Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

DY15 Q3

July 1, 2023 – September 30, 2023

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

Submitted ___December 12, 2023_____

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Report Demonstration Reporting

Period: DY 15 July 1, 2023 – December 30, 2023

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.

During 2023 Q3, Rhode Island made significant progress in several important areas, with some highlights here and full detail within the report:

- Health System Transformation Project:
    - All seven AE contract agreements for PY6 have been signed.
    - Outcome Performance Year 5 Outcome Metric results have been finalized and shared with AEs.
    - Quality program metrics have been established for PY7.
- Modernizing Health and Human Services Eligibility Systems:
    - The Medicaid Systems team and Deloitte implemented three (3) software releases to address 84 data fixes and 17 software enhancements for the RI Bridges eligibility system.
- Home and Community-Based Services Conflict-Free Case Management:
    - The State team determined that it would pursue certification standards instead of an RFP for CFCM providers and began drafting those standards.
    - The State team began monthly stakeholder meetings to gather feedback and share updates, and posted additional materials to support stakeholder education.
- Home and Community-Based Services Quality Improvement:
    - The project governance team completed individual check ins with each agency. Due to the success of the past year, the team determined it did not need an additional year of technical assistance support from New Editions, whose TA contract ended in August.
    - The QIS team continues to meet monthly, to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups.
- LTSS System Modernization:
    - The State team has identified a revised timeline for full Wellsky implementation in light of interdependencies with other State systems.
- State Plan Amendments: CMS approved two (2) Rhode Island SPAs in this quarter.
- Other Programmatic Changes Related to the 1115 Waiver:
    - In Q3, the State begam making the program and policy changes needed to transition approximately 60 participants from the Independent Provider program into the Personal Choice program, consistent with recent State legislation directing EOHHS to merge its two self-directed programs, Personal Choice and Independent Provider, into one program effective July 1.
    - The State FY2024 Budget as Enacted, effective July 1, included $14.4 million (all funds) to support the State's implementation of person-centered planning and conflict-free case management.

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:

The number of current enrollees as of the last day of the month in the reported quarter (September 30, 2023) with eligibility for full benefits is **361,779**. This count does not include another 3,315 members with full benefits but are eligible under Rhode Island's separate CHIP program (and not reflected in **Table III.1**). Nor does it include an additional **11,887** members with only limited Medicaid coverage.

The 1.4% decrease in Medicaid enrollment (full benefits) over the quarter represents a decrease over prior quarters. The decrease is due to the Rhode Island Unwinding of the continuous coverage requirement in place since the start of the of the Public Health Emergency in March 2020.

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

	DY13	DY14	DY15					
	Dec-21	Dec-22	Mar-23	Jun-23	Sep-23	Dec-23	Quarter Δ	YTD Δ
01: ABD no TPL	15,633	15,526	15,755	15,900	15,981		81	455
02: ABD TPL	34,489	36,872	37,176	37,361	36,754		-607	-118
03: Rite Care	138,841	144,008	144,867	146,408	147,074		666	3,066
04: CSHCN	12,246	12,440	12,575	12,650	12,538		-112	98
05: Family Planning	1,369	1,104	1,065	1,003	948		-55	-156
06: Pregnant Expansion	56	96	99	95	101		6	5
07: CHIP Children	33,615	33,924	34,743	34,034	34,614		580	690
10: Elders 65+	1,591	1,167	1,188	1,192	1,211		19	44
14: BCCPT	87	93	96	97	72		-25	-21
15: ORS CNOM	74	100	117	131	112		-19	12
17: Early Intervention	1,782	1,482	1,625	1,619	1,576		-43	94
18: HIV	834	806	742	736	731		-5	-75
21: 217-like	4,704	5,145	5,283	5,480	5,501		21	356
22: New Adult Group	103,758	112,605	115,073	115,022	109,144		-5,878	-3,461
27: Undocumented	59	55	74	68	17		-51	-38
Grand Total	**349,138**	**365,423**	**370,478**	**371,796**	**366,374**		**-5,422**	**951**
Subtotal – Full Benefits	343,429	360,709	365,667	367,047	361,779		-5,268	1,070
Subtotal – Partial Medicaid	5,709	4,714	4,811	4,749	4,595		-154	-119

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

	DY13	DY14	DY15					
			Mar-23	Jun-23	Sep-23	Dec-23	Quarter Δ	YTD Δ
07: CHIP Pregnant & Unborn	2,277	2,912	3,040	3,201	3,315		144	403
10: Elders 65+ - MPP Only	7,375	7,075	7,032	7,085	7,289		204	214
99: Base	3	2	3	3	3		0	1

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)

	DY13	DY14	DY15					
			Mar-23	Jun-23	Sep-23	Dec-23	Δ Quarter	Δ YTD
01: ABD no TPL	106	90	72	84	87		3	-3
02: ABD TPL	19	5	7	8	5		-3	0
03: Rite Care	59	54	39	38	39		1	-15
04: CSHCN	2	7	7	1	3		2	-4
21: 217-like	1		0	0	0		0	0
22: New Adult Group	487	390	339	343	377		34	-13
Grand Total	**674**	**546**	**464**	**474**	**511**		**37**	**-32**

Notes to Table III.3:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the two 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 a 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 **12,900**.

The cumulative count of terminations among those with full Medicaid benefits in the current demonstration year is **21,086**.

