Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

DY14 Quarterly

January 1, 2022 – March 31, 2022

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

Submitted August 2022

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 14 January 1, 2022 – March 31, 2022

II. Introduction

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

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

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of:

1) Disproportionate Share Hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D Contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third-party payer.

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

changes implemented using the processes described in section IV of the STCs.

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

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

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

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

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

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

III. Enrollment Information

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

Note:

Enrollment counts should be participant counts, not participant months.

Summary:

Number of current enrollees as of the last day of the month in the reported quarter (March 31, 2022) with eligibility for full benefits is **345,504**. This does not include another 2,396 members eligible under Rhode Island's separate CHIP program (and not reflected in **Table III.1**). Nor does it include an additional **14,032** members with partial Medicaid coverage.

The 1.1% increase in Medicaid enrollment (full Benefits) over the quarter is due to continued moratorium on redeterminations consistent with CMS guidance related to Public Health Emergency. EOHHS only terminated members due to death, a request for termination by the member and a member moving out-of-state.

Table III.1 Medicaid-Eligible Enrollment Snapshot as of Quarter-End (in Current DY) and Year-End

	DY12	DY13	DY14					
	Dec-20	Dec-21	Mar-21	Jun-21	Sep-21	Dec-21	Quarter Δ	YTD Δ
01: ABD no TPL	15,560	15,418	15,377				-41	-41
02: ABD TPL	31,953	32,990	33,206				216	216
03: Rite Care	135,642	138,844	139,480				636	636
04: CSHCN	12,460	12,209	12,055				-154	-154
05: Family Planning	1,688	1,366	1,243				1	1
06: Pregnant Expansion	43	56	57				781	781
07: CHIP Children	32,154	35,871	34,377				92	92
10: Elders 65+	8,919	9,563	9,655				2	2
14: BCCPT	78	87	89				40	40
15: ORS CNOM	539	585	625				-81	-81
17: Early Intervention	1,795	1,775	1,694				-17	-17
18: HIV	774	808	791				46	46
21: 217-like	4,465	4,671	4,717				2,311	2,311
22: New Adult Group	92,321	103,835	106,146				0	0
27: Undocumented	105	24	24				-123	-123
Grand Total	**337,009**	**355,827**	359,536				121	121
Subtotal - Full Benefits	**323,189**	**341,706**	**345,504**				3,830	3,830
Subtotal - Partial Medicaid	13,820	14,121	14,032				3,881	3,881

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

	DY12	DY13	DY14					
			Mar-22	Jun-22	Sep-22	Dec-22	Quarter Δ	YTD Δ
07: CHIP Pregnant & Unborn	1,487	2,275	2,396				121	121
10: Elders 65+ - MPP Only	7,488	8,094	8,160				66	66
99: Base	14	14	14				0	0

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. These members are not 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)

	DY12	DY13	DY14					
			Mar-22	Jun-22	Sep-22	Dec-22	Quarter Δ	YTD Δ
01: ABD no TPL	104	101	82				-19	-19
02: ABD TPL	32	25	21				-4	-4
03: Rite Care	58	59	49				-10	-10
04: CSHCN	1	2	2				0	0
21: 217-like	1	0	0				0	0
22: New Adult Group	486	487	381				-106	-106
Grand Total	**682**	**674**	**535**				-139	-139

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
3. These counts will be updated (and increase) as more claims are paid and submitted to EOHHS thereby identifying more individuals with an IMD SUD related claim.

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 **3,807**.

The cumulative count of terminations in the current demonstration year is **3,807**.

Table III.4 Medicaid-eligible members that lost eligibility by Quarter (in Current DY) and in Demonstration Year

	DY12	DY13	DY14				
			Mar-22	Jun-22	Sep-22	Dec-22	YTD
01: ABD no TPL	549	599	196				196
02: ABD TPL	3,271	2,072	388				388
03: Rite Care	5,443	4,781	1,393				1,393
04: CSHCN	288	416	322				322
05: Family Planning	195	86	60				60
06: Pregnant Expansion	2	2	1				1
07: CHIP Children	1,562	1,085	303				303
10: Elders 65+	1,555	404	126				25
14: BCCPT	9	2	0				0
15: ORS CNOM	5	1	293				293
17: Early Intervention	1,097	1,014	266				266
18: HIV	72	60	38				38
21: 217-like	390	354	64				64
22: New Adult Group	5,638	4,269	1,240				1,240
27: Undocumented	8	88	7				7
Grand Total	**20,084**	**15,233**	**4,697**				**4,735**
Subtotal - Full MA Only	**17,152**	**13,580**	**3,807**				**3,807**

Notes to Table III.4:

1. Loss of Eligibility reflects complete the 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.
3. Within current DY, YTD refers to number who have lost eligibility between December 31 of prior fiscal year and end of the most recent quarter. Members who regained eligibility in a quarter would not be counted.

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

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of DY 14 January 1, 2022 – March 31, 2022:

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

	DY12	DY13	DY14				
			Mar-22	Jun-22	Sep-22	Dec-22	YTD Avg.
New	28	68	52				52
Continuing	506	571	695				695
Grand Total	**534**	**638**	**747**				**747**

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 DY14 January 1, 2022 – March 31, 2022 (by category or by type) with a total of **$4,403.22** for special purchases expenditures.

