Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2017 – March 31, 2017

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

April 2018

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Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Demonstration Reporting

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

II. Introduction

The Rhode Island Medicaid Reform Act of 2008 (Rhode Island General Law §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 established 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: 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 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 Connect Care Choice component provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.

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

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

h. Rhody Health Options is a managed care delivery system for 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) 3/31/2017***	**Number of Enrollees That Lost Eligibility in the Quarter Ending 3/31/2017****
Budget Population 1: ABD no TPL	13,551	226
Budget Population 2: ABD TPL	34,125	169
Budget Population 3: RIte Care	139,649	1,574
Budget Population 4: CSHCN	12,256	194
Budget Population 5: EFP	298	25
Budget Population 6: Pregnant Expansion	38	5
Budget Population 7: CHIP Children	25,866	360
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	1,792	6
Budget Population 11, 12, 13: 217-like group	3,679	24
Budget Population 14: BCCTP	117	6
Budget Population 15: AD Risk for LTC	3,270	0
Budget Population 16: Adult Mental Unins	12,024	0
Budget Population 17: Youth Risk Medic	3,710	7
Budget Population 18: HIV	265	49
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	75,662	1,463
Total	326,302	4,108

*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 9 January 1, 2017 – March 31, 2017:

Quarter 1: 2:499 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 the quarter of DY8 October 1, 2016 – December 31, 2016 (by category or by type) with a quarterly total of $4,397.15 for special purchases expenditures.

Q3 2016	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	4	Over the counter medicines		$737.10
	3	Fitness Training		$144.00
	17	Massage Therapy		$750.00
	7	Supplies, non-medical	Gloves, support stockings, PERS, Ensure, Ramp	$806.05
	0	Laundry		$ 0
	0	Acupuncture		$ 0
	5	Service Dog Training		$462.50
	0	Landscaping		$ 0
	0	Diabetes Monitoring		$ 0
	5	Bus tickets		$20.00
	CUMULATIVE TOTAL			$ 2,919.65

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices during the quarter DY9 January 1, 2017 – March 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. During January 1, 2017 – March 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 our consultants from University of Massachusetts/Commonwealth Medicine regarding partnership build with IHEs, and development 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 like the IHE Steering Committee, DSHP components of allowable activities, general guidelines associated with IHE participation in RI HSTP, etc.
- Continued meetings and trainings (with key leadership at IHEs especially Provosts, Vice Presidents, fiscal officers, budget, operations, academic affairs, etc.)
- Academic and policy strategies developed associated with IHE DSHP deliverables.

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 provide, and developed algorithm for distribution of awards.
- Began developing Access database to store performance results and develop reports.
- Met with stakeholders to inform of process and timing.

Health Workforce Development Program

- In collaboration with SIM staff and leadership, conducted additional stakeholder meetings to further refine healthcare workforce transformation priorities and recommendations to be included in the Healthcare Workforce Transformation Report.
- In partnership with Jobs for the Future, developed and reviewed labor market and education data, national and local best practices, local workforce development resources, and stakeholder input to prepare a draft of the Healthcare Workforce Transformation Report for publication in May, 2017.
- Worked closely with staff from the National Governors Association (as part of a technical assistance grant to RI from the NGA) to review national best practices in healthcare workforce and system transformation and to identify presenters for a Healthcare Workforce Transformation Summit in June, 2017.
- Continued to work closely with Healthcare Workforce Transformation Advisory Committee and other key partners to identify current healthcare workforce transformation needs and capacity- as well as prospective education and training partnerships and resources – consistent with RI's Health System Transformation Program (HSTP).
- Conducted additional research; stakeholder meetings; and program, policy, and strategy development; as needed, to identify and address compelling healthcare workforce barriers and opportunities to provide care and services to Medicaid beneficiaries.

