Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

July 1, 2018 – September 30, 2018

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

Submitted January 2019

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 10 July 1, 2018 – September 30, 2018

II. Introduction

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

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

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

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

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

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

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

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

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

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

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

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

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	**Number of Current Enrollees (to date)* 09/30/18**	**Number of Enrollees That Lost Eligibility in 09/30/18****
Budget Population 1: ABD no TPL	14,308	659
Budget Population 2: ABD TPL	35,828	237
Budget Population 3: RIte Care	129,682	3703
Budget Population 4: CSHCN	12,448	341
Budget Population 5: EFP	787	35
Budget Population 6: Pregnant Expansion	29	2
Budget Population 7: CHIP Children	37,192	986
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	2,315	39
Budget Population 11, 12, 13: 217-like group	4,492	38
Budget Population 14: BCCTP	89	18
Budget Population 15: AD Risk for LTC	3,506	0
Budget Population 16: Adult Mental Unins	12,022	0
Budget Population 17: Youth Risk Medic	5,234	44
Budget Population 18: HIV	200	90
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	76,831	3,858

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

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

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

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the quarter in DY 10 July 1, 2018 – September 30, 2018:

Q3--Quarter 3: 8:498 at the close of the quarter.

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during DY10 July 1, 2018 – September 30, 2018 (by category or by type) with a total of $13,637.93 for special purchases expenditures.

Q 1 2018	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter supplements		$ 880.47
	2	Strength Training		$ 96.00
	25	Massage Therapy		$ 1,797.50
	5	Supplies, non-medical	Gloves, support stockings, Sterile Gloves, Rollator, Special bed linens	$ 1,011.96
	1	Diabetes management		$ 60.00
	4	Service Dog Training		$ 370.00
	15	Acupuncture		$ 1,125.00
	1	TempurPedic Bed & Frame		$ 8,297.00
	CUMULATIVE TOTAL			**$13,637.93**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for Q3, July 1, 2018 – September 30, 2018.

Innovative Activities

Health System Transformation Project

On October 20, 2016, CMS approved the state's 1115 Waiver request to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain delivery system reform efforts. The RI HSTP proposes to foster and encourage this critical transformation of RI's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities. During Q3 the following activities occurred.

Health Workforce Development Program

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

- 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.
- Provided guidance and support to other healthcare workforce transformation projects to maximize alignment, collaboration, and impact of efforts

Accountable Entities (AEs)

- The Medicaid AEs are eligible for HSTP incentive funds once the AE meets two key milestones: 1) Execution of an APM/Total Cost of Care contract with an MCO based on the established EOHHS requirements 2) Certification from EOHHS as a Medicaid AE. As of September 30, 2018, AEs have met both key milestones.
- In follow up to the Medicaid AE certification process, EOHHS met with each AE to review their conditions of certification and address questions or concerns with specific deliverables.
- AE reporting templates have been finalized and reviewed with the MCOs. In addition, EOHHS continues to work with each MCO to discuss program implementation as part of our managed care oversight process.
- Dashboards on attribution, total cost of care, outcomes, quality, and other operational reporting are in development.
- In September, a joint meeting between EOHHS, MCOs, and AEs was held to discuss Medicaid AE program expectations and the implementation of the Accountable Entity Incentive Program, inclusive of the Health System Transformation Project (HSTP) plan development. The HSTP project plan includes each AEs goal and objectives over the course of the HSTP project, and their specific milestones for Program Year 1. This plan must be approved by EOHHS before an AE is able to earn incentive dollars for milestone achievement.
- As part of the HSTP project, EOHHS has contracted with the Center for Health Care Strategies (CHCS) to provide Technical Assistance (TA) to both MCOs and AEs. In addition, CHCS is conducting an evaluation of the AE pilot program (2016-2017). As of Q3, CHCS completed the identification of TA needs and has begun to develop modules for one-on-one TA as well as future learning collaboratives. CHCS has also completed a draft evaluation of the AE pilot.
- In Q3, EOHHS applied and was awarded two technical assistance opportunities; 1) the CMS Innovator Accelerator Program on Value Based Purchasing, and 2) Center for Health Care Strategies, Primary Care APM.
- EOHHS continues to align with Rhode Island's Office of Health Insurance Commissioner on care transformation, valued based models of care, and quality measure alignment.

