Report to the Centers for Medicare and Medicaid Services

Quarterly Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

October 1, 2016 – December 31, 2016

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

February 2017

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Quarterly Demonstration Reporting

Period: DY 8 October 1, 2016 – December 31, 2016

II. Introduction

The Rhode Island Medicaid Reform Act of 2008 (Rhode Island General Law §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 established 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 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 Connect Care Choice component provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. 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.

f. 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.

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

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

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

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	**Number of Current Enrollees (to date) 12/31/2016***	**Number of Enrollees That Lost Eligibility in the Quarter Ending 12/31/2016****
Budget Population 1: ABD no TPL	13,765	48
Budget Population 2: ABD TPL	33,477	22
Budget Population 3: RIte Care	137,914	299
Budget Population 4: CSHCN	12,038	5
Budget Population 5: EFP	404	6
Budget Population 6: Pregnant Expansion	39	0
Budget Population 7: CHIP Children	23,641	10
Budget Population 8: Substitute care	N/A	N/A
Budget Population 9: CSHCN Alt	N/A	N/A
Budget Population 10: Elders 65 and over	1,737	35
Budget Population 11, 12, 13: 217-like group	3,692	66
Budget Population 14: BCCTP	117	1
Budget Population 15: AD Risk for LTC	3,227	0
Budget Population 16: Adult Mental Unins	12,025	0
Budget Population 17: Youth Risk Medic	3,394	3
Budget Population 18: HIV	263	21
Budget Population 19: AD Non-working	0	0
Budget Population 20: Alzheimer adults	N/A	N/A
Budget Population 21: Beckett aged out	N/A	N/A
Budget Population 22: New Adult Group	73,376	291
Total	319,109	714

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

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

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

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the quarter in DY 8 October 1, 2016 – December 31, 2016:

Quarter 3: 6:490 at the close of the quarter

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during the quarter of DY8 October 1, 2016 – December 31, 2016 (by category or by type) with a quarterly total of $4,397.15 for special purchases expenditures.

Q3 2016	# of Units/ Items	Item or Service	**Description of Item/Service** (if not self-explanatory)	**Total Cost**
	5	Over the counter medicines		$ 895.65
	3	Fitness Training		$ 144.00
	14	Massage Therapy		$ 900.00
	3	Supplies, non-medical	Gloves, support stockings, tub lift	$ 569.00
	9	Laundry		$ 186.00
	15	Acupuncture		$ 1,125.00
	3	Service Dog Training		$ 277.50
	5	Landscaping	Assistance with mowing grass and snow shoveling (for a wheelchair dependent individual who owns his own home and is unable to maintain the outside of his home)	$ 200.00
	1	Diabetes Monitoring		$ 60.00
	2	Bus tickets		$ 40.00
	CUMULATIVE TOTAL			$ 4,397.15

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices during the quarter DY8 October 1, 2016 – December 31, 2016

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 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 DY8 quarter October 1, 2016 through December 31, 2016, the following activities occurred.

Collaboration with Institutes of Higher Education (IHEs)

- Continued work to establish innovative partnerships with the state's three public IHEs: University of Rhode Island, Rhode Island College, and the Community College of Rhode Island.
- Collaboration with IHEs to detail out the accounting processes to inform the development of Attachment S: Health Workforce Development Claiming Protocol

Hospital and Nursing Home Incentive Program

- Working with providers to collect data needed to inform measures that are driven by self-reported information
- Data extraction for measures that use enrollment or MDS data

Health Workforce Development Program

- In collaboration with SIM staff, convened approximately 125 stakeholders representing healthcare providers, educators, policy-makers, payers, labor organizations, and advocates to begin the process of assessing the workforce development needs of healthcare providers and workers in order to achieve the state's health system transformation and population health goals.
- Subsequent meetings with specific system focuses were held to identify numerous workforce needs and strategies specific to each focus area. Focus areas included 1) primary care, 2) behavioral health practice and integration, 3) social determinants of health, 4) data, quality, and reporting Health Information Technology (HIT), 5) home and community-based care, 6) chronic disease, and 7) oral health.
- The strategic planning consultant, Jobs for the Future also participated and conducted 30 one-on-one telephone interviews with key informants throughout November and December for additional stakeholder input.
- EOHHS and SIM aim to release our Healthcare Workforce Transformation Needs

Assessment and Strategic Plan within the next quarter. It will include labor market information and analysis and an inventory of current workforce education and training resources, as well as best practices, priorities, and recommendations to guide healthcare workforce development policies, programs, partnerships, and investments. We are using this planning process to align our healthcare workforce and system transformation efforts.

Accountable Entities

- Drafted the Accountable Entity Roadmap, which includes a draft of key documents such as the certification standards and quality scorecard. The Roadmap was posted for public comment and shared with a diverse and broad group of stakeholders on December 21, 2016 with comments due by January 27, 2017.
- EOHHS plans to hold meetings to engage stakeholders in-person for feedback on the Roadmap
- Continued oversight of MCOs' monitoring of Pilot AEs

Outreach Activities

Rhode Island has continued to execute the State's comprehensive communications strategy to inform stakeholders about the 1115 Demonstration Waiver. In addition, efforts have increased to inform stakeholders about all aforementioned innovation activities with the intent to keep all processes strong with effective, and open, feedback.

