STATE OF RHODE ISLAND
OFFICE OF GOVERNOR DANIEL J. MCKEE

December 14, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

On behalf of the residents of Rhode Island, it is with great pleasure that I submit to the Centers for Medicare and Medicaid Services (CMS) the enclosed Section 1115 Demonstration Waiver application to extend the Rhode Island Comprehensive Demonstration (the Demonstration). With this application, Rhode Island seeks to continue to build upon its foundational Medicaid program aims while implementing new focused enhancements, particularly aimed at addressing health inequities and health-related social needs (HRSNs), to improve the overall health and well-being of Rhode Islanders.

Since 2009, the Demonstration has served as the foundation for Rhode Island's entire Medicaid program. The Demonstration offers a complete array of services, including medical, behavioral health, and Home and Community-Based Services (HCBS), to multiple eligibility groups. In addition to its central coverage objectives, over the years, the state has tested a number of cutting-edge pilots and transformative projects under the Demonstration, including the Health System Transformation Program and the Accountable Entities initiative. Building on this successful tradition, this Demonstration extension seeks to strengthen the core parts of the Demonstration, while also implementing new program enhancements centered around our core values of voice, choice, and equity.

Rhode Island sees addressing health equity as a critical component of Medicaid and is excited about new opportunities to advance equity through the Demonstration. After the COVID-19 pandemic shed even greater light on the persistent disparities in healthcare and across all social determinants of health, Rhode Island has reaffirmed its unwavering commitment to rectify health inequities. The state is eager to pursue multiple avenues for achieving health equity for Rhode Islanders with particular interest in place-based strategies that meet Medicaid beneficiaries where they are. Rhode Island seeks to advance the objectives of the Medicaid program through strong Medicaid investments in proven services, programs, and interventions that can improve the health of entire communities, particularly those communities that have long experienced health disparities. To continue to work toward a more equitable and inclusive Medicaid program, Rhode

Island is utilizing this Demonstration extension request to seek authority for several initiatives aimed at improving the wellbeing of communities and targeting vulnerable populations, including, but not limited to the following new health equity features:

- Expanding support for housing for certain individuals. The state is requesting to improve its existing Home Stabilization program and to implement a new Restorative and Recuperative Care (Medical Respite) Pilot.

- Empowering communities to address health equity. The state is requesting to use the Demonstration to evaluate the impact of an existing equity initiative called Health Equity Zones, to support the potential future opportunity for the waiver to support Health Equity Zones.

- Supporting individuals' transition to the community following incarceration. The state seeks authority to provide Medicaid coverage and pre-release supports for incarcerated individuals, both adults and youth, 30 days prior to release.

In addition to new enhancements, Rhode Island has taken this opportunity to assess the administration of the waiver as a whole and analyze how it can best serve beneficiaries more than a decade after it was first approved. In identifying the operational enhancements, Rhode Island examined its current program through the lens of the four foundational principles that have guided the Demonstration since 2015:

- Pay for value, not volume;
- Coordinate physical, behavioral, and long-term healthcare;
- Rebalance the delivery system away from high-cost settings; and
- Promote efficiency, transparency, and flexibility.

Under this Demonstration extension, Rhode Island has requested a number of operational improvements, most significantly several revisions aimed at improving the HCBS service array that will expand the availability of flexible, person-centered supports. New flexibilities include increased access to virtual and/or telephonic assessment, a new remote supports services, and authority for parents to be paid as service providers. The state is also seeking to advance its service offerings through technical revisions targeted at supporting transparency and benefit clarity. Rhode Island is committed to a balanced, person-centered HCBS program and anticipates that these requests will support that. Rhode Island will continue to study and understand all available opportunities to improve HCBS to serve beneficiaries with disabilities and others that rely on this critical service array. Through these numerous operational improvements, the state anticipates that the Demonstration will act as an efficient and effective vehicle to serve beneficiaries for many more years.

We believe the requests made in this extension request will advance the objectives of Medicaid by ensuring that voice, choice, and equity for the beneficiary remains the steadfast focus of all aspects of the program. By implementing these program enhancements and operational improvements, especially those that address the critical health needs of beneficiaries, the state anticipates significant improvements to health outcomes for all populations served by Rhode

Island Medicaid. We look forward to continued collaboration and arriving at an 1115 Demonstration waiver extension that will make meaningful improvements to the health outcomes of the people of Rhode Island. Thank you for your consideration.

Sincerely,

[redacted]

Daniel J. McKee

Governor

Request to Extend the Rhode Island Comprehensive Section 1115 Demonstration Waiver

Project No. 11-W-00242/1

The Rhode Island 1115 Waiver

Extension Request

December 21, 2022

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Section 1: Executive Summary

Rhode Island is submitting this application to renew the authorities granted in its Medicaid Section 1115 Demonstration Waiver (the Rhode Island Comprehensive Demonstration, hereinafter also referred to as "the Demonstration") from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support continued progress for healthy outcomes, quality, and value, with a focus on equity for all populations served by our state Medicaid program.

Rhode Island Medicaid has a long history of successfully serving beneficiaries through tailored programs offering cost-effective and high-quality services. The state has one of the best performing health systems in the country, ranking seventh in 2019.[1] Rhode Island Medicaid has routinely been recognized for its provision of effective, person-centered benefits, behavioral health care, and children's services and supports, and has taken bold strides to impact the state's health care delivery system in pursuit of better health outcomes.

The Rhode Island Comprehensive Demonstration has served as the foundation for Rhode Island's Medicaid program since 2009. During an economic downturn, the state of Rhode Island sought out an innovative method for running its Medicaid program that would save costs while providing high-quality care. The Rhode Island Comprehensive Demonstration was the state's chosen solution. While the Demonstration has evolved greatly since its inception, the state's intent to utilize the Demonstration to improve the lives of Medicaid beneficiaries has not. By combining all waiver authorities in the state into one waiver, Rhode Island has been able to take a holistic approach to serving Medicaid beneficiaries with considerations of equity and access at the forefront while reducing administrative inefficiencies and improving the delivery system. With approximately one-third of all Rhode Islanders enrolled in at least one aspect of the Medicaid program, the 1115 waiver is a vital mechanism through which the health and well-being of the state can be greatly improved.

Over the last 12 years, Rhode Island's waiver has grown from a budget management vehicle to an innovative mechanism to serve the most vulnerable Rhode Islanders across all of their health and wellness needs. Through the Demonstration, the state has obtained authority for multiple leading-edge programs addressing the value and quality of care and the social determinants of health. Rhode Island's waiver is distinctive in its global approach. Unlike most states, all authorities that govern the Medicaid program beyond the state plan are contained within Rhode Island's Demonstration. This has given the state the opportunity to reinvent the Demonstration several times and change its focus based on the needs of the state.

Rhode Island Medicaid has regularly achieved or exceeded key quality and performance metrics. According to its most recent Medicaid Managed Care Expenditure Report[2], the state showed better than average performance on both the CMS Medicaid Scorecard and National Committee for Quality Assurance (NCQA) scores. Rhode Island scored above the 50th

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[1] Alletto, M., & Ganim, M. (2019, September 11). Rhode Island: A most-improved state in health performance. Retrieved September 15, 2022, from https://www.commonwealthfund.org/blog/2019/rhode-island-most-improved-state-health-performance

[2] Rhode Island Executive Office of Health and Human Services. (2021, May 6). Rhode Island Medicaid Expenditure Report SFY 2019. Retrieved September 15, 2022, from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-05/RIMedicaidExpenditureReport_SFY19.pdf

percentile on 18 out of 20 adult core set measures, and above the 50th percentile for 17 out of 22 child core set measures, with many measures ranking above the 75th percentile nationally. Additionally, member satisfaction surveys ranked Rhode Island's managed care organizations (MCOs) with an average score of 4.5/5—only one percent of MCOs nationwide had a higher score. MCOs also received high marks on both prevention (4.25) and treatment (4.0).

Rhode Island's success in providing high quality, whole-person care can be traced back to the foundational principles of the Demonstration. Four principles have guided the Rhode Island Comprehensive Demonstration since 2015, and Rhode Island Medicaid remains committed to these aims today:

- Pay for value, not volume;
- Coordinate physical, behavioral, and long-term healthcare;
- Rebalance the delivery system away from high-cost settings; and
- Promote efficiency, transparency, and flexibility

Numerous Demonstration initiatives have illustrated Rhode Island's success at fulfilling these principles. For example, Rhode Island's Health System Transformation Program (HSTP), and particularly the Accountable Entities (AE) initiative, shifted care from traditional MCOs to accountable partnerships in which provider organizations are responsible for the quality of care, outcomes, and total cost of care.

Rhode Island Medicaid also has long demonstrated a commitment to equity and seeks to uphold its commitment as a critical piece of this waiver extension. The state of Rhode Island has received national recognition for its Health Equity Zone (HEZ) program, a place-based, community-driven model to build healthy and resilient communities statewide.[3] Utilizing a braided funding model, the HEZ program has invested more than $30 million in public health funding[4] to fund initiatives addressing the social determinants of health such as housing, parks and open space, access to fresh, healthy food, and more.[5] While HEZs are housed under the Department of Health, the HEZ program has been strengthened by effective collaboration with Medicaid and other departments. For example, as part of the HSTP, the Rhode Island Executive Office of Health and Human Services (EOHHS) made funding available for learning and action collaboratives called the Rhode to Equity. The collaboratives were led by HEZs and funded health equity-focused knowledge sharing.[6] Outside of the HEZs, during the COVID-19 pandemic, Rhode Island Medicaid has worked to ensure emergency response strategies considered the needs of communities most impacted by the pandemic. Medicaid developed an Equity Council to shape the state's COVID-19 response based on equity principles.[7]

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[3] Newman, K. (2020, February 18). In Rhode Island, Health Equity Zones Offer Communities a Voice. Retrieved September 15, 2022, from https://www.usnews.com/news/healthiest-communities/articles/2020-02-18/health-equity-zones-offer-rhode-island-residents-a-voice

[4] Rhode Island Department of Health. (n.d.). Rhode Island's Health Equity Zone (HEZ) Initiative. Retrieved September 15, 2022, from https://health.ri.gov/programs/detail.php?pgm_id=1108

[5] Rhode Island Department of Health. (May 2022). Health Equity Zones. Retrieved September 15, 2022, from https://health.ri.gov/publications/brochures/HealthEquityZones.pdf

[6] Care Transformation Collaborative of Rhode Island. (n.d.). Rhode to Equity. Retrieved September 15, 2022, from https://www.ctc-ri.org/other-programs/rhode-equity

[7] Rhode Island Executive Office of Health and Human Services. (n.d.). Equity Council. Retrieved September 15, 2022, from https://eohhs.ri.gov/Initiatives/EquityCouncil.aspx

The state also made behavioral health a priority in recent years with the addition of new triage center and support services. These features not only provide support to beneficiaries during a crisis but offer important care coordination to ensure that individuals with behavioral health needs are connected to all the services they need across the care continuum.

EOHHS seeks to utilize this Demonstration renewal to continue to build upon its foundational goals while implementing new focused enhancements targeted at behavioral health, social determinants of health, and long-term services and supports.

The vision of EOHHS is to support resilient, equitable, and just communities nurturing the health, safety, wellbeing, and independence of all Rhode Islanders. The state seeks to achieve this vision by centering three key values: voice, choice, and equity. Rhode Island has integrated these values throughout this waiver extension to ensure that all changes and enhancements support a high-quality program that meets the needs of beneficiaries. At the core of these enhancements is our ongoing focus on equitable improvements to health outcomes and increased quality of care for individuals across the spectrum of health.

The following statements set forth Rhode Island's priorities for this waiver extension:

Goal 1: Health Equity Improve health equity through strong community-clinical linkages that support beneficiaries in addressing social determinants of health, including ensuring access to stable housing.
Goal 2: Behavioral Health Continue to ensure expanded access to high-quality integrated behavioral healthcare that is focused on prevention, intervention, and treatment.
Goal 3: Long-Term Services & Supports (LTSS) Continue progress toward rebalancing LTSS toward home and community-based services (HCBS).
Goal 4: Maintain and Expand on Our Record of Excellence Streamline administration of the Demonstration to strengthen current services and processes, while supporting continued progress towards our state's goals of improving healthcare quality and outcomes for Medicaid beneficiaries.

As Rhode Island Medicaid looks to its third Demonstration extension, it seeks to reflect on one principle in particular that was set forth in 2015: the promotion of efficiency, transparency, and flexibility. The state sees this extension as an opportunity to take stock of the components of the Demonstration that exist today, analyze their implementation and operation, and gain a better understanding of what authorities and programs would best serve beneficiaries going forward. To ensure that its programs are operating efficiently and effectively, Rhode Island is utilizing this extension request to make technical changes or edits, first, to ensure existing programs are operating as intended, and second, to remove references to programs or pilots which the state has discontinued. Because Rhode Island utilizes a global Medicaid waiver structure, the Demonstration represents a significant programmatic undertaking, and periodic reviews of its content are necessary to ensure good stewardship of the Medicaid program as a whole.

In addition to making technical changes and updates, Rhode Island submits this Demonstration extension to accomplish an array of important new initiatives, notably concerning the areas of

equity including housing, behavioral health, and LTSS. Rhode Island Medicaid worked to identify these areas as being critical program improvements for the state's Medicaid beneficiaries, especially as the COVID-19 pandemic continues (and in its aftermath), based on input from many stakeholders.

Of utmost importance to the state is that any new Medicaid initiative is implemented and operationalized with the considerations of equity in mind. The state is acutely aware of the connection between social determinants and healthcare[8], and hopes to utilize its requested waivers to address issues that affect health like housing and behavioral health. The evidence shows that addressing individuals holistically and focusing on more than just primary care makes a difference in both short and long-term health. Rhode Island also seeks to utilize this waiver opportunity to elevate health equity. To build off the state's commitment to ensuring that every person has a fair and just opportunity to be healthy, Rhode Island Medicaid is proposing efforts to advance equity for beneficiaries across all identities and strives for a system in which no one is disadvantaged from achieving their full potential.

Section 2: Historical Narrative and Program Description

2.1 Historical Narrative & Program Objectives

The Rhode Island 1115 Demonstration has outlined a number of principles, goals and objectives which have continuously evolved since it was first approved; however, at its core, supporting health system transformations that will make Medicaid more effective, efficient, and flexible for the state and beneficiaries alike have been consistent since the Demonstration inception. At its most simplistic, as demonstrated by the increased enrollment and expanded benefit packages that have occurred since 2008, this Demonstration has met and continues to meet its primary objective of providing high quality, person-centered care. Progress towards the specific goals and objectives of the current Demonstration period are documented via monitoring reports and evaluation reports, as summarized and further described in *Section 4*.

2008 Application and 2009 Amendment

In 2008, the Rhode Island legislature passed the Rhode Island Medicaid Reform Act.[9] The Act instructed the EOHHS to apply for a "global waiver." The legislature's intent was for the Medicaid program to be a "sustainable, cost-effective, person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options." In response, Rhode Island submitted an application for its first global 1115 Demonstration waiver. The waiver was approved to begin in 2009. The initial Demonstration was designed with a five-year aggregate cap of federal funds. The aggregate cap design was intended to shift some financial risk from the federal government to the state with respect to caseload and per-member per-month (PMPM) cost trends.

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[8] Bernazzani, S. (2016, May 1). The Importance of Considering the Social Determinants of Health. Retrieved September 15, 2022, from https://www.ajmc.com/view/the-importance-of-considering-the-social-determinants-of-health

[9] Chapter 12.4: The Rhode Island Medicaid Reform Act of 2008. (n.d.). Retrieved September 15, 2022, from http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-12.4/INDEX.htm

The initial waiver requested authority to operate the state's entire Medicaid program under the Demonstration, excluding disproportionate share hospital (DSH) payments, administrative expenses, phased-Part D contributions, and payments to local education agencies (LEAs) for services that are furnished only in a school-based setting, and for which there is no third-party payer. To accomplish this, the state terminated its other existing waivers, including the 1115 RIte Care and RIte Share demonstrations, a 1915(b) Dental Waiver, and several 1915(c) HCBS waivers, and combined these elements into the global waiver document. The initial waiver also featured a unique structure for making changes. The Special Terms and Conditions

(STCs) that were negotiated with CMS listed several categories of changes, examples, and processes that the state would be required to follow to make those changes.[10] A 2009 amendment made small technical changes to the Demonstration, including modifying an expenditure authority to allow coverage of uninsured pregnant individuals.[11]

2013 Extension #1

In 2013, Rhode Island submitted the first waiver extension request. The original objective of the Demonstration was to implement a program functioning under a fixed funding cap in order to produce savings and streamline administrative processes. In the first extension request, the state sought to remove the federal funding cap from the Demonstration, stating that the cap's value and impact to Rhode Island's Medicaid program had been minimal. The state did find value in its ability to use the additional spending authority to fund costs not otherwise matchable (CNOMs). The other component of the extension was to respond to the introduction of the Affordable Care Act (ACA). The state planned to implement Medicaid expansion and thus needed to update the Demonstration to accommodate newly eligible adults without dependent children.[12]

2016 Amendment #2

By 2015, state officials began to develop a plan to "reinvent" and enhance the state's Medicaid program. To begin work toward achieving those goals, then-Governor Gina Raimondo signed an executive order establishing a Working Group to Reinvent Medicaid.[13] The purpose of the Group was to engage Medicaid stakeholders to conduct a comprehensive review of the

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[10] Centers for Medicare & Medicaid Services. (2009, January 16). Rhode Island Comprehensive Demonstration: Special Terms and Conditions (01/16/09-12/31/13 Amended December 2009. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-stc-01162009-12312013-amended-122009.pdf

[11] Centers for Medicare & Medicaid Services. (2009, December 9). Rhode Island Comprehensive Demonstration: Approval to Amend Letter (12/09/09). Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-amend-appvl-ltr-12092009.pdf

[12] Rhode Island Executive Office of Health and Human Services. (2013, March 31). Rhode Island Comprehensive Demonstration: 1115 Waiver Extension Request (March 2013). Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-waiver-ext-req-032013.pdf

[13] Rhode Island Executive Office of Health and Human Services. (n.d.). Reinventing Medicaid. Retrieved September 15, 2022, from https://eohhs.ri.gov/initiatives/reinventing-medicaid

Medicaid program and make recommendations for short and long-term plans to transform Medicaid.[14] The Workgroup resulted in the request made in a 2016 amendment, the Health System Transformation Program (HSTP). The HSTP has two components—infrastructure funding for AEs and a health workforce initiative. The AE component sought to award performance-based infrastructure funding through MCOs to Medicaid-certified AEs. The health workforce initiative was designed to provide financing for workforce training infrastructure investments at three state colleges and universities.[15] To finance these programs, Rhode Island received federal funding of designated state health programs (DSHPs).[16] The aims of HSTP are to encourage accountability at the provider level, develop the next generation of managed care, and build a robust healthcare workforce.[17]

Two programs have been developed under the AE component: the Comprehensive AE program and a specialized AE program called the Long-Term Services and Supports Alternative Payment Methodology (LTSS APM) program. The Comprehensive AE program began in 2016 and is the primary entity responsible for "enacting change in alignment with the Demonstration's transformation activities."[18] The LTSS APM began in July 2022 and will provide infrastructure funding to home care agencies, first on a pay-for-reporting basis and then on a pay-for-performance basis.

2018 Amendment #3

The state made its third amendment to the Demonstration in 2018 with the addition of the Recovery Navigation and Peer Recovery Specialist programs. The Recovery Navigation Program was a non-residential, community-based, recovery-oriented program. The program was intended to serve individuals under the influence of substances within a less-traumatic, less costly setting than the Emergency Department, where individuals would be assessed, monitored, and provided with case management and peer support. Peer Recovery Specialists are individuals who provide an array of interventions that promote socialization, long-term

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[14] Raimondo, G. M. (2015, February 26). Executive Order 15-08: Establishing the Working Group to Reinvent Medicaid. Retrieved from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/ReinventMedicaid/ExecOrder_15-08_02262015.pdf

[15] Rhode Island Executive Office of Health and Human Services. (2016, June 10). Rhode Island Comprehensive Demonstration: Health System Transformation Program Demonstration Application (06/10/2016). Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-demo-app-transform-prgrm-06102016.pdf

[16] Centers for Medicare & Medicaid Services. (2016, October 20). Rhode Island Comprehensive Demonstration: CMS Demonstration Amendment Approval – October 2016 (10/20/2016). Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-demo-amed-appvl-october-2016.pdf

[17] Centers for Medicare & Medicaid Services. (2021, March 17). Rhode Island Comprehensive Demonstration: CMS Attachment K Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-global-consumer-choice-compact-attachment-k-appvl-03172021.pdf

[18] See Interim Evaluation, *Appendix C*.

recovery, wellness, self-advocacy and connections to the community, as well as other services, for individuals with behavioral health needs.[19]

2018 Extension #2

Rhode Island's 2018 extension application contained a significant number of waiver requests affecting eligibility, benefits, the delivery system, and financing. The authority requests approved by CMS were:

- Expenditure authority to cover treatment in a psychiatric residential treatment facility (PRTF) for certain children with serious emotional disturbance (SED) not otherwise eligible for Medicaid or CHIP
- Establishment of the Family Home Visiting Services Program
- Expansion of Peer Support Services
- Development of Home-Based Primary Care Services
- Behavioral Health Link Program
- Dental Case Management Pilot
- Substance Use Disorder Program
- Reauthorization of the Waiver of Retroactive Eligibility
- Continuation of October 2016 Approved Funding for the HSTP
- Home and Community-Based Therapeutic Services (HBTS) to Adults

In this waiver extension[20], the state anticipated that it would achieve certain objectives by 2022. Those objectives included rebalancing, decreasing readmission rates, preventable hospitalizations, and preventable ED visits, increasing the provision of coordinated primary and behavioral health care, and increasing the number of Medicaid members who choose or are assigned to a primary care practice that functions as a patient centered medical home. While progress has been made, rebalancing remains a key priority for the state in this waiver extension, and the state seeks to enhance its focus on this critical effort. The most recent evaluation, available in *Appendix C*, found that the state has made progress in decreasing readmissions but saw some increases in hospitalizations, potentially attributable to behavioral health needs during the COVID-19 pandemic. The state has reaffirmed its commitment to behavioral health in this extension request, including through new enhancements designed to connect vulnerable populations to primary and behavioral health care in one setting. Finally, the AE program continues to show success in connecting beneficiaries with accountable care coordination. The state sees this program and the success it has demonstrated as a key component of its efforts to enhance patient-centered care.

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[19] Centers for Medicare & Medicaid Services. (2018, February 8). Rhode Island Comprehensive Demonstration: Recovery Navigation and Peer Recovery Programs Demonstration. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-recov-nav-peer-rcvry-02082018.pdf

[20] Rhode Island Executive Office of Health and Human Services. (2018, July 11). Rhode Island Comprehensive Demonstration: State 2018 Extension Application. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-pa2.pdf

2020 Amendment #4[21]

Building upon many of the innovative programs and services authorized in 2018, the state received approval for two additional sets of services through a 2020 amendment: (1) Home Stabilization services, and (2) telephonic psychiatric consultation services. Home stabilization services encompass both "Home Find" and "Home Tenancy" services to assist individuals with behavioral or complex physical health needs to obtain and maintain housing. Telephonic psychiatric consultation services allow primary care providers to consult with psychiatrists or other licensed behavioral health providers about a beneficiary while the beneficiary is not present.[22] The addition of these new sets of services moved the state toward its goal of providing enhanced care to individuals with behavioral health needs and were well-timed in the face of the COVID-19 pandemic.

2020 Appendix K

When the COVID-19 pandemic began in 2020, states were given the option to exercise a variety of emergency authorities to better serve beneficiaries who may have been unable to access traditional services. Rhode Island elected to submit an Appendix K to request amendments to the Demonstration. The state has submitted several additions and extensions of its Appendix K. The most recent request includes the following authorities[23]:

- Allowances to exceed service definition limitations, provide shift nursing as a discrete service, and provide supplemental habilitation
- Permitting payment to all HCBS providers in alternative settings
- Allowances to exceed the maximum number of individuals served in a service location, remove staffing ratios, and suspension of the requirement to provide services in community locations
- Conducting level of care determinations via telephonic and/or video conference and a temporary postponement of reevaluations
- Conducting person-centered service plan development through written, telephonic, or video means, including the use of e-signatures; temporary postponement of reviews
- Temporary retainer payments
- Limitations on visitors
- Electronic delivery of case management, personal care, in-home habilitation, and monthly monitoring
- Additional medical supplies, equipment, and appliances

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[21] While this amendment was approved in 2020, Home Stabilization services were requested in 2015 and telephonic psychiatric consultation services were included in the 2018 extension request.
[22] Centers for Medicare & Medicaid Services. (2020, February 6). Rhode Island Comprehensive Demonstration: RI Home Stabilization and Psychiatric Consultation Amendment Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-global-consumer-choice-compact-home-stabilization-psych-consult-amend-appvl.pdf
[23] Centers for Medicare & Medicaid Services. (2021, March 17). Rhode Island Comprehensive Demonstration: CMS Attachment K Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-global-consumer-choice-compact-attachment-k-appvl-03172021.pdf

- Allowing payment for family caregivers and legally responsible individuals to provide HCBS, including spouses and parents of minor children providing personal care services
- Adjusting prior approval/authorization elements as approved in waiver

Future Vision

Rhode Island's Medicaid program will continue to provide high quality whole-person care over the course of the Demonstration by centering EOHHS' vision, values, and priorities in partnership with governance and other health and human service agencies. Drawing on our key values of **voice, choice, and equity**, EOHHS will consider the voice of the Rhode Island communities in all its programmatic and policy decisions and commit to continuing transparency and accountability. Similarly, EOHHS seeks to be responsive to the unique needs of every individual it serves by hearing, valuing, and respecting the choices of individuals, families, and communities. EOHHS will ensure that equity remains at the heart of all of its decision-making and will work to ensure that all Rhode Islanders have the resources and opportunity to achieve their full potential.

These three values have guided the state throughout the development of this waiver extension. By utilizing this waiver extension as an opportunity to fine-tune program eligibility and benefits, Rhode Island has strongly emphasized beneficiary experience. The state has focused on the functionality of the waiver to ensure that it is operating effectively for all who are served by it. This waiver extension also continues to support choice by offering extensive, high-quality benefits. Rhode Island prides itself on expanding access to care rather than limiting it and has adhered to that principle in this application. Finally, EOHHS' commitment to equity is woven throughout this application both in new initiatives and as part of existing programs. Equity is critically important to Rhode Island Medicaid and is a core consideration for every policy and programmatic decision.

The priorities, listed below, serve to ensure that all Rhode Islanders have access to high quality and cost-effective services that foster health, safety, and independence.

- Focus on the root causes and the socioeconomic and environmental determinants of health that ensure individuals can achieve their full potential.
- Promote continuums of care that deliver efficient, effective, and equitable services across the life course.
- Address addiction, improve the behavioral health system, and combat stigma, bias, and discrimination.
- Develop and support a robust and diverse health and human services workforce to meet the needs of every Rhode Islander.
- Modernize, integrate, and transform health information technology and data systems to support value-based systems of care.

Given the role of Medicaid in the health and welfare of Rhode Islanders, these priorities also seek to promote and support the vision for the state, which includes major initiatives focused on early childhood and housing. By partnering to meet the challenges of improving systems of care for young children, and securing and stabilizing housing for vulnerable populations, Rhode Island's Medicaid program can leverage its work in the near term to drive positive health outcomes for future Rhode Islanders.

2.2 Basic Description of Current Program

The entirety of the Rhode Island Medicaid program is operated under this Demonstration. This includes all Medicaid benefits and programs, including LTSS, behavioral health services, and other unique components of Rhode Island's Medicaid program.

The global waiver concept allowed Rhode Island to take a unique, holistic approach to its Medicaid program. Prior to the Demonstration, Rhode Island's Medicaid program was fragmented into several different 1115 and 1915(c) waivers. Rather than utilizing multiple waivers with separate eligibility, benefits, and quality management requirements, Rhode Island's global waiver approach has allowed the state to create and maintain a comprehensive program with extensive benefits available to an expanded population. The global waiver has been recognized for its innovation and ability to streamline Medicaid in a way that is difficult to accomplish in a system where programs operate independently.

The original Demonstration was approved by CMS in 2009 and has evolved greatly since that first application. The waiver supported implementation of the ACA, expansion of HCBS, and the conversion from an aggregate cap to a PMPM budget neutrality model.

Since the last waiver extension in 2018, Rhode Island has been successful in achieving many of the Demonstration's goals while also facing the issues associated with the ongoing COVID-19 public health emergency (PHE). Prior to the PHE, Rhode Island Medicaid experienced consistent decreases in PMPM expenditures and a lower increase in overall expenditures compared to the national average. As one of the state's first goals is to decrease the total cost of care for beneficiaries, this was an important step in the right direction to achieving that goal. However, the COVID-19 pandemic created significant impacts on both expenditures and enrollment.

The Families First Coronavirus Response Act responded to the PHE by instituting a moratorium on most regular eligibility termination activities, which resulted in increased enrollment. This increased enrollment, along with the cost of treating members affected by the pandemic, led to an increase in Medicaid program expenditures averaging 4.9 percent across all programs. Other key factors contributing to the expenditure increase and higher PMPM costs were certain legislatively mandated price increases to hospital and nursing home rates as well as an increase in the average acuity of members.

Throughout the PHE, Rhode Island continued to implement coordinated and integrated care through the AE Program. "Accountable Entities" are Rhode Island Medicaid's version of Accountable Care Organizations, in which a provider organization is accountable for quality health care, outcomes, and the total cost of care for beneficiaries. All members in the AE program are also enrolled in an MCO, requiring coordination between the AE and MCO to achieve these goals. RIte Care Core and the Expansion program (for adults aged 19-64 who gained coverage under the ACA Medicaid expansion) are the two managed care programs that account for the most AE beneficiaries. Incentive payments for the AE Program began in SFY 2019. They are time-limited payments and are expected to be distributed only through SFY 2024. This spending is reflected in the overall benefits expenditures on fully-covered Medicaid members.

The incentive payments in the AE Program are intended to enhance AE providers' capabilities in the areas of data and analytics, population health including a focus on social determinants, workforce planning and programming, care management, member engagement and access,

quality, interdisciplinary partnerships, and leadership and management. Improved coordination, integration, and care management will improve quality and outcomes for members while also reducing the total cost of care for the Medicaid program.

Other steps to improve quality outcomes and to pay for value rather than for volume included, for example, the state's investments of $30.2 million in Rhode Island's health delivery system in SFY 2020. Of this amount, $21.4 million was distributed as incentive payments through the Medicaid MCOs and $8.8 million was spent within EOHHS' central management budget for healthcare workforce development and administrative-related expenditures.[24]

2.2.1 Delivery System Overview

The majority of Rhode Islanders receiving Medicaid are served through managed care. Since the inception of the state's managed care program in 1994, Rhode Island has steadily increased the populations served by managed care, including carving in behavioral health and serving populations with more complex needs.[25] As of July 2021, the program serves 286,533 individuals through the RIte Care, Medicaid Expansion, and Rhody Health Partners eligibility groups, representing approximately 86 percent of all Medicaid members. Managed care expenditures for these populations account for approximately 60 percent or $1.4 billion of total Medicaid program expenditures.[26]

Rhode Island Medicaid's current MCOs – Neighborhood Health Plan of RI (NHPRI), UnitedHealthcare (UHCCP-RI), and Tufts Health Public Plans (THPP) – have demonstrated strong ongoing performance, having been consistently ranked among the top Medicaid plans nationally over multiple years.[27] MCOs have also built comprehensive partnerships with AEs and play a key role in the state's push for accountable care. Rhode Island's Medicaid managed care program has received high ratings on both the CMS Medicaid Scorecard and NCQA scores. The state is particularly proud of the high rates of overall consumer satisfaction in Medicaid managed care, with Rhode Island's MCOs scoring better than 99 percent of MCOs nationwide.

In Rhode Island, LTSS is carved out of managed care for all populations except for dual eligible beneficiaries. Since July 2016, Rhode Island has operated a Financial Alignment Initiative (FAI) Demonstration to provide dual eligible beneficiaries receiving LTSS with a more coordinated, person-centered care experience. In response to the recent CMS Final Rule, Rhode Island

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[24] Rhode Island Executive Office of Health and Human Services. (n.d.). Rhode Island Medicaid Expenditure Report SFY 2020. Retrieved September 15, 2022, from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-04/MedExp%20Rep%20SFY2020_FINAL.pdf

[25] Rhode Island Executive Office of Health and Human Services. (2019, May 3). Rhode Island Medicaid Managed Care Quality Strategy. Retrieved September 15, 2022, from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Reports/QUALITY-STRATEGY.DRAFT.5.3.19.pdf

[26] Rhode Island Department of Administration Division of Purchases. (2021, November 12). Request for Qualification 7664814: Medicaid Managed Care Services. Retrieved September 15, 2022, from https://purchasing.ri.gov/rivip/stateagencybids/7664814.pdf

[27] Rhode Island Executive Office of Health and Human Services. (2019, May 3). Rhode Island Medicaid Managed Care Quality Strategy. Retrieved September 15, 2022, from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Reports/QUALITY-STRATEGY.DRAFT.5.3.19.pdf

intends to submit a Transition Plan to CMS that affirms its proposal to convert its FAI Demonstration Medicare-Medicaid plan (MMP) to a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). Rhode Island envisions an integrated Medicare and Medicaid system that promotes member choice and enables vulnerable populations to access and navigate high-quality, equitable care and services with ease. Rhode Island intends to move towards managed care for all full duals and Medicaid-only beneficiaries eligible for LTSS to tightly integrate the provision and coordination of those services between Medicare and Medicaid.