Accountable Entities

- EOHHS received comments from 24 stakeholders (advocacy, community, provider organizations and managed care organizations) on the AE Roadmap document.
- Stakeholder engagement is ongoing on both the comprehensive Accountable Entities and Specialized Accountable Entities for Long Term Services and Supports. EOHHS held three (3) stakeholder sessions as well as 1:1 meetings with each Medicaid Accountable Entity and the MCOs to obtain additional input on Accountable Entity development. This feedback was used to inform the final draft of the AE Roadmap.
- EOHHS has also engaged in 1:1 meetings and presentation with various stakeholders, community and provider groups to provide more information on the program development and next steps. In addition to the broader stakeholder sessions, in Quarter 1, EOHHS made 13 presentations to community and provider groups.
- Ongoing development and drafting of other key deliverables are in progress specific to attribution, total cost of care, inclusive of quality, and incentive funding. This is inclusive of the determined analytic needs and key decision points.
- Continued oversight of MCOs' monitoring of Pilot AEs. In Quarter 1, 2017 EOHHS began a new work stream with MCOs on AE analytic and reporting to focus on the identification of data and reporting needs, inclusive of new reporting opportunities.

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 two meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (née 1115 Waiver Task Force) on January 23, 2017 and March 27, 2017.

- Convened stakeholder sessions, 1:1 meetings, and multiple presentations with Accountable Entities and Specialized Accountable Entities for Long Term Services and Supports stakeholders to obtain additional input on Accountable Entity development and to provide information on program development and next steps. Please see *Accountable Entities* on page 10 for details.

- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs, provided program updates at the January, February and March Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting, and convened the ICI Implementation Council in January 2017 and the ICI Provider Workgroup in January, February and March.

- CHT-RI outreached and engaged with Primary Care Providers at the Federally Qualified Community Health Centers to further engage the most vulnerable populations.

- Conducted the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on March 1, 2017

- Posted Monthly Provider Updates in January - March 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 the quarter DY9 January 1, 2017 – March 31, 2017.

State Innovation Model (SIM)

During the DY 9 January 1, 2017 – March 31, 2017, Rhode Island SIM has 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. They are the product of a rigorous and collaborative stakeholder engagement process that OHIC and SIM staff facilitated last quarter, with representatives from health plans, providers, ACOs, consumer advocates, and State agencies.
- The APCD data aggregation and analytics reprocurement was awarded this quarter to a single vendor to increase efficiency and coordination.
- We began implementing 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 is closed and proposals are currently under review.
- Participating in weekly Health System Transformation Project (HSTP) meetings and ensuring communication between our projects.
- 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, and the Trans* Health Program Manager and a Social Worker from Thundermist Health Center

Healthy Aging Reform

EOHHS has been actively working on proposals to promote healthy aging for Rhode Island's seniors. This work builds on the successful Reinventing Medicaid efforts achieved under Governor Raimondo. As Rhode Island continues to encourage system transformation, our long-term services and supports (LTSS) system is a particular area of focus and priority. It is EOHHS' goal to achieve the rebalancing goals of Reinventing Medicaid by effectively enabling and encouraging aging populations to live successfully in the community. During the DY9 January 1, 2017 – March 31, 2017 reporting period, the following activities occurred:

- Healthy Aging Reform initiatives included in the Governor's proposed budget.
- Organized Healthy Aging Reform initiative project plan and work groups.
- Work groups tasked with addressing the following areas for the Healthy Aging initiatives: design/development, stakeholder, policy, Federal and State authority, procurement, contracts, communication and systems

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island has been established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall goals are to improve quality of care for Rhode Island's elders and people with disabilities, 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 the reporting quarter January 1-March 31, 2017 are provided below.

Phase I – Rhody Health Options (RHO)

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 March 2017, 11,737 individuals were enrolled in this voluntary program.

Phase II – Medicare-Medicaid Plan (MMP)

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 30,000 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 requires 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 are receiving 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. Approximately 14,000 people are expected to be enrolled during the initial enrollment period. Small increases in enrollment are anticipated throughout the Demonstration following the initial enrollment period.

