Report to the Centers for Medicare and Medicaid Services

Annual Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2017 – December 31, 2017

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

August 2018

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Annual Report Demonstration Reporting

Period: DY 9 January 1, 2017 – December 31, 2017

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.

All Medicaid funded services on the continuum of care, with the exception of those four aforementioned expenses, 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, the state's previous section 1915(b) Dental Waiver and the state's previous section 1915(c) home and community-based services (HCBS) waivers were subsumed under this demonstration. 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 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 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.

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

g. Rhody Health Options is a managed care delivery system for individuals eligible for Medicaid only and for individuals eligible for both Medicare and Medicaid that integrates acute and primary care and long term care services and supports.

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 an effective 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)* 03/31/17	Number of Enrollees That Lost Eligibility in 03/31/17**	Number of Current Enrollees (to date)* 06/30/17	Number of Enrollees That Lost Eligibility in 06/30/17**	Number of Current Enrollees (to date)* 09/30/17	Number of Enrollees That Lost Eligibility in 09/30/17**	Number of Current Enrollees (to date)* 12/31/17	Number of Enrollees That Lost Eligibility in 12/31/17**
Budget Population 1: ABD no TPL	13,551	226	13,659	212	16,503	280	18,317	426
Budget Population 2: ABD TPL	34,125	169	34,938	168	32,565	213	30,712	491
Budget Population 3: RIte Care	139,649	1,574	142,732	1,700	138,354	5,635	134,533	4,936
Budget Population 4: CSHCN	12,256	194	12,696	189	12,791	303	12,820	264
Budget Population 5: EFP	298	25	318	23	383	19	674	31
Budget Population 6: Pregnant Expansion	38	5	29	6	32	2	28	4
Budget Population 7: CHIP Children	25,866	360	26,942	314	29,879	561	33,550	1,043
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	1,792	6	1,909	5	2,016	5	1,870	35
Budget Population 11, 12, 13: 217-like group	3,679	24	3,728	16	3,812	28	4,198	42
Budget Population 14: BCCTP	117	6	118	0	115	4	119	1
Budget Population 15: AD Risk for LTC	3,270	0	3,310	0	3,362	0	3,408	1
Budget Population 16: Adult Mental Unins	12,024	0	12,024	0	12,024	0	12,023	1
Budget Population 17: Youth Risk Medic	3,710	7	3,910	14	4,189	18	4,304	1
Budget Population 18: HIV	265	49	263	19	276	17	276	28
Budget Population 19: AD Non-working	0	0	0	0	0	0	0	0
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	75,662	1,463	78,988	1,258	75,013	7,739	78,793	6,135

*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 each quarter in DY 9 January 1, 2017 – December 31, 2017 is listed below:

Q1--Quarter 1: 2:499 at the close of the quarter
Q2--Quarter 2: 9:508 at the close of the quarter
Q3--Quarter 3: 2:515 at the close of the quarter
Q4--Quarter 4: 6:506 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 DY9 January 1, 2017 – December 31, 2017 (by category or by type) with an annual total of $16,032.19 for special purchases expenditures.

Q 1 2017	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Over the counter medicines		$ 714.18
	3	Fitness Training		$ 144.00
	17	Massage Therapy		$ 750.00
	5	Supplies, non-medical	Gloves, support stockings, Ensure, Mobile Lifeline	$ 386.06
	1	Diabetes Monitoring		$ 60.00
	5	Service Dog Training		$ 462.50
	1	OTC		$ 22.92
	5	Bus Tickets		$ 20.00
	1	Ramp		$ 419.99
	CUMULATIVE TOTAL			**$ 2,979.65**

Q 2 2017	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	4	Over the counter medicines		$ 833.33
	3	Fitness Training		$ 144.00
	26	Massage Therapy		$ 1,460.00
	11	Supplies, non-medical	Support stockings, Mobile Lifeline, Ensure, Bidet, Specialized Utensils	$ 1,612.10
	15	Acupuncture		$ 1,125.00
	4	Service Dog Training		$ 390.00
	4	Landscaping	Grass mowing	$ 160.00
	1	Diabetes Monitoring		$ 60.00
	1	Bus Tickets		$ 20.00
	CUMULATIVE TOTAL			**$ 5,804.43**

Q 3 2017	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	4	Over the counter medicines		$ 839.82
	3	Fitness Training		$ 144.00
	31	Massage Therapy		$ 1,432.50
	6	Supplies, non-medical	Support stockings, gloves, Ensure	$ 355.67
	15	Acupuncture		$ 1,125.00
	3	Service Dog Training		$ 277.50
	6	Landscaping	Grass mowing	$ 240.00
	2	Diabetes Monitoring		$ 120.00
	10	Bus tickets		$ 40.00
	CUMULATIVE TOTAL			**$ 4,574.49**

Q 4 2017	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Over the counter medicines		$ 607.16
	3	Fitness Training		$ 144.00
	22	Massage Therapy		$ 1,215.00
	15	Acupuncture		$ 1,125.00
	5	Supplies, non-medical	Gloves, support stockings, sheets, Bidet	$ 519.96
	3	Service Dog Training		$ 277.50
	4	Landscaping	Grass mowing	$ 200.00
	2	Diabetes Monitoring		$ 120.00
	1	Bus tickets		$ 20.00
	CUMULATIVE TOTAL			**$ 4,228.62**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the quarters during DY9 January 1, 2017 – December 31, 2017.

Innovative Activities

Health System Transformation Project

On October 20, 2016, CMS approved the state's 1115 Waiver request to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain delivery system reform efforts. The RI HSTP proposes to foster and encourage this critical transformation of RI's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities (AEs). During January 1, 2017 – December 31, 2017, the following activities occurred.

Collaboration with Institutes of Higher Education (IHEs)

- Established and documented efforts associated with orienting and training IHE leadership in the Designated State Health Plan initiatives, especially pertaining to Healthcare Workforce development and RI HSTP.
- Continued collaboration with consultants from University of Massachusetts/Commonwealth Medicine regarding partnership building with IHEs, and execution of signed agreements with IHEs.
- In March 2017 received CMS approval of IHE claiming, tracking and payment protocol pertaining to Attachment S: Health Workforce Development Claiming Protocol.
- In March 2017 created, signed, and executed Inter Agency Service Agreements (ISAs) with the state's IHEs; whereby specific claiming, tracking, payment and reporting protocols were integrated, as well as specific partnership protocols regarding items such as the IHE Steering Committee, DSHP components of allowable activities, and general guidelines associated with IHE participation in RI HSTP. Executed Amendment 1 to the ISAs with the state's IHEs for technical corrections
- Submitted first claim for matching funds for Institutions of Higher Education expenditures for the period from the date of CMS approval of the STCs (October 20, 2016) through March 31, 2017.
- Submitted claiming protocols for the additional CMS approved Designated State Health Programs - the Wavemaker Fellowship, Tuberculosis Clinic at Miriam Hospital, Center for Acute Infectious Disease Epidemiology, Rhode Island Child Audiology Center and the Consumer Assistance Programs of the Office of the Child Advocate and the Commission on the Deaf and Hard of Hearing – which are required attachments to the STCs.

Hospital and Nursing Home Incentive Program

- Finalized providers' reports on strategies used to increase Medicaid enrollment in Current Care and on percentage of revenue derived from alternative payment models.

- Calculated Medicaid enrollment in CurrentCare, readmission measures, and the proportional Medicaid spend of each provider, and developed the algorithm for distribution of awards.
- Began developing Access database to store performance results and develop reports.
- Met with stakeholders to inform them of process and timing.
- Distributed provider-specific report cards to each hospital for verification of performance on each measure
- Finalized incentive payment amounts for each hospital
- Met with managed care organizations to plan for the distribution of hospital incentive payments. Distributed hospital incentive payments through NHPRI and UHCPRI to each hospital

Health Workforce Development Program

- Published the EOHHS Healthcare Workforce Transformation (HWT) Report, which included a description of RI's health system transformation and population health goals, drivers of system transformation, a healthcare workforce needs assessment, local and national best practices in healthcare workforce transformation, a RI healthcare workforce development resource guide, a compendium of "transformative" healthcare occupations, and healthcare workforce transformation priorities and strategies to achieve RI's system transformation goals.
- Convened over 200 healthcare colleagues (35% providers, 25% educators, 25% public health, 15% other) at the first-ever EOHHS Healthcare Workforce Transformation Summit. The focus of the keynote presentation was "Workforce Planning in a Rapidly Changing Healthcare System". Plenary session and workshop topics included Direct Care Workforce Issues & Strategies, Community Health Teams, Transforming RN Education & Practice, Community-Based Interprofessional Education, Integrated Behavioral Healthcare, and New and Emerging Healthcare Occupations.
- Began steps to implement HWT priorities and strategies through HSTP and related statewide efforts (e.g., SIM), including preparation for the first meeting of the HSTP Higher Education Steering Committee, one-on-one meetings with leadership of Medicaid Accountable Entities to discuss Medicaid HWT priorities and strategies, AE workforce needs, opportunities to utilize HSTP and other funds to address AE workforce needs, and consideration of addressing workforce transformation priorities in SIM-funded projects.
- Prepared and presented HWT priorities, strategies, and process to HSTP Higher Education Steering Committee.
- Held individual meetings with each public higher education (IHE) partner to discuss areas of alignment between HWT priorities & strategies and IHE interests and capacity.
- Assisted in the development of AE certification standards and application to incorporate HWT priorities and strategies, and address AE workforce needs.