- Convened two meetings of the Executive Office of Health and Human Services (EOHHS) Task Force (née 1115 Waiver Task Force) on October 31, 2016 and December 5. 2016.
- Updated the EOHHS website on new initiatives.
- Continued refinements to the EOHHS website and partnership with the Governor's office to improve communications and transparency.
- Conducted the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on December 7, 2016
- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs
- Continued mailing notices to adult beneficiaries eligible for the Community Health Team-RI program
- Conducted numerous "office hour" meetings for on the Integrated Care Initiative for providers to voice their concerns and ask specific questions.
- Posted Monthly Provider Updates in October - December 2016

- Posted public notice on rule, regulations and procedures for EOHHS
- Convened two ICI Implementation Council stakeholder groups on October 17, 2016 and November 21, 2016

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the quarter DY8 October 1, 2016 – December 31, 2016.

State Innovation Model (SIM)
During the DY 8 October 1, 2016 – December 31, 2016, Rhode Island SIM has conducted the following activities.

- Public and commercial insurers, providers, community advocates and state health and human services agencies stakeholders were successfully brought together around aligned measure sets for behavioral health and maternity care
- Through a public workgroup process, a set of projects that would integrate and align efforts of state and community agencies around our SIM population health focus areas to be undertaken in the current year were identified
- Awarded contracts this quarter for SIM's state evaluation and our Practice Transformation project (including PCMH Kids and Integrated Behavioral Health). We will make an award in the next quarter for the SBIRT/Community Health Team project and the SBIRT Training Center.
- Participating in weekly meetings regarding the state's recently approved Health System Transformation Project (HSTP) and ensuring communication between our projects.

Healthy Aging Reform

EOHHS has been actively working on proposals to promote healthy aging for Rhode Island's seniors. This work builds on the successful Reinventing Medicaid efforts achieved under Governor Raimondo. As Rhode Island continues to encourage system transformation, our long-term services and supports (LTSS) system is a particular area of focus and priority. It is EOHHS' goal to achieve the rebalancing goals of Reinventing Medicaid by effectively enabling and encouraging aging populations to live successfully in the community. During the DY8 October 1, 2016 – December 31, 2016 reporting period, the following activities occurred:

- Targeted key Healthy Aging Reform initiatives for SFY 2018, reviewed the LTSS Rebalancing Strategies Report and developed financing strategies for the initiatives
- Prepared the Healthy Aging budget proposal for the consideration by the Governor

Integrated Care Initiative
The Integrated Care Initiative (ICI) in Rhode Island has been established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall goal is to improve care for Rhode Island's elder and people with disabilities to improve quality of care; maximize the ability of members to live safely in their homes and communities; improve continuity of care

across settings and promote a system that is person-centered and helps members attain or maintain personal health goals. Rhode Island is implementing the ICI in two phases. A description of each phase and a summary of the activities conducted in the reporting quarter in DY8 October 1, 2016 – December 31, 2016 are provided below.

Phase I – Rhody Health Options

In November 2013, as part of Phase I of the ICI, EOHHS established a capitated Medicaid managed care program, called Rhody Health Options, for dual-eligible beneficiaries with full Medicare and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS) through Rhode Island Medicaid. Rhody Health Options enrollees receive their Medicaid coverage through Neighborhood Health Plan of Rhode Island (NHPRI). As of December 2016, 31,352 individuals were eligible for this voluntary program. Of them, a total of 15,234 were enrolled in December 2016.

Rhody Health Options program activities conducted between October 1, 2016 and December 31, 2016 include:

- Mailed ICI enrollment letters to 1,072 newly eligible beneficiaries.
- Conducted ICI trainings for stakeholders including consumers, advocates, and providers.
- Provided program updates at the October, November and December 2016 Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting and the October, November and December 2016 EOHHS Integrated Care Initiative Implementation Council meetings.
- Continued operational oversight of the managed care organization.
- Monitored Enrollment Help Line activities.
- Processed enrollment opt-out requests and mailed confirmation of ICI program opt-out.
- Provided guidance to providers regarding enrollment opt-out procedures and billing procedures.
- Identified and resolved enrollment and other systems issues.
- Worked with the managed care organization to resolve operational challenges.

Phase II – Medicare-Medicaid Plan

Under Phase II of the ICI, EOHHS established a fully integrated capitated Medicare-Medicaid plan for dual-eligibles with full Medicare and full Medicaid coverage starting in July 2016. Federal authority for the Medicare-Medicaid plan is through CMS' Financial Alignment Initiative, a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. EOHHS currently has authority to participate in the Financial Alignment Initiative through December 31, 2020.

Medicare-Medicaid plan enrollees receive their Medicare (Parts A, B, and D) and Medicaid coverage through NHPRI. Approximately 30,000 individuals are eligible for this voluntary program. Initial enrollment into the plan began on July 1, 2016 through a phased-in enrollment schedule. The initial enrollment period began with three months of opt-in enrollment, which requires eligible individuals to complete a paper or phone application to enroll. This is followed by at least six months of passive (auto) enrollment into the plan for people who are already enrolled in NHPRI for their Medicaid benefits and are receiving their Medicare benefits through

Original Medicare. EOHHS will offer opt-in and passive enrollment to newly eligible individuals on a quarterly basis after the initial enrollment period ends. About 12,000-14,000 people are expected to be enrolled during the initial enrollment period. Small increases in enrollment are anticipated throughout the Demonstration following the initial enrollment period.

As of December 2016, 7,983 people were enrolled in the Medicare-Medicaid plan. In addition, passive enrollment notices were sent during the reporting period to 2,551 people living in the community without LTSS who were eligible for a January 1, 2017 enrollment effective date and to 1,562 people who have severe and persistent mental illness with a February 1, 2016 enrollment effective date. All of the people who received passive enrollment notices were enrolled in the Rhody Health Options program and were receiving their Medicaid benefits through NHPRI.