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

	DY13	DY14	DY15				
			Mar-23	Jun-23	Sep-23	Dec-23	YTD
01: ABD no TPL	632	778	165	180	206	0	486
02: ABD TPL	2,545	1,626	416	354	844	0	1,560
03: Rite Care	4,795	4,679	1227	1,784	1,801	0	4,164
04: CSHCN	419	700	121	122	113	0	334
05: Family Planning	86	77	12	13	33	0	59
06: Pregnant Expansion	2	0	1	4	2	0	6
07: CHIP Children	1,087	1,013	268	415	287	0	792
10: Elders 65+ - OHA Copay	113	493	51	52	47	0	116
14: BCCPT	3	2	0	0	21	0	20
15: ORS CNOM	62	62	59	73	80	0	82
17: Early Intervention	1,020	1,036	225	276	268	0	715
18: HIV	82	92	84	25	29	0	121
21: 217-like	371	279	71	49	93	0	215
22: New Adult Group	4,301	4,225	1,161	3,440	9,403	0	13,231
27: Undocumented Immigrants	125	39	33	50	54	0	41
Grand Total	**15,643**	**15,101**	**3,894**	**6,837**	**13,281**	**0**	21,942
Subtotal - Full Medicaid	**14,202**	**13,926**	**3,598**	**6,475**	**12,900**	**0**	21,086

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. As of September 30, 2022, a total of **2,111** Medicaid-eligible members were in a self-directed HCBS program, including 1,025 in a program administered by EOHHS and 1,201 in a program for I/DD members and administered by Rhode Island's Department of Behavioral Health Developmental Disabilities & Hospitals (BHDDH).

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

	DY12	DY13	DY14	DY15				
				Mar-23	Jun-23	Sep-23	Dec-23	YTD Avg.
New	98	262	227	68	68	95		77
Continuing	437	464	631	835	885	930		883
Subtotal - EOHHS	**535**	**726**	**858**	**903**	**953**	**1,025**		**960**
Subtotal - BHDDH			**1,071**	**1,102**	**1,151**	**1,201**		**1,151**
Grand Total			**1,929**	**2,006**	**2,105**	**2,226**		**2,211**

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 was eligible for services across subsequent quarters.
4. For prior demonstration data, the counts reflect the average of the quarter-ending results within the year.
5. For figure for the BHDDH Self-Directed program for I/DD members represent total quarter-end snapshot only.

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during DY15 July 1, 2023 – September 30, 2023 (by category or by type) with a total of **$5,036.60** for special purchases expenditures.

Q2 2023	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter medications		$ 802.77
	2	Acupuncture		$ 630.00
	11	Service Dog Training		$1,375.00
	10	Massage Therapy		$ 850.00
	7	Massage Float Therapy		$ 665.00
	1	Air Conditioner		$ 713.83
	CUMULATIVE TOTAL			**$5,036.60**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for July 1, 2023 – September 30, 2023.

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.

Accountable Entities (AEs)

Q3 2023

- All 7 AE PY6 contract agreements have been signed.

- The MCOs completed and shared final OPY5 AEIP Annual Outcome Metrics with EOHHS and communications were sent to the AE's pertaining to their performance.

- EOHHS continued to work with Bailit Health on the AE/MCO Quality Work Group and have finalized changes for the AE quality measure slate, outcome measure slate, and measure specs for the upcoming Program Year 7, in alignment with the 2024 OHIC Measure Set and the 2024 HEDIS Measure Set. The PY5-PY7 Implementation Manual and Quality Measure Specs have been updated and posted to the EOHHS website as well as emailed to the AE/MCO Quality Workgroup.

- The PCF and CPO Health Equity Zones (HEZs) that were given Participatory Budgeting grants finalized the ideas collected from their respective communities and turned them into formal project proposals with associated budgets. Community members from Pawtucket/Central Falls and Central Providence were then able to vote on which finalized projects they would like to see implemented in their community. Winning projects will now start the implementation process.

- The Rhode to Equity (R2E) learning and action collaborative wrapped up their second and final year. Evaluation trends through the duration of the project identified tangible improvements across all portfolios of work, indicating transformative efforts were successful.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in DY 15 July 1, 2023 – September 30, 2023.

Modernizing Health and Human Services Eligibility Systems

DY15 Q3
Between July 1 and September 30, 2023, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 84 data fixes and 17 software enhancements for the RI Bridges eligibility system. These releases improved services for Medicaid Eligibility & Enrollment, Appeals Processing, Program Applications, Long Term Services and Supports, as well as functionality improvements to our customer/worker interfaces. No significant program development or issues were identified.

HCBS Conflict-Free Case Management

DY15 Q3
EOHHS is leading an interagency initiative to establish a statewide conflict-free case management (CFCM) program to serve Medicaid long-term services and supports (LTSS) beneficiaries who participate in the State's home and community-based services (HCBS) programs. A core component of this initiative is the establishment of a contractual network of qualified CFCM entities with the capacity to serve approximately 11,000 Rhode Island HCBS participants who have a varying and changing array of LTSS needs.

The CFCM initiative serves the broader goals of making the LTSS system more person-centered, quality-driven, and resilient, while bringing Rhode Island into compliance with federal requirements governing the Medicaid HCBS programs authorized by the State's Section 1115 Demonstration Waiver.

Implementation of CFCM is scheduled to begin on January 1, 2024. RI EOHHS will transition HCBS participants into CFCM throughout CY2024 based on a HCBS Participant Transition Plan. RI EOHHS anticipates that all HCBS participants under this initiative will be enrolled in the CFCM services system by December 31, 2024.

In July, August, and September 2023, the interagency redesign team continued to meet regularly to develop the CFCM implementation plan and communication strategy. Most notably:

- **CAP Updates:** The State continued to implement its corrective action plan (CAP) for CFCM and provide monthly progress updates to CMS.
- **Moved from RFP to certification standards**: EOHHS reviewed feedback from the State's RFI and determined that it would pursue certification standards instead of an RFP. This new approach presents the greatest opportunity and flexibility for RI to meet CFCM

capacity requirements. EOHHS began drafting the certification standards in Q3, to be posted for a 30-day public comment period in October.

- **Began monthly stakeholder webinars**: In August, EOHHS began monthly stakeholder meetings to gather feedback and share regular updates on key activities. EOHHS will hold monthly CFCM stakeholder meetings from August through December. During the State's first two meetings, it covered:
    - Updates to the CFCM implementation timeline;
    - Key policy changes;
    - An outline of the State's approach to stakeholder engagement;
    - An overview of roles and responsibilities under CFCM; and
    - The process for becoming a CFCM entity.
- **Posted additional stakeholder materials**: The team posted additional materials to support stakeholder education including a conflict-of-interest fact sheet, a CFCM fact sheet, and a flyer for participants. These documents are posted on the CFCM webpage.
- **Continued to design the State's case management system**: The team continued its work with WellSky, the vendor selected to provide the State's case management system.