- Continued collaborative efforts between Medicaid and Institutions of Higher Education (IHEs) to accomplish the following:
    - Develop and review infrastructure proposals from each IHE to provide administrative capacity and support for a) DHSP claiming, b) Healthcare Workforce Transformation (HWT) project development, and c) administration and implementation of Medicaid-IHE partnership agreement
    - Develop HWT proposals consistent with HSTP objectives
    - Review, revise, and approve funding of HWT proposals consistent with HSTP objectives
    - Develop, review, and approve funding of Technical Assistance contracts with third-party vendors (i.e., UMass/Commonwealth Medicine and Center for Health Care Strategies) to support DSHP claiming, Medicaid-IHE partnership development and administration, and Accountable Entity capacity building
    - Develop and implement a SIM-funded project – in conjunction with the Medicaid-IHE Partnership – to train staff from community-based healthcare and social service agencies to serve as preceptors for interprofessional teams of healthcare students.
- Conducted additional research, stakeholder meetings, and program, policy, and strategy development as needed to identify and address compelling healthcare workforce barriers and opportunities and achieve HSTP objectives.

Accountable Entities

- EOHHS received comments from 24 stakeholders (advocacy, community, provider organizations and managed care organizations) on the AE Roadmap document. A final draft of the AE Roadmap was submitted to CMS on April 14, 2017. EOHHS received approval of the AE Roadmap on November 17, 2017.
- All required deliverables per Table #5 Schedule of Deliverables in the RI Medicaid 1115 Waiver amendment including the AE Roadmap, AE Certification Standards, and an Alternate Payment Methodology (APM) guidance document, which specifies the Medicaid AE's total cost of care and quality methodologies, attribution and incentive funding requirements. This was submitted to CMS on September 29, 2017.
- The EOHHS Medicaid Accountable Entity application and scoring/readiness tool was finalized and shared with stakeholders and prospective applicants on November 15, 2017.
- Continued oversight of MCOs' monitoring of Pilot AEs, inclusive of the development of an evaluation and analytic framework and an ongoing work stream with MCOs on AE data reporting needs/opportunities.

- EOHHS developed an Accountable Entity stakeholder strategy which commenced on July 1, 2017.

- EOHHS drafted measure specification for two measures, Social Determinants of Health and a Health Status measure, that are included as part of the quality measure slate within the Medicaid Accountable Entity APM/total cost of care methodology. The measures were shared with stakeholders for feedback and incorporated into the Medicaid Accountable Entity technical measure specification manual.

DSHP State Spending Analysis

STC 100 requires EOHHS to provide an analysis of the net change in federally-matched state expenditures related to the DSHP programs. Since DY9 was the first full year of the HSTP program, data to provide a meaningful year-over-year comparison for this analysis is not yet available. When this data becomes available, an analysis will be provided.

Health Graduates Employment Data

This table represents the graduates by Rhode Island's Institutions of Higher Education (University of Rhode Island, Community College of Rhode Island, and Rhode Island College) detailed by professional type/program from which they graduated. All fields of educational study are designated with a Classification of Instructional Program (CIP) Code which is a taxonomic scheme that identified the professional type/program that all participating schools can use. The data below is for the academic year 2014-2015 and at the time of submitting claims was the most recently available graduation and employment data for the FFP claims submitted for the States FY17.

CIP Code	CIP Title	URI	CCRI	RIC	TOTAL
41.03	Physical Science Technologies/Technicians.	-	-	-	-
42.01	Psychology, General.	33	-	35	68
42.99	Psychology, Other.	-	-	6	6
44.07	Social Work.	-	4	43	47
51.00	Health Services/Allied Health/Health Sciences, General.	-	-	3	3
51.02	Communication Disorders Sciences and Services.	6	-	-	6
51.06	Dental Support Services and Allied Professions.	-	26	-	26
51.07	Health and Medical Administrative Services.	-	14	13	27
51.08	Allied Health and Medical Assisting Services.	-	16	3	19
51.09	Allied Health Diagnostic, Intervention, and Treatment Professions.	-	41	17	58
51.10	Clinical/Medical Laboratory Science/Research and Allied Professions.	12	16	-	28
51.15	Mental and Social Health Services and Allied Professions.	-	3	1	4
51.16	Nursing.	-	-	-	-
51.18	Ophthalmic and Optometric Support Services and Allied Professions.	-	1	-	1
51.20	Pharmacy, Pharmaceutical Sciences, and Administration.	5	-	-	5
51.22	Public Health.	-	-	-	-
51.31	Dietetics and Clinical Nutrition Services.	9	-	-	9
51.35	Somatic Bodywork and Related Therapeutic Services.	-	-	-	-
51.38	Registered Nursing, Nursing Administration, Nursing Research and Clini	86	188	85	359
51.39	Practical Nursing, Vocational Nursing and Nursing Assistants.	-	6	-	6
	Total	**151**	**315**	**206**	**672**

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 9 meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (née 1115 Waiver Task Force) on January 23, March 27, May 22, June 26, August 28, September 25, October 23, November 27, and December 18, 2017

- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs. Provided program updates at the monthly Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting, held a provider summit on May 16, and convened the monthly ICI Implementation Council and ICI Provider Workgroup meetings.

- CTC continues to meet bi-weekly with the PCMH-Kids Planning team. Other CTC stakeholder meetings held during quarter DY9 include a Practice Transformation

Committee Meeting (7/20/17), a Nurse Care Manager/Care Coordinator Best Practice Sharing Meeting (8/15/17), a PCMH-Kids Stakeholder Meeting (9/7/17), and a Pediatric Integrated Behavioral Health Meeting (9/14/17). CTC hosted a second CHT meeting with the health plans and shared management reports from the first quarter (October – December 2016) and obtained feedback for future quarterly reports.

- Conducted two meetings of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on June 7, 2017 and September 6, 2017.

- Posted Monthly Provider Updates in January - December 2017.

- 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 DY9 January 1, 2017 – December 31, 2017.

State Innovation Model
During DY 9 January 1 – December 31, 2017 Rhode Island SIM conducted the following activities:

- In January, Commissioner Hittner approved OHIC's 2017-2018 Care Transformation and Alternative Payment Methodology Plans, outlining goals and targets addressing the Affordability Standards' regulatory requirements for Payment Reform and Care Transformation. In Q2, OHIC convened the Primary Care APM Workgroup and the APM Advisory Committee to advance the saturation of APMs and non-fee-for-service payment methods in the RI commercial market.

- The APCD data aggregation and analytics reprocurement was awarded in Q1 to a single vendor to increase efficiency and coordination.

- Implementation of Practice Transformation (PCMH Kids/Integrated Behavioral Health), SBIRT Training and Resource Center, the Child Psychiatry Access Program (PediPRN), and the State Evaluation.

- The Healthcare Quality Measurement Reporting and Feedback System Updates RFP was submitted and proposals reviewed.

- Four Patient Engagement Projects were procured, including End of Life Advance Care Planning Training Program for Consumers and Primary Care Providers (awarded to Healthcentric Advisors), Complex Care Conversations Training for Primary Care Providers (awarded to Hope Hospice and Palliative Care), End of Life Consumer Engagement Platform (awarded to Rhode Island Quality Institute), and the Conscious Discipline Program (awarded to The Autism Project).

- Participated in weekly Health System Transformation Project (HSTP) meetings and ensured communication between both projects.