Q1 2022	# of Units / Items	Item or Service	Description of Item/ Service (if not self-explanatory)	Total Cost
	4	Over the counter medications		$ 718.94
	7	Acupuncture		$ 1,853.00
	13	Service Dog Training		$1,625.00
	1	Massage Therapy		$ 95.00
	1	Protein Powder		$ 51.29
	1	Medic Alert		$ 59.99
	CUMULATIVE TOTAL			**$4,403.22**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for January 1, 2022 – March 31, 2022.

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 2022

- EOHHS focused on implementation of Program Year 5 (PY5) including certifying Accountable Entities to bear downside risk and reviewing and approving certification applications.
- AEs continued working on remaining project milestones for PY3 as they began working on Q2 PY4 HSTP Project Plan Milestones.
- EOHHS continued to work with Bailit Health on 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., OPY4/QPY4) and next performance year (i.e., OPY5/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 meetings in January on “Best Practices in Transitions of Care” and a final technical assistance meeting in March on “Program Achievements and Lessons Learned”.
- EOHHS held a stakeholder meeting for the Accountable Entities and Managed Care Organizations in February presenting on the Community Referral Platform “UniteUs”; a presentation by the Commission for the Deaf and Hard of Hearing on Workforce Training and a presentation by the 1115 Waiver Evaluator that detailed an overview of the evaluation.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in DY 14 January 1, 2022 – March 31, 2022.

Modernizing Health and Human Services Eligibility Systems

DY14 Q1
Between January 1, 2022 and March 31, 2022, the Deloitte and State teams implemented three (3) software releases to address 97 data incidents and 22 software enhancements for the RI Bridges eligibility system. These releases improved services for RIte Share, Medicaid Eligibility & Enrollment, Medicaid Medicare Premium Program as well as functionality improvements to customer and worker interfaces. No significant program development or issues were identified.

HCBS Quality Improvement

(DY 14/CY 2022 Q1)

In January 2022, the quality improvement team continued its biweekly technical assistance meetings with New Editions and monthly meetings with CMS. The team was particularly focused on timely compiling and submitting the data and deliverables due to CMS on January 31. According to the technical assistance plan, the State was required to submit:

- The State's Quality Assurance System and Strategy (STC 22c and 22g);
- The State's methodology for identifying the HCBS population (STC 22h); and
- A list of HCBS functions that are delegated from EOHHS to other State agencies through Memorandums of Understanding or other written documentation (STC 22f).

The State submitted these deliverables on time on January 31, 2022. In this submission, EOHHS also noted that its written agreements with other agencies (Interagency Service Agreements, or ISAs) would be revisited and revised to further clarify EOHHS' ongoing oversight and monitoring of these delegated functions, including performance metrics, definitions, data collection, reporting, and frequency. Drafts of updated ISAs with DCYF, DHS, BHDDH, and RIDOH will be provided by June 1, 2022.

In February and March, the quality team shifted focus to the remaining deliverables due in quarter 1. The State was required to submit the number of unduplicated participants served in CY 2019, CY 2020, and CY 2021 and estimated number of participants for CY 2022 (STC 22h) by February 28. The State was also required to submit an outline detailing its process and structure for reporting and remediating deficiencies in HCBS programs by March 1. These deliverables were submitted

together, ahead of the deadline, on February 25, 2022. The quality team also updated the Quality Strategy based on feedback provided by CMS at the monthly meeting in February.

The focal point of quarter 1 work was the evidentiary report due to CMS on March 31. This report provides data and other evidence of the State's ability to meet its established HCBS quality performance measures during CY 2019, CY 2020, and CY 2021. The quality team held individual meetings with each operating agency to highlight and address concerns with data submissions to ensure accuracy. EOHHS timely submitted the evidentiary report on March 31. The State and New Editions also developed a go-forward work plan to inform the goals and milestones of the quality monitoring project in the future.

Challenges and Steps to Address Challenges

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 in quarter 1:

- **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. The quality team has also established a subgroup focused specifically on data analytics.
- **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. The quality team has also established a subgroup focused on critical incidents, with representation from each operating agency involved in the project.
- **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 to the State. Aligning practices for information and education is a focal point for the critical incident subgroup.
- **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 for the remainder of DY 14 is to standardize provider training requirements.

