Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

July 1, 2017 – September 30, 2017

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

August 2018

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Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Demonstration Reporting

Period: DY 9 July 1, 2017 – September 30, 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) 9/30/2017***	**Number of Enrollees That Lost Eligibility in the Quarter Ending 9/30/2017****
Budget Population 1: ABD no TPL	16,503	280
Budget Population 2: ABD TPL	32,565	213
Budget Population 3: RIte Care	138,354	5635
Budget Population 4: CSHCN	12,791	303
Budget Population 5: EFP	383	19
Budget Population 6: Pregnant Expansion	32	2
Budget Population 7: CHIP Children	29,879	561
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	2,016	5
Budget Population 11, 12, 13: 217-like group	3,812	28
Budget Population 14: BCCTP	115	4
Budget Population 15: AD Risk for LTC	3,362	0
Budget Population 16: Adult Mental Unins	12,024	0
Budget Population 17: Youth Risk Medic	4,189	18
Budget Population 18: HIV	276	27
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	75,013	7,739
Total	331,314	14,834

*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 July 1, 2017 – September 30, 2017:

Quarter 3: 2:515 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 DY9 April 1, 2017 – June 30, 2017 (by category or by type) with a quarterly total of $5,804.43 for special purchases expenditures.

Q3 2017	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	4	Over the counter medicines		$839.82
	3	Fitness Training		$144.00
	31	Massage Therapy		$1,432.50
	6	Supplies, non-medical	Support stockings, Gloves, Ensure	$355.67
	0	Laundry		0
	15	Acupuncture		$1,125.00
	3	Service Dog Training		$277.50
	6	Landscaping	Grass mowing	$240.00
	2	Diabetes Monitoring		$120.00
	10	Bus tickets		$40.00
	CUMULATIVE TOTAL			**$4,574.49**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices during the quarter DY9 July 1, 2017 – September 30, 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 July 1, 2017 – September 30, 2017, the following activities occurred.

Hospital and Nursing Home Incentive Program

- Distributed provider-specific report cards to each hospital for verification of performance on each measure
- Finalized incentive payment amounts for each hospital
- Distributed hospital incentive payments through NHPRI and UHCPRI to each hospital

As of September 30, the Hospital and Nursing Home Incentive Program has been completed.

Health Workforce Development Program

- Prepared and presented HWT priorities, strategies, and process to HSTP Higher Education Steering Committee.
- Held individual meetings with each public higher education (IHE) partner to discuss areas of alignment between HWT priorities & strategies and IHE interests and capacity.
- Continued meetings and trainings with key leadership at IHEs especially Provosts, Vice Presidents, fiscal officers, budget, operations, academic affairs.
- Continued collaboration with consultants from University of Massachusetts/Commonwealth Medicine regarding partnership build with IHEs, and execution of signed agreements with IHEs.
- Held individual meetings with Accountable Entity (AE) leadership to discuss Medicaid HWT priorities and strategies, AE workforce needs, and opportunities to utilize HSTP and other funds to address AE workforce needs.
- Assisted in the development of AE certification standards and application to incorporate HWT priorities and strategies and address AE workforce needs.
- Developed a proposal for SIM Steering Committee to utilize unallocated SIM funds to support community-based interprofessional education and community preceptors.

- 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

- A final draft of the *AE Roadmap* was submitted to CMS on April 14, 2017. CMS approval is necessary to draw down claimed/matched funds for the Health System Transformation Program, part of which is the AE Program. EOHHS is still awaiting approval on the *AE Roadmap,* and has responded to questions from CMS in the interim
- Several deliverables have been drafted and shared for public review, including an Alternate Payment Methodology Guidance, which is specific to the Medicaid AE's total cost of care and quality methodologies, attribution guidance and incentive funding guidance. All three documents were submitted to CMS on September 29,2017.
- The EOHHS Medicaid Accountable Entity application and scoring/readiness tool is in development. Medicaid is aiming to release the application for the next phase of the AE program in the Fall of 2017.
- Continued oversight of MCOs' monitoring of Pilot AEs, inclusive of the development of an evaluation and analytic framework and an ongoing work stream with MCOs on AE data reporting needs, inclusive of new reporting opportunities.
- EOHHS developed an Accountable Entity stakeholder strategy which commenced on July 1, 2017. As part of this strategy EOHHS continues to meet with provider and community groups in various forums.

