Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2019 – March 31, 2019

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

Submitted December 2019

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 11 January 1, 2019 – March 31, 2019

II. Introduction

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

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

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

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

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

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

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

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

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

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

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	Number of Current Enrollees (to date)* 03/31/19	Number of Enrollees That Lost Eligibility in 03/31/19**
Budget Population 1: ABD no TPL	15,120	887
Budget Population 2: ABD TPL	33,672	651
Budget Population 3: RIte Care	125,639	3,697
Budget Population 4: CSHCN	12,131	215
Budget Population 5: EFP	1,090	61
Budget Population 6: Pregnant Expansion	37	3
Budget Population 7: CHIP Children	38,987	1,122
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	1,742	15
Budget Population 11, 12, 13: 217-like group	4,353	58
Budget Population 14: BCCTP	84	2
Budget Population 15: AD Risk for LTC	3,566	4
Budget Population 16: Adult Mental Unins	12,016	4
Budget Population 17: Youth Risk Medic	5,836	50
Budget Population 18: HIV	304	41
Budget Population 19: AD Non-working	0	0
Budget Population 20: Alzheimer adults	N/A	N/A
Budget Population 21: Beckett aged out	N/A	N/A
Budget Population 22: New Adult Group	74,677	5,582

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

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

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

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the quarter in DY 11 January 1, 2019 – March 31, 2019:

Quarter 1: 18:478 at the close of the quarter.

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during DY11 January 1, 2019 – March 31, 2019 (by category or by type) with a total of $2,357.50 for special purchases expenditures.

Q 1 2019	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter medications		$ 229.25
	10	Acupuncture		$ 750.00
	14	Massage Therapy		$ 925.00
	5	Supplies, non-medical	Supportive devices	$ 208.25
	1	Diabetes management		$ 60.00
	1	Service Dog Training		$ 185.00
	CUMULATIVE TOTAL			**$2,357.50**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for Q1, January 1, 2019 – March 31, 2019.

Innovative Activities

Health System Transformation Project

On October 20, 2016, CMS approved the state's 1115 Waiver request to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain delivery system reform efforts. The RI HSTP proposes to foster and encourage this critical transformation of RI's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities. During Q1, the following activities occurred.

Health Workforce Development Program

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

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

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

Accountable Entities (AEs)

- Five (5) Medicaid certified AEs participated in the Health System Transformation Project (HSTP) Program Year (PY) 1, (July 1, 2018-June 30, 2019). During PY 1 managed care organizations (MCOs) and AE collaborated on the development and implementation of HSTP project plans.

- As a condition of approval by CMS from the AE Roadmap, the Executive Office of Health and Human Services (EOHHS) established the HSTP AE Advisory Committee to advance the goals of payment and delivery system reform in the State. The purpose of the advisory committee is to provide guidance on the strategic direction of the HSTP program. In Q1 2019, the topic was "Behavioral Health: Defining "acceptable" models of BH integration.

- EOHHS began work with Bailit Health to address the following tasks for the AE Program:
    - Recommend specific enhancements to the AE Quality Standards
    - Recommend specific enhancements to the AE Program Outcome Measurement Plan
    - Convene stakeholders to seek robust input and advice on the completion of all tasks
    - Recommend specific enhancements to the RI Medicaid Comprehensive Quality Strategy

  Stakeholder meetings on outcome measures, quality measures and scoring methodology, as well as social determinants of health were held in January and March.

- Some AEs received $540,783 in incentive funds for signing subcontracts with social determinants of health (SDOH), behavioral health (BH), and substance use disorder (SUD) service providers. The MCOs earned $679,875 in incentive funds.

Dental Case Management Program

Waiver Authority

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

Dental Case Management Quarterly Report - Q1 2019

	Q1 2019
New providers receiving online training during this quarter	6 (from 3 practices)
Total Providers Trained	14 (from 3 practices)
New providers enrolled to bill DCM codes through DXC	2
Total providers enrolled to bill DCM codes through DXC	2
DCM claims submitted during this quarter	4

Baseline is currently being collected. No additional data for evaluation at this time.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in Q1, January 1, 2019 – March 31, 2019.

Modernizing Health and Human Services Eligibility Systems

Between January 1, 2019 and March 31, 2019, the Deloitte and EOHHS teams implemented maintenance releases to address software and data incidents identified in the RI Bridges application and implemented enhancement releases to improve the usability of the application as well as implement new functionality. Improvements to the Medicaid program can be summarized across the focus areas below:

Batches- *Batch process* jobs can run without any end-user interaction or can be scheduled to start up on their own as resources permit. Two new batches were deployed during this timeframe:

PARIS – The Public Assistance Reporting Information System (PARIS) data is now being utilized in RI Bridges matching recipients of public assistance to check if they receive duplicate benefits in two or more states.