As of March 2017, 12,120 people were enrolled in the Medicare-Medicaid plan. In addition, passive enrollment notices were sent during the reporting period to 640 people living in the community with LTSS, people who suffered from severe and persistent mental illness, and people with intellectual and developmental disabilities who were eligible for an April 1, 2017 enrollment effective date. Passive enrollment notices were also mailed to 742 people living in the community without LTSS with a May 1, 2017 enrollment effective date. All the people who received passive

enrollment notices were enrolled in the Rhody Health Options program and were receiving their Medicaid benefits through NHPRI.

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

- Mailed Rhody Health Options enrollment letters to 1,475 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.
- 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.
- 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.
- Provided information on ICI to internal and external stakeholders, including consumers, advocates, and providers.
- Provided program updates at the January, February and March Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting.
- Created a consumer advisory board for ICI called the ICI Implementation Council. The first meeting was held on January 18.
- Provided support and presented ICI information at the January, February and March ICI Implementation Council meetings.
- Held ICI Provider Workgroup meetings in January, February and March. 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.
- 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.

Health Reform/New Adult Group (Medicaid Expansion)

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

- Continued on-going enrollment.
- As of March 31, 2017, enrollment in Medicaid through HealthSource RI was 75,662.
- 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 the reporting quarter, 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.
- CTC continues to meet bi-weekly with the PCMH-Kids Planning team to discuss items such as: the Pediatric Integrated Behavioral Health (IBH) Learning Collaborative currently working on Attention Deficit Hyperactivity Disorder (ADHD), and Maternal Depression in April; Discussion items for the quarterly PCMH-Kids Stakeholder Meetings; different areas and ideas for high risk patient population engagement with the practices and the health plans; the 2017 expansion to 10 pediatric practices; and ways to improve the overall PCMH-Kids program in the PCMH model.
- The practices continue to work with the health plans to come to a common definition to be able to accurately identify high risk populations for care coordination. Additionally, CTC hosted special learning sessions in February and March to hear from other practices and assist with formulation high risk definition.
- CTC meets with the Pediatric Practice Facilitators each month to review their monthly reports for to verify that practices are up to date on their deliverables. Eight out of the

nine practices fully utilize the practice facilitators and noted that they are a great resource, especially for the practices that applied for the National Committee for Quality Assurance (NCQA) recognition in December 2016.

- The three practices that applied for NCQA were awarded: Level 3 for the two Hasbro sites and Level 2 for Pediatric Associates.
- The two PCMH-Kids co-chairs, Dr. Pat Flanagan and Dr. Elizabeth Lange, were asked to speak on a panel at the SIM April Stakeholders Meeting. The topic will be pediatric behavioral health and the panel will include Dr. Henry Sachs from Bradley Hospital and Elizabeth Tobin-Tyler from Brown, co-author of the Millbank report, and will be moderated by Dr. Ailis Clyne from the Department of Health.
- The six PCMH-Kids practices that are participating in the pediatric IBH Learning Collaborative focused on ADHD attended the quarterly pediatric IBH meeting to work together on their ADHD story boards for the 4/26 Learning Collaborative focused on Postpartum Depression Screening.
- CTC management staff continues to work on the APCD application for the customized reports needed for PCMH-Kids utilization and quality data. Brown University is also involved in this process as they are collecting the patient specific data.

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 managed care. In February 2016, Community Health Team-RI (CHT-RI) 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 focusing on the 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.

- During the DY January 1, 2017-March 31, 2017 reporting quarter, CHT-RI has focused the work in terms of improving Operational Strategies to ensure that the right beneficiaries are receiving the right services at the right time to achieve the expected positive outcomes.
- CHT-RI has outreached and engaged with Primary Care Providers at the Federally Qualified Community Health Centers to further engage the most vulnerable populations. The collaboration is key for the integration needed to support our beneficiaries.
- The Care Management Dashboard went live in March which allows real-time data including emergency room visits and inpatient admissions every 45 minutes to support the care management team with intervening and providing evidenced based interventions that demonstrate improved health outcomes.
- CHT-RI has worked on clearly defining their protocols to enable the care team to work smarter and more efficiently.
- EOHHS continues to provide guidance to CareLink, our partner for monthly Oversight Monitoring meetings, for improving the quality of services our beneficiaries receive. The goal is for CareLink to demonstrate the value to EOHHS in order to sustain the program.