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 August 28, 2017 and September 25, 2017. Agenda topics at the August meeting included an update on the progress of the waiver renewal, an update on Accountable Care Entities, a legislative update, and a regulatory update. The September agenda included a regulatory update and an update on the progress of the waiver renewal.
- Provided information on ICI to internal and external stakeholders, provided program updates at the Lt. Governor's Long-Term Care Coordinating Council (LTCCC) meeting, held monthly public ICI Implementation Council meetings, and held ICI Provider Workgroup meetings in July, August, and September.

- CTC continues to meet bi-weekly with the PCMH-Kids Planning team. Other CTC stakeholder meetings held during quarter DY9 July 1, 2017 – September 30, 2017 include a Practice Transformation Committee Meeting (7/20/17), a Nurse Care Manager/Care Coordinator Best Practice Sharing Meeting (8/15/17), a PCMH-Kids Stakeholder Meeting (9/7/17), and a Pediatric Integrated Behavioral Health Meeting (9/14/17).
- Conducted the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on September 6, 2017.
- Posted Monthly Provider Updates in April – June 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 July 1, 2017 – September 30, 2017.

State Innovation Model (SIM)

A major success story for the quarter DY9 July 1, 2017 – September 30, 2017 is the procurement of four Patient Engagement Projects:

1. End of Life Advance Care Planning Training Program for Consumers and Primary Care Providers: Healthcentric Advisors
2. Complex Care Conversations Training for Primary Care for Primary Care Providers: Hope Hospice and Palliative Care
3. End of Life Consumer Engagement Platform: Rhode Island Quality Institute.
4. Conscious Discipline Program: The Autism Project

Another significant activity for the SIM staff and Steering Committee this quarter was a strategic planning process to determine how to reallocate approximately $1.1M in demonstrated savings from procurements that did not require the funding anticipated and ending the SIM project management contract. Planning steps included:

1. SIM Steering Committee approval of criteria for decision-making
2. Individual discussions with Steering Committee members to get input into SIM priorities
3. Discussions with current vendors
4. Consultation with state agency leaders
5. Creation of a strawman for discussion at the September 2017 Steering Committee meeting

The planning process produced five initiatives (and two additional initiatives to be considered if funds allow) which the Steering Committee will consider at a future meeting:

1. Child Psychiatry Access Program Expansion
2. Linkage with Health Equity Zones
3. SBIRT Practice Support
4. Community Preceptor program
5. End-of-Life Training Expansion

Healthy Aging Reform

EOHHS continued to work 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 July and August of 2017 period the Governor's budget was finalized and did not include the funding needed for the Healthy Aging Initiatives proposed. A shift was made to consider low or no cost alternative strategies to rebalance the Long Term Care system. These strategies will be focused on system improvements and the streamlining of eligibility and enrollment processes.

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island was established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall 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 July 1-September 30, 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 September 2017, 11,197 individuals were enrolled in this voluntary program. Enrollment numbers continue to decrease because members are transferring into the Medicare-Medicaid Plan.

Phase II – Medicare-Medicaid Plan (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 to 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 required eligible individuals to complete a paper or phone application to enroll. Passive (auto) enrollment began in October 2016 with nine phases separated by population groups. Passive enrollment was offered to people who were already enrolled in NHPRI (Rhody Health Options) for their Medicaid benefits and receive their Medicare benefits through Original Medicare. EOHHS will offer opt-in and

passive enrollment to newly eligible individuals on a quarterly basis after the initial enrollment period ends.

