Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

DY13 Annual

January 1, 2021 – December 31, 2021

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

Submitted April 2022

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I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 13 January 1, 2021 – December 31, 2021

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.

<u>Key Accomplishments</u>:

During DY 13, January 1, 2021 to December 31, 2021, Rhode Island:

- Worked with Deloitte to continue modernization of the State's eligibility systems;
- Worked with three Accountable Entities to enter managed care contracts with

downside risk;

- Certified a new Accountable Entity;
- Launched a new project with Accountable Entities, called Rhode to Equity;
- Submitted 26 State Plan Amendments, of which 23 are currently approved;
- Developed and began implementing a major project to ensure HCBS quality and reporting compliance;
- Implemented provider rate increases to increase access to services; and
- Engaged in ongoing Active Contract Management with managed care organizations to maximize impact on emerging issues, including issues related to the COVID-19 pandemic.

III. Enrollment Information

Complete the following tables 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. The count reflects the month-end snapshot.*

Summary:

Number of current enrollees as of the last day of the month in the reported quarter with eligibility for full benefits is **341,706**. This does not include another 2,275 members eligible under Rhode Island's separate CHIP program (and not reflected in **Table III.1a**). Nor does it include an additional **14,121** members with partial Medicaid coverage.

The 5.8% increase in Medicaid enrollment for 2021 is due in part to the general moratorium on redeterminations. EOHHS only terminated members due to death, a request for termination by the member and a member moving out-of-state.

Please note that prior 1115 reporting by Rhode Island understated certain populations as the reporting queries did not include all eligibility aid categories for each of the budget populations and included some categories that had ceased being valid. Aid categories excluded from reporting included the New Adult Group (i.e., Medicaid Expansion and Previously Eligible Medicaid Expansion), a subset of 217-like group, and some new aid categories for LTSS-eligible members. Overstated eligibility groups included Population No. 17 Early Intervention that is only authorized for children up to the member's third birthday.

Table III.1 Medicaid-Eligible Enrollment Snapshot

	DY09	DY10	DY11	DY12	DY13			
	Dec-17	Dec-18	Dec-19	Dec-20	Mar-21	Jun-21	Sep-21	Dec-21
01: ABD no TPL	15,861	15,812	15,549	15,560	15,501	15,525	15,401	15,418
02: ABD TPL	34,127	33,203	32,356	31,953	32,136	32,391	32,686	32,990
03: Rite Care	138,427	130,044	120,876	135,642	137,457	138,620	139,361	138,844
04: CSHCN	12,427	12,039	12,042	12,460	12,227	12,215	12,207	12,209
05: Family Planning	1,145	1,152	1,671	1,688	1,612	1,519	1,452	1,366
06: Pregnant Expansion	26	29	19	43	46	54	56	56
07: CHIP Children	31,812	37,107	34,215	32,154	33,048	34,177	35,231	35,871
10: Elders 65+	8,461	9,307	9,802	8,919	9,383	9,484	9,579	9,563
14: BCCPT	117	84	76	78	81	85	84	87
15: ORS CNOM	417	470	514	539	571	564	647	585
17: Early Intervention	2,226	2,362	2,038	1,795	1,817	1,806	1,808	1,775
18: HIV	681	706	693	774	788	786	808	808
21: 217-like	4,083	4,126	4,342	4,465	4,501	4,535	4,630	4,671
22: New Adult Group	79,647	78,092	73,261	92,321	96,102	99,102	101,852	103,835
27: Undocumented	17	37	14	105	105	130	24	24
Grand Total	**328,483**	**323,106**	**306,352**	**337,009**	**343,681**	**349,069**	**353,712**	**355,827**
Subtotal - Full MA Only	**315,536**	**309,072**	**291,620**	**323,189**	**329,405**	**334,780**	**339,394**	**341,706**
Change in Full MA over Prior DY	7.5%	-1.5%	-5.3%	10.1%				5.8%

Notes to Table III.1:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the four prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. “03: Children with Special Healthcare Needs (CHSCN)” includes Budget Populations, “08: Substitute Care” and “09: CSHCN Alt.”
3. “07: CHIP Children” includes members eligible under CMS 64.21U and CMS 21. The former reflects the state’s CHIP Expansion program for low-income children, whereas the later includes pregnant women and unborn children who are eligible under the Separate CHIP program. Only the CMS 64.21U eligible members are eligible under the Rhode Island’s 1115 financial reporting and so included above. Details on the members excluded from this Budget Population for purposes of calculating Rhode Island’s Budget Neutrality PMPM are shown in Table III.1b.
4. "10: Elders 65+" includes members eligible under the (a) Office of Health Aging (OHA) CNOM program to assist elders paying for medically-necessary Adult Day and Home Care services, and (b) Medicare Premium Payment (MPP) Only (i.e., QMB Only, SLMB, and Qualifying Individuals). The MPP Only subgroup, however, are excluded for purposes of calculating PMPM b/c these costs are invoiced in aggregate and only reported under "02: ABD TPL.” Details on this Budget Population are shown in Table III.2.
5. "Hypothetical 03: IMD SUD" are reported here for informational purposes. The expenditures (for Budget Services 11 per the Rhode Island’s 1115 Waiver) for such members are reported under the member’s underlying eligibility group. Where these members appear for purposes of calculating Rhode Island’s Budget Neutrality PMPM are shown in Table III.3.
6. “22: New Adult Group” and “Low-Income Adults” are used interchangeably.

Table III.2. Medicaid-Eligible members excluded for 1115 Budget Neutrality Calculations

	DY09	DY10	DY11	DY12	DY13			
					Mar-21	Jun-21	Sep-21	Dec-21
07: CHIP Pregnant & Unborn	991	1,464	1,116	1,487	1,694	1,924	2,114	2,275
10: Elders 65+ - MPP Only	7,092	7,813	8,281	7,488	7,953	8,029	8,099	8,094
99: Base	16	15	14	14	14	14	14	14

Notes to Table III.2:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the four prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. "07: CHIP Pregnant & Unborn" are members eligible under Rhode Island's Separate CHIP program. Their expenditures are reported under form CMS 21 and not included in the 1115 waiver reporting. Nor are these members included in **Table III.1**.
3. "10: Elders 65+ MPP Only" includes members eligible exclusively for support with their Medicare premium payments (i.e., QMB Only, SLMB, and Qualifying Individuals). The MPP Only subgroup is included in **Table III.1** but are excluded for purposes of calculating PMPM b/c these costs are invoiced in aggregate and only reported under "02: ABD TPL."

Table III.3. Medicaid-Eligible members receiving IMD SUD Services (Budget Services No 11)

	DY09	DY10	DY11	DY12	DY13			
					Mar-21	Jun-21	Sep-21	Dec-21
01: ABD no TPL	80	130	81	104	96	100	94	101
02: ABD TPL	39	34	20	32	29	30	32	25
03: Rite Care	76	70	42	58	48	71	62	59
04: CSHCN	2	4	2	1	2	3	4	2
14: BCCPT						1	1	
21: 217-like	1			1	3	2	2	
22: New Adult Group	492	510	375	486	474	554	555	487
Grand Total	**690**	**748**	**520**	**682**	**652**	**761**	**750**	**674**

Notes to Table III.3:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the four prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. Members using IMD SUD Budget Services meet the following criteria within the quarter:
   - Full Medicaid benefits
   - Aged between 21 and 64 years old inclusive
   - Have at least one residential stay for SUD purposes at an state-designated IMD within the fiscal quarter. Current list of IMDs providing with 16+ beds for SUD-related services include: The Providence Center, Phoenix House, MAP, Bridgemark, Adcare, and Butler Hospital

Number of Enrollees that Lost Eligibility

The number of enrollees eligible in the prior quarter who had lost eligibility for full Medicaid benefits as of the last day in the current quarter is **5,655**.

The cumulative count of terminations in the current demonstration year is **13,580**. This is less than the sum of the individual quarterly counts as some member would have regained eligibility within a subsequent quarter. The comparatively low number of members who have lost eligibility in the current quarter and Demonstration Year is due in part to the general moratorium on redeterminations.

Please note that prior reporting reflected the gross count of members who lost eligibility within a budget population and not members who lost general eligibility. That is, members who moved to a new budget population would count as having lost eligibility in their previous eligibility group in the current quarter. The above reflects only those that lost all forms of Medicaid eligibility.

Table III.4 Medicaid-eligible members that Lost eligibility in Current DY's Quarter and past 4 Demonstration Years

	DY09	DY10	DY11	DY12	DY13				
					Mar-21	Jun-21	Sep-21	Dec-21	YTD
01: ABD no TPL	642	1,144	1,072	549	139	155	189	174	599
02: ABD TPL	2,905	3,790	3,760	3,271	728	490	554	412	2,072
03: Rite Care	12,369	15,142	20,538	5,443	965	1,019	1,142	2,307	4,781
04: CSHCN	753	958	856	288	60	104	139	126	416
05: Family Planning	397	424	550	195	13	19	7	44	86
06: Pregnant Expansion	11	8	10	2	1			4	2
07: CHIP Children	1,811	4,198	4,868	1,562	217	242	215	559	1,085
10: Elders 65+	522	688	1,179	1,555	36	19	18	19	404
14: BCCPT	14	35	20	9		1	1	1	2
15: ORS CNOM				5	269	291	264	344	1
17: Early Intervention	1,202	1,186	1,383	1,097	275	289	300	254	1,014
18: HIV	120	134	154	72	37	34	12	4	60
21: 217-like	304	346	343	390	112	87	78	107	354
22: New Adult Group	15,214	17,047	20,132	5,638	886	1,241	1,132	1,965	4,269
27: Undocumented	12	13	35	8	11	8	112	9	88
Grand Total	**36,276**	**45,113**	**54,900**	**20,084**	**3,749**	**3,999**	**4,163**	**6,329**	**15,233**
Subtotal - Full MA Only	**34,023**	**42,668**	**51,599**	**17,152**	**3,108**	**3,339**	**3,450**	**5,655**	**13,580**

Notes to Table III.4:

1. Loss of Eligibility reflects complete loss of Medicaid eligibility between subsequent reporting periods (i.e., member was eligible on March 31 but no longer eligible on June 30). Members who move from one eligibility group to another are not reported herein; nor are members who gained and lost eligibility within the same quarter.
2. Annual counts of members losing eligibility compares subsequent December 31 snapshots. Only those that lost all eligibility are counted. Members who lost eligibility and regained eligibility prior to end of DY would not be included; nor are members who gained and lost eligibility within the same DY.

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 by quarter in the current Demonstration Year as well as the average quarterly counts in the prior four demonstration year are below.

Please note that prior reporting did not include the new independent provider program that is considered a self-directed program. Current and prior periods are reflected with updated/corrected counts.

Table IV.1. Self-Directed/Personal Choice New-to-Continuing Ratio

	DY09	DY10	DY11	DY12	DY13				
					Mar-21	Jun-21	Sep-21	Dec-21	YTD Avg.
New	21	19	28	28	47	77	82	64	68
Continuing	453	455	478	506	494	530	597	661	571
Grand Total	**474**	**473**	**506**	**534**	**541**	**607**	**679**	**725**	**638**

Notes to Table IV.1:

1. Self-Directed includes Personal Choice and Independent Provider models as administered by Medicaid.
2. Additional self-directed members with an I/DD are administered by the Department of Behavioral Health, Developmental Disabilities, and Hospital, but are not reported herein.
3. "New" is defined as a member eligible for services on the last day of the quarter and not previously eligible for services on the last day of the prior quarter. "Continuing" means that the member maintained eligibility for services across subsequent quarters.
4. For prior demonstration data, the counts reflect the average of the quarter-ending results within the year.

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during DY13 January 1, 2021 – December 31, 2021 (by category or by type) with a total of **$13,334.65** for special purchases expenditures.

Q 1 2021	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Over the counter medications		$ 606.78
	17	Acupuncture		$ 1,445.00
	7	Massage Therapy		$ 525.00
	1	Medic alert		$ 59.99
	12	Service Dog Training		$ 1,500.00
	CUMULATIVE TOTAL			**$4,136.77**

Q2 2021	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter medications		$ 143.27
	4	Acupuncture		$ 340.00
	2	Massage Therapy		$ 150.00
	3	Service Dog Training		$ 375.00
	CUMULATIVE TOTAL			**$1,008.27**

Q3 2021	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	2	Over the counter medications		$ 446.58
	14	Acupuncture		$ 1,190.00
	17	Service Dog Training		$2,125.00
	1	Medical Supplies		$ 139.98
	3	Alan Cathers		$ 55.97
	CUMULATIVE TOTAL			**$3,957.33**

Q4 2021	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	4	Over the counter medications		$ 869.08
	12	Acupuncture		$ 1,020.00
	13	Service Dog Training		$1,725.00
	8	Massage Therapy		$ 600.00
	1	Protein Powder		$ 18.00
	CUMULATIVE TOTAL			**$4,232.08**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for January 1, 2021 – December 31, 2021.

Innovative Activities

Health System Transformation Project

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

Health Workforce Development Program

1. Continued collaborative efforts between Medicaid, RI Department of Labor and Training, Institutions of Higher Education (IHEs), RI Department of Health, and Commission on the Deaf and Hard-of-Hearing 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. Provided guidance and support regarding program and policy changes related to the COVID-19 pandemic

2. Assisted in the development of workforce objectives and metrics related to the development of an LTSS APM.

3. Explored opportunities to align and leverage enhanced HCBS FMAP workforce investments with HSTP workforce investments.

3. 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.

Accountable Entities (AEs)

Q1 2021

- All Accountable Entities that qualified to enter into a risk-based contracts achieved pre-qualification to bear downside risk in contracts with Medicaid Managed Care Organizations (MCO's) for Program Year 4 on March 15, 2021.

- All certified Accountable Entities re-applied for PY4 Certification. Of the six that applied, five were fully certified and one was certified with a final condition that must be met by June 30,2021.
- One new applicant applied for certification for the PY4 program year and was certified with conditions.
- AE's continued working remaining project milestones for PY2 as they continued working on PY3 HSTP Milestones. All AE PY4 project plans were received in March and meetings were scheduled with each AE to review with EOHHS and the Managed Care Organizations.

- EOHHS focused on Operations for PY3 and preparation for PY4 implementation through meetings and preparing final guidance and documentation for AE's and MCO's on the following topics:
    - Reviewing the TCOC PY4 Implementation process and updates to the TCOC data requests due to the entrance of a newly certified Accountable Entity;
    - Reviewing PY3 quarter 1 TCOC performance with the AE's and MCO's.

- EOHHS continued to work with Bailit Health on the ongoing purpose of the AE/MCO Quality Work Group, which is to adopt updated measure specifications and review measures and/or the incentive methodology for the current (i.e., OPY/QPY4) and next performance year (i.e., OPY/QPY5).
- 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, CHCS s facilitated an open forum call with AE's on Patient Engagement in February and REL Data Collection in March.
- The HSTP Advisory Committee held one meeting in February. The February meeting included a presentation by the Providence Community Health Center on their PY3 Outcome Performance Improvement Project: PCHC Diabetes Management and Avoidable ED Visits and program updates on AE Certification/Re-Certification; the procurement of a Community Resource Platform (CRP) RFP; the Rhode to Equity (R2E) RFA initiative that is a part of HSTP SDOH strategy and an update on the status of the Managed Care Procurement.

Q2 2021

- All Accountable Entities re-applied for PY4 Certification. Of the six that applied, five were fully certified on April 30, 2021 and one was certified with a final condition that must be met by June 30, 2021. The final condition was met by the deadline and the AE was fully certified for Program Year 4.
- AEs continued working remaining project milestones for PY2 as they continued working on PY3 HSTP Milestones. All AE PY4 project plans were received in March and meetings

were scheduled with each AE to review with EOHHS and the Managed Care Organizations. All PY4 project plans were approved in May after requested updates were made.

- EOHHS focused on Operations for PY3 and preparation for PY4 implementation through meetings and preparing final guidance and documentation for AE's and MCO's on the following topics:
    - Reviewing the TCOC PY4 Implementation process and updates to the TCOC data requests due to the entrance of a newly certified Accountable Entity;
    - Reviewing PY3 quarter 1 TCOC performance with the AE's and MCO's.

