Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

April 1, 2019 – June 30, 2019

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

Submitted December 2019

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 11 April 1, 2019 – June 30, 2019

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.

On December 2, 2018, CMS renewed the Comprehensive demonstration through December 31, 2023. This renewal includes changes to support a continuum of services to treat addictions to opioids any other substances, including services provided to Medicaid enrollees with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Disease (IMD). The Comprehensive demonstration renewal commenced with an effective date of January 1, 2019.

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)* 06/30/19	Number of Enrollees That Lost Eligibility in 06/30/19**
Budget Population 1: ABD no TPL	14,183	682
Budget Population 2: ABD TPL	34,046	386
Budget Population 3: RIte Care	124,533	3,961
Budget Population 4: CSHCN	12,095	117
Budget Population 5: EFP	1,101	56
Budget Population 6: Pregnant Expansion	26	3
Budget Population 7: CHIP Children	36,797	968
Budget Population 8: Substitute care	N/A	N/A
Budget Population 9: CSHCN Alt	N/A	N/A
Budget Population 10: Elders 65 and over	1,854	10
Budget Population 11, 12, 13: 217-like group	4,448	45
Budget Population 14: BCCTP	83	2
Budget Population 15: AD Risk for LTC	3,601	0
Budget Population 16: Adult Mental Unins	12,016	0
Budget Population 17: Youth Risk Medic	6,092	54
Budget Population 18: HIV	282	13
Budget Population 19: AD Non-working	0	0
Budget Population 20: Alzheimer adults	N/A	N/A
Budget Population 21: Beckett aged out	N/A	N/A
Budget Population 22: New Adult Group	74,679	3,887

*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 quarter in DY 11 April 1, 2019 – June 30, 2019:

Quarter 2: 23:489 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 DY11 April 1, 2019 – June 30, 2019 (by category or by type) with a total of $2,086.24 for special purchases expenditures.

Q 1 2019	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Over the counter medications		$ 589.24
	10	Acupuncture		$ 750.00
	4	Massage Therapy		$ 270.00
	1	Supplies, non-medical	Supportive devices	$ 107.00
	1	Diabetes management		$ 60.00
	1	Lawn Care		$ 125.00
	2	Service Dog Training		$ 185.00
	CUMULATIVE TOTAL			**$ 2,086.24**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for Q2, April 1, 2019 – June 30, 2019.

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. During Q2 the following activities occurred.

Health Workforce Development Program

1. Continued collaborative efforts between Medicaid and Institutions of Higher Education (IHEs) to advise, monitor, and align HSTP-funded IHE healthcare workforce transformation projects with the needs of Accountable Entities and other system transformation objectives.

2. Provided guidance and support to other healthcare workforce transformation initiatives throughout RI to maximize alignment, collaboration, and impact of efforts related to primary care, long-term care, behavioral health, developmental disabilities, and other areas with critical workforce needs.

3. Provided research and policy recommendations regarding training, credentialing, recruitment and other workforce development aspects of RI's newly-enacted Independent Provider model of consumer-directed LTSS.

4. Assisted in the development of a new partnership between EOHHS and the RI Department of Labor & Training to strengthen connections between Accountable Entities and IHEs.

Accountable Entities (AEs)

- AEs had a delayed start with project plans, but all were approved. Additionally, more SDOH, BH, SUD service providers were contracted. In Q2, the AEs received $12,929,643 in incentive funds. The managed care organizations (MCOs) earned $549,944 in incentive funds for oversight and management of the AEs.

- In advance of PY 2 (July 1, 2019-June 30, 2020), six (6) Medicaid AEs were certified with conditions for PY 2. Note: AEs are eligible for HSTP incentive funds if they are certified and execute an Alternative Payment Methodology (APM) total cost of care contract with a Medicaid managed care organization (MCO).

- A series of stakeholder meetings were held to solicit input and feedback and formal public comment on Rhode Island's Draft Medicaid Managed Care Policy Statement specific to Managed Care Organization Member Assignment Related to AEs, Managed Care Delegation to Accountable Entities, and Managed Care Organization and Accountable Entity Risk Adjustment.

- EOHHS/Medicaid continue to work with our vendor Bailit Health on the implementation of the AE quality component, including recommendations for Program Year 3 quality component of the APM contract, data collection and reporting specific to clinical quality (hybrid) measures, development of technical specification for a social determinant of health, and standardization of scoring criteria and methodology. A quality and outcome implementation manual is being drafted as part of this work.