Program activities conducted between October 1, 2016 and December 31, 2016 include:

- Conducted opt-in and passive enrollment activities (e.g., processed enrollment applications, conducted data exchanges with CMS' vendor, processed enrollment cancellations and disenrollments, mailed opt-in and passive enrollment notices).
- Operationalized a contract with the Rhode Island Parent Information Network to act as the Demonstration ombudsman in November 2016.
- Provided information on the Demonstration to internal and external stakeholders, including consumers, advocates, and providers.
- Provided program updates at the October, November and December 2016 Lt. Governor's Long Term Care Coordinating Council (LTCCC) meeting and the October, November and December 2016 EOHHS Integrated Care Initiative Implementation Council meetings.
- Worked with consumer advocates to transition the ICI Implementation Council to a consumer-led council. Council members were chosen which include eight consumer/family members and seven providers/advocate members. The first meeting led by the Council will be in January 2017.
- Provided guidance and training to providers and consumer advocates, particularly related to Demonstration enrollment requirements and processes, program benefits, and beneficiary protections.
- A Provider Workgroup was started in November 2016. This workgroup is offered to all providers of adults eligible or enrolled in the Demonstration. The workgroup is a meeting for providers to learn about the Demonstration, receive enrollment and program updates, ask questions, raise concerns, and provide helpful feedback.
- Participated in the Center for Health Care Strategies' technical assistance initiative, Implementing New Systems of Care for Dually Eligible Enrollees (INSIDE), which is supported by The SCAN Foundation and The Commonwealth Fund.
- Worked with CMS, NHPRI, the enrollment broker, providers, the ombudsman, and consumer advocates to address enrollment-related issues and ensure access to services for dual-eligibles.
- Worked with the state's MMIS vendor on systems modifications needed to address enrollment-related issues for the Demonstration.
- Conducted contract management and operational oversight of the Medicare-Medicaid plan in collaboration with CMS.
- Monitored Enrollment Broker activities.
- Worked with the Medicare-Medicaid plan and CMS to resolve operational challenges

associated with the Demonstration.

Health Reform/New Adult Group (Medicaid Expansion)

On January 1, 2014, enrollment under Health Reform through HealthSource RI into a Qualified Health Plan (QHP) and the Medicaid New Adult Group became effective. Individual and families could apply online or by phone, in-person, or by mail. The Health Source RI Contact Center staff, the Navigator Program (with 140 individuals available to assist), Department of Human Services Field Staff and EOHHS/Medicaid staff have been assisting clients with the enrollment process since October 1, 2013. The activities conducted are outlined below.

- Continued on-going enrollment
- As of December 31, 2016, enrollment in Medicaid through HealthSource RI was 73,376
- Continued oversight of the managed care organizations
- Continued systems modifications to support enrollment of the New Adult Group
- Monitored enrollment of newborns into Medicaid and QHPs
- Worked with customer service staff from the state and HealthSource RI to resolve enrollment issues

Patient Centered Medical Home/High Utilizers Strategy

Rhode Island's Care Transformation Collaborative Initiative (CTC-RI) brings together key health care stakeholders, including Medicaid, to promote care for patients with chronic illness through the patient-centered medical home model. CTC-RI's mission is to lead the transformation of primary care in Rhode Island. During the reporting quarter, the following activities have occurred.

- CTC-RI was awarded a three year (January 1, 2017-June 30, 2019) $870,000 grant from the Rhode Island State Innovation Model (SIM) to support the work of providing Integrated Behavioral Health (IBH) in primary care; and practice transformation for PCMH-Kids Practices. Program goals include testing how primary care interventions improve quality and efficiency through a two-pronged multi-payer practice transformation project.
- PCMH Kids stakeholder group had Pediatric PRN (the SIM funded program that provides pediatric primary care practices with access to psychiatry services) present their program which included information on how to sign up and obtain services;
- CTC hosted the 2016 Learning Collaborative "Advancing Primary Care: Practicing with Value" on 10/20/16. There were two breakout sessions dedicated to identifying children who are at high risk and addressing the needs of children who are at high risk.
- With the vigorous assistance of the Pediatric Practice Facilitators, the remaining three PCMH-Kids practice met the required deadline for submitting their PCMH NCQA recognition application by December 31, 2016. All other PCMH-Kids practices have met the other Year 1 requirements.
- All PCMH Kids practices successfully addressed the OHIC requirements by submitting quality data information and cost management strategy attestations by 10/15/17.
- PCMH-Kids hosted two Pediatric High Risk meeting discussions with the health plans and practice champions in November to work on coming to a common definition and

understanding of high risk patient populations. The group continues to strategize and discuss the potential need for different algorithms for identifying children who are at high risk and in need of care coordination services as it is anticipated that the algorithms presently used by health plans to identify high risk are based on adult population scoring criteria. CTC has organized three upcoming best practice sharing sessions specific to the pediatric population (2 in January and 1 in February).

- CTC formed a Selection Committee that was tasked with identifying learning platforms to "on-board" new nurse care managers/care coordinators. The Selection Committee recommended contracting with xG Learn for on-line training modules that would be augmented with NCM/CC faculty sessions. The Board of Directors approved this recommendation and United Health Plan provided funding for up to 100 licenses and 5 NCM/CC Faculty.
- CTC project management staff continued to track practice performance deliverables, quality metrics and ADHD milestones in the PCMH-Kids Dashboard.
- CTC hired two contract psychologists to serve as content experts for the practices that are participating in the ADHD Learning Collaborative. The PCMH Kids participating in the ADHD collaborative submitted their data and participated in a "best practice" sharing meeting, discussion their AIM statements and progress to date. The psychologists provided feedback to assist practices with addressing the needs of children and families.

