Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2018 – March 31, 2018

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

August 2018

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Annual Report Demonstration Reporting

Period: DY 10 January 1, 2018 – March 31, 2018

II. Introduction

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

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

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

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid eligibility under

RIte Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL. Section X of the STCs details the requirements.

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

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

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

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

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

On December 23, 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes changes to support the state's implementation of the Affordable Care Act (including coverage of the new adult group for adults with incomes at or below 133 percent of the FPL), the expansion of the state's home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model. The Comprehensive demonstration renewal commenced with an effective date of January 1, 2014.

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	**Number of Current Enrollees (to date)* 03/31/18**	**Number of Enrollees That Lost Eligibility in 03/31/18****
Budget Population 1: ABD no TPL	15,311	447
Budget Population 2: ABD TPL	34,370	277
Budget Population 3: RIte Care	132,947	4,174
Budget Population 4: CSHCN	12,814	149
Budget Population 5: EFP	746	85
Budget Population 6: Pregnant Expansion	25	2
Budget Population 7: CHIP Children	33,569	1,181
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	2,190	16
Budget Population 11, 12, 13: 217-like group	4,561	32
Budget Population 14: BCCTP	120	0
Budget Population 15: AD Risk for LTC	3,444	0
Budget Population 16: Adult Mental Unins	12,022	1
Budget Population 17: Youth Risk Medic	4,675	22
Budget Population 18: HIV	253	47
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	77,425	4,331

*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 10 January 1, 2018 – March 31, 2018:

Q1--Quarter 1: 6:497 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 DY10 January 1, 2018 – March 31, 2018 (by category or by type) with a total of $2,838.88 for special purchases expenditures.

Q 1 2018	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	2	Over the counter medicines		$ 433.90
	2	Fitness Training		$ 96.25
	15	Massage Therapy		$ 672.50
	4	Supplies, non-medical	Gloves, support stockings, shoes, Mobile Lifeline	$ 326.23
	15	Acupuncture		$ 1,125.00
	2	Service Dog Training		$ 185.00
	CUMULATIVE TOTAL			**$ 2,838.88**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for Q1, January 1, 2018 – March 31, 2018.

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 Q1 the following activities occurred.

Health Workforce Development Program

- Continued collaborative efforts between Medicaid and Institutions of Higher Education (IHEs) to accomplish the following:

  - Ensure thoroughness and accuracy of DSHP claiming process by each IHE

- Develop and review infrastructure proposals from each IHE to provide administrative capacity and support for a) DHSP claiming, b) Healthcare Workforce Transformation (HWT) project development, and c) administration and implementation of Medicaid-IHE partnership agreement

- Develop HWT proposals consistent with HSTP objectives

- Review, revise, and approve funding of HWT proposals consistent with HSTP objectives

- Develop, review, and approve funding of Technical Assistance contracts with third-party vendors (i.e., UMass/Commonwealth Medicine and Center for Health Care Strategies) to support DSHP claiming, Medicaid-IHE partnership development and administration, and Accountable Entity capacity building

- Develop and implement a SIM-funded project – in conjunction with the Medicaid-IHE Partnership – to train staff from community-based healthcare and social service agencies to serve as preceptors for interprofessional teams of healthcare students.

  - Conducted additional research, stakeholder meetings, and program, policy, and strategy development as needed to identify and address compelling healthcare workforce barriers and opportunities and achieve HSTP objectives.

- Served on Medicaid Accountable Entity proposal review team to maximize alignment of AEs with healthcare workforce transformation priorities.

- Participated in the Governor's Long-Term Services and Support Workgroup

- Presented on healthcare workforce transformation at the Managed Long-Term Services and Supports Conference in Washington, DC;

Accountable Entities

- The EOHHS Medicaid AE application was finalized and the shared with stakeholders and prospective applicants on November 15, 2017. EOHHS received submission from all six participating pilot entities. Prospective applicants are expected to be notified of the State review certification process in May of 2018.

