtr. CY 2015	DY 7 3rd Qtr. CY 2015	DY 7 4th Qtr. CY 2015	DY 7 2015 YTD
ABD Adults No TPL	$ 549,082,463	$ 135,170,019	$ 125,906,541	$ 129,747,088	$ 120,516,983	$ 511,340,631
ABD Adults TPL	$ 1,081,111,664	$ 288,281,089	$ 294,603,773	$ 293,226,679	$ 297,320,232	$ 1,173,431,773
RIte Care	$ 777,080,793	$ 212,815,125	$ 211,937,633	$ 215,424,608	$ 216,042,492	$ 856,219,858
CSHCN	$ 388,266,894	$ 103,838,680	$ 103,124,052	$ 103,053,436	$ 101,963,133	$ 411,979,301
217-like Group	$ 149,939,393	$ 38,844,000	$ 38,851,470	$ 39,968,235	$ 40,296,915	$ 157,960,620
Low-Income Adult Group	$ 440,412,112	$ 150,121,263	$ 154,020,411	$ 157,720,374	$ 155,269,179	$ 617,131,227
Family Planning Group	$ 46,171	$ 6,011	$ 5,040	$ 6,699	$ 11,658	$ 29,409

Attachment 2: Statement of Certification of Accuracy of Reporting of Member Months

Statement of Certification of Accuracy of Reporting Member Months

As the Executive Office of Health and Human Services Chief Financial Officer, I certify the accuracy of reporting member months for demonstration population under the 1115 Comprehensive Demonstration Waiver for the purpose of monitoring the budget neutrality agreement.

Name: Robert Farley

Title: EOHHS Chief Financial Officer

Signature:

Date: June 3, 2016

XIII. State Contact(s)

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XIV. Date Submitted to CMS

Enter the date submitted to CMS in the following format: (06/03/2016).