Money Follows the Person Demonstration Grant

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011. The goal of the demonstration is to rebalance long term services and supports from institutional based care to community based care. Activities accomplished include the following.

- Received 107 referrals for individuals interested in transitioning from a nursing facility to the community.
- Transitioned 14 participants from nursing facilities to qualified community-based residences.
- Facilitated 288 transitions from program inception through March 31, 2017.
- Convened a committee that is developing recommendations for use of MFP rebalancing funds.
- Conducted outreach with nursing home trade organizations to increase referrals.

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 Base Services (HCBS) Final Rules

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

- Validation process continues to move forward and is anticipated to conclude in the near future.
- Held meetings with DD and LTSS providers to explain the process to all.
- Held a team call with CMS to discuss further concerns regarding the state transition plan and needed updates to achieve final approval.
- State Transition Plan is currently being updated for eventual resubmission.
- Continued discussions about monitoring and oversight, and leases and/or rental agreements for all settings.

Non-Emergency Medical Transportation

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

change to the transportation system is for Non-Emergency Medical Transportation only. The broker provides member services, eligibility verification for transportation services, schedules appointments with contracted transportation providers, quality assurance and monitoring and program reporting. During the DY9 January 1, 2017 – March 31, 2017 EOHHS conducted the following:

- Continued oversight and monitoring of LogistiCare contract activities.
- Continued to report to external committees and/or multi-agency groups including the Alliance for Better Long Term Care and the Lt. Governor's Long Term Care Coordinating Council.

Behavioral Health Delivery System Redesign
The Rhode Island General Assembly transferred all Medicaid-funded behavioral health services to EOHHS on July 1, 2014. In January 2016, the delivery of the behavioral health benefit package was included in the managed care covered services. In addition, as a result of the Reinventing Medicaid initiative, staff have developed the Behavioral Health Integrated Health Home. 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 quarter, staff from both EOHHS and BHDDH have been working closely to oversee the movement of services into managed care. Staff have continued to hold regular meetings with providers and managed care plans to address claims payment issues 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 a contract 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 has contracted with three (3) MCO's; Neighborhood Health Plan of Rhode Island, Tufts Health Plan and United Healthcare Community Plan. Currently, the State is in active readiness meetings with all three MCO's, particularly with Tufts Health Plan who is a new entrant to the RI market. The State will be conducting an open enrollment for all members in late fall.

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 during 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, EOHHS 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 the 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. Work will continue to actively monitor the implementation of the new eligibility system to ensure that clients' coverage is not disrupted.

VIII. Waiver Category Change Requests

The following Waiver Category request changes or State Plan Amendments have been submitted or are awaiting CMS action during the DY9 period January 1,2017 – March 31, 2017.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Cortical Integrative Therapy	9/22/2015		
Cat III	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		
SPA	Inpatient Hospital Rate Increase	9/21/2016		
SPA	Outpatient Hospital Rate Increase	9/26/2016		
SPA	Centers of Excellence for Opioid Treatment	12/22/2016	Approved	3/14/2017

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the DY 9 January 1, 2017 –March 31, 2017 quarter, 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. 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.

X. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the DY8 October 1, 2016 – December 31, 2016. 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, 2017 – March 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[1]. 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 to watch 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 send 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), Children in Substitute Care (Sub Care)[3] and Rhody Health Options (RHO)[4].

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

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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. Effective January 31, 2016, EOHHS discontinued its primary care delivery systems Connect Care Choice and Connect Care Choice Community Partners and moved those individuals into the managed care options.

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

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

[4] Same MCO that has the RIte Care for Children with Special Health Care Needs also has the Rhody Health Options population.

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, there is one dental MCO, United Healthcare Dental that administers the RIte Smiles program to children born on or after May1, 2000. They monitor informal complaints as well and report a decrease in the number of informal complaints in Q1 2017 (6) as compared to Q1 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 this quarter. The category in which most of the informal complaints fall for the quarter is Balance Billing.