Death Match – The monthly validation of death match was updated:

COMPLEX: This activity is performed in two categories,

a. Two-point Match
   If the Deceased date received from SSA matches the death date received from DOH, then it is considered as two-point match.
   In this scenario, death date is updated in RI Bridges and this individual is Auto terminated through the Mass Updates process.
b. One-point match
   If the Deceased date is received from SSA but not from DOH, then it is considered as one-point match.
   In this scenario, death date is updated in RI Bridges and RDOC is sent out to the deceased individual. If the response document is not received within 15 days, the individual is terminated through the Mass Updates process.

MAGI programs, the Deceased data-point is verified though two processes, PEV and Passive renewal.

PEV

a. PEV process verifies death information for all MAGI eligible individuals every month.
b. This verification happens in two-steps.

i. In first step, the death data is verified with the data received from SSA.
ii. If above verification fails, it moves on to step-2 to verify using the information received through DOH process.

c. RDOC is sent out when the verification fails.
d. Individual is terminated if the document is not received within 15 days.

Passive Renewal

a. As part of Passive Renewal process, Death data is verified for MAGI eligible individuals who are up for recertification in 60 days,
b. SSA and DOH are two sources of information used for this verification.
c. RDOC is sent out when the verification fails.
d. Individuals are terminated if the document is not received within 35 days.

Notices: 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. Ongoing meetings are held to prioritize and implement improvements to notices and meet all federal requirements.

MMIS Transaction Stabilization: EOHHS continues to focus on the discrepancies between RI Bridges and the MMIS. As of this report, the number of active recipients in RI Bridges who do not have an active eligibility record in the MMIS is steady around 200. This data is tracked daily and the report has been edging downward for several months. The recipients who have active eligibility in MMIS and no active segment is RI Bridges continues to be a focus for the State – this number has now been reduced to 3% of the total active Medicaid population.

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

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the period of January 1, 2019 – March 31, 2019.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	Nursing Facility Rate Increase	8/7/2018	Approved	1/23/2019
	Adult Day	11/8/2018	Approved	1/16/2019
	Assisted Living and Home Care Rates	11/8/2018	Approved	1/2/2019
	Skilled Nursing, PT, OT, Speech	11/8/2018	Approved	1/10/2019
	Pre-Eligibility Medical Expenses	12/13/2018	Approved	3/13/2019
	Home Equity	3/20/2019	Approved	4/11/2019
	Medically Needy Income Limit and State Supplementary Payments	3/20/2019	Approved	3/19/2019
	RIte Share	3/20/2019		

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for Quarter 1 of DY 11 January 1, 2019 – March 31, 2019, or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

January – March 2019

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 Managed Care Organization (MCO) monitors member complaints to identify trends and/or emerging consumer issues. Informal complaints Report track consumer reported issues grouped into seven (7) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service, Parity and Billing Issues. As of Q1 2020 (January 1, 2020) informal complaints will be captured in the quarterly Grievance report submitted to RI EOHHS.

The grievance/informal complaint reports are submitted to EOHHS quarterly and reviewed by the appropriate staff at EOHHS. Any questions or requests for clarification by EOHHS are sent back to the MCOs with an expected response date. Data is disaggregated according to Medicaid cohort: Core RIte Care (Med), Rhody Health Partners (RHP), Rhody Health Expansion (ACA)[1], RIte Care for Children with Special Health Care Needs (CSHN), and Children in Substitute Care (Sub Care)[2].

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

NHPRI reported an 44% decrease in the number of informal complaints in Q1 2019 (58) in comparison to Q1 2018 (104) and experienced a 22% decrease in the number of informal complaints filed in Q1 2019 (58) in comparison to Q4 2018 (74). This quarter's complaints represented the following categories: Quality of Care and Access to care for RIte Care, RHP and RHE populations.

UHCP-RI reported a 22% decrease in the number of informal complaints in Q1 2019 (71) in comparison to Q1 2018 (91) and an 11% increase in the number of informal complaints in Q1 2019 (71) compared to Q4 2018 (64). This quarter's complaints represented the following: Billing Issues for RIte Care, RHP and RHE populations.

RIT reported two (2) complaints to date both represented enrollment concerns.

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

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

In addition to the three (3) medical MCOs, there is one (1) 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 but had none to report for this quarter.

RI EOHHS utilizes Grievance/Informal Complaint reports to identify consumer issue trends and, as part of active contract oversight, collaborate with the Medical and Dental managed care organizations to develop strategies to prevent future occurrence.