- EOHHS continued to work with Bailit Health on the ongoing purpose of the AE/MCO Quality Work Group, which is to adopt updated measure specifications and review measures and/or the incentive methodology for the current (i.e., OPY/QPY4) and next performance year (i.e., OPY5/QPY5).

- Under the contract 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, CHCS facilitated two webinars in April on "Supporting Effective Team-Based Primary Care through Medicaid Managed Care" and "Building Trust with Patients".

- The HSTP Advisory Committee held two meetings in April and June. The April meeting included a presentation on the States' initiatives to address Social Determinants of Health including the "Rhode to Equity" challenge Funded by RI Executive Office of Health and Human Services (Health Systems Transformation Project (HSTP) and RI Department of Health to build place-based teams with local partners and community residents funded to improve population health with an equity lens; apply evidence-based Pathways to Population Health tools to more effectively build responsive community-clinical linkages that improve health (physical and behavioral) and social outcomes and use clinical and community data to identify population health needs, test strategic actions, and build sustainable community solutions. The June meeting focused on PY2 Total Cost of Care Results, Workforce Initiatives, LTSS Resiliency including the proposed LTSS APM and the Hospital Care Transitions Initiative (HCTI).

Q3 2021

- Seven certified Accountable Entities began Program Year 4 operations. Of the seven AEs, three entered into the first year of down-side risk contracts. The remaining four AEs that are Federally Qualified Health Centers (FQHCs) will remain in shared savings-only contracts if they progress towards value-based care and alternative payments as evidenced by an EOHHS-approved proposal demonstrating a positive ROI. Such proposals may include the development of evidence-based processes, incentives for

cost reduction, and the establishment of sustainability for interventions currently funded by grants.

- AEs continued working remaining project milestones for PY3 as they continued working on PY4 HSTP Milestones. All AE PY4 project plans were received in March and meetings were scheduled with each AE to review with EOHHS and the Managed Care Organizations. All PY4 project plans were approved in May after requested updates were made.

- EOHHS continued to work with Bailit Health on the ongoing purpose of the AE/MCO Quality Work Group, which is to adopt updated measure specifications and review measures and/or the incentive methodology for the current (i.e., OPY/QPY4) and next performance year (i.e., OPY5/QPY5).

- Under the contract 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, CHCS facilitated a webinar in September on "Screening for and Addressing Adverse Childhood Experiences (ACEs)".

- The HSTP Advisory Committee held one meeting in September. The September meeting included a review of program updates; a budget update; a review of the final HSTP Roadmap and Sustainability Plan and review of proposed changes to the Program Year 5 Requirements

- The States' initiative to address Social Determinants of Health, the "Rhode to Equity" challenge Funded by RI Executive Office of Health and Human Services (Health Systems Transformation Project (HSTP) and RI Department of Health to build place-based teams with local partners and community residents funded to improve population health with an equity lens; apply evidence-based Pathways to Population Health tools to more effectively build responsive community-clinical linkages that improve health (physical and behavioral) and social outcomes and use clinical and community data to identify population health needs, test strategic actions, and build sustainable community solutions began the first year of a now two year challenge. Teams successfully completed all quarter one deliverables including the Challenge Kick-Off, participating in coaching sessions and workshops and individual team meetings.

Q4 2021

- Program Year 5 (PY5) Roadmap, Sustainability Plan and Program Requirements were posted for public comment, finalized and submitted to CMS.
- EOHHS focused on Operations for PY4 and preparation for PY5 implementation through meetings with stakeholders on program changes, posting the updated Certification

application and project plan, communicating PY3 Q4 TCOC performance and communicating PY3 Quality performance.

- All AEs achieved the 75% threshold for onboarding practices to the ECDE platform except Prospect Community Health center under their contract with United Health Care.
- AE's continued working on remaining project milestones for PY3 as they began working on Q1 PY4 HSTP Project Plan Milestones.
- EOHHS continued to work with Bailit Health on the ongoing purpose of the AE/MCO Quality Work Group to adopt updated measure specifications and review measures and/or the incentive methodology for the current performance year (i.e., OPY/QPY4) and next performance year (i.e., OPY/QPY5).
- 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, CHCS s facilitated a Fall Meeting in October that covered Best Practices for Effective SUD and AUD Treatments and a webinar in November on Homelessness.
- The HSTP Advisory Committee held meetings in September and December. The September meeting included an update on the HSTP budget, an update on the changes to the Roadmap and the Sustainability plan and the proposed changes to the PY5 Program Requirements. The December meeting agenda included program updates, a presentation by the Rhode Island Department of Health on the Community Health Network, a report out by the AEs on how they integrated Community Health Workers into their practices and a review of PY3 Quality Performance.

DSHP State Spending Analysis

The amount of federal matching funds for support of DSHPs in SFY 2021 ($26,875,734) decreased by approximately $5.66 million from SFY 2020 ($32,539,890).

Health Graduates Employment Data*

This table represents the graduates by Rhode Island's Institutions of Higher Education (University of Rhode Island, Community College of Rhode Island, and Rhode Island College) detailed by professional type/program from which they graduated. All fields of educational study are designated with a Classification of Instructional Program (CIP) Code which is a taxonomic scheme that identified the professional type/program that all participating schools can use. The data below is through academic year 2019-2020 and is the most recently available graduation and employment data for the FFP claims submitted for the States FY21.

*Receipt of the Health Graduates Employment Data was delayed until June. In order to provide one full year of employment post-graduations (as in previous submissions), EOHHS requires the

wage quarters from Dept. of Labor and Training (DLT) for 2020 Q4, 2021 Q1, 2021 Q2, and 2021 Q3. Unfortunately, there is currently a lag of 6+ months in receiving the Q3 data which was further delayed due to staffing turnover at DLT. EOHHS is pleased to now provide this data.

Health Graduates Employment Data		URI			URI			URI			CCRI			CCRI			CCRI			RIC			RIC			RIC		
		2017-2018 Grads			2018-2019 Grads			2019-2020 Grads			2017-2018 Grads			2018-2019 Grads			2019-2020 Grads			2017-2018 Grads			2018-2019 Grads			2019-2020 Grads		
CIP Code	CIPTitle	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC	Total	Employed in RI: All	Employed in RI: HC
41.03	Physical Science Technologies/Technicians.				0	0	0	0	0	0	5	5	2	17	11	1	17	9	1				0	0	0	0	0	0
42.01	Psychology, General.	202	133	98	215	111	71	239	120	79				0	0	0	0	0	0	29	25	17	157	111	76	142	97	65
42.28	Clinical, Counseling and Applied Psychology.	12	8	8	10	4	4	19	5	5				0	0	0	0	0	0	0	0	0	15	9	6	15	9	6
42.99	Psychology, Other.				0	0	0	0	0	0				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
44.07	Social Work.				0	0	0	0	0	0	1	1	1	14	11	9	14	11	9	2	2	2	194	148	121	196	136	114
51.00	Health Services/Allied Health/Health Sciences, General.				0	0	0	111	55	37				0	0	0	0	0	0	6	5	4	18	15	12	18	13	11
51.02	Communication Disorders Sciences and Services.	78	47	28	81	39	29	82	28	20				0	0	0	0	0	0				0	0	0	0	0	0
51.06	Dental Support Services and Allied Professions.				0	0	0	0	0	0	35	28	26	37	29	27	37	27	25	1	1	1	1	0	0	2	0	0
51.07	Health and Medical Administrative Services.	0	0	0	1	1	0	3	3	2	6	3	2	19	11	4	19	12	5	7	7	7	27	19	13	25	15	8
51.08	Allied Health and Medical Assisting Services.				0	0	0	0	0	0	31	25	21	42	33	31	42	31	29	1	1	1	0	0	0	0	0	0
51.09	Allied Health Diagnostic, Intervention, and Treatment Professions.				0	0	0	0	0	0	52	39	33	66	48	40	66	45	38	0	0	0	45	34	32	43	26	23
51.10	Clinical/Medical Laboratory Science/Research and Allied Professions.	45	32	20	39	20	18	49	25	20	3	37	33	50	38	33	51	38	33	0			1	1	1	1	1	1
51.15	Mental and Social Health Services and Allied Professions.				0	0	0	0	0	0	0	0	0	6	5	4	6	5	4	0	0	0	40	29	23	40	27	21
51.16	Nursing.				0	0	0	0	0	0				0	0	0	0	0	0	0			0	0	0	0	0	0
51.18	Ophthalmic and Optometric Support Services and Allied Professions.				0	0	0	0	0	0	4	4	3	2	2	2	2	2	2				0	0	0	0	0	0
51.20	Pharmacy, Pharmaceutical Sciences, and Administration.	136	86	77	123	37	31	124	28	25				0	0	0	0	0	0				0	0	0	0	0	0
51.22	Public Health.	1			0	0	0	0	0	0	2	1	0	0	0	0	0	0	0				1	1	1	0	0	0
51.23	Rehabilitation and Therapeutic Professions.	27	21	20	29	16	15	29	12	12				0	0	0	0	0	0				0	0	0	0	0	0
51.31	Dietetics and Clinical Nutrition Services.	45	30	23	75	20	10	77	20	8				0	0	0	0	0	0				0	0	0	0	0	0
51.35	Somatic Bodywork and Related Therapeutic Services.				0	0	0	0	0	0	5	4	3	7	4	1	8	5	2				0	0	0	0	0	0
51.38	Registered Nursing, Nursing Administration, Nursing Research and Clini	208	139	125	410	223	217	469	225	215	163	147	137	247	217	210	247	214	208	68	57	54	190	144	140	190	129	125
51.39	Practical Nursing, Vocational Nursing and Nursing Assistants.				0	0	0	0	0	0	0	0	0	25	22	22	25	22	22				0	0	0	0	0	0
Current	Totals	893	496	399	983	471	395	1202	521	423	307	294	261	532	431	384	534	421	378	114	98	86	689	511	425	672	453	374

Demonstration Public Forum/ Comment Opportunity

In CY21, the Health System Transformation Advisory Committee met five times:

- February 2, 2021
- April 1, 2021
- June 24, 2021
- September 14, 2021
- December 16, 2021

The Advisory Committee meetings are open to the public. Meeting times and agendas are shared with the state's "interested parties" email list and posted on both the EOHHS and Secretary of State's website at least 30 days before the meeting.

Meetings were conducted over Zoom for much of the pandemic period but resumed taking place at the EOHHS offices in September 2021.

The 1115 waiver demonstration is critical to the operation of Accountable Entities and health system transformation in the state. The HSTP Advisory Committee, therefore, is an important forum to discuss the progress of the demonstration and surface any concerns. In particular, the meetings are an opportunity for EOHHS staff to present updates and propose any program changes; for Accountable Entities and Medicaid managed care organizations to share updates and feedback; for other stakeholders to share updates and feedback; and for the general public to learn about the program and share feedback.

Regular attendees include: representatives of each Accountable Entity; representatives of each Medicaid managed care organization; representatives from consumer/advocacy organizations (One Neighborhood Builders, Economic Progress Institute of RI, Family Service of RI); representatives from non-AE providers; and representatives of state agencies (EOHHS; Behavioral Health, Developmental Disabilities, and Hospitals; Department of Health; Office of the Health Insurance Commissioner).

<u>Summary of public comment received at each meeting:</u>

<u>February meeting</u>:

Comment on presentation of Accountable Entity quality measures and performance data:

- Concern about the impact of COVID on patients receiving blood pressure screening and mammogram.
- Discussion of best practices around outreach and referrals – and equity issues with referrals, where patients may be refused appointments/referrals to mammography centers due to past no-shows. Also language barriers are a concern, with limited bilingual capacity. Mobile mammography can work, and evening/weekend walk-in hours can, too.

- For diabetic A1C testing, concern that again having to go to a different location for blood draws is a barrier, and potential that adding coverage for home testing machines would make a big difference.
- For the mental health hospitalization 30-day follow-up, discussion around data sharing as a need/barrier. Feedback that performance can/should be higher across AEs – it is well below the rates of follow up after non-mental health inpatient admissions, for which the information sharing is much better. There is difficulty for AEs in knowing when a member has been discharged from a psych facility because the info does not come through the ADT feed. MCOs are working to get the information to the AEs. Specific concern about data privacy and interpreting both federal and state law both too strictly and in varying ways across providers.
- For BMI assessments, feedback was that hybrid measures may reflect differences in self-reported rates rather than underlying performance differences.

Comment on presentation on diabetes management and avoidable ED visits with clinical pharmacist intervention:

- General excitement about the model of leveraging pharmacists for diabetes management.
- Feedback on the difficulty of finding bilingual clinical pharmacists and the importance of workforce development statewide. Since pharmacists are highly trusted and be effective counselors to patients, worth considering a larger strategic plan for pathways and recruitment.
- Agreement that this type of approach can impact total cost of care, and the total cost of care methodology is an incentive to pursue it.

<u>April meeting</u>:

Comment on presentation on a joint HSTP project with the RI Department of Health, called Rhode to Equity, as well as a presentation by a leader at a clinic that participates in one of the AEs who had worked with RIDOH on a related project, the Diabetes Health Equity Challenge:

- Interest in understanding the definition of equity/inequity – whether it includes race/ethnicity, income, disability, etc.
- Comment that home health workers may be important to these efforts.
- Questions on the data sources that will be available, how the funding will work, how applications for Rhode to Equity will work.
- Questions on the role of the Health Equity Zones.
- Questions on the potential for partnership with the state agriculture department and the Food and Nutrition Policy Council.
- General positive feedback that the idea of Rhode to Equity is a good one.

<u>June meeting</u>:

Comment on total cost of care (TCOC) methodology explanation and Program Year 2 results:

- With respect to differences in performance across MCOs, this would be expected even with identical models (which were not in place for PY2). This is more likely with smaller patient panels.
- Questions regarding how the models accounted for differences in AEs' efficiency at baseline – this was a required component for years 1 and 2, but the plans approached it differently, and for year 3 it will be handled the same way for all plans.
- Question of the impact of spending for the population with intensive behavioral health needs and discussion of how the new custom weights in the program year 3 risk adjustment method account for this more effectively.
- Question whether the state tried to account for the impact of COVID and concern that some external "shocks" could unfairly harm AE savings opportunities. Discussion of the importance of ensuring that baseline data is appropriate to compare to performance data, and that EOHHS is committed to ensuring that a year like 2020, with known depressed utilization, is not used as a baseline.
- Questions regarding adverse selection and risk adjustment in general, as well as ongoing interest in better understanding the market/efficiency adjustment.
- Questions on whether the state will apply the current TCOC methodology to past years' data to see the impact of the method. (This is not feasible with limited resources.)

Comment on presentation on HSTP workforce development work:

- Feedback that this is really good work and a great program.
- Question whether the Real Jobs partnerships must be hosted by AEs – response that these projects do focus on AE-driven projects.

Comment on LTSS presentation:

- Comment recommending inclusion of adult day in the discussion and questioning why it was not a focus.
- Recommendation to consider opportunities to expand education and connection between home care and primary care.
- Recommendation to support home modifications and in-community housing to support aging in place and discussion of how the housing stock, especially in the urban core, is not amenable to this.
- Need to retain focus on building self-directed care capacity.
- Concern about LTSS APM being limited to managed care, since only about half of dual-eligible members are in managed care.
- General excitement for the LTSS APM design phase. Question whether we can focus on "pre-Medicaid" population for LTSS reimbursement to keep people at home, since once they are in a nursing facility getting back out is very hard.
- Recommendation to consider expanding income eligibility for Health Aging homecare program.

Comment on Hospital Care Transitions Initiative presentation:

- Intervention is impressive, well-constructed, and complements and overlaps current services.
- Idea that it would be great to have gaps in care flagged by MCOs.

<u>September meeting</u>:

Comment on AE program budget update and sustainability:

- Question on what we are focused on when considering sustainability.
- Concern that AEs will not be able to meet quality gate and will earn less shared savings, impacting sustainability.
- Question on the reasons for wide variation in the budget variations across AEs (what AEs say they spend). Agreement that getting numbers that support a better apples-to-apples comparison is importance.
- Questions on how to understand the cost for unengaged members, on whom very little is spent. Questions on how to separate the costs for AE members, specifically, to support sustainability/budget reporting.
- Comment that we cannot rely on shared savings to sustain AE activities.