As of September 2017, 13,553 people were enrolled in the Medicare-Medicaid plan. This quarter marked the beginning of quarterly passive enrollment, with the first enrollment effective date on October 1. People who are NHPRI (Rhody Health Options) members and are eligible for passive enrollment, were mailed enrollment notifications in August and again in September. Mailings were not population specific. Approximately 1,100 passive enrollment letters were mailed for the October 1 enrollment. Voluntary enrollment is offered ongoing; however, mailings to eligible beneficiaries are mailed quarterly, in conjunction with the passive enrollment schedule. In August, approximately 2,970 letters were mailed to people who were eligible for voluntary enrollment into the MMP. Recipients of this letter are instructed to call the MMP enrollment line to be enrolled into the plan.

Program activities for ICI Phase I & II conducted between July 1-September 30, 2017 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.
- 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. EOHHS staff attended an INSIDE meeting via conference call on July 13. Participants discussed each state's perspective on the factors that make or break a state's investment in integrated care programs.
- Provided information on ICI to internal and external stakeholders, including consumers, advocates, and providers.
- Provided program updates at the September Lt. Governor's Long-Term Care Coordinating Council (LTCCC) meeting.
- Held monthly public meetings in July and August of the consumer advisory board for ICI called the ICI Implementation Council.
- Held ICI Provider Workgroup meetings in July, August and September. 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.
- EOHHS staff attended a National call with CMS and other Demonstration states on August 15. A presentation was given by the Office of Minority Health (OMH) on Health Disparities.
- On September 29, EOHHS staff attended the Leading Age Policy Conference that addressed delivering better care to people who have long-term services and supports.

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 September 30, 2017, enrollment in Medicaid through HealthSource RI was 75,013.
- 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:

- The PCMH-Kids practices continue to work together on best practices to identify high risk patients and families who would benefit from care coordination, and improving the overall health of the children and adolescents.

- CTC-RI hosted a New Practice Orientation for the 26 Adult and Pediatric practices that were accepted into the CTC-RI and PCMH-Kids program on 7/20/17.
- The CTC and PCMH-Kids High Risk Workgroup revised the Cedar tool into the PCMH-Kids High Risk Screening Tool using the common definition to accurately identify high risk populations for care coordination (developed by the workgroup) as a reference. The tool was piloted and brought back to the workgroup and the August Nurse Care Manager (NCM)/Care Coordinator (CC) Best Practice Sharing meeting for feedback. The workgroup will reconvene to revise the tool and test again with different pediatric practices.
- CTC-RI offered a standardized learning curriculum for NCM/CC practices starting the end of June and extending for a 12 to16 week time period.
- Convened four pediatric focused meetings this quarter
- All cohort 1 PCMH-Kids practices are now PCMH NCQA Level 3.
- Margaret Howard, Ph.D., continues to provide behavioral health subject matter expertise for the PCMH-Kids practices that are participating in the postpartum depression learning collaborative. The practices continue to modify their approach to consistently implement evidence based practice guidelines.
- CTC management staff submitted the All Payer Claims Database (APCD) application for the utilization reports needed for evaluation. CTC worked with OnPoint to identify the PCMH-Kids comparison group (non-PCMH-Kids practices) and update provider files; Pediatric practices received cost of care reports based on APCD data, and practices met during the September Breakfast of Champion meeting to review data and identify potential strategies to reduce Emergency Department (ED) utilization.
- CTC worked with Data Stat to develop a Consumer Assessment Health Plans Study (CAHPS) "Starter Kit" for practices to register for participation in the CAHPS survey and the OnPoint Performance Portal; all practices are to submit patient panels in October to facilitate the selection of patients for CAHPS surveys by Data Stat; CTC used the September Practice Reporting Committee to assist practices with understanding how to meet this expectation.
- CTC arranged to have NCQA come to Rhode Island for the 2017 NCQA PCMH training program in July on the 2017 patient centered medical home standards and obtained sponsorships to offset the training costs.