HCBS Quality Improvement

DY15 Q3

In July, August, and September 2023, the standing project governance team, quality improvement team, and two focused subgroups—Critical Incidents and Data Analytics—continued to meet regularly.

- **Project Governance Team:** In addition to overall project planning and leadership, the project governance team focused on reviewing and updating the HCBS Work Plan. The governance team completed the individual check-ins with each agency. The meetings proved successful, with each agency sharing feedback of positive progress since the beginning of RI's HCBS Quality Improvement work. The governance team also researched various experience of care tools to address standards in the HCBS Final Rule and proposed Access Rule. A memo was developed and shared with leadership for review. Due to the success of the past year, the governance team determined it did not need an additional year of technical assistance support from New Editions, whose TA contract ended in August. The team continues to follow the HCBS Work Plan and will continue to address items outlined for the remainder of CY2023.

- **Quality Improvement Team:** The full QIS team adjusted its cadence to a monthly meeting. This meeting still serves as a time to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups. The team continued highlighting the connection between RI's implementation of conflict free case management (CFCM) and data collection of the QIS Performance Measures and the need for continued collaboration between these workstreams. In the September meeting, the team reviewed the Q1 data, addressed

changes in each performance area, and discussed agency-specific performance and remediation where needed.

- **Critical Incidents Subgroup:** The Critical Incident subgroup has paused the regular monthly meeting cadence and convenes on an as-needed basis. EOHHS occasionally hosts small-group meetings or communicates with the various agencies via email when agency-specific questions or concerns arise during the quarterly data collection and review process. The group continues to review the performance measures and will make updates as the need arises. The group intends to restart regular meetings upon the official rollout of the proposed Access Rule and work to adjust the performance measures and data collection processes as needed.

- **Data Analytics Subgroup:** The CY2023 Q1 data call, which was sent to program offices in June, was received in a timely manner by July 17. The results were aggregated by the EOHHS data team and presented at the September meeting using the data dashboard. The data team continues to prepare for future changes in data collection measures once the WellSky system is implemented; this system will serve as a single data source across all state agencies for many of the performance measures. A member of the data team continues to participate in WellSky development meetings to ensure a smooth transition. On September 15, the CY2023 Q2 data template was sent to the program offices, to be returned in October.

LTSS System Modernization

DY15 Q3

As noted in the Q2 report, the State has identified several interdependencies with Wellky, the State's current eligibility system (RI Bridges), and the Medicaid claims system (MMIS) that were expected to impact the implementation timeline. Based on the latest project status assessment, the State has determined that completion of Phase II will be delayed to April 2024. The State continues to work through these impacts and is developing alternative business processes until Wellsky achieves full functionality. Additionally, the State will begin utilizing a single conflict free case management billing code starting April 2024.

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the period of July 1, 2023 – September 30, 2023.

Request Type	Description	Date Submitted	CMS Action	Date
SPA	21-0006 COVID 19 Vaccines and Vaccine Administration	5/17/21	RAI	8/10/21

Request Type	Description	Date Submitted	CMS Action	Date
SPA	21-0007 Psychiatric Residential Treatment Centers (PRTF)	6/29/21	Approved	7/14/23
SPA	23-0006 Medicare Premium Payment Program	6/30/23	Approved	9/22/23
SPA	23-0007 First Connections Temporary Rate Increase Extension	8/15/23	Pending	N/A
SPA	23-0008 Personal Needs Allowance	9/18/23	Pending	N/A
SPA	23-0009 DCYF Group Home Rate Increase	9/18/23	Pending	N/A
SPA	23-0010 Cedar Rates	9/20/23	Pending	N/A

Other Programmatic Changes Related to the 1115 Waiver

- In June, the Governor signed legislation (2023-H-5991Aaa and 2023-S-1030Aaa) directing EOHHS to merge its two self-directed programs, Personal Choice and Independent Provider, into one program effective July 1. In Q3, EOHHS began making the program and policy changes needed to transition approximately 60 participants from the Independent Provider program into the Personal Choice program. EOHHS anticipates that the merger will be complete by October 2023.

Rate Increases

- The FY2024 Budget as Enacted, effective July 1, included $14.4 million (all funds) to support the State's implementation of person-centered planning and conflict-free case management.

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 15 July 1, 2023 – September 30, 2023 or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in **Attachment E- XII., Enclosures –Attachments, Attachment 1: Rhode Island Budget Neutrality Report**.

IX. Consumer Issues

July 1, 2023 – September 30, 2023

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. The Appeals and Grievances charts can be found in Section XII. Enclosures – Attachments - Attachment 2 – Appeals, Grievances and Complaints.

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 Medicaid eligible people enrolled in Managed Care:

- 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, and tracks trends and/or emerging consumer issues through a formal Appeals and Grievance process. Additionally, all Grievance, Complaint, and Appeal 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 use disorder residential services,
- partial hospitalization services,
- detoxification services,
- opioid treatment services
- behavioral health services (non-residential).

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

The quarterly reports are reviewed by the RI EOHHS 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 submit 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. 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 Q3-2023 the appeals and grievance data reviews continue to remain an area of focus, which is further demonstrated by the Annual Appeal and Grievance Audit for 2022, which officially commenced in Q3 2023.

An additional and continuing area of focus has continued to be Network Adequacy within the managed care. EOHHS has continued to require each MCO to submit their current Network Adequacy plan and provide in network contracting strategies to address any lack of in-network

BH service access. EOHHS continued to build on its work related to Network Adequacy and oversight.

During Q3, Tufts remains on a Corrective Action Plan (CAP) related to network adequacy, specifically "mainstreaming." EOHHS recently re-directed Tufts to provide an updated and detailed analysis /l report to furthertheir outreach efforts and planning activities related to network adequacy in all areas but with an emphasis both primary care and appropriate access to behavioral health services. .

In addition to the quarterly A&G data review, EOHHS Compliance conducts reviews of the total number of prior authorizations (PAs) as well as the PA denial rate per MCO.