Comment on PY5 Program Requirements:

- Question on how the risk-bearing provider organization certification process works and how much administrative work it will be.
- Discussion of concerns regarding quality measurement and how we will do race/ethnicity, language, and disability stratification. Questions around how we can collect better race/ethnicity data as part of the Medicaid application process.
- Discussion of how the incentive program intersects with total cost of care downside risk.
- Appreciation for state consideration of previous feedback on AE Certification Standards during informal meetings.

<u>December meeting</u>:

Comment on community resource platform presentation:

- Can the Unite Us system be used for case management?
- Question on how AEs are using the system.
- Question on how the closed loop feature is working.
- Discussion among AEs who use the system to describe to others how the workflow works.

Comment on presentation on RI Dept of Health Chronic Disease Prevention and Management programs:

- Can referrals to these programs go through Unite Us (yes).
- Is texting an option? (not yet).
- Question whether the programs can be modified at all – they are evidence-based but there may be ways to modify within the structure.

Comment on community health worker benefit:

- Confirmation that this will be a FFS not managed care benefit.
- Question whether there will be any rate differentials for specialized certifications.
- Discussion of how utilization management will/should work, especially concern that the daily limit of 3 hours absent a prior authorization would be a barrier. (Note that the state subsequently removed that limit in response to community feedback.)
- Questions on CHW billing operations, including for FQHCs and dual-eligible members.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in DY 13 January 1, 2021 – December 31, 2021.

As described in more detail below, Rhode Island has made major progress across a range of Medicaid initiatives.

The State and Deloitte worked diligently to implement software releases that will improve functionality for customers and workers.

During DY 13, Rhode Island made substantial updates to the Medicaid State Plan, submitting 26 State Plan Amendments (of which 23 have been approved and three remain under discussion with CMS). These SPAs included updates to properly reflect payment methodologies and comply with a range of federal requirements, as well as enhancements to the state benefit package (e.g., adding Community Health Worker and Doula services) and provider rate increases made possible through the Enhanced FMAP provisions of the American Rescue Plan Act.

The State looks forward to continuing to update the Medicaid State Plan in DY 14, including with SPAs to cover new services aimed at children and families (First Connections, Parents as Teachers, postpartum continuous eligibility) and to enhance access to nursing facilities and mental health psychiatric rehabilitative residences for certain beneficiaries with behavioral health conditions.

In addition, Rhode Island embarked on a major effort to improve oversight and quality monitoring for HCBS. With invaluable assistance from CMS' technical assistance vendor New Editions, the State is on track to resolve compliance concerns and ensure quality.

Finally, the State has implemented provider rate increases, in some but not all cases leveraging American Rescue Plan Act funding. This has been a vital step to protect access to care for beneficiaries at a time of major workforce limitations across the healthcare section, in Rhode Island and nationally.

The State also wishes to note that DY 13 saw a significant staff turnover in the Medicaid Policy team. While the current staff received excellent guidance from departing team members, there has been a great deal to learn. The State appreciates the support from CMS throughout this process and looks forward to ongoing collaboration.

Modernizing Health and Human Services Eligibility Systems

DY13 Q1
Between January 1, 2021 and March 31, 2021, the Deloitte and State teams implemented three (3) software releases to address 121 data incidents and 14 software enhancements for the RI Bridges eligibility system. These releases improved services for RIte Share, Medicaid Eligibility & Enrollment, Long-Term Services and Supports (LTSS) as well as functionality improvements to customer and worker interfaces. No significant program development or issues were identified.

DY13 Q2
Between April 1, 2021 and June 30, 2021, the Deloitte and State teams implemented two (2) software releases to address 82 data incidents and 10 software enhancements for the RI Bridges eligibility system. These releases improved services for RIte Share, Medicaid Eligibility & Enrollment, Long-Term Services and Supports (LTSS) as well as functionality improvements to customer and worker interfaces. RI Bridges also received a system upgrade to Oracle v12 processing automation in May. No significant program development or issues were identified.

DY13 Q3
Between July 1, 2021 and September 30, 2021, the Deloitte and State teams implemented four (4) software releases to address 153 data fixes and 18 software enhancements for the RI Bridges eligibility system. These releases improved services for RIte Share, Medicaid Eligibility & Enrollment, Long-Term Services and Supports (LTSS) as well as functionality improvements to customer and worker interfaces. No significant program development or issues were identified.

DY13 Q4
Between October 1, 2021 and December 31, 2021, the Medicaid Systems team and Deloitte implemented five (5) software releases to address 349 data fixes and 49 software enhancements for the RI Bridges eligibility system. These releases improved services for RIte Share, Medicaid Eligibility & Enrollment, Long-Term Services and Supports (LTSS) as well as functionality improvements to customer and worker interfaces. No significant program development or issues were identified. The systems team also began initial phases of Centers for Medicare and Medicaid (CMS) Eligibility & Enrollment system certification for RI Bridges. Tentative date for certification review with CMS is March 3, 2022.

HCBS Quality Improvement

Q1-Q3 Activities:
CMS imposes quality measure and reporting requirements for 1915(c) home and community-based services (HCBS) under 42 CFR §§ 441.301-441.303. These HCBS quality requirements are incorporated as 6 assurances and 17 sub-assurances in STC 22 and Attachment F of Rhode Island's 1115 Waiver. STC 22 requires the state to develop a Quality Assurance System (QAS) and Quality Improvement Strategy (QIS) for HCBS, with specific deliverables due to CMS throughout the five-year demonstration period.

In March 2021, per STC 22f, EOHHS submitted critical incident data—a report on the number of substantiated instances of abuse, neglect, exploitation, and/or unexplained death—for CY 2019 and CY 2020. CMS identified several respects in which the reporting was not in adherence to its annual reporting requirements.

In April 2021, CMS notified EOHHS of other concerns with the State's compliance with CMS' HCBS Quality expectations. Rhode Island began receiving free technical assistance through CMS' vendor, New Editions, to design and implement an approach for the State to meet CMS' requirements. With New Editions, Rhode Island quickly developed a quality strategy to make progress towards CMS' objectives. The high-level plan is to (1) develop a set of performance measures; (2) identify, collect, and regularly report data on each performance measure; (3) submit an evidence report on March 31, 2022; and (4) if necessary, develop a corrective action plan for any measure reported under 86% compliance.

On April 30, 2021, RI held a kick-off meeting to engage stakeholders and discuss expectations of the various agencies that provide or oversee Medicaid-funded HCBS programs. The goal of this meeting was to provide the relevant background for the project and identify the agency representatives that would participate in a cross-agency quality improvement team. The kick-off meeting was followed by a series of more focused meetings between May and August 2021 to discuss and identify data sources for each of the six assurances in the 1115 Waiver—Administrative Authority, Level of Care, Certified Providers, Service Plan, Health and Welfare, and Financial Accountability. These meetings were designed to better understand each assurance, focus more specifically on each agency's existing processes for oversight, and develop performance measures.

Through these meetings, the HCBS Quality cross-agency stakeholder group developed a set of 22 performance measures to demonstrate compliance with each of the sub-assurances described in the 1115 Waiver. A draft of these measures was submitted to CMS in September 2021. All state agencies reported that they can participate in both prospective and retrospective case record reviews to collect data for these measures. Stakeholders agreed on a sampling methodology for the purposes of data collection.

Q4 Activities:

In quarter 4, monthly meetings with CMS continued in addition to frequent meetings with New Editions. CMS initiated a technical assistance plan with a specific timeline and deliverables to be met by EOHHS in DY 14. The State continued to make progress towards compiling data and submitting the required information to CMS on time. The Technical Assistance plan included the following objectives and associated milestones:

1. **Develop HCBS performance measures, QAS, and QIS (STC 22c and 22g).** As previously noted, the draft performance measures were submitted in September 2021. The QAS deadline was set for January 31, 2022.
2. **Report the number of unduplicated individuals served and estimate the number for CY 2022 (STC 22h).** The due date for the sampling methodology was set for January 31, 2022, with reports for CY 2019 through CY 2021 and estimates for CY 2022 due February 28, 2022.
3. **Report deficiencies found during monitoring and evaluation of HCBS assurances and develop a remediation structure (STC 22f).** The plan for a reporting structure and remediation is due March 1, 2022, with actual reporting incorporated into Item 5, due March 31, 2022.
4. **Report substantiated instances of abuse, neglect, exploitation, and unexplained death (critical incidents) (STC 22f).** A list of delegated HCBS functions is due January 31, 2022, with comprehensive critical incident reports for CY 2019 through CY 2021 due June 30, 2022.
5. **HCBS evidentiary report (STC 22d)** for CY 2019 through CY 2021 due March 31, 2022.

In quarter 4, CMS also reviewed and provided feedback on the draft performance measures submitted in September. EOHHS made the requested edits and submitted a final set of performance measures on December 21, 2021. EOHHS continued to work with New Editions and the cross-agency team to implement these performance measures to be incorporated into the evidentiary report due on March 31, 2022. As part of this process, New Editions and EOHHS held separate meetings with each agency to discuss the retrospective review process in more detail, with a large focus on the data collection process and methods. EOHHS also held discussions with its internal data analytics team to finalize the methodology for identifying the HCBS population in order to report on the number of unduplicated individuals served consistent with STC 22(h). Opportunities for improvement and system changes were identified throughout this process and are being incorporated into a work plan that will inform the next phase of this work.

<u>Challenges and Steps to Address Challenges:</u>

Because of the wide array of HCBS programs and different procedures in place for the State agencies responsible for oversight, the State faced several challenges with the HCBS Quality project in DY 13 and took steps to address them:

- **Understanding sister agency roles and responsibilities in demonstrating quality assurance.** To address this challenge, the State convened a cross-agency team, which includes the EOHHS data analytics team, to develop improved processes for collecting, reporting, and analyzing data consistent with the overall goals of the HCBS Quality

project. EOHHS recognizes that, as the State Medicaid Agency, it is responsible for ensuring that HCBS Quality oversight is not siloed and, instead, is conducted uniformly across the agencies. This team also emphasizes that every agency providing Medicaid-funded HCBS is expected to participate and contribute.

- **Distinguishing HCBS participants from other Medicaid recipients under the 1115 Waiver.** The goal is to continue to communicate expectations and streamline reporting so that Rhode Island can report consistent and reliable data across all agencies and performance measures. Ongoing conversations with the cross-agency team and New Editions continue to identify and rectify the barriers that are unique to each agency.
- **Identifying data sources and addressing gaps in data.** To address this challenge, the cross-agency team met frequently with New Editions to understand the expectation and identify how each agency can capitalize on their existing processes. Ongoing conversations with the cross-agency team will ensure that all stakeholders understand and develop a standardized methodology to report data and demonstrate ongoing compliance.
- **Applying consistent definitions, especially for critical incident reporting.** To address this challenge, the State's goal is to establish a policy to provide a standardized definition of critical incidents and develop a process for centralized reporting, investigation, and remediation.
- **Education.** Rhode Island recognizes the importance of regularly educating HCBS participants and their families/guardians of their rights as well as how to report allegations of abuse, neglect, and exploitation. Rhode Island agencies do not have consistent practices to provide such education and it is recommended that processes and tools be developed to do so. Rhode Island plans to address this in the conversations about centralized critical incident reporting.
- **Provider training.** EOHHS offers provider training ranging from new provider orientation sessions and billing to training to targeted HCBS providers regarding specific policies and practices. A formal policy and practice for provider training does not currently exist. Therefore, this information and data is not captured. One of the priorities of the newly established HCBS quality team will be to standardize provider training requirements.

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the period of January 1, 2021 –December 31, 2021.

Request Type	Description	Date Submitted	CMS Action	Date
SPA	Cost Based Reimbursement for Government-Owned and Operated Hospitals	5/5/20	Approved	3/25/21
SPA	Medicaid Disaster Relief for the COVID-19 National Emergency – Coverage of Experimental Drugs/Treatments for COVID-19	1/21/21	Approved	4/20/21
SPA	Medication-Assisted Treatment	3/30/21	Approved	6/25/21
SPA	Home Equity Limits	3/30/21	Approved	5/10/21
SPA	Medically Needy Income Limit (MNIL)	3/30/21	Approved	5/28/21
SPA	GME Payment Increase	5/17/21	Approved	5/25/22
SPA	Covid 19 Vaccines and Vaccine Administration	5/17/21	Pending	N/A
SPA	Psychiatric Residential Treatment Centers (PRTF)	6/29/21	Pending	N/A
SPA	21-0008 GME Elimination	8/13/21	Approved	5/25/22
SPA	21-0009-Home Home Care Rate Increases and Enhancements	9/7/21	Approved	5/24/22
SPA	21-0010-Hospice	8/13/21	Approved	5/24/22
SPA	21-0011-Inpatient UPL Payments	8/16/21	Approved	6/7/22
SPA	21-0012-Community Health Workers (CHW) Services	9/28/21	Approved	5/24/22
SPA	21-0013-Doula Services	9/28/21	Approved	5/24/22
SPA	21-0014-Category F Elimination	11/23/21	Approved	2/10/22
SPA	21-0015- Nursing Home Minimum Staffing	12/3/21	Approved	6/7/22

Request Type	Description	Date Submitted	CMS Action	Date
SPA	21-0016- Inpatient Inflation Update	12/3/21	Approved	5/25/22
SPA	21-0017- Outpatient Inflation Update	12/6/21	Approved	5/24/22
SPA	21-0018- ARPA Adult Day Rate Increase	12/10/21	Approved	3/8/22
SPA	21-0019-ARPA Home Care Rate Increase	12/10/21	Approved	3/10/22
SPA	21-0020- ICF	12/23/21	Approved	6/16/22
SPA	21-0021- Congregate Dental	12/23/21	Approved	5/24/22
SPA	21-0022-NEMT	12/23/21	Approved	1/21/22
SPA	21-0023-Third Party Liability (TPL) Federal Compliance	12/23/21	Approved	2/3/22
SPA	21-0024-Tribal NIHC	12/23/21	Approved	5/25/22
SPA	21-0025-ARPA ACT Rate Increase	12/23/21	Pending	N/A
SPA	21-0026- ARPA Adult BH Rate Increase	12/23/21	Approved	3/16/22

Other Programmatic Changes Related to the 1115 Waiver

HCBS MNA Increase

In order to enable EOHHS to provide sufficient support for Individuals who are able to, and wish to, receive services in their homes, EOHHS increased the Home and Community Based Services (HCBS) Maintenance of Needs Allowance from one hundred percent (100%) of the Federal Poverty Limit (FPL) plus twenty dollars ($20) to three hundred percent (300%) of the Federal Social Security Income (SSI) Benefit rate. This allows individuals who are living in the community receiving HCBS to be able to keep more of their income for living expenses. 210-RICR-50-00-8 was amended to reflect this change and the amendment became effective on September 2, 2021.

Rate Increases

Shared Living

Pursuant to the Enacted SFY 22 RI State Budget, effective July 1, 2021, EOHHS is increasing specific FFS and MCO shared living rates by 10%. This increase was included in a LTSS resiliency package that seeks to bolster RI's HCBS capacity, as Shared Living expenditure currently comprise only 0.5% of all RI Medicaid expenditures and fewer than 300 individuals utilize this

service. Our recent data show Medicaid eligible persons aged 65 and older have an interest in Shared Living as there was a 23% increase in utilization from 2018 to 2019, and shared living had the fastest growing utilization among home care, adult day services, and assisted living, if there were additional care givers available, EOHHS believes the service would see additional utilization shift from these settings.

Unlike HCBS, nursing facilities, and hospice rates, Shared Living rates do not receive annual increases based on inflationary indices. Since these rates are much lower than other HCBS rates, caregivers are less incentivized to provide Shared Living arrangements, limiting their availability as a viable HCBS service. The average payment rate for Medicaid Shared Living services in RI (prior to this July 1, 2021 rate increase) is 15% lower than the average Medicaid shared living rate in Massachusetts and 13% lower than the rate in Connecticut.

Assisted Living Tiered Rates

Pursuant to the Enacted SFY 22 RI State Budget, effective October 1, 2021, EOHHS will create an acuity-based tiered payment system for Assisted Living with each tier tied to the services required to meet the beneficiary's needs. All tier payments cover core services (personal care, homemaker, meal prep, medication cuing, therapeutic day and transportation) provided today. Tiers B and C cover an array of additional services required to meet a beneficiary's acuity needs. The enacted tier methodology is a 13%, 42%, and 75% increase above the current rate, depending on patient classification.