RI EOHHS utilizes Summary of Informal Complaints reports and participation in the Internal Health Plan Oversight Committee meetings to identify consumer issue trends and develop strategies to prevent future occurrence. We also look to find new ways to offer consumer protections as is demonstrated by our requiring the provision of the RI Office of Health Insurance Commissioner's consumer assistance contact line information on specified member communications. In addition, members may contact the RI Department of Health Office of Managed Care to lodge a complaint or voice displeasure with the MCOs complaint process. This offers our managed care members other avenues by which they may seek assistance in invoking their member rights or in voicing dissatisfaction with the process.

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. Both of the medical MCOs were rated Excellent by NCQA. Adherence to this standard dictates that Health Plans:

- Educate members about their right to make a complaint and about the difference between a complaint and an appeal, and about the Plan's process for remediation; and
- Develop and implement an internal process for the tracking, investigation and remediation of complaints.

The State also participates in two advisory groups, the long-standing Consumer Advisory Committee (CAC) and the Integrated Care Initiative's 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 twice during Q1 2017:

Thursday, January 12, 2017

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

Thursday, March 9, 2017

- Review of Minutes
- Medicaid Updates
- RI Bridges System Update
- Managed Care Reprocurement and Open Enrollment Update
- Membership/Enrollment
- 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 providers/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 the transportation reservation and the top five complaint areas during DY 9 January 1, 2017 – March 31, 2017.

NEMT Analysis	DY 9 Q1
All NEMT & Elderly Complaints	1,287
All NEMT & Elderly Trip Reservations	532,097
Complaint Performance	0.24 %

Top 5 Complaint Areas	DY 9 Q1
Transportation Provider Late	691
Transportation Provider General Complaint	336
Transportation Provider No Show	130
Complaint about Rider	105
Rider No Show	25

XI. 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 subsidy program participation during DY9 January 1, 2017 – March 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 accessed 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 has had an impact on eligibility.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment for 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

XII. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in the quarters in DY9.

The following report represents the major evaluation, quality assurance and monitoring during the reporting quarters in DY9 January 1, 2017 – March 31, 2017.

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

On a monthly basis, the RI EOHHS leads oversight and administration meetings with the State's three (3) Medicaid participating Plans, NHPRI, UHCP-RI, and UHC Dental. These monthly meetings are conducted separately with each Health Plan; agenda items focus upon both standing areas of focus as well as emerging items. EOHHS has moved away from a cyclical quarter topic for each oversight meeting (ie 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 Quarter 1 2017:

Operations, Quality& Compliance:

- 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 health 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. Tufts Health Public Plan will continue to have regular Readiness meetings until go-live date tentatively planned for June 2017. Thereafter, EOHHS will assess the needed frequency of meetings for readiness and oversight.

- 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 the progress on 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. These plans presented these 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 staffing sufficient to address the concerns of growing membership.

All three Health Plans (NHPRI, UHCP-RI, and UHC Dental) participate in quarterly Program Integrity meetings with the Rhode Island Executive Office of Health and Human Services and the Rhode Island Attorney General's Medicaid Fraud and Control Unit (MFCU) to discuss the status of open investigations from quarterly Fraud and Abuse reporting. Tufts Health Public Plan will begin to attend these meetings after go-live date, tentatively planned for June 2017.

Section 1115 Waiver Quality and Evaluation Work Group

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

The following table outlines the areas of focus that were addressed during in Quarter 1 2017 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
1.12.17	Data Quality (on 837 claims) Deep dive on ED visits and Long term care
2.9.17	Data Quality (on 837 claims) Discussion on using data to inform policy development and program measures Impact of ACA in Rhode Island
3.9.17	Discussion of DUA procedure and HIPAA rules Updates on UHIP Data Quality (on 837 claims) Dashboard for OMB and Reinventing Medicaid metrics

Development of a Draft Evaluation Design for the Section 1115 Demonstration

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

Performance Management

- Quality Measures reported to OMB: We currently report quality measures monthly to the RI Office of Management and Budget which are reviewed directly by the Governor.
  - Reconstructed reporting process into new Power BI software.
  - Revised reporting categories as designated by program staff.
- Measures include LTC indicators, PCP visits, ED visits, and total cost of care for both general Medicaid populations and SPMI population.
- Reinvent Medicaid initiatives including evaluation strategies for:
  - AE
  - Community Health Teams
  - Children with Special Health Care Needs
  - Adult Day Services
  - IHH/ACT Program
  - Home Stabilization Program

XIII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Exp.