Moving to a FIDE-SNP for dually eligible beneficiaries is part of Rhode Island's larger mission to foster and strengthen a community-driven, equitable, comprehensive, responsive, and high-quality health and human services system. EOHHS will request that the MMP be extended to December 31, 2025 to allow time for this transition.

Managed care options would include:

- Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)– for full duals who want Medicare and Medicaid services integrated in one plan
- Managed Long-Term Services and Supports (MLTSS) Plan– for full duals who do not choose a FIDE-SNP and would prefer an alternative Medicare plan
- Medicaid Managed Care with LTSS– for Medicaid-only beneficiaries eligible for LTSS

2.2.2 Eligibility Overview

Rhode Island's Medicaid program provides an essential safety net for many Rhode Islanders. The program ensures low-income and vulnerable populations can access high quality healthcare services. Since its inception, the Demonstration has greatly expanded eligibility and increased the number of Rhode Islanders covered by Medicaid. After Rhode Island expanded Medicaid in 2014, approximately 140,000 more Rhode Islanders are covered by Medicaid than were covered previously.[28]

All the eligibility groups covered presently by Rhode Island Medicaid are included within the Rhode Island Section 1115 Comprehensive Demonstration, including all eligibility categories included in the Medicaid State Plan. The underlying authority for the state's current eligibility groups include categorically eligible groups (mandatory and optional) as described in the Medicaid State Plan, the medically needy (mandatory and optional) as described in the Medicaid State Plan, groups that could be covered under the Medicaid State Plan but are currently only covered under the Demonstration, and groups that have eligibility via Demonstration authority only.

During this waiver extension period, EOHHS is seeking a few technical modifications to eligibility, but will otherwise continue to cover all eligibility groups. Below is a list of the Demonstration based eligibility groups only as they exist today. However, some of these groups may change upon approval of this extension request. Specifically, Rhode Island is requesting to expand postpartum coverage to 12 months, as well as increase the income standard for Budget Population 15 to 400% SSI, and has requested to remove Budget Population 23 due to the

[28] Norris, L. (2021, December 14). Rhode Island and the ACA's Medicaid expansion. Retrieved September 15, 2022, from https://www.healthinsurance.org/medicaid/rhode-island/

conclusion of the HSTP as described in *Section 3.6.1*. Reference to Rhode Island's previous postpartum coverage period have been removed.

Mandatory Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	§1931 low-income families with children §1902(a)(10)(A)(i)(I); §1931	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 4 CSHCN	Children receiving IV-E payments (IV-E foster care or adoption assistance) §1902(a)(10)(A)(i)(I)	Income: Up to 100 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Individuals who lose eligibility under §1931 due to employment §1902(a)(10)(A)(i)(I); §402(a)(37); §1925	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Individuals who lose eligibility under §1931 because of child or spousal support §1902(a)(10(A)(i)(I); §406(h)	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Individuals participating in a work supplementation program who would otherwise be eligible under §1931 §1902(a)(10(A)(i)(I); §482(e)(6)	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Individuals who would be eligible AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) 42 CFR 435.114	Income: Up to 110 percent of FPL Resource: No resource test

Mandatory Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 1 ABD no TPL	Disabled children no longer eligible for SSI benefits because of a change in definition of disability §1902(a)(10)(A)(i)(II)(aa)	Income: 100 percent of SSI Resource: $2,000
Budget Population 1 ABD no TPL	Individuals under age 21 eligible for Medicaid in the month they apply for SSI §1902(a)(10)(A)(i)(II)(cc)	Income: 100 percent of SSI Resource: $2,000
Budget Population 3 RIte Care	Qualified pregnant women §1902(a)(10)(A)(i)(III); §1905(n)(1)	Income: Up to 100 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Qualified children §1902(a)(10)(A)(i)(III); §1905(n)(2)	Income: Up to 100 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Poverty level pregnant women and infants §1902(a)(10)(A)(i)(IV)	Income: up to 185 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Qualified family members §1902(a)(10)(A)(i)(V)	Income: Up to 100 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Poverty level children under age 6 §1902(a)(10)(A)(i)(VI)	Income: Up to 133 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Poverty level children under age 19, born after September 30, 1983 (or, at State option, after any earlier date) §1902(a)(10)(A)(i)(VII)	Income: Up to 100 percent of FPL Resource: No resource test

Mandatory Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(e)(4)	Income: up to 185 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Pregnant women who lose eligibility receive coverage for pregnancy related and postpartum services §1902(e)(5)	Income: Resource: No resource test
Budget Population 3 RIte Care	Pregnant women who lose eligibility because of a change in income remain eligible post-partum §1902(e)(6)	Income: up to 185 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Poverty level infants and children who while receiving services lose eligibility because of age must be covered through an inpatient stay §1902(e)(7)	Resource: No resource test
Budget Population 1 ABD no TPL	Individuals receiving SSI cash Benefits §1902(a)(10)(A)(i)(II)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Disabled individuals whose earning exceed SSI substantial gainful activity level §1619(a)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple

Mandatory Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 1 ABD no TPL	Disabled individuals whose earnings are too high to receive SSI cash benefits §1902(a)(10)(A)(i)(II)(bb); §1905(q); 1619(b)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Pickle: individuals who would be eligible for SSI if Title II COLAs were deducted from income §503 of P.L. 94-566; §1939(a)(5)(E)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Disabled widows and widowers §1634(b); §1939(a)(2)(C)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Disabled adult children who lose SSI due to OASDI §1634(c); §1939(a)(2)(D)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Early widows/widowers §1634(d); §1939(a)(2)(E)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Individuals ineligible for SSI/SSP because of requirements prohibited under Medicaid 42 CFR 435.122	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 2 ABD TPL	Qualified Medicare Beneficiaries §1902(a)(10)(E)(i); §1905(p)(1)	Income: 100 percent of FPL Resource: $4,000 single, $6,000 couple

Mandatory Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 2 ABD TPL	Qualified disabled and working individuals (defined in §1905(s)); not otherwise eligible for Medicaid §1902(a)(10)(E)(ii)	Income: 200 percent of FPL Resource: $4,000 single, $6,000 couple
Budget Population 2 ABD TPL	Specified Low-Income Medicare Beneficiaries §1902(a)(10)(E)(iii)	Income: >100 percent but ≤ 120 percent of FPL Resource: $4,000 single, $6,000 couple
Budget Population 2 ABD TPL	Qualified Individuals; not otherwise eligible for Medicaid §1902(a)(10)(E)(iv)	Income: >120 percent but ≤ 135 percent of FPL Resource: $4,000 single, $6,000 couple

Optional Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Individuals who are eligible for but not receiving IV-A §1902(a)(10)(A)(ii)(I)	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Individuals who are eligible for IVA cash assistance if State did not subsidize child care §1902(a)(10)(A)(ii)(II)	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 3 RIte Care	Children under age 1	Income: Up to 250 percent of FPL Resource: No resource test

Optional Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 4 CSHCN	Children under 21, (or at State option, 20, 19, or 18) who are under State adoption agreements §1902(a)(10)(A)(ii)(VIII)	Income: Title IV-E (§1931 Standard; up to 110 percent of FPL) Resource: Title IV-E (§1931 Standard; no resource test)
Budget Population 4 CSHCN	Independent foster care Adolescents §1902(a)(10)(A)(ii)(XVII)	Income: 110 percent of FPL Resource: No resource test
Budget Population 7 XXI Children	Optional Targeted Low-Income Children §1902(a)(10)(A)(ii)(XIV); §1905(u)(2)	Income: ≤ 250 percent of FPL Resource: No resource test
Budget Population 4 CSHCN	Individuals under 21 or at State option, 20, 19, 18, or reasonable classification 1 §1905(a)(i); 42 CFR 435.222	Income: Up to 110 percent of FPL Resource: No resource test
Budget Population 1 ABD no TPL	Individuals who are eligible for but not receiving SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Individuals who would have been eligible for SSI or State supplement if not in a medical institution §1902(a)(10)(A)(ii)(IV)	Income: 100 percent of SSI Resource: $2,000 individual, $3,000 couple

Optional Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 1 ABD no TPL	Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of SSI income standard §1902(a)(10)(A)(ii)(V)	Income: 300 percent of SSI Federal benefit level Resource: $2,000 individual, $3,000 couple
Budget Population 1 ABD no TPL	Aged or disabled individuals whose SSI income does not exceed 100% of FPL §1902(a)(10)(A)(ii)(X)	Income: ≤ 100 percent of FPL Resource: $4,000 individual, $6,000 couple
Budget Population 1 ABD no TPL	Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under Title XVI §1902(a)(10)(A)(ii)(XI)	Income: Based on living arrangement cannot exceed 300 percent of SSI Resource: $2,000 individual $3,000 couple
Budget Population 1 ABD no TPL	BBA working disabled group: Working disabled individuals who buy in to Medicaid §1902(a)(10)(A)(ii)(XIII)	Income: Up to 250 percent FPL Resource: Up to $10,000 individual, up to $20,000 couple
Budget Population 14 BCCTP	Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program and not eligible for Medicaid §1902(a)(10)(A)(ii)(XVIII)	

Optional Categorically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 4 CSHCN	TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care	Income: 300 percent of SSI Federal benefit level Resource: $2,000
Budget Population 14 BCCTP	Presumptive eligibility for women who are screened for breast or cervical cancer under CDC program §1920B	Include eligibility requirements

Mandatory Medically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Individuals under 18 who would be mandatorily categorically eligible except for income and resources §1902(a)(10)(C)(ii)(I)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100

Mandatory Medically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Pregnant women who would be categorically eligible except for income and resources §1902(a)(10)(C)(ii)(II)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
Budget Population 3 RIte Care	Newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(a)(10)(C); §1902(e)(4)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
Budget Population 3 RIte Care	Pregnant women who lose eligibility received coverage for pregnancy-related and post-partum services §1902(a)(10)(C); §1902(e)(5)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
Budget Population 3 RIte Care	All individuals under 21 or at State option, 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 §1902(a)(10)(C); §1905(a)(i)[1]	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100

Mandatory Medically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Specified relatives of dependent children who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(ii)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
[1] EOHHS covers this group up to age 21 in the following classifications: (1) individuals for whom public agencies are assuming full or partial financial responsibility and who are (a) in foster homes and (b) in private institutions; (2) individuals placed in foster homes or private institutions by private, non-profit agencies; (3) individuals in nursing facilities; and (4) individuals in Intermediate Care Facilities for People with Intellectual Disability (ICFs/ID).		

Optional Medically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 1 ABD no TPL	Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
Budget Population 1 ABD no TPL	Blind individuals who are ineligible as categorically needy §1902(a)(10)(C);§1905(a)(iv)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100

Optional Medically Needy Coverage Groups		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 1 ABD no TPL	Disabled individuals who are ineligible as categorically needy §1902(a)(10)(C); §1902(v)	Income: 133 1/3 percent of §1931 income standard Resource: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100
Budget Population 4 CSHCN	TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)	Income: 300 percent of SSI Federal benefit level Resource: $4,000

Groups That Could Be Covered Under the Medicaid State Plan but Gain Eligibility Through §1115 Demonstration		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Parents/Caretakers with Children	Income: Above 110 percent to 175 percent FPL Resource: No resource test
Budget Population 6 RIte Care	Pregnant Women	Income: Above 185 percent to 250 percent FPL Resource: No resource test
Budget Population 3 RIte Care	Children Under 6	Income: Above 133 percent to 250 percent FPL Resource: No resource test

Groups That Could Be Covered Under the Medicaid State Plan but Gain Eligibility Through §1115 Demonstration		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 3 RIte Care	Children Under 19	Income: Above 100 percent to 250 percent FPL Resource: No resource test

Expansion Groups Under 1115 Demonstration		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Group	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 5 – Extended Family Planning (EFP)	Women who lose Medicaid postpartum eligibility received 24 months of family planning services	Income: Up to 250% FPL Resource: No resource test
Budget Population 8 – Substitute Care	Children and families in managed care enrolled in RIte Care (children under 19 & parents) when the parents have behavioral health conditions (substance abuse/mental illness) that result in their children being placed in temporary State custody	Income: Up to 200% FPL Resource: No resource limit
Budget Population 9 – Children with Special Health Care Needs (CSHCN) not voluntarily placed in State custody	Children with special healthcare needs (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody—residential diversion	Income: 300% SSI Resource: No resource limit
Budget Population 10 – Elders at risk for Long Term Care	Individuals 65 and over at risk for LTC who need home and community-based services (state only group)	Income: At or below 250% FPL Resource Test: No resource test

Expansion Groups Under 1115 Demonstration		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Group	Income and Resource Standards and/or Other Qualifying Criteria
Budget Population 11, (217-like & PACE-like in the Highest need category)	Categorically Needy Individuals under the State Plan receiving HCBS services & PACE-like participants in the Highest need group	Based on institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 of the federal regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs
Budget Population 12 (217-like & PACE like in the High need category)	Categorically needy individuals under the State Plan receiving HCBS services & PACE-like participants High need group	Based on institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the federal regulations and 1924 of the Social Security Act if the State had 1915(c) waiver programs.
Budget Population 13 (217-like & PACE like Medically needy in both the High & Highest category)	Medically needy under the State Plan receiving HCBS services in the community (high and highest group) Medically needy PACE-like participants in the community	Based on the medically needy income standard plus $400 and institutional eligibility rules, including the application of spousal impoverishment eligibility rules.
Budget Population 15 – Adults with disabilities at risk for long-term care.	Adults with disabilities served by the Office of Rehabilitation Services (ORS) who are not eligible for Medicaid, but may become so if these services are not provided	Income: Up to 300% of SSI

Expansion Groups Under 1115 Demonstration		
Expenditure and CMS 64 Eligibility Group Reporting	Medicaid Eligibility Group	Income and Resource Standards and/or Other Qualifying Criteria
Budget Services 4 – At risk youth Medicaid eligible	Medicaid eligible youth who are at risk for placement in residential treatment facilities and or inpatient hospitalization	Income: Up to 250% FPL Resource: No resource limit
Budget Population 17 – Youth at risk for Medicaid	Children under age 18 who are at risk for Medicaid or institutional care not eligible for Medicaid	Income: Up to 300% of SSI for child Resource: No resource limit
Budget Population 20 – Alzheimer adults	Adults aged 19-64 who have been diagnosed with Alzheimer's Disease or a related Dementia as determined by a physician, who are at risk for LTC admission, who are in need of home and community care services	Income: At or below 250% FPL
Budget Population 21 – Beckett aged out	Young adults aged 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 percent of the FPL, who are otherwise ineligible for Medical Assistance, and need services and/or treatment for behavioral health, medical or developmental diagnoses.	Income: At or below 250% FPL
Budget Population 23 – Designated State Health Programs (DSHPs)	Expenditures for cost of designated programs that provide or support the provision of health services that are otherwise state-funded	

2.2.3 Benefits Overview

In addition to widely available coverage, Rhode Island Medicaid offers a comprehensive benefit package. The state prides itself in providing high quality services for all eligibility groups. Benefits provided through this demonstration program for each eligibility group are as follows:

- RIte Care. RIte Care is Rhode Island's Medicaid managed care program for families with children, pregnant individuals, and children under age 19. Benefits for this group include the full scope of benefits set forth in the approved State Plan and this Demonstration. Benefits are delivered through MCOs or managed care delivery systems, with the exception of certain services paid by the state on a fee for service (FFS) basis, as outlined in the applicable managed care contracts.
- Alternative Benefit Plan. The New Adult Group receives benefits provided through the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective as of the effective date in the approved ABP SPA. Individuals in the New Adult Group may receive, as part of their ABP under this demonstration, Expenditure Authority services such as those benefits specified in Attachment A of the STCs.
- Extended Family Planning Program. Family planning services (including annual gynecological exams, pap smears, sterilization, some lab tests, contraceptives, and other family planning related services and referrals to primary care services) are provided to eligible recipients at or below 253 percent of the FPL who lose Medicaid eligibility at the conclusion of their postpartum period. The postpartum coverage period will extend to twelve months this year. Eligible individuals may receive family planning related benefits for up to 24 months.
- Long-Term Care Benefits. Individuals eligible as aged, blind, or disabled (ABD) under the Medicaid State Plan will receive benefits for institutional and home and community-based long term care services (HCBS) including an option for self-direction. Primary care for this population may be provided through mandatory or voluntary managed care or FFS programs. Based on a level of care determination, individuals eligible as ABD under the Medicaid State Plan can fall into the following groups: 1) highest, 2) high, and 3) preventive.
- HCBS. HCBS benefit packages for all individuals who meet the highest or high level of care criteria will include access to core and preventive HCBS. Benefit packages for all individuals who meet the preventive level of care will include access to preventive HCBS as described in STC 22 subject to any waiting list as described in STC 27. The state will assure compliance with the characteristics of home and community-based settings as described in the applicable section 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.
- Limited Benefit Packages. Individuals in Budget Populations 10,16,18 and 20 are eligible for limited benefits under the demonstration. Benefit packages may include, but are not limited to, limited pharmacy, physical health, or mental health services.

2.2.4 Cost Sharing Overview

In 2019, Rhode Island revised the cost-sharing requirements specified in the State Plan to reflect that the state does not charge cost sharing (deductibles, co-insurance, or co-payments) to individuals covered under Medicaid. The SPA making this change was approved on August 7,2019 with an effective date of July 1, 2019.

2.2.5 Demonstration Program Distinct Component Overview

The Demonstration includes the following distinct components:

- Managed Care. The Managed Care component provides Medicaid State Plan benefits as well as supplemental benefits as identified in Attachment A of the STCs to most recipients eligible under the Medicaid State Plan, including the New Adult Group. Benefits are provided through comprehensive mandatory managed care delivery systems.
- Family Planning. The Extended Family Planning component provides access to family planning and referrals to primary care services for postpartum beneficiaries 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 postpartum period.
- Premium Assistance. 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.
- Rhody Health Partners. Rhody Health Partners is a comprehensive, risk-based program that provides acute and primary care services to older adults and individuals with disabilities who are not enrolled in Connect Care Choice. 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.
- HCBS Program. The HCBS component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need HCBS either as an alternative to institutionalization or otherwise based on medical need.
- RIte Smiles. The RIte Smiles Program is a managed dental benefit program for Medicaid eligible children.

Other Initiatives of the Demonstration Project

Several other notable initiatives have been featured in Rhode Island’s work under the Demonstration, resulting in positive outcomes and increased quality and satisfaction for program beneficiaries.

Accountable Entities

The state has developed initiatives over the past several years emphasizing the importance of provider roles in accountable care. The AE program has been recognized as a national model for incentivizing quality and outcomes while addressing other aspects of care like the social

determinants of health.[29] In the AE model, there is a shared savings agreement between MCOs and AEs. In this unique partnership between MCOs and AEs, AEs serve as a source of referrals, health system navigation, and care coordination for the beneficiary. By linking MCOs and AEs, Rhode Island has laid the groundwork for a person-centered system of care capable of supporting even the most complex individuals.

The goals set forth at the outset of the AE initiative included the following:

- Transition from FFS to value-based purchasing
- Focus on Total Cost of Care (TCOC)
- Create population-based accountability for an attributed population
- Build interdisciplinary care capacity that extends beyond traditional health care providers
- Deploy new forms of organization to create shared incentives across a common enterprise
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs[30]

The AE program has demonstrated great success at moving the needle on accountable care and intentionally shifting Rhode Island's Medicaid program toward a value-based care model. To date, Rhode Island has successfully enrolled almost 70 percent of the Medicaid population into accountable care. The AE program has also led to demonstrable increases in preventive care. Most importantly, members have reported high satisfaction with the care received through AEs.

Behavioral Health Expansion

Rhode Island's waiver features a comprehensive set of behavioral health benefits, including those targeted at substance use disorders (SUD) and crisis care. Many authorities were requested in the state's previous extension. The state seeks to use this extension to continue to build on the progress made through these programs and services.

In its last waiver extension, the state requested expenditure authority to waive the Institution of Mental Diseases (IMD) Exclusion for beneficiaries diagnosed with an opioid use disorder (OUD) or other SUD. Rhode Island's goal in implementing this initiative was to increase access to critical levels of care for OUD and SUD patients by allowing larger SUD residential treatment providers to obtain reimbursement for services.[31] At the same time, Rhode Island adjusted behavioral health and SUD services available across the continuum of care, as follows.

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[29] Higgins, E. (2018, November 27). Q&A: How Rhode Island Tackles Social Determinants of Health through its Accountable Entity Model. Retrieved September 15, 2022, from https://www.nashp.org/qa-how-rhode-island-tackles-social-determinants-of-health-through-its-accountable-entity-model/

[30] Centers for Medicare & Medicaid Services. (2018, December 20). Rhode Island Comprehensive Demonstration: CMS Approval - Extension Request. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-cms-ext-request-appvl-12202018.pdf

[31] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

The Peer Recovery Specialist (PRS) and Family and Youth Support Partners (FYSP) programs are targeted at individuals with behavioral health needs. PRS offers peer services for individuals with mental health and/or SUD who are having trouble stabilizing in the community or need supports to maintain their stability. Eligible individuals can include those at risk of hospitalization, overdose, or homelessness, as well as people released from institutional settings. The PRS program is designed to meet beneficiaries where they are by providing support from someone with lived experience. The FYSP program similarly offers supports for behavioral health needs but is targeted at supporting children under 21 and their caregivers. The intent of the program is to improve the child's functioning within family and community settings and prevent institutionalization.[32]

Rhode Island's Demonstration specifically targets crisis as one significant component of behavioral health. Through the Behavioral Health Link (BH Link) program, the state was granted authority to support crisis stabilization and short-term treatment for beneficiaries experiencing a behavioral health crisis through a triage center. Services offered through BH Link include screening and evaluation, treatment, and crisis intervention.[33]

Taken together, these behavioral health initiatives have been critical tools in helping the state address the increased behavioral health needs of Rhode Islanders during and immediately following the pandemic. In the state's required SUD Mid-Point Assessment, evaluators determined that Rhode Island is on track to meet the six milestones it laid out in its SUD implementation plan.[34] Additionally, while COVID-19 presented barriers to evaluating the success of BH Link, program evaluators found that the program made "substantial progress" filling gaps in Rhode Island's mental health and substance use crisis care services.

Section 3: Requested Program Enhancements

The Demonstration has served as the foundation for Rhode Island's Medicaid program since 2009 and includes nearly every aspect of the Medicaid program in Rhode Island. For nearly 15 years, the demonstration has continually evolved to meet the needs of Rhode Islanders. The next five-year renewal will be no exception. EOHHS is seeking to build upon prior successes and make targeted program enhancements in programs and interventions aimed at achieving the following goals:

- Improving health equity and addressing social determinants of health;
- Supporting access to critical behavioral health;
- Continuing progress on rebalancing LTSS toward HCBS; and

[32] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf
[33] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf
[34] NORC. (2020, June 30). Rhode Island Comprehensive Demonstration: State SUD Mid-Point Assessment. Retrieved September 15, 2022, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-global-consumer-choice-compact-sud-midpoint-assessment-06302021.pdf

- Streamlining administration of the Demonstration.

In addition to essential enhancements in the areas of health equity, behavioral health and HCBS, EOHHS views this renewal as an opportunity to make a number of technical updates to the program's STCs to support ease of administration, as well as increased clarity for stakeholders. It is critically important to the state that the Demonstration functions at full capacity for beneficiaries. This extension has allowed the state to complete a full, extensive review of the waiver and update it to reflect existing operational and policy realities.

At the core all of the requests in this waiver are the three values that guide all of EOHHS' policy and programmatic decisions: voice, choice, and equity. This waiver extension has been designed in order to put the needs of the beneficiary at the forefront and support a wide array of services and programs that beneficiaries can seek to utilize. Equity has been considered as a key component of every enhancement and technical change. Rhode Island Medicaid has developed this extension to support EOHHS' larger vision of building resilient, equitable, and just communities nurturing the health, safety, wellbeing, and independence of all Rhode Islanders.

3.1 Health Equity

The COVID-19 pandemic has brought to greater light the stark health inequities that have been present in Rhode Island and our nation for decades. One of the primary goals for the next demonstration period is to leverage the Demonstration to address health inequities driven by external factors not directly related to the healthcare system. By improving health equity through strong community--clinical linkages that support beneficiaries in addressing these social determinants of health, including ensuring access to stable housing, EOHHS hopes to improve healthcare quality and outcomes for all Medicaid beneficiaries. Specifically, EOHHS seeks to include the following enhancements in the Demonstration, each described in more detail below:

- Support stable housing by expanding Home Stabilization benefits;
- Implement a recuperative care (medical respite) pilot program; and
- Develop linkages between Medicaid and existing Health Equity Zones with the intent to support future investment in public health and equity initiatives.

3.1.1 Home Stabilization Expansion

A particularly critical social determinant driving health outcomes is access to stable housing. Housing instability has been linked to poor mental health, chronic illness, HIV and other infectious diseases, SUD, and high mortality.[35] Studies have found that individuals with unstable housing experience frequent hospital readmission and place a burden on emergency

[35] Koeman, J. & Mehdipanah, R. (2021, June 8). Prescribing Housing: A Scoping Review of Health System Efforts to Address Housing as a Social Determinant of Health. Retrieved September 15, 2022, from https://www.liebertpub.com/doi/10.1089/pop.2020.0154

department services.[36] Thus, housing interventions have been shown to improve health outcomes and decrease health care costs.[37]

The connections between housing and health can be illustrated through four pathways[38]:

- Stability: Moving frequently or falling behind on rent
- Safety and quality: Environmental factors within homes such as exposure to lead, poor ventilation, and pest infestation
- Affordability: Spending a significant portion of income on housing; 38.9 million American families spent more than 30 percent of their income on housing in 2015, meeting the designation of being "cost-burdened"
- Neighborhood: Physical surroundings and availability of resources like public transportation and grocery stores

Federal regulations generally limit state Medicaid programs to utilizing funding to address stability and safety and quality. Within these confines, Rhode Island Medicaid has long demonstrated its commitment to addressing housing insecurity. In 2020, Rhode Island received authority for and began to implement its Home Stabilization initiative. The purpose of the program was to make an organized set of Medicaid-funded tenancy support services available to Medicaid beneficiaries. Rhode Island's Home Stabilization program is designed to support recipients experiencing housing instability to become self-sufficient. By assisting individuals in finding and maintaining housing, the state seeks to address one component of health to create better outcomes for beneficiaries.

The existing Home Stabilization program is split into two categories of services—Home Tenancy services and Home Find services.

Home find services are a set of time-limited services to promote an individual's ability to find housing. Services can include tenant screening and housing assessments; developing an individualized housing support plan; and supports to assist the individual with the housing application and search process, among other services.

Home tenancy services are a set of time-limited services to build a set of skills that promote independence and ensure that an individual is able to meet the obligations of tenancy and successfully maintain housing. Services can include coordinating and linking recipients to supports that assist in early identification and intervention for behaviors that jeopardize housing, such as late rent payment; connecting the individual to education and training on the role, rights, and responsibilities of the landlord and tenant; and providing supports to assist the individual in developing and maintaining key relationships with landlords/property manager with a goal of fostering successful tenancy.

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[36] Koeman, J. & Mehdipanah, R. (2021, June 8). Prescribing Housing: A Scoping Review of Health System Efforts to Address Housing as a Social Determinant of Health. Retrieved September 15, 2022, from https://www.liebertpub.com/doi/10.1089/pop.2020.0154

[37] Taylor, L. (2018, June 7). Housing and Health: An Overview of the Literature. Retrieved September 15, 2022, from https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/

[38] Taylor, L. (2018, June 7). Housing and Health: An Overview of the Literature. Retrieved September 15, 2022, from https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/

The state currently has nine approved agencies that provide Home Stabilization services, with four of those currently providing and billing for the service. Based on experience from the implementation as well as the promise of the early successes, EOHHS would like to expand and enhance the current Home Stabilization benefit in several ways, including (i) relaxing education requirements for service providers; (ii) clarifying and expanding the population eligible for the services; (iii) creating operational flexibility through removal of specific assessment tool requirements; and (iv) adding payment of first/last/security and other required funds to secure stable housing as well as payment of up to six months of rent. Each proposed revision is described in more detail below.

(i) Education Requirement. Rhode Island seeks to change the education requirement to a minimum of a High School Diploma or GED with one (1) year of lived or professional experience.

Various certification standards exist for service providers. In addition to requirements for organizational structure, capability, and program operations, several standards for provider staff persons apply. Currently, staff providing direct support to beneficiaries must have either:

(i) a Bachelor's degree in a human/social services field; or
(ii) an Associate's degree in a relevant field with one (1) year of case management experience.

When the program was designed, the state felt that these educational requirements were appropriate. However, as the program was operationalized, the education requirements have proved to be burdensome and a barrier to offering Home Stabilization services to more qualified individuals. Rhode Island is not alone in facing serious workforce challenges in the wake of the pandemic. Finding staff who meet these qualifications has been difficult for participating agencies. Agencies and the state alike see the relaxation of these education requirements as critical to providing necessary housing services to more beneficiaries, thus achieving Rhode Island's goals of comprehensively addressing the social determinants of health.

The state also believes that changing the education requirement will encourage more agencies to sign up to provide services. There is currently a gap in the type of providers who offer the service, with many providers that target unhoused individuals not participating. Rhode Island sees this as an opportunity to greatly expand the provision of services by utilizing providers with a variety of experiences, especially those from non-traditional backgrounds who may have lived experience. The state believes this change will significantly improve service access and further the goal of assisting beneficiaries in obtaining and maintaining safe, stable housing.

(ii) Eligible Population. Rhode Island would like to expand access to the service to a broader population that may require housing support services.

Under the state's current Demonstration, to receive Home Stabilization services, an individual must have at least one risk factor related to housing: history of eviction and/or unstable housing; history of frequent turnover of in-home caregivers; history of institutionalization in a medical or

penal facility; and/or past or present substance use that interfered with ability to maintain housing. Individuals must also meet at least one of the following health needs-based criteria[39]:

- The individual is assessed to have a mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning resulting from the presence of a mental illness; and/or
- Any complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deteriorating functioning.

Rhode Island sees Home Stabilization services as playing a key role in the state's efforts to improve social determinants of health. To expand the impact of Home Stabilization to more beneficiaries in need, the state requests to eliminate the health needs-based eligibility criteria for Home Stabilization and to add an additional housing-related risk factor to capture a broader population: "Current or past experience of homelessness or currently at risk of homelessness." This will better direct the services to those it is intended to serve—individuals experiencing housing instability.

The existing eligibility criteria also specify a number of exemptions, including one for the Community Transition population. This exemption was appropriate when the services provided under Home Stabilization and Community Transition were similar. However, because the state is now requesting enhancements to Home Stabilization, the state believes all beneficiaries should have access to the service that is most appropriate for them. Accordingly, the state requests to remove this exemption, so that eligibility for Community Transition does not preclude eligibility for Home Stabilization in the case that Home Stabilization will better meet a beneficiary's needs.

Additionally, the state would like to take this opportunity to further target the services to families, youth aging out of care, those impacted by a criminal record, and individuals and families experiencing or with a history of interpersonal or community violence. The state clarifies that by targeting certain populations under the service definition, the state does not intend to limit the service to these populations. While portions of these population groups could currently receive services under the current service definitions, Rhode Island would like to make explicit reference to them in the Demonstration to expand the pool of potential service recipients. The state believes that these population groups could specifically benefit from Home Stabilization services and would like to draw particular attention to them for that reason; but all individuals who meet the eligibility criteria may receive services.

(iii) **Flexibility in Assessment Tools**. To support flexibility in program administration, EOHHS requests removal of any references to specific assessment tools within the approval documentation.

A small change that the state seeks to make is to remove the requirement to review and approve provider housing assessment tools. Currently, the Demonstration states that the state must review and approve all tools. Rhode Island would like to remove the reference to this

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[39] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

review requirement. While a housing assessment will still be required, providers will be allowed to conduct the assessment with the tool of their choice without needing approval. The state anticipates that by allowing providers to utilize the tool of their choosing without administrative review, it will encourage provider participation, thus increasing the number of beneficiaries served. This aligns with Rhode Island's aims to increase access and address a strong social determinant of health.

(iv) **Transitional Supports**. Add one-time transition-related payments to the Home Stabilization benefit.

The final change that Rhode Island seeks to make to its Home Stabilization benefit is to add non-recurring set-up expenses for individuals who are transitioning to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses and additional support for individuals to maintain tenancy and avoid eviction.