An assessment of the beneficiaries' clinical/functional need conducted when determining initial and continuing Medicaid LTSS eligibility will determine the per diem rate the ALR will receive for the beneficiary. EOHHS will pay an ALR the rate associated with a beneficiary's tier if the ALR meets the RIDOH licensure and Medicaid certification standards below. ALRs are paid for beneficiaries up to their level of certification- for example, a tier B ALR would be paid Tier A rates for all Tier A residents, Tier B rates for all Tier B residents, but not Tier C rates as the ALR is not certified to provide Tier C services.

EOHHS anticipates the cost of these reforms to be $3.3M in SFY 22.

Home Stabilization Rate Increase

Pursuant to the Enacted SFY22 RI State Budget, effective July 1, 2021, EOHHS is increasing the Home Stabilization rate from a rate of $145 PMPM to $331 PMPM.

This increase came after community agencies throughout the State reported to Home Stabilization representatives at EOHHS that the $145 was not a sustainable amount to justify becoming providers. Of the five current certified providers, there are no agencies from rural areas, and only one traditional homeless service provider. The only billing has come from the State's largest mental health provider, which has a large workforce and numerous funding sources for an array of different programs. Two other comparable State examples (Minnesota and Washington) show a much higher funding rate when compared with Rhode Island.

This increase is necessary to achieve a realistic, impactful, and stable housing first intervention for Medicaid beneficiaries experiencing homelessness and housing insecurity in Rhode Island. It will also create enough sustainability to allow a more diverse provider portfolio in terms of agency type, size, and location in assisting our most vulnerable population.

Direct Service Professionals Rate Increase

Pursuant to the State of Rhode Island's Consent Decree for individuals with intellectual and developmental disabilities (I/DD), the State has worked collaboratively with the Court and the provider community to update some assumptions in the current rate setting model (Burns and Associates model) that is currently used for the I/DD services codes.

The State has updated the base assumptions for the hourly wage of Direct Service Professionals (DSPs), to reflect a base assumption of $15.75 per hour. In addition, the State has also updated the assumptions for the Direct Care Overnight positions (base wage assumption of $12.25) and DSP supervisors (base wage assumption of $21.99). By modifying the assumption, the base rates have been re-calculated for all service codes that include an assumption for DSPs, DSP Overnights and DSP supervisors. The attached rate sheet provides a detailed description by service code. The effective dates of the rate increases are 7/1/21. The COVID-19 pandemic has directly impacted the DSP workforce, and this rate increase is intended to continue to support the DSP workforce in order for the DSP workforce to continue to support and provide services to Medicaid beneficiaries.

ARPA Related Temporary Rate Increases

EOHHS Submitted an Appendix K template to CMS to effectuate the following temporary rate increases pursuant to Pursuant to RI's spending plan for the implementation of the American Rescue Plan Act of 2021, Section 9817. Approval is pending as of submission of this document.

Effective 5/1/21-7/31/21:

1. HBTS/PASS rate to increase by 261.1%

Effective 11/1/21-3/31/22

1. Day Habilitation rate to increase by 74%
2. Self-Directed Community Services Personal Choice Program Financial Management Service rate to increase by 10%
3. Self Directed Community Services Independent Provider Financial Management Service rate to increase by 10%
4. Budget Population 10 Adult Day (DEA Co-Pay) 120%
5. Rehabilitation Program rate to increase by 116%

Effective 12/1/21-3/31/22

1. Peer Recovery and Family/Youth Support Services (Budget Service 6) rate to increase by 78.8%

Effective 1/1/22-3/31/22

1. Case Management rate to increase by 132%

Supporting and building the HCBS workforce is a cornerstone of Rhode Island's Covid-19 pandemic recovery strategy as well as a fundamental approach in the State's long-term services and supports (LTSS) re-balancing initiative. The support that direct care workers and licensed health professionals provide to Medicaid enrollees who have physical or behavioral support needs helps to promote individual wellness and self-determination, allowing enrollees the choice to remain in their homes and communities and avoid unnecessary acute care or facility-based care. The pandemic has exacerbated challenges in meeting consumer demand for HCBS services due to workforce shortages.

Based on policy analysis and substantial stakeholder survey feedback highlighting a critical need to strengthen the HCBS workforce via improved compensation, EOHHS is dedicating an estimated $30 million of its HCBS ARPA funds to a HCBS Workforce Recruitment and Retention plan for LTSS providers, some of which are in our State Plan, with the goal of increasing compensation to frontline HCBS workers specifically by improving HCBS workforce recruitment and retention. Providers will have until March 31, 2023 to expend the funds.

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 DY 13 January 1, 2021 – December 31, 2021 or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E-XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

January – December 2021

The Rhode Island 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 Medicaid managed care consumer issues. Quarterly, the Managed Care Organizations (MCO) submit Appeals and Grievance reports to EOHHS. The State reviews reports to identify emerging consumer issues, trends and recommend actions to mitigate and/or improve member satisfaction.

There currently are three (3) medical MCOs and one (1) dental Prepaid Ambulatory Health Plan (PAHP) that are contracted with RI EOHHS to provide care to RI managed Medicaid members:

- Neighborhood Health Plan of RI (NHPRI)*****,
- Tufts Health Public Plan RITogether (THRIT),
- United Healthcare Community Plan (UHCP-RI),
- United Healthcare Dental RIte Smiles (RIte Smiles)******.

***NHPRI** continues to be the only managed care organization that services the RIte Care for Children in Substitute Care populations.

****United Healthcare Rite Smiles *RIte Smiles*** is the dental plan for children and young adults who are eligible for Rhode Island Medicaid who were born after May 1, 2000.

Each Managed Care Organization (MCO) monitors consumer appeals, complaints, tracks trends and/or emerging consumer issues through the Appeals and Grievance process. Grievances, Complaints, and Appeals reports are submitted to RI EOHHS on a quarterly basis.

Data is disaggregated according to Medicaid cohort:

- RIte Care
- Rhody Health Partners (RHP),
- Rhody Health Expansion,
- Children with Special Health Care Needs (CSHN),
- Children in Substitute Care (Sub Care).

Consumer reported grievances are grouped into six (6) categories: access to care, quality of care, environment of care, health plan enrollment, health plan customer service and billing Issues.

Consumer appeals are disaggregated into nine (9) categories:

- medical services,
- prescription drug services,

- radiology services,
- durable medical equipment,
- substance abuse residential services,
- partial hospitalization services,
- detoxification services,
- opioid treatment services
- behavioral health services.

Where appropriate, appeals and grievances directly attributed to Accountable Entities (AE) are indicated as a subcategory for each cohort.

In addition to the above, RI EOHHS monitors consumer issues reported by RIte Smiles. Consumer reported issues are grouped into three (3) categories:

- general dental services,
- prescriptions drug services
- dental radiology.

Beginning in Q1 2022, dental services reporting will be divided to specifically identify consumer issues with orthodontic services.

The quarterly reports are reviewed by the RI EOHHS Compliance staff. Upon review, any concerning trends or issues of non-compliance identified by EOHHS are forwarded to the respective MCO. The Plan is then required to investigate the issue(s) and provide a report to EOHHS Medicaid Managed Care Oversight team within thirty (30) days of notification and, if appropriate monthly at the EOHHS/MCO Oversight meeting.

Please note, the State of Rhode Island is still operating under the Public Health Emergency (PHE) and, accordingly, has continued to require the MCOs to remove the prior authorization requirements on specific services. MCOs attribute the significant decrease of Prior Authorizations (PA) requests to this temporary rule reducing PA requirements for services. This rule will be lifted as of October 1, 2021, except for PAs related to behavioral healthcare services, which will not resume until January 1, 2022.

EOHHS/ Managed Care Organization (MCO) Improvement Process

As part of a continued effort to monitor MCOs Appeals and Grievance processes as well as to ensure member satisfaction and quality care at the appropriate time and in the most appropriate place, EOHHS has implemented improvements to the A&G reporting templates and CMS' 1115 Waiver Consumer Issues Appeals and Grievance reporting. Going forward, RI EOHHS 1115 Waiver Appeals and Grievance report format will change to reflect improved oversight and more efficient review process for CMS.

Per Managed Care Organization (MCO)

Data Analysis report for each MCO will be added as an attachment

Data elements will include:

- Prior authorization (PA) requests and percentage of requests denied
- Total number of internal appeals, both standard and expedited and percentage of appeals overturned
- Total number of State Fair Hearings- external appeals and percentage of decisions overturned
- Total number of grievances and total complaints
- Total number of Appeals, Grievances/Complaints attributed specifically to Accountable Entities (AE)
- Individual MCO quarter over quarter comparisons

In addition to reviewing and documenting the above information for each MCO, EOHHS will continue to document emerging trends, oversight activities implemented by EOHHS, as well as quarter over quarter comparisons for all MCOs.

As the member distribution is quite unique (one (1) MCO having over sixty-five (65%) of total state Medicaid MCO membership) total numbers vary greatly between MCOs. However, appeals are disaggregated into nine (9) categories* and grievances are disaggregated into six (6) categories*, comparative information and/or trends between MCOs will be documented in the summary.

In addition, EOHHS will continue to monitor consumer issues reported by Rite Smiles (Dental PAHP). Issues are disaggregated into four (4) categories, general dentistry, prescription drugs, dental radiology and orthodontic services. Quarter over quarter comparisons will be reported.

*Categories listed above are in Introduction

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 six (6) times in DY 13 January 1 – December 30, 2021:

January meeting agenda

- Welcome and Introductions
- Review of November 12, 2020 Meeting Minutes
- Medicaid Change Plan Opportunity (Open Enrollment)
- HSRI Updates
- COVID-19 Updates
    - Vaccination Efforts
    - Telehealth and Prior Authorizations
    - COVID-Testing
    - Transportation
- Address Change Project
- RIte Smiles Enrollment Update
- Data Reports – Enrollment & Auto Assignment

March meeting agenda

- Welcome and Introductions
- Review of January 14, 2021 Meeting Minutes
- Medicaid Managed Care Member Feedback Sessions
- HSRI Updates
- COVID-19 Updates
    - Federal Regulations
    - Vaccination Efforts
    - Telehealth and Prior Authorizations
    - COVID-Testing
    - Transportation
- Address Change Project
- Data Reports – Enrollment & Auto Assignment

May meeting agenda

- Welcome and Introductions
- Review of March 11, 2021 Meeting Minutes
- Medicaid Managed Care Member Feedback Sessions
- HSRI Updates

- COVID-19 Updates
    - Vaccination Efforts
    - Telehealth and Prior Authorizations
    - COVID-Testing
    - Transportation
- Address Change Project
- Data Reports – Enrollment & Auto Assignment

July meeting agenda

- Welcome and Introductions
- Review of May 13, 2021 Meeting Minutes
    - Budget and Program Updates
    - Doula Coverage
    - RIte Share
- Medicaid Managed Care Member Feedback Sessions and Focus Group
- HSRI Updates
- COVID-19 Updates
    - Telehealth and Prior Authorizations
    - Vaccination Efforts
- Medicaid Plan Change Opportunity
- Address Change Project
- Data Reports – Enrollment & Auto Assignment

October meeting agenda

- Welcome and Introductions
- Review of July 8, 2021 Meeting Minutes
- Budget Initiatives Updates
    - Doulas
- COVID-19 Updates
    - Telehealth and Prior Authorizations
    - Redetermination Updates
    - Vaccination Efforts
- Medicaid Plan Change Opportunity
- HSRI Updates
- Address Change Project
- Data Reports – Enrollment & Auto Assignment

November meeting agenda

- Welcome and Introductions
- Review of October 14, 2021 Meeting Minutes
    - Meeting Follow ups
        - No Wrong Door (presentation)

        - Impact of Prior Authorizations
- No Wrong Door Presentation
- RIDOH's Psychiatry Resource Network Programs
- HSRI Open Enrollment Update
- Budget Initiatives Updates
    - Doulas
- Medicaid Plan Change Opportunity
- COVID-19 Updates
    - Telehealth and Prior Authorizations
    - Redetermination Updates
- Address Change Project
- Data Reports – Enrollment & Auto Assignment

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 13 January 1 – December 31, 2021.

NEMT Analysis	DY 13 Q1	DY 13 Q2	DY 13 Q3	DY 13 Q4	DY 13 YTD
All NEMT & Elderly Complaints	327	386	465	472	1,650
All NEMT & Elderly Trip Reservations	455,020	466,285	532,538	548,744	2,002,587
Complaint Performance	0.07%	0.08%	0.09%	0.09%	
Top 5 Complaint Areas	DY 13 Q1	DY 13 Q2	DY 13 Q3	DY 13 Q4	DY 13 YTD
Transportation Provider No Show	64	79	101	113	357
Transportation Provider Late	36	37	63	79	215
Transportation Broker Processes	52	62	61	79	254
Transportation Provider Behavior	41	33	47	46	167
Transportation Broker Client Protocols	34	48		35	117
Driver Service/Delivery			38		38

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.

For calendar year 2021, the average monthly participation was 172 enrollees. The average subsidy was $42.48 per individual, with an average total of $7,303 per month. EOHHS is currently assessing whether to implement another mass mailing, which would reach approximately 650 potentially eligible individuals.

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	66	(26)	$ 46.23	$ 3,051
February	145	79	$ 43.50	$ 6,307
March	172	27	$ 43.34	$ 7,454
April	180	8	$ 43.28	$ 7,791
May	183	3	$ 42.97	$ 7,863
June	196	13	$ 42.74	$ 8,378
July	191	(5)	$ 42.22	$ 8,064
August	191	0	$ 41.93	$ 8,009
September	186	(5)	$ 41.95	$ 7,802
October	195	9	$ 41.46	$ 8,085
November	180	(15)	$ 41.84	$ 7,531
December	178	(2)	$ 41.04	$ 7,306

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in DY 13, January 1, 2021 – December 31, 2021.

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, UHCCP-RI, Tufts Health Public Plans (THPP) 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.

Areas of focus addressed during Q1:

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 1 (Q4) of 2021, the third quarter of State Fiscal Year (SFY) 2021:

COVID-19 Public Health Emergency (PHE) Response Effort

During Q1, EOHHS and the three (3) medical MCOs, including NHPRI, UHCCP-RI, and THPP, dedicated significant time and resources to collaborating with EOHHS, Rhode Island Department of Health (RIDOH), local and municipal organizations, and one another for coordinated planning, outreach, and marketing material development pertaining to COVID-19 vaccine distribution. Bi-weekly, the MCOs submitted iterative versions of their innovative strategic plans for how to successfully promote and distribute the COVID-19 vaccines among their membership. Plans included forecasting models, including best-case and worst-case scenarios for vaccination utilization based upon supply, administration, efficiency, hesitancy rate, and member stratification, as well as corresponding communications plans to address those factors. The MCOs and the State's non-emergency medical transportation (NEMT) vendor, Medical Transportation Management (MTM), coordinated to develop a process that more easily facilitated rides to vaccination appointments.

Active Contract Management (ACM)

For Q1 2021 ACM, MCOs focused on increasing low colonoscopy and mammography utilization rates resulting from limitations posed by the COVID-19 pandemic. Simultaneously, MCOs focused on decreasing preventable ED utilization. MCOs also continued their Q4 2020 focus of increasing childhood immunizations, well visits, and lead screening rates that had declined to low rates due to provider offices and schools being closed and the pent-up demand that followed. They submitted monthly immunization/lead screening data to assist the State in evaluating progress toward addressing the decline in immunizations and lead screening among children each month, and MCOs were required to present their data and strategic next steps at

each monthly oversight meeting. NHPRI and UHCCP continued their focused efforts for improvement of Accountable Entities (AE) attribution and PCP assignment.

As part of the SFY 2022 capitation rate setting process, EOHHS and the State's actuary, Milliman, distributed a rate setting survey to MCOs to provide them the opportunity to comment and ask questions prior to the rate development. EOHHS launched the 2021 reporting calendar to enhance data collection and utilization across the three (3) medical MCOs and UHC Dental. In addition, EOHHS, along with the Non-Emergency Transportation Provider (NEMT), initiated and ACM project focusing on missed transportation trips to analyze and improve on the process for care coordination and outreach to members who continuously missed NEMT trips. MCOs were tasked with facilitating care coordination with their care management team and respective AEs to determine the cause of missed trips, triaging high-risk members with substance use disorders, cancer, and dialysis, whose missed trips posed life-threatening consequences.

