Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

July 1, 2019 – September 30, 2019

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

Submitted December 2019

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 11 July 1, 2019 – September 30, 2019

II. Introduction

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

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

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

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

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

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

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

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

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

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

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	Number of Current Enrollees (to date) * 09/30/19	Number of Enrollees That Lost Eligibility in 09/30/19**
Budget Population 1: ABD no TPL	14,290	547
Budget Population 2: ABD TPL	33,884	345
Budget Population 3: RIte Care	121,348	5,711
Budget Population 4: CSHCN	12,105	188
Budget Population 5: EFP	1,157	73
Budget Population 6: Pregnant Expansion	18	3
Budget Population 7: CHIP Children	36,689	1,363
Budget Population 8: Substitute care	N/A	N/A
Budget Population 9: CSHCN Alt	N/A	N/A
Budget Population 10: Elders 65 and over	1,858	68
Budget Population 11, 12, 13: 217-like group	4,584	44
Budget Population 14: BCCTP	78	2
Budget Population 15: AD Risk for LTC	3,621	2
Budget Population 16: Adult Mental Unins	12,016	0
Budget Population 17: Youth Risk Medic	6,021	361
Budget Population 18: HIV	265	10
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	73,921	4,124

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

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

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the quarter in DY 11 July 1, 2019 – September 30, 2019:

Quarter 3: 22:498 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 DY11 July 1, 2019 – September 30, 2019 (by category or by type) with a total of $5,200.03 for special purchases expenditures.

Q 3 2019	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Over the counter medications		$ 1,024.10
	1	Acupuncture		$ 50.00
	21	Massage Therapy		$ 1,575.00
	1	Medical Supplies		$ 107.00
	1	Diabetes management		$ 60.00
	9	Lawn Care		$ 444.93
	4	Service Dog Training		$ 370.00
	1	Computer		$ 379.00
	1	Specialized Van Repairs		$ 500.00
	CUMULATIVE TOTAL			**$ 5,200.03**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for Q2, July 1, 2019 – September 30, 2019.

Innovative Activities

Health System Transformation Project

On October 20, 2016, CMS approved the state's 1115 Waiver request to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain delivery system reform efforts. The RI HSTP proposes to foster and encourage this critical transformation of RI's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities. During Q2 the following activities occurred.

Health Workforce Development Program

1. Continued collaborative efforts between Medicaid, DLT, and Institutions of Higher Education (IHEs) to advise, develop, review, and monitor HSTP-funded healthcare workforce transformation projects to support the establishment of Accountable Entities and other related system transformation objectives.

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

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

Accountable Entities (AEs)

- A new Accountable Entity, Coastal, began full participation in PY2, as did a new Managed Care Organization (MCO), Tufts Public Health Plans.

- AEs continued work on PY1 HSTP Project Plans due to the delayed start with PY1 project plans. AEs began working on PY2 HSTP Project Plans as they negotiated contracts with the Managed Care Organizations (MCOs).

- EOHHS focused on preparation for PY3 through meetings and preparing documentation for public comment on the following topics:
    - Attribution Guidance
    - Incentive Program Requirements
    - Total Cost of Care Requirements
    - AE Certification Standards

- EOHHS/Medicaid continue to work with our vendor Bailit Health in the development and release of an Implementation Guide for the AE quality program, including recommendations for Program Year 3 quality component of the APM contract, data collection and reporting specific to clinical quality (hybrid) measures, development of technical specification for a social determinant of health, and standardization of scoring criteria and methodology.

- Under the contact with the Center for Health Care Strategies (CHCS) individualized technical assistance was provided to Medicaid AEs and MCOs. In addition to bi-weekly meetings with EOHHS, plans were made for an in-person learning collaborative in November with EOHHS, the MCOs, and the Medicaid AEs. The focus is: Ready for Risk-Paving a Successful Plan Forward. CHCS expanded efforts to include technical assistance to MCOs contracted with and managing AEs.

- The HSTP Advisory Committee held 3 meetings. The June meeting included a presentation by the Rhode Island Medicaid Director regarding the evaluation of The AE Program conducted by Day Health Strategies on Strategic Vision, Goals & Planning, and Stakeholder Process. The August meeting was an open discussion that included Program Updates and Discussion and Public Comments on Key Findings from Day health Strategies. The September meeting included Public Updates, a Department of Labor and Training Update, and Discussion and Public Comment on PY3 Strategic Changes and Program Requirements.