- In Q 2 2019, EOHHS has executed an MOU with the Rhode Island Office of the Health Insurance Commissioner (OHIC) to develop a set of criteria to assess a provider's capacity to enter into downside-risk arrangements. Ongoing work continues between EOHHS and OHIC.

- Under the contact with the Center for Health Care Strategies (CHCS) individualized technical assistance was provided to Medicaid AEs and MCOs. An in-person learning collaborative took place in May with EOHHS, the MCOs, and the Medicaid AEs. The topics included:
    - Integrating the Voice of Consumers
    - Complex Care Management
    - Building Partnerships with Health Systems, Managed Care Organizations, and Community-Based Organizations

- For the Q2 the HSTP Advisory Committee meeting, Day Health Strategies presented "Medicaid Managed Care Draft Strategic Vision, Goals & Planning, and Stakeholder Process."

Dental Case Management Program

Waiver Authority

The Dental Case Management (DCM) Pilot uses a select group of trained dental practices across the state. The DCM Pilot focuses on using four new dental case management service codes to emphasize health care coordination, improve oral health literacy and to support patient compliance among Medicaid beneficiaries. The state may implement this pilot less than statewide, and the state will select up to six (6) dental practices. The state must require that the dental practices complete a no-cost training program developed in partnership with the Medicaid/Medicare CHIP Services Dental Association (MSDA) and submit verification documentation showing completion of the training to the state to be part of the DCM pilot. Once selected, dental practices will be able to bill and be reimbursed for four (4) new dental case management CDT codes. The pilot project will phase-in the new dental case management codes into the state's standard Medicaid oral health policies while continuing to monitor utilization, patient outcomes, and fiscal feasibility. The state will conduct this pilot program for 12 months and may extend the pilot program by seeking and receiving approval from CMS.

Dental Case Management Quarterly Report – Q2 2019

	Q2 2019
New providers receiving online training during this quarter	3 (from 2 practices)
Total Providers Trained	17 (from 4 practices)
New providers enrolled to bill DCM codes through DXC	1
Total providers enrolled to bill DCM codes through DXC	2
DCM claims submitted during this quarter	68

Broken Appointments among Adult Beneficiaries	
Tri County	4% drop

Below is a report of the Dental Case Management services that is used to monitor utilization by provider, provider type, age, and gender of the beneficiary.

Utilization of Dental Case Management Service by Code	
D9991	0
D9992	8
D9993	8
D9994	52

Utilization of Dental Case Management Service by Provider	
Tri-County Health Center	4
St. Joseph Hospital	64

Utilization of Dental Case Management Service by Provider Type	
Tri-County Health Center	4
St. Joseph Hospital	64

Utilization of Dental Case Management Service by Age	
21 - 30	13
31 - 40	22
41 - 50	4
51 - 60	26
61 +	4

Utilization of Dental Case Management Service by Gender	
Female	45
Male	23

VII. Operational/Policy Developments/Issues

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	RIte Share	3/20/2019	Approved	6/25/2019
SPA	Medicaid and CHIP Final Rule	6/26/2019		
SPA	Medicaid Premiums and Cost Sharing	6/28/2019		

Identify all significant program developments/issues/problems that have occurred in Q2, April 1, 2019 – June 30, 2019.

Modernizing Health and Human Services Eligibility Systems

Between April 1, 2019 and June 30, 2019, the Deloitte and EOHHS teams implemented maintenance releases to address software and data incidents identified in the RI Bridges application and implemented enhancement releases to improve the usability of the application as well as implement new functionality. Improvements to the Medicaid program can be summarized across the focus areas below:

Notices: Terminations are no longer being held for manual review. Termination outcome goals have been achieved and pre-mailing review is no longer required.

MMIS Transaction Stabilization: RI continues to focus on the discrepancies between RI Bridges and the MMIS. As of this report, the number of active recipients in RI Bridges who do not have an active eligibility record in the MMIS is steadily around 185 – this data is tracked daily and this report has been edging downward for several months. The recipients who have active eligibility in MMIS and no active segment is RI Bridges continues to be a focus for the State – this number remains at 3% of the total active Medicaid population.