Of note, EOHHS evaluates trends in issues of dissatisfaction specifically attributed to Accountable Entities (AE).

Important to note, that NHPRI covers approximately 65% of Medicaid eligible members with UHCCP covering approximately 25% and RIT approximately 10% of Medicaid eligible members.

DY15 Q3

MCO Prior Authorization and Denials Summary

NHPRI Q3-2023: Prior Authorizations and Denials: NHPRI reported twenty thousand two hundred and eighty-five (20,285) PAs (across all cohorts) of which one thousand seven hundred and seventy-seven (1,777) PAs were denied representing an 8.76% denial rate. There was a decrease in denials from Q2-2023 (20.24%) to Q3 2023. Representing a 1.4% decrease in denial rate.

UHCCP Q3-2023: Prior Authorizations and Denials: UHCCP-RI reported fourteen thousand seven hundred and eighty-nine (14,789) PAs (across all cohorts) of which three thousand one hundred and fifteen (3,115) PAs were denied representing a 21.06% total denial rate. There was a substantive change in PA and denials from Q2 2023 to Q3 2023 representing a 14.45% decrease in the denial rate.

THRIT Q3-2023: Prior Authorizations and Denials: THRIT reported one thousand one hundred and ninety-five (1,195) PAs (across all cohorts) of which one hundred and twenty-nine (129) PAs were denied representing 10.79% denial rate. There was a slight change in PA requests and denials from Q2 2023 (6.57%) to Q3 2023. Representing 5.42% decrease in denial rate.

Dental (RIte Smiles) Q3-2023: Prior Authorizations and Denials: RIte Smiles reported a total of two thousand eight hundred and seventy-one (2,871) PAs of which one thousand one hundred and eighty-one (1,181) PAs were denied representing 41.14% total denial rate. Requests for

orthodontic services represent 46.23% denial rate which represents a decrease of more than .15% from Q2.

MCO Q3-2023: Appeals and Overturn Rate Summary

NHPRI Q3-2023: NHPRI reported a total of three hundred and thirty-four (334) standard internal appeals, eleven (11) expedited internal appeals and one hundred and three (103) state fair external hearings across all cohorts. Of the four hundred and forty-eight (448) total appeals, one hundred and eighty-seven (187) appeals were overturned representing 41.74% overturn rate. Of the one hundred and three (103) external appeals, thirty (37), appeals, 35.92% were overturned.

UHCCP Q3-2023: UHCCP reported a total of fifty (50) standard internal appeals, eighty-three (83) expedited internal and zero state fair- external hearings across all cohorts. Of the one hundred and thirty-three (133) total appeals, eighty-seven (87) were overturned representing 65.41% overturn rate. There were no external appeals in Q3.

THRIT Q3-2023: THRIT reported a total of seven (7) standard internal appeals, six (6) expedited internal appeals and zero state fair – external hearings across all cohorts. Of the thirteen (13) total appeals six (6) were overturned representing 46.15% overturn rate. There were no external appeals in Q3.

Dental (RIte Smiles) Q3-2023: RIte Smiles reported a total of sixty-five (65) standard internal appeals and twelve (12) expedited state fair -external hearings. Of the seventy-seven (77) total appeals seventeen (17) appeals were overturned representing 22.08% overturn rate. Denials for orthodontic services represented 100% of appeal requests. EOHHS is currently reviewing trends to ensure that members are fully aware to initiate an appeal given this trend.

MCO Q3-2023 Grievances and Complaints Summary

NHPRI Q3-2023: Grievances and Complaints: NHPRI reported a total of total of one hundred and four (104) Grievances and Complaints; forty-eight (48) Grievances and fitty-four (56) Complaints; ten (10) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the forty-eight (48) Grievances, twenty-six (26) represented quality of care issues, twenty-three (23) to access of care and zero (0) customer service issues. Access to care issues were related to in-network BH provider availability. There was a slight decrease (less than 1%) in grievances /complaints from Q3 over Q2. This is being monitored during oversight and flagged as a part of the provider enrollment screening process related to the 21st Century CURES ACT.

UHCCP Q3-2023: Grievances/Complaints: UHCCP-RI reported a total of forty-one (41) Grievances and Complaints; thirty-nine (39) Grievances and two (2) Complaints; twenty-three (23) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the thirty-nine (39) Grievances, two (2) represented quality of care issues and sixteen (16) represented balance billing issues. UHCCP comparatively receives more complaints regarding balance billing than the other two (2) MCOs. After making progress at the end of 2022, UHCCP has reported a

slight increase in balance billing in Q2 and Q3 and trending upwards. A cursory review has determined this is largely due to Accountable Entities. his will once again be addressed in the monthly Oversight meetings with a request for the MCOs to provide additional analyses.

THRIT Q3-2023: Grievances and Complaints: THRIT reported one (1) Grievance (Quality of Care) and zero Complaints in Q3-2023.

RIte Smiles (Dental) Q3-2023: Grievances and Complaints: RIte Smiles reported a total of zero consumer Grievance and one (1) Complaint in Q3-2023.

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

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 15 July 1, 2023 - September 30, 2023:

July meeting agenda

- **X.** Welcome and Introductions
- **XI.** Review of Minutes & Approval
- **XII.** Return to Normal Operations (also called “unwinding”) Update
- **XIII.** Data Reports – Enrollment & Auto Assignment

September meeting agenda

- **XIV.** Welcome and Introductions
- **XV.** Review of Minutes & Approval
- **XVI.** Return to Normal Operations (also called “unwinding”) Update
- **XVII.** 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 15 July 1, 2023 – September 30, 2023.

NEMT Analysis	Q1 2023	Q2 2023	Q3 2023		Q4 2023	DY15 YTD
All NEMT & Elderly Complaints	271	292	309			872
All NEMT & Elderly Trip Reservations	565,241	575,718	577,880			1,718,839
Complaint Performance	0.05%	0.05%	0.05%			0.05%
Top 5 Complaint Areas						
Transportation Provider No Show	85	88	105	1		278
Transportation Broker Processes	29	39	45	2		113
Transportation Provider Behavior	37	42	35	4		114
Transportation Provider Late	45	51	44	3		140
Transportation Broker Client Protocols	20	11	20			51
Driver Service/Delivery	19	24	25	5		68
Transportation Broker Customer Service						0

XI. 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 57 enrollees. The average subsidy was $38.22 per individual, with an average total of $2,192 per month.