- An open discussion on how to improve the Incentive Program was held with stakeholders and interested parties.

- EOHHS and the Rhode Island Quality Institute (RIQI) began work together to provide access to contracted AEs to RIQI's Care Management Dashboard. The dashboard provides live feeds of patients in the hospitals and emergency departments so AEs can intervene and assist with transitions of care. Although this exists throughout Rhode

Island to those organizations willing to pay for this service, EOHHS is utilizing HSTP funds to provide a specific AE attribution file so AEs at risk can more effectively manage their attributed populations. A demo for the AEs is planned for early Q4.

Dental Case Management Program

Waiver Authority

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

Dental Case Management Quarterly Report – Q3 2019

	Q3 2019
New providers receiving online training during this quarter	0
Total Providers Trained	17 (from 4 practices)
New providers enrolled to bill DCM codes through DXC	0
Total providers enrolled to bill DCM codes through DXC	3
DCM claims submitted during this quarter	3

Broken Appointments among Adult Beneficiaries	
Tri County	2.6% drop

Below is a report of the Dental Case Management services that is used to monitor utilization by provider, provider type, age, and gender of the beneficiary.

Utilization of Dental Case Management Service by Code	
D9991	0
D9992	0
D9993	0
D9994	3

Utilization of Dental Case Management Service by Provider	
Tri-County Health Center	4
St. Joseph Hospital	64

Utilization of Dental Case Management Service by Provider Type	
Tri-County Health Center	1
St. Joseph Hospital	2

Utilization of Dental Case Management Service by Age	
21 - 30	0
31 - 40	2
41 - 50	0
51 - 60	0
61 +	1

Utilization of Dental Case Management Service by Gender	
Female	2
Male	1

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in Q3, July 1, 2019 – September 30, 2019.

Modernizing Health and Human Services Eligibility Systems

Between July 1, 2019 and September 30, 2019, the Deloitte and State teams implemented maintenance releases to address software and data incidents identified in the RI Bridges application and implemented enhancement releases to improve the usability of the application as well as implement new functionality. Improvements to the Medicaid program can be summarized across the focus areas below:

Retirement of Interim Business Processes:

Interim Business Processes (IBPs) related to the Medicare Premium Payment (MPP) program, termination batches and patient share transactions between RI Bridges and the MMIS have all been retired as a result of RI Bridges functionality modifications this quarter. All manual workaround involving Medicaid staff and/or specialized system scripting have now been phased out because our eligibility system is now functioning properly.

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, 2019 – September 30, 2019.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Home Stabilization Initiative	11/16/2015		
SPA	Medicaid and CHIP Final Rule	6/26/2019	Approved	8/9/2019
SPA	Medicaid Premiums and Cost Sharing	6/28/2019	Approved	8/9/2019
SPA	Inpatient Hospital Rate Increase	8/15/2019		
SPA	Outpatient Hospital Rate Increase	8/15/2019		
SPA	Elimination of Inpatient Hospital Supplemental Payments	8/15/2019		
SPA	Graduate Medical Education	8/15/2019		

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for Quarter 3 of DY 11 July 1, 2019 – September 30, 2019, or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

July – September 2019

Rhode Island 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 Managed Care Organization (MCO) monitors member complaints to identify trends and/or emerging consumer issues. Informal complaints Report track consumer reported issues grouped into seven (7) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service, Parity and Billing Issues.

Currently the grievance/informal complaint reports are submitted to EOHHS quarterly and reviewed by the appropriate staff at EOHHS. Any questions or requests for clarification by EOHHS are sent back to the MCOs with an expected response date. Data is disaggregated according to Medicaid cohort: Core RIte Care (Med), Rhody Health Partners (RHP), Rhody Health Expansion (ACA)[2], RIte Care for Children with Special Health Care Needs (CSHN), and Children in Substitute Care (Sub Care)[3] . As of Q1 2020 (January 1, 2020) informal complaints will be captured in the quarterly Grievance report submitted to RI EOHHS.