- Through a competitive bid process, an award was made to the Care Transformation Collaborative (CTC) of RI to establish a centralized operation for developing and delivering three new Community Health Teams and 24 screeners to provide Screening Brief Intervention, Referral and Treatment (SBIRT) services. These projects were launched in Q4 of 2017, with the goal of increasing patients' engagement in their own healthcare, specifically with respect to their end-of-life wishes.
- The SBIRT Training Center website has been completed and interactive simulation modules of the training curriculum were prepared.

- Health information technology activities included "go live" for nine of the 10 contracted Care Management Dashboards, testing of the Provider Directory website, and the approval by the Data Release Review Board of the All-Payer Claims Database of three applications for data from HealthFacts RI, the state's All Payer Claims Database (APCD).

- Stakeholder engagement with the following groups: the Advisory Council for Rhode Island's Child Opportunity Zones (COZs), the Arts in Health Council, the Rhode Island Oral Health Commission, the Trans* Health Program Manager, RI Healthy Schools Coalition, Planning Sessions for RI Unified Social Service Directory Project, RI College Nursing Education Program Representatives, and a Social Worker from Thundermist Health Center.

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island was established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall goal is to improve care for Rhode Island's elders 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 implemented the ICI in two phases. A description of each phase and a summary of the activities conducted in DY9 January 1, 2017 – December 31, 2017 are provided below.

Phase I – Rhody Health Options

In November 2013, as part of Phase I of the ICI, EOHHS established a capitated Medicaid managed care program, called Rhody Health Options, for dual-eligible beneficiaries with full Medicare and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS) through Rhode Island Medicaid. Rhody Health Options enrollees receive their Medicaid coverage through Neighborhood Health Plan of Rhode Island (NHPRI). As of December 2017, 11,039 individuals were enrolled in this voluntary program. Enrollment numbers continue to decrease because members are transferring into the Medicare-Medicaid Plan.

Phase II – Medicare-Medicaid Plan

Under Phase II of the ICI, EOHHS established a fully integrated capitated Medicare-Medicaid plan for dual-eligibles with full Medicare and full Medicaid coverage. Federal authority for the Medicare-Medicaid plan is through CMS' Financial Alignment Initiative, a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. EOHHS currently has authority to participate in the Financial Alignment Initiative through December 31, 2020.

Medicare-Medicaid plan enrollees receive their Medicare (Parts A, B, and D) and Medicaid coverage through NHPRI. Approximately 33,000 individuals are eligible for this voluntary program. Initial enrollment into the plan began on July 1, 2016 through a phased-in enrollment

schedule. Enrollment started with three months of opt-in enrollment, which required eligible individuals to complete a paper or phone application to enroll. Passive (auto) enrollment began in October 2016 with nine phases separated by population groups. Passive enrollment was offered to people who were already enrolled in NHPRI (Rhody Health Options) for their Medicaid benefits and receive their Medicare benefits through Original Medicare. EOHHS will offer opt-in and passive enrollment to newly eligible individuals on a quarterly basis after the initial enrollment period ends.

As of December 2017, 14,248 people were enrolled in the Medicare-Medicaid plan. Q3 of DY9 marked the beginning of quarterly passive enrollment, with the first enrollment effective date on October 1. People who were eligible for passive enrollment were mailed enrollment notifications 60 days prior to their enrollment effective date. Mailings were not population specific. Approximately 1,100 passive enrollment letters were mailed for the October 1 enrollment, and approximately 200 letters were mailed for the December 1 enrollment. Voluntary enrollment is offered ongoing; however, mailings to eligible beneficiaries are mailed quarterly, in conjunction with the passive enrollment schedule. In October, approximately 1,070 letters were mailed to people who were eligible for voluntary enrollment into the MMP. Recipients of this letter are instructed to call the MMP enrollment line to be enrolled into the plan.

Program activities for ICI Phase I & II conducted between January 1-December 31, 2017 include:

- Mailed Rhody Health Options enrollment letters on a monthly basis to newly eligible beneficiaries.
- Conducted opt-in and passive enrollment activities for the MMP (e.g., processed enrollment applications, conducted data exchanges with CMS' vendor, processed enrollment cancellations and disenrollments, mailed opt-in and passive enrollment notices).
- Completed the first six-month Demonstration evaluation for CMS in January, which was conducted by RTI International.
- From January 19-20, CMS visited RI for an enrollment site visit held at NHPRI in Smithfield, RI.
- Rhode Island was chosen as one of the Demonstration states to participate in the third phase of Implementing New Systems of Care for Dually Eligible Enrollees (INSIDE), through the Center for Health Care Strategies and supported by The Commonwealth Fund and The SCAN Foundation. The first meeting was held on February 28 through a conference call and EOHHS staff attended the INSIDE Conference in Washington, DC May 2-3, and a conference call on July 13th.
- Attended the Ombudsman Leadership Collaborative in Washington, DC from April 25-26.
- On May 16, NHPRI, CMS and EOHHS held a provider summit titled, Strategies for Primary Care Providers Managing High Risk Populations. Panelists included members from CMS, NHPRI, EOHHS and the primary care community. The purpose was to target primary care providers and educate them about the Demonstration, identify practice-based ways to serve dual-eligibles, and how to use various tools offered through NHPRI's MMP.

- Provided contract oversight to the Rhode Island Parent Information Network who provides ombudsman services for the Demonstration and healthcare assistance to dual eligibles.
- Provided contract oversight to Automated Health Systems, Inc., the enrollment call center for the Demonstration.
- Provided information on ICI to internal and external stakeholders, including consumers, advocates, and providers.
- Provided program updates at the monthly Lt. Governor's Long-Term Care Coordinating Council (LTCCC) meeting.
- Created a consumer advisory for ICI called the ICI implementation Council and held monthly public meetings.
- Held monthly ICI Provider Workgroup meetings. The workgroup is a meeting for providers to learn about the Demonstration, receive enrollment and program updates, ask questions, raise concerns, and provide helpful feedback.
- EOHHS staff attended a National call with CMS and other Demonstration states on August 15. A presentation was given by the Office of Minority Health (OMH) on Health Disparities.
- On September 29, EOHHS staff attended the Leading Age Policy Conference that addressed delivering better care to people who have long-term services and supports.
- Worked with CMS, NHPRI, the enrollment broker, providers, the ombudsman, and consumer advocates to address enrollment-related issues and ensure access to services for dual-eligibles.
- Worked with the state's MMIS vendor on systems modifications needed to address enrollment-related issues for the Demonstration.
- Conducted contract management and operational oversight of the Medicare-Medicaid plan in collaboration with CMS.
- Monitored Enrollment Broker activities.
- Worked with the Medicare-Medicaid plan and CMS to resolve operational challenges associated with the Demonstration.
- Participated in the Ombudsman Fall Learning Collaborative in Washington, DC.
- RI was invited to attend a Long-Term Care meeting at the NASHP Conference in Portland, OR.

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. Individuals and families could apply online, 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, 2017, enrollment in Medicaid through HealthSource RI was 78,793.
- 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.

CTC-RI/PCMH-Kids:

CTC-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-RI's mission is to lead the transformation of primary care in Rhode Island. CTC-RI 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 DY9, January 1-December 31, 2017, the following activities have occurred:

- CTC was awarded a three-year $870,000 grant from the Rhode Island State Innovation Model (SIM) to support the work of Integrated Behavioral Health and PCMH-Kids programs.
- The PCMH-Kids practices continue to work together on best practices to identify high risk patients and families who would benefit from care coordination, and overall improving the health of the children and adolescents.
- RI hosted a New Practice Orientation for the 26 Adult and Pediatric practices that were accepted into the CTC-RI and PCMH-Kids program on 7/20/17.
- The High-Risk Workgroup developed a common definition to accurately identify high risk populations for care coordination. The CTC and PCMH-Kids High Risk Workgroup revised the Cedar tool into the PCMH-Kids High Risk Screening Tool using the common definition (developed by the workgroup) as a reference. The tool was piloted and brought back to the workgroup and the August Nurse Care Manager (NCM)/Care Coordinator (CC) Best Practice Sharing meeting for feedback.
- The RI Department of Health provided a presentation of the medical home portal at the Care Coordinators meeting on May 16, 2017. Attendees also discussed and provided feedback on the Pediatric High-Risk Screening Tool.

- CTC-RI offered a standardized learning curriculum for NCM/CC practices starting the end

of June and extending for a 12 to16 week time period.