Home Stabilization services cover two kinds of supports: Home Find and Home Tenancy. The Home Find support includes assisting "the individual in identifying resources to cover moving and start-up expenses." Since implementing these supports, providers and participants note that resource barriers encumber and/or prevent achieving the mutual goal of stable, long-term housing. In order to address these barriers, Rhode Island is seeking in this Demonstration extension to leverage the experience of other state Medicaid programs by providing Transitional Supports to Home Find and Home Tenancy recipients.

Rhode Island proposes the following Transitional Supports for Home Find recipients:

- A one-time payment for each - security deposit, first month's rent and last month's rent at 125% of Fair Market Rent (FMR) based on family size.
- A one-time payment for move-in supports, which includes setting up essential utility services/payment of past-due amounts, remediation of asthma triggers, and pest removal, at 125% of FMR based on family size.

Rhode Island proposes the following Transitional Supports for both Home Find and Home Tenancy recipients:

- A one-time allocation of funds equal to 100% of FMR based on family size for Healthy Home Goods, which includes mold/asthma remediation and pest control, and that covers non-Durable Medical Equipment household items needed to support a healthy home environment. Such home goods include air filtration, refrigerator, humidifier, air conditioner, mattresses, linens, pantry stocking, kitchen items needed for meal preparation, adequate lighting, household furniture, and other goods as approved. Healthy Home Goods also can include smart home devices that will advance the participants ability to safely remain in a home and are preventive in nature.
- Up to six months of rent payments.

Rhode Island believes that adding these Transitional Supports will improve the program's efficacy and reduce the risk of homelessness. Studies have shown that such monetary support significantly reduce the likelihood that an individual will become homeless,[40] one of the core

[40] Shultz, D. (2016, August 11). A bit of cash can keep someone off the streets for 2 years or more. Retrieved September 15, 2022, from https://www.science.org/content/article/bit-cash-can-keep-someone-streets-2-years-or-more

aims of the Home Stabilization program. In particular, Rhode Island sees the ability to pay for six months of rent as a substantial change to the Home Stabilization benefit that will have a significant impact on beneficiary outcomes. The core tenet of the Home Stabilization program is to support recipients in becoming self-sufficient with their housing needs. By providing a tenant with rent assistance during an unstable period, Rhode Island believes that more beneficiaries will be able to stay in their home and continue to maintain their housing even after the assistance ends.

To be eligible for Transitional Support, beneficiaries must be actively working with a Home Stabilization provider and be identified by that provider as being in need of Transitional Support after exhausting all other traditional and natural supports.

3.1.2 Restorative and Recuperative Care (including Medical Respite) Pilot

Recuperative care, commonly referred to as medical respite, is acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, a congregate setting, or other location inappropriate for their condition or treatment needs, but do not meet hospital level of care criteria from a clinical standpoint. The care provided via medical respite services is short-term residential care that allows individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services.[41]

As of 2021, the existing research on medical respite found that programs reduced hospitalizations and cost of care, filled a need gap within services, and improved the health of persons experiencing homelessness.[42] Additionally, individuals who use medical respite spend less time in the hospital, are less likely to be readmitted to the hospital, and are more likely to use primary care.[43] Studies on the consumer perspective found that individuals served by medical respite programs highly value them and find that they promote health, wellbeing, and recovery.[44]

Based on the positive outcomes of medical respite programs, Rhode Island seeks authority to implement a Recuperative Care Center Pilot Program ("Pilot"). The state envisions that the Pilot will support at least three Recuperative Care Center sites. Recuperative Care Centers will provide services to individuals experiencing homelessness to prepare for, undergo, and recover from medical treatment, injuries, and illness. Individuals will be required to obtain a referral or be evaluated for medical necessity to receive services. The length of stay will be limited to active treatment and/or recovery not to exceed 36 months.

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[41] National Health Care for the Homeless Council. (n.d.) Medical Respite Care. Retrieved September 15, 2022, from https://nhchc.org/clinical-practice/medical-respite-care/
[42] National Institute for Medical Respite Care. (March 2021). Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care. Retrieved September 15, 2022, from https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf
[43] Levi, R. & Gorenstein, D. (2022, May 20). Medical respite offers refuge for homeless people recovering from illness. Retrieved September 15, 2022, from https://www.npr.org/sections/health-shots/2022/05/30/1099760410/homeless-medical-respite
[44] National Institute for Medical Respite Care. (March 2021). Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care. Retrieved September 15, 2022, from https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

The complete details of the program can be found below.

Program Definition: A care setting designed to provide individuals experiencing homelessness with the services they need to prepare for, undergo, and recover from medical treatment and to recuperate from injuries and illness, including infectious diseases. Care Centers must be able to provide acute care but do not need to meet a hospital level of care.

Care Centers will ensure that referrals will be screened and managed using equitable admissions criteria and will strive to offer a low barrier to access services. Individuals are eligible to receive services through the Pilot by meeting each of the following two criteria:

1. Unsheltered, unhoused or at high-risk of homelessness OR staying in a setting that is inappropriate for pre or post hospitalization or recovery; and
2. Have a health need that requires a safe and supportive environment.

Given the level of care provided, the individual must also be:

a. Able to complete all Activities of Daily Living (ADLs) independently or with mechanical assistive device (e.g., wheelchairs, walkers, etc.);
b. Able to self-administer medication;
c. Medically and psychiatrically stable;
d. Able to recover/rest without intensive medical or psychiatric supervision;
e. Negative for Clostridioides difficile; and
f. Not actively in acute detox from alcohol and/or opiates.

Care Centers must provide nursing care and case management and have on-call capabilities. They must also provide coverage and consultation by a prescribing medical provider and have access to a BH specialist to provide as-needed support. Care Centers are responsible for ensuring high quality care and supervision of participants' medical condition and wellness, which includes arranging for outpatient care and supportive services. Care Centers are also responsible for arranging for cleaning and medical waste services, making laundry services available to participants, arranging for appropriate security services as needed, and providing three (3) daily meals that meet the nutritional, medical and cultural needs of participants.

Limitations: The length of stay at the Recuperative Care Center shall be limited to the time an individual is either: a) actively preparing for or recovering from healthcare treatment; b) undergoing medical treatment or diagnostic evaluation; or c) recovering from an injury or illness. The initial referral or evaluation of a potential patient must indicate the expected length of stay, although this can be revised as needed if circumstances change. However, in no circumstance may the length of stay exceed 36 months.

Delivery System: The Pilot will operate through the FFS delivery system with the goal of transitioning to managed care following the pilot period.

3.1.3 Health Equity Zones

Background

Research shows that up to 80 percent of health outcomes stem not from genes, biology, or clinical care, but from factors in our homes, schools, jobs, and communities.[45] Similarly, differing health outcomes between groups are not primarily the result of individual choices or a lack of access to healthcare. Instead, health inequities predominantly arise from root causes in the surrounding physical, social, political, and economic environment.[46] Experts broadly agree that systems and policies directly influence health inequities. To address health inequities, in collaboration with community partners, Rhode Island developed the Rhode Island Health Equity Measures, which include 15 indicators of health equity within five primary domains: integrated health care, community resiliency, physical environment, socioeconomics, and community trauma.[47]

These indicators were chosen because in Rhode Island, as is the case nationally, local conditions impact health and often dictate the availability and quality of resources that promote healthy lives. Differences in the places where individuals live, work, and play frequently result in inequities in opportunities like quality childcare and education, quality housing, access to healthy foods, and safe places to be physically active. Disparate economic, social and health outcomes are especially prevalent in communities of color.[48]

In Rhode Island:

- Communities of color have higher poverty rates than their Whites counterparts and the state as a whole. (Native Peoples 42 percent; Hispanic/Latinx 36 percent; Black/African American 28 percent; Asian & Pacific Islander 19 percent; White 11 percent; statewide 14.4 percent)
- Native Peoples have the highest percentages of children living in poverty (54 percent), compared to all other groups (Hispanic/Latinx 40 percent; Black/African American 39 percent; Asian & Pacific Islander 22 percent; White 14 percent)
- Hispanics/Latinos, Blacks/African Americans, and Native Peoples have higher unemployment rates than Asians and Pacific Islanders, Whites, and the state as a whole. (Native Peoples 26 percent; Hispanic/Latinx 18 percent; Black/African American 14 percent; Asian & Pacific Islander 8 percent; White 9 percent; statewide 10 percent)
- All minority groups have lower percentages of home ownership and are more likely to rent their housing than Whites and renters are significantly more likely to be housing cost-burdened (spending 30 percent or more of their income on housing costs)

Where communities have historically lacked investment, and communities of color remain disproportionally lower income, people suffer worse health outcomes. For example, in the cities

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[45] National Academy for State Health Policy. (n.d.) Health Is Determined by Life Conditions. Retrieved September 15, 2022, from https://www.nashp.org/wp-content/uploads/2019/05/Slide2-Help-State-Leg-Improve-Health.pdf
[46] Frieden, T. (April 2010). A Framework for Public Health Action: The Health Impact Pyramid. Retrieved September 15, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340
[47] Rhode Island Department of Health. (n.d.). The Rhode Island Health Equity Measures. Retrieved September 15, 2022, from https://health.ri.gov/publications/factsheets/HealthEquityIndicators.pdf
[48] Lee, E. (2020, April 10). Redlining & Health Equity: How Health Systems Can Help Dismantle Structural Racism. Retrieved September 15, 2022, from https://healthbegins.org/redlining-health-equity-how-health-care-can-help-dismantle-structural-racism/

of Central Falls, Pawtucket, Providence, and Woonsocket, infants are disproportionately born with low birthweight (8.8 percent in these cities compared to 7.7 percent statewide), women are more likely to delay prenatal care (20 percent in these cities; 15.8 percent statewide), and more likely to have preterm births (9.9 percent in these cities; 9.0 statewide). With disproportionately unhealthy housing stock and lower environmental protectors (like tree coverage), these cities see rates of hospitalizations for Asthma in children under 18 more than twice as high as the remainder of the state. Additionally, children living in these cities are three times as likely as children in the remainder of the state to have confirmed elevated blood lead levels.[49] Racial and ethnic inequities exist in diabetes, heart disease, and stroke, which align with disproportionately high food insecurity rates. According to the *2021 Status Report on Hunger in Rhode Island*, 14 percent of White households reported food insecurity, while the rate was significantly higher among non-White households: 34 percent for Black households, 34 percent for Latinx households, and 25 percent among all remaining households, including Asian, Native People, and multi-racial households.

The COVID-19 pandemic reinforced the understanding of how identities, historic and present inequities, and place can all impact health outcomes. Throughout the COVID-19 pandemic, Rhode Island saw disproportionately high infection rates in marginalized communities, places that were formerly redlined areas. Termed “high density” communities, these geographically underinvested communities saw higher rates of COVID-19 than their wealthier counterparts.

Given the importance of ‘place’, since 2015, Rhode Island has invested more than $30 million in the development and sustainability of a place-based community infrastructure through the Health Equity Zone (HEZ) initiative. Links between places, communities, and health have long been established. Research has shown that place-based interventions designed to impact the physical environment, such as providing opportunities for physical activity, modifying or providing housing, increasing access to food through the development of new supermarkets, and increasing access to transportation can improve health, health behaviors, and social determinants of health outcomes.[50] The HEZ initiative is designed to support the strategic priority of addressing social determinants of health and achieving health equity through community clinical linkages. HEZ is a health equity-centered approach to prevention that leverages place-based, community-led solutions to address the social determinants of health. Health Equity Zones are identified geographic areas where opportunities to address health inequities through investment in the community exist. Each HEZ is led by a community-based collaborative that conducts an assessment to identify, describe, and prioritize inequities of importance to the community, and develops and implements an action plan informed by the assessment to address root causes of health inequities.

The Rhode Island Department of Health (RIDOH) supports the establishment and growth of these place-based community collaboratives through a series of intensive and sustained

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[49] Rhode Island KIDS COUNT. (n.d.). 2022 Rhode Island Kids Count Factbook. Retrieved September 15, 2022, from https://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202022/fm6798_Factbook2022_web.pdf?ver=2022-05-18-151346-817

[50] McGowan, V.J., Buckner, S., Mead, R. et al. (2021, October 19). Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review. Retrieved September 15, 2022, from https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-11852-z

technical assistance forums, which include trainings and professional development on financial management, performance management, conflict resolution, governance, data management, IT enhancements, and more.

Overview of Beneficiaries, Services and Outcomes

To date, there are 15 Health Equity Zones covering approximately 80 percent of the state, with a goal of having HEZ coverage wherever necessary by 2024. Residing in, and therefore served by the existing HEZs, are over 179,000 AE-attributed Medicaid beneficiaries, including both those who do and those who do not engage with their medical care team, who are at risk of losing their Medicaid coverage, and more. These beneficiaries can both receive direct services funded through the HEZ (including, but not limited to, Community Health Worker systems navigation) and benefit from upstream community advancements.

Rhode Island's HEZ initiative is strategically designed to resolve inefficiencies inherent in traditional prevention work, and to create measurable, sustainable gains in health equity at the state and local levels. To date, some of the significant outcomes from direct HEZ activities and interventions include:

- Overdose crisis response supporting an 8.3 percent reduction in drug overdose deaths statewide from 2016 to 2019
- Mental health first aid and suicide prevention training to more than 1,000 police officers, clergy, teachers, parents, and staff of youth-serving organizations
- Reduction in childhood lead poisoning by 44 percent (Pawtucket and Central Falls)
- Graduating over 1,000 residents from evidence based chronic disease and prevention programs
- Reduction in teen pregnancy by 24 percent through intensive education and programming (Central Falls)
- Increasing redemption of SNAP farmers' market incentives by 40 percent (West Warwick)
- Increased access to fruits and vegetables by 36 percent through multi-faceted strategies (Central Providence)

Having this place-based community infrastructure proved to be essential to Rhode Island's COVID-19 response. Because HEZs are embedded in the communities, HEZs were uniquely positioned to respond to critical needs that quickly emerged and continue to emerge during the COVID-19 pandemic. HEZs became trusted resources to provide relevant and essential information and outreach, community testing, vaccination clinics, and access to services and supports for basic needs (such as food, rent assistance, and support during quarantine) to communities throughout Rhode Island.

Throughout the COVID-19 response, HEZs have again proven their ability to have a significant impact on the communities served. Since the beginning of the pandemic, HEZs have supported:

- Distribution of nearly 3 million masks to the hardest hit and most vulnerable residents
- Distribution of almost 700,000 meals to those severely impacted by COVID-19 and those most in need
- Distribution of roughly 104,000 COVID-19 self-test kits directly into communities in the span of only 6 months since becoming available in December 2021
- Provision of 275,000 COVID-19 related, language appropriate educational materials

- Outreach to 250,000 Rhode Islanders, plus additional vaccine specific outreach to 130,000 residents
- 175 Community Health Workers to support directly serving well over 200,000 residents
- Provision of full quarantine and isolation support to 15,000 residents
- Vaccinated 17,000 of the hardest to reach Rhode Islanders, including undocumented and homebound populations

This outreach has fostered confidence and trust in the COVID-19 vaccine and has brought testing and vaccination sites directly to the communities that were most impacted by COVID-19, including mobile vaccination clinics. Thus, through collaboration with cities and towns across Rhode Island, the HEZs continue to provide door-to-door canvassing; COVID-19 education; personal protective equipment (PPE) and self-test kits; quarantine supports for food, unemployment, and rent assistance; and responding to COVID-19 hot spot areas with testing and vaccination information so residents know where to get tested and vaccinated, including helping locations be more welcoming, visible, trustworthy, culturally and linguistically competent, and operationally efficient.

Beyond the direct services provided by the HEZs before and throughout the COVID-19 pandemic, the HEZs have worked to improve community conditions, such as increasing healthy and affordable housing stock and food access, and have also achieved upstream policy changes such as public smoking and vaping bans and green and complete street ordinances for lasting, community wide impacts on preventing illness.

Health Equity Zone Funding

Addressing the drivers of inequity can help improve health and opportunity for all residents in a state or locality. Unfortunately, nationally, per-capita public health expenditures have fallen by 9.3 percent since 2008,[51] and researchers project that public health spending will fall to only 2.4 percent of total health spending by 2023. In line with the rest of the country, non-profit, community-based organizations in Rhode Island have been chronically under-resourced. In fact, Rhode Island is the only state to see negative growth from 2007-2017. HEZ represents a paradigm shift in community investment by meaningfully investing in the capacity of trusted organizations and networks that serve the most vulnerable and are best positioned to advance health equity. Community participation is a critically important component of HEZ. Community buy-in is a necessary part of any successful public health initiative. By involving communities in the decision-making and operational processes of the HEZs, communities are more trustworthy of the initiative and invested in its success. Community participation is a key pillar of EOHHS' values.

Health Equity Zones are not reimbursed on the basis of services provided but instead have historically been grant-funded for the work that they do to improve equity in communities. The Health Equity Zone initiative's ability to improve equity is evident by the multi-sector, diverse array of funding streams that have invested in the initiative. To date, $30 million has been invested in the HEZs from private and public agencies. In fiscal year 2023, the 15 HEZs are

[51] Himmelstein, D. & Woolhandler, S. (January 2016). Public Health's Falling Share of US Health Spending. Retrieved September 15, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695931/

funded at $7.43 million with state funds, grants from private foundations, federal and state agency allocations, and funds from multiple programs throughout the Department of Health.

Through the HSTP, several HEZs have partnered closely with Rhode Island Medicaid. Rhode Island Medicaid sees HEZs as a key component in its efforts to address health inequities and unmet health-related social needs. However, Medicaid recognizes that more can be done and seeks to play a larger role in the success of HEZs.

Future Efforts

To date, the role of Medicaid in paying for HEZ-developed initiatives and services has been limited. Through this waiver extension, Rhode Island sees an exceptional opportunity for Medicaid to become more involved in HEZ work and demonstrate its deep commitment to health equity and public health. As HEZs are currently structured, funding for these initiatives can be utilized for projects that lift up and provided critical supports for entire communities. While these initiatives create significant benefit for Medicaid beneficiaries living in the community, they do not single out or target services only to Medicaid beneficiaries, creating challenges for leveraging traditional Medicaid reimbursement mechanisms to support these initiatives.

However, with the upcoming Medicaid managed care procurement, Rhode Island seeks to fully leverage its contracting authority to identify MCOs willing to partner with the state in making meaningful investments in the HEZ initiative. Specifically, Rhode Island will be pursuing various Medicaid managed care strategies to drive additional funding and support to the HEZs in its upcoming MCO procurement, which may include all or some of the following specific contract requirements:

- **Community Reinvestment**. The state of Rhode Island will consider requiring MCOs to reinvest a portion of their revenues back into the communities being served by supporting HEZ funding. These funds would be limited to a portion of MCO profits.
- **Activities that Support Healthcare Quality**. MCOs are permitted to include non-benefit services in the medical loss ratio (MLR) that are not provided through direct claims. These non-benefit services must meet the definition of an activity that supports healthcare quality. Rhode Island will contemplate whether to structure this arrangement as a request to invest in HEZs or as a requirement.
- **MCO Contracts and Quality Initiatives**. Rhode Island will determine whether to pursue an arrangement in which MCOs are required to contract with HEZs. This contracting relationship could be supplemented with quality requirements such as pay-for-performance or other value-based purchasing tools.

The state has made significant investments in the HEZs to date and seeks to expand funding through managed care for community-based activities that improve the health and wellbeing of Medicaid beneficiaries. Through the HSTP partnership, Rhode Island Medicaid has already made a strong statement about the importance of health equity and the state's commitment to it. Following the addition of managed care participation, the state intends to continue to seek opportunities to find new investments and new partners to support the state's unwavering dedication to promoting health equity.

Rhode Island is aware that CMS conceptually shares our state's deep commitment to health equity, as evidenced by CMS establishing the first pillar of its 2022 strategic plan to be health equity. CMS has repeatedly expressed this dedication to advancing health equity, such as in its

statement that it is "designing, implementing, and operationalizing policies and programs that support health for all people served by our programs by incorporating the perspective of lived experiences and integrate safety net providers and community-based organizations into our programs."[52] This is substantially similar to the vision of Rhode Island's HEZs, particularly in the purposeful incorporation of community-based organizations as partners. We applaud CMS' release of its 2022-2023 Framework for Health Equity, which outlines priorities including collecting data, assessing inequities, building healthcare organization capacity, advancing language access, health literacy, and the provision of culturally tailored services, and increasing accessibility.[53] As vehicles to seek out individuals in need and provide them with community-based, equity-focused services, HEZs fulfill all of these health equity priorities.

While no specific request for federal funding is being made in this waiver extension at this time, Rhode Island does intend to use this opportunity to evaluate the effectiveness of the HEZs with the intent of seeking financial participation in the future. With substantial investments being made in the HEZ initiative across several agencies and with the anticipated participation of MCOs, the state would like to measure the impacts and health outcomes of Medicaid beneficiaries living in communities supported by a HEZ.

Outcomes from evaluation of the HEZ initiative will be available when the interim evaluation is complete. When the interim evaluation has been finished, Rhode Island will review the findings concerning HEZs and determine whether positive outcomes have been demonstrated. If HEZs support positive health equity outcomes among service recipients, Rhode Island will seek funding for HEZ services through an amendment. Again, while no request for funding is being made in this waiver extension, Rhode Island sees the potential in the HEZs for having significant impacts on health equity in Rhode Island and aligning closely with CMS's priorities in addressing equity on a large scale. Rhode Island looks forward to partnering with CMS on this initiative to improve outcomes and access to care among Rhode Islanders in need.

3.2 Outreach and Pre-Release Supports for Incarcerated Individuals

Rhode Island Medicaid has demonstrated an ongoing commitment to improving behavioral health services and outcomes for all populations. Rhode Island offers an array of clinical, supportive, and peer services for individuals and families managing behavioral health issues. The state has also long valued community-based services that meet beneficiaries where they live to support positive health outcomes. However, due to current limitations in federal Medicaid regulations, these services and supports cannot be fully leveraged to support individuals as they transition from a correctional institution back to the community. This creates significant gaps in care for Rhode Islanders who are exiting prison or jail and returning home to families and communities.

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[52] Centers for Medicare & Medicaid Services. (n.d.). CMS Strategic Plan Pillar: Health Equity. Retrieved September 15, 2022, from https://www.cms.gov/files/document/health-equity-fact-sheet.pdf
[53] Centers for Medicare & Medicaid Services. (n.d.). CMS Framework for Health Equity 2022–2032. Retrieved September 15, 2022, from https://www.cms.gov/files/document/cms-framework-health-equity.pdf

In general, incarcerated individuals experience complex health care needs. Justice-involved individuals have particularly high rates of SUD and other severe mental health needs.[54] A 2009 study estimated that 58 percent of state prisoners and 63 percent of jail inmates across the country met the criteria for drug dependence or abuse.[55] The Rhode Island Department of Corrections (RIDOC) estimates that 15-20 percent of incarcerated individuals suffer from severe and persistent mental illness (SPMI) and 70-80 percent of the incarcerated population "has a significant history of SUDs."[56] Additionally, upon release from prison or jail, individuals are more likely to use hospital services and have a higher risk of mortality.[57] Coverage and active enrollment in managed care for individuals leaving prison or jail is thus critically important both for supporting positive health outcomes for Medicaid beneficiaries and to continue the state's efforts in combating overdose fatalities and the negative impacts of addiction and untreated mental health conditions. During Fiscal Year 2021, RIDOC processed a total of 2,044 releases. Because people who are incarcerated are disproportionately low-income, a substantial number of individuals being released qualify for Medicaid. Connecting these individuals to coverage can support successful reentry and overall health and well-being.

As evident in provisions of the 2018 SUPPORT Act and the version of the Build Back Better Act passed by the House and revised by the Senate Finance Committee, the federal government recognizes the critical need to improve coverage and care for incarcerated individuals in preparation for release. Rhode Island also recognizes this need and is seeking, through the Demonstration, to fill in the gaps for beneficiaries reintegrating into communities across the state.

Given the morbidity and mortality associated with the lack of health care services and care coordination for formerly incarcerated individuals, addressing these gaps is imperative to Rhode Island's Medicaid program. As the country's oldest unified correctional system, and as one of only six states with a unified system, Rhode Island is uniquely positioned to implement and evaluate the effectiveness of an initiative that improves discharge planning and service coordination pre-release for eligible individuals.

RIDOC is responsible for all incarcerated individuals in the state, from pre-trial to community supervision. The six RIDOC facilities, called Adult Correctional Institutions (ACI), are located within one square mile on Rhode Island's state agencies campus. With one agency overseeing

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[54] Camhi, N., Mistak, D., & Wachino, V. (2020, November 18). Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System. Retrieved September 15, 2022, from https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system

[55] Bronson, J., Stroop, J., Zimmer, S. et. al. (June 2017). Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. Retrieved September 15, 2022, from https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

[56] Rhode Island Department of Corrections. (n.d.). Behavioral Health. Retrieved September 15, 2022, from https://doc.ri.gov/programs-services/healthcare-services/behavioral-health-services

[57] Camhi, N., Mistak, D., & Wachino, V. (2020, November 18). Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System. Retrieved September 15, 2022, from https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system; Erlyana, E., Fisher, D. G., & Reynolds, G. L. (2014, March 25). Emergency room use after being released from incarceration. Retrieved September 15, 2022, from https://healthandjusticejournal.biomedcentral.com/articles/10.1186/2194-7899-2-5; https://www.nejm.org/doi/10.1056/NEJMsa064115

all of corrections in the state, collaboration with Medicaid and other health and human services agencies is streamlined, and implementation of corrections-wide initiatives are less challenging than a system of separate county-based and municipal correctional systems. For example, Rhode Island was first in the nation to implement a Medication for Opioid Use Disorder (MOUD) treatment protocol within its correctional system[58] and is poised to continue to innovate to achieve better health for all Rhode Islanders.

Currently in Rhode Island, individuals already receiving Medicaid benefits before incarceration have their eligibility suspended rather than terminated to facilitate reinstatement of benefits at the time of release. However, administrative procedures require the termination of managed care enrollment, resulting in limitations in discharge planning and continuity of care.

To support individuals who are transitioning back to the community following release from custody, especially individuals with SUD or mental illness, Rhode Island requests authority to provide Medicaid coverage 30 days prior to their release from state custody, including the provision of "reach-in" services provided by the MCOs. Rhode Island requests this 30 days of pre-release coverage to allow for managed care enrollment and access to the full set of Medicaid covered benefits, excluding services provided by DOC providers. The MCOs will also be required to provide intentional care coordination during this period to support reintegration and improve access to care and support services upon release. Rhode Island is requesting this authority for all incarcerated individuals, including both adults and youth.

Connecting individuals with coverage before release is of particular importance to the state. By offering coverage prior to release, the state seeks both to improve the beneficiary's understanding of their coverage and to connect them to the MCO through which they will receive services. It has been shown that pre-release Medicaid enrollment assistance increases the likelihood of outpatient healthcare visits.[59] Rhode Island understands that for this effort to be successful, individuals who are incarcerated, their families, and RIDOC's discharge planners must fully understand the health benefits that are available to them. Rhode Island will utilize the 30 days before release to assess the physical and behavioral health needs of eligible individuals during their incarceration. There will be several expectations for MCOs concerning incarcerated individuals. First, MCOs will be expected to provide information to individuals that will allow them to make an informed decision about MCO enrollment. Second, once an individual selects an MCO, the state expects that the MCO will support the individual and discharge planners to set up post-release appointments with the MCO's provider network for needed services just as any other beneficiary would. Finally, Rhode Island expects that the state's MCOs will provide comprehensive care coordination for formerly incarcerated individuals shortly after they obtain coverage.

In addition to medical services, Rhode Island Medicaid coverage will provide formerly incarcerated individuals with a variety of services targeted at social determinants to support community integration. For example, Rhode Island's Home Stabilization benefit can assist

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[58] Green, T. C., Clarke, J., Brinkley-Rubinstein, L., et. al. (April 2018). Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. Retrieved September 15, 2022, from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411

[59] Spartz, J. T. (2022, April 20). Medicaid Enrollment Before Re-Entry: Regaining Access To Healthcare After Incarceration. Retrieved September 15, 2022, from https://www.irp.wisc.edu/resource/medicaid-enrollment-before-re-entry-regaining-access-to-healthcare-after-incarceration/

formerly incarcerated individuals in obtaining and maintaining stable housing, especially with the additional enhancement requested to target the service at individuals with criminal records. Ultimately, with this enrollment change, Rhode Island hopes to improve the long-term health outcomes of individuals transitioning back to the community following a period of incarceration. Rhode Island will evaluate the success of pre-release enrollment by assessing how it improves access to medical care and health outcomes. The state's goals include seeing an increase in individuals enrolling in Medicaid following incarceration and accessing primary care and other necessary services during their transition back into the community through the initiative.

3.3 Home and Community Based Services

Rhode Island Medicaid recognizes the importance of a robust array of home and community-based services (HCBS) in keeping beneficiaries in their communities and out of institutions. It is critically important that LTSS is person-centered and respects the needs and wishes of the individual receiving LTSS, including receiving services in home and community-based settings.[60] The state emphasized the provision of high quality, person-centered HCBS in its previous extensions of the Demonstration, and continues to view rebalancing as a key priority. The importance of rebalancing became especially clear during the COVID-19 pandemic, when the demand for home-based services greatly increased due the temporary closure of many care settings, as well as concerns regarding safety. To meet these increased needs, Rhode Island Medicaid made temporary changes to many of its HCBS rules and services to enhance home and community-based care, such as adding virtual service capabilities. Due to the success of many of these temporary changes in expanding access to services during the PHE, Rhode Island seeks to codify several service enhancements, including (i) allowing telephonic HCBS assessments, (ii) adding a benefit for remote supports, also referred to as surveillance monitoring, and (iii) continuing to permit parents of adult children and other relatives who are not "legally responsible" to provide day and community-based services. More information on each HCBS enhancement is described below.

3.3.1 Telephonic/Virtual HCBS Evaluations, Assessments, and Service Planning

In the wake of the COVID-19 pandemic, CMS offered states the flexibility to utilize several emergency authorities to better serve beneficiaries. For individuals receiving HCBS, states were permitted to submit an Appendix K to request amendments to approved 1915(c) waivers (or, in Rhode Island's case, 1115 waiver). The Appendix K offered a variety of time limited changes to access and eligibility, services, payment, provider qualifications, level of care evaluations, and more. Rhode Island chose to exercise several of the options in the Appendix K, such as allowing service limitations to be exceeded and utilizing retainer payments.

One particularly beneficial change was obtaining authority to conduct level of care evaluations, functional assessments, and person-centered service planning via telephonic or video conference rather than requiring face-to-face meetings in all cases. Rhode Island proposed to utilize information received through the medical records submitted by the applicant's physician,

[60] Centers for Medicare & Medicaid Services. (November 2020). Long-Term Services and Supports Rebalancing Toolkit. Retrieved September 15, 2022, from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

telephonic and/or virtual conversations with the Medicaid beneficiary, and telephonic and/or virtual conversations with the individual's caregiver and/or power of attorney.

Rhode Island seeks to continue its authority to conduct LTSS level of care evaluations, functional assessments, and service planning virtually. While in-person meetings will remain the default approach, the state proposes to utilize telephonic/virtual options when medically appropriate and in accordance with the individual's service plan, which details their self-described preferences for service delivery. The state has found that for many beneficiaries and their families, conducting evaluations, assessments, and service planning remotely has increased flexibility for the beneficiary, which aligns with Rhode Island's goals around choice and voice.

The virtual assessment option is especially beneficial for individuals with disabilities who can now receive an assessment at the location most convenient to them. Rhode Island believes that virtual assessments support the ideals of HCBS—providing person-centered care in the home. Rhode Island will continue to utilize in-person evaluations, assessments, and service planning when appropriate to fully assess and account for the beneficiary's living environment, social determinants of health, mobility, or other factors.

3.3.2 Remote Supports

Rhode Island seeks to add remote supports, also known as surveillance monitoring, as a new core HCBS service. Remote supports upholds independence by combining technology for service delivery with limited contact with trained staff when the individual requires assistance. Technology, including equipment such as motion sensors, door sensors and a two-way audio-video communication devices, can be leveraged to aid the individual in completing necessary daily activities and tasks with minimal direct interventions to support the individual in retaining maximum levels of independence

Examples of remote supports could include:

- A sensor in a bed has been disengaged multiple times throughout the night. This is unusual for the beneficiary and could indicate that they are feeling sick. A remote support worker calls the individual to make sure they feel okay and asks if they need help.
- An individual who is prone to liver infections is asked to take their temperature multiple times each day and show the results to a remote support worker via camera to make sure there is no fever.[61]

Remote supports encourage recipients to be more independent by allowing caregivers to both monitor and actively respond to the person's needs through live two-way communication rather than in person supports and services. Whether for extended periods of time, or just a few hours a day, remote supports are flexible and can assist individuals to live more independently or help support a safe transition to independent living. Remote support can also include the use of home-based sensors, two-way communication systems that monitor activity, and other

[61] Wagner, J. B., Tasse, M. J., & Ornan, G. (2022, March 25). Implementation of remote support services: Pre-COVID-19. Retrieved September 15, 2022, from https://onlinelibrary.wiley.com/doi/full/10.1111/jppi.12420

technologies that allow a remotely located caregiver to monitor the safety and well-being of individuals living independently.