MCOs continued progress toward EVV implementation, collaborating regularly with EOHHS, Sandata (EVV implementation vendor), and their respective providers to prepare for the 2021 launch. As part of a new process, MCOs began assuming responsibility for direct Federally Qualified Health Center (FQHC) wrap payments, formerly handled by the State. At the request of the American Lung Association (ALA), the MCOs submitted data as part of the Asthma Guidelines-Based Care Coverage Project that tracks coverage of guidelines-based asthma care, along with barriers to care, by annually reviewing publicly available fee-for-service and Medicaid MCO documents (including formularies, provider manuals, member handbooks, and other relevant documents). EOHHS Compliance kicked off the Appeals & Grievances and CMS audits in Q1; they will continue through several quarters.

Specific to the unique details of Q1 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI proactively convened with UHCCP and THPP to schedule regular meetings with RIDOH to ensure all entities were aligned with RIDOH's guidance, and that integrated, consistent messaging was being developed to maximize COVID-19 vaccinations across the Medicaid population.
- NHPRI started the process of working with RIDOH to obtain vaccination data.
- NHPRI continuously met with RIDOH to determine to strategize about the best approach for sharing member-level vaccination utilization data, and other data elements needed to accurately gauge trends across the State.
- For durable medical equipment (DME) claims adjudication, NHPRI transitioned claims processing from Integra (a contracted Accountable Entity) to NHPRI (in-house). EOHHS is providing active oversight of this transition.

UnitedHealthcare Community Plan (UHCCP-RI)

- UHCCP and their behavioral health vendor, Optum, convened with EOHHS several times to establish substance abuse residential treatment (SART) claims configuration changes related to procedure codes and modifiers.
- UHCCP informed EOHHS that they received a perfect score of 100 resulting from the NCQA virtual onsite survey in December 2020. This portion of the accreditation pertains to standards around policies, reports, and file reviews, among other factors. UHCCP noted that NCQA is not providing star ratings this year due to the pandemic, but that UHCCP would have earned a 4.5 out of 5 score.
- UHCCP introduced a proposed and later EOHHS-approved Doula Pilot launch to improve maternal and child outcomes. As part of the program, UHCCP analyzes poor outcomes for women by geographic area, emphasizing the importance of the post-partum period.
- UHCCP added more housing units to house additional homeless members with comorbities as part of their Housing Pilot program in partnership with Crossroads Rhode Island.

Tufts Health Public Plans (THPP)

- Tufts Health Plan and Harvard Pilgrim Health Care merged organizations, effective January 1, 2021, to now serve 2.4 million members in Rhode Island, Massachusetts, Maine, Connecticut and New Hampshire.
- As part of the Central Falls Van Project, discussions between THPP and Jenks Pediatrics transpired regarding transporting patients to and from the practice. Patients would include both Medicaid and non-Medicaid populations. Tufts has outreached to MTM for assistance.
- THPP continued to work satisfactorily with EOHHS to address encounter claims submission.

UnitedHealthcare-Dental (UHC Dental)

- UHC Dental submitted monthly iterations of their strategic plan for increasing utilization of preventative dental services by RIte Smiles members in accordance with CMS' PDENT-CH measures. EOHHS' data analytics team built a dashboard from claims data to measure trends in the level of preventive care received month over month, reviewed at monthly oversight meetings.
- UHC Dental developed a strategy for collaborating with medical MCOs, area hospitals, and dental provider practices to institute a process and workflow that increases operating room access for RIte Smiles members who require treatment under general anesthesia and who are not equipped to be treated in a general dental office.
- UHC Dental developed an analytic approach toward selecting dental providers with whom to contract as their first step in administering alternative payment methodologies that reward outcomes over volume. By the end of Q1 2021, UHC Dental had identified three providers with whom to contract, had finalized amendments in the queue for legal signature, and established thresholds in collaboration with their data team in preparation of engaging with these providers.

- UHC Dental's Community Based Coordinator continued innovative outreach efforts in collaboration with Latino-based organizations and sub-populations impacted by SDOH that inhibited the ability to attend dental visits during the PHE due to school closures.
- UHC Dental presented tele-dentistry utilization updates at monthly oversight meetings.

Areas of focus addressed during Q2:

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 2 (Q2) of 2021, the fourth quarter of State Fiscal Year (SFY) 2021:

COVID-19 Public Health Emergency (PHE) Response Effort

During Q2, EOHHS and the three (3) medical MCOs, including NHPRI, UHCCP-RI, and THPP, dedicated significant time and resources to collaborating with EOHHS, Rhode Island Department of Health (RIDOH), local and municipal organizations, and one another for coordinated planning, outreach, and marketing material development pertaining to COVID-19 vaccine distribution. This involved EOHHS establishing a payment mechanism to reimburse MCOs for administration of the COVID-19 vaccinations. Additionally, NEMT vendor MTM enabled MCO case managers portal access for ease of scheduling transportation to testing and vaccination sites.

Bi-weekly, the MCOs continued to submit iterative versions of their innovative strategic plans for how to successfully promote and distribute the COVID-19 vaccines among their membership, as well as stratified data on vaccination rates after successfully instituting data exchanges with IMAT. This was a major initiative aimed at understanding vaccination rates broken down by MCO, region, age, and a variety of other data points, achieved through cooperative interagency (EOHHS/RIDOH) and MCO collaboration. This data enabled MCOs to conduct more targeted outreach campaigns and strategies for how to promote and deliver COVID-19 vaccines to the most vulnerable subpopulations in communities with the lowest vaccination rates.

Active Contract Management (ACM)

For Q2 2021 ACM, MCOs focused on increasing low colonoscopy and mammography utilization rates resulting from limitations posed by the COVID-19 pandemic. Simultaneously, MCOs focused on decreasing preventable ED utilization. MCOs focus of increasing childhood immunizations, well visits, and lead screening rates that had declined to low rates due to provider offices and schools being closed and the pent-up demand that followed. They submitted monthly immunization/lead screening data to assist the State in evaluating progress toward addressing the decline in immunizations and lead screening among children each month, and MCOs were required to present their data and strategic next steps at each monthly oversight meeting.

EOHHS distributed drafts of medical MCO contract Amendment 5 for MCOs to review and submit questions ahead of finalizing the SFY 2022 Amendment.

Specific to the unique details of Q2 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to convene meetings with UHCCP, THPP and RIDOH to ensure all entities were aligned with RIDOH's guidance, and that integrated, consistent messaging was being developed to maximize COVID-19 vaccinations across the Medicaid population.
- NHPRI continued to work with RIDOH to test and obtain vaccination data for NHPRI members.
- For durable medical equipment (DME) claims adjudication, NHPRI successfully transitioned claims processing from Integra (a contracted Accountable Entity) to NHPRI (in-house). EOHHS continued to provide active monitoring and oversight of this transition.
- EOHHS conducted oversight activities of NHPRI behavioral health vendor, Optum, concerning needed areas of improvement.

UnitedHealthcare Community Plan (UHCCP-RI)

- UHCCP collaborated with AEs and high-volume providers to strategize about how to effectively educate members regarding when it is appropriate to go to the ED, versus when to first consult with their PCP, due to high ED utilization due to members experiencing upper respiratory symptoms they fear to be COVID-19.
- UHCCP, in partnership with Crossroads Rhode Island, added more housing units to house additional homeless members with comorbidities as part of their Housing Pilot program. UHC filled the 10 housing units, expanded and contracted with Crossroads on five units, and put forth efforts to obtain IDs for the homeless population. There are a few members on whose behalf UHC is working to obtain birth certificates, social security cards, and identification.
- UHCCP established a House Calls Program as a value-add benefit for the Medicare Advantage DSNP program; it also serves as an educational opportunity to ensure members are aware of their care plan, which includes a summary also received by their PCP to discuss unresolved issues. On an annual basis, members are offered a visit from an advanced practice clinician who makes an in-home or telephonic connection to conduct a 1-hour visit that includes a comprehensive assessment, including a person's health history, medication and diagnoses. If in person, this includes a physical exam.
- UHCCP presented their Optum vendor oversight structure, including how the two entities identify trends, resolve issues, and collaborate to execute a best-in-class Medicaid market behavioral health strategy.
- UHCCP finalized vendor contracts to launch the Doula Program.

Tufts Health Public Plans (THPP)

- THPP reported that a new CEO had been hired to manage the newly merged Tufts/Harvard Pilgrim Health Care organizations.
- Tufts worked with MTM to set up the Central Falls Van Project. Discussions continued between THPP and the Jenks Pediatrics regarding transporting patients to and from the practice. Patients would include both Medicaid and non-Medicaid populations.
- THPP continued to work satisfactorily with EOHHS to address encounter claims submission.
- THPP worked with EOHHS analytics' staff concerning population health strategies & measures related to ACM project metrics.

UnitedHealthcare-Dental (UHC Dental)

- UHC Dental continued submitting monthly iterations of their strategic plan for increasing utilization of preventative dental services by RIte Smiles members in accordance with CMS' PDENT-CH measures. EOHHS' data analytics team built a dashboard from claims data to measure trends in the level of preventive care received month over month, reviewed at monthly oversight meetings. UHC Dental informed that, from their perspective, utilization has improved beyond pre-pandemic levels, significantly rebounding since October-December 2020. They noted the rebound correlates with evidence of deferred care, such that services not deemed in Q4 2020 showed a higher resurgence rate in Q1 2021.
- UHC Dental focused on gaining a better understanding of the ongoing barriers leading to network capacity challenges and developed in-person provider monitoring and outreach strategies.
- The Rhode Island Dental Director and EOHHS issued recommended guidance for increasing and improving RIte Smiles provider engagement.
- EOHHS tasked UHC Dental with developing a policy and workflow around member orthodontics appeals and to diminish the level of cases that result in State fair hearings.
- UHC Dental contracted with three (3) providers to institute alternative payment methodologies.

Areas of focus addressed during Q3:

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 (Q3) of 2021, the first quarter of State Fiscal Year (SFY) 2022:

Active Contract Management (ACM)

For Q3 2021 ACM, EOHHS introduced three (3) new areas of focus for MCOs to prioritize their efforts for Q3 and Q4. These included the effort to increase the rate of pap smears and prostate exams due to members deferring these important screenings during the PHE. Simultaneously, MCOs focused on decreasing preventable ED utilization. MCOs also continued their quest to increase childhood immunization rates, with particularly around lead screening rates that had

declined due to provider offices and schools being closed and the pent-up demand that followed. MCOs continued to submit monthly reports to EOHHS concerning childhood immunizations to assist the State in evaluating progress toward addressing the decline in immunizations and lead screening among children each month.

COVID-19 Public Health Emergency (PHE) Response Effort

During Q3, EOHHS and the three (3) medical MCOs, including NHPRI, UHCCP-RI, and THPP, partnered with EOHHS, RIDOH, school departments, faith-based organizations, provider offices, pediatrician and pediatric dentist offices, and accountable entities (AEs) to establish and align plans for disseminating the most important, updated vaccine-related information and the importance of parents and any other eligible household members to get vaccinated as soon as possible ahead of children returning to in-person learning. MCOs executed upon their continuously evolving member and provider outreach plans. Member-specific outreach (and follow-up, as necessary) included but was not limited to phone calls, text messages, emails, direct mailings, and website and social media posts.

Bi-weekly, the MCOs continued to submit iterative versions of their innovative strategic plans for how to successfully promote and distribute the COVID-19 vaccines among their membership, as well as stratified data on vaccination rates. MCOs prepared their respective teams and in-network providers for the reinstatement of prior authorizations, effective October 1. MCOs and EOHHS discussed their plans for indefinitely covering telemedicine as a covered benefit in accordance with the new Telemedicine Coverage Act.

General Updates

- The State mailed Medicaid Annual Plan Change Opportunity (MAPCO) letters to MCO members in five (5) waves, based on zip codes, beginning in September.
- EOHHS Compliance department conducted the annual MCO Appeals & Grievance audits.

- Due to RIDOH's concerns about the early, unusually high prevalence of Respiratory Syncytial Virus (RSV) in Rhode Island, and nationally, EOHHS requested that MCOs submit clinical policies, prior authorization requirements, and barriers and restrictions for RSV testing and access to Synagis (palivizumab).
- MCOs presented their respective plans for meeting CMS Interoperability and Patient Access Final Rule requirements at monthly oversight meetings.
- EOHHS kicked off the 21st Century Cures Act Provider/Enrollment Screening Project with MCOs.

Specific to the unique details of Q3 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.

- For durable medical equipment (DME) claims adjudication, NHPRI successfully continued to refine the process for smooth claims processing transitioned from Integra (a contracted Accountable Entity) to NHPRI (in-house). EOHHS continued to provide active monitoring and oversight of this transition.
- NHP worked satisfactorily with EOHHS to address 834 data file issues.

UnitedHealthcare Community Plan (UHCCP-RI)

- UHCCP made significant strides at increasing the rate of pap smears to better than pre-pandemic levels through interventions and incentives associated with receiving a cervical cancer screening. They launched communication, targeted live-call outreach, and reminders, and issued gift cards.
- UHCCP surpassed the intended year-end benchmark for improving lead screening rates, noting a 90 percent screening rate before the end of Q3.
- UHCCP case managers conducted targeted outreach to mothers and families identified as vaccine-averse, emphasizing the importance of all eligible household members obtaining a vaccine prior to children returning to in-person learning during the 2021-2022 school year.
- UHCCP submitted an updated version of their Sanvello Application proposal. UHCCP requested approval to launch the on-demand, digital treatment support application aimed at engaging their members via on-demand interface that provides self-help for stress, anxiety, and depression.

Tufts Health Public Plans (THPP)

- THPP reported that the newly-merged Tufts/Harvard Pilgrim Health a new CEO is formally in place at Care organizations.
- Tufts reported issues identified with their interpreter services vendor that resulted in delays. This prompted improved training and higher staffing volume, including more multilingual staff.
- THPP continued to work satisfactorily with EOHHS to address encounter claims submission.

UnitedHealthcare-Dental (UHC Dental)

- UHC Dental continued submitting monthly iterations of their strategic plan for increasing utilization of preventative dental services by RIte Smiles members in accordance with CMS' PDENT-CH measures. UHC focused on integrating and collaborating with the medical MCOs, working closely with NEMT vendor MTM to mitigate transportation barriers, focus on provider engagement to foster and preserve provider satisfaction, and strategically place their Community Based Coordinator throughout the community at a wide variety of events, focusing on various faith-based and culturally-homogenous subpopulations across the State.
- UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to

staffing shortages and social distancing restrictions, and pent-up demand. They also monitored provider office vaccine compliance.

- UHC Dental and EOHHS (including the RI Dental Director) focused on better monitoring and improving prior authorization policies and procedures, as well as State Fair Hearings.
- UHC Dental launched the Medical Access Request Form & Process in a kick-off meeting with all medical MCOs to improve timely access to operating room settings needed to treat members who require dental procedures under general anesthesia.

Areas of focus addressed during Q4:

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 4 (Q4) of 2021, the second quarter of State Fiscal Year (SFY) 2022:

Active Contract Management (ACM)

For Q4 2021 ACM, EOHHS continued to work with MCOs on improving certain health measures affected by the pandemic. These included the effort to increase the rate of pap smears and prostate exams due to members deferring these important screenings during the PHE. Simultaneously, MCOs focused on decreasing preventable ED utilization. MCOs also continued their quest to increase childhood immunization rates, particularly around lead screening rates that had declined due to provider offices and schools being closed and the pent-up demand that followed. MCOs continued to submit monthly reports to EOHHS concerning childhood immunizations to assist the State in evaluating progress toward addressing the decline in immunizations and lead screening among children.

COVID-19 Public Health Emergency (PHE) Response Effort

During Q4, EOHHS and the three (3) medical MCOs, including NHPRI, UHCCP-RI, and THPP, continued to partner with EOHHS, RIDOH, school departments, faith-based organizations, provider offices, pediatrician and pediatric dentist offices, and accountable entities (AEs) to establish and align plans for disseminating the most important, updated vaccine-related information and the importance of parents and any other eligible household members to get vaccinated as soon as possible ahead of children returning to in-person learning. MCOs executed upon their continuously evolving member and provider outreach plans. Member-specific outreach (and follow-up, as necessary) included but was not limited to phone calls, text messages, emails, direct mailings, and website and social media posts.