- All cohort 1 PCMH-Kids practices are now PCMH NCQA Level 3.
- Margaret Howard, Ph.D., continues to provide behavioral health subject matter expertise for the PCMH-Kids practices that are participating in the postpartum depression learning collaborative, who continue to modify and implement their approach to consistently implement evidence based practice guidelines.
- CTC management staff submitted the All Payer Claims Database (APCD) application for the utilization reports needed for evaluation. CTC worked with OnPoint to identify the PCMH-Kids comparison group (non-PCMH-Kids practices) and update provider files; Pediatric practices received cost of care reports based on APCD data and practices met during the September Breakfast of Champions meeting to review data and identify potential strategies to reduce Emergency Department (ED) utilization.
- CTC worked with Data Stat to develop a Consumer Assessment Health Plans Study (CAHPS) "Starter Kit" for practices to register for participation in the CAHPS survey and the OnPoint Performance Portal
- CTC arranged to have NCQA come to Rhode Island for the 2017 NCQA PCMH training program in July on the 2017 patient centered medical home standards
- Over 300 people attended the 2017 CTC Annual Learning Collaborative on 11/7/17 which featured national, regional, and local experts speaking on topics to assist primary care practices with using practical and evidence based approaches to improve health outcomes through better utilization of team based care and patient activation strategies.

Community Health Team-RI

As part of Re-Inventing Medicaid, Rhode Island's goal was to advance the Community Health Team Model for the Managed Care Delivery systems as well as the FFS population who were not eligible for enrollment in managed care. In February 2016, Community Health Team-RI (CHT-RI) was launched with our community partner CareLink. CareLink acts as an extension of the Primary Care Practices, providing a multi-disciplinary team of nurses, social workers, and community health workers focused on social determinants of health. The overall goal is to improve care for Rhode Island's FFS beneficiaries who are not receiving care management/care coordination in any other program. On October 6, 2017 the decision was made by executive leadership to terminate the program effective December 1, 2017. This decision was made due to the State's lack of federal authority to provide services through a Community Health Team and the financial impact of the program being limited to state-only funds. During DY 9, January 1 – December 31, 2017, the following activities occurred.

- The Care Management Dashboard went live in March. The dashboard makes available real-time data, including emergency room visits and inpatient admissions, every 45 minutes. The Dashboard is intended to support the care management team by providing opportunities for evidence based interventions that result in improved health outcomes for members.

- In June the State awarded CTC-RI a 1-year contract, with options to renew for four years, to implement three additional CHTs and SBIRT screeners in a variety of clinical settings. CTC-RI was identified as the prime vendor with nine partners.

- United Health Care provided startup funding for one additional CHT in Newport.

- CTC executed contracts with South County Health (SCH) and Blackstone Valley Community Health Center (BVCHC) to continue their CHTs with an SBIRT worker, and has new contracts in place with Thundermist, Family Service of RI, and East Bay Community Action Program to establish new CHTs with an SBIRT worker.

- CTC contracted with SCH to provide centralized management support for reporting and quality management to all CHTs. A project coordinator and data manager were hired.
- CHT staff at SCH completed Mental Health First Aid training and established connections with programs to begin regular case review.

- CHT staff participated in SBIRT training activities, led by Rhode Island College.
- CHT staff participated in SBIRT/CHT grant activities, such as monthly Executive and Implementation Team meetings as well a September SWAT incentive program to kick-start SBIRT screenings.

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.

- The following referrals and transitions occurred in DY9 January 1 – December 31, 2017.

Referrals/Transitions	Q1 CY 2017	Q2 CY 2017	Q3 CY 2017	Q4 CY 2017	Total CY 2017
Total referrals	110	82	90	103	385
Total transitioned from nursing facilities to community based residences	22	18	18	29	87
Of total, number of MFP participants that transitioned	10	10	14	10	44

- Convened a committee that is developing recommendations for use of MFP rebalancing funds.
- Conducted outreach with nursing home trade organizations to increase referrals.
- Established a list of program enrollees eligible for Section 811 Project Rental Assistance

housing, which is expected to be available before the end of the year.

- Participated in a local housing conference to promote the development of relationships between housing providers and human services providers.
- Participated in the national MFP Intensive session.
- Conducted an outreach presentation, in conjunction with the MCO, about behavioral health issues, transitions, and expanded efforts to work with the state mental health agency on transitions from nursing homes.

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.
- Continued the implementation and oversight of the Integrated Health Home Initiative for Behavioral Health SPA as part of Reinventing Medicaid.
- Continued the implementation and oversight of the children's health home (Cedar) SPA.

Home and Community Based Services (HCBS) Final Rules

In January 2014, CMS published the HCBS final rules. Rhode Island examined the final rules and began planning for implementation. The activities that have occurred during DY 9 January 1, 2017 – December 31, 2017 are outlined below.

- Meetings were held with DD and LTSS providers to explain the process to all. BHDDH held one-on-one conversations with their providers.
- Held a team call with CMS to discuss further concerns regarding the state transition plan and needed updates to achieve final approval.
- Compliance reviews completed, letters and reports mailed to providers for both OHHS and DD programs. Compliance plans received for most settings. BHDDH set a deadline of 12/17 for DD providers to submit work plans.
- Held one-on-one sessions with both ADC and AL providers regarding compliance letters.
- Multiple one-on-one visits completed regarding compliance issues. Five settings that were designated as unable to meet compliance will be closed.
- Continued work is occurring on heightened scrutiny, transition planning, and ongoing monitoring.

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, coordinates 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 was for Non-Emergency Medical Transportation only. The broker also provides member services, eligibility verification for transportation services, appointment

scheduling with contracted transportation providers, quality assurance and monitoring, and program reporting. During DY 9 January 1 – December 31, 2017 EOHHS conducted the following:

- Continued oversight and monitoring of LogistiCare contract and activities.
- Continued to report to external committees and 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. In January 2016, the delivery of the behavioral health benefit package was moved into managed care for MCO enrollees. In January 2016, the Behavioral Health Integrated Health Home services were included in the managed care and Medicaid Fee for Service delivery system. During the reporting year, staff from both EOHHS and BHDDH have worked closely to oversee and monitor adult behavioral health services in managed care. Staff continue to have regular communications with providers and managed care plans to address any issues that may arise, and to identify areas of opportunity to improve the delivery of behavioral healthcare to Medicaid members.

Managed Care Re-procurement

Throughout 2016 the State developed, procured, and tentatively awarded contracts for Rhode Island's Medicaid managed care program covering over 235,000 Medicaid beneficiaries. The procurement clearly identified the requirements MCO's participating in the Medicaid managed care program would be contractually obligated to provide. The intent of the procurement was to enter into long-term contracts with MCO's that will bring the highest possible levels of quality, efficiency, effectiveness, member experience, and progressive collaboration with the State to this important program. Consistent with the importance and size of the procurement, MCO's were required to provide considerable detail on their programs and proposed approach.

The State contracted with three (3) MCO's; Neighborhood Health Plan of Rhode Island, Tufts Health Plan, and United Healthcare Community Plan. The State conducted an open enrollment for all members in late fall of 2017. Oversight and management of the three MCOs is conducted on an ongoing basis.

Modernizing Health and Human Services Eligibility Systems

The state launched RI Bridges on September 13, 2016. RI Bridges is the State's full-service Eligibility System servicing Medicaid recipients as well as a host of DHS-related programs. After a twelve (12) day transition period in the beginning of September, the Go-Live came with some typical and atypical concerns. Directly from system access concerns and through subsequent steps including Plan enrollment, there were numerous concerns that the vendor, Deloitte, needed to address. As EOHHS transitioned into using the new system, the state quickly realized that functionality was not fully utilized in Program, Data, and Plan areas. Therefore, EOHHS utilized Interim Business Processes which included workarounds to the system. Post

launch, staff from the UHIP vendor were deployed in state offices to assist staff that were utilizing the new system and to identify and triage any possible glitches. EOHHS also established a process to categorize and prioritize these functionality issues.

During 2017 the Deloitte and State teams implemented maintenance releases to address hundreds of software and data incidents identified in the RI Bridges application as well as enhancement releases to improve the usability of the application and implement new functionality. Activities that took place during DY 9 to improve and stabilize the system are listed below:

- Enforce program integrity – Through a number of processes that included a daily review of transactions between the Eligibility (RIBridges) and Enrollment (MMIS) systems, implementing an automated Post Eligibility Verification process to verify that individuals continue to have the most up-to-date information associated with their accounts by checking external sources, and reconciliations of data between RIBridges and MMIS, the team has standardized the approach to reviewing Medicaid Terminations. The result of these efforts has been an increase from roughly 1,500 terminations per month to over 3,000 in June, which reduced the Medicaid caseload and enforced greater program integrity so that only eligible members continue to receive benefits.