- EOHHS submitted a CMS pre-print form seeking approval to implement a value based arrangement via our Medicaid managed care contract. Subsequently, a contract amendment was sent to CMS and the Medicaid managed care organizations incorporating all of the Medicaid Accountable Entity program requirements and operational components. The goal is to have a signed Medicaid MCO contract amendment effective 7/1/18.

- EOHHS is in the process of transitioning from a design and development phase to

operational implementation of the AE program as part of Medicaid managed care oversight and monitoring functions.

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 4 meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (née 1115 Waiver Task Force) on January 1, January 22, February 26, and March 26, 2018
- Continue to meet with provider and community groups on AEs
- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs. Provided program updates at the monthly Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting.
- Conducted two meetings of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on January 3, and March 7, 2018.
- Posted Monthly Provider Updates in January - March 2018.
- 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 Q1, January 1, 2018 – March 31, 2018.

State Innovation Model
During Q1, January 1 – December 31, 2017, Rhode Island SIM conducted the following activities:

- Improved coordination with EOHHS: SIM Director Marti Rosenberg began attending EOHHS senior staff meetings, EOHHS policy workgroup, and EOHHS Public Affairs meetings. SIM staff member served on the team to evaluate Medicaid Accountable entity applications.

- Held two SIM Steering Committee meetings.

- SIM staff members participated in several activities related to population health, including, but not limited to the Hunger Elimination Task Force, CTC-RI PCMH-Kids Post-Partum Depression learning collaborative, Pharmacy Transformation Workgroup, and the Overdose Task Force

- Continued work on Unified Social Service directory to link United Way or RI's 2-1-1 directory to the Department of Health.

- Helped to launch the Community Preceptor Institute (CPI) and developed the SIM-supported training program for community-based preceptors.

- Presented at the Managed Long-Term Services and Supports Conference in DC, and the RI Interprofessional Education Collaborative Symposium

- State users have begun to use HealthFacts RI through Power BI. HealthFacts RI is working on a series of new reports to be published to the DOH website.

Integrated Care Initiative
The Integrated Care Initiative (ICI) in Rhode Island has been established to coordinate 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, 2018 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 2018, 12,208 individuals were enrolled in this voluntary program. Enrollment numbers for Q1 2018 increased 11% over Q4 2017.

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 33,000 individuals are eligible for this voluntary program. Initial enrollment into the plan began on July 1, 2016 through a phased-in enrollment schedule. Enrollment started with three months of opt-in enrollment, which required eligible individuals to complete a paper or phone application to enroll. Passive (auto) enrollment began in October 2016 with nine phases separated by population groups. Passive enrollment was offered to people who were already enrolled in NHPRI (Rhody Health Options) for their Medicaid benefits and receive their Medicare benefits through Original Medicare.

During quarter 1, 2018, only opt-in enrollment was offered. As of March 2018, 13,745 people were enrolled in the Medicare-Medicaid plan. New opt-in enrollees for the quarter was 267. Values for enrollees include: care management, one health plan card and no out-of-pocket costs for prescription medications.

Program activities for ICI Phase I & II conducted between January 1-March 31, 2018 include:

- Provided contract oversight to the Rhode Island Parent Information Network who provides ombudsman services for the Demonstration and healthcare assistance to dual eligibles.
- Provided contract oversight to Automated Health Systems, Inc., the enrollment call center for the Demonstration.
- Provided information on the 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.
- Held monthly public meetings in February and March of the consumer advisory board for ICI, known as the ICI Implementation Council.

- 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.
- Held a CMT Technical Site Visit at the plan to discuss various program operations.
- Participated in the one-year Demonstration evaluation by RTI.

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, 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, 2018, enrollment in Medicaid through HealthSource RI was 77,425.
- 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 (PCMH) 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 (CHT). 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 DY10, January 1-March 31, 2018, the following activities have occurred:

- CTC continues to meet bi-weekly with the PCMH-Kids Planning team to discuss items such as: the initial Pediatric Integrated Behavioral Health (IBH) Learning Collaborative that focuses on postpartum depression screening

- The seven practices participating in the postpartum depression learning collaborative wrapped up the program on March 28th by giving an overview of their project outcomes and providing feedback. These seven practices represent ~ 65 providers and a total pediatric population of ~36,000.