Community Health Team-RI

As a result of the Reinventing Medicaid initiative, EOHHS launched the Community Health Team-RI (CHT-RI) during February 2016, with its community partner, CareLink. CHT-RI allows Medicaid members who are not eligible for managed care to receive care coordination services. CareLink acts as an extension of the Primary Care Practices providing a multi-disciplinary team of nurses, social workers and community health workers focusing on the social determinants of health. During the reporting quarter, the following activities have occurred.

- A Clinical Manager was added to the team as well as a Community Health Worker training and care management certification programs were made available. The increase in staff numbers ensures availability to members, comprehensive identification of member's needs and increased ability for programming.
- CHT-RI staff received training in sixteen educational areas ranging from Excel training to Client Track Training. In addition to the trainings the CHT staff has attended Leading Age Conference and the Elderly Housing Conference.
- CHT-RI completed an internal audit of the Health Risk Assessment charts. The chart audits were completed in order to assess the quality of the CHT-RI member enrollment process and have quantifiable understanding of the enrollment process.
- EOHHS provided guidance to CareLink for upcoming monthly Oversight & Monitoring meetings.
- EOHHS continues to work collaboratively with CareLink providing the CHT services to improve outcomes for our most vulnerable population (FFS beneficiaries not eligible for managed care).

Medicaid Adult Quality Grant

The Centers For Medicare and Medicaid Services (CMS) awarded EOHHS an Adult Medicaid Quality Grant (AMQ) in December 2012. A second and final no-cost extension of the grant will end December 20, 2016. The status of each area of work is detailed below:

- The Antidepressant Medication Management Quality Improvement Project (AMM QIP) with the expanded scope of work was completed during the final quarter of the AMQ grant period, October through December 2016.
- During the final quarter of 2016 the URI team focused on specification and analysis for the Adherence to Antipsychotic Medication in Schizophrenia measure. This measure's specifications are entirely different from the approach required for the Antidepressant Medication Management measure, having a more complex case finding algorithm and requiring calculation of the proportion of days covered as a measure of medication adherence.
- In October – November the team performed analyses to define the measure sample. This involved programming inclusion criteria to qualify individuals having at least 1 inpatient diagnosis or at least 2 outpatient visits specific to various provider settings.
- In November – December the team completed programming for the numerator, which defines the adherence rate. The measure requires a proportion of days covered approach. This entailed excluding overlapping days supply for different medications, and adjusting start dates for same medications filled with overlapping supply. This also included identifying injectable products administered during institutional stays.
- Measure rates were calculated across demographic and other subgroups. The team also identified cases having utilization of medications for opioid treatment (few cases were found).
- Though Brown University, our EHR project vendor, submitted a final report (Comparison of EHR-based and Claims-based Diabetes Care Quality Measures, to EOHHS in May 2016, they are currently preparing a manuscript for publication. Target date for publication is June 2017.

Money Follows the Person Demonstration Grant

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011 to rebalance care from an institutional setting to a qualified community based setting of care. Rhode Island has made strides in the rebalancing effort and the activities accomplished are outlined below.

- The program received 76 referrals.
- 12 participants transitioned from nursing facilities to community-based residences.
- As of September 30, 2016, the program had facilitated 273 transitions since inception.
- Continued cooperative work with Rhode Island Housing in the development and implementation of the Section 811 Project Rental Assistance program.

Health Homes

Rhode Island continues to operate three programs under the Health Home opportunity. Activities conducted are outlined below.

- Continued the implementation and oversight of the Opioid Treatment Health Home SPA
- Continued the implementation and oversight of the Integrated Health Home Initiative for Behavioral Health SPA as part of Reinventing Medicaid
- Continued the implementation and oversight of the children's health home (Cedar) SPA.

Home and Community Base Services (HCBS) Final Rules

In January 2014, CMS published the HCBS final rules. Rhode Island has examined the final rules and has begun the planning of the requirements for implementation of the final rules. The activities that have occurred are outlined below.

- Completed all agency assessments via self-survey
- Consumer surveys for all programs are to be completed by the end of February
- Validation process continues to move forward with goal of end of February
- Meetings planned with providers in both ID/DD and LTSS communities
- State Transition Plan is currently being updated for eventual resubmission
- Developing documents for distribution to settings

Non-Emergency Medical Transportation

Effective May 1, 2014, the Executive Office of Health and Human Services implemented a new Non-Emergency Medical Transportation management broker contract. The vendor, LogistiCare, began coordinating transportation services for Medicaid beneficiaries and individuals over the age of 60 who do not have access to transportation for critical appointments and services. This change to the transportation system is for Non-Emergency Medical Transportation only**.** The broker provides member services, eligibility verification for transportation services, schedules appointments with contracted transportation providers, quality assurance and monitoring and program reporting. During the DY 8 October 1, 2016 – December 31, 2016 EOHHS conducted the following:

- Continued oversight and monitoring of LogistiCare contract activities
- Continued to report to external committees and/or multi-agency groups including: the Alliance for Better Long Term Care and the Lt. Governor's Long Term Care Coordinating Council

Behavioral Health Delivery System Redesign

The Rhode Island General Assembly transferred all Medicaid-funded behavioral health services to EOHHS on July 1, 2014. In January 2016, the delivery of the behavioral health benefit package was included in the managed care covered services. In addition, as a result of the Reinventing Medicaid initiative, staff have developed the Behavioral Health Integrated Health Home. In January 2016, the Behavioral Health Integrated Health Home services were included in the managed care and Medicaid Fee for Service delivery system. During the reporting quarter, staff from both EOHHS and BHDDH have been working closely to oversee the movement of services into managed care. The state received approval on three SPAs that allow for the redesign of payment methodologies to Cedar Health Homes, Opioid Treatment Health Homes, and the BH Integrated Health Home. Staff have continued to hold regular meetings with

providers and managed care plans to address claims payment issues and to identify areas of opportunity to improve the delivery of behavioral healthcare to Medicaid members.