Medicaid Populations	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 488,249,580	$ 125,400,086	$ 125,400,086
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 1,271,228,068	$ 346,343,703	$ 346,343,703
RIte Care	$ 777,080,793	$ 856,219,858	$ 933,125,256	$ 260,581,920	$ 260,581,920
CSHCN	$ 388,266,894	$ 411,979,301	$ 417,839,643	$ 113,506,532	$ 113,506,532
TOTAL	**$ 2,795,541,814**	**$ 2,952,971,564**	**$ 3,110,442,547**	**$ 845,832,241**	**$ 845,832,241**

With Waiver Total Expenditures

Medicaid Populations	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 411,236,473	$ 396,437,538	$ 540,181,908	$ 96,512,978	$ 96,512,978
ABD Adults TPL	$ 732,046,454	$ 734,368,831	$ 616,430,588	$ 184,860,186	$ 184,860,186
RIte Care	$ 461,963,029	$ 554,398,258	$ 496,945,206	$ 125,274,526	$ 125,274,526
CSHCN	$ 175,942,555	$ 198,981,132	$ 175,292,128	$ 42,387,668	$ 42,387,668
Excess Spending: Hypotheticals	$ 13,615,182	$ 14,317,741	$ 12,251,991	$ 1,063,041	$ 1,063,041
Excess Spending: New Adult Group	$ 54,721,943	$ -	$ -	$ -	
CNOM Services	$ 13,794,518	$ 10,007,986	$ 8,969,196	$ 2,311,449	$ 2,311,449
TOTAL	**$ 1,863,320,154**	**$ 1,908,511,486**	**$ 1,850,071,016**	**$ 452,409,848**	**$ 452,409,848**
Favorable / (Unfavorable) Variance	$ 932,221,660	$ 1,044,460,078	$ 1,260,371,531	$ 393,422,393	$ 393,422,393
Budget Neutrality Variance (DY 1 - 5)					
Cumulative Bud. Neutrality Variance	**$ 3,719,182,810**	**$ 4,763,642,888**	**$ 6,024,014,419**	**$ 6,417,436,812**	**$ 6,417,436,812**

Budget Neutrality Table 1

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2017 YTD
217-like Group	$ 149,939,393	$ 157,960,620	$ 169,392,808	$ 43,897,984	$ 43,897,984
Family Planning Group	$ 46,171	$ 29,409	$ 89,922	$ 20,878	$ 20,878
TOTAL	**$ 149,985,564**	**$ 157,990,029**	**$ 169,482,730**	**$ 43,918,862**	**$ 43,918,862**

With-Waiver Total Exp.	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2017 YTD
217-like Group	$ 163,527,102	$ 172,275,322	$ 181,671,673	$ 44,971,858	$ 44,971,858
Family Planning Group	$ 73,644	$ 32,448	$ 63,048	$ 10,045	$ 10,045
TOTAL	**$ 163,600,746**	**$ 172,307,770**	**$ 181,734,721**	**$ 44,981,903**	**$ 44,981,903**

Excess Spending	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2017 YTD
217-like Group	$ 13,587,709	$ 14,314,702	$ 12,278,865	$ 1,073,874	$ 1,073,874
Family Planning Group	$ 27,473	$ 3,039	$ (26,874)	$ (10,833)	$ (10,833)
TOTAL	**$ 13,615,182**	**$ 14,317,741**	**$ 12,251,991**	**$ 1,063,041**	**$ 1,063,041**