- On March 28th, the second half of the PCMH Kids Behavioral Health Learning Collaborative kicked off the Screen Brief Intervention Refer to Treatment (SBIRT) Learning Collaborative with eleven practices enrolled, representing ~75 providers and a total pediatric population of ~34,000. .

- CTC provided practices with the OnPoint tool that practices could use for displaying practice level information and creating trend lines for emergency department and inpatient utilization, total cost of care, pharmacy cost and use of specialists;

    - CTC worked with Data Stat to field the CAHPS version 3 customer experience surveys. CAHPS information was received in March and will be shared with practices in April. Practices in PCMH Kids Cohort 1 will be eligible for incentive payment based on meeting 2017-2018 Performance standards (clinical quality, customer experience and utilization).

    - CTC initialized the Salesforce data base to include practice information, quality, customer experience and utilization information as well as documents related to practice requirements outlined in the Service Delivery Requirements.

Money Follows the Person Demonstration Grant

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011 to rebalance care from an institutional setting to a qualified community based setting of care. Rhode Island continues to operate MFP and will facilitate transitions from nursing homes to the community through December 31, 2018. Rebalancing activity will continue through the end of the grant in September 2020. Activities during this quarter include the following:

- Received 96 referrals for individuals interested in transitioning from a nursing facility to the community during this quarter.
- Transitioned 19 participants from nursing facilities to qualified community-based residences during this quarter.
- Facilitated 337 transitions from program inception through March 31, 2018.
- Implemented use of an algorithm based on data from the Minimum Data Set (MDS) to identify nursing home residents who are potential candidates for transition.

- Engaged in planning for sustainability of transition work following the end of the MFP grant period by developing protocols and best practices for the RI Nursing Home Transition Program.

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 planning for implementation. The activities that have occurred during the reporting quarter are outlined below.

- Two settings that had been designated as unable to meet heightened scrutiny are in process of closing.
- Three additional settings that were workshop-type settings have been closed or will be closed by the end of the calendar year.
- Continued work on heightened scrutiny, transition planning, and ongoing monitoring.

Non-Emergency Medical Transportation

Effective May 1, 2014, the Executive Office of Health and Human Services implemented a new Non-Emergency Medical Transportation management broker contract. The vendor, LogistiCare, coordinates transportation services for Medicaid beneficiaries and individuals over the age of 60 who do not have access to transportation for critical appointments and services. This change to the transportation system was for Non-Emergency Medical Transportation only. The broker also provides member services, eligibility verification for transportation services, appointment scheduling with contracted transportation providers, quality assurance and monitoring, and program reporting. During DY 10 January 1 – March 31, 2018 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 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 worked closely to oversee and monitor adult behavioral health services in managed care. Staff continue to have regular communications with providers and managed care plans to address any issues that may arise and to identify areas of opportunity to improve the delivery of behavioral healthcare to Medicaid members.

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, the state quickly realized that functionality was not fully utilized in Program, Data, and Plan areas. Therefore, EOHHS utilized Interim Business Processes which included workarounds to the system. Post launch, staff from the UHIP vendor were deployed in 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.

During January 1, 2018 – March 31, 2018 the Deloitte and State teams implemented maintenance releases to address hundreds of software and data incidents identified in the RIBridges 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:

Eligibility Batches:

- Renewals- MAGI and Complex Medicaid renewals began in August 2017 for September renewals. Data points are verified by external sources when possible. If the verification fails then a request for additional documentation is added to the renewal form. Those that respond have the renewal packet (and any additional documents) scanned and processed by case workers, eligibility rerun, and renewed when applicable. Those that don't respond are picked up by subsequent batches.
    - Updates completed during this timeframe included modifying the notice for Complex Medicaid to not display Medicaid renewal information and updating SWICA income utilization to occur for both renewal batches (20-day batch was referring to the updated SWIC income but the 60-day batch did not).
- Age out- All cases are evaluated for other forms of eligibility based on the information in the system before any action is taken (i.e, "aging out" of a category of coverage). If the system cannot make a determination of eligibility in another category of coverage, an age-out notice is mailed to the beneficiary on the first day of the month prior to the month they will "age out" (approx. 30-60 days prior to the birthday). The notice informs beneficiary of his/her approaching birthday

and Ex Parte process (possible eligibility in a different category but more information is required). If a determination cannot be made, eligibility runs and terminates individual.
    - During this timeframe, specific work was completed to identify and process individuals who had previously aged out of their category – the backlog – to align individuals into their correct categories.
- Post Eligibility Verification (PEV)- PEV was run for the first time in production in July of 2017. PEV Batch is typically run on the 21st of the month. MAGI beneficiaries have 15 days to respond to any request for additional documentation. Those that do not respond in time are picked up by OPA Med Batch and redetermined (and most likely terminated). Verifies:
    - Employment Income (SWICA) from DLT
    - Unemployment Income (UI) from DLT
    - Death from DOH
- Negative Action Batch/20-day batch- The Negative Action Batch runs for Complex Medicaid programs to verify if documents have been returned for the Passive Renewal batch. The 20-day batch works in the same manner but is for the MAGI population only. Any case that has documents returned will be shielded from processing in either of these batches to allow the workers time to process the case. Both batches are heavily QC'd due to the likelihood of termination for individuals in these batches and must be completed in time before the adverse action cut off dates (typically on the 15th of the month).

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

Notices: Notice denial reasons and their triggers were updated on March 24, 2018 for better clarity of language. Citations were updated to be aligned with the State's revised code. Approvals, denials and changes are released in a timely manner. Terminations continue to be held and manually reviewed to identify and resolve potential issues prior to termination of the customer and release of the termination notice. Workgroup sessions are ongoing to implement improvements to LTSS notices and meet all federal requirements.

Appeals: On March 24, 2018, system design improvements were implemented to enhance the usability of the RIBridges system during the appeals process. The appeals process was reviewed end to end, gaps were identified and addressed, and unnecessary processes were eliminated. The improved functionality standardizes the business process in the field offices, with the goal of preventing and reducing backlog and ensuring that all legal requirements are met.

Program Integrity: EOHHS continues to further the optimization of batches and notices including PEV, Passive Renewals, Age Out as well as daily activity. This helped reduce

the Medicaid caseload and enforced greater program integrity so that only eligible members continue to receive benefits.

CMS Eligibility Compliance: RI continues to address issues found in the RIBridges 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 the corrective action plans for pilot eligibility rounds 3, 4 and 5.

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 January 1, 2018 – March 31, 2018.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	Nursing Home Rate Increase	12/27/2017	Approved	2/8/2018
SPA	Home Care Rate Increase	12/27/2017	Approved	3/23/2018
SPA	Medically Needy Income Limit	3/30/2018		
SPA	State Supplementary Payments	3/30/2018		
SPA	Home Equity	3/30/2018		

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the DY 10 January 1, 2018 – March 31, 2018 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.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in DY10 January 1 – March 31, 2018. 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 DY10 January 1 – March 31, 2018 are outlined below.

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

Each MCO continuously monitors member complaints 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), RIte Care for Children with Special Health Care Needs (CSHN), Children in Substitute Care (Sub Care), and Rhody Health Options (RHO).

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 RITogether (THRIT) and United Healthcare Community Plan(UHCP-RI). NHPRI continues to be the only managed care organization that services both the RIte Care for Children in Substitute Care and Rhody Health Options populations.

Q1 Data
NHPRI reported an 46% decrease in the number of informal complaints in Q1 2018 (69) in comparison to Q1 2017 (128) and experienced a 5.5% decrease in the number of informal complaints filed in Q1 2018 (69) in comparison to Q4 2017 (73). These changes represent a decrease in the number of Quality of Care and Health Plan Enrollment complaints across all populations.