There currently are three (3) MCOs that are contracted with EOHHS to provide care to RI managed Medicaid members: Neighborhood Health Plan of RI (NHPRI), Tufts Health Plan RI Together (RIT) and United Healthcare Community Plan (UHCP-RI). NHPRI continues to be the only managed care organization that serves the RIte Care for Children in Substitute Care population. In addition to the three (3) MCOs there is one (1) dental MCO, United Healthcare Dental that administers the RIte Smiles program

RI EOHHS utilizes Grievance/Informal Complaint reports to identify consumer issue trends and, as part of active contract oversight, collaborate with the Medical and Dental managed care organizations to develop strategies to prevent future occurrence. Reports are further analyzed to identify and ensure increased consumer protections as demonstrated through the requirement that MCOs offer the RI Office of Health Insurance Commissioner's consumer assistance contact information on member communications. In addition, members may contact RI Department of Managed Care to register a concern or displeasure with the MCO complaint process. Thus, allowing members multiple avenues in which they may invoke the full scope of their member rights.

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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.

DATA – Q3 2019

NHPRI reported a 26.6% increase in the number (19) of informal complaints in Q3 2019 in comparison to Q2 2019. Of this quarter's 19 complaints, RHP and RHE cohorts represented the highest percentage of concerns with billing and health plan customer service complaints with a slight uptick (2) in complaints regarding enrollment. NHPRI is the only MCO that administers Rite Care for Children in Substitute Care; there were no informal complaints submitted by Sub Care beneficiaries in either Q1, Q2 or Q3 2019.

UHCP-RI reported a 26.7% increase in the number (57) of informal complaints in Q3 2019 in comparison to Q2 2019. Of this quarter's 57 complaints the following cohorts RIte Care and RHP represent the highest number of informal complaints. Complaints regarding billing issues remain the highest category (31); the steady increase in member complaints about billing is an alarming trend. Of note, there is a decrease in informal complaints from members attributed to an Accountable Entity (9 in Q3 compared to 31 in Q2). Unlike the MCOs, UHC does not have a category tracking informal complaints based on Parity issues. This will be a required, distinct category for all MCOs beginning Q1 2020.

RIT reports (0) informal complaints in Q3 2019 as has been reported in previous quarters.

United Healthcare Dental reported no change in the number of informal complaints in Q3 2019 in comparison to Q2 2019. Of note, Dental reports Informal Complaints using the following categories: Access to Care, Quality of Care, Environment of Care, Enrollment Disputes, Health Plan Customer Services, Billing Issues and Transportation.

EOHHS also participates in two advisory groups, the long-standing Consumer Advisory Committee (CAC) and the Integrated Care Initiative's ICI Implementation Council. CAC stakeholders include individuals who are enrolled in RIte Care, and representatives of advocacy groups, health plans, the Department of Human Services (DHS), and EOHHS. The CMS Regional Officer participates in these meetings as her schedule permits. The CAC met once in Q3 July 1 – September 30, 2019:

July meeting agenda

- Welcome and Introductions
- Enrollment Report Update
- Care Management Update
- Auto Assignment Update
- Open Enrollment Update
- 90-Day Letter Update
- Legislative Update
- Q&A

The EOHHS Transportation Broker, Medical Transportation Management (MTM), reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservations and the top five complaint areas during DY 11 July 1 – September 30, 2019.

NEMT Analysis	DY 11 Q3
All NEMT & Elderly Complaints	720
All NEMT & Elderly Trip Reservations	604,394
Complaint Performance	0.12%
Top 5 Complaint Areas	**DY 11 Q3**
Transportation Provider No Show	**184**
Transportation Provider Late	142
Transportation Broker Processes	85
Transportation Provider Behavior	83
Transportation Client Protocols	60

X. Marketplace Subsidy Program Participation

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

With Open Enrollment, EOHHS saw a slight increase in enrollees for the month of January, whereas subsequent months showed a steady decline. The decline in monthly enrollment is likely due to natural churn, as well as a decrease in the number of new applications received by EOHHS. The last mass mailing to potentially eligible applicants was done in September 2018. EOHHS is currently assessing whether to execute another mass mailing for October 2019.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy received by Enrollee	Projected Costs	Actual Costs
January	295	30	$ 41.65	$ 12,286.00	ACTUAL
February	238	-57	$ 41.73	$ 9,931.00	ACTUAL
March	194	-44	$ 41.66	$ 8,082.00	ACTUAL
April	161	-33	$ 41.63	$ 6,702.00	ACTUAL
May	178	17	$ 42.68	$ 7,597.00	ACTUAL
June	161	-17	$ 41.89	$ 6,744.00	ACTUAL
July	166	5	$ 42.93	$ 7,126.00	ACTUAL
August	166	0	$43.20	$ 7,172.00	ACTUAL
September	147	-19	$ 43.00	$ 6,321.00	ACTUAL

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in Q2 of DY 11, July 1, 2019 – September 30, 2019.