<u>Workforce Recruitment and Retention</u>

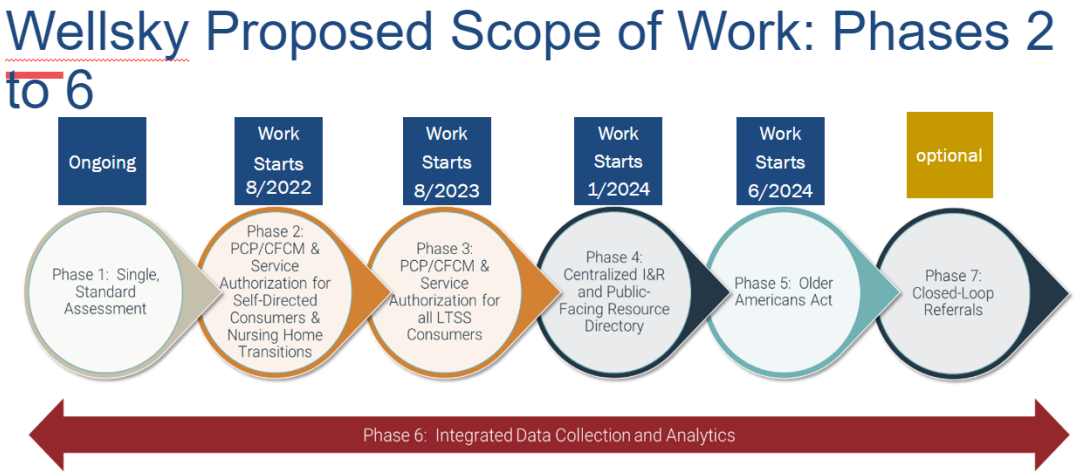
Supporting and building the HCBS direct care workforce is a cornerstone of Rhode Island's COVID-19 recovery strategy as well as our LTSS system rebalancing initiative. Many stakeholders have cited wages and training as priorities and highlighted that many direct care workers (DCWs) are tempted to leave the HCBS workforce due to better paying positions in retail or food service. As such, Rhode Island is investing nearly half of its funding available through the HCBS enhanced FMAP to support direct care workforce recruitment, retention, and training. In quarter 1, we made significant progress in distributing more that $57 million in funding to the HCBS direct care workforce. Specifically, we:

- Finalized fee schedules and distributed rate increases through EOHHS' vendor, Gainwell, for adjustments to approved claims to HBTS/PASS providers.
- Developed a funding mechanism and pre-print for the Enhanced Outpatient Service providers.
- Distributed $3.9 million to support workforce recruitment and retention for personal care attendants working in self-directed settings.
- Finalized workplans for a direct care worker outreach campaign.
- Defined our two primary audiences for workforce outreach campaign—existing HCBS workforce who may be interested in continuing their education or obtaining advanced certification and new prospective members of the HCBS workforce.
- Began audience research to develop demographic and psychographic profiles of these two audiences, with the goal of understanding drivers of and barriers to behavior change that will ultimately influence how we message these opportunities to the audiences.

LTSS System Modernization

Rhode Island continues to make progress towards implementing a true No Wrong Door System to improve the consumer experience with LTSS, reduce historic agency silos, and ensure compliance with the HCBS Final Rule.

This work includes an IT cloud-based solution for all ancillary functions that establishes an LTSS e-record at the point of entry and provides information that follows the person as they move across agencies, providers, and the service continuum. Wellsky has been chosen as the software vendor for this work. In quarter 1, the LTSS interagency team agreed to the following framework for software development over a period of three years:



In quarter 1, we finalized the scope of work for phase 1 to implement a single standard functional assessment for LTSS HCBS. Finalizing the scope and contract for phases 2-7 is a priority for quarter 2.
Significant business process and policy work needs be done alongside the IT solution development in order to effectively implement a robust No Wrong Door system. The following steps were taken in quarter 1 to meet this goal:

- Partnered with New Editions to provide technical assistance through CMS and help the State meet CMS' HCBS Final Rule requirements for conflict-free case management.
- Partnered with Guidehouse to provide project management and implementation support for conflict-free case management.
- Conducted other state research to support the State's CFCM/PCP design and implementation.
- Analyzed the state's current approach to CFCM/PCP delivery to support its future state design.
- Issued a cost survey to DD providers, including service coordination/case management activities.
- Developed and refined a draft stakeholder developed strategic plan to support CFCM/PCP implementation.

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, 2022 – March 31, 2022.

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	Pending	N/A
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	Pending	N/A
SPA	21-0009-Home Home Care Rate Increases and Enhancements	9/7/21	Pending	N/A
SPA	21-0010-Hospice	8/13/21	Pending	N/A
SPA	21-0011-Inpatient UPL Payments	8/16/21	Pending	N/A
SPA	21-0012-Community Health Workers (CHW) Services	9/28/21	Pending	N/A
SPA	21-0013-Doula Services	9/28/21	Pending	N/A

Request Type	Description	Date Submitted	CMS Action	Date
SPA	21-0014-Category F Elimination	11/23/21	Approved	2/10/22
SPA	21-0015- Nursing Home Minimum Staffing	12/3/21	Pending	N/A
SPA	21-0016- Inpatient Inflation Update	12/3/21	Pending	N/A
SPA	21-0017- Outpatient Inflation Update	12/6/21	Pending	N/A
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	Pending	N/A
SPA	21-0021- Congregate Dental	12/23/21	Pending	N/A
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	Pending	N/A
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

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 14 Q1 January 1, 2022 – March 31, 2022 or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

January – March 2022

The Rhode Island Executive Office of Health and Human Services (RI 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 Prior Authorization (PA) requests, PA request denials, 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.

Currently there 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, (RHE)
- Children with Special Health Care Needs (CSN),
- Children in Substitute Care (Sub Care). NHPRI ONLY

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
- 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 and included in the total data.