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 3 meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (née 1115 Waiver Task Force) on July 23, August 27, and September 24, 2018.
- Continue to meet with provider and community groups on AEs.
- Continued monthly mailings to adult beneficiaries eligible for managed care programs.
- Provided program updates at the monthly Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting.
- Conducted one meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on September 5, 2018.
- Posted Monthly Provider Updates in July - September 2018.
- Posted public notice on rule, regulations, and procedures for EOHHS.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in Q3, July 1, 2018 – September 30, 2018.

State Innovation Model
During Q3, July 1 – September 30, 2018, Rhode Island SIM conducted the following activities:

- Developed and approved a work plan focused on implementation, sustainability planning, and oversight and evaluation of SIM projects
- Applied for and were awarded a grant to expand and sustain the Child Psych Access Project.
- SIM staff members participated in several stakeholder engagement activities, including, but not limited to the Governor's Long-Term Services and Supports Workforce Think Tank, the Working Group on Statewide Behavioral Health, CTC-RI Sustainability Planning Meeting, and the RI Action Coalition.
- Continued to support the launch of the Community Preceptor Institute (CPI) and developed the SIM-supported training program for community-based preceptors.

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island was established to coordinate Medicare and Medicaid benefits for program eligible beneficiaries. The overall goals are to improve quality of care for Rhode Island's elders and people with disabilities, maximize the ability of members to live safely in their homes and communities, improve continuity of care across settings, and promote a system that is person-centered and helps members attain or maintain personal health goals. Rhode Island implemented the ICI in two phases. A description of each phase and a summary of the activities conducted in the reporting quarter July 1- September 30, 2018 are provided below.

Phase I – Rhody Health Options (RHO)

In November 2013, as part of Phase I of the ICI, EOHHS established a capitated Medicaid managed care program, called Rhody Health Options, for dual-eligible beneficiaries with full Medicare and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS) through Rhode Island Medicaid. Rhody Health Options enrollees received their Medicaid coverage through Neighborhood Health Plan of Rhode Island (NHPRI). The Rhody Health Options program was sunsetted effective September 30, 2018. Approximately 12,900 members were transitioned from RHO into either the Medicare-Medicaid Plan (MMP) or Medicaid Fee-For-Service.

Phase II – Medicare-Medicaid Plan (MMP)

Under Phase II of the ICI, EOHHS established a fully integrated, capitated Medicare-Medicaid plan for dual-eligibles with full Medicare and full Medicaid coverage. Federal authority for the Medicare-Medicaid plan is through CMS' Financial Alignment Initiative, a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. EOHHS currently has authority to participate in the Financial Alignment Initiative through December 31, 2020.

Medicare-Medicaid plan enrollees receive their Medicare (Parts A, B, and D) and Medicaid coverage through NHPRI. Approximately 35,000 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 enrollment waves. Passive enrollment was offered to people who were already enrolled in NHPRI (Rhody Health Options) for their Medicaid benefits and receive their Medicare benefits through Original Medicare.

During Quarter 3, 2018, only opt-in enrollment was offered. As of the end of September 2018, 13,150 people were enrolled in the Medicare-Medicaid plan. Total enrollment went down from Q2 to Q3 by 188 beneficiaries. Values for enrollees include: care management, one health plan card and no out-of-pocket costs for prescription medications.

Program activities for ICI Phase I & II conducted between July 1 - September 30, 2018 include:

- Provided contract oversight to the Rhode Island Parent Information Network who provides ombudsman services for the Demonstration and healthcare assistance to dual eligibles.
- Provided contract oversight to Automated Health Systems, Inc., the enrollment call center for the Demonstration.
- Provided information on 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, August, and September of the consumer advisory board for ICI called the ICI Implementation Council.
- Worked with CMS, NHPRI, the enrollment broker, providers, the ombudsman, and consumer advocates to address enrollment-related issues and ensure access to services for dual-eligibles.
- Worked with the state's MMIS vendor on systems modifications needed to address enrollment-related issues for the Demonstration.