- Long Term Care –LTSS functionality was an area of focus to improve the usability of the system and reduce the amount of time taken to process an application. The teams implemented changes to reduce the number of screens a worker needs to navigate to process an LTSS application while still capturing the necessary information to perform an eligibility determination. In addition, the Level of Care and Service Plan data entry was streamlined.

- Application Processing Backlog – Significantly reduced the total number of pending applications and the Medicaid Pending backlog. Work on the backlog has continued and additional decreases are being realized.

- Notices - Notice denial reasons and their triggers were reviewed and will be updated for better clarity of language. Citations will be updated to be aligned with the State's revised code. Approvals, denials, and changes are released in a timely manner. Terminations are held and manually reviewed to identify and resolve potential issues prior to termination of the customer and release of the termination notice. Workgroup sessions have implemented improvements to LTSS notices to improve clarity and meet all federal requirements.

- Appeals - System design improvements are being implemented to enhance the usability of the RIBridges system during the appeals process. The appeals process was reviewed end to end, gaps were identified and addressed, and unnecessary processes were eliminated. The improved functionality will standardize the business process in the field offices, with the goal of preventing and reducing backlog and ensuring that all legal requirements are met.

- Program Integrity - EOHHS continued to further the optimization of batches and notices including PEV, Passive Renewals, and Age Out, as well as daily activity. This helped reduced the Medicaid caseload and enforced greater program integrity so that only eligible members continue to receive benefits. Added focus was put on the reconciliation of recipients with returned mail and out-of-state mailing addresses. Updates to case address information was solicited and EOHHS terminated individuals who failed to report updates to their addresses.

- CMS Eligibility Compliance - RI continues to test the RIBridges Eligibility System for compliance to CMS' Rules and Regulations to ensure correct eligibility determinations result from system processing. RI provided test results to CMS to support the Pilot Eligibility testing process.

Batches:

- Renewals- The process for MAGI and Complex Medicaid renewals began in August 2017 for September renewals. Data points are verified by external sources when possible. If the verification fails then a request for additional documentation is added to the renewal form. Those that respond have the renewal packet (and any additional documents) scanned and processed by case workers, their eligibility rerun and renewed when applicable. Those who do not respond are picked up by subsequent batches.

- Age out- All cases are evaluated for other forms of eligibility based on the information in the system before any action is taken (i.e, "aging out" of a category of coverage). If the system cannot make a determination of eligibility in another category of coverage, an age-out notice is mailed to the beneficiary on the first day of the month prior to the month they will "age out" (approx. 30-60 days prior to the birthday). The notice informs beneficiary of his/her approaching birthday and Ex Parte process (possible eligibility in a different category but more information is required). If a determination cannot be made, eligibility runs and terminates individual.

- Post Eligibility Verification (PEV)- PEV was run for the first time in production in July of 2017. PEV Batch is typically run on the 21st of the month. MAGI beneficiaries have 15 days to respond to any request for additional documentation. Those that do not respond in time are picked up by OPA Med Batch and redetermined (and most likely terminated). Verifies:

- Employment Income (SWICA) from DLT

- Unemployment Income (UI) from DLT

- Death from DO

- Negative Action Batch/20-day batch- The Negative Action Batch runs for Complex Medicaid programs to verify if documents have been returned for the Passive Renewal batch. The 20-day batch works in the same manner, but is for the MAGI population only. Any case that has documents returned will be shielded from processing in either of these

batches to allow workers time to process the case. Both batches are heavily QC'd due to the likelihood of termination for individuals in these batches. Both must be resolved before the adverse action cut off dates (typically on the 15th of the month).

LTSS Backlog: The State continues to make progress in reducing the LTSS backlog of applications. Given the system challenges with LTSS, a contingency payment process was established to ensure nursing and assisted-living facilities receive prompt reimbursement from the State as work continues to drive down the backlog.

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during DY 9, January 1, 2017 – December 31, 2017.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Cortical Integrative Therapy	9/22/2015	DENIED	8/25/2017
Cat III	Recovery Navigation Program (formerly known as STOP)	11/16/2015		
Cat III	Home Stabilization Initiative	11/16/2015		
Cat II	Peer Specialist	11/30/2015		
SPA	Cedar Center Redesign	3/15/2016	Approved	1/13/2017
SPA	BH Health Home Redesign (IHH/ACT)	3/23/2016	Approved	1/12/2017
SPA	Disproportionate Share Hospital Policy	9/19/2016	Approved	6/15/17
SPA	Inpatient Hospital Rate Increase	9/21/2016	Approved	6/15/17
SPA	Outpatient Hospital Rate Increase	9/26/2016		
SPA	Centers of Excellence for Opioid Treatment	12/22/2016	Approved	3/14/2017
SPA	Medically Needy Income Limit	3/30/2017	Approved	5/25/2017
SPA	Standards for Optional State Supplementary Payments	3/30/2017	Approved	6/26/2017
SPA	Increase in Home Equity Limit for Long-Term Care	3/30/2017	Approved	5/25/2017
SPA	Covered Outpatient Drug Reimbursement Methodology	6/26/2017	Approved	9/20/2017
SPA	Home Health Face-to-Face Requirements	8/15/2017	Approved	8/30/2017
SPA	Outpatient Hospital Rate Increase	9/8/2017	Approved	10/20/2017
SPA	Disproportionate Share Hospital Payment Policy	9/8/2017	Approved	10/31/2017
SPA	Inpatient Hospital Rate Increase	9/8/2017	Approved	11/7/2017
SPA	Recovery Audit Contractor Program Exemption	9/8/2017	Approved	11/28/2017
SPA	Nursing Home Rate Increase	12/27/2017		
SPA	Home Care Rate Increase	12/27/2017		

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 DY 9, or allotment neutrality and CMS-21 reporting for the year. The Budget Neutrality Report can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report. Please note that revisions have been made to the "Excess Spending: Hypotheticals" row within the With Waiver Total Expenditures table, per

STC 123(c) which prohibits the state from obtaining budget neutrality "savings" from the New Adult population.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in DY9 January 1 – December 31, 2017. 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 DY9 January 1 – December 31, 2017 are outlined below.

Consumer Issues
RI Executive Office of Health and Human Services (EOHHS) employs procedures to monitor consumer issues across the managed care delivery system. These procedures include tracking, investigating and remediating consumer issues, which allows the State to identify trends and take preventive action.

Each MCO continuously monitors member complaints and watches for trends or emerging consumer issues. A Summary of Informal Complaints report is submitted to RI EOHHS on a quarterly basis. These reports present consumer reported issues grouped into six (6) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service and Billing Issues. The informal complaint reports are reviewed by the appropriate staff at EOHHS and any questions or requests for clarification are sent back to the MCOs with an expected response date. Data is disaggregated according to Medicaid cohort: Core RIte Care (Med), Rhody Health Partners (RHP), Rhody Health Expansion (ACA), RIte Care for Children with Special Health Care Needs (CSHN), Children in Substitute Care (Sub Care), and Rhody Health Options (RHO).

In March of 2017, RI EOHHS completed a re-procurement for the RI managed Medicaid contract which resulted in the award of the contract to three managed care organizations: Neighborhood Health Plan of RI (NHPRI), Tufts Health RITogether (THRIT) and United Healthcare Community Plan(UHCP-RI). NHPRI continues to be the only managed care organization that services both the RIte Care for Children in Substitute Care and Rhody Health Options populations.

Q1 Data
Neighborhood Health Plan of RI (NHPRI) reported an increase of 54% in the number of informal complaints in Q1 2017 (128) in comparison to Q1 2016 (83) and a 6% decrease in the number of informal complaints filed in Q1 2017 (128) in comparison to Q4 2016 (136). The increase in the year-to-year comparisons is attributed to a significant increase in the volume of informal complaints from both ACA and RHO members. The noteworthy categories for all populations were Quality of Care, specifically rude or disrespectful treatment and inappropriate treatment. There were no notable trends related to any specific provider.

United Healthcare Community Plan (UHCP-RI) reported no change in the number of informal complaints in Q1 2017 (70) in comparison to Q1 2016 (70) and a 13% increase in the number of informal complaints in Q1 2017 (70) compared to Q4 2016 (62). This increase was due

predominately to Quality of Care, specifically rude and disrespectful providers for RHP and RHE members across all provider types and Balance Billing for RHE members.