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
- orthodontic services

Please note, in accordance with CMS, the State of Rhode Island required the MCOs to temporarily removed the prior authorization requirements during the federally mandated Public Health Emergency (PHE) on most medical, specific pharmaceutical and behavioral health services. This rule was lifted as of October 1, 2021, with the exception of prior authorizations (PAs) related to behavioral healthcare services. Subsequently, as of January 1, Behavioral Health PA restrictions were lifted. Quarter 1, 2022 data reflects lifting PA restrictions.

The quarterly reports are reviewed by the RI EOHHS Chief Compliance Officer and/or designee. 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. In Q1-2022 appeals and grievance data reviews have not resulted in EOHHS implementing any corrective actions. EOHHS Compliance department reviews submitted A&G quarterly reports for trends in member service dissatisfaction, including but not limited to, access to services, balance billing and quality of care. In addition to the quarterly A&G data review, EOHHS Compliance reviews total number of PAs as well as the PA denial rate per cohort.
Of note, EOHHS reviews for any increases in issues of dissatisfaction specifically attributed to AEs.

I. Neighborhood Health Plan of Rhode Island (NHPRI)

QUARTERLY REPORT Q1-2022<> APPEALS, GRIEVANCES AND COMPLAINTS

Quarterly Report Q1-2022_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	6312	6312	0	0	1044	1044	0	0	3525	3525
Prior Authorization Denials	545	545	0	0	38	38	0	0	259	259

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	0	0	8030	8030	0	0	233	233
Prior Authorizations Denials	0	0	729	729	0	0	8	8

*(AE) represents authorization requests submitted by cohort

2022 Quarterly Report Q1 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	78	78	15	15	55	55	133	133	2	2
Overturned	46	46	5	5	16	16	80	80	2	2
Expedited	6	6	1	1	4	4	8	8	0	0
Overturned	4	4	1	1	4	4	4	4	0	0

State Fair Hearing - External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare	SubCare YTD
Standard	11	11	3	3	20	20	26	26	233	233
Overturned	4	4	2	2	5	5	7	7	0	0
Expedited	0	0	0	0	0	0	1	1	0	0

Overturned	0	0	0	0	0	0	0	0	0	0

*Quarterly appeal rate = appeals per 1000/members

Summary

Internal Appeals

Q 1 2022: Prior Authorizations: NHPRI reported nineteen thousand and one hundred and thirty- four (19,134) PAs (across all cohorts) of which one thousand and five hundred and seventy-nine (1579) PAs were denied representing a 8.25% denial rate.

- PA Denial Rates/Total # of PAs per cohort:
  - Rite Care: 9%
  - CSN 4%
  - RHP 7%
  - RHE 9%
  - SubCare 3%

Q1 2022 Internal Standard Appeals: NHPRI reported two hundred and eighty-three (283) standard internal appeals (across all cohorts) of which one hundred and forty-nine (149) were overturned

- Internal Standard Appeal denial rates/total denials
  - Rite Care 59%
  - CSN 35%
  - RHP 29%
  - RHE 60%
  - SubCare 100%

Q1 2022 Internal Expedited Appeals: NHPRI reported nineteen (19) expedited internal appeals (across all cohorts) of which thirteen (13) were overturned.

- Internal Expedited Appeal denial rates/total denials
  - Rite Care 67%
  - CSN 100%
  - RHP 100%
  - RHE 50%
  - Sub 0%

External Appeals

Q1 2022 External Standard Appeals (State Fair Hearings): NHPRI reported two hundred and ninety-three (293)* standard external appeals (across all cohorts) of which eighteen (18) were overturned

- External Standard Appeal denial rates/total denials
  - Rite Care 36%
  - CSN 67%
  - RHP 25%
  - RHE 26%
  - Sub 0%
- * NHPRI reported two-hundred and thirty-three (233) Appeals were forwarded

to SFH (external), NHPRI is investigating this number as it is an anomaly and appears to be a data entry issue. The issue is currently under investigation by NHPRI and RI EOHHS.

Q1 2022 External Expedited Appeals (State fair Hearings): NHPRI reported one (1) expedited external appeals (across all cohorts) of which zero (0) were overturned.

- External Expedited Appeal denial rates/total denials
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%
  - Sub 0%

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

NHPRI Quarterly Report Q1-2022_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	9	9	2	2	9	9	17	17	0	0	10	10
Number of Complaints	10	10	0	0	16	16	17	17	0	0	7	7
Total	19	19	2	2	25	25	34	34	0	0	17	17

Summary

Grievances/Complaints

Q 1 2022:_Grievances and Complaints: NHPRI had a total of eighty (80) Grievances and Complaints; thirty-seven (37) Grievances and 43 Complaints; 10 were directly attributed to Accountable Entities (AE). Of the thirty-seven (37) total; ten (10) grievances and complaints were directly attributed to Accountable Entities (AE) (included in totals). Of the thirty-seven (37) Grievances, twenty-six (26) represented quality of care issues and eleven (11) access to care issues

II. United HealthCare Community Plan – Rhode Island (UHCCP-RI)

QUARTERLY REPORT Q1-2022 UHCCP_RI APPEALS, GRIEVANCES AND COMPLAINTS

Quarterly Report Q1-2022_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	4755	4755	208	208	392	392	23	23	2760	2760
Prior Authorization Denials	1200	1200	27	27	71	71	2	2	537	537