Managed Care Re-procurement

Throughout 2016 the State developed documents for the procurement of its managed care contracts, which cover over 235,000 Medicaid beneficiaries. The procurement clearly identified the requirements MCO's participating in the Medicaid managed care program would be contractually obligated to provide. The intent of the procurement was to enter into long-term contracts with MCO's that will bring the highest possible levels of quality, efficiency, effectiveness, member experience and progressive collaboration with the State to this important program. Consistent with the importance and size of the procurement MCO's were required to provide considerable detail on their programs and proposed approach. During this timeframe, the conclusion of the procurement review and tentative awards were completed. The State recommended that three (3) MCO's be tentatively awarded contracts; Neighborhood Health Plan of Rhode Island, Tufts Health Plan and United Healthcare Community Plan. Currently, the State is in active contract negotiations and readiness meetings with all three MCO's. A final contract and "go-live" date is anticipated for March 1, 2017.

Modernizing Health and Human Services Eligibility Systems

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

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 DY 8 period October 1, 2016 – December 31, 2016.

Request Type	Description	Date Submitted	CMS Action	Date
Cat III	Cortical Integrative Therapy	9/22/2015		
SPA	Outpatient Hospital Rate Reduction and Community Lab Rate Alignment	2/3/2015	Approved	12/21/2016
Cat III	STOP	11/16/2015		
Cat III	Home Stabilization Initiative	11/16/2015		
Cat II	Peer Specialist	11/30/2015		
SPA	Cedar Center Redesign	3/15/2016		
SPA	BH Health Home Redesign (IHH/ACT)	3/23/2016		
Cat III	Health System Transformation Project (DSHP/CNOM)	5/17/2016	Approved	10/20/2016
Cat II	Level of Care Determination Policy	8/2/2016	Approved	10/20/2016
SPA	Disproportionate Share Hospital Policy	9/19/2016		
SPA	Inpatient Hospital Rate Increase	9/21/2016		
SPA	Outpatient Hospital Rate Increase	9/26/2016		
SPA	OTP Health Home	9/29/2016	Approved	12/9/2016
SPA	Centers of Excellence for Opioid Treatment	12/22/2016		

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 the DY 8 October 1, 2016 – December 31, 2016 quarter, or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report is can be found in Attachment E- XII., Enclosures –Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the DY8 October 1, 2016 – December 31, 2016. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

The summary of the consumer issues identified during DY8 October 1, 2016 – December 31, 2016 are outlined below.

Consumer Issues

RI Executive Office of Health and Human Services (EOHHS) employs procedures to monitor consumer issues across the managed care delivery system[1]. These procedures include tracking, investigating and remediating consumer issues which enables the State to identify trends and take preventive action.

Each MCO continuously monitors member complaints to watch for trends or emerging consumer issues. A Summary of Informal Complaints report is submitted to RI EOHHS on a quarterly basis. These reports present consumer-reported issues grouped into six (6) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service and Billing Issues. The informal complaint reports are reviewed by the appropriate staff at EOHHS and any questions or requests for clarification are send back to the MCOs with an expected response date. Data is disaggregated according to Medicaid cohort: Core RIte Care (Med), Rhody Health Partners (RHP), Rhody Health Expansion (ACA)[2], RIte Care for Children with Special Health Care Needs[3] (CSHN), and Rhody Health Options[4] (RHO).

The first MCO reported an increase of 113% in the number of informal complaints in Q4 2016 (136) in comparison to Q4 2015 (64) and a 45% increase in the number of informal complaints filed in Q4 2016 (136) in comparison to Q3 2016 (94). The increase in both the year-to-year and quarter-to-quarter comparisons is attributed to a significant increase in the volume of informal complaints from both ACA and RHO members. The noteworthy categories for ACA were Access to Care related to PCPs and Quality of Care, specifically rude or disrespectful treatment across all provider types. There were no notable trends related to any specific provider.

The second MCO reported a 5% decrease in the number of informal complaints in Q4 2016 (62) in comparison to Q4 2015 (65) and a 38% increase in the number of informal complaints in Q4 2016 (62) compared to Q3 2016 (45). This increase was due predominately to three categories: Quality of Care and Balance Billing for RHP members and and Health Plan Customer Service related to authorizations for ACA members.

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[1] The State's capitated managed care programs are: RIte Care, RIte Care for Children with Special Health Care Needs, RIte Care for Children in Substitute Care, Rhody Health Partners, RIte Smiles, Rhody Health Options, and Rhody Health Expansion. Effective January 31, 2016, EOHHS discontinued its primary care delivery systems Connect Care Choice and Connect Care Choice Community Partners and moved those individuals into the managed care options.

[2] The Rhody Health Expansion (RHE) cohort became Medicaid eligible in conjunction with the implementation of the Affordable Care Act (ACA).

[3] The first MCO identified is the only MCO that has the RIte Care for Children with Special Health Care Needs population.

[4] Same MCO that has the RIte Care for Children with Special Health Care Needs also has the Rhody Health Options population.