As of 2018, at least 21 states funded remote supports as HCBS program benefits. Remote supports can help supplement the workforce and help with provider shortages.[62] Rhode Island has experienced significant challenges in meeting demand for HCBS due to workforce shortages.[63] Because remote supports can be provided virtually, one provider may be able to work with multiple beneficiaries across several unique locations. Some research has surmised that remote support could contribute to lowering turnover rates among Direct Support Professionals (DSPs).[64]

Consumers have expressed high levels of satisfaction with remote supports. A statewide study conducted in Ohio sought information on the experiences of individuals with intellectual and developmental disabilities (I/DD) who used remote support services and their family members. Benefits cited by recipients and their families included safety and independence.[65]

Finally, remote supports have a low upfront cost to the state and the federal government. In Ohio, the use of remote supports resulted in savings for county boards of developmental disabilities by reducing the service costs associated with having DSPs in the home. Savings could be used for additional investment in DSP wages and career advancement.[66]

Eligibility:

- Approved for Core HCBS services;
- Assessment determined situational appropriateness and potential benefit;
- Resides in the community in a non-congregate setting; and
- Individual chooses to have remote supports and is able to participate in an informed consent process.

Provider Criteria:

The remote caregiver can respond to identified problems via video chat, phone calls or if needed, dispatch a backup staff member to provide hands-on assistance. In this role, someone

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[62] Barth, S., Lewis, S., & Simmons, T. (October 2020). Medicaid Services for People with Intellectual or Developmental Disabilities – Evolution of Addressing Service Needs and Preferences. Retrieved September 15, 2022, from https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Services-for-People-with-Intellectual-or-Developmental-Disabilities-%E2%80%93-Evolution-of-Addressing-Service-Needs-and-Preferences.pdf

[63] Rhode Island Executive Office of Health and Human Services. (n.d.). HCBS Workforce Recruitment and Retention. Retrieved September 15, 2022, from https://eohhs.ri.gov/initiatives/hcbs-workforce-recruitment-and-retention

[64] Wagner, J. B., Tasse, M. J., Davies, D. K. et. al. (2018, May 1). Use of Remote Support in Ohio and Emerging Technologies on the Horizon. Retrieved September 15, 2022, from https://nisonger.osu.edu/wp-content/uploads/2017/02/White-Paper-Use-of-Remote-Support-in-Ohio-and-Emerging-Technologies-on-the-Horizon.pdf

[65] Wagner, J. B., Tasse, M. J., & Ornan, G. (2022, March 25). Implementation of remote support services: Pre-COVID-19. Retrieved September 15, 2022, from https://onlinelibrary.wiley.com/doi/full/10.1111/jppi.12420

[66] Wagner, J. B., Tasse, M. J., Davies, D. K. et. al. (2018, May 1). Use of Remote Support in Ohio and Emerging Technologies on the Horizon. Retrieved September 15, 2022, from https://nisonger.osu.edu/wp-content/uploads/2017/02/White-Paper-Use-of-Remote-Support-in-Ohio-and-Emerging-Technologies-on-the-Horizon.pdf

who works for a remote support vendor is responsible in the same ways as an in-home direct support professional. The main difference being that they provide this monitoring at a distance.

"Remote support provider" means the appropriately certified provider that may be:

a. A remote support vendor; or
b. A provider of home-based services who also acts as a remote support vendor or maintains a contract with a remote support vendor to provide paid backup support.

"Remote support vendor" means the agency provider that supplies the monitoring base, the remote support staff who monitor an individual from the monitoring base, and the equipment used in the delivery of remote support.

The responsibilities of remote support staff may vary but will generally involve monitoring of conditions in an individual's home by tracking sensor data on a remote computer screen and engaging in individualized responses, in accordance with the person's service plan.

Equipment:

The following is a list of equipment utilized for remote supports and covered by the benefit.

- Motion sensing system;
- Radio frequency identification;
- Live video feed and or audio feed;
- Web-based monitoring system;
- Sensor detection monitoring systems; or
- Another device that facilitates live two-way communication.

The use of this service is not intended to replace an individual's ability or right to engage with the community.

Remote Support Service Delivery Model:

The levels of care available through the remote support service delivery model are designed to meet different levels of needs of beneficiaries approved for the services. The levels of care include the following:

- Active Support: real-time oversight during scheduled times. The remote caregiver is monitoring the system in real-time and responding immediately as needed.
- On-Demand Active Support: real-time oversight only when needed. This type of "as needed" live real-time support is typically started when a triggering event occurs indicating the need for immediate support.
- Scheduled Check-In: remote caregiver checks-in with the person at scheduled times. These are typically centered around ADLs or can be a simple wellness check.
- Drop-In/Check-In: a remote caregiver checks-in at random times to ensure the wellness of the person supported to determine if they need any assistance.[67]

[67] Remote Supports service definition created utilizing example: D.C. Department on Disability Services. (n.d.). Remote Support Services Overview. Retrieved September 15, 2022, from https://dds.dc.gov/sites/default/files/dc/sites/dds/release_content/attachments/Remote%20Services%20Overview%20Draft%201.21.22.pdf

3.3.3 Parents as Service Providers

Prior to the PHE, Rhode Island had authority for non-parent relatives to be paid to provide day and community-based services to adult members with I/DD. In its COVID-19 Appendix K, the state requested and obtained the authority to allow parents of adult members with I/DD to be paid as well.

The state understands that the authority allowing non-parent relatives to provide services is still in place, as it was not a temporary COVID-19-related authority. However, the state would like to request to permanently extend the authority beyond the PHE and expand it to include all disabled adult members otherwise enrolled in the Self-Directed Programs, regardless of disability. The authority, if approved, will allow all parents of adult members with disabilities to be paid to provide day and community-based services through the Self-Directed programs. Safeguards will continue to exist for this service, as parents will be required to review and attest that they are following the plan of care and document case notes reflecting services.

In support of the state's dedication to providing voice and choice to Medicaid beneficiaries, the state would like to extend this authority due to the resounding beneficiary satisfaction with the flexibility. Beneficiaries with I/DD and their parents have expressed strong interest in the continuation of this authority, as it has supported beneficiary choice, independence, and strong caregiver relationships. Rhode Island also sees a benefit for all beneficiaries with disabilities, not just those with I/DD, who may seek the flexibility and support afforded by this option. Second, as discussed throughout this extension, Rhode Island is experiencing severe workforce shortages of HCBS providers. The state sees allowing parents to be caregivers as another mechanism to continue services in the face of such shortages to ease the burden on the delivery system as a whole.

Rhode Island recognizes that for legally responsible individuals (typically the parent of a minor child or a spouse) to provide personal care services under traditional 1915(c) authority, states are only permitted to make payments for person care or other similar services when such services are deemed "extraordinary care." Because the authority to be extended only allows parents of adult beneficiaries be paid for services, Rhode Island does not believe the "extraordinary care" policy applies to this request.

3.4 Accountable Entities and Future of Value Based Payment Models

Rhode Island's HSTP is a cutting-edge, value-based care initiative that has allowed the state to shift a majority of Medicaid beneficiaries into accountable care structures. The primary component of the program is based on the development of AEs.

The establishment of Comprehensive AEs is the core objective of the HSTP initiative. Comprehensive AEs are partnerships of providers with a strong primary case base that ensure coordinated access to other services like specialty care and behavioral health. AEs are accountable for healthcare costs and quality and must adopt a population health approach that meet specified criteria, including addressing social determinants of health and providing care management and care coordination.

The pillars of the AE program are:

- *Certification of AEs*. AEs are certified based on readiness and system transformation factors. Examples of domains include breadth and characteristics of participating

providers, leadership and management, integrated care management, quality management. In Program Years 3-6, AEs were required to complete an application and/or re-certification for ongoing Medicaid AE certification.

- *Requirements that certified AEs enter into APMs with managed care partners*. All managed care contracts with comprehensive AEs must be based on total cost of care (TCOC). These TCOC-based contractual arrangements must demonstrate a progression of risk to include meaningful downside shared risk or full risk. This is to ensure that after AE incentive funding is phased out, AEs will be sustained on financial rewards associated with successful performance.

- *Incentives for AEs who have entered into qualifying APM contracts with managed care partners*. Funds for AE incentives are held in a Total Incentive Pool, consisting of an Accountable Entity Incentive Pool and an MCO Incentive Management Pool.

These pillars reflect Rhode Island's goal to develop a program that is evidence-based, flexible, robust enough to accomplish meaningful change, and specific enough to ensure clarity and consistency.

The state sought funding for the AE program incentive payments through the Demonstration and was approved for a $129.8 million in DSHP funds[68] from late 2016 through December 2020.[69]

With the DSHP investments, the AE program has a firm foundation and has demonstrated markers of success while being widely regarded as leading example of value-based care in Medicaid. For example, AEs have made significant investments in care coordination and population health management that have laid the groundwork for savings to sustain the program. The following are examples of investments that have been made by AEs:

- *Technology*: Utilizing population health tools (NextGen Population Health) to compile claims, using telehealth visits to increase access to behavioral health care, utilizing data tools (URI's DataSpark) to conduct a gap analysis for behavioral health services

- *Staff training*: Training regarding social determinants of health, online learning management system content to educate providers regarding population health principles and practices

- *New internal structures and processes*: Adding a psychiatric nurse practitioner, implementing universal screenings for depression, anxiety, and social determinants of health, implementing Care Conferences

EOHHS has also made a number of statewide investments in infrastructure to support AEs and reduce the need for AEs to incur high costs, in order to further encourage expansion and

[68] The state was approved for this amount but did not draw down all funding.
[69] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

provider engagement in the alternative payment model. The state has contracted to develop and enhance Care Management Alerts to inform a primary care practice when a beneficiary is admitted to or discharged from a hospital or skilled nursing facility; a Quality Reporting System; and a health information exchange called CurrentCare.

Early results have also demonstrated the program's success in generating shared savings. In Program Year 1, only 3 of 6 AEs obtained shared savings for a total payment of $3,030,628. By Program Year 2, 5 of 6 AEs obtained shared savings for a total payment of $7,133,427. In Program Year 3, all AEs obtained shared savings for a total payment of $23,853,473.

In July 2022, EOHHS, in partnership with CMS, extended its three-way contract with the state's participating MMP through CY 2023. In addition to the MMP program, Rhode Island has four Dual Eligible Special Need Plans (D-SNPs) that serve the state's dual eligible population. EOHHS is piloting a specialized AE program (henceforth referred to as a LTSS APM) through the MMP program. D-SNPs operating in the state will not be eligible to participate in the LTSS APM program during the pilot period. However, EOHHS anticipates expanding the LTSS APM program to include other managed care participants for the full program beginning in January 2024, dependent on initial results and pilot program learnings.

It has been EOHHS' long-standing objective to encourage and enable LTSS eligible and aging populations to live successfully in their communities. The impacts of the COVID-19 PHE make this goal of successful home and community-based services all the more important as we construct our recovery. The HSTP program provides EOHHS with an opportunity to implement an APM model focused specifically on HCBS necessary to prevent the Medicaid-eligible population from needing institutional LTSS. This requires a "specialized" approach and focus that acknowledges the unique challenges including but not limited to:

- Multiple payers (Medicare, Medicaid)
- Small populations subject to highly volatile cost experience
- Highly fragmented delivery systems

The LTSS APM launched in July 2022 as an 18-month pilot, during which time participating home care agencies will receive infrastructure funding on a pay-for-reporting basis. The collection of performance data on key quality measures will inform the design of the full program implementation. The full program is expected to launch in January 2024, and run for four years, through December 2027, although this timeline is highly dependent on the timeline associated with amending the MMP contract. During the full program implementation, home care agencies will be incentivized on a pay-for-performance basis.

Through the availability of federal DSHP funds, EOHHS has been able to make significant strides in payment reform that is transitioning the state to paying for value, not volume. The HSTP and the AEs have been incredibly important to move delivery and payment toward value-based payment and advanced value-based payment in the future.

Rhode Island seeks to preserve the concepts of the HSPT and the AEs as the Demonstration moves forward. However, with the expiration of the DSHP funds, EOHHS formally requests removal of the HSTP and AE requirements from the Demonstration documentation. While the state intends for the AEs to continue, because waiver DSHP funding for the HSTP will no longer be available, the Demonstration authorities for HSTP will no longer be necessary, including all authorities related to the HSTP program and corresponding DSHP funding. The removal of these authorities from the waiver will not affect the AE program or reduce access to programs or services provided by AEs.

Although the federal investment of DSHP funds in the HSTP has concluded, the state will continue to support the continuation and growth of the AEs, as they have shown substantial progress toward the goal of value-based care. Value-based payment remains a strong priority for the state, and the state hopes to analyze the use of advanced value-based payment in future iterations of this waiver. AEs have shown promising results in the areas of community investment and shared savings. Additionally, the state is particularly proud of the number of Rhode Islanders benefitting from accountable care and receiving person-centered services in a care model that answers to the beneficiary. The HSTP is an accomplishment for the state and should serve as a foundation and model for continued innovation, which would not have been possible without the strong initial investment in federal funds. Going forward, the state intends to continue to promote value-based payment in the Medicaid program outside of the Demonstration through the implementation of 42 CFR 438.6(c) directed payment preprints in managed care for both TCOC and the LTSS APM, building upon the progress made by HSTP and supporting continued expansion of total cost of care models in Rhode Island.

3.5 Managed Dental Benefits

Rhode Island has a strong managed delivery system with the majority of services being provided through managed care. However, adult dental benefits remain in FFS, while children's dental benefits have long been in managed care through the RIte Smiles Program, a managed dental benefit program, under a pre-paid ambulatory health plan (PAHP) contract currently held by United Healthcare (UHC).

Since its inception, RIte Smiles has been credited for improving access to dental care for children. At the outset of the program in 2006, the state strategically raised reimbursement rates to encourage provider participation. Due in part to strong reimbursement, from the start of the program to FY 2021, the number of dentists accepting children with Medicaid coverage increased from 27 before RIte Smiles to 290.[70] At the end of 2021, 123,268 children were enrolled in RIte Smiles. As of June 2021, almost half of children who were enrolled in RIte Care received a dental service during state fiscal year 2021.[71]

The RIte Smiles program continues to demonstrate success and the positive impact of managed care. In the 2020 External Quality Review (EQR) of the RIte Smiles program[72], it was confirmed that UHC complied with requirements regarding Quality Improvement Projects, accurately reported performance measures, and met network adequacy standards. Members across the program reported satisfaction with their dentist and access to dental services.

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[70] Rhode Island KIDS COUNT. (n.d.). 2022 Rhode Island Kids Count Factbook. Retrieved September 15, 2022, from https://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202022/fm6798_Factbook2022_web.pdf?ver=2022-05-18-151346-817

[71] Rhode Island KIDS COUNT. (n.d.). 2022 Rhode Island Kids Count Factbook. Retrieved September 15, 2022, from https://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202022/fm6798_Factbook2022_web.pdf?ver=2022-05-18-151346-817

[72] IPRO. (April 2022). RIte Smiles, a Rhode Island Medicaid Dental Program, UnitedHealthcare Dental: 2020 External Quality Review Annual Technical Report. Retrieved September 15, 2022, from https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-04/RI%202020%20EQR%20Annual%20Techncial%20Report%20for%20UHC-Dental%20-%20Final.pdf

Additionally, providers reported satisfaction with revenue and compensation received through the program.

Due to the success of the RIte Smiles and managed dental programs in improving access, utilization, quality, and cost-effectiveness, Rhode Island is seeking to expand RIte Smiles managed care to include all adult beneficiaries. The state has seen the improvements to both access to and quality of care as a result of the RIte Smiles program and believes that providing adult dental through managed care will lead to the same quality improvements. This change aligns with Rhode Island's longstanding goal to provide integrated care to beneficiaries by ensuring that adults receive all services through MCOs rather than through a patchwork of FFS and managed care. The state's current contracted plan has regularly received high quality ratings, both for the provision of services and beneficiary satisfaction. Managed care has been highly effective in Rhode Island and the state sees this enhancement as a logical improvement to its adult dental program to ensure equal access to the opportunities and enhanced benefits available through managed care.

3.6 Technical Revisions and Updates

Rhode Island sees this waiver extension as an opportunity to significantly tailor the Demonstration to make it function as effectively as possible. To achieve that goal, the state has analyzed the existing authorities in the Demonstration to determine those that may no longer be active, those that require updates, and those that may be able to move to the State Plan. With a global waiver structure, it is prudent for the state to regularly consider which authorities should live within the Demonstration and which would better serve beneficiaries by being operationalized within the State Plan.

In addition to determining whether any authorities can exist outside the Demonstration, the state has taken this opportunity to make various small updates to existing programs and authorities. This "clean up" has been undertaken to ensure that all programs are functioning at a high-level and efficiently serving beneficiaries. Rhode Island Medicaid is enthusiastic about the opportunity to make existing programs work better to achieve its goal of facilitating high quality care.

To that end, EOHHS is proposing a number of technical revisions aimed at supporting program operations, aligning with current operations, and promoting transparency through concise and streamlined program documentation in the STCs approving the demonstration.

Proposed Technical Revisions
• Expanding postpartum coverage
• Use of inclusive pregnancy language
• Budget population revisions
• Clarifying the distinction between Family/Youth Support Partners and Peer Recovery Specialists benefits
• Expanding access to complementary alternative medicine to individuals based on medical necessity
• Codifying family home visiting services as a State Plan service

• Removing Dental Case Management, Healthy Behaviors Incentives, and Recovery Navigation
• HCBS benefit clarity

3.6.1 Eligibility Updates

One component of Rhode Island's technical waiver review was to analyze the eligibility categories in the Demonstration. The primary focus of the process was to ensure transparency and clarity surrounding eligibility categories and to align eligibility categories with current operations. Rhode Island Medicaid does not intend these changes to limit or restrict eligibility in any way. In fact, one change will reflect increased access to services for pregnant individuals. The following technical revisions are only intended to ensure that program authorities are accurate and easy to understand.

(i) Expand Postpartum Coverage

The postpartum period is a crucial time for healthcare. Birth parents face recovery from childbirth, complications of delivery, managing infant care, and transitioning from obstetrical care back to primary care. Risks are high for birth parents and include the risk of pregnancy-related death. Most pregnancy-related deaths occur among populations covered by Medicaid during birth.[73] Racial and ethnic inequities are common in maternal health outcomes—for example, severe maternal morbidity is 1.9 times higher among Black populations than White populations.[74] Severe maternal morbidity has been increasing in recent years.[75] The Centers for Disease Control has found that 3 out of 5 deaths among women during pregnancy, childbirth, and the first 12 months after delivery could be prevented with adequate medical attention.[76]

In 2020, Medicaid financed an estimated 42 percent of births in the United States. That number was even higher in Rhode Island at 48 percent. Currently, pregnant individuals in Rhode Island receive Medicaid coverage through 60 days postpartum. However, after 60 days, they either become uninsured, must obtain coverage from another source, or must obtain Medicaid coverage through another eligibility group, if available. This lack of stable coverage can cause many birth parents to fall through the cracks between maternity care and ongoing primary or

[73] Gordon, S., Sugar, S., Chen, L. et. al. (2021, December 7). Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage. Retrieved September 15, 2022, from https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf

[74] Gordon, S., Sugar, S., Chen, L. et. al. (2021, December 7). Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage. Retrieved September 15, 2022, from https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf

[75] American Public Health Association. (2021, October 26). Expanding Medicaid Coverage for Birthing People to One Year Postpartum. Retrieved September 15, 2022, from https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Expanding-Medicaid-Coverage-for-Birthing-People-to-One-Year-Postpartum

[76] Vestal, C. (2022, May 31). 4 States Extend Medicaid Coverage for a Year After Childbirth. Retrieved September 15, 2022, from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/05/31/4-states-extend-medicaid-coverage-for-a-year-after-childbirth

specialty care in the postpartum year.[77] Expansion of coverage during the postpartum period is associated with improvements in maternal health.[78]

Based on the overwhelming evidence supporting expanding insurance coverage for postpartum individuals to improve health, Rhode Island will be submitting a SPA in Fall 2022 requesting authority to extend its postpartum coverage from 60 days to 12 months, consistent with Sections 9812 and 9822 of the American Rescue Plan Act of 2021.[79] To ensure that the Demonstration is aligned with this SPA, Rhode Island would like to obtain identical authority for all eligible pregnancy related eligibility categories under the waiver including Budget Population 3, Budget Population 6a, and Budget Population 6b.

Rhode Island does not seek to place any coverage, population, or benefit limits on this extension. The state anticipates that this extension will lead to significant positive impact on the health and well-being of pregnant individuals and improve postpartum care and outcomes throughout the first year after pregnancy.

(ii) Use of Inclusive Pregnancy Language

As evidenced by the state's strong commitment to health equity, Rhode Island Medicaid aims to be inclusive of individuals of all backgrounds, including gender identity. One way the state intends to do so is to by using inclusive language. Traditionally, Rhode Island Medicaid has used the term "pregnant woman" in the Demonstration. However, in discussing reproductive health, including pregnancy, using the term "pregnant woman" excludes other people who are capable of becoming pregnant and giving birth. Utilizing such gendered terms can potentially deter individuals from seeking care and affect the quality of care received.[80] To better support Medicaid beneficiaries of all gender identities, Rhode Island requests to change the use of the term "pregnant woman" or "women" in its Demonstration to "pregnant individual" throughout the STCs.

(iii) Budget Populations Revisions

As currently written, one budget population (Population 15) in the Demonstration requires a technical update, while two budget populations (Populations 16 and 23) are no longer active.

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[77] American Public Health Association. (2021, October 26). Expanding Medicaid Coverage for Birthing People to One Year Postpartum. Retrieved September 15, 2022, from https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Expanding-Medicaid-Coverage-for-Birthing-People-to-One-Year-Postpartum

[78] American Public Health Association. (2021, October 26). Expanding Medicaid Coverage for Birthing People to One Year Postpartum. Retrieved September 15, 2022, from https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Expanding-Medicaid-Coverage-for-Birthing-People-to-One-Year-Postpartum

[79] Centers for Medicare & Medicaid Services. (2021, December 7). SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). Retrieved September 15, 2022, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf

[80] Moseson, H., Zazanis, N., Goldberg, E. et. al. (May 2020). The Imperative for Transgender and Gender Nonbinary Inclusion. Retrieved September 15, 2022, from https://journals.lww.com/greenjournal/Fulltext/2020/05000/The_Imperative_for_Transgender_and_Gender.10.aspx

The state would like to remove references to these populations to support the state's overall effort to streamline the content of the Demonstration.

> **Budget Population 15:** This authority is for expenditures for HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the Social Security Federal Benefit Rate (FBR) with income and resource levels above the Medicaid limits. The state would like to request to increase the income level to 400 percent. Because other eligibility categories have expanded to reach the 300 percent level, individuals are not able to qualify for and benefit from this group. Increasing the income level to 400 percent will capture the intended population.
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> **Budget Population 16**: This authority is for expenditures for a limited benefit package of supplemental services for uninsured adults with mental illness and/or substance abuse problems with incomes above 133 and below 200 percent of the FPL not eligible for Medicaid. This budget population was eliminated in 2014 when Rhode Island expanded Medicaid under the Affordable Care Act. Rhode Island requests to remove the references to this budget population.
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> **Budget Population 23:** This authority is for expenditures for the cost of designated programs that provide or support the provision of health services that are otherwise state-funded, as specific in STC 79. This budget population is a reference to DSHP spending for the HSTP and AEs. As discussed in *Section 3.4*, the state is requesting to remove all authorities related to the HSPT program and expired DSHP funding. Therefore, consistent with that request, the state requests to remove the references to this budget population.

The requested eligibility changes to budget populations 16 and 23 are technical in nature and will not impact eligibility or benefit coverage of any Medicaid enrolled beneficiaries.

3.6.2 Services Updates

Rhode Island's Demonstration has been lauded for its expansive programs and extensive benefit package. The state is committed to expanding coverage, and this focus on coverage has been exceptionally important to vulnerable populations, especially during the COVID-19 pandemic. The state's coverage expansions, new and cutting-edge services, pursuit of equitable and culturally competent care—have all been recognized. During the demonstration extension, the state seeks to maintain its current expansive benefit package and make the following refinements and enhancements to the services definitions:

(i) Clarifying the distinction between Family/Youth Support Partners and Peer Recovery Specialists benefits;
(ii) Expanding access to complementary alternative medicine to individuals based on medical necessity; and
(iii) Codifying family home visiting services as a State Plan service.

(i) Family/Youth Support Partners and Peer Recovery Specialists

Rhode Island seeks to make a small change to the structure of the Family/Youth Support Partners program in the Demonstration. In the current waiver, the Peer Recovery Specialist (PRS) and Family/Youth Support Partners (FYSP) programs are referred to as one program.

However, PRS and FYSP are two different sets of services with different provider types. PRS features Peer Recovery Specialists who provide support services for individuals with mental health and/or SUD who are having trouble stabilizing in the community. FYSP offers services to children under 21 years of age and their caregivers related to supporting a child with behavioral health needs to improve functioning within family and community settings.[81] Due to differing eligibility criteria for the services and distinct provider types, Rhode Island requests to separate the two sets of services in the Demonstration and refer to them as stand-alone programs for purposes of clarity for providers and beneficiaries. This change will not impact the eligibility criteria, services available, or eligible providers. The state sees this change as an opportunity to make the Demonstration clearer for stakeholders and encourage beneficiaries to obtain the services for which they may be eligible. Both PRS and FYSP provide critical behavioral health supports. The state intends that this change will expand access to services by making program criteria easier to understand.

(ii) Complementary Alternative Medicine Eligibility

The Demonstration contains a provision that authorizes a set of demonstration-only benefits that are not provided under the State Plan. The services include nutrition services; individual/group education, parenting and childbirth education classes; tobacco cessation services for non-pregnant individuals; window replacement for lead-poisoned children; and complementary alternative medicine services to a subset of beneficiaries with chronic pain diagnoses. Rhode Island is proud to provide these enhanced services to beneficiaries with unique needs. Rhode Island seeks to continue its use of complementary alternative medicine for beneficiaries with chronic pain but would like to expand beyond chronic pain and offer the service for all beneficiaries for whom the service is medically necessary. Studies have shown that complementary alternative medicine can benefit individuals beyond just those with chronic pain. In one study of the impact of complementary alternative medicine on mental health, researchers found impacts for individuals with major depressive disorder, PTSD, and SUD.[82] Rhode Island sees expanding access to complementary alternative medicine as a means to expand its array of holistic treatment, especially for individuals for which traditional methods of care have not been successful. To expand the provision of complementary alternative medicine, the state requests to revise the service description to include all beneficiaries for whom the service is medically necessary.

(iii) Family Home Visiting/Nurse Family Partnership

The Family Home Visiting Services program covers evidence-based home visiting services under the statewide Nurse-Family Partnership and Healthy Families America programs. As written in the Demonstration, the Nurse-Family Partnership program is available to Medicaid beneficiaries who are first time pregnant individuals and enroll before 28 weeks gestation. Participants can remain eligible until their child is two years of age. Healthy Families America is

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[81] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

[82] RAND Corporation. (2021). Systematic Reviews of Complementary and Alternative Therapies for Psychological and Behavioral Health Disorders. Retrieved September 15, 2022, from https://www.rand.org/pubs/research_briefs/RBA428-1.html

for Medicaid beneficiaries who are pregnant or are parents of children under three months of age. Participants can remain eligible until their child is four years old, and the parent remains a Medicaid beneficiary.

The above programs are two long-term, evidence-based models utilized by the RIDOH Office of Family Home Visiting to support pregnant individuals and their children. Family Home Visiting programs have demonstrated the ability to improve maternal health outcomes, alleviate poverty, and encourage financial security. Rhode Island first implemented family home visiting programs in 2010. Since their inception, the programs have experienced significant growth and improvements in outcomes. The number of participants served by RIDOH's Office of Family Home Visiting programs in Rhode Island has increased from 225 in 2011 to 1,726 in 2020. In 2020, the programs showed performance improvement in the areas of preterm birth, breastfeeding, literacy support, developmental screening/referrals, continuity of insurance, postpartum care, and more. The programs have also increased rates of well-child visit completion to 74 percent in 2020 and showed significant improvements in the rates of maternal depression and symptom management.[83]

Due to the resounding success of these programs for Medicaid beneficiaries through inclusion in the Demonstration, Rhode Island would like to transition the authority for the existing family home visiting services programs covered by Medicaid, specifically the Nurse-Family Partnership and Healthy Families America programs, to the State Plan. The state does not seek to change any aspect of these programs or the authority provided for them beyond moving the enabling language to the State Plan. By transitioning the underlying regulatory authority for the home visiting programs to the State Plan, EOHHS hopes to keep Family Home Visiting as long-term fixture of the Medicaid program, where it can continue to improve outcomes for all pregnant individuals and new parents receiving Medicaid.

3.6.3 Remove Inactive Programs

As the Demonstration has served as the operating vehicle of the Rhode Island Medicaid for more than a decade, numerous programs have been added, implemented, evaluated, and removed to best meet the needs of the beneficiaries. After undertaking a comprehensive review of the Demonstration and its components in preparation for this extension, the state has identified three programs that it would like to remove from the Demonstration. Due to challenges imposed by administrative burdens, payment, and the COVID-19 pandemic, these programs are not currently active and the state no longer needs to maintain authority for them.

The three programs the state wishes to remove are: (i) Dental Case Management, (ii) Healthy Behaviors Incentives, and (iii) Recovery Navigation. These are all technical changes in the STCs that will not impact current beneficiaries as these programs have concluded or have not been implemented to date.

(i) Dental Case Management

[83] Rhode Island Department of Health. (2021, March 25). Family Visiting Legislative Report. Retrieved September 15, 2022, from https://health.ri.gov/publications/reports/2021Family-Visiting-Legislative-Report.pdf

The Dental Case Management program was a time-limited pilot that utilized four new dental case management service codes to emphasize health care coordination, improve oral health literacy, and support beneficiary compliance.[84] The pilot was designed to engage with six dental practices for a period of 12 months.

As discussed below in the *Section 4.2.3*, implementation of the Dental Case Management program was difficult, in part due to the COVID-19 pandemic, and the state did not see high rates of uptake. The state did find that reporting requirements were burdensome for providers and will consider that factor in future pilot programs. Due to the lack of participation, the state is not requesting to extend the Dental Case Management program.

However, access to high-quality dental care remains important to the state, as evidenced by its request in this extension to expand the use of managed care to provide dental services. The RIte Smiles program currently provides dental case management to children, and through this waiver extension request, EOHHS seeks to expand these important services to adults as well, allowing managed care to fill the promise of this former pilot. See *Section 3.6* for more information on the request to expand RIte Smiles.

(ii) Healthy Behaviors Incentives

The Healthy Behaviors Incentives program allows Medicaid to provide incentives to individuals who adopt healthy behaviors. Incentives may include gift cards for health-related goods. The program can also include penalties to disincentivize behaviors. The state seeks to remove the authority for this program as it is no longer active.

(iii) Recovery Navigation Program

The Recovery Navigation Program was a non-residential, community-based, recovery-oriented program that assessed, monitored, and provided case management and peer support for individuals under the influence of substances in a less-traumatic and costly setting than the Emergency Department.[85] Efforts were made to connect individuals to SUD treatment and support services.

Rhode Island operated the Recovery Navigation Program for 18 months. The state is proud to have served 1,200 individuals through the program and was able to divert 30 percent of those served from the Emergency Department. However, the program was not ultimately successful due to the use of a payment model that did not account for the full cost of the program. Approximately 50 percent of individuals served through the program were undocumented. Using lessons learned from the recovery navigation program pilot, another state agency is pursuing a different model of care called Safe Landings to address the issue of diverting individuals from

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[84] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

[85] Centers for Medicare & Medicaid Services. (2020, July 28). Rhode Island Comprehensive Demonstration: Demonstration Approval. Retrieved September 15, 2022, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf

Emergency Department care. The state seeks to remove authority for the Recovery Navigation Program from the Demonstration.

3.6.4 HCBS Benefit Clarity

The structure of Rhode Island's comprehensive 1115 waiver is rather unique, as with four limited exceptions, the Demonstration encompasses the entire Medicaid program as a whole, including both the standard underlying authorities for the program, as well as a series of new demonstration authorities testing new policies or services. Due to the unique structure of the global waiver, in some instances the STCs serve in the role similar to that of the Medicaid state plan or 1915(c) waiver and document a mandatory service, while in other instances the STCs simply grant permission for EOHHS to implement a specific service or test a new innovation. Additionally, some services are also available in the state plan, while others are not. It is critical that the STCs clearly specify the requirements from the 1915(c) waivers that apply in the 1115 context, not only for compliance purposes but for transparency with beneficiaries and other stakeholders.