UHCP-RI reported a 4% increase in the number of informal complaints in Q1 2018 (73) in comparison to Q1 2017 (70) and a 10% decrease in the number of informal complaints in Q1 2018 (73) compared to Q4 2017 (80). These changes are not significant in any category of complaints for any population.

THRIT reported no complaints to date.

In addition to the three medical MCOs, there is one dental MCO, United Healthcare Dental that administers the RIte Smiles program to children born on or after May 1, 2000. They monitor informal complaints as well and reported the number of informal complaints in Q1 2018 (8) as compared to Q1 2017 (6). The comparison of Q1 2018 (8) to Q4 2017 (1) shows an increase in the number of Billing issues. Because the numbers are so small, any impact has skewed the values significantly.

RI EOHHS utilizes Summary of Informal Complaints reports and participation in the Managed Care Oversight Team 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. This provides members another way 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 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
- Develop and implement an internal process for the tracking, investigation and remediation of complaints.

While THRIT does not yet have the membership level to pursue NCQA accreditation for their RI Medicaid business, EOHHS monitors their quarterly complaint report to ensure members are satisfied with their coverage and have adequate access to care through this "new to the market" MCO.

The State also participates in the long-standing Consumer Advisory Committee (CAC). 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 2018:

January meeting agenda

- Welcome and Introductions
- Review of November meeting minutes
- 2018 CAC Meeting Schedule
- Medicaid Updates
  - New Location - Virks Building
  - Open Enrollment
  - Returned mail

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

March meeting agenda

- Welcome and Introductions
- Review of January meeting minutes
- Medicaid Updates
- UHIP/DHS Updates
- Membership/Enrollment Updates
- Ad Hoc Items
  - Brainstorm: invite more consumers, advocates to CAC

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 10 January 1 – March 31, 2018.

NEMT Analysis	DY 10 Q1
All NEMT & Elderly Complaints	1,328
All NEMT & Elderly Trip Reservations	598,856
Complaint Performance	0.22 %
Top 5 Complaint Areas	**DY 10 Q1**
Transportation Provider Late	464
Transportation Provider General Complaint	305
Complaint about Rider	110
Transportation Provider No Show	172
Rider No Show	81

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.

The following chart identifies the marketplace subside program participation during Q1 of DY 10, January 1 – March 31, 2018.

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	372	107	$42.05	$15,643.00	ACTUAL
February	306	-66	$41.87	$12,812.00	ACTUAL
March	305	-1	$41.83	$12,758.00	ACTUAL

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q1 of DY 10, January 1, 2018 – March 31, 2018.

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 four (4) Medicaid participating Plans, NHPRI, UHCP-RI, Tufts 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.

Specific to quality improvement and compliance the following areas of focus were addressed during the cycle of oversight and administration meetings that were conducted during Quarter 1 of 2018:

Areas of focus addressed during Q1:

Quality & Compliance:

- In the January meeting, NHP and UHCP-RI presented data on their annual CAHPS survey results. Both plans presented data on the child and adult surveys. They identified areas with the greatest performance and what activities contributed to this high performance. They also identified areas for opportunity and what activities would be of focus in the coming year.

- In January EOHHS held an introductory meeting with Tufts and addressed the purpose and process of these monthly oversight meetings. EOHHS also discussed the Open Enrollment process.

- Additionally, EOHHS held compliance audits with NHP and UHCP-RI in the month of January.

- In the February meeting, EOHHS addressed the OIG audit report findings with NHP and UHCP-RI. EOHHS also reviewed the encounter data guidance document detailing EOHHS policies for encounter data submissions (this guidance was reviewed with NHP, UHCP-RI, and Tufts).

- In the March meeting, EOHHS met with NHP, UHCP-RI, and Tufts to review data related to the care management program Communities of Care and the Pain Management Program. There was also a detailed discussion on the OIG report findings (for NHP and UHCP-RI only).

- Beginning in March, EOHHS held a kick-off all-plan meeting to collaborate with the health plans on upcoming budget initiatives, planning for transition of services, and other important topics that are relevant to our collective goals and responsibilities.