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 and provides a multi-disciplinary team of nurses, social workers, and community health workers, who focus on social determinants of health. The overall goal is to improve care for Rhode Island's FFS beneficiaries who are not receiving care management/care coordination in any other program.

- CTC has executed contracts with South County Health (SCH) and Blackstone Valley Community Health Center (BVCHC) to continue their CHTs with a Screening, Brief Intervention, and Referral to Treatment (SBIRT) worker, and has new contracts in place with Thundermist, Family Service of RI, and East Bay Community Action Program to establish new CHTs with an SBIRT worker.
- CTC has a contract in place with SCH to provide centralized management support for reporting and quality management to all CHTs. A project coordinator and data manager have been hired.
- CHT staff at SCH have completed Mental Health First Aid training and established connections with programs to begin regular case review.
- CHT staff have participated in SBIRT training activities, led by Rhode Island College.
- CHT staff have participated in SBIRT/CHT grant activities such as monthly Executive and Implementation Team meetings and a September SWAT incentive program to kick-start SBIRT screenings.
- New CHTs have developed job descriptions and started staff recruitment.

Money Follows the Person Demonstration Grant

Rhode Island continues to operate its Money Follows the Person (MFP) Demonstration Grant 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 91 referrals for individuals interested in transitioning from a nursing facility to the community.
- Transitioned 12 participants from nursing facilities to qualified community-based residences.
- Facilitated 305 transitions from program inception through September 30, 2017.
- Participated in a local housing conference to promote development of relationships between housing providers and human services providers.
- Participated in the national MFP Intensive session.

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.
- 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 occurred during DY 9 July 1, 2017 – September 30, 2017 are outlined below.

- Compliance letters mailed and work plans/ compliance plans received for most settings. DD provider have until 12/17 to provide work plans.
- Held multiple one-on-one visits with settings on compliance issues.
- Sections of rewritten transition plan near completion, while some have been vetted by state advocates.

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 July 1, 2017 – September 30, 2017 reporting period, EOHHS conducted the following activities:

- 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, 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 worked 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.

Modernizing Health and Human Services Eligibility Systems

During July 1, 2017 – September 30, 2017 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:

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

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

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

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

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 July 1, 2017 – September 30, 2017.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Cortical Integrative Therapy	9/22/2015	DENIED	8/25/2017
Cat III	STOP	11/16/2015		
Cat III	Home Stabilization Initiative	11/16/2015		
Cat II	Peer Specialist	11/30/2015		

Request Type	Description	Date Submitted	CMS Action	Date
SPA	Covered Outpatient Drug Reimbursement Methodology	6/26/2017	Approved	9/20/2017
SPA	Home Health Face-to-Face Requirements	8/15/2017	Approved	8/30/2017
SPA	Outpatient Hospital Rate Increase	9/8/2017		
SPA	Disproportionate Share Hospital Payment Policy	9/8/2017		
SPA	Inpatient Hospital Rate Increase	9/8/2017		
SPA	Recovery Audit Contractor Program Exemption	9/8/2017		

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 July 1, 2017 – September 30, 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 DY9 July 1, 2017 – September 30, 2017. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

The summary of the consumer issues identified during DY9 July 1, 2017 – September 30, 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 sent back to the MCOs with an expected response date. Data is disaggregated according to Medicaid cohort: Core RIte Care (Med), Rhody Health Partners (RHP), Rhody Health Expansion (ACA)[2], RIte Care for Children with Special Health Care Needs (CSHN), Children in Substitute Care (Sub Care)[3] and Rhody Health Options (RHO)[4].

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

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

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[1] The State's capitated managed care programs are: RIte Care, RIte Care for Children with Special Health Care Needs, RIte Care for Children in Substitute Care, Rhody Health Partners, RIte Smiles, Rhody Health Options, and Rhody Health Expansion.