The global structure has at times caused confusion for the state, CMS, providers, and beneficiaries alike, particularly as it relates to HCBS. As a result, in the most recent waiver extension approval, CMS added several new requirements including a requirement in STC 32 to identify portions of the Demonstration that could be transitioned to 1915(c) and 1915(i) authorities, and work to transition those aspects from the 1115 waiver to the appropriate 1915(c) and 1915(i) waivers by January 2024. Further, the STCs require the state to ensure that any "new state amendment request for HCBS will be authorized under the appropriate authority of 1915(c) and 1915(i) and not through the 1115 demonstration."

However, CMS subsequently instructed the state that it was not required to comply with the STC transitioning all HCBS to 1915(c) or (i) authorities. Consequently, the state seeks to have this STC removed to reflect instructions from CMS and to maintain the current global waiver structure.

In addition to removing this STC, Rhode Island seeks to make several other clarifying changes.

Since the 1915(c) waivers were originally combined into the 1115 waiver, EOHHS has had the flexibility to break down traditional barriers; however, EOHHS recognizes the intent and spirit behind CMS' desire to transition back to the more traditional 1915(c) authority to better support benefit clarify and federal oversight. Rather than implementing separate 1915(c) waivers, Rhode Island would like to use the extension to request a number of significant technical revisions to the STCs aimed at clarifying benefits, eligibility, and state oversight requirements for these 1915(c)-like benefits.

(i) Preventive HCBS

Rhode Island elected to utilize its 1115 waiver to authorize a set of 13 preventive HCBS services. The services were designed to serve any beneficiary who could demonstrate that such services would maintain their abilities and prevent the need for more intensive services (i.e., prevent the beneficiary from reaching a point where they met the LTSS level of care). Rhode Island envisioned that these services would greatly benefit eligible individuals and lead to decreased service use in the future.

Under the global waiver structure, the state manages multiple, distinct categories of services within the Demonstration. The state must also regularly reconcile the contents of the expansive Demonstration with the State Plan. After Rhode Island added the 13 preventive HCBS services, it was later determined that some of the services were available under the State Plan. However, several were not in the State Plan. Those preventive services that were not in the State Plan were not implemented due to a lack of state legislative authority.

The state sees this as an excellent opportunity to clarify the status of those preventive services that are not in the State Plan. For the following services, Rhode Island requests to clarify that they will be available only "as authorized by the state legislature:"

- Chore service
- Community transition
- Home-delivered meals
- Medication management
- Non-medical transport
- Peer supports
- Respite

Rhode Island remains committed to the provision of high-quality HCBS. However, it is important to the state to use this opportunity to organize and update the Demonstration so that it properly reflects the current operations of the Rhode Island Medicaid program. Rhode Island will use this opportunity to continue to identify ways to improve the delivery of services currently operationalized through the Demonstration. The process of improving the organization and formal documentation of the Demonstration, especially as it relates to HCBS, is ongoing and of high priority to the state.

(ii) Core Services

Rhode Island seeks to utilize this extension to align the definitions of home and community-based services as described in the Demonstration with the 1915(c) technical guide published by CMS, as well as with applicable state law and policy requirements. The state hopes to utilize this opportunity to support clarity and consistency on a statewide basis with federal guidance and legislative intent.

Other changes the state seeks to call out are the removal of the Healthy Young Adult Supports and Community-Based Supported Living Arrangements services. Healthy Young Adult Supports has been removed from the waiver as it is available under the State Plan. Community-Based Supported Living Arrangements has been replaced with Adult Foster Care for purposes of clarity. This replacement will not affect program operations.

Please see *Appendix A* for updated definitions.

(iii) Level of Care

EOHHS intends to retain the two LTSS levels of care currently in place for beneficiaries who are not eligible on the basis of an I/DD:

1. The “Highest” level of care is for beneficiaries who are determined based on medical need to require the institutional level of care. This population will receive services through nursing homes, long-term care hospitals, or ICF/IDs. Beneficiaries meeting this level of care will have the option to choose community-based care, including services defined in *Appendix A*;
2. The “High” level of care is for beneficiaries who are determined based on medical need to benefit from either the institutional level of care or a significant level of home and community-based services. This population will have access to community-based services defined in *Appendix A*.

EOHHS seeks to modify the State’s level of care determination process to ensure that the process (1) reflects prevailing standards of care and practice in the community, (2) uses modern tools for assessing level of need, and (3) uses the most reliable person-centered measures available to assess the full range of a person’s needs and preferences for Medicaid LTSS. We do not intend for these changes to adversely affect current beneficiaries or new applicants.

To incorporate the prevailing standards of care and practice in the community and align with assessment instruments that have been validated on a nationwide basis, EOHHS proposes to use the “InterRai 10” tool to determine level of care. If a person is determined through InterRai 10 to meet the “Highest” level of care, and the person chooses an institutional setting for their care, the State will continue to use the MDS to determine the member’s RUG score in that setting. If the person meets the “High” level of care or meets the “Highest” level of care and chooses a home or community setting, the results from the InterRai 10 assessment will serve as the “functional assessment” needed to identify the specific services a person can receive through HCBS.

(iv) Self-Direction

Under the Demonstration, Rhode Island’s Medicaid program operates three types of self-directed programs. The “Personal Choice” and “Independent Provider” programs are available to all eligible adults. For eligible beneficiaries with an intellectual disability and/or developmental delay, an additional option is available, referred to as “Self-Directed for I/DD.”

Each self-directed program meets the requirements of self-direction: person-centered processes, service plans, individual budgets, information and assistance, support brokers, the availability of Financial Management Services (FMS), and quality assurance and improvement mechanisms.

The self-directed programs available through Rhode Island’s Medicaid program give eligible beneficiaries a choice based on their needs, priorities, and preferences. The differences among the programs are in part a legacy of their original design under separate 1915(c) waivers, and in part a reflection of operational structures within administrating agencies.

Given the importance of transparency to the State, the following STCs related to self-direction are updated to reflect areas in which the available options differ and/or have evolved over the course of the Demonstration. The following also includes elements where the service definition was changed per CMS technical guidance:

Paid Providers of Services. In accordance with rules related to legally liable relatives, any individual capable of providing the assigned tasks and freely chosen by a participant to be a paid provider of self-directed services and supports may be hired by the participant. Participants

retain the right to: 1) train their workers in the specific areas of services and supports needed; 2) have those services and supports furnished in a manner that comports with the participants' personal, cultural, and/or religious preferences; and 3) access other training provided by or through the state for their workers so that their workers can meet any additional qualifications required or desired by the participants.

Budget Authority. Participants in the "Personal Choice" and "Self-Directed for I/DD" programs also have the opportunity to exercise choice and control over a specified amount of funds in a participant-directed budget. Under the budget authority, the participant has decision-making authority and management responsibility for the participant-directed budget from which the participant authorizes the purchase of long-term care Demonstration services and supports that are authorized in the person-centered service plan.

Services to be Self-Directed. Participants who elect the self-direction opportunity will have the option to self-direct some of the long-term care core and preventive services and supports under the Demonstration. The services, goods, and supports that a participant will self-direct are limited to the core and preventive services. For the "Personal Choice" and "Independent Provider" programs, personal care and homemaker services are eligible for self-direction. "Personal Choice" and "Self-Direction for I/DD" include goods and services, and "Self-Direction for I/DD" includes additional services and supports. Services, goods, and supports that are not subject to employer and budget authority, (i.e., where participants do not have hiring authority and do not become the employer of record over these services, goods, or items) will still be included in the calculations of participants' budgets. Participants' budget plans will reflect the plan for purchasing these needed services, goods and supports.

Information and Assistance in Support of Participant Direction (Supports Brokerage). Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management

Individual Directed Goods and Services. For participants in the "Personal Choice" and "Self-Directed for I/DD" programs, individual directed goods and services may be purchased from accumulated funds ("savings") as approved in the individual budget plan. Goods and services must relate to a need or goal identified in the person-centered service plan. Accumulated funds or savings may be carried over from month to month, and year to year, only if designated for a specific good or service. If the goods or services are not purchased at the time indicated in the budget plan, the state will recoup any unspent and un-earmarked funds at designated intervals and according to procedures established by the state. Goods and services that can be individually directed are defined in *Appendix A*.

Participant Direction by Representative. The state provides for the direction of services by a representative. The representative may be a legal representative of the participant, or a non-

legal representative freely chosen by an adult participant (except for participants in the "Self-Directed for I/DD" program). The representative shall not be paid and must pass a screen indicating ability to perform the functions in the best interest of the participant as well as a criminal background check. A participant who demonstrates the inability to self-direct his or her services and supports whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, will be required to select a representative to assist him or her with the responsibilities of self-direction. If a participant refuses to select a representative, or if a participant loses a representative (if already required for participation) and cannot locate a replacement, he or she will be required to transfer to a non-self-directed traditional service delivery system. Service advisors will assist the participant in the transition to the traditionally delivered service system to ensure continuity of care.

Financial Management Services. Service/function that assists the family or participant to: (a) manage and direct the disbursement of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities

Fair Hearing. Participants may request a fair hearing when a reduction in services occurs or when a requested adjustment to the budget is denied or the amount of the budget is reduced. For participants in "Personal Choice" and "Self-Directed for I/DD," a fair hearing can also be requested for denial of goods and services.

(v) Quality Requirements

When Rhode Island elected to utilize a global waiver, it required transitioning several distinct 1915(c) HCBS waivers into a 1115 waiver concept. Due to the transition, the state can now manage all of its waiver authorities in one governing document. However, the state has been required to manage different components of the Demonstration under different expectations. For example, 1115 waivers require formal evaluations, while 1915(c) waivers have specific quality requirements that must be adhered to.

Rhode Island recently came to an agreement with CMS to utilize the 1915(c) waiver quality requirements to measure HCBS performance under the Demonstration. The state has had to undertake significant administrative restructuring to ensure that the necessary requirements are identified, tracked, and reported upon. While the state continues to develop the infrastructure to manage a new, complex reporting system, it has made significant improvements and taken affirmative steps toward compliance with all 1915(c) quality measures. To ensure continued success and to codify and document the application of the 1915(c) quality requirements, EOHHS requests the addition of an Appendix to the STCs that explicitly documents each of the requirements applicable from the technical quality guide.

In addition, EOHHS seeks to clarify reporting requirements related to Preventive HCBS. EOHHS has identified that it is often very burdensome for a beneficiary who would qualify to receive preventive HCBS services to undergo a full Level of Care determination. While in some cases an individual applies for LTSS, is denied LTSS, and is directed to the preventive benefits for which they are actually eligible; in many other cases, a person is aware that they need only preventive services and it does not make sense to complete an LTSS application.

For individuals enrolled in FFS, EOHHS has contracted with the Rhode Island Parent Information Network (RIPIN) to assess the need for preventive services. Once a person is referred (by DHS, a community provider, community member, or by self-referral), RIPIN will conduct a Health Risk Assessment and, as appropriate, work with the individual's PCP to complete a Preventive Medical Necessity Evaluation Request. Upon state approval, RIPIN develops a care plan and completes prior authorization for the individual to receive services from a specific provider through the state's home care provider portal. Managed care beneficiaries use their MCOs' prior authorization process to access preventive benefits.

Both FFS and managed care approaches are far less time-consuming for the beneficiary than a full LTSS application, and the state intends to continue to minimize barriers to accessing these services. However, one consequence of this approach is that it is challenging for the state to specifically identify individuals who may receive one or more preventive services based on a medical necessity determination by an MCO. In addition, because several HCBS preventive services are also State Plan services, it is challenging to distinguish whether a person is receiving a given service as an "HCBS preventive service" or simply as a State Plan service. Due to these circumstances, Rhode Island requests that HCBS quality monitoring and reporting requirements not be applied to individuals receiving "preventive" services.

Section 4: Program Evaluation

4.1 Managed Care Quality

Quality Management Structure

Rhode Island EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island. Rhode Island Medicaid oversees and monitors all contractual obligations of the MCOs to further enhance the goals of improving access to care, promoting quality of care, and improving health outcomes while containing costs. Rhode Island Medicaid also provides technical assistance to MCOs and takes corrective action when necessary to enhance the provision of high quality, cost-effective care.

1. Medicaid quality functions include:
2. Measurement selection and/or development,
3. Data collection,
4. Data analysis and validation,
5. Identification of performance benchmarks,
6. Presentation of measurement and analysis results, including changes over time, and
7. Quality improvement activities.

The above functions are conducted at different levels including: the Rhode Island Medicaid program level, the MCO level, the AE level, and the provider level, where appropriate and feasible. The cadence of each activity aligns with federal guidelines and best practices. The Rhode Island Medicaid managed care quality strategy demonstrates an increase in alignment of priorities and goals across state agencies and Medicaid MCOs. This quality strategy will continue to evolve to increase the strategic focus and measurement linked to state objectives for managed care.

Rhode Island Medicaid conducts oversight and monitoring meetings with all MCOs. These monthly meetings are conducted separately with each of the MCOs. Meeting agendas focus on

routine and emerging items accordingly. The following content areas are addressed on at least a quarterly basis:

- Managed care operations
- Quality measurement, benchmarks, and improvement
- Managed care financial performance
- Medicaid program integrity

As part of this waiver extension and its ongoing quality assurance processes, Rhode Island also reviewed each STC and has operationalized the demonstration in compliance with all applicable STCS.

Rhode Island Medicaid utilizes a collaborative approach to quality improvement activities at the State level. Rhode Island Medicaid coordinates with state partners across health and human services agencies. On a routine basis, representatives from the Department of Children, Youth, and Families, Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, Department of Human Services, and Department of Health (DOH) join Rhode Island Medicaid in routine oversight activities to lend their expertise related to subject matter and populations served. This collaborative approach has proven to be sustainable and efficient.

In addition to managed medical care, there is also state oversight of managed dental care provided to Medicaid managed care members. The focus of the Rhode Island Medicaid dental quality strategy continues to be on ensuring access to preventive dental services for members under age 21 and effective collaboration between state partners. Along with the Rhode Island Medicaid dental contract oversight, the DOH regulates the utilization review and quality assurance or quality management (utilization review/quality assurance (UR/QA)) functions of all licensed dental plans, including the RIte Smiles Medicaid plan. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

External Quality Review

As required by 42 CFR 438.350, an annual EQR of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. IPRO is under contract with Rhode Island Medicaid as its External Quality Review Organization (EQRO) to conduct the EQR function for the State. Rhode Island's current Medicaid managed care EQR contract with IPRO has recently been extended through June 30, 2023.

In accordance with 42 CFR Part 438, subpart E, the EQRO performs, at minimum, the mandatory activities of the annual EQR. Rhode Island Medicaid may ask the EQRO to perform optional activities for the annual EQR. The EQRO provides technical guidance to MCOs/PAHPs on the mandatory and optional activities that provide information for the EQR. These activities will be conducted using protocols or methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. The EQRO must perform the following activities for each MCO/PAHP:

1. **Quality Improvement Projects (QIPs) - Validation of QIPs required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months**. Currently, MCOs are required to complete at least four QIPs each year. Additionally, the contract for the MMP requires at least one more QIP. The PAHP is required to complete

at least two performance improvement projects each year. High Level Findings from the most recent EQR Technical Reports (2020 measurement year) are below.

2. **Performance Goal Program (PGP) - Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months**. The Rhode Island PGP program no longer provides a financial incentive for performance, however the State still requires reporting of the measures by the MCOs and PAHPs.

3. **Access - Validation of MCO and PAHP network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 438.14(b)(1) and state standards established in the respective MCO contracts as summarized in *Section 5*.** Validation of network adequacy will include, but not be limited to, a secret shopper survey of MCO and dental PAHP provider appointment availability in accordance with contractual requirements established by the state.

4. **Accreditation Compliance Review - A review, conducted within the previous three-year period, to determine each MCO's and PAHP's compliance with the standards set forth in 42 CFR Part 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330**. Within the contracts for Rite Care, Rhody Health Partners, Rhody Health Expansion, Rhody Health Options, and the MMP, the state requires the MCOs to be accredited by NCQA as a Medicaid Managed Care Organization. The PAHP is accredited by the Utilization Review Accreditation Commission (URAC).

5. **Special enhancement activities as needed**. In addition, the State reserves the option to direct the EQRO to conduct additional tasks to support the overall scope of this EQR work in order to have flexibility to bring on additional technical assistance and expertise in a timely manner to perform activities which require similar expertise and work functions as those described in 1 to 4 above. Recent examples of special activities performed by the EQRO include:
    - Behavioral Health Utilization Reviews
    - MCO Encounter Validations
    - HCBS Validation Projects

High-Level Conclusions and Findings from 2020 EQR Aggregate Technical Report

The following represents high-level summary findings from a selected section of the EQR report. For all conclusions made, see the full 2020 EQR Report available in *Appendix B*.

Validation of Quality Improvement Projects

IPRO's validation of the MCPs' 2020 QIPs confirmed the state's compliance with the standards of 42 CFR § 438.330(a)(1).

- The results of the validation activity determined that Neighborhood Health Plan of Rhode Island was compliant with the standards of 42 CFR § 438.330(d)(2) for all six QIPs. IPRO's assessment of Neighborhood's methodology found that there were no validation findings that indicated that the credibility of QIP results were at risk.

- The results of the validation activity determined that UnitedHealthcare Community Plan of Rhode Island (UHCCP-RI) was compliant with the standards of 42 CFR § 438.330(d)(2) for the four QIPs. IPRO's assessment of UHCCP-RI's methodology found that there were no validation findings that indicated that the credibility of QIP results were at risk.
- The results of the validation activity determined that Tufts Health Plan was not compliant with the standards of 42 CFR § 438.330(d)(2) for either of the two QIPs conducted. IPRO's assessment of Tufts Health Plan's methodology found that Tufts Health Plan did not conduct the QIPs using the appropriate framework. (Rhode Island EOHHS is working with Tufts Health Plan to improve compliance and performance.)

4.2 Evaluation Results from Current Demonstration Period

Rhode Island has contracted with NORC at the University of Chicago to evaluate the Demonstration. NORC conducted an evaluation of the Demonstration during the current waiver period. The interim evaluation is available in *Appendix C*.

The interim evaluation outlined that the following principles and goals were developed in Rhode Island's 2013 waiver extension and reaffirmed in the 2016 amendment. The goals were incorporated from the Reinventing Medicaid Act of 2015, and the evaluation measured specific program aspects against these underlying goals.

Principle 1: Pay for value, not volume
GOAL 1: Substantially transition away from fee-for-service (FFS) models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes, and total cost of care for their members.
GOAL 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.
GOAL 3: Maintain and expand on our record of excellence – including our #1 ranking – on delivering care to children.
Principle 2: Coordinate physical, behavioral, and long-term health care
GOAL 4: Maximize enrollment in integrated care delivery systems
GOAL 5: Implement coordinated, accountable care for high-cost/high-need populations
GOAL 6: Ensure access to high-quality primary care
GOAL 7: Leverage health information systems to ensure quality, coordinated care
Principle 3: Rebalance the delivery system away from high-cost settings
GOAL 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings
GOAL 9: Encourage the development of accountable entities for integrated long-term care
Principle 4: Promote efficiency, transparency, and flexibility
GOAL 10: Improve operational efficiency

Rhode Island's evaluation highlighted that nine new programs were added in the 2018 extension.

- Accountable Entities Program
- Behavioral Health Link (BH Link)
- Dental Case Management Pilot
- Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the Institution of Mental Diseases (IMD) Exclusion
- Peer Recovery Specialists and Family/Youth Support Partners Programs
- Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes
- Supporting Home- and Community-Based Therapeutic Services for the Adult Population
- Improving Access to Care for Homebound Individuals
- Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package

The evaluation focused its review on the first 5 programs and assessed how well the programs achieved 3 of 4 principles of the Demonstration—paying for value, not volume; improving coordination of physical, behavioral, and long-term health care; and rebalancing the delivery system away from high-cost settings.

At a high level, the results of the demonstration showed high participation in Rhode Island's AE program, indicating that a majority of Rhode Islanders are receiving coordinated, accountable care. The evaluation found steady usage of the behavioral health services made available through the BH Link program and the IMD Exclusion Waiver, demonstrating the value of expanding such critical behavioral health services to beneficiaries. The state plans to continue to provide access to and improve upon the provision of such crucial behavioral health services. Data showed mixed impact to acute care utilization over the demonstration time period. For example, while the AE program showed a decrease in readmissions, higher rates of all-cause readmissions were seen in the BH Link program. These variations are discussed in more detail below. Improvements were seen across several programs in the areas of ambulatory and preventive care utilization, with increases in follow-up rates in the AE and BH Link programs. Finally, limited impact was shown on Medicaid spending, in part because of higher acute care utilization, including hospitalizations, for individuals utilizing the BH Link program and accessing services under the IMD Exclusion Waiver.

The programs considered in the evaluation were largely operating during the COVID-19 pandemic. Thus, it was difficult for evaluators to determine the impact of COVID on utilization and care-seeking patterns. The COVID-19 pandemic also impacted the state's ability to operationalize some of its waiver programs. Three of the five programs evaluated began in 2019,[86] meaning that early months of operation took place during the pandemic. The effects of this timing on outcomes are considered in more detail below.

[86] Dental Case Management also began in 2019 but was conducted before the COVID-19 pandemic.

4.2.1 Accountable Entities Program Evaluation Results Summary

Based upon the goals established for the Demonstration by the state, evaluators identified the following hypotheses applicable to this component:

- The AE Program will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members
- The AE Program will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members

The evaluation found that member attribution to the AE Program rose steadily over the course of the period, representing 65 percent of Rhode Island's Medicaid population by September 2021. With more than half of members receiving care through accountable entities, this shows substantial progress toward moving away from FFS models and toward accountable care.

Researchers found that the AE program led to increased rates of preventative care, care that will lay the groundwork for effective treatment planning that is coordinated to the unique needs of the member. The AE program saw an increased rate of breast cancer screenings, weight assessment and counseling for adolescents, developmental screenings, screening, and cessation intervention for tobacco use, and HbA1c control for diabetes. These screenings can often be the first step in improving health outcomes. The 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey also found that MCO members—generally considered as part of the AE Program due to partnerships between MCOs and AEs—reported strong satisfaction with their access to care, receiving needed care right away. Members also reported that their doctors always or usually communicated about care, listened, and showed them respect. High levels of self-reported satisfaction show that members feel they are receiving high quality care from the AE program, a crucial component of program success.

As a whole, the interim evaluation did not find that the AE Program had a statistically significant impact on Medicaid spending over the duration of the evaluation period. There were mixed results on quality and utilization metrics, as members did have lower rates of all-cause readmissions and improved rates of 7-day follow-ups, but saw increases in hospitalizations, among other metrics.

4.2.2 Behavioral Health Link Program Evaluation Summary

Based upon the goals established for the Demonstration by the state, evaluators identified the following hypotheses applicable to this component:

- The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members
- The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members
- The Demonstration will shift care away from high-cost settings (e.g., the ED), reducing spending while increasing utilization in lower-cost settings

The evaluation found that BH Link has made "substantial progress" filling gaps in Rhode Island's mental health and substance use crisis care services. BH Link did not reduce utilization or spending, however, evaluators pointed to a potential increased need for these services as a reason. Additionally, a key component of BH Link is to connect users to other types of care.

Results found higher rates of 30-day follow ups for behavioral health-related emergency department visits, which could be connected to BH Link.

The research team encountered difficulties in measuring the BH Link program, in part due to its near-complete overlap with the COVID-19 pandemic. However, evaluators did note the importance of BH Link during a time of high-acuity and high-need. While BH Link did not definitively lower costs for the state, it did likely increase care coordination for individuals with behavioral health needs during a time of increased mental health crises.[87]

4.2.3 Dental Case Management Pilot Program Evaluation Summary

Based upon the goals established for the Demonstration by the state, evaluators identified the following hypotheses applicable to this component:

- The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members
- The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members

Implementation of the Dental Case Management Program was limited and thus an in-depth evaluation was not possible. The Pilot was designed to make care accessible, and participants did incur more claims for dental services. Otherwise, the state noted several challenges of the pilot including low financial incentives, insufficient resources to successfully market the pilot, and lack of enrollment. Providers may have also found reporting requirements burdensome. The state has noted these challenges and areas for improvement and will utilize the lessons of the pilot to modify other initiatives going forward, including considering broadening the scope and duration of future initiatives.

4.2.4 Institutions of Mental Disease (IMD) Exclusion Waiver Evaluation Summary

Based upon the goals established for the Demonstration by the state, evaluators identified the following hypotheses applicable to this component:

- The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members
- The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members

Researchers drew limited conclusions about the IMD Exclusion Waiver in this evaluation and noted that a more comprehensive discussion of the IMD Exclusion Waiver can be found in the state's SUD Mid-Point Assessment. The evaluation found an increased demand for SUD services with members accessing more residential SUD services in IMDs during the evaluation period. In part because of an increase in inpatient hospitalizations, Medicaid spending per member per quarter increased by $1,486. Much like BH Link, though the Waiver did not

[87] World Health Organization. (2022, March 2). COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide. Retrieved September 15, 2022, from https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

decrease Medicaid spending, members were able to access vital behavioral health services during the pandemic, a period of particularly acute need, especially for SUD services.[88]

4.2.5: Peer Recovery Specialist (PRS) and Family/Youth Support Partners (FYSP) Program Evaluation Summary

Based upon the goals established for the Demonstration by the state, evaluators identified the following hypotheses applicable to this component:

- The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members
- The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members
- The Demonstration will shift care away from high-cost settings (e.g., the ED), reducing spending while increasing utilization in lower-cost settings

Due to the overlap of PRS/FYSP services with the COVID-19 pandemic, evaluators were not able to accurately assess the drivers of spending and utilization. The evaluation did find that spending and utilization decreased in the time after the programs were implemented. Evaluators spoke with stakeholders who made a number of suggested improvements for the PRS/FYSP programs. Rhode Island Medicaid considered these challenges with staffing and billing during the development of this extension and has identified a number of program enhancements as outlined in this request. State officials did note that beneficiaries who engaged with a peer support specialist were more likely to enter treatment. Medicaid sees the value of this program for individuals seeking or receiving recovery supports and hopes to continue to improve it going forward.

4.3 Hypothesis and Evaluation Design for New Demonstration Period

The state seeks to utilize the evaluation for the new Demonstration period to measure several of the newly added priority features included in this extension. Because of the breadth of the Demonstration, the state sees value in focusing the evaluation on individual programs in order to more carefully and closely measure impact. By evaluating new initiatives such as the Recuperative Care Pilot and 30 day pre-release enrollment, Rhode Island aims to complete a thorough evaluation that captures a detailed picture of the programs' successes and opportunities for improvement. The specific evaluation approach for each of the four programs to be studied is explained in detail below.

4.3.1. Home Stabilization Benefit Analysis

Evaluation Approach: the Rhode Island evaluation team proposes to use descriptive statistics to characterize participation in the program, including number of participants served, participant demographics (e.g. age, sex, race, ethnicity), and socioeconomic characteristics (measured using zip-code level data). Evaluators propose to conduct an interrupted time-series analysis

[88] National Institute on Drug Abuse. (2022, February 25). COVID-19 & Substance Use. Retrieved September 15, 2022, from https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use

for evaluation of the Home Stabilization program, wherein the team will compare outcomes for members receiving services under the Home Stabilization program before and after they started receiving services from the program, using repeated observations (quarterly or annual, as data allows) in both time periods. One limitation of this design is that members receiving services need to have been enrolled in Medicaid prior to their engagement in the Home Stabilization program. If the majority of the members receiving these services are newly enrolled in Medicaid (and have no "pretest" period), evaluators will plan to conduct a one-group posttest-only analysis, tracking outcomes for members receiving Home Stabilization services over time. Evaluators do not anticipate being able to construct a comparison group but will assess the feasibility of doing so before deciding on the final design.

Hypothesis 1: The Home Stabilization program will increase community living and reduce unnecessary institutionalization for participants

- *Example research question #1*: How many members receiving services under the Home Stabilization program have obtained housing in the community? How many have maintained community housing for six months or more? Do these trends vary by race or ethnicity?
- *Example research question #2*: What are the trends in members receiving services under the Home Stabilization program accessing homeless services? Does this vary by type of homelessness service, or by race or ethnicity?
- *Example research question #3*: What are the trends in IMD use among members receiving services under the Home Stabilization program? Does this vary by race or ethnicity?

Example measures	Data Source(s)
Number of members living in the community	Program data (if available longitudinally)
Homelessness status	Ecosystem Homeless Management Information System (HMIS) data linked to Medicaid population grid
Number of members accessing homelessness services	Ecosystem HMIS data linked to Medicaid population grid
Types of homelessness services used by members	Ecosystem HMIS data linked to Medicaid population grid
IMD admissions for SUD and, if feasible, for non-SUD conditions	Medicaid claims

Hypothesis 2: The Home Stabilization program will identify and address participants' social determinants of health

- *Example research question #1:* What types of barriers to successful tenancy do members receiving Home Stabilization services report? Does this differ by race or ethnicity?
- *Example research question #2*: What are the social needs and barriers to housing retention experienced by members receiving services under the Home Stabilization program? Do these differ by race or ethnicity?

- *Example research question #3*: How did Home Stabilization providers use data on social needs and barriers to housing retention provided by members?
- *Example research question #4*: What were successes in and barriers to Home Stabilization providers addressing members' social needs and housing retention barriers?

Example measures	Data Source(s)
Housing assessments	Program Data
Current social needs and housing retention barriers	Housing support and crisis plans (document review)
How do Home Stabilization Providers try to address SDOH? Where are the gaps in service provision?	Interviews with Home Stabilization Providers

Hypothesis 3: The Home Stabilization program will improve health outcomes for participants

- *Example research question #1:* What are the trends over time in utilization (inpatient hospitalization, emergency department (ED) visits, nursing home admission, behavioral health (BH) facility admission, IMD admission) for members using Home Stabilization services? Does this differ by race or ethnicity?

Example measures	Data Source(s)
Inpatient hospitalization	Medicaid claims
ED visits and potentially avoidable ED visits	Medicaid claims
Nursing home admission	Medicaid claims
BH facility admission	Medicaid claims
IMD admissions for SUD and, if feasible, for non-SUD conditions	Medicaid claims

Hypothesis 4: The Home Stabilization program will decrease Medicaid spending for participants after successful home placement

- *Example research question #1:* What are the trends over time in total Medicaid spending for members using Home Stabilization services? Does this differ by race or ethnicity?

Example measures	Data Source(s)
Total Medicaid spending	Medicaid claims

4.3.2 Recuperative Care (Medical Respite) Pilot

Evaluation Approach: the Rhode Island evaluation team proposes to use descriptive statistics to characterize participation in the program, including number of participants served, participant demographics (e.g. age, sex, race, ethnicity), and socioeconomic characteristics (measured

using zip-code level data). To assess the effects of the program, evaluators will use an interrupted time-series analysis comparing outcomes for members receiving services under the program before and after service use, using repeated observations (quarterly or annual, as data allows) in both time periods. One limitation of this design is that members receiving services need to have been enrolled in Medicaid prior to their engagement in the program. As with the Home Stabilization program, evaluators will plan to conduct a one-group posttest-only analysis if most members receiving these services are newly enrolled in Medicaid. Evaluators do not anticipate being able to construct a comparison group but will assess the feasibility of doing so before deciding on the final design.

Hypothesis 1: The Medical Respite program will improve healthcare utilization for participants

- *Example research question #1:* What are the trends over time in utilization (primary care/preventative services, inpatient hospitalization, ED visits) for members using Medical Respite services? Do trends differ by race or ethnicity?
- *Example research question #2:* How many referrals (specialists, BH services, SUD/OUD services, community organizations) are made through the Medical Respite program?

Example measures	Data Source(s)
Primary care & preventative services	Medicaid claims
MH & SUD/OUD services	Medicaid claims
Inpatient hospitalization, rehospitalization	Medicaid claims
ED visits and potentially avoidable ED visits	Medicaid claims
Inpatient length of stay	Medicaid claims
Referrals for specialists, BH services, and/or SUD/OUD services	Program data, if available

Hypothesis 2: The Medical Respite program will decrease Medicaid spending for participants

- *Example research question #1:* What are the trends over time in spending (total Medicaid, inpatient, ED, outpatient) for members using Medical Respite services? Does this differ by race or ethnicity?

Example measures	Data Source(s)
Total Medicaid spending	Medicaid claims
Medicaid spending for inpatient visits	Medicaid claims
Medicaid spending for ED visits	Medicaid claims
Medicaid spending for outpatient visits	Medicaid claims

Hypothesis 3: The Medical Respite program will improve housing status and access to social services for participants

- *Example research question #1*: How many members receiving services under the Medical Respite program have obtained housing in the community? How many have

maintained community housing for six months or more? Do these trends vary by race or ethnicity?

- *Example research question #2*: What are the trends in members receiving services under the Medical Respite program accessing homeless services? Does this vary by type of service, or by race or ethnicity?
- *Example research question #3*: What are the trends in members receiving services under the Medical Respite program accessing social services? Does this vary by type of social service, or by race or ethnicity?
- *Example research question #4*: What are the trends in SSI/SSDI enrollment among members receiving services under the Medical Respite program? Does this vary by race or ethnicity?