- Separate meetings were held for UHC Dental. In January, EOHHS reviewed concerns with the dental contract compliance and quality and discussed the use of specific dental codes by providers in the context of overutilization. In March, EOHHS continued the conversation on these dental codes and also discussed the grievance and appeal process. In March, EOHHS partnered with the RI Department of Health to deliver a full-day quality improvement training to the UHC Dental staff.

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

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

Section 1115 Waiver Quality and Evaluation Work Group

Rhode Island's Section 1115 Quality and Evaluation Work Group, which includes Medicaid enterprise-wide representation, was established in 2009 and was responsible for the development of the 1115 Waiver's initial draft *Evaluation Design.* This work group has met regularly since the implementation of the Demonstration Waiver to analyze the findings from on-going quality monitoring activities that span the areas of focus as delineated in the Waiver's Special Terms and Conditions, STC # 143 (*State Must Separately Evaluate Components of the Demonstration*). This work group has since transformed into multiple work groups: "Analytics Big Group Meeting" and a "Quality Improvement Work Group", and "Data Quality Work Group".

The following outlines the areas of focus that were addressed during the reporting quarter by the 1115 Quality and Evaluation workgroups.

Q1 Activity

- Discussed updates on program quality work, the population grid, and data quality for encounter data
- Discussed findings and recommendations from meetings with program managers related to quality. Laid out plan for working towards standardization and best practice sharing.
- Established Utilization Tracking Template, populated cells with respective utilization metrics and initiated vetting process. Integrated process with program and policy staff. Incorporated HSTP into group and rolled in LTC, DD, Behavioral Health programs.

Performance Management

- Quality Measures reported to OMB: While we continue to report quality measures to OMB, we are in the process of expanding the measurement process and revising the

queries for measurement construction. In addition, we have implemented a "Pulse Check" process that focuses on a specific programmatic area each month such as Integrated Health Homes, Diabetes Treatment, and Substance Use Disorders.

- All measures are reported using Power BI software which has been uploaded on a larger/more efficient server that makes analytics easier (see above).
- Revisions continue to be conducted with input from program staff. We have also brought the managed care organizations (MCOs) into the oversight and monitoring process more effectively and established routine status updates with the MCOs.
- Measures include LTC indicators, PCP visits, ED visits, and total cost of care. In addition, we are monitoring births, cesarean sections, and observation stays. We now have detailed program reports on home and community-based services (HCBS) and IHH/ACT Services.
- Additional measures under consideration include ACSC (Ambulatory Care Sensitive Conditions) ED rates, ACSC inpatient admission rates, Substance Use Disorders Treatment Programs, and stratifications for special populations. We have completed our preliminary analysis of ACSC ED visits and are working on applying the methodology to Inpatient Stays.
- Evaluation Strategies have been updated in the following programmatic areas:
    - Accountable Entities
        - Logic Model
        - Data development
        - Programmatic buy in
        - Initial assess of total cost of care methodology (TCOC)
    - IHH/ACT/OTP Programs
        - Logic Model
        - Administrative Tracking System
        - Ongoing programmatic support
    - Community Health Teams
    - HBTS
    - Health Aging Initiatives
        - MFP analytic support
        - Setting HSTP objectives
        - Develop business model (in progress)

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 Q1 CY 2018
ABD Adults No TPL	$ 488,249,580	$ 520,451,772	$ 155,453,488
ABD Adults TPL	$ 1,271,228,068	$ 1,399,941,483	$ 350,168,077
RIte Care	$ 933,125,256	$ 1,060,816,730	$ 278,531,838
CSHCN	$ 417,839,643	$ 469,098,220	$ 125,179,158
TOTAL	**$ 3,110,442,547**	**$ 3,450,308,205**	**$ 909,332,561**