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare** (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	87	87	6798	6798	225	225	N/A	N/A
Prior Authorizations Denials	21	21	1599	1599	26	26	N/A	N/A

2022 Quarterly Report Q1 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare ** (NHP Only)	SubCare YTD (NHP Only)
Standard	49	49	1	1	33	33	77	77	N/A	N/A
Overturned	37	37	1	1	27	27	62	62	N/A	N/A
Expedited	2	2	0	0	9	9	41	41	N/A	N/A
Overturned	1	1	0	0	8	4	29	29	N/A	N/A

State Fair Hearing – External	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare (NHP Only)	SubCare YTD (NHP Only)
Standard	0	0	0	0	0	0	0	0	N/A	N/A
Overturned	0	0	0	0	0	0	0	0	N/A	N/A
Expedited	0	0	0	0	0	0	0	0	N/A	N/A
Overturned	0	0	0	0	0	0	0	0	N/A	N/A

*(AE) represents authorization requests submitted by cohort
**SubCare – NHPRI Only

Summary

Prior Authorizations
Q 1 2022: Prior Authorizations: UHCCP-RI reported fourteen thousand-seven hundred and five (14705) PAs (across all cohorts) of which one three thousand four hundred and seven (3407) PAs were denied representing a 23.16% total denial rate.

- PA denial rates/total # of PAs per cohort:
  - Rite Care: 25%
  - CSN 18%
  - RHP 19%
  - RHE 24%

Internal Appeals
Quarterly appeal rate = appeals per 1000/members

Q1 2022 Internal Standard Appeals: UHCCP-RI reported one-hundred and sixty (160) standard internal appeals (across all cohorts) of which one-hundred and twenty-seven (127) were overturned

- Internal standard appeal denial rates/total # denials per cohort
  - Rite Care 76%
  - CSN 100%
  - RHP 82%
  - RHE 81%

Q1 2022 Internal Expedited Appeals: UHCCP-RI reported fifty-two (52) expedited internal appeals (across all cohorts) of which thirty-eight (38) were overturned.

- Internal expedited appeal denial rates/total # denials per cohort
  - Rite Care 83%
  - CSN 0%
  - RHP 89%

- RHE 71%

External Appeals

Q1 2022 External Standard Appeals (State Fair Hearings): UHCCP-RI reported zero (0)standard external appeals (across all cohorts)

- External standard appeal denial rates/total denials
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%

Q1 2022 External Expedited Appeals (State fair Hearings): UHCCP-RI reported zero (0) expedited external appeals (across all cohorts).

- External Expedited Appeal denial rates/total denials
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%

UHCCP-RI Quarterly Report Q1-2022_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	9	9	2	2	9	9	17	17	0	0	10	10
Number of Complaints	10	10	0	0	16	16	17	17	0	0	7	7
Total	19	19	2	2	25	25	34	34	0	0	17	17

Summary

Grievances/Complaints

Q 1 2022: Grievances and Complaints: UHCCP-RI had a total of twenty-six (26) Grievances and Complaints; seven (7) Grievances and nineteen (19) Complaints; eleven (11) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the twenty-six (26) Grievances, five (5) represented quality of care issues, two (2) access to care issues and seven (7) balance billing issues.

III. Tufts Health Public Plan RITogether – (THRIT)

QUARTERLY REPORT Q1-2022 THRIT_ APPEALS, GRIEVANCES AND COMPLAINTS

Quarterly Report Q1-2022_Prior Authorization Requests

	RIte Care	RIte Care YTD	(AE)*	(AE)* YTD	CSN	CSN YTD	(AE)	(AE) YTD	RHP	RHP YTD
Prior Authorization Requests	362	362	36	36	0	0	0	0	706	706
Prior Authorization Denials	47	47	6	6	0	0	0	0	80	80

	(AE)	(AE) YTD	RHE	RHE YTD	(AE)	(AE) YTD	SubCare** (NHP Only)	SubCare (NHP Only) YTD
Prior Authorization Requests	137	137	0	0	0	0	N/A	N/A
Prior Authorizations Denials	13	13	0	0	0	0	N/A	N/A

2022 Quarterly Report Q1 _Appeals

Appeals Internal	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare ** (NHP Only)	SubCare YTD (NHP Only)
Standard	2	2	0	0	1	1	0	0	N/A	N/A

Overturned	0	0	0	0	0	0	0	0	N/A	N/A
Expedited	0	0	0	0	11	11	0	0	N/A	N/A
Overturned	0	0	0	0	4	4	0	0	N/A	N/A

External -State Fair Hearing	RIte Care	RIte Care YTD	CSN	CSN YTD	RHP	RHP YTD	RHE	RHE YTD	SubCare (NHP Only)	SubCare YTD (NHP Only)
Standard	0	0	0	0	0	0	0	0	N/A	N/A
Overturned	0	0	0	0	0	0	0	0	N/A	N/A
Expedited	0	0	0	0	0	0	0	0	N/A	N/A
Overturned	0	0	0	0	0	0	0	0	N/A	N/A

*(AE) represents authorization attributed to AEs by cohort -included in totals
**SubCare – NHPRI Only

Summary

Prior Authorizations

Q 1 2022: Prior Authorizations: THRIT reported one-thousand and four (1104) PAs (across all cohorts) of which one hundred and forty-six (146) PAs were denied representing 13.22% denial rate.