Example measures	Data Source(s)
Homelessness status	Ecosystem HMIS data linked to Medicaid population grid
Housing supports appointments	Program data, if available
Health-related social needs screenings	Program data, if available
Social services referrals (number, type)	Program data, if available
Number of clients approved for SSI/SSDI	Program data, if available

4.3.3 30-Day Enrollment Pre-Release

Evaluation Approach: the Rhode Island evaluation team proposes to use descriptive statistics to characterize participation in the program, including number of participants served, participant demographics (e.g. age, sex, race, ethnicity), and socioeconomic characteristics (measured using zip-code level data). Evaluators propose to conduct a one-group posttest-only analysis for evaluation of the Pre-Release Enrollment program, wherein the team will compare outcomes for members receiving services under the Pre-Release Enrollment program before and after they started receiving services from the program. Because this program enrolls new Medicaid members, there is no data for program enrollees in Medicaid administrative data available with which we can create a "pretest" period for comparison. Similarly, since this is meant to be a universal program that is offered to all incarcerated individuals regardless of diagnosis or medical status, there will be no available comparison group during the posttest period (even if some incarcerated individuals decline the Medicaid enrollment, an evaluator working with Medicaid data will have no way to track those individuals over time for a potential comparison).

Hypothesis 1: Pre-release enrollment will improve access to medical care for recently incarcerated members

- *Example research question #1:* How many previously incarcerated individuals enroll in Medicaid through the Pre-Release Enrollment program over time?
- *Example research question #2:* How many previously incarcerated individuals enrolled in Medicaid through the Pre-Release Enrollment program access primary care services within one year of release?

Example measures	Data Source(s)

Number of previously incarcerated individuals enrolling in Medicaid	Medicaid population grid, Ecosystem RIDOC data
Number of previously incarcerated individuals accessing primary care services	Medicaid population grid, Medicaid claims, Ecosystem RIDOC data

Hypothesis 2: Pre-release enrollment will improve health outcomes for recently incarcerated members

- *Example research question #1:* What are the trends in utilization (as measured by primary care and preventative services, mental health (MH) and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members enrolled through the Pre-Release Enrollment program?

Example measures	Data Source(s)
Primary care & preventative services	Medicaid claims, Ecosystem RIDOC data
MH & SUD/OUD services	Medicaid claims, Ecosystem RIDOC data
Inpatient hospitalization, rehospitalization	Medicaid claims, Ecosystem RIDOC data
ED visits and potentially avoidable ED visits	Medicaid claims, Ecosystem RIDOC data

4.3.4 HEZ Impact on Healthcare

Evaluation Approach: the Rhode Island evaluation team proposes to use descriptive statistics to characterize Medicaid members living in a Health Equity Zone (HEZ), including demographics (e.g. age, sex, race, ethnicity) and socioeconomic characteristics (measured using zip-code level data). To assess the effects of the program, evaluators propose an interrupted time-series analysis comparing outcomes for members residing in a HEZ before and after program implementation, using repeated observations (quarterly or annual, as data allows) in both time periods. One limitation of this design is that evaluators will not be able to directly identify members receiving direct services from the HEZ but will be able to assess overall changes over time. To the extent possible using available data, evaluators will control for participation in other healthcare and social service programs (e.g. Accountable Entities) to isolate the effect of the HEZ.

Hypothesis 1: Residing in Health Equity Zones will improve health utilization overall for Medicaid members

- *Example research question #1:* What are the trends in community rates of services utilization (as measured by primary care and preventative services, mental health and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members living in a Health Equity Zone?

- *Example research question #2:* What are the trends in racial/ethnic disparities in utilization (as measured by primary care and preventative services, mental health and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members living in a Health Equity Zone?

Example measures	Data Source(s)
Primary care & preventative services	Medicaid claims
MH & SUD/OUD services	Medicaid claims
Inpatient hospitalization, rehospitalization	Medicaid claims
ED visits and potentially avoidable ED visits	Medicaid claims

Hypothesis 2: Residing in Health Equity Zones will improve housing status for Medicaid members

- *Example research question #1:* How many members residing in a HEZ have obtained housing in the community? How many have maintained community housing for six months or more? Do these trends vary by race or ethnicity?

Example measures	Data Source(s)
Homelessness status	Ecosystem HMIS data linked to Medicaid population grid

Section 5: Demonstration Financing and Budget Neutrality

Detailed financing and budget neutrality reports are provided in *Appendices D and E*.

Section 6: Waivers and Expenditure Authorities

The state seeks to maintain all existing waiver and expenditure authorities except as explicitly specified below. Further, EOHHS requests new authorities for the specific enhancements described in *Section 3*, including those outlined in the table below.

Authority Requested	Waiver Category	Statutory/Regulatory Citation
No Authorities		
Enhancements to Home Stabilization Benefit	Benefits	No new authorities needed
Accountable Entity Program	Finance and Expenditure Authority	No new authorities needed
Waiver Authorities		

Authority Requested	Waiver Category	Statutory/Regulatory Citation
New Recuperative Care/Medical Respite Pilot	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B); Freedom of Choice Section 1902(a)(23)(A)
Allow Use of Telephonic HCBS Assessments	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Addition of Remote Supports Benefit	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Allow Parents to be Service Providers	Benefits	Self-Direction 1902(a)(32)
Managed Dental	Finance and Expenditure Authority	Freedom of Choice Section 1902(a)(23)(A)
Expenditure Authorities		
Reimbursement of HEZ Services	Finance and Expenditure Authority	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Provide Coverage for Incarcerated Individuals 30 Days Prior to Release	Eligibility	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
New Recuperative Care/Medical Respite Pilot	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Allow Use of Telephonic HCBS Assessments	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Addition of Remote Supports Benefit	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)

EOHHS requests removal of the following expenditure authorities for programs and authorities which are no longer active.

- Health System Transformation Project-Accountable Entity Incentive and Hospital and Nursing Home Incentive. Expenditures for performance-based incentive payments to providers who participate in the Hospital and Nursing Home Incentive Program and to providers who participate as a certified Accountable Entity.
- Expenditures for Healthy Behaviors Incentives. Expenditures for incentives to individuals who adopt healthy behaviors such as a gift card for health-related goods.
- Expenditures for Recovery Navigation Program (RNP). Expenditures to deliver a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services, with the necessary level of detox, treatment, and recovery services within a less-intensive and less-costly level of care than is furnished in an inpatient hospital setting.

Section 7: Public Comment

7.1 Public Notice & Public Comment Process Summary

In accordance with 42 CFR section 431.408, EOHHS provided the public and other interested parties the opportunity to review and provide input on the Demonstration through a formal thirty-two (32) day public notice and comment process which ran from September 30, 2022, to November 1, 2022. During this time, the state also held a total of three dedicated public hearings, as well as a fourth opportunity for public comment during the Health System Transformation Project (HSTP) Accountable Entity (AE) Advisory Committee Meeting (an existing commission where meetings are open to the public).

Public Notice

The state verifies that public notice of the Demonstration application was published on September 30, 2022 to the state's Administrative Record and on a dedicated webpage on the agency's website. The state used an electronic mailing list, comprised of 528 interested individuals and organizations, to notify the public of the extension, hearings, and opportunity to comment on the waiver draft. To encourage feedback and compliance with accessibility, a copy of the draft waiver was also made accessible at a public web link and available in hard copy format as well.

A copy of the formal public notice is attached as *Appendix F* and a copy of the abbreviated public notice document is attached as *Appendix G*. Both documents are also available for viewing on the state's website: https://eohhs.ri.gov/reference-center/medicaid-state-plan-and-1115-waiver/waiver-extension.

Public Hearings

Although federal regulations only require two public hearings, EOHHS held three (3) public hearings during the notice and comment period in geographically diverse areas of the state. The hearings were available for interested parties to attend either in person or virtually via Zoom platform. The state confirms the three public hearings were held on the following dates and locations, as scheduled and as publicized in the formal notice:

Public Hearing #1	Public Hearing #2	Public Hearing #3
October 12, 2022 5:30-7:00 p.m. Pawtucket Public Library 13 Summer Street Pawtucket, RI 02860	October 25, 2022 3:00-4:30 p.m. Peace Dale Library 1057 Kingstown Road Peace Dale, RI 02879	October 27, 2022 5:30-7:00 p.m. Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895

In addition to the above public hearings, EOHHS also accepted public comment on the Demonstration as a whole, as well as the Demonstration extension application and proposed changes, during the Health System Transformation Project (HSTP) Accountable Entity (AE) Advisory Committee Meeting, which was held on October 18, 2022, 8:30 a.m. at 3 West Road,

Virks Building 1st Floor Training Room, Cranston, RI 02920, and available for virtual participation for interested parties. In compliance with §42 CFR 431.420(c), this particular existing forum has annually served as the post-award public input process for Rhode Island's Demonstration. Members of the public and individuals serving on the committee were both provided with an opportunity to ask questions and comment on the current waiver as well as the proposed extension application during this committee meeting.

Tribal Consultation

Rhode Island has one federally recognized tribe in the state, the Narragansett Indian Tribe. EOHHS sent public notice of the Demonstration extension request to the representative of the federally recognized tribe in accordance with 42 CFR § 431.408, with the option to schedule a separate tribal consultation to discuss the Demonstration. No formal comments were received, and a tribal consultation was not requested. A copy of the formal correspondence sent to the Narragansett Indian Tribe soliciting input on the extension request can be found in *Appendix H*.

7.2 Summary of Public Comments & State Responses

In total, EOHHS received comments from 47 unique individuals from the public and other interested parties during the public comment period, including 38 written comments and 9 verbal testimonies provided during public hearings. Many of the individual commenters provided comprehensive comments addressing several different aspects of the waiver. EOHHS identified each unique item of feedback contained within an individual commenter's formal submission and thoughtfully analyzed and considered each item individually.

All verbal and written comments, along with the state's responses, are summarized below by relevant topic areas. Please note, because many comments responded to multiple components of the waiver, the "total comments" captured below reflects the number of unique points received for each topic, rather than total number of individual commenters.

7.2.1 Comments re: Home Stabilization Expansion

EOHHS received a total of 21 comments related to the proposed revisions to the Home Stabilization benefit, many writing in support of the expansion and/or proposing specific revisions to the proposed scope of the expansion.

Several commenters requested that additional populations (seniors, people experiencing domestic violence, LGBTQ individuals) be included in the list of targeted groups for Home Stabilization services. Based on these comments, EOHHS would first like to clarify that Home Stabilization is not limited to the groups specifically listed as targeted groups. EOHHS's intent in calling out these targeted populations was and remains to identify populations that could likely benefit the most from Home Stabilization services. The service is available to all individuals who meet eligibility criteria. However, EOHHS continues to see value in listing targeted groups. Therefore, based on commenter feedback, EOHHS intends to both clarify the eligibility criteria for Home Stabilization benefits and expand the list of targeted groups. Specifically, EOHHS will remove the existing exemption for the Community Transition population. Second, Home Stabilization eligibility will not require a complex physical or behavioral health need; rather, eligibility will target individuals based on housing-related risk factors, including the additional factor of experiencing homelessness or being at risk of homelessness, regardless of any

complex physical or behavioral health need. Finally, while the list of targeted populations listed in the waiver is illustrative only rather than eligibility based, EOHHS will seek to expand the list to specifically include individuals and families currently experiencing or with a history of interpersonal or community violence.

Two comments, one from a senior housing provider and another from a homelessness advocacy organization, discussed the recent health related social needs (HRSN) service opportunities in other state's section 1115 waivers that were approved after this Demonstration was posted for public comment. These commenters suggested that EOHHS should pursue these new opportunities by further expanding Home Stabilization to encompass newly approved expenditures such as six months of rent. Similarly, another comment from an affordable housing developer suggested seeking an amendment to use Medicaid funding to pay for construction and renovation of existing housing stock for leased rental homes for homeless and high-cost Medicaid members. While the use of funds for construction and renovation is not currently permitted under Medicaid rules, EOHHS thanks this commenter for their support of innovative housing concepts for high-need beneficiaries. However, based on known recent approvals, EOHHS will amend the Home Stabilization expansion as requested to seek additional authority to fund rent payments for up to six months.

Related to eligibility for the proposed transitional supports, we had written that "beneficiaries must be actively working with a home stabilization provider and be identified by that provider as being in need after exhausting all other traditional and natural supports." One commenter requested additional clarification on the intent behind "exhausting all other traditional and natural supports." EOHHS clarifies that in order for an individual to receive Home Stabilization supports, an assessment must be made by a qualified provider as to whether they can receive housing supports from another source, such as a family member or other non-Medicaid funding streams. This process is to ensure that the limited funding available through Medicaid is being targeted at individuals who have exhausted all other sources of support. EOHHS does not intend and will not apply this criterion in a manner that creates a barrier to individuals who are otherwise eligible for Home Stabilization.

One commenter requested that EOHHS establish an intensive housing support model for parents or caregivers with involvement with child welfare or behavioral health systems. EOHHS thanks this commenter for their feedback but will not be able to pursue this model under a Medicaid waiver at this time, due in part to the availability of other federal funding sources.

A few commenters raised questions about provider qualifications and billing standards. Specifically, one commenter from an MCO requested that EOHHS expand the provider type eligible to administer Home Stabilization services to include Accountable Entities (AEs) and Federally Quality Health Centers (FQHCs). EOHHS clarifies that any entity that meets the established provider qualifications is permitted to administer Home Stabilization services. Another requested that EOHHS change the billing threshold from one hour to a minimum of 15 minute increments. We have considered this suggestion but decided to keep the current billing threshold at one hour.

One commenter requested an increase in Home Stabilization reimbursement rates. While EOHHS appreciates the provider community's concerns with reimbursement rates, reimbursement changes are outside the scope of this waiver and are contingent on state legislative authority. EOHHS remains committed to engaging with the legislature on provider rates.

7.2.2 Restorative and Recuperative Care (including Medical Respite) Pilot

EOHHS received a total of 21 comments related to the proposed Restorative and Recuperative Care Pilot, with nine commenters expressing support for the initiative and others offering proposed enhancements to the pilot. Two commenters requested clarification on the eligibility criteria that requires an individual be able to complete all activities of daily living (ADLs) independently or with mechanical assistive devices. EOHHS clarifies that restorative and recuperative care sites are not intended to be equipped to handle individuals requiring a nursing facility level of care. Therefore, individuals needing assistance with ADLs are not appropriate for this setting. These eligibility criteria are aligned with national standards for restorative and recuperative care sites.

Similarly, one commenter recommended expanding pilot eligibility to include individuals with behavioral health conditions. EOHHS recognizes the potential benefit to individuals with behavioral health conditions and will thus be changing the requirement from having "an acute medical illness and/or condition" to having a "health need" that requires a safe and supportive environment. EOHHS notes that pilot sites are not intended to provide advanced psychiatric care and therefore may not be appropriate for individuals with significant care needs.

Several commenters requested clarification on whether the 36-month length of stay limitation is cumulative or consecutive. This program is envisioned as a stepping-stone to finding permanent housing. Therefore, EOHHS intends for stays to be consecutive, short-term stays that are episodic in nature. A prior authorization or redetermination process will be utilized to ensure an appropriate, short-term stay duration and to limit the number of short-term qualifying events. More implementation details are forthcoming.

One commenter representing health centers encouraged allowing any interested provider to apply as a pilot site. EOHHS agrees and does not intend to discourage any specific provider types from applying at this time. EOHHS intends to develop a fair application process to identify and select qualified provider(s) that can meet the program requirements for the provision of pilot services.

7.2.3 Health Equity Zones

EOHHS received a total of 17 comments related to the proposed Health Equity Zone initiative, all of whom expressed general support of the HEZ initiative and many who encouraged EOHHS to further expand its pursuit of health equity goals beyond what was listed in the original request.

One commenter representing an organization that connects healthcare providers with social services providers encouraged that EOHHS should seek federal financial participation (FFP) for health-related social needs (HRSN) services, referring to those services addressing social determinants of health (SDOH) that have recently been approved by CMS. Other related concepts were also proposed, such as implementing a Flexible Services Program similar to Massachusetts. The Flexible Services Program is a means by which Accountable Care Organizations provide HRSN supports to members. EOHHS is currently analyzing how to maximize its opportunity to receive federal support for HRSN, including through identifying new opportunities to leverage Designated State Health Program (DSHP) funds. It is important to note that EOHHS released its waiver for public comment at the same time the first federal approval of an HRSN-focused Section 1115 waiver was released. EOHHS is very interested in pursuing

future implementation of HRSN services but will need to take time to analyze the new opportunities available through new DSHP funds.

One comment stated that EOHHS should not decrease direct financial support of the HEZs. EOHHS affirms that this proposal does not substitute any existing HEZ funding.

Two commenters, including one from the Unite Us organization, requested clarification on the future of the use of the Unite Us platform, specifically related to how the social services platform could be leveraged to support the HEZ initiative. The Unite Us platform is a coordinated care network of health and social service providers. Providers are able to use the platform to send referrals and make other connections to support social needs. We will continue to explore opportunities to promote the use of Unite Us, including through federal support for health information technology (HIT). EOHHS is aiming to provide beneficiaries with social service support via the Home Stabilization enhancement.

Six comments addressed the proposed role of MCOs in the HEZ initiative, including some from MCOs who are supportive of having a larger role. Commenters provided a number of operational suggestions, including but not limited to (i) including HEZ funding in the MCO contracts, (ii) requiring MCOs to contract with HEZ organization, (iii) including MCO HEZ investments as non-benefit services within the MLR, and (iv) providing standardized contracting approaches for MCO and HEZ partnerships. Other commenters expressed concern related to potential unintended consequences of MCO influence in the HEZ, which may undermine the integrity of the community led initiatives. We thank these commenters for their input and will consider the role of MCOs carefully in the upcoming MCO procurement and contracting requirements to be developed by EOHHS.

7.2.4 Outreach and Pre-Release Supports for Incarcerated Individuals

EOHHS received 13 comments on the proposal to provide outreach and pre-release supports for incarcerated individuals, 11 of which expressed general support. We thank the 11 commenters for their support of the proposal and others that provided thoughtful suggested revisions to our proposed approach.

Several commenters, including one MCO, requested clarification on several aspects of the proposal, such as eligibility and scope of services to be included during the pre-release period. To clarify, eligibility will include both incarcerated adults and youth; however, it will exclude individuals awaiting trial. For the services, MCOs will be expected to provide more than just reach-in care coordination services. The state is requesting authority to provide full Medicaid coverage for all care provided to incarcerated beneficiaries during the 30 day pre-release period, except for medical services delivered by Department of Corrections (DOC) providers.

One commenter from an MCO sought to expand the request from 30 days to a full 90 days prior to release. However, the EOHHS will retain the request as written at 30 days to ensure the scope is limited to the imminent transition activities. EOHHS intends for this request to be narrowly tailored such that funding will primarily focus on the care coordination and transition needs of individuals who are about to be released. EOHHS plans to work with the DOC and the MCOs to develop operational processes and monitor outcomes to ensure the 30-day time period is sufficient to plan for and support individuals during their transition to the community.

Another commenter requested the state provide defined strategies for the 30-day period, including more information about how DOC will coordinate with Medicaid to identify release

dates. We thank this commenter for their request for additional operational detail. EOHHS intends to provide more information after such a request is approved, as part of planning and implementation for this new initiative.

7.2.5 Telephonic/Virtual HCBS Evaluations, Assessments, and Service Planning

EOHHS received 4 comments regarding telephonic HCBS evaluations, assessments, and service planning, 3 of which were supportive of the proposed enhancements.

One commenter was opposed to the use of telephonic and/or virtual HCBS in any capacity, due to access concerns and ensuring individuals' needs are appropriately identified and escalated. EOHHS recognizes that telephonic and virtual evaluations, assessments, and service planning will not be appropriate for all situations. Further, while EOHHS is not making any specific change to the waiver request, we would like to reiterate and clarify that in-person evaluations, assessments, and service planning will remain the default option unless telephonic or virtual is both preferred by the member and medically appropriate.

7.2.6 Remote Supports

EOHHS received 5 comments about remote supports. Three commenters were supportive of the initiative, while 2 offered suggestions for expanding to include other remote home-based service offerings, such as home blood pressure devices and technology applications to monitor chronic conditions. Some comments requested clarifications to the proposed remote support services as outlined below.

Two commenters sought confirmation that remote services will not replace in-person services and that EOHHS will identify guardrails to ensure enhancements meet beneficiary needs. EOHHS affirms that any telephonic or virtual HCBS is provided at the beneficiary's option, is not supplanting any in-person services, and will be subject to the same guardrails as in-person services.

Another comment requested clarification on whether coverage of installation and troubleshooting will be provided as a component of remote support. EOHHS confirms that installation and troubleshooting will be covered by Medicaid.

7.2.7 Parents as Service Providers

EOHHS received 11 comments, many directly from beneficiaries and/or their parents, on the proposal to allow parents as service providers. While most commenters were in support of the initiative with several even requesting expansion to additional populations, EOHHS also notes and appreciate the feedback from several commenters who are not in favor of allowing parents to act as service providers.

Those opposed indicated concern with extending this authority beyond the Public Health Emergency (PHE) out of concern that in many cases the family caregiver may become the only option, noting the importance of individuals developing relationships with persons outside of their family. EOHHS thanks these commenters for this input. The variety of perspectives received from beneficiaries itself demonstrates that this is a deeply personal decision. Therefore, EOHHS does not intend to make changes to this proposal based on these comments; however, we affirm that EOHHS does not intend for family caregivers to supplant other types of care available to individuals. EOHHS will continue to ensure that beneficiaries are

educated about and supported in choosing among different service provider options. Further, EOHHS assures that making family caregiving available as a service provider option will not deter the State's efforts to address overall workforce shortages. Ultimately, EOHHS supports individuals in choosing whether or not to have a parent as a service provider.

Other commenters recommended that this authority be even further expanded to include legally responsible individuals. To clarify, the EOHHS request is limited to adults who are not legally responsible, as states are only permitted to elect to make payment to legally responsible individuals for personal care services in extraordinary cases. Additionally, EOHHS recognizes that allowing legally responsible individuals to provide personal care services may raise additional risks of conflicts of interest. Ultimately, the federal limitations and regulatory requirements make expansion to legally responsible adults prohibitive at this time.

Two comments suggested allowing the parents of adult children with physical disabilities to provide services. EOHHS appreciates this feedback and will amend the waiver to clarify that this authority is not specific to only individuals with intellectual/developmental disabilities. This option is available to any Medicaid-enrolled adult who is otherwise entitled to self-direction, regardless of the nature of their disability. However, as stated above, this option is only available to parents who are not otherwise legally responsible for their adult children.

7.2.8 Accountable Entities and Future of Value Based Payment Models

EOHHS received 17 comments about the Accountable Entities (AE) program. Many commenters expressed concern that the technical removal from the waiver may signal a broader intent from EOHHS to change the current successful program. We thank the commenters for their support of the initiative and interest in ensuring it continues in the future. EOHHS reiterates that our request to remove the DSHP authority from the waiver, including the related provisions detailing the AE requirements, will not end or otherwise change the existing AE program in Rhode Island. Rather, EOHHS simply seeks to streamline the waiver documentation by removing an authority that is no longer necessary. Since federal authority through the 1115 waiver is no longer required due to the expiration of DSHP, the removal from the waiver is simply a technical change. The Accountable Entities program, including the LTSS APM, will continue as planned. Any future revisions or requirements for Accountable Entities will come through other EOHHS authorities and communication channels rather than through the demonstration.

7.2.9 Managed Dental Benefits

EOHHS received 8 comments on transitioning adult dental to managed care, almost all of which were in support. One MCO commenter suggested integrating the dental benefit within the existing comprehensive MCO benefit package, rather than expanding the separate dental pre-paid ambulatory health plan to include adult dental. One commenter, representing community health centers, requested more information on how benefits will migrate from fee-for-service (FFS) to managed care. Another commenter requested confirmation on certain Rite Smiles contract provisions, specifically ensuring robust care coordination. EOHHS plans to release the detailed operational and contract requirements as well as transition timeframes through the managed care procurement process.

7.2.10 HCBS Benefit Clarity

Commenters provided 19 thoughtful remarks about the provision of home and community-based services (HCBS) under the waiver, all generally supportive of EOHHS's efforts to provide a comprehensive array of preventive and other HCBS services while providing specific suggestions for additional revisions to the approach.

Commenters made many suggestions for changes or additions to the state's existing HCBS service array. Examples ranged from expanding access to services provided in an acute hospital setting to adding a housing support model for Medicaid recipients receiving LTSS. Multiple commenters also recommended expanding or adding preventive services. While EOHHS supports a comprehensive HCBS service array, EOHHS is unable to pursue the addition of many of these services at this time, as the agency is constrained by the lack of budget authority granted by the state legislature. EOHHS will consider these suggestions to expand or add services in later amendments and/or extension requests and will consider requesting state budget authority when planning for the State Fiscal Year 2025 budget. EOHHS is committed to ongoing communication about the preventive services that are available and will continue to identify activities to maximize the utilization of preventive services.

Several other commenters suggested EOHSS address improvements to provider reimbursement by implementing HCBS rate increases. EOHHS continues to support fair and adequate rates within the confines of its budget as appropriated by the general assembly. Reimbursement increases are not addressed through the Demonstration. However, EOHHS remains committed to working with the legislature to ensure appropriate rates for services.

Another commenter stated that a level of care determination should not be required to access preventive services. EOHHS would like to clarify that a level of care determination is not required to access preventive services.

One commenter requested that the State make an exception in Participant Direction by Representative for participants in a self-directed intellectual/developmental disability (I/DD) program. Another commenter suggested renaming "Adult Foster Care" to a more inclusive term that respects the autonomy of individuals with disabilities. Regarding Participant Direction by Representative, the service definition EOHHS is using mirrors language provided by CMS. Similarly, "Adult Foster Care" is the terminology used to describe this service by CMS. Accordingly, EOHHS will retain the parameters of Participant Direction as stated. However, we will change the name of the service "Adult Foster Care" to "Shared Living (Adult Foster Care)" for clarity and to be responsive to the request of the disability community.

7.2.11 Dual Demonstration

EOHHS received 4 comments concerning the phase-out of the Dual Demonstration in Rhode Island, and we appreciate the commenters' interest in this upcoming service delivery change. Although the Dual Demonstration is not a component of the waiver, a brief summary was provided in the delivery system summary section providing a basic overview of the state's current Medicaid program. This description and mention of the Dual Demonstration transition was not intended to signal that any decisions on detailed direction have been made in advance of the more robust stakeholder engagement that will be occurring in Rhode Island through that initiative. EOHHS encourages interested parties to view the draft formal transition plan previously submitted to CMS and available online at https://eohhs.ri.gov/mmp-transition-plan.

Separate stakeholder engagement opportunities for feedback on the future of care for duals in Rhode Island are outlined in the transition plan,and we look forward to working with all interested parties in the coming months.

7.2.12 Technical Updates to Eligibility and Services

EOHHS received 21 comments on proposed technical updates to eligibility. Eight commenters responded to the proposal to extend postpartum Medicaid eligibility to 12 months and all were in support of the initiative. We thank these commenters for their support of EOHHS efforts to improve maternal and child health. Commenters were in agreement that this eligibility change will lead to improved outcomes and healthier parents and children in Rhode Island.

A number of commenters were opposed to the ongoing waiver of three months of retroactive eligibility. EOHHS appreciates the feedback on this important issue and will consider requesting state budget authority to remove this specific waiver when planning for the State Fiscal Year 2025 budget.

We thank the 3 commenters for their support of the requested eligibility expansion for complementary alternative medicine services from just those individuals with chronic pain to all beneficiaries for whom the service is medically necessary. EOHHS believes this expansion will holistically improve care for populations in need.

7.2.13 Other

The state received 32 comments beyond the initiatives that were proposed in the extension and thanks commenters for their helpful input on the future direction of the Medicaid program.

Both pediatric advocacy organizations and MCOs suggested a number of enhancements to eligibility and services for youth, such as requiring MCOs to report the proportion of dollars spent on individuals 21 and younger, continuous eligibility for children 0-3, and utilizing pediatric risk stratification. While the majority of suggestions cannot be implemented through the 1115 waiver at this time, EOHHS thanks the commenters for feedback on how to best serve Rhode Island's youth.

One comment suggested that EOHHS should cover mobile crisis services and intensive home-based services for youth. EOHHS is appreciative of the engagement on these important issues and reiterates its support for behavioral health initiatives occurring outside the Medicaid program. Medicaid actively participates in our state's adult and children's behavioral health systems of care and will continue to do so within the confines established by the legislature and the agency's current budget authority.

Another comment recommended implementing reimbursement for services delivered through Supervised Drug Consumption Centers. This effort is currently moving forward separate from the 1115 waiver. EOHHS notes that there are currently no restrictions that would prevent otherwise billable services provided at Consumption Centers from being reimbursed by Medicaid. While this is not an EOHHS-led initiative, Medicaid covered services will continue to be available to meet members where they are.

Three commenters supported covering E-Consult services. E-consults are electronic communications between healthcare providers, not telehealth services. EOHHS thanks commenters for their feedback and will consider this idea in the future, including whether it could be part of future managed care contracts.

One commenter recommended adding Peer Recovery Specialist and Home Stabilization services as covered-in plan benefits in managed care. EOHHS appreciates this feedback. While the state plans to keep these services under FFS for the time being, it will evaluate this option and decide how it fits into future plans, including requests for any additional HRSN services.

A commenter suggested implementing a standardized fee schedule. As with all rate setting issues, this is an issue to be addressed through state legislative budget authority and managed care procurement, rather than via federal approval through this Demonstration. EOHHS is only permitted to take action on rates when expressly permitted and given budget authority by the general assembly. EOHHS will continue to work with the general assembly to make any necessary changes to the Medicaid rate structure and/or fee schedule.

Another commenter suggested allowing funding to be used for nontraditional transportation like Uber and Lyft. EOHHS clarifies that this is already allowed for non-emergency medical transportation when other options are not available.

7.3 Summary of Revisions

Above, EOHHS summarized and responded to all of the public comments received concerning the Demonstration extension request during the 30-day public comment period. EOHHS considered each comment and has decided to make several changes to the Demonstration extension request based on the feedback provided. In this section, EOHHS has explained and summarized the changes that have been made in response to public comment as well as the impetus for making those changes. A table summarizing these changes can be found below, while the following section also provides a more detailed description of each change and its impact on the overall request, as applicable.

Waiver Section	Description of Revisions to Waiver Draft
3.1.1 Home Stabilization Expansion	• Remove exemption for Community Transition population • Change eligibility to eliminate health-related factors and add a housing-related factor to include individuals experiencing homelessness or at risk of homelessness • Expand target populations to add individuals and families experiencing/with a history of interpersonal or community violence • Add rent payments for six months and details regarding Healthy Home Goods
3.1.2 Restorative and Recuperative Care Pilot	• Expand eligibility to individuals with a "health need that requires a safe and supportive environment," including behavioral health
3.2 Outreach and Pre-Release Supports for Incarcerated Individuals	• Clarify scope to include coverage of all services except those provided by DOC providers • Clarify population to include both adults and youth
3.3.3 Parents as Service Providers	• Allow parents of all disabled adult children utilizing self-direction, not just those with intellectual and/or developmental disabilities, to act as service providers
Appendix A	• Change the name of Adult Foster Care to Shared Living (Adult Foster Care)

Revisions to Section 3.1.1: Home Stabilization Expansion. Based on feedback received, EOHHS also made a number of updates to the Home Stabilization expansion as described in *Section 3.1.1*, including several changes to both the service eligibility requirements as well as the service definitions as detailed below.

- Remove exemption for Community Transition population. First, while not spelled out in this extension request, EOHHS removed the exemption for the Community Transition population that currently exists in the service definition. EOHHS believes this exemption is unnecessary and does not align with the principles of a service expansion.

- Change eligibility to eliminate health-related factors and add a housing-related factor to include individuals experiencing homelessness or at risk of homelessness. EOHHS changed the Home Stabilization eligibility to the following standard: "individuals who are experiencing homelessness or at risk of homelessness". By removing the requirement for an individual to have a complex physical or behavioral health need, Home Stabilization will be available to all vulnerable Medicaid populations in need of housing supports, not just those experiencing serious health problems. This change enables preventive care to individuals experiencing homelessness or at risk of homelessness, without waiting for their health to deteriorate.

- Expand target populations to add individuals and families experiencing/with a history of interpersonal or community violence. The extension request identifies a list of targeted populations for Home Stabilization. EOHHS made edits to this section to clarify that the service is not intended to be limited to these populations. Instead, the list represents examples of targeted populations that EOHHS believes could greatly benefit from Home Stabilization services. Based on comments received, EOHHS also expanded the list of targeted populations to explicitly include individuals and families currently experiencing or with a history of interpersonal or community violence.

- Add rent payments for six months and details regarding Healthy Home Goods. EOHHS also updated its Home Stabilization request to seek authority to fund rent payments for up to six months and to add more detail to the Healthy Home Goods request. Several commenters discussed the recent health-related social needs (HRSN) service approvals in other states' section 1115 waivers, including those addressing housing needs, and suggested that EOHHS pursue these new opportunities. EOHHS sees the addition of a request to fund six months of rent and a wider range of Healthy Home Goods for individuals eligible for Home Stabilization services to be a natural extension of its existing requests. Funding six months of rent will greatly increase the impact of Home Stabilization by addressing the root issue and allow EOHHS the opportunity to provide beneficiaries with a variety of supportive services without concerns of eviction or other unstable housing circumstances. The additional Health Home Goods items will let EOHHS support people in moving into and maintaining a home where especially those with chronic conditions such as asthma can maintain their wellbeing. EOHHS will also conduct further research and analysis on the other HRSN approvals for a potential future waiver amendment.