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

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

[4] NHPRI has the RIte Care for Children with Special Health Care Needs and also has the Rhody Health Options population.

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 May 1, 2000. They monitor informal complaints and reported four (4) in Q3 2017 as compared to fourteen (14) in Q3 2016, which represents a 71% decrease in the number of complaints. The comparison of Q3 2017 (4) to Q2 2017 (6) represents a 34% decrease. There is no trend identified for these complaints. Because the numbers are so small, any impact may skew the values significantly.

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. EOHHS also looks 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; 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 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 Q3 2017:

Thursday, July 13, 2017
10:00 a.m. – 12:00 p.m.

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

Thursday, September14, 2017
10:00 a.m. – 12:00 p.m.

- Welcome and Introductions

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

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 number of transportation reservations, and the top five complaint areas during DY 9 July 1, 2017 – September 30, 2017.

NEMT Analysis	DY 9 Q3
All NEMT & Elderly Complaints	1,025
All NEMT & Elderly Trip Reservations	549,265
Complaint Performance	0.18 %

Top 5 Complaint Areas	DY 9 Q3
Transportation Provider Late	422
Transportation Provider General Complaint	368
Transportation Provider No Show	109
Complaint about Rider	82
Rider No Show	32

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 July 1, 2017 – September 30, 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 to help pay 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.

During the months of April and June 2017, EOHHS identified and contacted approximately 600 potentially eligible applicants via mail. In the months following the April and June mailings, EOHHS saw a noticeable increase in the number of applications returned, as well as an increase in monthly enrollees.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Actual Costs
January	156	22	$42.95	$6,700.00
February	158	2	$43.27	$6,837.00
March	119	-39	$44.55	$5,301.00
April	130	11	$43.59	$5,667.00
May	234	104	$41.98	$9,823.00
June	265	31	$42.18	$11,177.00
July	265	0	$42.18	$11,179.00
August	314	49	$42.26	$13,269.00
September	318	4	$42.45	$13,498.00

XII. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q3 of DY9.

The following report represents the major evaluation, quality assurance and monitoring during the reporting quarters in DY9 July 1, 2017 – September 30, 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.

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 3, 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 (MCOs): NHPRI, UHCP-RI and a new MCO, Tufts Health Public Plan of RI. EOHHS concluded the readiness review of NHPRI and UHCP-RI in March and resumed regular oversight meetings. In Quarter 3, EOHHS continued a series of "Readiness" meetings with Tufts Health Public Plan of RI in place of the oversight meetings.
    - Within these Readiness meetings, EOHHS assessed Tufts' system capacity to accept new members and pay claims. EOHHS also reviewed Tufts' policies and procedures and member and provider materials.
    - Tufts began accepting new members in July 2017.
- In the July meeting, EOHHS met with NHPRI and UHCP-RI separately to discuss updates on their Provider Incentive Programs. NHPRI and UHCP-RI were provided a pool of funding to support providers as Accountable Entities (AEs). The health plans presented the baseline performance results for each measure for each Accountable Entity. They also provided current performance on the process measures for each Accountable Entity and detailed how the plan was evaluating performance on these measures. Additionally, the plans provided details on how much money each AE is predicted to earn and how much has been paid to date to each Accountable Entity.
- In the August meeting, EOHHS met with NHPRI and UHCP-RI separately to discuss the Accountable Entity Pilot Status. Specific to quality, the plans presented on care management progress and their quality performance and analytics.
- In the September meeting, EOHHS met with NHPRI to address specific concerns related to member access to services. EOHHS reviewed a number of quarterly reports that

indicated issues regarding member access. The September meeting with UHC-RI was not related to quality.

- Separate meetings were held for UHC Dental in August and September in which the plan provided updates on the HEDIS rates and Quality Improvement Projects.
- EOHHS reviewed quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care for the MCOs, including Dental.