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 RIte Care, and representatives of advocacy groups, health plans, the Department of Human Services (DHS), and EOHHS. The CMS Regional Officer participates in these meetings as her schedule permits. The CAC met two times in Q1 January 1 – March 31, 2019:

January meeting agenda

- Welcome and Introductions
- Review of November 8, 2018 Meeting Minutes
- Medicaid Waiver Updates
- NEMT Transition Updates
- Ad Hoc Items

March meeting agenda

- Introductions
- Purpose and Goals of Advisory Committee
    - Group Discussion
- Review of Enrollment Process
- Application Updates
- Review of General Enrollment Information
- Transportation Updates
- Questions and Answers- All

The EOHHS Transportation Broker, Medical Transportation Management (MTM), reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservations and the top five complaint areas during DY 11 January 1 – March 31, 2019.

NEMT Analysis	DY 11 Q1
All NEMT & Elderly Complaints	2,038
All NEMT & Elderly Trip Reservations	559,988
Complaint Performance	0.36 %
Top 5 Complaint Areas	**DY 11 Q1**
Transportation Provider No Show	735
Transportation Broker Processes	447
Transportation Broker Client Protocols	171
Transportation Provider Late	156
Complaint about Transportation Provider General	94

X. Marketplace Subsidy Program Participation

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 142% and 179% of the Federal Poverty Level (FPL), who are not Medicaid eligible themselves, can apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HeathSource RI Contact Center, online at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Application_for_State_Assistance_Program.pdf, or can be requested by calling RIte Share at (401) 462-0311. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI.

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

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Projected Costs	Actual Costs
January	295	30	$ 41.65	$ 12,286.00	ACTUAL
February	238	-57	$ 41.73	$ 9,931.00	ACTUAL
March	194	-44	$ 41.66	$ 8,082.00	ACTUAL

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q1 of DY 11, January 1, 2019 – March 31, 2019.

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

Monthly Oversight Review

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

Specific to quality improvement and compliance the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 1 of 2019:

All MCOs received an update in February regarding the transition to NEMT vendor, MTM. MTM provided information and contact information to all MCOs. MCOs and NEMT vendor to schedule regularly meetings to meet the needs of members in care management programs.

NHPRI

- EOHHS has provided extensive oversight for the transition of two delegated vendors:
  - 1) Transition from BH vendor Beacon to Optum
  - 2) Transition to PBM vendor CVS
- EOHHS and NHPRI has identified risks associated with the transition and has worked with NHPRI to ensure safeguards for member access to BH services, as well as, address financial concerns from safety net BH providers.
- NHPRI has been requested to provide EOHHS bi-weekly status updates on transition outreach. Weekly calls are scheduled with EOHHS, NHPRI and Optum staff to review and update implementation plan.
- EOHHS has been working with NHPRI on improved processes to resolve issues related to returned mail and newborn payments.
- CVS transition update provided to EOHHS in February meeting. One script error, however, was triaged and addressed with CVS promptly.

UHCP-RI

- EOHHS has been working with NHPRI on improved processes to resolve issues related to returned mail and newborn payments.
  - EOHHS has reviewed submitted files to determine reconciliation work to ensure correct capitation payment for UHCP-RI.

Tufts Public Health Plans

- EOHHS reviewed the renewal of QIPs. Focus should be on access and membership. THP should still work on NCQA accreditation along with QIPs.
- Tufts and EOHHS reviewed the implementation of new 2019 Reporting Calendar. Review of timeliness standards and compliance of Calendar.
- Starting in March, Tufts to provide EOHHS monthly updates on status of encounter data submission. Review of ensuring compliance and processing backlog of data with EOHHS.
- Tufts shared that they spoke with BH providers who raised concerns regarding i.e. infrastructure, claims, etc. Tufts is working with providers to rectify and will escalate as needed.

UHC Dental

- In January, UHC presented findings of the Brushlink pilot. 300 patients were the testing goal for the program. 114 have been distributed and 73 are active users. Shared the post pilot packets to those who have been distributed for follow-up.
    - Three-month pilot so the data. Seasonality did play into this and the demographics of the Medicaid populations.
- UHC Dental working with the RI Oral health Coalition to improve network access efforts.
- In February, EOHHS reviewed findings of member survey. Noticed a positive trend in NPS.
- EOHHS reviewed the two QIPs:
    - Preventive QIP Q42018
        - Goal: 56.87%, Reported Rate: 51.85% (increase from previous rate of 48.33%)
        - Noticed trend and provided recommendations.
    - Sealants
        - Goal: 23.40%, Reported Rate: 17.37% (increase from previous rate of 16.95%)
        - Review of trend and recommendations provided to make improvements.
- Review of efforts for returned mail.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

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

With Waiver Total Expenditures

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

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

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

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

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

LOW INCOME ADULT ANALYSIS

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

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

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

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

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

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: 12/2/2019

XIII. State Contact(s)

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XIV. Date Submitted to CMS

12/3/2019