Month	Marketplace Subsidy Program Participation	Change in Marketplace Participation	Average Subsidy per Enrollee	Total Subsidy Payments
January	123	6	$40.62	$4,996
February	83	(39)	$41.70	$3,461
March	81	(2)	$41.56	$3,366
April	53	(21)	$39.00	$2,067
May	61	8	$40.56	$2,474
June	66	5	$39.70	$2,620
July	62	(4)	$38.08	$2,361
August	60	(1)	$38.57	$2,314
September	50	(10)	$38.02	$1,901
October				
November				
December				

XII. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in DY 15, July 1, 2023 – September 30, 2023.

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 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 2023, the fourth quarter of State Fiscal Year (SFY) 2023:

Active Contract Management (ACM)

EOHHS continued its ACM review with MCOs of the following annual goals:

- **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).
    - 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 and increase COVID-19 vaccination rates for both boosters and newly eligible populations.

<u>General Updates</u>

- EOHHS continues to make progress for Provider Screening – 21st Century Cures Act enrollment requirements. EOHHS has enlisted its vendor to manage the project from a technical perspective. EOHHS is providing oversight to external vendor (Gainwell Technologies) re: compliance with the enrollment requirements with the 3 MCOs, and Dental plan. Meetings with both the vendor and MCOs continue to be held on a weekly basis to ensure adherence with the project plan. Given the intense oversight and research related to compliance with the CURES ACT, compliance with the ACT has improved. However, there remains a discrepancy between the MCE's self-reported compliance rates and the rates reported by Gainwell. During edit testing it was discovered that the definitions of "in-network" differed between the MCEs and EOHHS. EOHHS helped to address this by refining a compendium that included clear guidance and definitions. This effort is being monitored closely with a soft rollout of edit logic going live on July 1, 2023.

During Q3, RI collected edit logic data to better determine the next iteration of the project to reach compliance.

- EOHHS reviewed results of QIP Reports with each MCO and collected data to share with the EQRO.
- EOHHS received confirmation from CMS that PHE would end during Q2 on May 11, 2023. EOHHS has worked internally and with its MCO's to begin activities related to redeterminations and eligibility. To date, Rhode Island's Return To Normal Operations has proven to be a multi-agency collaborative effort with much success. EOHHS continues to explore creative ways to mitigate the risk for fraud and abuse, as well as treatment disruption for members. The MCOs have assisted within federal guidelines and their efforts have proven to be helpful.

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.

UnitedHealthcare Community Plan (UHCCP-RI)

- During Q3, UHCCP oversight largely focused on subcontractor management related to their behavioral health vendor processing authorization for service and adjudicating claims. As noted in previous Q's, there were recent rate changes that required remediation and retroactive reimbursement. UHCCP/Optum reported that there was an issue with claims' denials that required a manual edit. Because the resolution process was manual, it required more time which equated to monies owed to providers. EOHHS continues to monitor their progress towards completion as well as UHCCP's ability to adequately oversee their subcontractor. EOHHS has kept Optum Oversight as a standing agenda item during Q3.
- UHCCP case managers continued targeted outreach to members in areas with low COVID-19 vaccination rates.

Tufts Health Public Plans (THPP)

- As noted on previous Q's EOHHS monitored THPP's transition to OptumRX from CVS as their pharmacy benefit manager. EOHHS oversaw the project planning and milestones very closely to adequately prepare for any unforeseen issues that may impact the implementation. Despite this, there was a significant disruption during January 2023, that resulted in issues with: members access, subcontractor oversight and the mainstreaming clause within the MCO contract. Due to the above infractions, THPP was placed on three (3) separate Corrective Action Plans (CAP) that included civil monetary penalties. THPP has been cooperative throughout the CAP process and despite issues in the beginning of Q1, progress was made throughout Q2 and Q3, with only one CAP remaining.
- THPP continued to make progress to address encounter claims submission and has worked with EOHHS' data team accordingly.

- THPP has attended the provider enrollment meetings related to the 21st Century CURES Act and continued to be a solid partner. EOHHS continues to delve deeper into THPP's network adequacy given recent trends by member requests to change plans. EOHHS will continue to monitor THPP's Network Adequacy very closely and if necessary, will impose a plan to address. EOHHS is seeking to make Network Adequacy a formal Active Contract Management Project in future Q's.

UnitedHealthcare-Dental (UHC Dental)

- EOHHS continued to monitor UHC Dental's availability for providers to offer services given the pandemic. 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. Additionally, during Q2 EOHHS new contract manager has fully integrated in the oversight role and has taken over the monthly meetings.
- EOHHS is currently working with UHC Dental to ensure adherence to CURES ACT. During Q3, UHC Dental has done a remarkable job with enrolling and screening providers. They are significantly further along than their counterparts.

XIII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Table A1.1 MEMBER MONTHS (ACTUALS)

	Historical:		Current:				
			DY 15				
Medicaid Eligibility Group (MEG)	DY 13 2021	DY 14 2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	186,735	187,748	47,274	47,758	48,082	0	143,114
ABD TPL	389,246	429,772	111,311	112,008	111,024	0	334,343
RIte Care	2,050,133	2,105,783	537,687	541,385	544,484	0	1,623,556
CSHCN	146,946	147,990	37,548	37,902	37,759	0	113,209
217-like Group	54,812	59,232	15,677	16,278	16,511	0	48,466
Family Planning Group	18,159	14,185	3,241	3,054	2,918	0	9,213
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Low-Income Adult	1,192,867	1,300,601	343,223	347,479	336,254	0	1,026,956
Additional Populations & CNOMS	56,713	46,922	11,193	11,199	11,021	0	33,413
Average Count of Members with Full Benefits	*335,062*	*352,594*	*364,240*	*367,603*	*364,705*	*0*	*365,516*