Revisions to Section 3.1.2: Restorative and Recuperative Care (including Medical Respite) Pilot. Based on comments received, EOHHS expanded the Restorative and Recuperative Care Pilot eligibility criteria, found in *Section 3.1.2*, as follows:

- Expand eligibility to individuals with a "health need that requires a safe and supportive environment," including behavioral health. As originally drafted, the Pilot was only available to those with "an acute medical illness and/or condition." EOHHS agreed with a commenter requesting the language be more inclusive to include individuals with behavioral health conditions. Based on the suggestion, EOHHS updated the criteria to make the pilot available to individuals with a "health need that requires a safe and supportive environment." This update better aligns the pilot with the goal of creating equitable care sites for individuals experiencing homelessness.

Revisions to Section 3.2 Outreach and Pre-Release Supports for Incarcerated Individuals. Some commenters requested EOHHS provide additional context for its request in *Section 3.2* to cover care provided to incarcerated individuals during the 30-day pre-release period, including providing clarification on both the eligibility criteria and services. Based on these comments, EOHHS made the following changes to the waiver:

- Clarify scope to include coverage of all services except those provided by DOC providers. EOHHS added language to *Section 3.2* to clarify that it is requesting full Medicaid coverage for all care provided to incarcerated beneficiaries during the 30-day pre-release period, except for medical services delivered by Department of Corrections (DOC) providers. This includes care coordination services, which are intended to be led by the MCOs providing significant contact individuals in the 30-day period to ensure that they are able to access necessary care upon release.

- Clarify population to include both adults and youth. EOHHS also received comments about the population included within this request. To clarify, the state intends to include both incarcerated adults and youth in this request, and therefore updated the narrative in *Section 3.2* to explicitly identify eligible participants. Both incarcerated adults and youth can benefit greatly from Medicaid service coverage and care coordination during this critical 30-day window.

Revisions to Section 3.3.3: Parents as Service Providers. EOHHS received many thoughtful comments on its proposal in *Section 3.3.3* to extend the authority for parents to serve as service providers for adult children utilizing self-direction. Based on these comments, EOHHS made one clarification in the eligible population to clarify its intent.

- Allow parents of all disabled adult children utilizing self-direction, not just those with intellectual and/or developmental disabilities, to act as service providers. In the original request, EOHHS limited this authority to parents of adult children with intellectual and developmental disabilities. EOHHS updated its request to include parents of all adult children with disabilities who self-direct their services, regardless of the nature of their disability. EOHHS is supportive of this option being available to all interested adult children utilizing self-direction and appreciates the feedback from beneficiaries and advocates.

Revisions to Appendix A: Core Service Definitions. Based on commenter feedback and objections to a core service definition, EOHHS made the following change to *Appendix A*:

- Change the name of Adult Foster Care to Shared Living (Adult Foster Care). Commenters requested that EOHHS change the name of Adult Foster Care as stated in *Appendix A* to a more inclusive term. EOHHS originally elected to use this name as it is

the term provided for this service by CMS. However, to respect the autonomy of individuals with disabilities, EOHHS changed the service name included in the waiver to “Shared Living (Adult Foster Care)”. Please note, EOHHS elected to retain the official CMS defined term in parentheses for purposes of clarity in documentation and alignment with federal definitions, however, it intends to primarily refer to the service as “Shared Living.”

Appendix A: Core Service Definitions

CORE SERVICES - Core services are only eligible to members that have a High or Highest level of care, although some of the services below may also be separately available under the Medicaid state plan.

Senior Companion/Adult Companion Services

Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the beneficiary with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the beneficiary. This service is provided in accordance with a therapeutic goal in the service plan of care.

Assisted Living Services

Personal care and supportive services (homemaker, chore, attendant services, companion services, meal preparation) that are furnished to HCBS beneficiaries who reside in a setting that meets the HCBS setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).

Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Assistive Technology

Assistive technology means an item, piece of equipment, service animal, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of beneficiaries, optimize their health and promote independence and self-care. Assistive technology service means a service that directly assists a beneficiary in the selection, acquisition, or use of an assistive technology device. The services under the demonstration are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Assistive technology includes:

- The evaluation of the assistive technology needs of a beneficiary, including a functional evaluation of the impact of the assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

- Training or technical assistance for the beneficiary, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the beneficiary; and
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of beneficiaries.

Bereavement Counseling

Counseling provided to the beneficiary and/or family members in order to guide and help them cope with the beneficiary's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the beneficiary and family members to manage this stress improves the likelihood that the individual with a life-threatening condition (certification of terminal illness) will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment, thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is receiving the HCBS but may continue after the death of the child for a period of up to six months. This service is for people who do not elect hospice.

Career Planning

Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for HCBS program beneficiaries to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the beneficiary's stated career objective and a career plan used to guide individual employment support.

Case Management

Services that assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Chore Services

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the beneficiary nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Shared Living (Adult Foster Care)

Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under state law)) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Shared living is furnished to adults who receive these services in conjunction with residing in the home. The

total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed two. Separate payment is not made for homemaker or chore services furnished to a participant receiving shared living services, since these services are integral to and inherent in the provision of shared living services. Payments for shared living services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for shared living services does not include payments made, directly or indirectly, to any individual who is legally responsible for the participant.

Community Transition Services

Community transition services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. Community transition services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Consultative Clinical and Therapeutic Services

Clinical and therapeutic services that assist unpaid caregivers in carrying out individual treatment/support plans that are not covered by the Medicaid State Plan and are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, counseling, and behavior management. The service may include assessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Day Treatment and Supports

Services that are necessary for the diagnosis or treatment of the individual's mental illness or disability. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization. These services consist of the following elements:

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law);
- Occupational therapy, requiring the skills of a qualified occupational therapist;
- Services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness;

- Drugs and biologicals furnished for therapeutic purposes, provided that the medication is not otherwise available under the State Plan or as a Medicare benefit to a beneficiary;
- Individual activity therapies that are not primarily recreational or diversionary;
- Family counseling (the primary purpose of which is treatment of the individual's condition);
- Training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and
- Diagnostic services.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Homemaker Services

Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Home Delivered Meals

The delivery of hot meals and shelf staples to the beneficiary’s residence. Meals are available to an individual who is unable to care for their nutritional needs because of a functional dependency/disability and who requires this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

Individual Directed Goods and Services

Individual directed goods and services are services, equipment, or supplies not otherwise provided through this HCBS or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the beneficiary’s opportunities for full membership in the community) and that meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the beneficiary’s safety in the home environment; AND the beneficiary does not have the funds to purchase the item or service or the item or service is not available through another source. Individual directed goods and services are purchased from the beneficiary-directed budget through the specific self-directed program options. Experimental or prohibited treatments are excluded. Individual directed goods and services must be documented in the service plan.

Supported Employment - Individual Supported Employment

Supported employment -individual employment support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided

through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment. Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services.

Supported Employment – Small Group Employment Support

Supported employment -small group employment support are services and training activities provided in regular business and industry settings for groups of two (2) to eight (8) workers with disabilities. Small group employment support does not include services provided in facility-based work settings. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in integrated employment in the community. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation, and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or 2. Payments that are passed through to users of supported employment services.

Medication Management/Administration

Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure. To clarify, “medication management” means the review of waiver participant medication regimens (e.g., the appropriateness of the medications that a person receives) and “medication administration” refers to the administration of medications to participants who are unable to administer their own medications by waiver providers.

Non-Medical Transportation

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant’s service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Peer Supports

Peer supports are provided by Peer Support Specialists that bring to the beneficiary a unique vantage point and the skills of lived experiences in either managing a health condition or disability, or in serving as the primary caregiver for a family member with a health condition or disability. This service is intended to provide individuals with a support system to develop and learn healthy living skills, to encourage personal responsibility and self-determination, to link individuals with the tools and education needed to promote their health and wellness (as well as the health and wellness of those that they are caring for, if applicable), and to teach the skills that are necessary to engage and communicate with providers and systems of care. Peer Support Specialists will work under the direction of a licensed healthcare practitioner or a non-clinical peer support supervisor. In addition to providing wellness supports, the Peer Support Specialists will utilize his or her own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary to succeed in leading a healthy, productive lifestyle.

Personal Care

A range of assistance to enable HCBS beneficiaries to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the beneficiary to perform a task. Personal care services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or direct service worker.

Personal Emergency Response System (PERS)

PERS is an electronic device that enables HCBS beneficiaries to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified herein.

Prevocational Services

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and their service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of prevocational services. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for individuals with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Private Duty Nursing

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law and as identified in the Individual Service Plan (ISP). These services are provided to a beneficiary at home.

Psychosocial Rehabilitation Services

Medical or remedial services recommended by a physician or other licensed practitioner of the healing arts under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- Social skills training in appropriate use of community services;
- Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention rather than diversion); and,
- Telephone monitoring and counseling services.

The following are specifically excluded from payment for psychosocial rehabilitation services:

- Vocational services,
- Prevocational services,
- Supported employment services, and
- Room and board.

Respite

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Skilled Nursing

Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Special Medical Equipment and Supplies

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Supports for Consumer Direction (Supports Facilitation)

Focuses on empowering beneficiaries to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the beneficiary through the service planning and delivery process. The Facilitator counsels, facilitates, and assists in development of an ISP which includes both paid and unpaid services and supports designed to allow the beneficiary to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the ISP are temporarily unavailable.

Training and Counseling Services for Unpaid Caregivers

Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to beneficiaries. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the HCBS. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain

the beneficiary at home. Counseling must be aimed at assisting the unpaid caregiver in meeting and managing the needs of the beneficiary. All training for individuals who provide unpaid support to the beneficiary must be included in the beneficiary's service plan.

Home Accessibility Adaptations (a.k.a., environmental accessibility adaptations)

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Minor Environmental Modifications

Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.

Appendix B: External Quality Review (EQR) Report

IPRO

Better healthcare, realized.

Rhode Island Medicaid Managed Care Program

2020 External Quality Review
Aggregate Annual Technical Report

April 2022

Prepared on behalf of:
The State of Rhode Island
Executive Office of Health and Human Services

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I. Executive Summary

Introduction

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care plans (MCPs) provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCP. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCPs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCP. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services[1] (CMS). Quality, as it pertains to an EQR, is defined in *42 CFR § 438.320 Definitions* as "the degree to which an MCO[2], PIHP[3], PAHP[4], or PCCM[5] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

The standards of *42 CFR § 438.364 External review results* (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness, and access to health care services that MCPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCPs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with Island Peer Review Organization (IPRO) to assess and report the impact of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provides IPRO's independent evaluation of the services provided by the three MCPs participating in the Rhode Island Medicaid managed care program: Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood), Tufts Health Public Plan , and UnitedHealthcare Community Plan of Rhode Island (UHCCP-RI),

It is important to note that the provision of health care services to each of the applicable eligibility groups (Core RIte Care, RIte Care for Children with Special Health Care Needs [CSHCN], RIte Care for Children in Substitute Care[6], Rhody Health Partners [RHP], Rhody Health Options [RHO][7], and Rhody Health Expansion [RHE]) is evaluated in this report. RHP is a managed care option for Medicaid-eligible adults with disabilities, while RHO members include those that are dual-eligible for Medicaid and Medicare. The RHE population includes Medicaid-eligible adults, ages 19 to 64 years, who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible for mandatory coverage under the state plan. As members of the Medicaid MCPs, each of these populations were included in all

[1] Centers for Medicare and Medicaid Services Website: https://www.cms.gov/
[2] Managed Care Organization
[3] Prepaid Inpatient Health Plan
[4] Prepaid Ambulatory Health Plan
[5] Primary Care Case Management
[6] Neighborhood is the only Health Plan that serves the Children in Substitute Care population.
[7] Neighborhood is the only Health Plan that serves the Rhody Health Options population.

measure calculations, where applicable. For comparative purposes, results for MY 2018 and MY 2019 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQR protocols, as well as state requirements.

Rhode Island Medicaid Managed Care Program

RIte Care, Rhode Island's Medicaid managed care program for children, families, and pregnant women, began enrollment in August 1994. RIte Care operates as a component of the State's Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which was approved through December 31, 2023[8]. In 2020 Rhode Island contacted with three MCPs and one dental MCP deliver health care services to Medicaid beneficiaries.

Scope of External Quality Review Activities

This report focuses on the four federally mandatory EQR activities (validation of performance improvement projects [PIPs], validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional EQR activity (validation of quality-of-care surveys) that were conducted. It should be noted that validation of provider network adequacy was instructed at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. As set forth by *42 CFR § 438.358 Activities related to external quality review (b)(1)* EQR activities are:

(i) **Validation[9] of Performance Improvement Projects (Protocol 1) –** This activity validates that MCP PIPs were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services. (Note: Rhode Island refers to PIPs as Quality Improvement Projects [QIPs] and the term QIP will be used in the remainder of this report.)

(ii) **Validation of Performance Measures (Protocol 2) –** This activity assesses the accuracy of MCP reported performance measures and determines the extent to which the performance measures follow state specifications and reporting requirements.

(iii) **Compliance Monitoring (Protocol 3) –** This activity determines MCP compliance with its contract and with state and federal regulations.

(iv) **Validation of Network Adequacy (Protocol 4)** – This activity assesses MCP adherence to state standards for time and distance for specific provider types, as well as the MCP's ability to provide timely care. (CMS has not published an official protocol for this activity.)

(v) **Validation of Quality-of-Care Surveys (Protocol 6) –** The activity assesses MCP compliance with contractual requirements to evaluate member and provider satisfaction annually.

The validation results of these EQR activities are reported in the **High-Level Conclusions and Findings** subsection that immediately follows.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an Information Systems Capabilities Assessment (ISCA) is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the NCQA HEDIS Compliance Audit™ may be substituted for

[8] In December 2019, the renewal request submitted by EOHHS was approved by CMS, resulting in an extension of the State's Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2023.

[9] CMS defines validation at *42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

an ISCA. Findings from IPRO's review of each MCP's HEDIS final audit report (FAR) for MY 2020 are in the **Validation of Performance Measures** subsection of **Section VII** of this report.

High-Level Conclusions and Findings

Validation of Quality Improvement Projects

IPRO's validation of the MCPs' 2020 QIPs confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*.

The results of the validation activity determined that Neighborhood was compliant with the standards of *42 CFR § 438.330(d)(2)* for all six QIPs. IPRO's assessment of Neighborhood methodology found that there were no validation findings that indicated that the credibility of QIP results were at risk.

The results of the validation activity determined that UHCCP-RI was compliant with the standards of *42 CFR § 438.330(d)(2)* for the four QIPs. IPRO's assessment of UHCCP-RI's methodology found that there were no validation findings that indicated that the credibility of QIP results were at risk.

The results of the validation activity determined that Tufts Health Public Plan Health Public Plan was not compliant with the standards of *42 CFR § 438.330(d)(2)* for either of the two QIPs conducted. IPRO's assessment of Tufts Health Public Plan Health Public Plan's methodology found that Tufts Health Public Plan Health Public Plan did not conduct the QIPs using the appropriate framework.

QIP summaries and detailed validation results are in **Section VII** of this report.

Validation of Performance Measures

IPRO's validation of the MCPs' performance measures confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that all MCPs were compliant with the standards of *42 CFR § 438.330(c)(2)*.

Information Systems Capabilities Assessment

The HEDIS MY 2020 FAR produced by Attest Health Care Advisors indicated that Neighborhood met all requirements to successfully report HEDIS data to EOHHS and to NCQA.

The HEDIS MY 2020 FAR produced by Attest Health Care Advisors indicated that Tufts Health Public Plan met all requirements to successfully report HEDIS data to EOHHS and to NCQA.

The HEDIS MY 2020 FAR produced by Attest Health Care Advisors indicated that UHCCP-RI met all requirements to successfully report HEDIS data to EOHHS and to NCQA.

HEDIS Performance

Unless otherwise noted, the benchmarks referenced below derive from NCQA's *2021 Quality Compass* MY 2020 for Medicaid (National – All Lines of Business [Excluding PPOs and EPOs]) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2020.

Concerning the Use of Services measures evaluating child and adolescent access to primary care, Neighborhood and UHCCP-RI reported MY 2020 rates for all three measures that exceeded the national Medicaid mean. Tufts Health Public Plan's MY 2020 rates did not meet the national Medicaid mean.

Concerning the Effectiveness of Care measures evaluating preventive screenings and care for members with acute and chronic illness, Neighborhood and UHCCP-RI reported MY 2020 rates for six of the seven measures that exceeded the national Medicaid mean. Tufts Health Public Plan reported four MY 2020 rates that exceeded that national Medicaid mean.

Concerning Access and Availability, Neighborhood and UHCCP-RI reported MY 2020 rates for all five measures that exceeded the national Medicaid mean. Tufts Health Public Plan's MY 2020 rates did not meet the national Medicaid mean.

All HEDIS performance measure rates are reported in **Section VII** of this report.

PGP Performance

Tufts Health Public Plan was not included in the Performance Goal Program for 2020 due to small membership.

Benchmarks referenced in the evaluation of PGP results derive from NCQA's *2020 Quality Compass* MY 2019 for Medicaid (National – All Lines of Business [Excluding PPOs and EPOs]) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2019.

Neighborhood

Neighborhood reported one 2020 PGP rate that benchmarked at the national Medicaid 95th percentile and five 2020 PGP rates that benchmarked at the national Medicaid 90th benchmark. Measures were related to well-child visits, prenatal care, cervical cancer screening, diabetes care, follow-up care after hospitalization for mental illness, and medication adherence.

Six 2020 PGP rates benchmarked at the national Medicaid 75th percentile. Measures were related to child and adolescent access to primary care, immunizations for children and adolescents, diabetes care, follow-up are after hospitalization for mental illness.

All other 2020 PGP rates performed below the national Medicaid 75th percentile. Measures were related to well-child visits, chlamydia screening, behavioral health medication management, and use of opioids.

UHCCP-RI

UHCCP-RI reported two 2020 PGP rates that benchmarked at the national Medicaid 90th percentile and seven at the national Medicaid 75th percentile. The measures that benchmarked at the 90th percentile were related to follow-up are after hospitalization for mental illness and the measures that benchmarked at the 75th percentile were related to well-child visits, access to primary care for children and adolescents, immunizations for children, diabetes care, antidepressant medication management, follow-up care for children prescribed ADHD medication, adherence to antipsychotic medications, and care for children and adolescents on antipsychotic medications.

All other 2020 PGP rates performed below the national Medicaid 75th percentile. Measures were related to well-child visits, access to care, adolescent immunizations, women's health, follow-up after emergency department visits for alcohol and other drug dependence, and use of opioids.

All PGP performance measure rates are reported in **Section VII** of this report.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO's review of the results of each MCPs' most recent NCQA accreditation review confirmed the state's compliance with evaluating MCP adherence to the standards of *42 CFR Part 438 Subpart D* and *42 CFR Part 438 Subpart E § 438.330.* The three MCPs met all federal Medicaid standards.

Detailed results of the MCPs' compliance reviews are in Section VII of this report.

Validation of Network Adequacy

IPRO's review of the MCPs' network evaluation reports confirmed the state's compliance with the requirements of *42 CFR § 438.68 Network adequacy standard (a)* and *(b).* In the absence of a CMS protocol for *42 CFR § 438.358 Activities related to external quality review (b)(1)(iv),* IPRO assessed the MCPs' compliance with the state-established standards for appointments and time and distance.

Neighborhood

In July 2020, Neighborhood met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.

Neighborhood monitored appointment availability during 2020 using the EOHHS–prescribed secret shopper methodology and reporting template. The reported mean for urgent adult specialty care did not meet the 24-hour standard for any specialty evaluated, however the reported mean for urgent pediatric specialty care met the 24-hour standard for all specialties evaluated. The mean number of days for routine adult behavioral health care met the 10-calendar day standard.

Tufts Health Public Plan

In December 2020, Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership. It is important to note that Tufts Health Public Plan's geographic time standards for PCPs and OB/GYNs exceeds the states standards.

Tufts Health Public Plan monitored appointment availability during 2020 using the EOHHS–prescribed secret shopper methodology and reporting template. Tufts Health Public Plan reported mean number of days to an appointment for routine adult and pediatric primary care met the 30-calendar day standard; the reported mean for urgent adult and pediatric primary care did not meet the 24-hour standard for any specialty evaluated; and the mean number of days for routine adult behavioral health care did not meet the 10-calendar day standard.

UHCCP-RI

Between July 1, 2019, and June 30, 2020, UHCCP-RI met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.

UHCCP-RI's reported mean number of days to an appointment for urgent adult and pediatric primary care and specialty care did not meet the 24-hour standard for any specialty evaluated. The reported mean for an urgent pediatric primary care appointment was 3 days, 6 days for an urgent adult dermatology appointment; and 31 days for an urgent pediatric neurology appointment. Further, appointment availability among the surveyed providers was low.

Detailed results of network adequacy assessments are reported in Section VII of this report.

Validation of Quality of Care Surveys

Member Satisfaction

Section 2.13.05 of the Contract requires each MCP to annually collect member satisfaction data. IPRO's review of available documentation confirmed the MCPs' compliance with Section 2.13.05. Three MCPs evaluated adult member satisfaction with services received in MY 2020 using NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult Medicaid 5.1H survey tool and two MCPs evaluated child member satisfaction using the Child Medicaid 5.1H survey tool.

The benchmarks referenced immediately below derive from NCQA's *2021 Quality Compass* MY 2020 *for* Medicaid (National – All Lines of Business [excluding PPOs and EPOs]) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2020.

Concerning the adult CAHPS survey, Neighborhood achieved six scores that exceeded that the national Medicaid mean, UHCCP-RI achieved three scores and Tufts Health Public Plan achieved one score that exceeded that the national Medicaid mean. No plan achieved a score for *Rating of Personal Doctor* that performed better than national Medicaid mean.

Of the two MCPs that administered the child CAHPS survey, UHCCP-RI achieved four scores that exceeded that national Medicaid mean, while Neighborhood achieved a single score.

Detailed results of the member satisfaction surveys are reported in in Section VII of this report.

Provider Satisfaction

Section 2.13.06 of the Contract requires each MCP to annually collect provider satisfaction data. IPRO's review of available documentation confirmed Neighborhood's compliance with Section 2.13.05. Overall, MY 2020 satisfaction with Neighborhood increased significantly from MY 2019. Provider satisfaction levels improved across all Neighborhood-specific measures, with nearly half of the increases from MY 2019 to MY 2020 being statistically significant. This finding differs greatly from the 2019 survey results in which all measures had declined from 2018.

Neighborhood

Qualitative feedback suggested improved satisfaction with Neighborhood's responsiveness, online tools, and claims processing.

Satisfaction with provider relations was identified as an area needing improvement.

Tufts Health Public Plan

Overall, MY 2020 scores demonstrated improvement from MY 2019. There was a statistically significant increase in providers reporting they were satisfied with Tufts Health Public Plan, overall. There was also an increase in providers reporting they view Tufts Health Public Plan as a strong collaborator in providing quality patient care, and a similar number who indicated that Tufts Health Public Plan is a valuable partner in a crisis. The key drivers for overall satisfaction were "Tufts Health Public Plan's contract arrangement has had a positive impact on my practice" and "*Tufts Health Provider Connect* is easy to navigate."

Tufts Health Public Plan displayed strengths in communicating information to providers, including having a website that is easy to navigate, making it easy to locate information on medical necessity guidelines, and making it easy to determine a member's plan by the ID card.

The provider payment dispute process was a key area identified as needing improvement, as were communications around Tufts Health Public Plan's COVID-19 response.

UHCCP-RI

The provider satisfaction rates for MY 2020 decreased in comparison to the rates reported in MY 2019.

Detailed results of the provider satisfaction survey are reported in **Section VII** of this report.

EQR Recommendations

Per *42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations for improving the quality of care health care services furnished by UHCCP-RI and recommendations on how EOHHS can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to Rhode Island Medicaid managed care enrollees.

EQR Recommendations the Rhode Island Executive Office of Health and Human Services

Recommendations towards achieving the goals of the Medicaid quality strategy are presented in **Section III** of this report.

EQR Recommendations for the Rhode Island Medicaid Managed Care Plans

MCP specific recommendations related to the **quality** of, **timeliness** of and **access** to care are in **Section X** of this report.

II. Introduction

States that provide Medicaid services through contracts with MCPs are required by federal mandate to conduct EQR activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. EOHHS contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent annual analysis of state and MCP performance related to the quality, timeliness, and accessibility of the care and services it provides. This report is the result of IPRO's evaluation of services furnished and QI activities conducted in 2020.

III. Rhode Island Medicaid Managed Care

Rhode Island Medicaid Managed Care Program

The state's initial Medicaid and CHIP managed care program, RIte Care, began in 1994. The RIte Care program covered children, families, and pregnant women, and began enrollment in August 1994 as a Section 1115 demonstration. Since 1994, the Rhode Island has expanded the Medicaid managed care program. **Table 1** displays the timeline for Rhode Island's Managed Care Program additions.

Table 1: Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	RIte Care, SCHIP
2000	Children in Substitute Care, RIte Share
2003	Children with Special Needs, RIte Smiles
2008	Rhody Health Partners
2014	Medicaid Expansion, Behavioral Health carved in to managed care
2015	Accountable Entities Pilot
2016	Medicare-Medicaid Plan (MMP)
2018	MCO-Certified Accountable Entities APMs

Rite Care operates as a component of the State's Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which was approved through December 31, 2019[10]. As is typical for Section 1115 waivers, CMS defined "Special Terms and Conditions" (STCs) for the demonstration. The STCs addressing quality assurance and improvement were as follows:

Contracted MCPs enroll members into the following lines of business: RIte Care Core (children and families); RIte Care Substitute Care (children in substitute care); RIte Care CSHCN (children with special healthcare needs); Rhody Health Expansion (low-income adults without children); Rhody Health Partners (aged, blind, disabled adults). The contracted dental plan enrolls members into the Rite Smiles program.

Rhode Island EOHHS contracts with three MCPs: Neighborhood, Tufts Health Public Plan and UHCCP-RI; and one managed dental health plan: United Healthcare Dental (UHC-Dental).

2019 State Medicaid Quality Strategy

For over 25 years, Rhode Island has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, the contracted Managed Care Entities (MCEs) program have the following responsibilities:

- ensuring a robust network beyond safety-net providers and inclusive of specialty providers,
- increasing appropriate preventive care and services, and
- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

[10] In December 2018, the renewal request submitted by EOHHS was approved by CMS, resulting in an extension of the State's Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2023.

Guiding Principles, Goals and Objectives

Rhode Island's Medicaid managed care program is dedicated to improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence, and quality of life. A working group was established to present innovative recommendations to modernize the state's Medicaid program and increase efficiency. The four guiding principles established by the Working Group are:

1. pay for value, not volume,
2. coordinate physical, behavioral, and long-term health care,
3. rebalance the delivery system away from high-cost settings, and
4. promote efficiency, transparency, and flexibility.

Rhode Island Medicaid also developed the Accountable Entity (AE) program as a core part of its managed care quality strategy which are Rhode Island's version of an accountable care organization. AEs represent interdisciplinary partnership among providers in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. The AE initiative focuses on achieving the following goals:

- Transition Medicaid from fee for service to value-based purchasing at the provider level
- Focus on Total Cost of Care (TCOC)
- Create population-based accountability for an attributed population
- Build interdisciplinary care capacity that extends beyond traditional health care providers
- Deploy new forms of organization to create shared incentives across a common enterprise, and
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

Evolving from the state's guiding principles, Rhode Island Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022. These goals are displayed in **Table 2**.

Table 2: Rhode Island Medicaid Quality Strategy Goals, 2019-2022

Rhode Island Medicaid Goals
1. Maintain high level managed care performance on priority clinical quality measures
2. Improve managed care performance on priority measures that still have room for improvement
3. Improve perinatal outcomes
4. Increase coordination of services among medical, behavioral, and specialty services and providers
5. Promote effective management of chronic disease, including behavioral health and comorbid conditions
6. Analyze trends in health disparities and design interventions to promote health equity
7. Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice
8. Reduce inappropriate utilization of high-cost settings

To support achievement of the Quality Strategy goals, Rhode Island Medicaid established specific objectives. The state developed these objectives to focus state, MCE, and other activities on interventions likely to result in progress toward the eight managed care goals. These objectives are displayed in **Table 3** along with the attached goal(s).

Table 3: Rhode Island Managed Care Quality Objectives

Objectives	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8
Continue to work with MCEs and the EQRO to collect, analyze, compare, and share clinical performance and member experience across plans and programs.	X	X	X	X	X	X	X	X
Work collaboratively with MCPs, AEs, OHIC and other stakeholders to strategically review and modify measures and specifications for use in Medicaid managed care quality oversight and performance incentives. Establish consequences for declines in MCE performance.	X							
Create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.	X	X						
Review and potentially modify financial incentives (rewards and/or penalties) for MCP performance to benchmarks and improvements over time.	X	X	X	X	X			
Work with MCPs and AEs to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.			X			X		X
Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.			X	X	X	X		X
Monitor and assess MCP and AE performance on measures that reflect coordination including: follow up after hospitalization for mental health and data from the new care management report related to percentage/number of care plans shared with primary care providers (PCPs).				X	X			X
Develop a chronic disease management workgroup and include state partners, MCEs, and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.					X			X
Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCPs and AEs to screen members related to social determinants of health and make referrals based on the screens.						X		
Share and aggregate data across all Rhode Island HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.						X		
Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCP CAHPS survey results with the MCAC.							X	
Explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs.							X	
Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.							X	

Improvement and Interventions

To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related to the vision and mission, Rhode Island Medicaid engages in multiple interventions. These interventions are based on the results of its MCE assessment activities and focus on the managed care goals and objectives displayed in **Table 3**. Rhode Island Medicaid's ongoing and expanded interventions for managed care quality and performance improvement include:

- **Ongoing requirements for MCEs to be nationally accredited:** Rhode Island Medicaid MCPs are required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status.
- **Tracking participation in APMs related to value-based purchasing (pay for value not volume):** Medicaid MCPs are required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including the Alternate Payment Methodology (APM) Data Report, the Value Based Payment Report and the Accountable Entity-specific reports.
- **Pay for Performance Incentives for MCEs and AEs:** Rhode Island Medicaid intends to create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics and outcomes – both online and in person.
- **Statewide collaboratives and workgroups that focus on quality of care:** Rhode Island Medicaid works with MCEs and the EQRO to collect, analyze, compare, and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement.
- **Soliciting member feedback through a variety of forums and mechanisms:** Rhode Island Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement.

Refer to **Appendix B** of this report for the full *2019-2022 Rhode Island State Medicaid Quality Strategy*.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

The EOHHS Medicaid quality strategy aligns with CMS's requirements and provides a framework for MCPs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required EQR activities, EOHHS's quality strategy includes state- and MCP-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

Recommendations to the Rhode Island Executive Office of Health and Human Services

In working towards the goals of the 2019-2022 strategy, IPRO recommends that the EOHHS consider:

- Establishing appointment availability thresholds for the Medicaid Managed Care program to hold the MCPs accountable for increasing the availability of timely appointments.
- Updating the Medicaid quality strategy to explicitly state how performance towards the goals will be evaluated. Each goal should be attached to an outcome measure along with baseline and target rates. Interim reporting of rate performance should be provided to the EQRO as part of the annual EQR assessment.
- Developing a separate quality strategy for the dental Medicaid managed care program or dedicate a section in the overall Medicaid quality strategy to Rite Smiles.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

IV. Neighborhood Health Plan of Rhode Island, Inc.

Neighborhood is a not-for-profit HMO that served the Medicaid populations. Neighborhood served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Table 4 displays Neighborhood enrollment for year-end 2018 through year-end 2020, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Neighborhood's enrollment increased 12% from 160,572 members in 2019 to 179,049 members in 2020.

Table 4: Neighborhood's Enrollment, 2018-2020

Eligibility Group	2018	2019	2020
Core RIte Care	100,923	93,611	100,594
Children with Special Health Care Needs[1]	5,066	5,119	5,237
Children in Substitute Care[2]	2,715	2,616	2,879
Extended Family Planning[3]	829	1,265	1,240
Rhody Health Partners[4]	7,465	7,446	7,497
Rhody Health Options[5]	15,698	13,875	12,914
Rhody Health Expansion[6]	38,135	36,640	48,688
Medicaid Total	**170,831**	**160,572**	**179,049**
Percent Change from Previous Year	**-7%**	**-6%**	**+12%**

[1] Children with Special Health Care Needs (CSHCN) were enrolled in RIte Care on a voluntary basis, effective 01/29/2003, because only one Health Plan was willing to enroll this population. As of 10/01/2008, managed care enrollment became mandatory for all RIte Care-eligible CSHCN who do not have another primary health insurance coverage. All of the State's current Medicaid-participating Health Plans serve CSHCN.