In addition to the two medical MCOs, the one dental MCO, United Healthcare Dental, administers the RIte Smiles program to children born on or after May1, 2000. United monitors informal complaints as well, and reports a decrease in the number of informal complaints in Q1 2017 (6) as compared to Q4 2016 (8). Because the numbers are so small, any impact may skew the values significantly. The comparison of Q1 2017 to Q4 2016 showed a decrease from 8 informal complaints to 6 for Q1. The category in which most of the informal complaints fall for the quarter is Balance Billing.

Q2 Data
Neighborhood Health Plan of RI (NHPRI) reported a decrease of 26% in the number of informal complaints in Q2 2017 (127) in comparison to Q2 2016 (160) and virtually remained unchanged in the number of informal complaints filed in Q2 2017 (127) in comparison to Q1 2017 (128). The noteworthy categories for all populations were Quality of Care and Access to Care. There were no notable trends related to any specific provider.

United Healthcare Community Plan (UHCP-RI) reported a 58% increase in the number of informal complaints in Q2 2017 (57) in comparison to Q2 2016 (24) and a 23% decrease in the number of informal complaints in Q2 2017 (57) compared to Q1 2017 (70). This increase was due predominately to billing issues across all provider types.

United Healthcare Dental reported the number of informal complaints in Q2 2017 (6) as compared to Q2 2016 (8). The comparison of Q2 2017 to Q1 2017 showed a total of 6 complaints for each quarter. There is no trend identified for these few complaints.

Q3 Data
Neighborhood Health Plan of RI (NHPRI) reported an 11% increase in the number of informal complaints in Q3 2017 (104) in comparison to Q3 2016 (94) and experienced an 18% decrease in the number of informal complaints filed in Q3 2017 (104) in comparison to Q2 2017 (127). The noteworthy categories for all populations were Quality of Care and Access to Care. While there were no notable trends related to any specific provider, inappropriate, rude or disrespectful treatment were the categories with the highest complaints for all lines of business except Sub Care.

United Healthcare Community Plan (UHCP-RI) reported a 102% increase in the number of informal complaints in Q3 2017 (91) in comparison to Q3 2016 (45) and a 60% increase in the number of informal complaints in Q3 2017 (91) compared to Q2 2017 (57). This increase was due predominately to billing issues across all provider types.

United Healthcare Dental reported the number of informal complaints in Q3 2017 (4) as compared to Q3 2016 (14) which represents a 71% decrease in the number of complaints. The comparison of Q3 2017 (4) to Q2 2017 (6) represents a 34% decrease. There is no trend identified for these few complaints.

Q4 Data

NHPRI reported an 86% decrease in the number of informal complaints in Q4 2017 (73) in comparison to Q4 2016 (136) and experienced a 42% decrease in the number of informal complaints filed in Q4 2017 (73) in comparison to Q3 2017 (104). These changes represent a decrease in the number of Quality of Care and Access to Care complaints across all populations except Rhody Health Partners.

UHCP-RI reported a 70% decrease in the number of informal complaints in Q4 2017 (80) in comparison to Q4 2016 (136) and a 14% decrease in the number of informal complaints in Q4 2017 (80) compared to Q3 2017 (91). These changes represent a decrease in the number of Quality of Care and Access to Care complaints across all populations except Rhody Health Partners. While the clinical complaints have decreased significantly, administrative complaints for balance billing has increased both the RIte Care and Rhody Health Expansion populations.

THRIT reported no complaints to date.

United Healthcare Dental reported the number of informal complaints in Q4 2017 (1) as compared to Q4 2016 (4) which represents a 300% decrease in the number of complaints. The comparison of Q4 2017 (1) to Q3 2017 (8) represents a 700% decrease. There is no trend identified for these few complaints.

RI EOHHS utilizes the Summary of Informal Complaints reports and the Internal Health Plan Oversight Committee meetings to identify consumer issue trends and develop strategies to prevent future occurrence. EOHHS also looks to find new ways to offer consumer protections, as demonstrated by the requirement that the RI Office of Health Insurance Commissioner's consumer assistance contact line information be included on specified member communications. This offers our managed care members another avenue to 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, 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 ICI Implementation Council. CAC stakeholders include individuals who are enrolled in RIteCare, and representatives of advocacy groups, health plans, the Department of Human Services (DHS), and EOHHS. The CMS Regional Officer participates in these meetings as her schedule permits. The CAC met six times in DY9 January 1 – December 31, 2017:

January meeting agenda

- Review of Minutes

- RI Bridges System Update
- Managed Care Reprocurement Update
- Open Enrollment
- Membership/Enrollment
- Health Plan Escalation Process

March meeting agenda

- Review of Minutes
- Medicaid Updates
- RI Bridges System Update
- Managed Care Reprocurement and Open Enrollment Update
- Membership/Enrollment
- Ad Hoc Items

May meeting agenda:

- Review of March Minutes
- Budget/Case Load
- Open Enrollment Update
- Membership/Enrollment
- UHIP/DHS Update
- Ad Hoc Items

July meeting agenda:

- Review of May Minutes
- Comments from Patrick Tigue, Medicaid Director
- Open Enrollment Update
- Membership/Enrollment
- UHIP/DHS Update
- Ad Hoc Items

September meeting agenda:

- Comments from January Angeles, Deputy Medicaid Director and Ralph Racca, Director Managed Care
- Review of July meeting minutes
- Open Enrollment Update
- UHIP/DHS Updates
- Membership/Enrollment Updates
- Ad Hoc Items

November meeting agenda:

- Review of September meeting minutes
- SFY 2018 Budget Update
- Update
- Medicaid Updates- January/Ralph

- Open Enrollment Update
- UHIP/DHS Updates
- Membership/Enrollment Updates
- Ad Hoc Items

The ICI Implementation Council is a consumer advisory board to EOHHS and the steering committee for the ICI Ombudsman Program. The group includes individuals who are Medicaid enrolled and receive Long Term Services and Supports as well as those dual eligible members in the Integrated Care Initiative. The Council is 51% consumer led and is comprised of eight consumer/family members and seven provider/advocate members. The activity regarding this council is reported in the Integrated Care Initiative section of this report.

The EOHHS Transportation Broker, Logisticare, reported on transportation related complaints. The following charts reflect the number of complaints compared to transportation reservations and the top five complaint areas during DY 9 January 1 – December 31, 2017.

NEMT Analysis	DY 9 Q1	DY9 Q2	DY 9 Q3	DY 9 Q4
All NEMT & Elderly Complaints	1,287	1,128	1,025	1,129
All NEMT & Elderly Trip Reservations	532,097	549,911	549,265	589,766
Complaint Performance	0.24 %	0.21 %	0.18 %	0.19%
Top 5 Complaint Areas	**DY 9 Q1**	**DY 9 Q2**	**DY 9 Q3**	**DY 9 Q4**
Transportation Provider Late	691	546	422	459
Transportation Provider General Complaint	336	311	368	239
Transportation Provider No Show	130	134	109	117
Complaint about Rider	105	103	82	68
Rider No Show	25	34	32	81

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 DY 9 January 1 – December 31, 2017.

2017 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	156	22	$42.95	$6,700.00
February	157	1	$43.24	$6,788.00

March	118	-39	$44.51	$5,252.00
April	130	11	$43.59	$5,667.00
May	234	104	$41.98	$9,823.00
June	265	31	$42.18	$11,177.00
July	265	0	$42.18	$11,179.00
August	314	49	$42.26	$13,269.00
September	318	4	$42.45	$13,498.00
October	319	0	$42.34	$13,505.00
November	296	-23	$42.60	$12,611.00
December	265	-31	$42.30	$11,209.00
Total				$120,678.00

Summary of Marketplace Activities for DY 9 January 1 – December 31, 2017
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 through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HealthSource 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.

With the September 2016 implementation of RIBridges, monthly reports of eligible families were still in development. The on-going refinement of RIBridges had an impact on eligibility for Q1 and Q2 of 2017. During the months of April and June 2017, EOHHS identified and contacted approximately 600 potentially eligible applicants via mail. In the months following the April and June mailings, EOHHS saw a noticeable increase in the number of applications returned, as well as an increase in monthly enrollees. This was followed by a decrease in enrollment in November and December of 23 and 31 enrollees respectively.

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in the quarters in DY 9.