- PA denial rates/total # of PAs per cohort:
  - Rite Care 13%
  - CSN 0%
  - RHP 11%
  - RHE 0%

Internal Appeals
Quarterly appeal rate = appeals per 1000/members

Q1 2022 Internal Standard Appeals: THRIT reported one (1) standard internal appeals (across all cohorts) of which zero (0) were overturned, representing 0% overturn rate.

- Internal standard appeal denial rates/total # denials per cohort
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%

Q1 2022 Internal Expedited Appeals: THRIT reported eleven (11) expedited internal appeals (across all cohorts) of which four (4) were overturned representing 36% denial rate.

- Internal expedited appeal denial rates/total # denials per cohort
  - Rite Care 0%
  - CSN 0%
  - RHP 36%
  - RHE 0%

External Appeals

Q1 2022 External Standard Appeals (State Fair Hearings): THRIT reported zero (0) standard external appeals (across all cohorts)

- External standard appeal denial rates/total denials
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%

Q1 2022 External Expedited Appeals (State fair Hearings): THRIT reported zero (0) expedited external appeals (across all cohorts).

- External Expedited Appeal denial rates/total denials
  - Rite Care 0%
  - CSN 0%
  - RHP 0%
  - RHE 0%

THRIT Quarterly Report Q1-2022_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	0	0	0	0	1	1	0	0	N/A	N/A	0	10
Number of Complaints	10	10	0	0	16	16	17	17	N/A	N/A	0	0
Total	19	19	2	2	25	25	34	34	N/A	N/A	0	0

Summary

Grievances/Complaints

Q 1 2022: Grievances and Complaints: THRIT reported a total of one (1) Grievances and Complaints.

IV. UnitedHealthcare RIte Smiles

Dental (RIte Smiles) QUARTERLY REPORT Q1 2022_ APPEALS, GRIEVANCES AND COMPLAINTS

Prior Authorization Requests

RIte Smiles Quarterly Report Q1 2022_Prior Authorization Requests

	Dental	Dental YTD	RX	RX YTD	RAD	RAD YTD	Orthodontic	Ortho YTD
Prior Authorization Requests	2130	2130	0	0	0	0	961	961
Denial Authorization Requests	746	746	0	0	0	0	623	623

RIte Smiles Appeals

RIte Smiles QUARTERLY REPORT Q1 2022_APPEALS

Appeals Internal	Dental/Ortho	Dental/Ortho YTD	RX	RX YTD	RAD	RAD YTD
Standard	3/70	3/70	0	0	0	28
Overturned	1/8	1/8	0	0	0	0
Expedited	0/0	0/0	0	0	0	0
Overturned	0/0	0/0	0	0	0	0
Appeals External (State Fair Hearing)	**Dental/Ortho**	**Dental/Ortho YTD**	**RX**	**RX YTD**	**RAD**	**RAD YTD**
Standard	5/5	5/5	0	0	0	0
Overturned	0	0	0	0	0	0
Expedited	0	0	0	0	0	0
Overturned	0	0	0	0	0	0

Summary

Internal Appeals
Q 4 2022: Internal Appeals: Rite Smiles had a total of seventy-three (73) internal appeals,
general dentistry had three (3) appeals of which one (1) appeal was overturned, representing 33.3% overturn rate. Seventy (70) orthodontic services were appealed of which eight (8) were overturned, representing a 11.43% overturn rate.

External Appeals (SFH)
Q1 2022: Rite Smiles had a total of ten (10) external appeals, general dentistry had five (5) external appeals of which zero (0) were overturned 2

RIte Smiles Quarterly Report Q4 2021_Grievances and Complaints

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

Summary
RIte Smiles reported zero (0) consumer grievances and complaints in Q1 2022

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

*Quarterly appeal rate = appeals per 1000/members

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 two (2) times in DY 14 January 1 – March 31, 2022:

January meeting agenda

- Welcome and Introductions

- Review of Minutes & Approval
- Medicaid Personnel Update
- HSRI Special Enrollment Period
- Governor's Budget
- COVID-19 Updates
    - Telehealth and Prior Authorizations
    - Redetermination Updates, i.e., Unwinding
- Data Reports – Enrollment & Auto Assignment

March meeting agenda

- Welcome and Introductions
- Review of January 13, 2022 Meeting Minutes
- Medicaid Personnel Update
- HSRI Special Enrollment Period
- Governor's Budget
- COVID-19 Updates
    - Telehealth and Prior Authorizations
    - Redetermination Updates
- 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 14 January 1 – March 31, 2022.