MCOs continued, on a monthly basis, to submit iterative versions of their innovative strategic plans for how to successfully promote and distribute the COVID-19 vaccines among their membership, as well as stratified data on vaccination rates. MCOs reinstated utilization of prior authorizations, effective October 1. MCOs and EOHHS discussed their plans for indefinitely covering telemedicine as a covered benefit in accordance with the new Telemedicine Coverage Act.

General Updates

- The State concluded the Medicaid Annual Plan Change Opportunity (MAPCO) on 10/29/2021. MCOs were provided with status reports summarizing the results of the MAPCO process.
- EOHHS began work with MCOs concerning outreach and care coordination efforts to enhance provision of Early Intervention Services for members.
- EOHHS Compliance department provided MCOs with results of the annual MCO Appeals & Grievance audits.
- EOHHS provided MCOs with flu vaccination resource information from CMS to support enhanced vaccination efforts.
- EOHHS has established Quarterly Financial Oversight Meetings with MCOs to enhance coordination and communication efforts concerning ongoing financial requirements.
- EOHHS began working with MCOs on the Provider Screening – 21st Century Cures Act enrollment requirements. EOHHS is providing oversight over compliance with the enrollment requirements with external vendor (Gainwell Technologies) and the 3 MCOs. Meetings with both the vendor and MCOs are held on a weekly basis to ensure adherence with the project plan.
- MCOs continued to provide updates concerning CMS Interoperability and Patient Access Final Rule requirements at monthly oversight meetings.
- EOHHS reviewed results of Q3 QIP Reports with each MCO.

Specific to the unique details of Q4 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.
- For durable medical equipment (DME) claims adjudication, NHPRI successfully completed the transition of claims processing from Integra Partner (a contracted DME vendor) to NHPRI (in-house). EOHHS continued to provide active monitoring and oversight of this transition.
- NHP introduced a Behavioral Health Emergency Department Diversion program to reduce unnecessary emergency room utilization for mental health, alcohol use and chronic pain disorders. EOHHS continues to monitor these efforts in monthly oversight meetings.
- NHP also continues to work with Accountable Entities on intervention strategies to reduce avoidable Emergency Room usage.

UnitedHealthcare Community Plan (UHCCP-RI)

- UHCCP continued their progress in significantly increasing the rate of pap smears through interventions and incentives associated with receiving a cervical cancer screening. They continued their targeted outreach.
- UHCCP case managers continued targeted outreach to members in areas with low COVID-19 vaccination rates. They innovatively collaborated with community

organizations and sponsored community events to educate about and administer vaccines. UHCCP pivoted as needed to address newly eligible age groups, launching many different communications to reach these diverse audiences from all angles

- UHCCP's doula pilot resulted in an increasing number of high-risk members' successful, healthy delivery of newborns. UHCCP continued to expand the program throughout the Quarter. Many mothers suffered with SUD and SPMI, and doulas were able to coach mothers through labor and delivery without the use of medication. Mothers expressed that they felt supported and grateful for the support offered. Doulas participate in post-partum visits.

Tufts Health Public Plans (THPP)

- THPP reported on planned PBM transition from CVS Health to OptumRx, effective 1/1/2023. Tufts provided an overview of the project plan and timeline for the transition. EOHHS will be providing oversight of the transition. This topic has been included in weekly encounter data calls with EOHHS.
- Tufts has successfully resolved Call Center issues to EOHHS satisfaction. Tufts had experienced challenges with call volumes, due to contracted staffing issues. These issues have been successfully resolved. EOHHS continues to monitor Call Center SLAs.
- THPP continued to work satisfactorily with EOHHS to address encounter claims submission.
- Tufts introduced the "Healthy Heroes Program", a wellness program to address obesity and weight related health conditions in youth.

UnitedHealthcare-Dental (UHC Dental)

- UHC Dental continued submitting monthly iterations of their strategic plan for increasing utilization of preventative dental services by RIte Smiles members in accordance with CMS' PDENT-CH measures.
- UHC Dental developed, tested and launched the UnitedHealthcare RIte Smiles mobile application for RIte Smiles program beneficiaries. The purpose of the app is to provide a user-friendly, technology-based solution that will enable members and their parent(s)/guardian(s) to access benefit information, locate a provider, obtain dental health awareness information, and support UHC Dental in maintaining strategies for increasing oral health awareness and closing gaps in EPSDT services.
- UHC Dental, RI EOHHS, and the RI Dental Director collaborated to develop a quality improvement projects to begin in 2022 that focus on a broader scope that will result not only in quality improvement for members, but in the collection of valuable data collected on an ongoing basis that will serve as benchmarks from which to improve the program in the future.
- UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to staffing shortages and pent-up demand. UHC Dental made great strides in establishing relationships with provider offices such that providers feel more supported and heard.

XII. Enclosures/Attachments

The following tables have been revised following extensive review by current EOHHS staff of past reporting and subsequent conversations with CMS in May and June 2022. The basis for reporting is EOHHS' CMS 64 reporting. This reporting is used to populate Schedule C that along with enrollment counts (reported in Section III above) are used to calculate the with-waiver PMPM for the purpose of determining budget neutrality. Schedule C includes all current and prior period adjustments reported on CMS64.9 WAIV, CMS 64.XIII WAIV, and CMS 64.21U WAIV.

However, EOHHS was unaware of the distinction between some of the reporting forms leading to certain expenditures being understated and some expenditures overstated due to their unintended exclusion from one of the valid forms. For example, all CHIP expenditures were reported on CMS 64.21U and CMS 21. The spending reported on CMS 64.21U should have been reported on the CMS 64.21U WAIV using one of the available drop-downs (the Separate CHIP spending reported on the CMS 21 should remain on that form). Similarly, the New Adult Group (i.e., Expansion) spending reported on CMS 64.XIII should have been reported on CMS 64.XIII WAIV.

Other spending reported on CMS 64.9 BASE was allocated to the budget population properly (for the purpose of this document) but were not transferred to Schedule C leading to misalignment in reporting. Examples of such spending included DSH payments, risk share payments and gain share recoupments, certain drug rebates.

EOHHS is presenting the quarters and YTD for the current Demonstration Year and re-reporting the prior 4 demonstration years such that 5 full years of history is presented.

Going forward EOHHS will report the current Demonstration and the prior two demonstration years so as to capture any prior period adjustments reported to CMS and reflected in the updated Schedule C.

Attachment 1: Rhode Island Budget Neutrality Report

Table A1.1 MEMBER MONTHS (ACTUALS)

	Historical:				Current:				
					DY 13				
Medicaid Eligibility Group (MEG)	DY 09 2017	DY 10 2018	DY 11 2019	DY 12 2020	31-Mar-21	30-Jun-21	30-Sep-21	31-Dec-21	YTD
ABD no TPL	188,891	189,086	188,727	187,407	46,804	46,862	46,538	46,531	186,735
ABD TPL	405,557	410,795	390,212	383,550	96,120	96,884	97,621	98,621	389,246
RIte Care	2,055,578	2,006,601	1,922,191	1,919,234	504,291	511,158	516,172	518,512	2,050,133
CSHCN	147,196	147,738	143,033	145,566	37,018	36,655	36,640	36,633	146,946
217-like Group	46,319	49,083	51,354	53,182	13,447	13,540	13,821	14,004	54,812
Family Planning Group	12,169	13,105	17,691	21,016	4,911	4,643	4,410	4,195	18,159
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Low-Income Adult	962,260	936,670	897,587	985,182	285,128	294,729	303,032	309,978	1,192,867
Additional Populations & CNOMS	56,944	59,027	60,289	57,336	14,027	14,127	14,513	14,046	56,713

Notes to Member Months (Actuals)

1. Care includes: 03: Rite Care, 06: Pregnant Expansion, 07: CHIP Children
2. SUD IMD member months reallocated to their underlying eligibility group. Approximately, 70% are reported within the Low-Income Adult Group.
3. Additional Populations & CNOMs include Early Intervention Only, ORS CNOM, Elders 65+Rite care

Table A1.2 WITHOUT WAIVER PMPM

	Historical:				Current:				
	DY 09	DY 10	DY 11	DY 12	DY 13				
Medicaid Eligibility Group (MEG)	2017	2018	2019	2020	31-Mar-21	30-Jun-21	30-Sep-21	31-Dec-21	YTD
ABD no TPL	$ 3,023	$ 3,152	$ 3,288	$ 3,429	$ 3,576	$ 3,576	$ 3,576	$ 3,576	$ 3,576
ABD TPL	$ 3,417	$ 3,563	$ 3,716	$ 3,876	$ 4,043	$ 4,043	$ 4,043	$ 4,043	$ 4,043
RIte Care	$ 530	$ 558	$ 587	$ 618	$ 650	$ 650	$ 650	$ 650	$ 650
CSHCN	$ 3,116	$ 3,273	$ 3,437	$ 3,608	$ 3,789	$ 3,789	$ 3,789	$ 3,789	$ 3,789
217-like Group	$ 3,968	$ 4,095	$ 4,222	$ 4,353	$ 4,488	$ 4,488	$ 4,488	$ 4,488	$ 4,488
Family Planning Group	$ 22	$ 23	$ 24	$ 26	$ 27	$ 27	$ 27	$ 27	$ 27
SUD IMD			$ 3,971	$ 4,185	$ 4,411	$ 4,411	$ 4,411	$ 4,411	$ 4,411
Low-Income Adult	$ 899	$ 945	$ 993	$ 1,044	$ 1,097	$ 1,097	$ 1,097	$ 1,097	$ 1,097

Table A1.3 WITHOUT WAIVER TOTAL EXPENDITURES

	Historical:				Current:				
	DY 09	DY 10	DY 11	DY 12	DY 13				
Medicaid Eligibility Group (MEG)	2017	2018	2019	2020	31-Mar-21	30-Jun-21	30-Sep-21	31-Dec-21	YTD
ABD no TPL	$ 571,017,493	$ 595,999,072	$ 620,446,807	$ 642,599,871	$ 167,387,146	$ 167,594,574	$ 166,435,839	$ 166,410,805	$ 667,828,363
ABD TPL	$ 1,385,788,269	$ 1,463,662,585	$ 1,450,109,346	$ 1,486,642,096	$ 388,581,848	$ 391,670,451	$ 394,649,902	$ 398,692,577	$ 1,573,594,779
RIte Care	$ 1,089,456,340	$ 1,119,683,358	$ 1,128,356,872	$ 1,185,205,361	$ 327,614,138	$ 332,075,305	$ 335,332,665	$ 336,852,853	$ 1,331,874,962
CSHCN	$ 458,662,736	$ 483,546,474	$ 491,554,359	$ 525,272,364	$ 140,257,745	$ 138,882,372	$ 138,825,539	$ 138,799,016	$ 556,764,673
Subtotal - Without Waiver	**$ 3,504,924,838**	**$ 3,662,891,489**	**$ 3,690,467,384**	**$ 3,839,719,692**	**$ 1,023,840,878**	**$ 1,030,222,703**	**$ 1,035,243,945**	**$ 1,040,755,251**	**$ 4,130,062,777**
217-like Group	$ 183,793,792	$ 200,994,885	$ 216,813,764	$ 231,491,955	$ 60,346,947	$ 60,764,309	$ 62,025,371	$ 62,846,631	$ 245,983,259
Family Planning Group	$ 267,718	$ 301,415	$ 428,458	$ 535,963	$ 131,881	$ 124,684	$ 118,427	$ 112,654	$ 487,646
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
New Adult Group	$ 865,071,740	$ 885,153,150	$ 891,478,920	$ 1,028,380,206	$ 312,809,421	$ 323,342,526	$ 332,451,616	$ 340,071,963	$ 1,308,675,527

Budget Neutrality Tables II

Table A1.4 HYPOTHETICALS ANALYSIS

	Historical:				Current:				
	DY 09	DY 10	DY 11	DY 12	DY 13				
Medicaid Eligibility Group (MEG)	**2017**	**2018**	**2019**	**2020**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**YTD**
Without Waiver Expenditure Baseline	$ 865,071,740	$ 885,153,150	$ 891,478,920	$ 1,028,380,206	$ 312,809,421	$ 323,342,526	$ 332,451,616	$ 340,071,963	$ 1,308,675,527
With Waiver Expenditures (Actuals):									
217-like Group	$ 182,709,505	$ 197,290,254	$ 195,308,260	$ 198,952,989	$ 50,825,781	$ 49,466,945	$ 57,631,979	$ 56,271,834	$ 214,196,539
Family Planning Group	$ 53,490	$ 116,238	$ 359,192	$ 406,225	$ 60,304	$ 46,316	$ 77,399	$ 61,670	$ 245,689
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal - Actuals	**$ 182,762,995**	**$ 197,406,492**	**$ 195,667,452**	**$ 199,359,214**	**$ 50,886,085**	**$ 49,513,261**	**$ 57,709,378**	**$ 56,333,504**	**$ 214,442,228**
Excess Spending: Hypotheticals	$ (1,298,515)	$ (3,889,808)	$ (21,574,770)	$ (32,668,704)	$ (9,592,744)	$ (11,375,733)	$ (4,434,420)	$ (6,625,781)	$ (32,028,677)

Table A1.5 LOW INCOME ADULT ANALYSIS

	Historical:				Current:				
	DY 09	DY 10	DY 11	DY 12	DY 13				
Medicaid Eligibility Group (MEG)	**2017**	**2018**	**2019**	**2020**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**YTD**
Without Waiver Expenditure Baseline	$ 865,071,740	$ 885,153,150	$ 891,478,920	$ 1,028,380,206	$ 312,809,421	$ 323,342,526	$ 332,451,616	$ 340,071,963	$ 1,308,675,527
With Waiver Expenditures (Actuals)	**$ 479,099,781**	**$ 451,290,490**	**$ 475,460,073**	**$ 545,106,889**	**$ 180,349,580**	**$ 131,343,042**	**$ 244,047,299**	**$ 209,904,748**	**$ 765,644,669**
Excess Spending: New Adult Group	$ (385,971,959)	$ (433,862,660)	$ (416,018,847)	$ (483,273,317)	$ (132,459,841)	$ (191,999,484)	$ (88,404,317)	$ (130,167,215)	$ (543,030,858)

Table A1.6 WITH WAIVER TOTAL ANALYSIS

Medicaid Eligibility Group (MEG)	DY 09 2017	DY 10 2018	DY 11 2019	DY 12 2020	DY 13 31-Mar-21	DY 13 30-Jun-21	DY 13 30-Sep-21	DY 13 31-Dec-21	DY 13 YTD
ABD no TPL	$ 385,752,320	$ 397,024,002	$ 446,183,890	$ 416,651,174	$ 115,601,311	$ 88,876,461	$ 136,235,327	$ 124,608,674	$ 465,321,773
ABD TPL	$ 693,934,555	$ 684,734,811	$ 728,785,341	$ 662,780,192	$ 159,297,890	$ 164,916,046	$ 186,970,405	$ 174,309,553	$ 685,493,895
RIte Care	$ 515,019,502	$ 523,900,737	$ 584,755,268	$ 540,281,451	$ 147,352,159	$ 124,592,522	$ 215,167,713	$ 174,491,988	$ 661,604,382
CSHCN	$ 170,107,095	$ 168,132,484	$ 167,369,332	$ 169,999,309	$ 44,773,683	$ 37,891,133	$ 54,734,511	$ 45,411,967	$ 182,811,295
Excess Spending: Hypotheticals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DSHP - Health Workforce & AIE Payments	$ 23,295,015	$ 54,220,164	$ 41,868,483	$ 68,749,417	$ 3,409,629	$ 8,522,816	$ 2,423,072	$ 4,572,974	$ 18,928,491
CNOM Services	$ 9,176,311	$ 9,399,975	$ 9,839,671	$ 8,397,342	$ 1,864,063	$ 2,271,685	$ 2,133,626	$ 1,882,683	$ 8,152,058
TOTAL	**$ 1,797,284,797**	**$ 1,837,412,172**	**$ 1,978,801,985**	**$ 1,866,858,885**	**$ 472,298,735**	**$ 427,070,663**	**$ 597,664,654**	**$ 525,277,839**	**$ 2,022,311,893**
Favorable / (Unfavorable) Variance	$ 1,707,640,041	$ 1,825,479,317	$ 1,711,665,399	$ 1,972,860,807	$ 551,542,143	$ 603,152,040	$ 437,579,291	$ 515,477,412	$ 2,107,750,885
Budget Neutrality Variance (DY 1 - 8)	$ 6.02 B								
Cumulative Budget Neutrality Variance	$ 7.71 B	$ 9.53 B	$ 11.24 B	$ 13.22 B	$ 13.77 B	$ 14.37 B	$ 14.81 B	$ 15.33 B	$ 15.33 B