CMS Eligibility Compliance: RI continues to address issues found in the RI Bridges Eligibility System during the pilot eligibility testing process. Findings are discussed during weekly theme meetings to ensure that the appropriate root cause analysis and corrective action is documented for CMS. RI continues to provide updates to CMS related to their corrective action plan.

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 period of April 1, 2019 – June 30, 2019.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	RIte Share	3/20/2019	Approved	6/25/2019
SPA	Medicaid and CHIP Final Rule	6/26/2019		
SPA	Medicaid Premiums and Cost Sharing	6/28/2019		

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 Quarter 2 of DY 11 April 1, 2019 – June 30, 2019, or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

April – June 2019

Rhode Island Executive Office of Health and Human Services (EOHHS) employs procedures to monitor consumer issues across the managed care delivery system[1]. These procedures include tracking, investigating and remediating consumer issues which allows the State to identify trends and take preventive action.

Each Managed Care Organization (MCO) monitors member complaints to identify trends and/or emerging consumer issues. Informal complaints Report track consumer reported issues grouped into seven (7) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service, Parity and Billing Issues.

Currently the grievance/informal complaint reports are submitted to EOHHS quarterly and reviewed by the appropriate staff at EOHHS. Any questions or requests for clarification by EOHHS 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)[2], RIte Care for Children with Special Health Care Needs (CSHN), and Children in Substitute Care (Sub Care)[3] . As of Q1 2020 (January 1, 2020) informal complaints will be captured in the quarterly Grievance report submitted to RI EOHHS.

There currently are three (3) MCOs that are contracted with EOHHS to provide care to RI managed Medicaid members: Neighborhood Health Plan of RI (NHPRI), Tufts Health Plan RI Together (RIT) and United Healthcare Community Plan (UHCP-RI). NHPRI continues to be the only managed care organization that serves the RIte Care for Children in Substitute Care population. In addition to the three (3) MCOs there is one (1) dental MCO, United Healthcare Dental that administers the RIte Smiles program

RI EOHHS utilizes Grievance/Informal Complaint reports to identify consumer issue trends and, as part of active contract oversight, collaborate with the Medical and Dental managed care organizations to develop strategies to prevent future occurrence. Reports are further analyzed to identify and ensure increased consumer protections as demonstrated through the requirement that MCOs offer the RI Office of Health Insurance Commissioner's consumer assistance contact information on member communications. In addition, members may contact RI Department of Managed Care to register a concern or displeasure with the MCO complaint process. Thus, allowing members multiple avenues in which they may invoke the full scope of their member rights.

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

[3] NHPRI is the only MCO that has the RIte Care for Children in Substitute Care.

4.1. 2019 – 6.30.2019
Data Q2

NHPRI reported a 71.1% decrease in the number (15) of informal complaints in Q2 2019 in comparison to Q2 -2019. Of this quarter's 15 complaints, RHP and RHE cohorts represented the highest percentage of concerns with billing and health plan customer service complaints. NHPRI is the only MCO that administers Rite Care for Children in Substitute Care; there were no informal complaints submitted by Sub Care beneficiaries in either Q1 or Q2 2019.

UHCP-RI reported a 36.6% decrease in the number (45) of informal complaints in Q2 2019 in comparison to Q1 2019. Of this quarter's 40 complaints the following cohorts RIte Care, RHP and RHE, represent the highest number of informal complaints. Complaints regarding billing issues remain the highest category (19) followed by health plan customer service. Of note, 30 of the 40 informal complaints were from members attributed to an Accountable Entity (AE). Unlike the MCOs, UHC does not have a category tracking informal complaints based on Parity issues. This will be a required, distinct category for all MCOs beginning Q1 2020.

RIT reports (0) informal complaints in Q2 2019 in comparison to 2 informal complaints in Q12019.

United Healthcare Dental reported a 50% decrease in the number of informal complaints in Q2 2019 in comparison to Q1 2019. Of this quarter's 2 informal complaints, both represented billing issues. Of note, Dental reports Informal Complaints using the following categories: Access to Care, Quality of Care, Environment of Care, Enrollment Disputes, Health Plan Customer Services, Billing Issues and Transportation.

EOHHS 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 RIte Care, 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 once in Q2 April 1 – June 30, 2019:

May meeting agenda

- Welcome and Introductions
- Data Update
    - Update on Caseload Estimating Conference
    - Enrollment Data Update
- Auto Assignment Update
- NEMT Update
- Ad Hoc Items

The EOHHS Transportation Broker, Medical Transportation Management (MTM), reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservations and the top five complaint areas during DY 11 April 1 – June 30, 2019.