NEMT Analysis	DY 14 Q1	DY 14 YTD
All NEMT & Elderly Complaints	**413**	**413**
All NEMT & Elderly Trip Reservations	**515,648**	**515,648**
Complaint Performance	**0.08%**	
Top 5 Complaint Areas	DY 14 Q1	DY 14 YTD
Transportation Provider No Show	**108**	**108**
Transportation Provider Late	**77**	**77**
Transportation Broker Processes	**76**	**76**
Transportation Provider Behavior	**52**	**52**

Transportation Broker Client Protocols	**24**	**24**

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 this quarter, the average monthly participation was 157 enrollees. The average subsidy was $41.16 per individual, with an average total of $6,449 per month. For May 2022, EOHHS is preparing to implement a mass mailing, which would reach approximately 620 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	172	(6)	$ 41.23	$ 7,092
February	152	(20)	$ 41.03	$ 6,237
March	146	(6)	$ 41.21	$ 6,017

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in DY 14, January 1, 2022 – March 31, 2022.

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 (Q1) of 2022, the third quarter of State Fiscal Year (SFY) 2022:

Active Contract Management (ACM)
For Q1 2021 ACM, revamped its ACM efforts be setting strategic goals in the four main areas for a kick-off at the January 2022 meetings with the following:

- **Goal 1**: Members receive quality care within all managed care delivery systems
    - Integrate NEMT Member No-Show ACM Project to reduce member no-shows and increase coordination for at-risk members with handoff between vendors. Streamline work directly between MCOs and NEMT vendor.
    - Improve access to behavioral care services for both children and adults with BHDDH and DCYF.
    - Improve integration with medical MCOs and UHC Dental. Increase childhood P-DENT by 10% by end of CY22
- **Goal 2**: Enhance financial & data analytic oversight of MCOs
    - Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. Review and provide feedback to FDCR to promote better financial oversight and accountability). Resubmit missing/incomplete encounter data by January 1, 2022.
    - Increase oversight of MCO interventions concerning utilization such as avoidable ED usage and reduced health care diagnostic screenings from 2021 benchmarks. Provide MCOs high-utilizers to provide direct care interventions.
    - Establish 6-month error free operations/financial reporting goal for MCOs.

    - Support provider financial solvency efforts to critical services including MCO financial oversight, enhance APMs, CMS pre-prints as appropriate
- **Goal 3**: Implement and oversee COVID-19 testing, treatment and vaccination
    - Implement successful COVID-19 vaccination plan, with focus on addressing SDOH among all Medicaid populations to promote greater health equity. Establish 85% vaccination goal for Medicaid members by end of CY22.
    - Establish and streamline MCOs member outreach efforts to prevent duplications for members in coordination with RIDOH.
    - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
    - Support youth vaccination efforts, with a goal of 90% vaccination by end of CY22 for youth aged 5-17.
- **Goal 4**: Integrate development of Accountable Entities in Managed Care Oversight
- Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
- MCOs to provide strategic plan to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery model.
- Implementation of race, ethnicity, and language (REL) data collection process to identify gaps in care.
- Support oversight efforts of MCO implementation of AE program, with a focus on program sustainability.

MCOs focused on decreasing preventable ED utilization. MCOs also continued their quest to increase childhood immunization rates.

<u>COVID-19 Public Health Emergency (PHE) Response Effort</u>
During Q2, 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 and EOHHS discussed their plans for indefinitely covering telemedicine as a covered benefit in accordance with the new Telemedicine Coverage Act.

<u>General Updates</u>

- Due to a surge in hospitalizations in December-January, EOHHS required MCOs to provide weekly discharge data and updates on admissions and discharges and request to decrease administrative barriers for hospitals.
- EOHHS continued work with MCOs concerning outreach and care coordination efforts to enhance provision of Early Intervention Services for members.
- EOHHS has established Quarterly Financial Oversight Meetings with MCOs to enhance coordination and communication efforts concerning ongoing financial requirements.
- EOHHS began Wave 1 of 4 for 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 Q4 QIP Reports with each MCO.

Specific to the unique details of Q2 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 for its updated for to decrease preventable ED usage by beneficiaries.
- NHP also continues to work with Accountable Entities on intervention strategies to reduce avoidable Emergency Room usage.
- MCO completed reprocessing denied edited claims to correct issue and ensure compliance with 98% encounter data threshold to ensure timely FY23 rates.

UnitedHealthcare Community Plan (UHCCP-RI)

- UHCCP continued work related to early intervention efforts and included their rate increase to providers for relief that was retroactive to the start of the fiscal year.
- 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.
- 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, 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. 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.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Table A1.1 MEMBER MONTHS (ACTUALS)

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
ABD no TPL	187,407	186,735	46,455				46,455
ABD TPL	383,550	389,246	99,281				99,281
RIte Care	1,919,234	2,050,133	520,121				520,121
CSHCN	145,566	146,946	36,268				36,268
217-like Group	53,182	54,812	14,120				14,120
Family Planning Group	21,016	18,159	3,813				3,813
SUD IMD	n/a	n/a	n/a				0
Low-Income Adult	985,182	1,192,867	316,573				316,573
Additional Populations & CNOMS	57,336	56,713	13,940				13,940

Notes to Member Months (Actuals)