LOW INCOME ADULTS ANALYSIS

Low-Income Adults (Expansion)	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2017 YTD
Without Waiver Total Exp.	$ 440,412,112	$ 617,131,227	$ 693,378,495	$ 202,259,717	$ 202,259,717
With-Waiver Total Exp.	$ 457,942,487	$ 448,818,617	$ 300,953,105	$ 117,294,158	$ 117,294,158
Excess Spending	**$ 17,530,375**	**$ (168,312,610)**	**$ (392,425,390)**	$ (84,965,559)	**$ (84,965,559)**

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2017
ABD Adults No TPL	205,847	183,870	42,580	42,788	41,801	41,251	168,420	41,482	41,482
ABD Adults TPL	358,498	373,223	95,473	96,360	97,240	98,733	387,806	101,359	101,359
RIte Care	1,706,932	1,787,590	454,709	459,408	465,683	471,639	1,851,439	491,664	491,664
CSHCN	144,379	145,853	35,224	35,220	34,986	35,399	140,829	36,427	36,427
217-like Group	41,317	42,292	10,939	11,087	11,052	10,943	44,021	11,063	11,063
Low-Income Adult Group	569,744	759,079	198,310	198,734	203,162	210,763	810,969	224,983	224,983
Family Planning Group	2,401	1,453	846	1,055	1,134	1,247	4,282	949	949

Without Waiver PMPMs	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2017
ABD Adults No TPL	$ 2,667	$ 2,781	$ 2,899	$ 2,899	$ 2,899	$ 2,899	$ 2,899	3,023	3,023
ABD Adults TPL	$ 3,016	$ 3,144	$ 3,278	$ 3,278	$ 3,278	$ 3,278	$ 3,278	3,417	3,417
RIte Care	$ 455	$ 479	$ 504	$ 504	$ 504	$ 504	$ 504	530	530
CSHCN	$ 2,689	$ 2,825	$ 2,967	$ 2,967	$ 2,967	$ 2,967	$ 2,967	3,116	3,116
217-like Group	$ 3,629	$ 3,735	$ 3,848	$ 3,848	$ 3,848	$ 3,848	$ 3,848	$ 3,968	$ 3,968
Low-Income Adult Group	$ 773	$ 813	$ 855	$ 855	$ 855	$ 855	$ 855	$ 899	$ 899
Family Planning Group	$ 19	$ 20	$ 21	$ 21	$ 21	$ 21	$ 21	$ 22	$ 22

Without Waiver Expendtures	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2017
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 123,439,420	$ 124,042,412	$ 121,181,099	$ 119,586,649	$ 488,249,580	$ 125,400,086	$ 125,400,086
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 312,960,494	$ 315,868,080	$ 318,752,720	$ 323,646,774	$ 1,271,228,068	$ 346,343,703	$ 346,343,703
RIte Care	$ 777,080,793	$ 856,219,858	$ 229,173,336	$ 231,541,632	$ 234,704,232	$ 237,706,056	$ 933,125,256	$ 260,581,920	$ 260,581,920
CSHCN	$ 388,266,894	$ 411,979,301	$ 104,509,608	$ 104,497,740	$ 103,803,462	$ 105,028,833	$ 417,839,643	$ 113,506,532	$ 113,506,532
217-like Group	$ 149,939,393	$ 157,960,620	$ 42,093,272	$ 42,662,776	$ 42,528,096	$ 42,108,664	$ 169,392,808	$ 43,897,984	$ 43,897,984
Low-Income Adult Group	$ 440,412,112	$ 617,131,227	$ 169,555,050	$ 169,917,570	$ 173,703,510	$ 180,202,365	$ 693,378,495	$ 202,259,717	$ 202,259,717
Family Planning Group	$ 46,171	$ 29,409	$ 17,766	$ 22,155	$ 23,814	$ 26,187	$ 89,922	$ 20,878	$ 20,878

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

Statement of Certification of Accuracy of Reporting Member Months

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

Robert F. Farley

Name: Robert Farley

Title: EOHHS Chief Financial Officer

Signature:

Date:

XIV. State Contact(s)

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XV. Date Submitted to CMS

Enter the date submitted to CMS: 04/18/2018