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

Monthly Oversight Review

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

Specific to quality improvement and compliance the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 3 of 2019:

During Q3, EOHHS introduced to NHPRI, UHCP-RI, and THPP the rollout of active contract management, a new strategic approach to evaluate how the State and medical MCOs collectively manage Medicaid members' care. By the close of Q1 2020, EOHHS intends to share with MCOs basic dashboards that illustrate data across all three (3) MCOs to drive deeper discussions and to connect it to AE initiative at later points in 2020.

EOHHS has been working with Deloitte on a system fix to remediate ongoing member address / demographic data issues that have caused increased return mail and lack of newborn payments due to newborns not found, duplicated, assigned to the wrong MCO. EOHHS executed contract Amendment 3 during Q3.

NHPRI

- As part of active contract management, EOHHS data focused on ED visits (AND), preventable hospital visits, and other trends, noting at a high level:
    - Overall trend remains steady with missing claims data for December 2018 and January 2019. The missing claims data will be further evaluated.
    - Length of stay (days) indicate that CHSN remains high with increases in ALOS for all populations.
    - EOHHS has been developing a data dictionary so MCO and EOHHS align in terms of what data they measure and how.
    - AE Metrics including ED visits, in-patient metrics, PCP assignment, among other analyses.
    - NHPRI presented how they analyze data and their use of the MARA concurrent risk score.
- BH Stabilization Project to resolve behavioral health provider fiscal and claiming issues in conjunction with Optum; the project involves developing recommendations for State

leadership to solve financial solvency issues in the short term and promote financial stability over time.

- Focused on claims processing configuration rules to include additional fields to better understand and avoid claims processing denials. NHPRI issued new provider policy ...
- As part of the transition from Beacon to Optum for behavioral health services, NHPRI has been working with Optum to monitor claims activity among the provider community, identifying code/modifier discrepancies.
- MMP discussions took place to determine what services should be covered under the Developmentally Disabled (DD) waiver, versus what NHPRI should cover, to best lead to positive health outcomes for the DD population. EOHHS anticipates an RFI to gather additional stakeholder input.
- Items discussed to be addressed in more detail during Q4 included:
    - Open Enrollment
    - Principles of FQHC reimbursement
    - Electronic Visit Verification (EVV) implementation and launch
    - Strengths and opportunities for improving the Accountable Entity (AE) Program.

UHCP-RI

- As part of active contract management, EOHHS informed UHCP-RI that the government performance model is used to identify areas of improvement, and that strategic planning is the step that is most frequently skipped. The focus of Q3 discussions has primarily involved the following:
    - EOHHS determined that the major cost drivers are related to members with substance use disorders (SUD) and serious and persistent mental illness (SPMI), and that eighty percent (80%) of costs are incurred by twenty percent (20%) of the population.
    - UHCP-RI has been collaborating with FQHCs to make progress on reducing hospital readmissions.
    - Inpatient admissions have been decreasing over the past four (4) years.
    - UHCP-RI's hospital admission rates were higher for those admitted for behavioral health reasons, versus medical reasons, as compared to NHPRI's and THPP's.
- BH Stabilization Project to resolve behavioral health provider fiscal and claiming issues in conjunction with Optum; the project involves developing recommendations for State leadership to solve financial solvency issues in the short term and promote financial stability over time.
- EOHHS approved UHCP-RI's Human Arc implementation and UHCP-RI mailed communications to 2,200 members they identified.
- EOHHS denied UHCP-RI's proposed paramedicine pilot design due to additional State-incurred costs.
- Items discussed to be addressed in more detail during Q4 included:
    - Open Enrollment: UHCP-RI requests that EOHHS provide disenrollment data.
    - Principles of FQHC reimbursement

- Electronic Visit Verification (EVV) implementation and launch
- Strengths and opportunities for improving the Accountable Entity (AE) Program.