1. Rite 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+.

Table A1.2 WITHOUT WAIVER PMPM

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
ABD no TPL	$ 3,429	$ 3,576	$ 3,891	$ 3,891	$ 3,891	$ 3,891	$ 3,891
ABD TPL	$ 3,876	$ 4,043	$ 4,398	$ 4,398	$ 4,398	$ 4,398	$ 4,398
Rlte Care	$ 618	$ 650	$ 719	$ 719	$ 719	$ 719	$ 719
CSHCN	$ 3,608	$ 3,789	$ 4,177	$ 4,177	$ 4,177	$ 4,177	$ 4,177
217-like Group	$ 4,353	$ 4,488	$ 4,770	$ 4,770	$ 4,770	$ 4,770	$ 4,770
Family Planning Group	$ 26	$ 27	$ 30	$ 30	$ 30	$ 30	$ 30
SUD IMD	$ 4,185	$ 4,411	$ 4,900	$ 4,900	$ 4,900	$ 4,900	$ 4,900
Low-Income Adult	$ 1,044	$ 1,097	$ 1,212	$ 1,212	$ 1,212	$ 1,212	$ 1,212

Table A1.3 WITHOUT WAIVER TOTAL EXPENDITURES

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
ABD no TPL	$ 642,599,871	$ 667,828,363	$ 180,734,148	$ -	$ -	$ -	$ 180,734,148
ABD TPL	$ 1,486,642,096	$ 1,573,594,779	$ 436,619,881	$ -	$ -	$ -	$ 436,619,881
Rlte Care	$ 1,185,205,361	$ 1,331,874,962	$ 373,953,228	$ -	$ -	$ -	$ 373,953,228
CSHCN	$ 525,272,364	$ 556,764,673	$ 151,501,212	$ -	$ -	$ -	$ 151,501,212
Subtotal - Without Waiver	**$ 3,839,719,692**	**$ 4,130,062,777**	**$ 1,142,808,470**	**$ -**	**$ -**	**$ -**	**$ 1,142,808,470**
217-like Group	$ 231,491,955	$ 245,983,259	$ 67,356,875	$ -	$ -	$ -	$ 67,356,875
Family Planning Group	$ 535,963	$ 487,646	$ 113,537	$ -	$ -	$ -	$ 113,537
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
New Adult Group	$ 1,028,380,206	$ 1,308,675,527	$ 383,635,917	$ -	$ -	$ -	$ 383,635,917

Budget Neutrality Tables II

Table A1.4 HYPOTHETICALS ANALYSIS

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
Without Waiver Expenditure Baseline	$ 232,027,918	$ 246,470,905	$ 67,470,412	$ -	$ -	$ -	$ 67,470,412
With Waiver Expenditures (Actuals):							
217-like Group	$ 198,952,989	$ 214,196,539	$ 55,530,877				$ 55,530,877
Family Planning Group	$ 406,225	$ 245,689	$ 46,216				$ 46,216
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal Hypotheticals (Actuals)	**$ 199,359,214**	**$ 214,442,228**	**$ 55,577,093**	**$ -**	**$ -**	**$ -**	**$ 55,577,093**
Excess Spending: Hypotheticals	$ (32,668,704)	$ (32,028,677)	$ (11,893,319)	$ -	$ -	$ -	$ (11,893,319)

Table A1.5 LOW INCOME ADULT ANALYSIS

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
Without Waiver Expenditure Baseline	$ 1,028,380,206	$ 1,308,675,527	$ 383,635,917				$ 383,635,917
With Waiver Expenditures (Actuals)	**$ 545,106,889**	**$ 765,644,669**	**$ 202,136,159**				**$ 202,136,159**
Excess Spending: New Adult Group	$ (483,273,317)	$ (543,030,858)	$ (181,499,758)				$ (181,499,758)

Table A1.6 WITH WAIVER TOTAL ANALYSIS

	Historical:		Current:				
	DY 12	DY 13	DY 14				
Medicaid Eligibility Group (MEG)	2020	2021	31-Mar-22	30-Jun-22	30-Sep-22	31-Dec-22	YTD
ABD no TPL	$ 416,651,174	$ 465,321,773	$ 113,228,568				$ 113,228,568
ABD TPL	$ 662,780,192	$ 685,493,895	$ 160,635,146				$ 160,635,146
Rlte Care	$ 540,281,451	$ 661,604,382	$ 168,026,663				$ 168,026,663
CSHCN	$ 169,999,309	$ 182,811,295	$ 45,163,851				$ 45,163,851
Excess Spending: Hypotheticals	$ -	$ -	$ -				$ -
Excess Spending: New Adult Group	$ -	$ -	$ -				$ -
DSHP - Health Workforce & AIE Payments	$ 68,749,417	$ 18,928,491	$ 1,997,352				$ 1,997,352
CNOM Services	$ 8,397,342	$ 8,152,058	$ 1,943,665				$ 1,943,665
TOTAL	**$ 1,866,858,885**	**$ 2,022,311,893**	**$ 490,995,244**				**$ 490,995,244**
Favorable / (Unfavorable) Variance	$ 1,972,860,807	$ 2,107,750,885	$ 651,813,225				$ 651,813,225
Cumulative Budget Neutrality Variance	$ 13.24 B	$ 15.35 B	$ 13.89 B	$ 13.89 B	$ 13.89 B	$ 13.89 B	$ 13.89 B

Notes to With Wavier 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 Hypotheticals 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: ___August 5, 2022_____

XIII. State Contact(s)

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XIV. Date Submitted to CMS

8/5/22