NEMT Analysis	DY 11 Q2
All NEMT & Elderly Complaints	919
All NEMT & Elderly Trip Reservations	592,712
Complaint Performance	0.16%
Top 5 Complaint Areas	**DY 11 Q2**
Transportation Provider Late	299
Transportation Provider No Show	205
Transportation Provider Behavior	115
Transportation Broker Processes	83
Transportation Broker Trip Accuracy	58

X. Marketplace Subsidy Program Participation

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 RIte Share at (401) 462-0311. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI.

With Open Enrollment, EOHHS saw a slight increase in enrollees for the month of January, whereas subsequent months showed a steady decline. The decline in monthly enrollment is likely due to natural churn, as well as a decrease in the number of new applications received by EOHHS.The last mass mailing to potentially eligible applicants was done in September 2018. EOHHS is currently assessing whether to execute another mass mailing for October 2019.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Projected Costs	Actual Costs
January	295	30	$ 41.65	$ 12,286.00	ACTUAL
February	238	-57	$ 41.73	$ 9,931.00	ACTUAL
March	194	-44	$ 41.66	$ 8,082.00	ACTUAL
April	161	-33	$ 41.63	$ 6,702.00	ACTUAL
May	178	17	$ 42.68	$ 7,597.00	ACTUAL
June	161	-17	$ 41.89	$ 6,744.00	ACTUAL

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q2 of DY 11, April 1, 2019 – June 30, 2019.

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

Monthly Oversight Review

On a monthly basis, the RI EOHHS leads oversight and administration meetings with the State's four (4) Medicaid participating managed care organizations (MCOs), NHPRI, UHCP-RI, Tufts Public Health Plans and UHC Dental. These monthly meetings are conducted separately with each MCO during the EOHHS MCO Oversight meetings; agenda items focus upon both standing areas of focus as well as emerging items related to quality assurance and oversight activities.

Specific to quality improvement and compliance the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 2 of 2019:

NHPRI

- EOHHS has provided extensive oversight for the transition from BH vendor Beacon to Optum.
    - EOHHS and NHPRI has identified risks associated with the transition and has worked with NHPRI to ensure safeguards for member access to BH services, as well as, address financial concerns from safety net BH providers. Since January 2019, NHPRI has been requested to provide EOHHS bi-weekly status updates on transition outreach. Weekly calls are scheduled with EOHHS, NHPRI and Optum staff to review and update implementation plan.
    - EOHHS with NHPRI/Optum regularly reviews breakdowns of claims denials and associated modifiers.
- EOHHS has been working with NHPRI on improved processes to resolve issues related to returned mail and timely newborn payments.

UHCP-RI

- EOHHS has been working with United on improved processes to resolve issues related to timely newborn payments.
    - EOHHS has reviewed submitted files to determine reconciliation work to ensure correct capitation payment for UHCP-RI.
- EOHHS has reviewed UHCP-RI's submission for the Human Arc program for allowing members to understand their SSI benefits.
- EOHHS has also reviewed with UHCP-RI the upcoming open enrollment and the submission of marketing materials.

Tufts Public Health Plans

- EOHHS reviewed the renewal of QIPs. Focus should be on access and membership. THP should still work on NCQA accreditation along with QIPs.
- Starting in March, Tufts to provide EOHHS monthly updates on status of encounter data submission. Review of ensuring compliance and processing backlog of data with EOHHS. Tufts is required to provide a monthly executive summary of progress.

UHC Dental

- In May, UHC met with transportation broker, MTM, to discuss strategies to allow for members to attend appointments timely. Also, the group discussed the appropriate uses of gas mileage reimbursement.
- UHC Dental working with the RI Oral health Coalition to improve network access efforts and various community organizations to provide updates.
- UHC released a newborn oral health video to engage newborns mothers in receiving oral heathcare.
- Review of efforts for returned mail.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 Q1 CY 2019	DY 11 Q2 CY 2019
ABD Adults No TPL	$520,451,772	$568,983,280	$139,792,608	$ 144,267,576
ABD Adults TPL	$1,399,941,483	$1,489,697,426	$397,247,832	$ 378,337,108
RIte Care	$1,060,816,730	$1,112,899,194	$288,484,320	$ 283,471,264
CSHCN	$469,098,220	$493,100,361	$124,989,942	$ 124,790,596
TOTAL	$3,450,308,205	$3,664,680,261	$950,514,702	$930,866,544