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 13	DY 14	DY 15				
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 3,576	$ 3,730	$ 3,891	$ 3,891	$ 3,891	$ 3,891	$ 3,891
ABD TPL	$ 4,043	$ 4,217	$ 4,398	$ 4,398	$ 4,398	$ 4,398	$ 4,398
RIte Care	$ 650	$ 683	$ 719	$ 719	$ 719	$ 719	$ 719
CSHCN	$ 3,789	$ 3,978	$ 4,177	$ 4,177	$ 4,177	$ 4,177	$ 4,177
217-like Group	$ 4,488	$ 4,627	$ 4,770	$ 4,770	$ 4,770	$ 4,770	$ 4,770
Family Planning Group	$ 27	$ 28	$ 30	$ 30	$ 30	$ 30	$ 30
SUD IMD	$ 4,411	$ 4,649	$ 4,900	$ 4,900	$ 4,900	$ 4,900	$ 4,900
Low-Income Adult	$ 1,097	$ 1,153	$ 1,212	$ 1,212	$ 1,212	$ 1,212	$ 1,212
Composite PMPM for Members with Full Benefits	*$ 1,414*	*$ 1,492*	*$ 1,563*	*$ 1,564*	*$ 1,564*	$ -	*$ 1,563*

Table A1.3 WITHOUT WAIVER TOTAL EXPENDITURES

	Historical:		Current:				
	DY 13	DY 14	DY 15				
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 667,828,363	$ 700,323,600	$ 183,920,484	$ 185,803,496	$ 187,064,025	$ -	$ 556,788,006
ABD TPL	$ 1,573,594,779	$ 1,812,137,608	$ 489,525,646	$ 492,590,926	$ 488,263,472	$ -	$ 1,470,380,043
RIte Care	$ 1,331,874,962	$ 1,439,165,613	$ 386,582,717	$ 389,241,481	$ 391,469,580	$ -	$ 1,167,293,779
CSHCN	$ 556,764,673	$ 588,756,306	$ 156,848,117	$ 158,326,871	$ 157,729,521	$ -	$ 472,904,509
Subtotal - Without Waiver	**$ 4,130,062,777**	**$ 4,540,383,127**	**$ 1,216,876,964**	**$ 1,225,962,774**	**$ 1,224,526,598**	**$ -**	**$ 3,667,366,337**
217-like Group	$ 245,983,259	$ 274,059,565	$ 74,784,258	$ 77,651,219	$ 78,762,703	$ -	$ 231,198,180
Family Planning Group	$ 487,646	$ 401,117	$ 96,505	$ 90,937	$ 86,887	$ -	$ 274,328
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
New Adult Group	$ 1,308,675,527	$ 1,499,639,103	$ 415,931,461	$ 421,089,053	$ 407,486,146	$ -	$ 1,244,506,661

Budget Neutrality Tables II

Table A1.4 HYPOTHETICALS ANALYSIS

	Historical:		Current:				
	DY 13	DY 14	DY 15				
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
Without Waiver Expenditure Baseline	$ 246,470,905	$ 274,460,682	$ 74,880,763	$ 77,742,155	$ 78,849,590	$ -	$ 231,472,508
With Waiver Expenditures (Actuals):							
217-like Group	$ 213,980,940	$ 249,615,556	$ 69,911,646	$ 69,636,940	$ 73,161,058	$ -	$ 212,709,644
Family Planning Group	$ 245,689	$ 167,696	$ 51,841	$ 37,462	$ 35,722	$ -	$ 125,025
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal - Actuals	**$ 214,226,629**	**$ 249,783,252**	**$ 69,963,487**	**$ 69,674,402**	**$ 73,196,780**	**$ -**	**$ 212,834,669**
Excess Spending: Hypotheticals	$ (32,244,276)	$ (24,677,430)	$ (4,917,276)	$ (8,067,753)	$ (5,652,810)	$ -	$ (18,637,839)

Table A1.5 LOW INCOME ADULT ANALYSIS

	Historical:		Current:				
	DY 13	DY 14	DY 15				
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
Without Waiver Expenditure Baseline	$ 1,308,675,527	$ 1,499,639,103	$ 415,931,461	$ 421,089,053	$ 407,486,146	$ -	$ 1,244,506,661
With Waiver Expenditures (Actuals)	**$ 749,543,250**	**$ 772,853,442**	**$ 216,028,652**	**$ 209,943,883**	**$ 187,467,043**	**$ -**	**$ 613,439,578**
Excess Spending: New Adult Group	$ (559,132,277)	$ (726,785,662)	$ (199,902,809)	$ (211,145,170)	$ (220,019,103)	$ -	$ (631,067,083)

Table A1.6 WITH WAIVER TOTAL ANALYSIS

	Historical:		Current:				
	DY 13	DY 14	DY 15				
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 512,917,727	$ 429,616,225	$ 121,110,707	$ 114,167,656	$ 120,326,809	$ -	$ 355,605,172
ABD TPL	$ 713,173,265	$ 716,972,584	$ 194,163,593	$ 218,021,586	$ 210,856,464	$ -	$ 623,041,642
RIte Care	$ 716,613,141	$ 640,551,514	$ 245,088,387	$ 172,088,103	$ 188,669,254	$ -	$ 605,845,744
CSHCN	$ 177,986,526	$ 195,422,916	$ 83,384,318	$ 58,405,752	$ 53,688,451	$ -	$ 195,478,521
Excess Spending: Hypotheticals	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DSHP - Health Workforce & AIE Payments	$ 18,928,491	$ 19,150,124	$ 3,209,751	$ 2,744,928	$ 10,608,523	$ -	$ 16,563,202
CNOM Services	$ 8,152,058	$ 10,175,765	$ 2,322,990	$ 1,922,498	$ 3,029,585	$ -	$ 7,275,073
TOTAL	**$ 2,147,771,207**	**$ 2,011,889,127**	**$ 649,279,746**	**$ 567,350,523**	**$ 587,179,086**	**$ -**	**$ 1,803,809,354**
Favorable / (Unfavorable) Variance	$ 1,982,291,570	$ 2,528,494,000	$ 567,597,218	$ 658,612,251	$ 637,347,512	$ -	$ 1,863,556,982
Cumulative Budget Neutrality Variance	$ 14.97 B	$ 17.50 B	$ 18.07 B	$ 18.73 B	$ 19.36 B	$ 19.36 B	$ 19.36 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 – Appeals, Grievances and Complaints – Quarterly Report Q3-2023