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 began to attend these meetings in 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*). This work group has since transformed into multiple work groups.

The areas of focus that were addressed by these multiple 1115 Quality and Evaluation workgroups during Quarter 3 of DY9 are as follows:

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

Development of a Draft Evaluation Design for the Section 1115 Demonstration

In concert with the development of the proposed Section 1115 Comprehensive Quality Strategy, EOHHS has analyzed the draft *Evaluation Design* which was submitted to CMS in July 2009. Based on a synthesis of the 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.

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 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 488,249,580	$ 125,400,086	$ 124,810,601	$ 125,956,318	$ 376,167,005
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 1,271,228,068	$ 346,343,703	$ 354,274,560	$ 360,469,581	$ 1,061,087,844
RIte Care	$ 777,080,793	$ 856,219,858	$ 933,125,256	$ 260,581,920	$ 266,720,380	$ 267,425,810	$ 794,728,110
CSHCN	$ 388,266,894	$ 411,979,301	$ 417,839,643	$ 113,506,532	$ 117,012,032	$ 119,233,740	$ 349,752,304
TOTAL	**$ 2,795,541,814**	**$ 2,952,971,564**	**$ 3,110,442,547**	**$ 845,832,241**	**$ 862,817,573**	**$ 873,085,449**	**$ 2,581,735,263**

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 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 2017 YTD
ABD Adults No TPL	$ 411,236,473	$ 396,437,538	$ 540,181,908	$ 96,512,978	$ 80,903,358	$ 126,779,576	$ 304,195,912
ABD Adults TPL	$ 732,046,454	$ 734,368,831	$ 616,430,588	$ 184,860,186	$ 158,923,299	$ 223,164,966	$ 566,948,451
RIte Care	$ 461,963,029	$ 554,398,258	$ 496,945,206	$ 125,274,526	$ 70,858,596	$ 169,700,715	$ 365,833,838
CSHCN	$ 175,942,555	$ 198,981,132	$ 175,292,128	$ 42,387,668	$ 40,015,844	$ 55,555,459	$ 137,958,971
Excess Spending: Hypotheticals	$ 13,615,182	$ 14,317,741	$ 12,251,991	$ 1,063,041	$ 699,354	$ 515,551	$ 2,277,946
Excess Spending: New Adult Group	$ 54,721,943	$ -	$ -	$ -	$ -	$ -	$ -
CNOM Services	$ 13,794,518	$ 10,007,986	$ 8,969,196	$ 2,311,449	$ 2,288,851	$ 2,206,161	$ 6,806,462
TOTAL	**$ 1,863,320,154**	**$ 1,908,511,486**	**$ 1,850,071,016**	**$ 452,409,848**	**$ 353,689,302**	**$ 577,922,429**	**$ 1,384,021,579**
Favorable / (Unfavorable) Variance	$ 932,221,660	$ 1,044,460,078	$ 1,260,371,531	$ 393,422,393	$ 509,128,271	$ 295,163,020	$ 1,197,713,684
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**	**$ 6,926,565,082**	**$ 7,221,728,102**	**$ 7,221,728,102**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	2017 YTD
217-like Group	$ 149,939,393	$ 157,960,620	$ 169,392,808	$ 43,897,984	$ 44,104,320	$ 44,667,776	$ 132,670,080
Family Planning Group	$ 46,171	$ 29,409	$ 89,922	$ 20,878	$ 20,152	$ 22,286	$ 63,316
TOTAL	**$ 149,985,564**	**$ 157,990,029**	**$ 169,482,730**	**$ 43,918,862**	**$ 44,124,472**	**$ 44,690,062**	**$ 132,733,396**

With-Waiver Total Exp.	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	2017 YTD
217-like Group	$ 163,527,102	$ 172,275,322	$ 181,671,673	$ 44,971,858	$ 44,816,225	$ 45,190,131	$ 134,978,214
Family Planning Group	$ 73,644	$ 32,448	$ 63,048	$ 10,045	$ 7,601	$ 15,482	$ 33,128
TOTAL	**$ 163,600,746**	**$ 172,307,770**	**$ 181,734,721**	**$ 44,981,903**	**$ 44,823,826**	**$ 45,205,613**	**$ 135,011,342**