- Conducted contract management and operational oversight of the Medicare-Medicaid plan in collaboration with CMS.
- Monitored Enrollment Broker activities.
- Worked with the Medicare-Medicaid plan and CMS to resolve operational challenges associated with the Demonstration.

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, 2018, enrollment in Medicaid through HealthSource RI was 76,831.
- Continued oversight of the managed care organizations.
- Continued systems modifications to support enrollment of the New Adult Group.
- Monitored enrollment of newborns into Medicaid and QHPs.
- Worked with customer service staff from the state and HealthSource RI to resolve enrollment issues.

CTC-RI/PCMH-Kids:

CTC-RI brings together key health care stakeholders, including Medicaid, to promote care for patients with chronic illness through the patient-centered medical home (PCMH) model. CTC-RI's mission is to lead the transformation of primary care in Rhode Island. CTC-RI brings together critical stakeholders to implement, evaluate, and spread effective models to deliver, pay for, and sustain high quality, comprehensive, accountable primary care. A pilot has been developed to address barriers to CTC practice sites success in meeting utilization targets for all cause hospitalization and all cause emergency use through the use of a Community Health Team (CHT). This effort aligns with Medicaid high utilizers' strategy. Additionally, the PCMH-Kids initiative, an all-payer medical home demonstration project for children and their families, identified a cohort of practices to participate in the PCMH-Kids practice transformation collaborative. During DY10, July 1- September 30, 2018, the following activities have occurred:

- Fifty-one Nurse Care Managers (NCM)/Care Coordinators (CC) completed a six-month xGLearn core curriculum training program in September. A key objective of the training was to assist NCM/CC with developing and immediately applying a working knowledge of care management strategies and using Rhode Island resources to meet the needs of high risk patients.

- CTC worked with PCMH Kids leadership to develop a sustainability case to present to Medicaid Managed Care Organizations.

- CTC continues to work to guide and support the Screening Brief Intervention and Referral to Treatment (SBIRT) for adolescents learning network program. The eleven pediatric practices enrolled in the SBIRT learning program continue their quality improvement projects.

- CTC selected DataStat as its qualified NCQA vendor for conducting the customer experience survey (CAHPS). As the certified data vendor for this project, DataStat will administer the PMCH Kids and Adult customer experience surveys (English, Spanish and Portuguese) and collect data from the patients seen at the practice site.

- The RI Department of Health partnered with CTC and submitted a "Healthy Tomorrow's" proposal to HRSA (10/1/18) whose aim will be to improve care coordination between the Home Visiting Program and PCMH Kids practices for "at risk" children identified at birth.

- CHT work continues with existing teams at South County Health (SCH), Blackstone Valley Community Health Center, East Bay Community Action Program, Thundermist Health Center, and Family Service of RI. These teams received 234 referrals from 32 primary care practices. 210 of these referrals were enrolled into a CHT.

- On-site implementation support continues to be provided to CHTs by centralized operations staff at SCH.

- Worked with the University of Rhode Island evaluator to finalize CHT outcome evaluation which includes data collection on social determinants of health, behavioral health, patient outcomes, and patient experience. Data collection to begin with intakes as of October 1, 2018.
- Finalized workflows with RI DOH for pharmacy and nutrition consultation services to all CHTs. Referrals began in September.

Money Follows the Person Demonstration Grant

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011 to rebalance care from an institutional setting to a qualified community-based setting of care. Rhode Island continues to operate 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 93 referrals for individuals interested in transitioning from a nursing facility to the community during this quarter.

- Transitioned 15 participants from nursing facilities to qualified community based residences during this quarter.

- Facilitated 365 transitions from program inception through September 30, 2018.

- Submitted two proposals to CMS for use of state rebalancing funds. One request is for consulting services to support development of a plan to rebalance the Rhode Island LTSS system, and the second request is to create a No Wrong Door website for the state.