Notes to With Waiver Analysis

1. Excess Spending: Hypotheticals and New Adult Group reflects spending, if any, that exceeds the Without Waiver benchmark. Any savings against the Hypothetical populations (i.e., IMD SUD, 217-like and Family Planning groups) do not contribute to Budget Neutrality Variance.
2. Favorable/(Unfavorable) Variance compares actual spending on base MEGs and any excess spending on hypothetical populations or new adult group and any spending on CNOM services or DSHP investments to the without waiver expenditure limit (calculated in Table A1.3 as the product of the actual member months multiplied PMPM benchmark).
3. The Cumulative Budget Neutrality variance considers total “savings” relative to Without Waiver limit

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: _____Katie Alijewicz_____

Date: _____8/3/2022_____

Attachment 3: 1115 Waiver Appeals and Grievance Data Analysis

Q1 2021

I. NHPRI QUARTERLY REPORT Q1 2021 APPEALS, GRIEVANCES AND COMPLAINTS

NHPRI Quarterly Report Q1 2021_Prior Authorization Requests

	RIte Care	(AE)*	CSN	(AE)	RHP	(AE)	RHE	(AE)	SubCare (NHP Only)
Prior Authorization Requests	5952	N/A	1052	N/A	2969	N/A	7665	N/A	230
Concurrent Authorization Requests	1778	N/A	416	N/A	953	N/A	1985	N/A	240

*(AE) represents authorization requests submitted by cohort
NHPRI reported Prior Authorizations based cohort, PAs not reported based on AE attribution

NHPRI Quarterly Report Q1 2021_APPEALS

Appeals Internal	RIte Care	CSN	RHP	RHE	SubCare
Standard	72	5	53	139	4
% Overturned	60%	40%	42%	48%	75%
Expedited	11	2	16	22	0
% Overturned	73%	100%	88%	59%	0%
State Fair Hearing – External	**RIte Care**	**CSN**	**RHP**	**RHE**	**SubCare**
Standard	11	2	13	24	1
% Overturned	27%	50%	33%	17%	0%

Expedited	0	0	2	0	0
% Overturned	N/A	N/A	0%	N/A	N/A

*Quarterly appeal rate = appeals per 1000/members
% Overturned = service denial decision not upheld in appeal

Summary

Q1 2021 rate of appeals represents a rate of 1.16 per 1000 members which represents 0.06 increase when compared to Q4 2020. In Q1 2021 OPTUM had an appeal rate of 0.88 per 1000 members compared to Q4 2020 appeal rate per 1000 members of 0.36.

*NHPRI subcontracts to OPTUM for BH, OPTUM conducts internal appeals.

NHPRI Quarterly Report Q1 2021_GRIEVANCES/COMPLAINTS

	RIte Care	CSN	RHP	RHE	SubCare	AE
Number of Grievances	11	0	6	7	0	3
Number of Complaints	23	2	14	16	0	5
Total	34	2	20	23	0	8

Summary

In Q1 2021 a total number of 79 Grievances and Complaints submitted by members, there were 19 quality of care and 5 access to care grievances, of those, 4 were attributed to AEs. There was no significant increase in submitted grievances and complaints from Q4 2020 (75 total).

II. THRIT QUARTERLY REPORT Q1 2021 APPEALS, GRIEVANCES AND COMPLAINTS

THPP Quarterly Report Q1 2021_Prior Authorization Requests

	RIte Care	**CSN**	**RHP**	**RHE**	**(AE)***
Prior Authorization Requests	336	0	690	0	0
Concurrent Authorization Requests	54	0	121	0	0

* (AE) represents authorization requests submitted by cohort members attributed to an AE.

Appeals Internal	RIte Care	CSN	RHP	RHE
Standard	1	0	0	0
% Overturned	0 %	0%	N/A	0%
Expedited	3	0	5	0
% Overturned	67%	0%	60%	0%
State Fair Hearing – External	**RIte Care**	**CSN**	**RHP**	**RHE**
Standard	0	0	0	0
% Overturned	N/A	N/A	N/A	N/A
Expedited	0	0	0	0
% Overturned	N/A	N/A	N/A	N/A

Summary

Q1 2021 rate of appeals represents a rate of 0.20 per 1000 members which presents a 0.02 increase when compared to Q4 2020.

THRIT Quarterly Report Q1 2021_GRIEVANCES and COMPLAINTS

	RIte Care	CSN	RHP	RHE	AE
Number of Grievances	2	0	3	0	2
Number of Complaints	0	0	0	0	N/A
Total	2	0	3	0	N/A

Summary

In Q1 2021 a total number of 5 Grievances and Complaints submitted by members, of those, 1 was attributed to AEs. There was no significant increase in submitted grievances and complaints from Q4 2020 (75 total).

III. UHCP-RI Quarterly Report Q1 2021 APPEALS, GRIEVANCES and COMPLAINTS

UHCP-RI Quarterly Report Q1 2021_Prior Authorization Requests

	RIte Care	(AE)*	CSN	(AE)	RHP	(AE)	RHE	(AE)

Prior Authorization Requests	2,865	203	150	27	1,074	84	2,716	254
Concurrent Authorization Requests	185	1	37	0	317-	3	647	0

* (AE) represents authorization requests submitted by cohort members attributed to an AE

UHCP-RI QUARTERLY REPORT Q1 2020_APPEALS

Appeals Internal	**RIte Care**	**CSN**	**RHP**	**RHE**
Standard	41	41	24	71
% Overturned	85%	78%	79%	92%
Expedited	32	2	24	45
% Overturned	88%	100%	79%	80%
State Fair Hearing – External	**RIte Care**	**CSN**	**RHP**	**RHE**
Standard	0	0	0	1
% Overturned	N/A	N/A	N/A	0%
Expedited	0	0	0-	0
% Overturned	N/A	N/A	N/A	N/A

Summary

Q1 2021 rate of appeals represents a rate of 0.24 per 1000 members, representing a 36% increase when compared to Q4 2020.

UHCP-RI Quarterly Report Q1 2021_GRIEVANCES and COMPLAINTS

	RIte Care	CSN	RHP	RHE	AE
Number of Grievances	2	0	2	2	3
Number of Complaints	6	1	0	11	7
Total	8	1	2	18	10

Summary

In Q1 2021 a total number of 29 Grievances and Complaints submitted by members, of those, 10 was attributed to AEs. Of the 29 Grievances/Complaints 16 concerned balance billing representing 55.17 % of total grievances. Of the 29 grievances/complaints, 10 were attributed to AEs.

IV. RIte Smiles (UHC Dental) Quarterly Report Q1 2021_APPEALS, GRIEVANCES and COMPLAINTS

RIte Smiles Quarterly Report Q1 2021_Prior Authorization Requests

	Dental	RX	RAD	Total
Prior Authorization Requests	525	488	635	1,648
Retrospective Authorization Requests	16	15	18	49

RIte Smiles QUARTERLY REPORT Q1 2021_APPEALS

Appeals Internal	Dental	RX	RAD
Standard	9	0	13
% Overturned	11%	N/A	70%
Expedited	4	4	21
% Overturned	0%	50%	76%
State Fair Hearing – External	**Dental**	**RX**	**RAD**
Standard	0	1	21
% Overturned	N/A	N/A	60.3%
Expedited	0	0	16-
% Overturned	N/A	N/A	76%

Summary:
Q1 2021 rate of appeals represents a rate of 0.48 per 1000 members representing a substantial decrease from Q4 2020. The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and subsequently submitted appeals and grievances and is reflected in the data.

RIte Smiles Quarterly Report Q1 2021_GRIEVANCES and COMPLAINTS

	RIte Smiles
Number of Grievances	0
Number of Complaints	1
Total	0

Summary

RIte Smiles reported 1 complaint in Q1 2021.
The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and, subsequently, submitted appeals and grievances and is reflected in the data.

Q2 2021

I. NHPRI QUARTERLY REPORT Q2-2021 APPEALS, GRIEVANCES AND COMPLAINTS

NHPRI Quarterly Report Q2-2021_ Prior Authorization Requests

	RIte Care	**(AE)***	**CSN**	**(AE)**	**RHP**	**(AE)**	**RHE**	**(AE)**	**SubCare (NHP Only)**
Prior Authorization Requests	5,975	N/A	1,140	N/A	3623	N/A	7,784	N/A	220
Concurrent Authorization Requests	2,153	N/A	470	N/A	980	N/A	2,189	N/A	240

*(AE) represents authorization requests submitted by cohort

NHPRI Quarterly Report Q2-2021 Appeals

Appeals Internal	RIte Care	CSN	RHP	RHE	SubCare
Standard	84	7	74	142	4
% Overturned	50%	14%	50%	54%	75%
Expedited	6	1	2	16	0
% Overturned	83%	100%	100%	63%	N/A
State Fair Hearing – External	**RIte Care**	**CSN**	**RHP**	**RHE**	**SubCare**
Standard	6	2	13	142	1
% Overturned	33%	50%	8%	54%	0%
Expedited	0	0	0	16	0
% Overturned	N/A	N/A	N/A	63%	0%

*Quarterly appeal rate = appeals per 1000/members

Summary

NHPRI's two hundred and fourteen (214) appeals in Q2 2021 represents 8% increase in appeal rate per thousand (1000) members from Q1 2021.

NHPRI subcontracts to OPTUM for BH and eviCore for high end radiological diagnostics, both entities conduct internal appeals which are reflected in total numbers.

OPTUM reported eleven (11) Appeals in Q2 2021 representing an appeal rate 0.26/1000 members.
eviCore reported one hundred and fifty-six (156) appeals in Q2 2021 representing an appeal rate of 0.92/1000members.

NHPRI Quarterly Report Q2-2021 Grievances and Complaints

	RIte Care	CSN	RHP	RHE	SubCare	AE
Number of Grievances	11	0	12	12	0	12
Number of Complaints	12	1	14	14	0	1
Total	23	1	26	26	0	13

Summary

NHPRI reported a total of seventy-six (76) Grievances and Complaints in Q2 2021. Grievances represented 46.05% of total and complaints represented 53.95% of total. Of the total reported grievances 47.37% were Access to Care and Quality of Care issues. Twenty-seven (27) of the seventy-six (76) grievances were reported as Quality of Care issues and all were attributed to three (3) Accountable Entities (AE) contracted with NHPRI.

II. THRIT QUARTERLY REPORT Q2-2021 - APPEALS, GRIEVANCES AND COMPLAINTS

THRIT Quarterly Report Q2-2021_ Prior Authorization Requests

	RIte Care	CSN	RHP	RHE	(AE)*
Prior Authorization Requests	355	0	810	0	174
Concurrent Authorization Requests	73	0	217	0	47

* (AE) represents authorization requests submitted by cohort members attributed to an AE

THRIT Quarterly Report Q2-2021 Appeals

Appeals Internal	RIte Care	CSN	RHP	RHE
Standard	0	0	1	0
% Overturned	0%	0%	100%	0%
Expedited	3	0	1	1
% Overturned	100%	0%	100%	0%
State Fair Hearing – External	**RIte Care**	**CSN**	**RHP**	**RHE**
Standard	0	0	0	0
% Overturned	0%	0%	0%	0%
Expedited	0	0	0	0
% Overturned	0%	0%	0%	0%

Summary

THPRIT reported a total number of five (5) consumer appeals representing a rate 0.10/ 1000 members.

THRIT Quarterly Report Q2 2021 Grievances and Complaints

	RIte Care	CSN	RHP	RHE	AE
Number of Grievances	1	0	1	0	
Number of Complaints	0	0	0	0	
Total	1	0	1	0	

Summary

The 2 grievances submitted by members represented issue with timely access to BH provider.

III. UHCP-RI Quarterly Report Q2-2021 - APPEALS, GRIEVANCES and COMPLAINTS

UHCP-RI Quarterly Report Q2-2021 Prior Authorization Requests

	RIte Care	**(AE)***	**CSN**	**(AE)**	**RHP**	**(AE)**	**RHE**	**(AE)**
Prior Authorization Requests	2,062	242	149	17	873	92	2,696	264
Concurrent Authorization Requests	313	5	50	0	348	8	703	12

* (AE) represents authorization requests submitted by cohort members attributed to an AE

UHCP-RI QUARTERLY REPORT Q2-2021 Appeals

Appeals Internal	**RIte Care**	**CSN**	**RHP**	**RHE**
Standard	60	3	31	80
% Overturned	78%	67%	65%	76%
Expedited	22	0	11	33
% Overturned	91%	0	73%	79%

State Fair Hearing – External	RIte Care	CSN	RHP	RHE
Standard	0	0	0	0
% Overturned	0%	0%	0%	0%
Expedited	0	0	0	0
% Overturned	0%	0%	0%	0%

Summary

UHCP-RI reported two hundred and forty (240) consumer appeals in Q2 2021 representing 1% increase in appeal rate per thousand (1000) members from Q1 2021.

UHCP-RI Quarterly Report Q2-2021 Grievances and Complaints

	RIte Care	CSN	RHP	RHE	AE
Number of Grievances	1	0	6	5	8
Number of Complaints	6	0	4	5	4
Total	7	0	10	10	12

Summary

Of the thirty-five (35) Grievances/Complaints submitted in Q2 2021; twelve (12) grievances represented issues with balance billing, this represents 34.29% of all member grievances.

Twelve (12) grievances were attributed to AEs and of these 12 all represented issues with quality and access to care.

IV. RIte Smiles (UHC Dental) Quarterly Report Q1 2021_APPEALS, GRIEVANCES and COMPLAINTS

RIte Smiles Quarterly Report Q1 2021_Prior Authorization Requests

	Dental	RX	RAD	Total
Prior Authorization Requests	1,975	0	0	1,975
Retrospective Authorization Requests	74	14	0	98

RIte Smiles QUARTERLY REPORT Q1 2021_APPEALS

Appeals Internal	**Dental**	**RX**	**RAD**
Standard	18	18	15
% Overturned	22%	33%	40%
Expedited	4	3	7
% Overturned	0%	0%	0%
State Fair Hearing – External	**Dental**	**RX**	**RAD**
Standard	0	0	0
% Overturned	0%	0%	0%
Expedited	0	0	0-
% Overturned	0%	0%	0%

Summary:
UHC Rite Smiles reported a total of 51 consumer appeals with an overturn rate of 31%. The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and subsequently submitted appeals and grievances and is reflected in the data.
The totals reported appeals represent a rate of 0.45/1000 members.

RIte Smiles Quarterly Report Q2 2021 Grievances and Complaints

	RIte Smiles
Number of Grievances	0
Number of Complaints	3
Total	3

Summary:
Rite Smiles reported 3 consumer complaints in Q2 2021. All three (3) complaints represented access and quality of care issues.

The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and, subsequently, submitted appeals and grievances and is reflected in the data.

Q3 2021

I. NHPRI QUARTERLY REPORT Q3-2021 APPEALS, GRIEVANCES AND COMPLAINTS

NHPRI Quarterly Report Q3-2021_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	5,713	17,640	N/A	N/A	1,137	3,329	N/A	N/A	3,489	10,081
Concurrent Authorization Requests	2,016	5,947	N/A	N/A	476	1,362	N/A	N/A	1,089	3,022

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	N/A	N/A	7,476	22,925	N/A	N/A	248	698
Concurrent Authorization Requests	N/A	N/A	2,339	6,513	N/A	N/A	229	709

*(AE) represents authorization requests submitted by cohort

NHPRI Quarterly Report Q3-2021 Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	111	267	10	22	42	169	125	406	3	11
% Overturned	61%		40%		50%		57%		67%	
Expedited	6	23	4	7	4	22	14	52	3	3
% Overturned	100%		75%		25%		43%		33%	

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	5	22	2	6	13	39	19	185	0	2
% Overturned	20%		50%		8%		21%		N/A	
Expedited	0	0	0	0	0	2	0	16	0	0
% Overturned	N/A		N/A		N/A		N/A		N/A	

*Quarterly appeal rate = appeals per 1000/members

Summary

NHPRI had a total of three hundred and twenty-two (322) internal appeals, two hundred and ninety-one (291) standard appeals and thirty-one (31) expedited. Thirty-nine (39) appeals were reviewed in State Fair Hearing. (SFH). Eleven (11) appeals were overturned in SFH.