Quality Assurance and monitoring of the State's Medicaid-participating Health Plans
On a monthly basis, EOHHS leads oversight and administration meetings with the State's four (4) Medicaid participating Plans, NHPRI, Tufts, UHCCP-RI, and UHC Dental. These monthly meetings are conducted separately with each Health Plan; agenda items focus on both standing agenda items and emerging areas of focus. EOHHS has moved away from a cyclical quarterly topic for each oversight meeting (i.e. addressing Medicaid managed care operations in January/April/July/October; Quality improvement, compliance, and program integrity in March/June/September/December; and Medicaid managed care financial performance in February/May/August/November). Rather, we are moving to address the key issues as they arise at each monthly meeting.

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 DY 9 January 1 – December 31, 2017.

Areas of focus addressed during Q1:

- Readiness reviews in 2016: EOHHS issued a procurement for a new contract for the RiteCare, Substitute Care, Rhody Health Partners, and Rhody Health Expansion lines of business. EOHHS selected three Managed Care Organizations (MCO): Neighborhood Health Plan of RI, United Healthcare Community Plan of RI and a new MCO, Tufts Health Public Plan of RI. In Quarter 1, EOHHS held a series of "Readiness" meetings with the MCOs in place of the oversight meetings.
    - Within these Readiness meetings EOHHS assessed the MCOs' ability to operationalize all aspects of the new contract with a specific focus on access to care, Accountable Entities and Alternative Payment Methodologies, behavioral health, care coordination, and quality.
    - The Readiness meetings for the new MCO, Tufts Health Public Plan, had a greater focus on network development, systems implementation, review of policies and procedures, and member-facing activities and materials.
- EOHHS concluded the readiness review of Neighborhood Health Plan of RI and United Healthcare Community RI in March and resumed regular oversight meetings. In the March meeting, the health plans discussed their progress implementing the new Managed Care Final Rule.
- EOHHS also discussed setting new priorities for contract oversight that focus on areas of the contract seen as most important to EOHHS and MCO activities.

- EOHHS reviewed quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care for all MCOs, including Dental.

- United Dental, Neighborhood Health Plan of RI and United Healthcare Community RI were required to conduct Secret Shopper Surveys on appointment availability in their network. The plans presented their results during the Readiness review. The results revealed several opportunities to update provider directories, close provider panels, and work with providers to understand and meet their contractual obligations of appointment availability times.

- The MCOs, including Dental, began activities with the EQRO for the annual technical report.

- Finally, EOHHS met with the Senior Leadership of UHC Dental in which they presented a plan to address EOHHS concerns with report submissions (content and timeliness), and sufficient staffing to address the concerns of growing membership.

Areas of focus addressed during Q2:

- Readiness review meetings continued with Tufts Health Public Plan

- In the April meeting, EOHHS held a joint oversight meeting including all four health plans to discuss Active Contract Management, the new method for EOHHS oversight. EOHHS also discussed expectations of the health plans in this new model of oversight.

- In the May oversight meetings, EOHHS met with health plans separately to address concerns with encounter data reporting. EOHHS also met with Senior Leadership of UHC Dental for an update on how they are addressing EOHHS concerns with report submissions (content and timeliness), and sufficient staffing to address growing membership in the plan

- In June, EOHHS held another joint meeting between NHP-RI and UHCP-RI to discuss quality improvement projects. In this meeting, health plans shared recent data points on each quality improvement project, shared best practices and successes, and identified barriers and next steps. The meeting was a collaborative effort between both health plans and EOHHS to advance quality improvement efforts.

- A separate meeting was held for UHC Dental in June to address their quality improvement projects: most recent data point, identify best practices/successes and identify barriers and next steps.

- EOHHS reviewed quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care for all MCOs, including Dental.

Areas of focus addressed during Q3:

- Tufts completed the readiness review process and began accepting new members in July 2017.

- In the July meeting, EOHHS met with NHPRI and UHCP-RI separately to discuss updates on their Provider Incentive Programs. NHPRI and UHCP-RI were provided a pool of funding to support providers as Accountable Entities (EOHHS's version of Accountable Care Organizations). The health plans presented baseline performance results for each measure and for each Accountable Entity. They provided current AE performance on process measures and detailed how the plan was evaluating performance on these measures. Additionally, the plans provided detail on each Accountable Entity's predicted earnings, as well as how much has been paid to date to each Accountable Entity.

- In the August meeting, EOHHS met with NHPRI and UHCP-RI separately to discuss the Accountable Entity Pilot Status. Specific to quality, the plans presented on care management progress and their quality performance and analytics.

- In the September meeting, EOHHS met with NHPRI to address specific concerns related to access to services. EOHHS reviewed a number of quarterly reports that indicated issues with member access. The September meeting with UHC-RI was not related to quality.

- Separate meetings were held for UHC Dental in August and September in which the plan provided updates on the HEDIS rates and Quality Improvement Projects.

- EOHHS reviewed quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care for the MCOs, including Dental.

Areas of focus addressed during Q4:

- In the November meeting, EOHHS met with NHPRI and UHCP-RI separately to discuss their behavioral health programs, specifically oversight and monitoring of the behavioral health vendors, contract compliance, and claims payment issues with providers.

- In the December meeting, EOHHS met with NHPRI to review compliance with the updated managed care rule.

- In October, November, and December, EOHHS met with UHCP-RI to discuss the implementation of a new program requiring PCP referrals for certain specialty care providers. EOHHS discussed the impacts on access this program would have.

- Separate meetings were held for UHC Dental. In October, EOHHS discussed program integrity requests, updates to the quality improvement projects,

- EOHHS reviewed quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care for the MCOs, including Dental.

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*). This work group has since transformed into multiple work groups.

The areas of focus that were addressed by these multiple 1115 Quality and Evaluation workgroups during DY9 are as follows:

Q1 Activity

- Data quality and 837 claims data
- ED visits and Long Term Care
- Use of data to inform policy development and measures
- Overall impact of the Affordable Care Act on Rhode Island
- DUA and HIPPA

Q2 Activity

- Data standardization
- Presentations on the Data Analytics Reference Almanac and Power BI Dashboards
- Data Governance best practices

Q3 Activity

- Discussed program/quality intersection, population grid, 837 encounter data
- Data standardization and best practices

Q4 Activity

- Discussed program/quality intersection, population grid, 837 encounter data

- Data standardization and best practices

Development of a Draft Evaluation Design for the Section 1115 Demonstration

In concert with the development of the proposed Section 1115 Comprehensive Quality Strategy, EOHHS has analyzed the draft *Evaluation Design* which was submitted to CMS in July 2009. Based on the synthesis of feedback that EOHHS has received from stakeholders in response to the proposed *Section 1115 Comprehensive Quality Strategy*, further modifications to the draft *Evaluation Design* are anticipated prior to its submission to CMS.

The draft *Evaluation Design* will include a discussion of the goals, objectives, and evaluation questions specific to the Comprehensive Demonstration. The following will be addressed:

- Outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval.
- The adequacy and appropriateness of the benefit coverage.
- The data sources and sampling methodology to be used.
- The proposed analytic plan.
- The party that will conduct the evaluation.

In addition, separate components of the Demonstration must be evaluated, including but not limited to the following:

- LTC Reform, including the HCBS-like and PACE-like programs
- RIte Care
- RIte Share
- The 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:
    1. Children and Families in Managed Care and Continued eligibility for Rite Care parents when kids are in temporary state custody.
    2. Children with Special Health Care Needs.
    3. Elders 65 and Over.
    4. HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth.
    5. Uninsured adults with mental illness/substance abuse problems.
    6. Coverage of detection and intervention services for at risk young children.
    7. HIV Services.