Home and Community Base Services (HCBS) Final Rules

In January 2014, CMS published the HCBS final rules. Rhode Island has examined the final rules is planning for implementation. The activities that have occurred during the reporting quarter are outlined below.

- The State Transition Plan was posted for public comment. Wherever possible, comments were incorporated into the plan, or integrated into future plans for oversight and monitoring.
- A meeting with stakeholders and advocates was held on September 6, 2018 to review public comments and plan updates
- Work is continuing on heightened scrutiny, transition planning, and ongoing monitoring.

Modernizing Health and Human Services Eligibility Systems

The state launched RI Bridges on September 13, 2016. RI Bridges is the State's full-service Eligibility System servicing Medicaid recipients as well as a host of DHS-related Programs. After a twelve (12) day transition period during the beginning of September, the new systems launch came with some typical and atypical concerns. Directly from system access concerns and through subsequent steps including Plan enrollment, there were numerous concerns that the vendor, Deloitte, needed to address. As EOHHS transitioned into using the new system, the state quickly realized that functionality was not fully utilized in Program, Data, and Plan areas. Therefore, EOHHS utilized Interim Business Processes which included workarounds to the system. Post launch, staff from the UHIP vendor were deployed in the offices to assist staff that were utilizing the new system and to identify and triage any possible glitches. EOHHS also established a process to categorize and prioritize these functionality issues.

Between July 1, 2018 and September 30, 2018, the Deloitte and State teams implemented maintenance releases to address hundreds of software and data incidents identified in the RIBridges application and implemented enhancement releases to improve the usability of the application as well as implement new functionality. Improvements to the Medicaid program can be summarized across the focus areas below:

Batches- Batch process jobs can run without any end-user interaction or can be scheduled to start up on their own as resources permit. Overall the following batches, now that they are running on a schedule, are helping to ensure termination accuracy and quality:

- Renewals- MAGI and Complex Medicaid renewals began in August 2017 for individuals with September renewal dates. Data points are verified by external sources when possible. If the verification fails then a request for additional documentation is added to the renewal form. Those that respond have the renewal packet (and any additional documents) scanned and processed by case workers, eligibility rerun, and renewed when applicable. Those that don't respond are picked up by subsequent batches.

    - During this time, much effort was completed to redistribute the older MAGI cases that have not been renewed since August 2017. Ongoing work is underway for the non-MAGI cases that need to be redistributed.

- Age out- All cases are evaluated for other forms of eligibility based on the information in the system before any action is taken (i.e, "aging out" of a category of coverage). If the system cannot make a determination of eligibility in another category of coverage, an age-out notice is mailed to the beneficiary on the first day of the month prior to the month they will "age out" (approx. 30-60 days prior to the birthday). The notice informs beneficiary of his/her approaching birthday and Ex Parte process (possible eligibility in a different category but more information is required). If a determination cannot be made, eligibility runs and terminates individual.

- Post Eligibility Verification (PEV)- PEV was run for the first time in production in July of 2017. PEV Batch is typically run on the 21st of the month. MAGI beneficiaries have 15 days to respond to any request for additional documentation. Those that do not respond in time are picked up by OPA Med Batch and redetermined (and most likely terminated). Verifies:

    - Employment Income (SWICA) from the Department of Labor and Training

    - Unemployment Income (UI) from the Department of Labor and Training

    - Death from the Department of Health

    - Negative Action Batch/20-day batch- The Negative Action Batch runs for Complex Medicaid programs to verify if documents have been returned for the Passive Renewal batch. The 20-day batch works in the same manner but is for the MAGI population only. Any case that has documents returned will be shielded from processing in either of these batches to allow the workers time to process the case. Both batches are heavily quality controlled due to the likelihood of termination for individuals in these batches and must be completed in time before the adverse action cut off dates (typically on the 15th of the month).

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: The interface between the eligibility system and the MMIS has been modified to fix several transactions that had previously errored and required manual fixes. These included errors to demographics and eligibility segments. Further optimization is planned for the next several code releases.