Attachment A2.1: NHPRI Q3-2023 Prior Authorization Requests

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	7,692	7,334	6,897	0	21,923
Prior Authorization Denials	673	912	731	0	2,316

RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

CSN	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	1,084	1,182	1,231	0	3,497
Prior Authorization Denials	47	40	39	0	126

CSN AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	3,361	3,335	3,135	0	9,831
Prior Authorization Denials	211	227	208	0	646

RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RHE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	9,641	9,820	8,849	0	28,310
Prior Authorization Denials	740	1,039	787	0	2,566

RHE AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

SubCare** (NHP Only)	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	281	252	173	0	706
Prior Authorization Denials	10	10	12	0	32

NHPRI Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	9%	12%	11%	0%
CSN	4%	3%	3%	0%
RHP	6%	7%	7%	0%
RHE	8%	11%	9%	0%
Subcare	4%	4%	7%	0%

Attachment A2.2: UHCCP Q3-2023 Prior Authorization Requests

2023 QUARTERLY PRIOR AUTHORIZATION REQUESTS - UHCCP

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	6,331	6,071	5,194	0	17,596
Prior Authorization Denials	1,343	1,278	1,160	0	3,781

RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	255	338	306	0	899
Prior Authorization Denials	16	12	12	0	40

CSN	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	451	429	123	37	1,040
Prior Authorization Denials	62	16	0	0	78

CSN AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	37	39	35	0	111
Prior Authorization Denials	2	2	4	0	8

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	3,051	3,025	2,601	0	8,677
Prior Authorization Denials	579	594	503	0	1,676

RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	87	103	89	0	279
Prior Authorization Denials	5	12	3	0	20

RHE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	7,979	7,950	6,871	0	22,800
Prior Authorization Denials	1,745	1,707	1,453	0	4,905

RHE AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	278	330	248	0	856
Prior Authorization Denials	16	23	18	0	57

SubCare** (NHP Only)	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	N/A	N/A	N/A	N/A	N/A
Prior Authorization Denials	N/A	N/A	N/A	N/A	N/A

UHCCP Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	21%	21%	22%	0%
CSN	14%	14%	30%	0%
RHP	19%	20%	19%	0%
RHE	22%	21%	21%	0%
Subcare	N/A	N/A	N/A	N/A

Attachment A2.3: THRIT Q3-2023 Prior Authorization Requests

2023 QUARTERLY PRIOR AUTHORIZATION REQUESTS - THRIT

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	402	434	411	0	1,247
Prior Authorization Denials	45	44	36	0	125
RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	70	67	74	0	211
Prior Authorization Denials	3	8	5	0	16

CSN	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0
CSN AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	807	845	784	0	2,436
Prior Authorization Denials	100	117	93	0	310
RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	181	178	184	0	543
Prior Authorization Denials	18	29	21	0	68

RHE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0
RHE AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

SubCare** (NHP Only)	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	N/A	N/A	N/A	N/A	N/A
Prior Authorization Denials	N/A	N/A	N/A	N/A	N/A

THRIT Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
:are	11%	10%	9%	0%
	0%	0%	0%	0%
	12%	14%	12%	0%
	0%	0%	0%	0%
are	N/A	N/A	N/A	N/A

Attachment A2.4: RIte Smiles Q3-2023 Prior Authorization Requests

2023 QUARTERLY PRIOR AUTHORIZATION REQUESTS - RIte Smiles

Dental	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	2,341	2,208	2,011	0	6,560
Prior Authorization Denials	803	718	635	0	2,156

RX	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RAD	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

Orthodontic	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	1,121	950	860	0	2,931
Prior Authorization Denials	670	621	546	0	1,837

RIte Smiles Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	Q2	Q3	Q4
Dental	34%	33%	32%	0%
Orthodontic	60%	65%	63%	0%

Attachment A2.5 NHPRI Q3-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	105	149	110	0	364
Overturned	42	68	38	0	148
Expedited	5	3	5	0	13
Overturned	4	1	2	0	7

Appeals External - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	39	28	40	0	107
Overturned	12	6	15	0	33
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - CSN	Q1	Q2	Q3	Q4	YTD
Standard	10	12	11	0	33
Overturned	2	4	2	0	8
Expedited	0	0	2	0	2
Overturned	0	0	2	0	2

Appeals External - CSN	Q1	Q2	Q3	Q4	YTD
Standard	3	1	9	0	13
Overturned	1	0	2	0	3
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	88	49	49	0	186
Overturned	27	22	21	0	70
Expedited	5	0	2	0	7
Overturned	4	0	2	0	6

Appeals External - RHP	Q1	Q2	Q3	Q4	YTD
Standard	52	22	14	0	88
Overturned	17	7	6	0	30
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHE	Q1	Q2	Q3	Q4	YTD
Standard	159	189	164	0	512
Overturned	70	90	82	0	242
Expedited	10	1	2	0	13
Overturned	8	1	1	0	10

Appeals External - RHE	Q1	Q2	Q3	Q4	YTD
Standard	46	28	0	0	74
Overturned	13	7	0	0	20
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	5	1	0	0	6
Overturned	1	0	0	0	1
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals External - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	6	0	0	0	6
Overturned	2	0	0	0	2
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Quarter over Quarter 2023 Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	40%	46%	35%	0%
CSN	20%	33%	18%	0%
RHP	31%	45%	43%	0%
RHE	44%	48%	50%	0%
Subcare	20%	0%	0%	0%

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	80%	33%	40%	0%
CSN	0%	0%	100%	0%
RHP	80%	0%	100%	0%
RHE	80%	100%	50%	0%
Subcare	0%	0%	0%	0%