NHPRI subcontracts to OPTUM for BH and eviCore for high end radiological diagnostics, both entities conduct internal appeals which are reflected in total numbers.

OPTUM reported eleven (11) Appeals in Q2 2021 representing an appeal rate 0.23/1000 members.
eviCore reported one hundred and fifty-six (156) appeals in Q3 2021 representing an appeal rate of 0.91/1000members.

NHPRI Quarterly Report Q3-2021 Grievances and Complaints

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD	AE	AE YTD

Number of Grievances	4	26	1	1	13	31	9	28	0	0	8	23
Number of Complaints	9	44	6	9	17	45	15	45	0	0	8	14
Total	13	70	7	10	30	76	24	73	0	0	16	37

Summary

NHPRI reported a total of seventy-four (74) Grievances and Complaints in Q3 2021. Of the seventy-four (74), sixteen (16) were attributed to Accountable Entities (AE).

II. THRIT QUARTERLY REPORT Q3-2021 - APPEALS, GRIEVANCES AND COMPLAINTS

THRIT Quarterly Report Q3-2021_ Prior Authorization Requests

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	(AE)*	(AE)* YTD
Prior Authorization Requests	334	1,025	0	0	847	2,347	0	0	174	348
Concurrent Authorization Requests	8	417	0	0	213	1,120	0	0	47	94

* (AE) represents authorization requests submitted by cohort members attributed to an AE

THRIT Quarterly Report Q3-2021 Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD
Standard	0	1	0	0	2	3	0	0
% Overturned	0%		0%		0%		0%	
Expedited	2	8	0	0	1	7	0	1

% Overturned	100%		0%		0%		0%	

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD
Standard	0	0	0	0	0	0	0	0
% Overturned	0%		0%		0%		0%	
Expedited	0	0	0	0	0	0	0	0
% Overturned	0%		0%		0%		0%	

Summary

THPRIT reported a total number of five (5) consumer appeals in Q3 2021

THRIT Quarterly Report Q3 2021 Grievances and Complaints

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	AE	AE YTD
Number of Grievances	0	3	0	0	2	6	0	0	0	2
Number of Complaints	0	0	0	0	0	0	0	0	0	0
Total	0	3	0	0	0	6	0	0	0	2

Summary

The 2 grievances submitted by members represented issue with timely access to BH provider.

III. UHCP-RI Quarterly Report Q3-2021 - APPEALS, GRIEVANCES and COMPLAINTS

UHCP-RI Quarterly Report Q3-2021 Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD
Prior Authorization Requests	2,080	7,007	205	650	170	469	22	66

Concurrent Authorization Requests	290	788	5	11	137	224	0	0

	RHP	RHP YTD	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD
Prior Authorization Requests	1,117	3,064	125	301	2,696	8,108	264	782
Concurrent Authorization Requests	377	1,042	60	71	703	2,053	12	24

* (AE) represents authorization requests submitted by cohort members attributed to an AE

UHCP-RI QUARTERLY REPORT Q3-2021 Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD
Standard	52	153	2	46	19	74	80	231
% Overturned	67%		100%		74%		76%	
Expedited	9	63	1	3	9	44	33	111
% Overturned	78%		0%		78%		79%	

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD
Standard	0	0	0	0	0	0	0	1
% Overturned	0%		0%		0%		0%	
Expedited	0	0	0	0	0	0	0	0
% Overturned	0%		0%		0%		0%	

Summary

UHCP-RI reported two hundred and five (205) consumer appeals in Q3 2021. One Hundred and Fifty-three (153) standard, fifty-two (52) expedited internal appeals. Zero (0) member appeals were sent to SFH.

UHCP-RI Quarterly Report Q3-2021 Grievances and Complaints

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	AE	AE YTD
Number of Grievances	2	5	0	0	0	8	4	11	3	14
Number of Complaints	4	16	2	3	1	5	9	25	9	20
Total	6	21	2	3	1	13	13	36	12	34

Summary

Of the thirty-four (34) Grievances/Complaints submitted in Q3 2021; seven (7) grievances represented issues with balance billing,

Twelve (12) grievances were attributed to AEs and of these 12 all represented issues with balance billing.

EOHHS continues to monitor UHCCP regarding complaints by members of balance billing. UHCCP continues to address and demonstrate improvement with said issues.

IV. RIte Smiles (UHC Dental) Quarterly Report Q3 2021_APPEALS, GRIEVANCES and COMPLAINTS

RIte Smiles Quarterly Report Q3 2021_Prior Authorization Requests

	Dental	Dental YTD	RX	RX YTD	RAD	RAD YTD	Total	Totals YTD
Prior Authorization Requests	1,780	4,280	0	488	0	635	1,780	5,403
Retrospective Authorization Requests	75	165	0	29	0	18	75	222

RIte Smiles QUARTERLY REPORT Q3 2021_APPEALS

Appeals Internal	Dental	Dental YTD	RX	RX YTD	RAD	RAD YTD
Standard	63	90	0	18	0	28

% Overturned	6%		0%		0%	
Expedited	0	8	0	7	0	28
% Overturned	0%		0%		0%	
State Fair Hearing – External	**Dental**	**Dental YTD**	**RX**	**RX YTD**	**RAD**	**RAD YTD**
Standard	0	0	0	1	0	21
% Overturned	0%		0%		0%	
Expedited	0	0	0	0	0	16
% Overturned	0%		0%		0%	

Summary

UHC Rite Smiles reported a total of sixty-three (63) consumer appeals. The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and subsequently submitted appeals and grievances and is reflected in the data.

RIte Smiles Quarterly Report Q3 2021 Grievances and Complaints

	RIte Smiles	**RIte Smiles YTD**
Number of Grievances	0	0
Number of Complaints	0	4
Total	0	4

Summary

RIte Smiles reported zero (0) consumer complaints in Q3 2021.

The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and, subsequently, submitted appeals and grievances and is reflected in the data.

Q4 2021

I. NHPRI QUARTERLY REPORT Q4-2021 APPEALS, GRIEVANCES AND COMPLAINTS

NHPRI Quarterly Report Q4-2021_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	6,089	18,016	N/A	N/A	1,116	4,445	N/A	N/A	3,253	13,334
Concurrent Authorization Requests	1,949	6,014	N/A	N/A	857	2,219	N/A	N/A	1,005	4,007

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	N/A	N/A	7,670	30,595	N/A	N/A	175	873
Concurrent Authorization Requests	N/A	N/A	1,985	8,498	N/A	N/A	318	1,027

*(AE) represents authorization requests submitted by cohort

NHPRI Quarterly Report Q4-2021 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	99	366	8	30	71	240	140	546	0	11
% Overturned	61%		63%		42%		59%		N/A	
Expedited	6	23	1	8	3	25	38%	52	1	4
% Overturned	57%		100%		100%		43%		100%	

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	13	35	4	10	13	39	21	206	1	3
% Overturned	63%		75%		8%		19%		100%	
Expedited	0	0	0	0	0	2	0	16	0	0
% Overturned	N/A		N/A		N/A		N/A		N/A	

*Quarterly appeal rate = appeals per 1000/members

Summary

Internal Appeals

Q 4 2022: Internal Appeals: NHPRI had a total of 380 internal appeals; 318 standard, 45% overturn rate and 62 expedited appeals, 80% overturn rate

Year to Date (YTD): Internal Appeals NHPRI had a total 1,312 internal appeals; 1,193 standard, and 119 expedited

State Fair Hearing-External Appeals

Q4 2022: State Fair Hearing (SFH): NHPRI had a total of 52 external appeals, 52 standard, 53% overturn rate and zero expedited.

Year to Date (YTD): SFH NHPRI had a total of 311 external appeals, 293 standard appeals and 18 expedited external appeals

NHPRI subcontracts to OPTUM for BH and eviCore for high end radiological diagnostics, both entities conduct internal appeals which are reflected in total numbers.

OPTUM reported five (5) Appeals in Q4 2022 representing an appeal rate 0.11/1000 members.

eviCore reported one hundred and ten (110) appeals in Q4 2022 representing an appeal rate of 0.63/1000members.

NHPRI Quarterly Report Q4-2021_Grievances and Complaints

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD	AE	AE YTD
Number of Grievances	10	46	1	3	8	47	10	48	0	0	4	29
Number of Complaints	15	59	4	13	10	55	14	59	1	0	10	24
Total	25	105	7	16	18	102	24	97	1	1	14	51

Summary

Grievances/Complaints

Q4 2022: Grievances and Complaints: NHPRI had a total of 73 Grievances and Complaints; 29 Grievances and 44 Complaints. Of the 73 total; 2 grievances and 2 complaints were directly attributed to Accountable Entities (AE) (included in totals). NHPRI reported 11 access to care and 19 quality of care grievances.

Year to Date (YTD): Grievances and Complaints: NHPRI had a total 330 Grievances and Complaints; 144 Grievances, 186 Complaints, 51 attributed to AE (included in total)

II. UHCPP_ QUARTERLY REPORT Q4-2021_APPEALS, GRIEVANCES AND COMPLAINTS

UHCCP Quarterly Report Q4-2021_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	2,301	9,308	172	822	189	658	17	83	1,116	4,180
Concurrent Authorization Requests	296	1,084	16	27	47	274	0	0	390	1,432

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	83	384	2,711	10,819	239	1,021	N/A	N/A
Concurrent Authorization Requests	44	159	505	2,558	65	89	N/A	N/A

UHCP Quarterly Report Q4-2021 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	40	193	5	55	30	104	86	317	N/A	N/A
% Overturned	80%		60%		77%		78%			
Expedited	17	80	2	5	15	59	31	111	N/A	N/A
% Overturned	88%		50%		67%		90%			

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	1	1	0	0	0	0	0	1	N/A	N/A
% Overturned	0%		0%		0%		0%			
Expedited	0	0	0	0	0	0	0	0	N/A	N/A
% Overturned	0%		0%		0%		0%			

*Quarterly appeal rate = appeals per 1000/members

Summary

Internal Appeals

Q4 2021: Internal Appeals: UHCP had a total of 226 internal appeals; 161 standard, overturn rate of 73.75% and 65 expedited appeals, 73.75% overturn rate

Year to Date (YTD): Internal Appeals UHCP had a total 924 internal appeals; 669 standard, and 255 expedited

State Fair Hearing-External Appeals
Q4 2021: State Fair Hearing (SFH): UHCCP had a total of 1 external appeals
Year to Date (YTD): SFH UHCCP had a total of 2 external appeals.

UHCP Quarterly Report Q4-2021_Grievances and Complaints

	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD	AE	AE YTD
Number of Grievances	3	8	0	0	2	8	3	11	N/A	N/A	4	6
Number of Complaints	5	21	1	4	1	9	8	19	N/A	N/A	7	7
Total	8	29	1	4	3	17	11	30	N/A	N/A	11	13

Summary

Grievances/Complaints
Q4 2021: Grievances and Complaints: UHCP had a total 23 Grievances and Complaints. There were 8 Grievances reported; 6 representing quality of care issues, 2 representing access to care. There were 17 Complaints reported; all 17 represented issues regarding provider balanced billing.
Year to Date (YTD): Grievances and Complaints: UHCP 80 reported grievances and complaints in 2021.

III. THRIT_ QUARTERLY REPORT Q4-2021_APPEALS, GRIEVANCES AND COMPLAINTS

THRIT Quarterly Report Q4-2021_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	356	1,381	N/A	N/A	0	0	N/A	N/A	757	2,347

Concurrent Authorization Requests	60	477	N/A	N/A	0	0	N/A	N/A	207	1,120

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	N/A	N/A	0	0	N/A	N/A	N/A	N/A
Concurrent Authorization Requests	N/A	N/A	0	0	N/A	N/A	N/A	N/A

*(AE THRIT did not participate in AE program in 2021)

THRIT Quarterly Report Q4-2021 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	0	1	0	0	1	9	0	0	N/A	N/A
% Overturned	N/A		N/A		N/A		N/A		N/A	N/A
Expedited	2	8	0	0	5	12		1	N/A	N/A
% Overturned	50%		N/A		80%		N/A		N/A	N/A

State Fair Hearing-External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	0	0	0	0	0	0		0	N/A	N/A
% Overturned	N/A		N/A		N/A		N/A		N/A	N/A
Expedited	0	0	0	0	0	0	N/A	0	N/A	N/A
% Overturned	N/A		N/A		N/A		N/A		N/A	N/A

*Quarterly appeal rate = appeals per 1000/members

Summary

Internal Appeals

Q 4 2021: Internal Appeals: THRIT had a total of 8 internal appeals; 1 standard, none overturn ed and 7 expedited appeals, 32% overturn rate

Year to Date (YTD): Internal Appeals THRIT had a total 31 internal appeals; 10 standard, and 21 expedited

State Fair Hearing-External Appeals

Q4 2021: State Fair Hearing (SFH): THRIT had a total of 0 external appeals

Year to Date (YTD): SFH NHPRI had a total of 0 external appeals.

THRIT Quarterly Report Q4-2021_Grievances and Complaints

Grievances/Complaints	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD	AE	AE YTD
Number of Grievances		3		0		6		0				2
Number of Complaints		0		0		0		0				0
Total												

Summary

Grievances/Complaints

Q4 2021: Grievances and Complaints: THRIT had a total 0 Grievances and Complaints.

Year to Date (YTD): Grievances and Complaints: THRIT had a total 9 Grievances and Complaints; 9 Grievances, 0 Complaints.

IV. UHC Dental QUARTERLY REPORT Q4 2021_ APPEALS, GRIEVANCES AND COMPLAINTS

UHC Dental (Rite Smiles) Quarterly Report Q4-2021_Prior Authorization Requests

RIte Smiles Quarterly Report Q4 2021_Prior Authorization Requests

	Dental	Dental YTD	RX	RX YTD	RAD	RAD YTD	Total	Totals YTD
Prior Authorization Requests	0	4,280	0	488	0	635		5,403
Retrospective Authorization Requests	0	165	0	29	0	18		222

RIte Smiles QUARTERLY REPORT Q4 2021_APPEALS

Appeals Internal	Dental	Dental YTD	RX	RX YTD	RAD	RAD YTD
Standard	61	111	0	18	0	28
% Overturned	16%		0%		0%	
Expedited	0	8	0	7	0	28
% Overturned	0%		0%		0%	
State Fair Hearing – External	**Dental**	**Dental YTD**	**RX**	**RX YTD**	**RAD**	**RAD YTD**
Standard	0	0	0	1	0	21
% Overturned	0%		0%		0%	
Expedited	0	0	0	0	0	16
% Overturned	0%		0%		0%	

Summary

Internal Appeals

Q4 2022: Internal Appeals: Rite Smiles had a total of 61 internal appeals; all 61 appeals representing general dentistry services covered with 16% overturn rate

Year to Date (YTD): Internal Appeals Rite Smiles had a total 200 internal appeals; 157 standard, and 43 expedited

State Fair Hearing-External Appeals

Q4 2022: State Fair Hearing (SFH): <>had a total of 52 external appeals, 52 standard, 53% overturn rate and zero expedited.
Year to Date (YTD): SFH NHPRI had a total of 311 external appeals, 293 standard appeals and 18 expedited external appeals

RIte Smiles Quarterly Report Q4 2021 Grievances and Complaints

	RIte Smiles	RIte Smiles YTD
Number of Grievances	0	0
Number of Complaints	0	4
Total	0	4

Summary
RIte Smiles reported zero (0) consumer complaints in Q4 2021

The Public Health Emergency (PHE) had a significant impact on dental services, directly impacting service requests and, subsequently, submitted appeals and grievances and is reflected in the data.

*Quarterly appeal rate = appeals per 1000/members

Aggregated Grievances, Appeals, Denials of Services Data

MCO	Total Grievances	Total Appeals	Total Denials of Services*
NHPRI	330	1,628	
THRIT	9	31	
UHCP	80	926	
RITE Smiles	0	511	
Totals	**419**	**3,096**	

*Total Denials per Prior Authorizations will be reported beginning with DY 14 Q1.

XIII. State Contact(s)

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XIV. Date Submitted to CMS

8/5/22