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

Worker Inbox: The worker inbox was re-designed in late 2017 and early 2018 to meet core business requirements. When launched in July 2018, improvements will include the replacement of previous worker inbox database tables with a new, custom database designed specifically for task management to allow for greater customization of task types to enable more accurate configuration; enhanced speed and reliability of task retrieval; improved task assignment methodology; and a streamlined field worker and supervisor dashboard to better organize work.

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 July 1, 2018 – September 30, 2018.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	CHIP MHPAEA	6/29/2018	Approved	8/10/2018
SPA	IHH/ACT	6/29/2018	Approved	9/27/2018
SPA	Pace Rates	8/1/2018		
SPA	Home Care, Hospice, HCBS Rates	8/1/2018		
SPA	Cedar In-Plan	8/1/2018		
SPA	Nursing Facility Rate Increase	8/7/2018		

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for Quarter 3 of DY 10 July 1, 2018 – September 30, 2018, 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

Summarize the types of complaints or problems enrollees identified about the program in DY10 July 1 – September 30, 2018. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

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

Each MCO continuously monitors member complaints to watch for trends or emerging consumer issues. A Summary of Informal Complaints report is submitted to RI EOHHS on a quarterly basis. These reports present consumer reported issues grouped into six (6) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service, and Billing Issues. While Quality of Care complaints are now formally categorized as grievances, they will continue to be reported along with the informal complaints as has been done historically.

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), RIte Care for Children with Special Health Care Needs (CSHN), Children in Substitute Care (Sub Care), and Rhody Health Options (RHO).

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

Q3 Data

NHPRI reported a 44% decrease in the number of informal complaints in Q3 2018 (58) in comparison to Q3 2017 (104) and experienced a 22% decrease in the number of informal complaints filed in Q3 2018 (58) in comparison to Q2 2018 (74). This quarter complaints are mostly in the categories of 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 Q3 2018 (71) in comparison to Q3 2017 (91) and an 11% increase in the number of informal complaints in Q3 2018 (71) compared to Q2 2018 (64). This quarter's complaints are related to mostly Billing Issues for RIte Care, RHP and RHE populations.

THRIT reported 2 complaints to date.

In addition to the three medical MCOs, there is one dental MCO, United Healthcare Dental that administers the RIte Smiles program to children born on or after May 1, 2000. They monitor informal complaints as well but had none to report for this quarter.

RI EOHHS utilizes Summary of Informal Complaints reports and participation in the Managed Care Oversight Team to identify consumer issue trends and develop strategies to prevent future occurrence. EOHHS also looks to find new ways to offer consumer protections as is demonstrated by requiring the provision of the RI Office of Health Insurance Commissioner's consumer assistance contact line information on specified member communications. This provides members another way they may seek assistance in invoking their member rights or in voicing dissatisfaction with the process.

EOHHS continues to require NHPRI and UHCP-RI to maintain National Committee for Quality Assurance (NCQA) accreditation and adhere to the NCQA's standards that pertain to members' rights and responsibilities. Both medical MCOs were rated Excellent by NCQA.
Adherence to this standard dictates that Health Plans:

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

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

EOHHS 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 2018:

Children and Family
Consumer Advisory Committee

Thursday, July 12, 2018
9:00 am – 11:00

- Welcome and Introductions
- Review of May 10, 2018 meeting minutes
- Medicaid Updates
- UHIP/DHS Updates
- Membership/Enrollment Updates
- Ad Hoc Items

Thursday, September 13, 2018
9:00 am – 11:00

- Welcome and Introductions
- Review of July 12, 2018 meeting minutes
- Medicaid Updates
- 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 enrolled in Medicaid and receive Long Term Services and Supports as well as those dual eligible members in the Integrated Care Initiative. The Council is 51% consumer led and is comprised of eight consumer/family members and seven providers/advocate members. The activity regarding this council is reported in the Integrated Care Initiative section of this report.

The EOHHS Transportation Broker, Logisticare, reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservations and the top five complaint areas during DY 10 July 1 – September 30, 2018.