Excess Spending	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	2017 YTD
217-like Group	$ 13,587,709	$ 14,314,702	$ 12,278,865	$ 1,073,874	$ 711,905	$ 522,355	$ 2,308,134
Family Planning Group	$ 27,473	$ 3,039	$ (26,874)	$ (10,833)	$ (12,551)	$ (6,804)	$ (30,188)
TOTAL	**$ 13,615,182**	**$ 14,317,741**	**$ 12,251,991**	**$ 1,063,041**	**$ 699,354**	**$ 515,551**	**$ 2,277,946**

LOW INCOME ADULTS ANALYSIS

Low-Income Adults (Expansion)	2014 YTD	2015 YTD	2016 YTD	1st Qtr. CY 2017	2nd Qtr. CY 2017	3rd Qtr. CY 2017	2017 YTD
Without Waiver Total Exp.	$ 440,412,112	$ 617,131,227	$ 693,378,495	$ 202,259,717	$ 209,056,157	$ 207,648,323	$ 618,964,197
With-Waiver Total Exp.	$ 457,942,487	$ 448,818,617	$ 300,953,105	$ 117,294,158	$ 69,125,024	$ 161,308,992	$ 347,728,174
Excess Spending	**$ 17,530,375**	**$ (168,312,610)**	**$ (392,425,390)**	**$ (84,965,559)**	**$ (139,931,133)**	**$ (46,339,331)**	**$ (271,236,023)**

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 2017
ABD Adults No TPL	205,847	183,870	168,420	41,482	41,287	41,666	124,435
ABD Adults TPL	358,498	373,223	387,806	101,359	103,680	105,493	310,532
RIte Care	1,706,932	1,787,590	1,851,439	491,664	503,246	504,577	1,499,487
CSHCN	144,379	145,853	140,829	36,427	37,552	38,265	112,244
217-like Group	41,317	42,292	44,021	11,063	11,115	11,257	33,435
Low-Income Adult Group	569,744	759,079	810,969	224,983	232,543	230,977	688,503
Family Planning Group	2,401	1,453	4,282	949	916	1,013	2,878

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

Without Waiver Expendture	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 2016 YTD	DY 9 1st Qtr. CY 2017	DY 9 2nd Qtr. CY 2017	DY 9 3rd Qtr. CY 2017	DY 9 2017
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 488,249,580	$ 125,400,086	$ 124,810,601	$ 125,956,318	$ 376,167,005
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 1,271,228,068	$ 346,343,703	$ 354,274,560	$ 360,469,581	$ 1,061,087,844
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217-like Group	$ 149,939,393	$ 157,960,620	$ 169,392,808	$ 43,897,984	$ 44,104,320	$ 44,667,776	$ 132,670,080
Low-Income Adult Group	$ 440,412,112	$ 617,131,227	$ 693,378,495	$ 202,259,717	$ 209,056,157	$ 207,648,323	$ 618,964,197
Family Planning Group	$ 46,171	$ 29,409	$ 89,922	$ 20,878	$ 20,152	$ 22,286	$ 63,316

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

Statement of Certification of Accuracy of Reporting Member Months

As the Executive Office of Health and Human Services Deputy Medicaid Program Director, Finance and Budget, I certify the accuracy of reporting member months for demonstration population under the 1115 Comprehensive Demonstration Waiver for the purpose of monitoring the budget neutrality agreement.

Name: Katie Alijewicz

Title: EOHHS Deputy Medicaid Program Director, Finance and Budget

Signature: [redacted]

Date: 8/15/2018

XIV. State Contact(s)

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XV. Date Submitted to CMS

8/17/2018