In addition to the two medical MCOs, there is one dental MCO that administers the RIte Smiles program to children born on or after May1, 2000. They monitor informal complaints as well and report an increase in the number of informal complaints in Q4 2016 (8) as compared to Q4 2015 (2). Despite there being a significant increase in the percentage of complaints year-over-year, the numbers are so small that any impact may skew the values. The comparison of Q4 2016 to Q3 2016 showed a decrease from14 informal complaints to 8 for this quarter. The category in which most of the informal complaints fall for the quarter is Balance Billing.

RI EOHHS utilizes Summary of Informal Complaints reports and participation in the Internal Health Plan Oversight Committee meetings to identify consumer issue trends and develop strategies to prevent future occurrence. We also look to find new ways to offer consumer protections as is demonstrated by our requiring the provision of the RI Office of Health Insurance Commissioner's consumer assistance contact line information on specified member communications. This offers our managed care members another avenue by which they may seek assistance in invoking their member rights or in voicing dissatisfaction with the Health Plans' processes.

The State continues to require NHPRI and UHCP-RI to maintain National Committee for Quality Assurance (NCQA) accreditation and adhere to the NCQA's standards that pertain to members' rights and responsibilities. Adherence to this standard dictates that Health Plans:

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

The State 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 RIteCare, and representatives of advocacy groups, health plans, the Department of Human Services (DHS) and EOHHS. The CMS Regional Officer participates in these meetings, as her schedule permits. The CAC met once during Q4 2016:

Thursday, November 10, 2016

- Review of Minutes
- RI Bridges Eligibility Update
- Managed Care Reprocurement
- Enrollment

The ICI Implementation Council is a consumer advisory board to EOHHS and the steering committee for the ICI Ombudsman Program. The group includes individuals who are Medicaid enrolled and receive Long Term Services and Supports as well as those dual eligible members in the integrated care initiative. The Council is 51% consumer led and is comprised of eight consumer/family members and seven providers/advocate members. The Council members were finalized in December 2016 and the first Council led meeting will be in January 2017. This

group met informally twice in October for orientation sessions and once in November and December to determine the structure of future meetings. There were two ICI Implementation Council stakeholder groups that met in Q4:

Monday, October 17, 2016

- Enrollment activities and update
- Call center report
- Ombudsman program
- Implementation Council Update
- Outreach materials and activities
- PACE Report
- Public Comment

Monday, November 21, 2016

- Enrollment activities and update
- Call center report
- Ombudsman program
- Implementation Council Update
- Outreach materials and activities
- PACE Report
- Public Comment

The EOHHS Transportation Broker, Logisticare, reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservation and the top five complaint areas during DY 8 October 1, 2016 – December 31, 2016.

NEMT Analysis	DY 8 Q4
All NEMT & Elderly Complaints	2,027
All NEMT & Elderly Trip Reservations	573,481
Complaint Performance	0.35%

Top 5 Complaint Areas	DY 8 Q4
Transportation Provider Late	739
Rider No Show	424
Transportation Provider General Complaint	396
Complaint about Rider	328
Transportation Provider No Show	147

X. Marketplace Subsidy Program Participation

Complete the following table that displays enrollment and cost information pertaining to the Marketplace Subsidy Program. Include a summary and explanation of any trends discovered.

The following chart identifies the marketplace subside program participation during DY8 October 1, 2016 – December 31, 2016.

Summary of Marketplace Activities for the DY 8 October 1, 2016 – December 31, 2016

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 142% and 179% of the Federal Poverty Level (FPL), who are not Medicaid eligible themselves, can apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HealthSource RI Contact Center, online at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Application_for_State_Assistance_Program.pdf, or can be requested by calling the RIte Care InfoLine at (401) 462-5300. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI. With the September 2016 implementation of RIBridges, monthly reports of eligible families were still in development. The on-going refinement of RIBridges has had an impact on eligibility in the last quarter of calendar year 2016.

Month	**Number of Marketplace Subsidy Program Enrollees**	**Change in Marketplace Subsidy Program Enrollment for Prior Month**	**Average Size of Marketplace Subsidy received by Enrollee**	**Actual Costs**
October	222	0	$42.09	$9,343.00
November	222	0	$42.09	$9,343.00
December	128	-94	$44.09	$5,644.00

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in the quarters in DY8.

The following report is represents the major evaluation, quality assurance and monitoring during the reporting quarters in DY8 October 1, 2016 – December 31, 2016.

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

Specific to quality improvement, compliance, and program integrity, the following areas of focus were addressed during the cycle of oversight and administration meetings that were conducted during Quarter 4 2016 with the State's three (3) Medicaid participating Plans, NHPRI, UHCP-RI, and UHC Dental:

Operations, Quality& Compliance:

- The Health Plans (including dental) provided a deep dive into each quality/compliance report that is submitted to EOHHS. They discussed how they collect the information, how they validate the information and how the information is used internally to improve their programs and operations. The health plans also gave feedback on how useful the reports were for their own internal operations/quality improvement and discussions were had about changes that could be made to the reports to benefit all parties.
- The health plans (including dental) presented on their Quality Improvement Projects for 2016 including results, interventions and barriers.
- The health plans discussed their implementation of the Managed Care Final Rule Regulations.
- The medical Health Plans (excluding dental) provided a deep dive of their oversight of the Behavioral Health delegated entities.
- Additionally, local organization Rhode Island Kids Count held their annual luncheon to celebrate the success of our state's Medicaid program. They shared data from the health plans HEDIS and CAHPS results, Performance Goal Program, Quality Improvement Projects, and EOHHS's Monitoring Quality and Access Report.
- Presentation of quarterly reporting and analytic trending of utilization, informal complaints, grievances and appeals, communities of care and pain management program, pharmacy and access to care.