NEMT Analysis	DY 10 Q3
All NEMT & Elderly Complaints	2,631
All NEMT & Elderly Trip Reservations	598,666
Complaint Performance	0.44 %
Top 5 Complaint Areas	DY 10 Q3
Transportation Provider Late	1,013
Transportation Provider General Complaint	357
Rider No Show	355
Transportation Provider No Show	282
Complaint about Rider	223

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 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 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.

During the month of September 2018, EOHHS identified and contacted approximately 500 potentially eligible applicants via mail. In the months following the September mailing, EOHHS expects to see a noticeable increase in the number of applications returned, as well as an increase in monthly enrollees. The following chart identifies the marketplace subside program participation during Q3 of DY 10, July 1 – September 30, 2018.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Projected Costs	Actual Costs
January	372	107	$42.05	$15,643.00	ACTUAL
February	306	-66	$41.87	$12,812.00	ACTUAL
March	305	-1	$41.83	$12,758.00	ACTUAL
April	317	12	$41.72	$13,224.00	ACTUAL
May	292	-25	$41.26	$12,047.00	ACTUAL
June	287	-5	$41.77	$11,988.00	ACTUAL
July	270	-17	$42.06	$11,356.00	ACTUAL
August	253	-17	$41.18	$10,419.00	ACTUAL
September	221	-32	$40.94	$9,048.00	ACTUAL

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q3 of DY 10, July 1, 2018 – September 30, 2018.

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

On a monthly basis, RI EOHHS leads oversight and administration meetings with the State's four (4) Medicaid participating Plans, NHPRI, UHCP-RI, Tufts and UHC Dental. These monthly meetings are conducted separately with each health plan; agenda items focus on standing areas of focus as well as emerging items. Furthermore, each month EOHHS hosts an all plan meeting which focuses on a topic pertinent to all the MCOs for oversight or program performance.

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings that were conducted during Quarter 3 of 2018:

Quality & Compliance Topics Covered:

- This quarter was the rollout of the managed care core contract CY19 Reporting Calendar for the medical managed care contracts (NHPRI, UHC Medical and Tufts). EOHHS engaged in a yearlong regulation and contract alignment process to reengineer standard reporting templates utilized by the MCOs. MCOs were given draft reporting templates and draft policies on August 30th.

- UHC Dental:
    - In July, EOHHS discussed QIPs with UHC regarding preventative visits and sealants. It was requested of UHC the two QIPS from 2018 would continue in in 2019. UHC has developed an intervention plan to further target these QIPs.
    - UHC Dental competed a Grievance and Appeals audit this quarter and is still ongoing review at EOHHS.
    - Provider Questionnaire was reviewed by EOHHS in September 2018
    - EOHHS has approved all member marketing and oversight policy and procedures for the UHC *Brushlink* pilot program. The Brushlink pilot is a value add pilot program where participating dental provider offer a digital accrometer attached to a standard toothbrush that measures time and thoroughness of daily brushing. EOHHS anticipates the pilot to conclude in March 2019 and will determine the effectiveness and engagement of members through this pilot with UHC Dental.
- NHPRI
    - As NHPRI transitions to a different behavioral health vendor, EOHHS has actively engaged with NHPRI to ensure a smooth transition for members and that BH providers are paid on-time. EOHHS has requested documentation related to a pre-delegation audit and system testing project plans. EOHHS has also engaged other state agencies, including the department of Behavioral Health, Developmental