Tufts Public Health Plans

- As part of active contract management, EOHHS informed THPP about the process and requested THPP's partnership in developing a data dictionary. THPP identified subject matter experts to participate in meetings to discuss population health management, how to change identified trends, and collaboration with AE partners to lay the groundwork. Cost associated with average length of stay for hospital admissions trended higher than NHPRI and UHCP-RI.
- There were ongoing discussions with THPP about improving the quality of encounter data. THPP instituted provider file fixes and prioritized financial reconciliations.
- THPP and EOHHS discussed AE Program updates, focused primarily on the future state with Prospect, Integra, and Lifespan.
- THPP is in the process of finalizing NCQA accreditation, with expected completion June 2020.
- Items discussed to be addressed in more detail during Q4 included:
  - Open Enrollment: UHCP-RI requests that EOHHS provide disenrollment data.
  - Principles of FQHC reimbursement
  - Electronic Visit Verification (EVV) implementation and launch
  - Strengths and opportunities for improving the Accountable Entity (AE) Program.

UHC Dental

- UHC Dental presented their plan to roll out an enhanced member-facing website, including a secure portal, claims details, provider searches, among other features.
- EOHHS and Freedman Healthcare coordinated to determine that UHC Dental will be added to the All Payer Claims Database (APCD) without an incurred cost.
- Once-per-lifetime limitations were implemented for dental codes D8050, D8060, and D8080.
- EOHHS approved UHC Dental's member survey and discussed approach for UHC's provider survey.
- UHC Dental partnered with Comprehensive Community Action Program (CCAP) and NHPRI to execute a collaborative clinic day that targeted members that did not attend a dental visit and well child visit.
- UHC Dental developed a Targeted Provider Sealant Incentive Program to be rolled out in Q4, with reports forthcoming in Q1 2020.
- Contract Amendment 9 was signed and executed.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 Q1 CY 2019	DY 11 Q2 CY 2019	DY 11 Q3 CY 2019
ABD Adults No TPL	$520,451,772	$568,983,280	$139,792,608	$ 144,267,576	$ 146,335,728
ABD Adults TPL	$1,399,941,483	$1,489,697,426	$397,247,832	$ 378,337,108	$ 371,484,804
RIte Care	$1,060,816,730	$1,112,899,194	$288,484,320	$ 283,471,264	$ 280,187,432
CSHCN	$469,098,220	$493,100,361	$124,989,942	$ 124,790,596	$ 125,577,669
TOTAL	$3,450,308,205	$3,664,680,261	$950,514,702	$ 930,866,544	$ 923,585,633

With Waiver Total Expenditures

Medicaid Populations	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019	DY 11 3rd Qtr. CY 2019
ABD Adults No TPL	$409,900,329	$415,613,308	$ 109,570,658	$ 110,745,562	$ 135,322,835
ABD Adults TPL	$753,679,210	$725,296,165	$ 186,466,360	$ 206,813,291	$ 210,846,009
Rlte Care	$513,027,120	$549,821,243	$ 134,627,877	$ 88,989,112	$ 182,873,426
CSHCN	$184,621,431	$182,172,130	$ 44,715,646	$ 36,255,884	$ 52,257,488
Excess Spending: Hypothetical	$2,277,946	$ -	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -
CNOM Services	$9,055,311	$9,347,322	$10,146,505	$ 10,939,223	$ 11,332,431
TOTAL	$1,872,561,346	$1,882,250,168	**$ 485,527,046**	**$ 453,743,071**	**$ 592,632,189**
Favorable / (Unfavorable) Variance	$1,577,746,859	$1,782,430,093	$ 464,987,656	$ 477,123,473	$ 330,953,444
Budget Neutrality Variance (DY 1-5)					
Cumulative Bud. Neutrality Variance	**$7,601,761,277**	**$9,384,191,371**	**$ 464,987,656**	**$ 942,111,129**	**$ 1,273,064,573**

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019	3rd Qtr. CY 2019
217-like Group	$181,591,552	$220,425,660	$54,138,706	$ 55,683,958	$ 57,566,970
Family Planning Group	$101,794	$206,839	$76,008	$ 75,408	$ 81,360
TOTAL	$181,693,346	$220,632,499	$54,214,714	$ 55,759,366	$ 57,648,330