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

Section 1115 Waiver Quality and Evaluation Work Group

Rhode Island's Section 1115 Quality and Evaluation Work Group, which includes Medicaid enterprise-wide representation, was established in 2009 and was responsible for the development of the 1115 Waiver's initial draft *Evaluation Design*. This work group has met regularly since

the implementation of the Demonstration Waiver to analyze the findings from on-going quality monitoring activities that span the areas of focus as delineated in the Waiver's Special Terms and Conditions, STC # 123 (*State Must Separately Evaluate Components of the Demonstration*).

The following table outlines the areas of focus that were addressed during in Quarter 4 2016 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
11.15.16 and 12.13.16	Data Quality (on 837 claims) Dashboard for OMB and Reinventing Medicaid metrics Defining Medicaid populations UHIP Conversion Health Insurance Survey Analysis

Development of Data Sets for Evaluation of Section 1115 Demonstration

During the DY8 reporting quarter October 1, 2016 through December 31, 2016, the State has made significant progress in developing analytic data sets that link utilization files with eligibility and enrollment files as well as provider files that are suitable for a comprehensive evaluation of all services provided under the components of the 1115 waiver. The following activities have occurred:

- Data sets were used to construct quality measures reported to CMS (Adult and Child Core Quality Measures Sets).
- Initiation of evaluation of health services by program/line of business.
- Recruiting outside consultants to maximize data platform and improve software access to assure more timely data analysis.
- Develop program specific workgroups to develop management and evaluation strategies for program evaluation.
- Rebalancing LTCSS: Significant progress in defining and operationalizing LTCSS as Institutional and HCBS including comprehensive interaction with program staff and Senior policy staff.
- Business plans to realign services from current distribution to more favorable distribution between institutional and HCBS.
- Develop analysis for transitioning behavioral health services for children with special health care services into managed care.
- Conducted health insurance survey to assess impact of ACA on access and utilization of services as well as cost and economic burden of attaining health insurance and impact on the state's un-insurance rate.
- Continued monitoring of HIV services.

Performance Management

Additionally, members of the evaluation team are integral to ongoing Department-wide performance management efforts with the RI Office of Management and Budget. That process has resulted in the identification of 3 primary goals, with multiple related measures for each. During the DY8 reporting quarter October 1, 2016 through December 31, 2016, the following activities occurred:

- Quality Measures reported on a monthly basis to the RI Office of Management and Budget which are reviewed directly by the Governor.
- Measures include LTC indicators, PCP visits, ED visits, and total cost of care for both general Medicaid populations and SPMI population.
- Developed evaluation strategies, as well as baseline measures and target objectives for the following Reinvent Medicaid initiatives:
    - AE
    - Community Health Teams
    - Children with Special Health Care Needs
    - Adult Day Services
    - IHH/ACT Program
    - Home Stabilization Program

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	20
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 123,439,420	$ 124,042,412	$ 121,181,099	$ 119,586,649	$ 488
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 312,960,494	$ 315,868,080	$ 318,752,720	$ 323,646,774	$ 1,27
RIte Care	$ 777,080,793	$ 856,219,858	$ 229,173,336	$ 231,541,632	$ 234,704,232	$ 237,706,056	$ 93
CSHCN	$ 388,266,894	$ 411,979,301	$ 104,509,608	$ 104,497,740	$ 103,803,462	$ 105,028,833	$ 41
TOTAL	**$ 2,795,541,814**	**$ 2,952,971,564**	**$ 770,082,858**	**$ 775,949,864**	**$ 778,441,513**	**$ 785,968,312**	**$ 3,11**

With Waiver Total Expenditures

Medicaid Populations	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 201
ABD Adults No TPL	$ 411,236,473	$ 396,437,538	$ 101,951,288	$ 80,813,715	$ 260,329,333	$ 97,087,571
ABD Adults TPL	$ 732,046,454	$ 734,368,831	$ 190,918,320	$ 165,707,705	$ 74,260,984	$ 185,543,578
RIte Care	$ 461,963,029	$ 554,398,258	$ 130,254,344	$ 66,333,615	$ 176,848,649	$ 123,508,598
CSHCN	$ 175,942,555	$ 198,981,132	$ 46,178,704	$ 37,532,121	$ 49,618,148	$ 41,963,155
Excess Spending: Hypotheticals	$ 31,145,557	$ (153,994,868)	$ (55,064,401)	$ (133,292,679)	$ (117,051,907)	$ (74,764,412
CNOM Services	$ 13,794,518	$ 10,007,986	$ 2,141,014	$ 2,533,691	$ 2,133,113	$ 2,161,378
TOTAL	**$ 1,826,128,586**	**$ 1,740,198,876**	**$ 416,379,270**	**$ 219,628,168**	**$ 446,138,320**	**$ 375,499,868**
Favorable / (Unfavorable) Variance	$ 969,413,228	$ 1,212,772,687	$ 353,703,588	$ 556,321,696	$ 332,303,193	$ 410,468,444
Budget Neutrality Variance (DY 1 - 5)						
Cumulative Bud. Neutrality Variance	**$ 3,756,374,378**	**$ 4,969,147,066**	**$ 5,322,850,654**	**$ 5,879,172,350**	**$ 6,211,475,543**	**$ 6,621,943,987**

Budget Neutrality Table I
HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	2014 YTD	2015 YTD	1st Qtr. CY 2016	2nd Qtr. CY 2016	3rd Qtr. CY 2016	4th Qtr. CY 201
217-like Group	$ 149,939,393	$ 157,960,620	$ 42,093,272	$ 42,662,776	$ 42,528,096	$ 42,108,664
Low-Income Adults (Expansion)	$ 440,412,112	$ 617,131,227	$ 169,555,050	$ 169,917,570	$ 173,703,510	$ 180,202,365
Family Planning Group	$ 46,171	$ 29,409	$ 17,766	$ 22,155	$ 23,814	$ 26,187
TOTAL	**$ 590,397,676**	**$ 775,121,256**	**$ 211,666,088**	**$ 212,602,501**	**$ 216,255,420**	**$ 222,337,216**