With Waiver Total Expenditures

Medicaid Populations	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019
ABD Adults No TPL	$409,900,329	$415,613,308	$109,539,341	$ 109,730,091
ABD Adults TPL	$753,679,210	$725,296,165	$186,497,677	$ 207,828,762
RIte Care	$513,027,120	$549,821,243	$134,627,877	$ 88,989,112
CSHCN	$184,621,431	$182,172,130	$44,715,646	$ 36,255,884
Excess Spending: Hypothetical	$2,277,946	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -
CNOM Services	$9,055,311	$9,347,322	$10,146,505	$ 2,750,964
TOTAL	$1,872,561,346	$1,882,250,168	$485,527,046	**$ 445,554,812**
Favorable / (Unfavorable) Variance	$1,577,746,859	$1,782,430,093	$464,987,656	$ 485,311,732
Budget Neutrality Variance (DY 1-5)				
Cumulative Bud. Neutrality Variance	**$7,601,761,277**	**$9,384,191,371**	**$464,987,656**	**$ 950,299,388**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019
217-like Group	$181,591,552	$220,425,660	$54,138,706	$ 55,683,958
Family Planning Group	$101,794	$206,839	$76,008	$ 75,408
TOTAL	$181,693,346	$220,632,499	$54,214,714	$ 55,759,366

With-Waiver Total Exp.	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019
217-like Group	$182,709,505	$197,290,254	$44,365,123	$ 49,961,714
Family Planning Group	$53,490	$116,238	$60,254	$ 54,155
TOTAL	$182,762,995	$197,406,492	$44,425,377	$ 50,015,869

Excess Spending	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019
217-like Group	$1,117,953	($23,135,406)	($9,773,583)	$ (5,722,244)
Family Planning Group	($48,304)	($90,601)	($15,754)	$ (21,253)
TOTAL	$1,069,649	($23,226,007)	($9,789,337)	$ (5,743,497)

LOW INCOME ADULT ANALYSIS

Low-Income Adults (Expansion)	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019
Without Waiver Total Exp.	$828,075,193	$875,438,550	$223,385,580	$ 221,674,860
With-Waiver Total Exp.	$458,848,954	$449,618,448	$106,919,488	$ 63,536,302
Excess Spending	($369,226,239)	($425,820,102)	($116,466,092)	$ (158,138,558)

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019
ABD Adults No TPL	$172,164	$180,515	$42,516	$43,877
ABD Adults TPL	$409,699	$418,102	$106,902	$101,813
RIte Care	$2,001,541	$1,994,443	$493,980	$485,396
CSHCN	$150,545	$150,657	$36,366	$36,308
217-like Group	$45,764	$53,828	$12,823	$13,189
Low-Income Adult Group	$921,107	$926,390	$225,642	$223,914
Family Planning Group	$4,627	$8,993	$3,167	$3,142

Without Waiver PMPMs	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019
ABD Adults No TPL	$3,023	$3,152	$3,288	$3,288
ABD Adults TPL	$3,417	$3,563	$3,716	$3,716
RIte Care	$530	$558	$584	$584
CSHCN	$3,116	$3,273	$3,437	$3,437
217-like Group	$3,968	$4,095	$4,222	$4,222
Low-Income Adult Group	$899	$945	$990	$990
Family Planning Group	$22	$23	$24	$24

Without Waiver Expenditures	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019
ABD Adults No TPL	$520,451,772	$568,983,280	$139,792,608	$144,267,576
ABD Adults TPL	$1,399,941,483	$1,489,697,426	$397,247,832	$378,337,108
RIte Care	$1,060,816,730	$1,112,899,194	$288,484,320	$283,471,264
CSHCN	$469,098,220	$493,100,361	$124,989,942	$124,790,596
217-like Group	$181,591,552	$220,425,660	$54,138,706	$55,683,958
Low-Income Adult Group	$828,075,193	$875,438,550	$223,385,580	$221,674,860
Family Planning Group	$101,794	$206,839	$76,008	$75,408

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: 12/2/2019

XIII. State Contact(s)

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XIV. Date Submitted to CMS

12/3/2019