With-Waiver Total Exp.	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019	3rd Qtr. CY 2019
217-like Group	$182,709,505	$197,290,254	$ 44,365,123	$ 49,961,714	$ 48,546,437
Family Planning Group	$53,490	$116,238	$60,254	$ 54,155	$ 156,211
TOTAL	$182,762,995	$197,406,492	$ 44,425,377	$ 50,015,869	$ 48,702,648

Excess Spending	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019	3rd Qtr. CY 2019
217-like Group	$1,117,953	($23,135,406)	$ (9,773,583)	$ (5,722,244)	$ (9,020,533)
Family Planning Group	($48,304)	($90,601)	($15,754)	$ (21,253)	$ 74,851
TOTAL	$1,069,649	($23,226,007)	$ (9,789,337)	$ (5,743,497)	$ (8,945,682)

LOW INCOME ADULT ANALYSIS

Low-Income Adults (Expansion)	2017 YTD	2018 YTD	1st Qtr. CY 2019	2nd Qtr. CY 2019	3rd Qtr. CY 2019
Without Waiver Total Exp.	$828,075,193	$875,438,550	$223,385,580	$ 221,674,860	$ 221,492,700
With-Waiver Total Exp.	$458,848,954	$449,618,448	$106,919,488	$ 63,536,302	$ 149,646,421
Excess Spending	($369,226,239)	($425,820,102)	($116,466,092)	$ (158,138,558)	$ (71,846,279)

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019	DY 11 3rd Qtr. CY 2019
ABD Adults No TPL	$172,164	$180,515	$42,516	$43,877	$44,506
ABD Adults TPL	$409,699	$418,102	$106,902	$101,813	$99,969
RIte Care	$2,001,541	$1,994,443	$493,980	$485,396	$479,883
CSHCN	$150,545	$150,657	$36,366	$36,308	$36,537
217-like Group	$45,764	$53,828	$12,823	$13,189	$13,635
Low-Income Adult Group	$921,107	$926,390	$225,642	$223,914	$223,730
Family Planning Group	$4,627	$8,993	$3,167	$3,142	$3,390

Without Waiver PMPMs	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019	DY 11 3rd Qtr. CY 2019
ABD Adults No TPL	$3,023	$3,152	$3,288	$3,288	$3,288
ABD Adults TPL	$3,417	$3,563	$3,716	$3,716	$3,716
RIte Care	$530	$558	$584	$584	$584
CSHCN	$3,116	$3,273	$3,437	$3,437	$3,437
217-like Group	$3,968	$4,095	$4,222	$4,222	$4,222
Low-Income Adult Group	$899	$945	$990	$990	$990
Family Planning Group	$22	$23	$24	$24	$24

Without Waiver Expenditures	DY 9 2017 YTD	DY 10 2018 YTD	DY 11 1st Qtr. CY 2019	DY 11 2nd Qtr. CY 2019	DY 11 3rd Qtr. CY 2019
ABD Adults No TPL	$520,451,772	$568,983,280	$139,792,608	$144,267,576	$146,335,728
ABD Adults TPL	$1,399,941,483	$1,489,697,426	$397,247,832	$378,337,108	$371,484,804
RIte Care	$1,060,816,730	$1,112,899,194	$288,484,320	$283,471,264	$280,187,432
CSHCN	$469,098,220	$493,100,361	$124,989,942	$124,790,596	$125,577,669
217-like Group	$181,591,552	$220,425,660	$54,138,706	$55,683,958	$57,566,970
Low-Income Adult Group	$828,075,193	$875,438,550	$223,385,580	$221,674,860	$221,492,700
Family Planning Group	$101,794	$206,839	$76,008	$75,408	$81,360

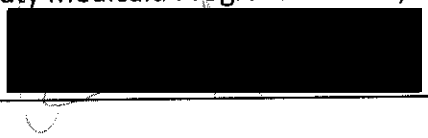
Attachment 2: Statement of Certification of Accuracy of Reporting of Member Months

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: 12/10/19

XIII. State Contact(s)

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XIV. Date Submitted to CMS

12/11/2019