With Waiver Total Expenditures

Medicaid Populations	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018
ABD Adults No TPL	$ 540,181,908	$ 409,900,329	$ 100,300,631
ABD Adults TPL	$ 616,430,588	$ 753,679,210	$ 177,096,375
RIte Care	$ 496,945,206	$ 513,027,120	$ 141,158,004
CSHCN	$ 175,292,128	$ 184,621,431	$ 45,418,236
Excess Spending: Hypothetical	$ 12,251,991	$ 2,277,946	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -
CNOM Services	$ 8,969,196	$ 9,055,311	$ 2,503,369
TOTAL	**$1,850,071,016**	**$1,872,561,346**	**$ 466,476,616**
Favorable / (Unfavorable) Variance	$1,260,371,531	$1,577,746,859	$ 442,855,945
Budget Neutrality Variance (DY 1-5)			
Cumulative Bud. Neutrality Variance	**$6,024,014,419**	**$7,601,761,277**	**$8,044,617,223**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2016 YTD	2017 YTD	1st Qtr. CY 2018
217-like Group	$ 169,392,808	$ 181,591,552	$ 54,021,240
Family Planning Group	$ 89,922	$ 101,794	$ 50,370
TOTAL	$ 169,482,730	$ 181,693,346	$ 54,071,610

With-Waiver Total Exp.	2016 YTD	2017 YTD	1st Qtr. CY 2018
217-like Group	$ 181,671,673	$ 182,709,505	$ 51,037,174
Family Planning Group	$ 63,048	$ 53,490	$ 35,382
TOTAL	$ 181,734,721	$ 182,762,995	$ 51,072,556

Excess Spending	2016 YTD	2017 YTD	1st Qtr. CY 2018
217-like Group	$ 12,278,865	$ 1,117,953	$ (2,984,066)
Family Planning Group	$ (26,874)	$ (48,304)	$ (14,988)
TOTAL	$ 12,251,991	$ 1,069,649	$ (2,999,054)

LOW INCOME ADULT ANALYSIS

Low-Income Adults (Expansion)	2016 YTD	2017 YTD	1st Qtr. CY 2018
Without Waiver Total Exp.	$ 693,378,495	$ 828,075,193	$ 220,038,525
With-Waiver Total Exp.	$ 300,953,105	$ 458,848,954	$ 113,980,573
Excess Spending	$ (392,425,390)	$ (369,226,239)	$ (106,057,952)

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018
ABD Adults No TPL	168,420	172,164	49,319
ABD Adults TPL	387,806	409,699	98,279
RIte Care	1,851,439	2,001,541	499,161
CSHCN	140,829	150,545	38,246
217-like Group	44,021	45,764	13,192
Low-Income Adult Group	810,969	921,107	232,845
Family Planning Group	4,282	4,627	2,190

Without Waiver PMPMs	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018
ABD Adults No TPL	$ 2,899	$ 3,023	$ 3,152
ABD Adults TPL	$ 3,278	$ 3,417	$ 3,563
RIte Care	$ 504	$ 530	$ 558
CSHCN	$ 2,967	$ 3,116	$ 3,273

217-like Group	$ 3,848	$ 3,968	$ 4,095
Low-Income Adult Group	$ 855	$ 899	$ 945
Family Planning Group	$ 21	$ 22	$ 23
Without Waiver Expenditures	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018
ABD Adults No TPL	$ 488,249,580	$ 520,451,772	$ 155,453,488
ABD Adults TPL	$1,271,228,068	$ 1,399,941,483	$ 350,168,077
RIte Care	$ 933,125,256	$ 1,060,816,730	$ 278,531,838
CSHCN	$ 417,839,643	$ 469,098,220	$ 125,179,158
217-like Group	$ 169,392,808	$ 181,591,552	$ 54,021,240
Low-Income Adult Group	$ 693,378,495	$ 828,075,193	$ 220,038,525
Family Planning Group	$ 89,922	$ 101,794	$ 50,370

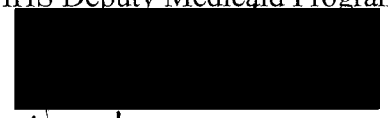
Attachment 2: Statement of Certification of Accuracy of Reporting of Member Months

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: 

Date: 8/15/2018

XIII. State Contact(s)

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XIV. Date Submitted to CMS

08/17/2018