- Progress towards these goals during DY9 include:
    - Dataset development: Refinement of population grid to capture relevant information on Waiver Groups.
    - Dashboard Development: PBI software linked to utilization data and population grid which leads to more efficient analytical access to data
    - Finalization of LTC/LTSS standardized metrics.
    - Initiation of IHH/ACT/OTP tracking
    - Implementation of behavioral program metrics
    - Initiation of the Utilization Tracking Report

- Evaluation Strategies have been updated in the following programmatic areas:
    - Accountable Entities
        - Logic Model
        - Data development
        - Programmatic buy in
        - Initial assess of total cost of care methodology (TCOC)
    - IHH/ACT/OTP Programs
        - Logic Model
        - Administrative Tracking System
        - Ongoing programmatic support
    - HBTS
    - Health Aging Initiatives
        - MFP analytic support
        - Setting HSTP objectives
        - Develop business model (in progress

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 Q1 CY 2017	DY 9 Q2 CY 2017	DY 9 Q3 CY 2017	DY 9 Q4 CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 511,340,631	$ 488,249,580	$ 125,400,086	$ 124,810,601	$ 125,956,318	$ 144,284,767	$ 520,451,772
ABD Adults TPL	$1,173,431,773	$ 1,271,228,068	$ 346,343,703	$ 354,274,560	$ 360,469,581	$ 338,853,639	$1,399,941,483
RIte Care	$ 856,219,858	$ 933,125,256	$ 260,581,920	$ 266,720,380	$ 267,425,810	$ 266,088,620	$1,060,816,730
CSHCN	$ 411,979,301	$ 417,839,643	$ 113,506,532	$ 117,012,032	$ 119,233,740	$ 119,345,916	$ 469,098,220
TOTAL	**$2,952,971,564**	**$ 3,110,442,547**	**$ 845,832,241**	**$ 862,817,573**	**$ 873,085,449**	**$ 868,572,942**	**$3,450,308,205**

With Waiver Total Expenditures

Medicaid Populations	DY 7 2015 YTD	DY 8 2016 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 8 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	DY 8 2016 YTD
ABD Adults No TPL	$ 396,437,538	$ 540,181,908	$ 96,512,978	$ 80,903,358	$ 126,779,576	$ 105,704,417	$ 409,900,329
ABD Adults TPL	$ 734,368,831	$ 616,430,588	$ 184,860,186	$ 158,923,299	$ 223,164,966	$ 186,730,759	$ 753,679,210
RIte Care	$ 554,398,258	$ 496,945,206	$ 125,274,526	$ 70,858,596	$ 169,700,715	$ 147,193,282	$ 513,027,120
CSHCN	$ 198,981,132	$ 175,292,128	$ 42,387,668	$ 40,015,844	$ 55,555,459	$ 46,662,460	$ 184,621,431
Excess Spending: Hypothetical	$ 14,317,741	$ 12,251,991	$ 1,063,041	$ 699,354	$ 515,551	$ (1,208,297)	$ 1,069,649
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -		$ -
CNOM Services	$ 10,007,986	$ 8,969,196	$ 2,311,449	$ 2,288,851	$ 2,206,161	$ 2,248,849	$ 9,055,311
TOTAL	**$1,908,511,486**	**$1,850,071,016**	**$ 452,409,848**	**$ 353,689,302**	**$ 577,922,429**	**$ 487,331,470**	**$1,871,353,049**
Favorable / (Unfavorable) Variance	$1,044,460,078	$1,260,371,531	$ 393,422,393	$ 509,128,271	$ 295,163,020	$ 381,241,472	$1,578,955,156
Budget Neutrality Variance (DY 1-5)							
Cumulative Bud. Neutrality Variance	**$4,763,642,888**	**$6,024,014,419**	**$6,417,436,812**	**$6,926,565,082**	**$7,221,728,102**	**$7,602,969,574**	**$7,602,969,574**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2015 YTD	2016 YTD
217-like Group	$ 157,960,620	$ 169,392,808
Family Planning Group	$ 29,409	$ 89,922
TOTAL	$ 157,990,029	$ 169,482,730

1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	4th Qtr. CY 2017	2017 YTD
$ 43,897,984	$ 44,104,320	$ 44,667,776	$ 48,921,472	$ 181,591,552
$ 20,878	$ 20,152	$ 22,286	$ 38,478	$ 101,794
$ 43,918,862	$ 44,124,472	$ 44,690,062	$ 48,959,950	$ 181,693,346

With-Waiver Total Exp.	2015 YTD	2016 YTD
217-like Group	$ 172,275,322	$ 181,671,673
Family Planning Group	$ 32,448	$ 63,048
TOTAL	$ 172,307,770	$ 181,734,721

1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	4th Qtr. CY 2017	2017 YTD
$ 44,971,858	$ 44,816,225	$ 45,190,131	$ 47,731,291	$ 182,709,505
$ 10,045	$ 7,601	$ 15,482	$ 20,362	$ 53,490
$ 44,981,903	$ 44,823,826	$ 45,205,613	$ 47,751,653	$ 182,762,995

Excess Spending	2015 YTD	2016 YTD
217-like Group	$ 14,314,702	$ 12,278,865
Family Planning Group	$ 3,039	$ (26,874)
TOTAL	$ 14,317,741	$ 12,251,991

1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	4th Qtr. CY 2017	2017 YTD
$ 1,073,874	$ 711,905	$ 522,355	$ (1,190,181)	$ 1,117,953
$ (10,833)	$ (12,551)	$ (6,804)	$ (18,116)	$ (48,304)
$ 1,063,041	$ 699,354	$ 515,551	$ (1,208,297)	$ 1,069,649

LOW INCOME ADULT ANALYSIS

Low-Income Adults (Expansion)	2015 YTD	2016 YTD
Without Waiver Total Exp.	$ 617,131,227	$ 693,378,495
With-Waiver Total Exp.	$ 448,818,617	$ 300,953,105
Excess Spending	$ (168,312,610)	$ (392,425,390)

1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	4th Qtr. CY 2017	2017 YTD
$ 202,259,717	$ 209,056,157	$ 207,648,323	$ 209,110,996	$ 828,075,193
$ 117,294,158	$ 69,125,024	$ 161,308,992	$ 111,120,780	$ 458,848,954
$ (84,965,559)	$ (139,931,133)	$ (46,339,331)	$ (97,990,216)	$ (369,226,239)

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 4th Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	183,870	168,420	41,482	41,287	41,666	47,729	172,164
ABD Adults TPL	373,223	387,806	101,359	103,680	105,493	99,167	409,699
RIte Care	1,787,590	1,851,439	491,664	503,246	504,577	502,054	2,001,541
CSHCN	145,853	140,829	36,427	37,552	38,265	38,301	150,545
217-like Group	42,292	44,021	11,063	11,115	11,257	12,329	45,764
Low-Income Adult Group	759,079	810,969	224,983	232,543	230,977	232,604	921,107
Family Planning Group	1,453	4,282	949	916	1,013	1,749	4,627

Without Waiver PMPMs	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2nd Qtr. CY 2017	DY9 3rd Qtr. CY 2017	DY 9 4th Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 2,781	$ 2,899	$ 3,023	$ 3,023	$ 3,023	$ 3,023	$ 3,023
ABD Adults TPL	$ 3,144	$ 3,278	$ 3,417	$ 3,417	$ 3,417	$ 3,417	$ 3,417
RIte Care	$ 479	$ 504	$ 530	$ 530	$ 530	$ 530	$ 530
CSHCN	$ 2,825	$ 2,967	$ 3,116	$ 3,116	$ 3,116	$ 3,116	$ 3,116
217-like Group	$ 3,735	$ 3,848	$ 3,968	$ 3,968	$ 3,968	$ 3,968	$ 3,968

Low-Income Adult Group	$ 813	$ 855	$ 899	$ 899	$ 899	$ 899	$ 899
Family Planning Group	$ 20	$ 21	$ 22	$ 22	$ 22	$ 22	$ 22
Without Waiver Expendtures	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 4th Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 511,340,631	$ 488,249,580	$ 125,400,086	$ 124,810,601	$ 125,956,318	$ 144,284,767	$ 520,451,772
ABD Adults TPL	$1,173,431,773	$ 1,271,228,068	$ 346,343,703	$ 354,274,560	$ 360,469,581	$ 338,853,639	$ 1,399,941,483
RIte Care	$ 856,219,858	$ 933,125,256	$ 260,581,920	$ 266,720,380	$ 267,425,810	$ 266,088,620	$ 1,060,816,730
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217-like Group	$ 157,960,620	$ 169,392,808	$ 43,897,984	$ 44,104,320	$ 44,667,776	$ 48,921,472	$ 181,591,552
Low-Income Adult Group	$ 617,131,227	$ 693,378,495	$ 202,259,717	$ 209,056,157	$ 207,648,323	$ 209,110,996	$ 828,075,193
Family Planning Group	$ 29,409	$ 89,922	$ 20,878	$ 20,152	$ 22,286	$ 38,478	$ 101,794

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 Deputy Medicaid Program Director, Finance and Budget, 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: Katie Alijewicz

Title: EOHHS Deputy Medicaid Program Director, Finance and Budget

Signature: [redacted]

Date: 8/15/2018

XIII. State Contact(s)

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XIV. Date Submitted to CMS

08/17/2018

XIV. Date Submitted to CMS

08/17/2018