Quarter over Quarter 2023 External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	31%	21%	38%	0%
CSN	33%	0%	22%	0%
RHP	33%	32%	43%	0%
RHE	28%	25%	36%	0%
Subcare	33%	0%	0%	0%

External Expedited Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	0%	0%
CSN	0%	0%	0%	0%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	0%	0%	0%	0%

Attachment A2.6 UHCCP Q3-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	45	31	18	0	94
Overturned	24	21	9	0	54
Expedited	26	30	31	0	87
Overturned	22	22	21	0	65

Appeals External - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	0	1	0	0	1
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - CSN	Q1	Q2	Q3	Q4	YTD
Standard	3	5	1	0	9
Overturned	2	1	0	0	3
Expedited	5	2	3	0	10
Overturned	4	1	3	0	8

Appeals External - CSN	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	16	20	5	0	41
Overturned	10	13	4	0	27
Expedited	27	16	5	0	48
Overturned	21	13	4	0	38

Appeals External - RHP	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHE	Q1	Q2	Q3	Q4	YTD
Standard	64	42	26	0	132
Overturned	48	26	16	0	90
Expedited	42	47	44	0	133
Overturned	32	36	30	0	98

Appeals External - RHE	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A
Expedited	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A

Appeals External - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A
Expedited	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A

Quarter over Quarter 2023 Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	53%	68%	50%	0%
CSN	67%	20%	0%	0%
RHP	63%	65%	80%	0%
RHE	75%	62%	62%	0%
Subcare	N/A	N/A	N/A	N/A

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	85%	73%	68%	0%
CSN	80%	50%	100%	0%
RHP	78%	81%	80%	0%
RHE	76%	77%	68%	0%
Subcare	N/A	N/A	N/A	N/A

Quarter over Quarter 2023 External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	0%	0%
CSN	0%	0%	0%	0%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

External Expedited Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	0%	0%
CSN	0%	0%	0%	0%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Attachment A2.7 THRIT Q3-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	0	1	4	0	5
Overturned	0	0	1	0	1
Expedited	2	2	3	0	7
Overturned	2	2	2	0	6

Appeals External - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - CSN	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals External - CSN	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	4	5	3	0	12
Overturned	3	1	0	0	4
Expedited	5	3	3	0	11
Overturned	1	2	3	0	6

Appeals External - RHP	Q1	Q2	Q3	Q4	YTD
Standard	1	0	0	0	1
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - RHE	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals External - RHE	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A
Expedited	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A

Appeals External - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A
Expedited	N/A	N/A	N/A	N/A	N/A
Overturned	N/A	N/A	N/A	N/A	N/A

Quarter over Quarter 2023 Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	25%	0%
CSN	0%	0%	0%	0%
RHP	75%	20%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	100%	100%	67%	0%
CSN	0%	0%	0%	0%
RHP	20%	67%	100%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Quarter over Quarter 2023 External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	0%	0%
CSN	0%	0%	0%	0%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

External Expedited Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte	0%	0%	0%	0%
CSN	0%	0%	0%	0%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Attachment A2.8 RIte Smiles Q3-2023 Appeals and Overturn Rates

Appeals Internal - Dental	Q1	Q2	Q3	Q4	YTD
Standard	0	0	1	0	1
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - Orthodontics	Q1	Q2	Q3	Q4	YTD
Standard	43	46	64	0	153
Overturned	7	6	16	0	29
Expedited	12	13	12	0	37
Overturned	1	1	1	0	3

Appeals External - Dental (State Fair Hearing)	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals External - Orthodontics (State Fair Hearing)	Q1	Q2	Q3	Q4	YTD
Standard	0	0	0	0	0
Overturned	0	0	0	0	0
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Quarter over Quarter 2023 Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
General Dental	0%	0%	**0%**	
Orthodontic	16%	13%	**25%**	

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
General Dental	0%	0%		
Orthodontic	8%	8%	8%	

Quarter over Quarter 2023 External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
General Dental	0%	0%	0%	
Orthodontic	0%	0%	0%	

External Expedited Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
General Dental	0%	0%	0%	
Orthodontic	0%	0%	0%	

Attachment A2.9 NHPRI Q3-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	15	22	11	0	48
CSN	3	1	0	0	4
RHP	12	15	20	0	47
RHE	24	16	18	0	58
SubCare (NHP only)	0	0	0	0	0
Total Number of Grievances					157
AE	12	13	5	0	30

Number of Complaints	Q1	Q2	Q3	Q4	YTD
RIte Care	17	16	15	0	48
CSN	5	0	1	0	6
RHP	12	15	15	0	42
RHE	18	12	24	0	54
SubCare (NHP only)	0	0	1	0	1
Total Number of complaints					151
AE	6	3	5	0	14

Attachment A2.10 UHCCP Q3-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	3	6	11	0	20
CSN	0	1	0	0	1
RHP	0	3	5	0	8
RHE	2	6	23	0	31
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of Grievances					60
AE	3	13	22	0	38

Number of Complaints	Q1	Q2	Q3	Q4	YTD
RIte Care	7	2	0	0	9
CSN	0	0	0	0	0
RHP	1	2	0	0	3
RHE	4	13	2	0	19
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of complaints					31
AE	7	13	1	0	21

Attachment A2.11 THRIT Q3-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	0	0	0	0	0
CSN	0	0	0	0	0
RHP	0	0	1	0	1
RHI	0	0	0	0	0
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of Grievances					1
AE	0	0	0	0	0

Number of Complaints	Q1	Q2	Q3	Q4	YTD
RIte Care	0	0	0	0	0
CSN	0	0	0	0	0
RHP	0	0	0	0	0
RHE	0	0	0	0	0
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of complaints					0
AE	0	0	0	0	0

Attachment A2.12 RIte Smiles Q3-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Smiles	2	0	0	0	2
Total Number of Grievances					2

Number of Complaints	Q1	Q2	Q3	Q4	YTD
RIte Smiles	0	3	1	0	4
Total Number of complaints					4

Attachment 3: 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: Kimberly Pelland

Title: Medicaid Chief Financial Officer

Signature: 

Date: 12/12/23

XIV. **State Contact(s)**

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XV. **Date Submitted to CMS**

12/12/23