Disabilities and Hospitals (BHDDH) and the Department of Children, Youth, and Families (DCYF), to participate in such discussions with EOHHS.
    - OIG audit follow-up was conducted at the July 2018 Oversight meeting with NHP.
    - Throughout Q3 2018, EOHHS and NHP have actively discussed the new reporting calendar and NHPRI crafted a series of clarify questions that were incorporated into the CY19 reporting calendar and reporting policy-procedure.
- UHCP- RI
    - In the September, EOHHS engaged with UHCP-RI in a discussion to clarify reporting questions related to the new reporting calendar and requirements. EOHHS and reporting specialists met with UHCP-RI to clarify new reporting requirements. EOHHS provided feedback to UHCP-RI on clarify questions in September's Oversight meeting. Many of their question focused on quality related reporting.
    - As UHCP- RI and NHP will have the same BH vendor, UHCP-RI provided a point of contact chart to EOHHS to make sure that there is consistency for members and providers to contact if an issue arises.
- Tufts
    - As outlined in the September 2018 meeting, Tufts has been required by the end of the year to be fully compliant in the three key areas: 1) Reporting 2) Quality 3) Encounter data submissions/SOBRA submissions. It was shared that Tufts needs to make considerable improvements in these three areas by the end of the year or else be put on a state-driven corrective action plan:
        - Quality—Tufts has met with EOHHS to refine QIP process and ensure that QIPs are submitted on time.
        - Encounter Data - weekly project plans submitted to EOHHS to ensure compliance by 10/17/19. Beginning the completion of SOBRA payments starting in 11/18.
        - Reporting—It is expected that Tufts will be fully compliant with reporting requirements starting on 1/1/19. Any previous reporting requirement overtures will no longer be waived starting in 2019 for Tufts.

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

During the reporting quarter the 1115 Quality and Evaluation workgroups discussed Standard updates to the UHIP system, Rebalancing LTSS reports, C-Section and Readmission rate metrics, and MacPro Quality Measurement Construction.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 Q1 CY 2018	DY 10 Q2 CY 2018	DY 10 Q3 CY 2018
ABD Adults No TPL	$ 488,249,580	$ 520,451,772	$ 155,453,488	$ 136,900,816	$ 142,508,224
ABD Adults TPL	$ 1,271,228,068	$ 1,399,941,483	$ 350,168,077	$ 380,792,062	$ 373,430,904
RIte Care	$ 933,125,256	$ 1,060,816,730	$ 278,531,838	$ 278,078,742	$ 278,933,598
CSHCN	$ 417,839,643	$ 469,098,220	$ 125,179,158	$ 122,855,328	$ 124,599,837
TOTAL	**$ 3,110,442,547**	**$ 3,450,308,205**	**$ 909,332,561**	**$ 918,626,948**	**$ 919,472,563**

With Waiver Total Expenditures

Medicaid Populations	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018	DY 10 2nd Qtr. CY 2018	DY 10 3rd Qtr. CY 2018
ABD Adults No TPL	$ 540,181,908	$ 409,900,329	$ 100,300,631	$ 94,951,944	$ 115,597,971
ABD Adults TPL	$ 616,430,588	$ 753,679,210	$ 177,096,375	$ 170,860,333	$ 208,506,331
RIte Care	$ 496,945,206	$ 513,027,120	$ 141,158,004	$ 68,891,561	$ 196,694,181
CSHCN	$ 175,292,128	$ 184,621,431	$ 45,418,236	$ 36,980,308	$ 55,723,160
Excess Spending: Hypothetical	$ 12,251,991	$ 2,277,946	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -
CNOM Services	$ 8,969,196	$ 9,055,311	$ 2,503,369	$ 2,417,357	$ 2,221,141
TOTAL	**$1,850,071,016**	**$1,872,561,346**	**$ 466,476,616**	**$ 374,101,503**	**$ 578,742,784**
Favorable / (Unfavorable) Variance	$1,260,371,531	$1,577,746,859	$ 442,855,945	$ 544,525,445	$ 340,729,779
Budget Neutrality Variance (DY 1-5)					
Cumulative Bud. Neutrality Variance	**$6,024,014,419**	**$7,601,761,277**	**$8,044,617,223**	**$8,589,142,668**	**$8,929,872,447**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2016 YTD	2017 YTD	1st Qtr. CY 2018	2nd Qtr. CY 2018	3rd QTR CY 2018
217-like Group	$ 169,392,808	$ 181,591,552	$ 54,021,240	$ 56,101,500	$ 56,023,695
Family Planning Group	$ 89,922	$ 101,794	$ 50,370	$ 49,749	$ 49,335
TOTAL	$ 169,482,730	$ 181,693,346	$ 54,071,610	$ 56,151,249	$ 56,073,030