With-Waiver Total Exp.	2014 YTD	2015 YTD	1st Qtr. CY 2016	2nd Qtr. CY 2016	3rd Qtr. CY 2016	4th Qtr. CY 201
217-like Group	$ 163,527,102	$ 172,275,322	$ 42,725,489	$ 47,472,917	$ 46,535,957	$ 44,937,310
Low-Income Adults (Expansion)	$ 457,942,487	$ 448,818,617	$ 113,858,010	$ 31,821,529	$ 52,649,794	$ 102,623,772
Family Planning Group	$ 73,644	$ 32,448	$ 18,188	$ 15,376	$ 17,762	$ 11,722
TOTAL	**$ 621,543,233**	**$ 621,126,387**	**$ 156,601,687**	**$ 79,309,822**	**$ 99,203,513**	**$ 147,572,804**

Excess Spending	2014 YTD	2015 YTD	1st Qtr. CY 2016	2nd Qtr. CY 2016	3rd Qtr. CY 2016	4th Qtr. CY 201
217-like Group	$ 13,587,709	$ 14,314,702	$ 632,217	$ 4,810,141	$ 4,007,861	$ 2,828,646
Low-Income Adults (Expansion)	$ 17,530,375	$ (168,312,610)	$ (55,697,040)	$ (138,096,041)	$ (121,053,716)	$ (77,578,593
Family Planning Group	$ 27,473	$ 3,039	$ 422	$ (6,779)	$ (6,052)	$ (14,465)
TOTAL	**$ 31,145,557**	**$ (153,994,868)**	**$ (55,064,401)**	**$ (133,292,679)**	**$ (117,051,907)**	**$ (74,764,412**

Budget Neutrality Table II
Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 2016	I 201
ABD Adults No TPL	205,847	183,870	42,580	42,788	41,801	41,251	
ABD Adults TPL	358,498	373,223	95,473	96,360	97,240	98,733	
RIte Care	1,706,932	1,787,590	454,709	459,408	465,683	471,639	
CSHCN	144,379	145,853	35,224	35,220	34,986	35,399	
217-like Group	41,317	42,292	10,939	11,087	11,052	10,943	
Low-Income Adult Group	569,744	759,079	198,310	198,734	203,162	210,763	
Family Planning Group	2,401	1,453	846	1,055	1,134	1,247	

	DY 6	DY 7	DY 8	DY 8	DY 7	DY 8

Without Waiver PMPMs	2014 YTD	2015 YTD	1st Qtr. CY 2016	2nd Qtr. CY 2016	3rd Qtr. CY 2016	4th Qtr. CY 201
ABD Adults No TPL	$ 2,667	$ 2,781	$ 2,899	$ 2,899	$ 2,899	$ 2,8
ABD Adults TPL	$ 3,016	$ 3,144	$ 3,278	$ 3,278	$ 3,278	$ 3,2
RIte Care	$ 455	$ 479	$ 504	$ 504	$ 504	$ 5
CSHCN	$ 2,689	$ 2,825	$ 2,967	$ 2,967	$ 2,967	$ 2,9
217-like Group	$ 3,629	$ 3,735	$ 3,848	$ 3,848	$ 3,848	$ 3,8
Low-Income Adult Group	$ 773	$ 813	$ 855	$ 855	$ 855	$ 8
Family Planning Group	$ 19	$ 20	$ 21	$ 21	$ 21	$

Without Waiver Expendtures	DY 6 2014 YTD	DY 7 2015 YTD	DY 8 1st Qtr. CY 2016	DY 8 2nd Qtr. CY 2016	DY 7 3rd Qtr. CY 2016	DY 8 4th Qtr. CY 20
ABD Adults No TPL	$ 549,082,463	$ 511,340,631	$ 123,439,420	$ 124,042,412	$ 121,181,099	$ 119,586,649
ABD Adults TPL	$ 1,081,111,664	$ 1,173,431,773	$ 312,960,494	$ 315,868,080	$ 318,752,720	$ 323,646,774
RIte Care	$ 777,080,793	$ 856,219,858	$ 229,173,336	$ 231,541,632	$ 234,704,232	$ 237,706,056
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217-like Group	$ 149,939,393	$ 157,960,620	$ 42,093,272	$ 42,662,776	$ 42,528,096	$ 42,108,664
Low-Income Adult Group	$ 440,412,112	$ 617,131,227	$ 169,555,050	$ 169,917,570	$ 173,703,510	$ 180,202,365
Family Planning Group	$ 46,171	$ 29,409	$ 17,766	$ 22,155	$ 23,814	$ 26,187

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 Chief Financial Officer, 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: Robert Farley

Title: EOHHS Chief Financial Officer

Signature:

Date:

XIII. State Contact(s)

Darren J. McDonald, Ph.D.
Deputy Medicaid Director
74 West Road
Hazard Building #74
Cranston, RI 02920

401-462-1965
401-462-6352 FAX

Darren.McDonald@ohhs.ri.gov

Deborah J. Florio
Deputy Medicaid Director
74 West Road
Hazard Building #74
Cranston, RI 02920

401-462-0140
401-462-6352 FAX

Deb.Florio@ohhs.ri.gov

XIV. Date Submitted to CMS

Enter the date submitted to CMS in the following format: (02/27/2017).