With-Waiver Total Exp.	2016 YTD	2017 YTD	1st Qtr. CY 2018	2nd Qtr. CY 2018	3rd QTR CY 2018
217-like Group	$ 181,671,673	$ 182,709,505	$ 51,037,174	$ 53,371,514	$ 48,582,139
Family Planning Group	$ 63,048	$ 53,490	$ 35,382	$ 17,909	$ 33,931
TOTAL	$ 181,734,721	$ 182,762,995	$ 51,072,556	$ 53,389,423	$ 48,616,070

Excess Spending	2016 YTD	2017 YTD	1st Qtr. CY 2018	2nd Qtr. CY 2018	3rd QTR CY 2018
217-like Group	$ 12,278,865	$ 1,117,953	$ (2,984,066)	$ (2,729,986)	$ (7,441,556)
Family Planning Group	$ (26,874)	$ (48,304)	$ (14,988)	$ (31,840)	$ (15,404)
TOTAL	$ 12,251,991	$ 1,069,649	$ (2,999,054)	$ (2,761,826)	$ (7,456,960)

LOW INCOME ADULT ANALYSIS

Low-Income Adults (Expansion)	2016 YTD	2017 YTD	1st Qtr. CY 2018	2nd Qtr. CY 2018	3rd Qtr. CY 2018
Without Waiver Total Exp.	$ 693,378,495	$ 828,075,193	$ 220,038,525	$ 219,665,250	$ 217,640,115
With-Waiver Total Exp.	$ 300,953,105	$ 458,848,954	$ 113,980,573	$ 63,694,496	$ 161,920,400
Excess Spending	$ (392,425,390)	$ (369,226,239)	$ (106,057,952)	$ (155,970,754)	$ (55,719,715)

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 8 2016 YTD	DY 9 2017 YTD	DY 10 1st Qtr. CY 2018	DY 10 2nd Qtr. CY 2018	DY 10 3rd Qtr. CY 2018
ABD Adults No TPL	168,420	172,164	49,319	45,212	43,433
ABD Adults TPL	387,806	409,699	98,279	104,808	106,874
RIte Care	1,851,439	2,001,541	499,161	499,881	498,349
CSHCN	140,829	150,545	38,246	38,069	37,536
217-like Group	44,021	45,764	13,192	13,700	13,681
Low-Income Adult Group	810,969	921,107	232,845	232,450	230,307
Family Planning Group	4,282	4,627	2,190	2,163	2,145

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

217-like Group	$ 3,848	$ 3,968	$ 4,095	$ 4,095	$ 4,095
Low-Income Adult Group	$ 855	$ 899	$ 945	$ 945	$ 945
Family Planning Group	$ 21	$ 22	$ 23	$ 23	$ 23
Without Waiver Expenditures	**DY 8 2016 YTD**	**DY 9 2017 YTD**	**DY 10 1st Qtr. CY 2018**	**DY 10 2nd Qtr. CY 2018**	**DY 10 3rd Qtr. CY 2018**
ABD Adults No TPL	$ 488,249,580	$ 520,451,772	$ 155,453,488	$ 142,508,224	$ 136,900,816
ABD Adults TPL	$1,271,228,068	$ 1,399,941,483	$ 350,168,077	$ 373,430,904	$ 380,792,062
RIte Care	$ 933,125,256	$ 1,060,816,730	$ 278,531,838	$ 278,933,598	$ 278,078,742
CSHCN	$ 417,839,643	$ 469,098,220	$ 125,179,158	$ 124,599,837	$ 122,855,328
217-like Group	$ 169,392,808	$ 181,591,552	$ 54,021,240	$ 56,101,500	$ 56,023,695
Low-Income Adult Group	$ 693,378,495	$ 828,075,193	$ 220,038,525	$ 219,665,250	$ 217,640,115
Family Planning Group	$ 89,922	$ 101,794	$ 50,370	$ 49,749	$ 49,335

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: 12/31/18

XIII. State Contact(s)

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XIV. Date Submitted to CMS

01/04/2019