[2] Appendix B of this report describes the eligibility criteria for Rhody Health Partners.

[3] Rhody Health Expansion serves Medicaid-eligible adults ages 19-64 who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage.

[4] Enrollment in the DSNP population began on 01/01/2019.

[5] The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

Neighborhood's 2020 Quality Improvement Program

The EOHHS requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members. Neighborhood's *2020 Quality Improvement Plan* meets these requirements.

Objectives and Goals

The overall goal of Neighborhood's QI Program is to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes.

Table 5 displays Neighborhood's QI goals as reported in the *2020 Quality Improvement Plan,* revised May 2020.

Table 5: Neighborhood's Quality Improvement Goals, 2020

Quality Improvement Goals
1. Assure access to high quality medical and behavioral healthcare
2. Support members with acute and long-term health care needs
3. Monitor and improve coordination of care across settings
4. Improve member and provider experience
5. Ensure the safety of members in all health care settings
6. Monitor quality of care in nursing facilities through Minimum Data Set (MDS) data and other data sources
7. Engage members in their own care
8. Improve HEDIS and CAHPS performance
9. Improve Medicare Health Outcomes Survey (HOS) performance
10. Achieve maximum NCQA Star Rating and Accreditation Status
11. Achieve maximum performance under the RI Medicaid Performance Goal Program
12. Achieve optimum performance for Quality Withhold under the INTEGRITY Medicare-Medicaid Plan (MMP) product line
13. Achieve maximum performance in the quality improvement projects required by contracts for Medicaid, INTEGRITY-MMP, and the Exchange products
14. Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access and other quality issues
15. Maintain collaborative relationships with network providers and state agencies
16. Improve operational efficiency in the work performed across the organization
17. Ensure Neighborhood's quality improvement structure and processes adhere to NCQA standards and state and federal requirements
18. Assess the QI Program annually and make changes as necessary to improve program effectiveness

Quality Improvement Program Activities

Neighborhood's QI program activities involve a variety of mechanisms to measure and evaluate the total scope of services provided to enrollees. The framework for program activities may vary and may include but is not limited to, the following functions:

- Clinical Quality Performance Indicators: HEDIS
- Member Satisfaction: CAHPS Member Satisfaction Surveys
- Member Satisfaction: Care Management Member Satisfaction Survey
- Provider Satisfaction Survey
- Clinical Practice Guidelines
- Disease Management and Wellness
- Peer Review Activity
- Actions to Address Quality of Care Complaints
- Quality Improvement Projects
- Chronic Care Improvement Programs (CCIP) – INTEGRITY MMP
- Activities to Improve Patient Safety
- Objectives to Enhance Service to a Culturally Diverse Membership
- Objectives to Enhance Services to Members with Complex Health Needs
- Population Health Management Strategy (PHMS)
- Annual Evaluation and Work Plan Development

Quality Improvement Program Oversight

Neighborhood's Chief Medical Officer has responsibility for the oversight, direction, delivery, and implementation of Neighborhood's Quality Improvement Program. The day-to-day operations of Neighborhood's Quality Improvement Program are overseen by the Medicaid & Commercial Quality Operations Committee and the INTEGRITY Quality and Operations Committee, including the development of Neighborhood's Quality Improvement Program Description, Annual Evaluation and Work Plan.

To assess the effectiveness of the QI Program, Neighborhood produces an annual evaluation which depicts the Plan's measurable performance achievements over the course of the year, with trended data when available. The Quality Improvement Annual Evaluation includes identification of the barriers which made quality improvement difficult to achieve, the interventions recommended to overcome these barriers, and a summary of the overall effectiveness of the program, with consideration given to the adequacy of resources, committee structure, and leadership involvement.

Table 6 displays key organizational roles of the Neighborhood QI program.

Table 6: Neighborhood's Organizational Structure for Quality Improvement

Title	Responsibilities
Board of Directors	The Board of Directors has final authority and responsibility for the care and service delivered to Neighborhood's members
Clinical Affairs Committee (CAC)	Provides direction to the Quality Improvement Program and Neighborhood staff for all activities described in the program, Annual Evaluation and Work Plan, including those quality improvement activities that have been delegated to the health plan's behavioral health vendor and other subcontractors.
Chief Medical Officer (CMO)	Guides the direction, delivery, and implementation of Neighborhood's QI Program, including the Population Health Strategy and oversees the functions, responsibilities, planning, design and implementation of activities undertaken by the QI committees and subcommittees.
Medical Director/Associate Medical Directors	Assists the CMO in providing clinical guidance to the organization by directing the development of new clinical programs, evaluating new medical technologies, developing criteria for standards of performance to evaluate individual provider compliance with clinical practice and preventive health guidelines, and providing oversight to physician reviewer and consultant activities and recruitment.
Medicaid and Commercial Quality and Operations Committee	Provides direction, guidance, and input to the quality improvement activities undertaken and implemented within the organization to monitor and improve the efficiency and operations of Neighborhood's departments and service to members and providers, with primary focus on quality in the Medicaid and Commercial products.
INTEGRITY Quality and Operations Committee	Monitors and reviews the quality improvement and operational activities of the INTEGRITY MMP product.
Clinical Management Committee	Provides direction for clinical services such as new and changing medical and behavioral health technology, clinical medical policies, utilization management procedures, and the assurance of consistent medical review criteria and actions.
Pharmacy and Therapeutics Committee	Acts in an advisory capacity to the Chief Medical Officer on the provision of quality pharmaceutical services.

Title	Responsibilities
Quality Assurance Committee	Responsible for investigating member complaints about their clinical quality of care as well as concerns that are forwarded by Neighborhood staff from their contact with members.
Management Team / Staff	All staff members are given the responsibility and authority to participate in Neighborhood's quality improvement efforts.
Department of Quality Improvement	Oversees the implementation and the effectiveness of the QI Program.

Recommendations on how Neighborhood can better achieve the goals in its quality strategy are presented in **Section X** of this report.

V. Tufts Health Public Plan

Tufts Health Public Plan is a not-for-profit HMO that served the Medicaid populations. Tufts Health Public Plan served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Table 7 displays Tufts Health Public Plan enrollment for year-end 2018 through year-end 2020, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Tufts Health Public Plan's enrollment increased by 57% from 8,973 members in 2019 to 14,075 members in 2020.

Table 7: Tufts Health Public Plan's Enrollment—2018-2020

Eligibility Group	2018	2019	2020
Core RIte Care	4,281	4,520	6,703
Children with Special Health Care Needs[1]	52	69	87
Rhody Health Partners[2]	505	566	658
Rhody Health Expansion[3]	4,600	3,765	6,571
Extended Family Planning (EFP)[4]	34	53	56
Health Plan Total	**9,472**	**8,973**	**14,075**
Percent Change from Previous Year	**112%**	**-5.6%**	**+56.9%**

[1] Children with Special Health Care Needs (CSHCN) were enrolled in RIte Care on a voluntary basis, effective 01/29/2003, because only one Health Plan was willing to enroll this population. As of 10/01/2008, managed care enrollment became mandatory for all RIte Care-eligible CSHCN who do not have another primary health insurance coverage. All of the state's current Medicaid-participating MCPs serve CSHCN.

[2] Appendix B of this report describes the eligibility criteria for Rhody Health Partners.

[3] Rhody Health Expansion serves Medicaid-eligible adults ages 19-64 years who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage.

[4] The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

Tufts Health Public Plan's 2020 Quality Improvement Program

The EOHHS requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members. Tufts Health Public Plan's *2020 Quality Improvement Plan* meets these requirements.

Objectives and Goals

The objective of Tufts Health Public Plan's Quality Improvement (QI) Program is to continuously improve the quality and safety of clinical care and services members receive, including physical and behavioral health and substance abuse care; assure adequate access to and availability of clinical care and services; increase member and provider satisfaction; improve the quality of service providers and members receive from the Health Plan; and improve the health and wellness of members while managing health care costs. The QI Program established the following objectives that encompass all QI activities within the MCP:

- Continuously and systematically monitor the quality of member care to improve member health outcomes and access to care, evaluate the quality of care through the application of objective criteria, identify problems and opportunities to improve quality of care, implement appropriate and coordinated member- and provider-directed actions to improve the quality and safety of member care, and evaluate the impact of corrective actions;
- Ensure quality improvement activities and decision-making are supported by quantitative and qualitative data collection as appropriate, and as directed by CMS and/or EOHHS;
- Foster a supportive environment to help practitioners and providers improve the safety of their practices through member and provider education and link technology solutions to patient safety and quality improvement;
- Arrange for the provision of cost-effective health care by qualified physicians, other designated licensed independent practitioners, and organizational providers;
- Monitor the use and ongoing evaluation of up-to-date, evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals, or where evidence-based practice guidelines do not exist, consensus of health care professionals;
- Identify potential areas of corporate risk due to adverse patient occurrences associated with care or service, to intervene, to prevent and reduce the occurrences that lead to liability, and to manage risk and minimize losses;
- Outline the Health Plan's approach to address the cultural and linguistic needs of membership;
- Ensure quality improvement activities are conducted in a culturally appropriate manner;
- Incorporate experience from members and providers with respect to clinical quality, access and availability, cultural competence of care and services, and continuity and coordination of care in the design, planning, and implementation of QI activities, including, but not limited to, member and provider satisfaction surveys and member advisory councils or boards;
- Coordinate quality activities with the Utilization Management department;
- Assess, participate in, and/or implement programs and initiatives that improve the health and wellness of identified segments of the member community in accordance with CMS and EOHHS quality improvement goals and requirements and public health needs and goals, including programs to impact members with complex health needs and to increase preventive health services;
- Monitor, assess, and develop quality improvement activities to assure appropriate access and availability of quality clinical care and services;
- Seamless continuity and coordination of care and transitions of care across the health care continuum; and
- Ensure that policies, procedures, and processes are in place through which clinical quality, access and availability of health care and services, and coordination of care are assured, including, but not limited to, appeals and grievances and utilization management.

Table 8 displays Tufts Health Public Plan's QI goals as reported in the *2020 Quality Improvement Plan,* revised October 2019.

Table 8: Tufts Health Public Plan's Quality Improvement Goals, 2020

Quality Improvement Goals
1. To continuously improve the quality and safety of clinical care, including physical health and behavioral health (inclusive of mental health and substance use) care, and service, including community-based services and Long-Term Services and Supports (LTSS) that Tufts Health Public Plan members receive from contracting health care providers. 2. To assure adequate access and availability to clinical care and services. 3. To increase member satisfaction. 4. To improve the quality of service that providers and members receive from Tufts Health Public Plan. 5. To increase provider satisfaction. 6. To improve the health and wellness of identified segments of the member community, while responsibly managing health care costs.

Quality Improvement Program Activities

Tufts Health Public Plan's 2020 QI program includes, but is not limited to, the following activities:

- Evaluation of quality if clinical care
- Evaluation of safety of clinical care
- Evaluation of quality of service
- Evaluation of member experience
- Monitoring of previously identified issues
- Evaluation of the QI program

Quality Improvement Program Oversight

Tufts Health Public Plan's QI Program Director monitors and evaluates the effectiveness of the QI program. The QI Program Director, in consultation with QI improvement-related committee members, program advisors and internal QI personnel identify opportunities for improvement and track potential deficiencies.

The Tufts Health Public Plan's Board of Directors is the Program's final policy-making body and has ultimate accountability for the Program's success. The Board of Directors has established a multi- disciplinary Care Management Committee (CMC), a Board of Director level committee whose function is to oversee the implementation of the program and the achievement of the program objectives. The Board of Directors shall continuously oversee the CMC through appointment of a Board member and at least annual review of the CMC reports.

An annual evaluation of the QI Program is completed to ascertain that the goals are met, and improvement initiatives are effective. The Quality Improvement Plan designates those resources, which are reasonably determined to be sufficient for the achievement of program goals and objectives. Further, it identifies the individuals and committees responsible for the Quality Improvement program development, oversight and operations and it describes the primary program components. The Quality Improvement plan also directs that each year an Annual Work Plan setting forth specific goals, objectives and activities for the year be developed, implemented, and evaluated which involves all product lines.

Table 9 displays key organizational roles of the Tufts Health Public Plan's QI program.

Table 9: Tufts Health Public Plan's Organizational Structure for Quality Improvement

Title	Responsibilities
Board of Directors	The final policy-making body with ultimate accountability for the QI Program.
Chief Medical Officer	Responsible for developing and implementing comprehensive medical programs and policies and ensuring the delivery of high-quality effective member supports across the care management continuum.
Senior Vice President/Chief Medical Officer	Appointed by Board of Directors to support the Program by providing day-to-day oversight, coordination, and management of quality improvement activities, and by monitoring the sufficiency of Tufts Health Public Plan resources committed to the Program so that Program objectives are achieved.
Vice President of Quality Management	Responsible for the preparation of QI information for the Board of Directors and internal committees and work closely with other QI Program staff as needed to develop, implement, monitor, and evaluate the QI Program, annual quality improvement objectives and clinical QI projects.
Senior Medical Director, Medical Affairs and Quality	Provides clinical support to the teams that manage and process member and provider QI activities; and provides clinical leadership and support to the credentialing functions and clinical quality functions.
Vice President of Population Health Management	Responsible for providing oversight for Population Health Programs which administered across the Tufts Health Plan enterprise and for ensuring compliance with all regulatory and accreditation standards related to the Care Management programs.
Senior Medical Director, Public Plans	Serves as a medical director and policy advisor to the clinical staff including the Utilization Management, Care Management and Quality Management Departments.
Corporate Medical Director for Behavioral health, Health Care Services	A Psychiatrist who provides physician leadership for all behavioral health programs, including both mental health and substance use, and performs and supervises utilization management and quality assurance functions for the behavioral health treatment network, and participates in the development and evaluation of behavioral health quality improvement initiatives and participates in the quality improvement program where behavioral health leadership and/or clinical expertise are needed.
Director of Behavioral Health	Participates in QI workgroups, and behavioral health (mental health/substance use related) QI initiatives and program development.
Vice President of Behavioral Health	Responsible for providing oversight for Behavioral Health Programs administered across all products, and responsible for process workflows, documentation including policies and procedures, and implementation and evaluation of both internal behavioral health programs, and utilization management activities for Behavioral Health services.
Program Director	A clinician/physician who is responsible for day-to-day oversight and management of the QI Program.
Director of Care Management for Public Plans	Oversees a team of medical and behavioral health care managers, community health outreach workers and care coordinators who work as an interdisciplinary care team to support the member's needs across the continuum of care.
Quality Improvement Personnel	Dedicated teams and staff provide end-to-end support of all QI activities and initiatives.

Recommendations on how Tufts Health Public Plan can better achieve the goals in its quality strategy are presented in **Section X** of this report.

VI. UnitedHealthcare Community Plan of Rhode Island

UHCCP-RI is a for-profit HMO that served the Medicaid populations. UHCCP-RI served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Table 10 displays UHCCP-RI enrollment for year-end 2018 through year-end 2020, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. UHCCP-RI's enrollment increased by 11% from 83,515 members in 2019 to 92,899 members in 2020.

Table 10: UHCCP-RI's Enrollment—2018-2020

Eligibility Group	2018	2019	2020
Core RIte Care	52,601	47,975	51,539
Children with Special Health Care Needs[1]	1,828	1,845	1,896
Rhody Health Partners[2]	6,883	6,536	6,463
Rhody Health Expansion[3]	29,511	26,742	32,622
DSNP[4]	Not Applicable	Not Reported	Not Reported
Extended Family Planning (EFP)[5]	344	417	379
Medicaid Total	**91,167**	**83,515**	**92,899**
Percent Change from Previous Year	**-6%**	**-9%**	**+11%**

[1] Children with Special Health Care Needs (CSHCN) were enrolled in RIte Care on a voluntary basis, effective 01/29/2003, because only one Health Plan was willing to enroll this population. As of 10/01/2008, managed care enrollment became mandatory for all RIte Care-eligible CSHCN who do not have another primary health insurance coverage. All of the State's current Medicaid-participating Health Plans serve CSHCN.

[2] Appendix A of this report describes the eligibility criteria for Rhody Health Partners.

[3] Rhody Health Expansion serves Medicaid-eligible adults ages 19-64 who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage.

[4] Enrollment in the DSNP population began on 01/01/2019.

[5] The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

UHCCP-RI's 2020 Quality Improvement Program

The EOHHS requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members. UHCCP-RI's *2020 Quality Improvement Program Description* (March 2020) *and 2020 UHCCP-RI Quality Improvement Work Plan* meet these requirements.

Objectives and Goals

UHCCP-RI's Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and quality of services provided to all members. UHCCP-RI strives to continuously improve the care and service provided by the health care delivery system, both from clinical and non-clinical perspectives.

Table 11 displays UHCCP-RI's QI goals as reported in the *Quality Improvement Program Description* (March 2020).

Table 11: UHCCP-RI's Quality Improvement Goals, 2020

Quality Improvement Goals
1. Promote and incorporate quality into the Health Plan's organizational structure and processes
2. Promote effective monitoring and evaluation of patient care and services provided by practitioners and providers for compatibility with evidence-based medicine guidelines
3. Identify and analyze opportunities for improvement and implement actions and follow-up
4. Coordinate quality improvement, risk management, patient safety, and operational activities
5. Maintain compliance with local, state, and federal regulatory requirements and accreditation standards
6. Serve culturally and linguistically diverse populations
7. Support members living healthier lives, including those with complex illnesses

Quality Improvement Program Activities

UHCCP-RI's QI program activities involve a variety of mechanisms to measure and evaluate the total scope of services provided to enrollees. Descriptions of these activities include, but are not limited to:

- Quality of Care (QOC)
- HEDIS
- Coordination of Care
- Performance Improvement Projects and Quality Improvement Projects
- Patient Safety
- Credentialing
- Peer Review
- Member Surveys
- Customer Service Metrics
- Language Services:
- Network Adequacy

Quality Improvement Program Oversight

The Board of Directors or its Executive Committee is responsible for oversight of the Quality Improvement (QI) Program. The oversight includes overseeing QI functions, annually reviewing and approving the Quality Improvement Program Description (QIPD) and Quality Improvement Work Plan (QIWP), reviewing the Annual QI Evaluation and other reports and information as required or requested and providing feedback and recommendations to the Quality Management Committee (QMC) related to reports, documents and any issues or concerns.

An annual review of the overall effectiveness of the QI Program is conducted using the QI Evaluation to assess how well resources have been deployed to improve the quality and safety of clinical care and service provided to members.

The QI Evaluation addresses all aspects of the QI Program described in the prior year's Quality Improvement Program Description (QIPD) and Quality Improvement Work Plan (QIWP), focusing on the overall effectiveness compared to goals and objectives. The QI Evaluation includes:

- Quantitative and qualitative analyses, as well as trending of data;
- Identified potential and actual barriers to achieving our goals;
- A summary of the adequacy of resources, committee structure, physician participation and leadership involvement; and

- The recommendations for QI Program revisions based on the evaluation.

Table 12 displays key organizational roles of the UHCCP-RI QI program.

Table 12: UHCCP-RI's Organizational Structure for Quality Improvement

Title	Responsibilities
Board of Directors	The governing body of the organization responsible for the oversight of the QI program.
Health Plan Chief Executive Officer	Responsible for oversight of the implementation of the QI Program; the monitoring of quality of care and service UHCCP provides and ensuring the appropriate level of resources are available for the QI Program.
Health Plan Chief Medical Officer	A Rhode Island licensed physician who is responsible for implementation of the QI Program; overseeing and implementing activities to measure and detect disparities in health services, and to determining the efficacy of the QI program.
Health Plan Senior Quality Improvement Director	Responsible for oversight of the implementation and evaluation of QI initiatives related to the QI program. The QI Director is also responsible for preparation of the annual QI program documents and oversight of activities including, but not limited to: HEDIS improvement activities, submissions of quality regulatory reports, QI studies, patient safety initiatives, member experience metrics, grievances and appeals, and delegated relationships. The QI Director is a point of contact for quality related regulatory inquiries and works with the Compliance Officer to promote compliance with quality related regulatory and accreditation standards
Health Plan Quality Improvement Manager	Supports the implementation of QI initiatives related to the QI program. The QI Manager is also responsible for the coordination of the Provider Advisory and Quality Management Committees and the preparation of the annual QI program documents. The QI Manager reports to the Senior QI Director and interfaces with the Chief Medical Officer, Director Health Services, Compliance Officer, Director Network Programs, Medicaid Operations and other areas to ensure appropriate completion of quality improvement activities and ongoing adherence to program requirements.
Clinical Practice Consultant	Responsible for developing and implementing clinical quality initiatives designed to assist providers in delivering timely and effective health services.
UnitedHealthcare Chief Medical Officer	A licensed physician and senior member of the UnitedHealthcare executive leadership team that provides clinical oversight for all aspects of the national quality program.
Senior Vice President, Population Health and Clinical Transformation	Provides clinical leadership in the development and oversight of strategies for improving population health.
UnitedHealth Group, Chief Equity Officer	Responsible for the advancement of health equity, including efforts to address health disparities and to foster culturally competent care services, across the enterprise within the various lines of business of the organization. The Chief Equity Officer is accountable for providing executive leadership for the health equity programs across all of the UHCCP plans.

Recommendations on how UHCCP-RI's can better achieve the goals in its quality strategy are presented in **Section X** of this report.

VII. EQRO Findings and Conclusions Related to Quality, Timeliness and Access

In order to assess the impact of the Rhode Island MMC program on **quality** of, **timeliness** of, and **access**, IPRO reviewed pertinent information from a variety of sources, including state managed care standards, health plan contract requirements, performance measures, and state monitoring reports.

This section of the report discusses the results, or findings, from the four required EQR activities (validation of QIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity. For each EQR activity, a summary of the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions and findings are presented.

The MCPs' strengths and recommendations related to the **quality** of, **timeliness** of, and **access** to care. These three elements are defined as:

- **Quality** is the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

Additionally, **Section VII** of this report IPRO's assessment of the MCPs' response to the EQR 2019 recommendations per *42 CFR § 438.364 External quality review results (a)(6).*

Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(i) mandates that the state or an EQRO must validate the PIPs that were underway during the preceding 12 months. IPRO performed this activity on behalf of EOHHS for the 2020 QIPs. The QIP validation was conducted using an evaluation approach developed by IPRO and consistent with the CMS EQR *Protocol 1-Validation of Performance Improvement Projects*.

Technical Methods of Data Collection and Analysis

Neighborhood and UHCCP-RI QIPs were documented using NCQA's *Quality Improvement Activity* (QIA) *Form*. A copy of the *QIA Form* is in **Appendix A** of this report. All QIPs were documented in Microsoft Excel.

The QIP assessments were conducted using an evaluation approach developed by IPRO and consistent with CMS EQR *Protocol 1-Validation of Performance Improvement Projects*. IPRO's assessment includes the following ten elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCP's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCP's enrollment and generalizable to the MCP's total population.

4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the QIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the MCP achieved sustained improvement.

Upon IPRO's review of the 2020 QIP QIA Forms completed by the MCPs and provided to IPRO by EOHHS, a determination was made as to the overall credibility of the results of each QIP, with assignment of one of three categories:

- There are no validation findings that indicate that the credibility is at risk for the QIP results.
- The validation findings generally indicate that the credibility for the QIP results is not at risk; however, results should be interpreted with some caution. Processes that put the findings at-risk are enumerated.
- There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at-risk are enumerated.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Conclusions and Findings

Neighborhood conducted the following QIPs in 2020:

- QIP 1 – Children's and Adolescents' Access to Primary Care Practitioners
- QIP 2 – Developmental Screening in the 1st, 2nd, 3rd Years of Life
- QIP 3 – Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication
- QIP 4 – Lead Screening in Children
- QIP 5 – Improve Performance for Care for Older Adults
- QIP 6 – Increase the Percentage of Transitions from the Nursing Home to the Community

UHCCP-RI conducted the following QIPs in 2020:

- QIP 1 – Improving Effective Acute Phase Treatment for Major Depression
- QIP 2 – Developmental Screening in the 1st, 2nd, 3rd Years of Life
- QIP 3 – Improving Lead Screening in Children
- QIP 4 – Improving Breast Cancer Screening

Tufts Health Public Plan conducted the following QIPs in 2020:

- QIP 1 – Promote Doula Program for Maternal and Child Health
- QIP 2 – Member Experience and Retention

Table 13 displays a summary of the IPRO's QIP validation activity, while **Table 14** displays MCP results by validation element.

Table 13: MCP QIP Validation Summary, MY 2020

MCP QIP Validation Summary
Neighborhood
IPRO's assessment of Neighborhood methodology found that there were no validation findings that indicated that IPRO's assessment of Neighborhood 's methodology found that there were no validation findings that indicated that the credibility of six QIPS was at risk.
UHCCP-RI
IPRO's assessment of UHCCP-RI's methodology found that there were no validation findings that indicated that IPRO's assessment of UHCCP-RI's methodology found that there were no validation findings that indicated that the credibility of four QIPS was at risk.
Tufts Health Public Plan
The results of the validation activity determined that Tufts Health Public Plan was not compliant with the standards of *42 CFR § 438.330(d)(2)* for either of the two QIPs conducted. IPRO's assessment of Tufts Health Public Plan's methodology found that Tufts Health Public Plan did not conduct the QIPs using the appropriate framework. Tufts Health Public Plan's conduct of QIP 1 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's QIP 1: ▪ The project indicator did not monitor Tufts Health Public Plan's performance at a point in time or over time and did not inform the selection and evaluation of quality improvement activities. ▪ The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for QIP reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied. ▪ The analysis did not include baseline and repeat measures of project outcomes; and the QIP results were not presented in a concise and easily understood manner. ▪ The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the QIP did not assess the extent to which the improvement strategy was successful Tufts Health Public Plan's conduct of QIP 2 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's QIP 2: ▪ The QIP topic was not selected through a comprehensive analysis of enrollee needs, care, and services. ▪ The project indicator did not inform the selection and evaluation of quality improvement activities. ▪ The data collection instrument did not allow for consistent data collection and reporting over the period studied. ▪ The QIP results were not presented in a concise and easily understood manner. ▪ The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the QIP did not assess the extent to which the improvement strategy was successful.

Table 14: MCP QIP Validation Results by Element, MY 2020

MCP/Validation Element	QIP 1	QIP 2	QIP 3	QIP 4	QIP 5	QIP 6
Neighborhood	Child Access to Primary Care	Developmental Screening	ADHD Medication Follow-up	Lead Screening	Care for Older Adults	Transition from Nursing Home to Community
Selected Topic	Met	Met	Met	Met	Met	Met
Study Question	Met	Met	Met	Met	Met	Met
Indicators	Met	Met	Met	Met	Met	Met
Population	Met	Met	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met	Met	Met
Data collection Procedures	Met	Met	Met	Met	Met	Met
Interpretation of Study Results	Met	Met	Met	Met	Met	Met
Improvement Strategies	Met	Met	Met	Met	Met	Met
UHCCP-RI	Depression Treatment	Developmental Screening	Lead Screening	Breast Cancer Screening	Not Required	
Selected Topic	Met	Met	Met	Met		
Study Question	Met	Met	Met	Met		
Indicators	Met	Met	Met	Met		
Population	Met	Met	Met	Met		
Sampling Methods	Met	Met	Met	Met		
Data collection Procedures	Met	Met	Met	Met		
Interpretation of Study Results	Met	Met	Met	Met		
Improvement Strategies	Met	Met	Met	Met		
Tufts Health Public Plan	Promotion of Doula Program	Member Experience and Retention			Not Required	
Selected Topic	Met	Not Met				
Study Question	Insufficient Data	Not Met				
Indicators	Insufficient Data	Met				
Population	Insufficient Data	Met				
Sampling Methods	Insufficient Data	Not Applicable				
Data collection Procedures	Insufficient Data	Not Met				
Interpretation of Study Results	Insufficient Data	Met				
Improvement Strategies	Insufficient Data	Met				

Table 15: Neighborhood's QIP Summaries, MY 2020

Neighborhood's QIP Summaries
QIP 1: Children and Adolescents' Access to Primary Care Practitioners (CAP), Ages 12-24 Months and 25 Months-6 Years **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: Neighborhood aimed to improve access to primary care practitioners for child and adolescent members aged 12 months-6 years. Indicators/Goals: HEDIS *Children and Adolescents' Access to Primary Care Practitioners* 1. The percentage of children aged 12–24 months who had one or more ambulatory or preventive care visits with a PCP during the measurement year. 2. The percentage of children aged 25 months-6 years who had one or more ambulatory or preventive care visits with a PCP during the measurement year. The goal for the 12-24 months age cohort was to meet or exceed the *2017 Quality Compass* national Medicaid 90th percentile. The goal for the 25 months-6 years age cohort was to meet or exceed the *2018 Quality Compass* national Medicaid 90th percentile. Member-Focused Interventions: ▪ Neighborhood posted to Facebook and Twitter regarding the importance of well visits targeting providers and members. ▪ Members were eligible to receive a $25 incentive gift card for completing an annual well visit at 18 months and between the ages of three and twelve years. ▪ Live outreach calls were conducted to non-compliant members regarding the importance of immunizations and well visits. ▪ Automated calls were conducted to promote the importance of well visits, immunizations, and lead screening to all families with Medicaid members two years old and under. ▪ Published an article on the importance of well visits and immunizations. Provider-Focused Interventions: ▪ Neighborhood posted to Facebook and Twitter regarding the importance of Well visits targeting providers and members. ▪ Provider articles were published on the importance of well visits during COVID-19/telehealth options and the COVID-19 impact on childhood immunizations and well visits. ▪ Shared best practices and HEDIS measure requirements with low performing providers. MCP-Focused Intervention: ▪ Conducted monthly quality improvement meetings to discuss barriers to performance and brainstorm interventions for prioritization and implementation. Results: Neighborhood's MY 2020 rates for the 12-24 months age cohort and the 25 months-6 years age cohort did not meet the goal rate.
QIP 2: Developmental Screening in the 1st, 2nd, 3rd Years of Life **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: Neighborhood aimed to increase the percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first, second and third birthdays. Indicators/Goals: National Quality Forum (NQF) *Developmental Screening in the First Three Years of Life*

1. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday.
2. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday; and
3. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday.

The goal for this QIP is to achieve the 90th percentile of the RI EOHHS State-specified performance goal, i.e., 65%.

Member-Focused Interventions:

- Automated voice calls to promote the importance of well visits, immunizations, and lead screening to all families with Medicaid member's two years old and under.
- A $25 incentive gift cards were offered to members who received an annual well visit at 18 months and between the ages of three and twelve.

Provider-Focused Interventions:

- Shared best practices with four community health centers, including suggestions on scheduling visits to ensure that the visits occur within specified timeframe in order to be compliant with the measure.
- Published two provider articles on the importance of well visits during COVID-19/telehealth options and the COVID-19 impact on childhood immunizations and well visits.

MCP-Focused Interventions:

- Emailed a letter to select low-performing accountable entities providing best practices for capturing and billing developmental screenings.
- Conducting monthly quality improvement meetings to discuss barriers to performance and brainstorm interventions for prioritization and implementation.

Results: Neighborhood reported higher rates of developmental screenings for all indicators. MY 2020 rates for these indicators exceeded goal rates.

QIP 3: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication
Validation Summary: There are no validation findings that indicate that the credibility is at risk for the QIP results.

Aim: Neighborhood aimed to improve the follow-up care for children prescribed ADHD medication.

Indicators/Goals: HEDIS *Follow-up Care for Children Prescribed ADHD Medication*

1. *Initiation Phase* – The percentage of members 6-12 years of age as of the earliest prescription dispensing date (index prescription start date) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30 days following the index prescription start date.
2. *Continuation and Maintenance Phase* – The percentage of members 6-12 years of age as of the earliest prescription dispensing date (index prescription start date) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least seven months (210 days), in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within nine months (270 days) after the initiation phase has ended.

The goals of this QIP for the initiation phase was to increase the rate to meet the *Quality Compass* national Medicaid 90th percentile (55.91%). For the continuation and maintenance phase, the goal was to increase the rate to meet the *Quality Compass* national Medicaid 90th percentile (69.14%).
Member-Focused Intervention:

Neighborhood's QIP Summaries
▪ Neighborhood conducted telephone calls to prescribers of members newly prescribed ADHD medication to ensure that members have a follow-up appointment scheduled. Provider-Focused Interventions: ▪ Neighborhood sent a fax form to practitioners of members with newly prescribed ADHD medication to confirm that each member had a follow-up appointment scheduled and if not, encourage them to schedule a follow-up appointment. ▪ Published provider newsletter article about ADHD in the Neighborhood provider newsletter. MCP-Focused Intervention: ▪ Published social media posts informing members about ADHD, as well as how to deal with social isolation. Results: Neighborhood's MY 2020 rates for the initiation phase and the continuation and maintenance phase did not achieve their QIP goals.
QIP 4: Lead Screening in Children **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: Neighborhood aimed to increase the percentage of children screened for lead by their second birthday. Indicator/Goal: HEDIS *Lead Screening in Children* 1. The percentage of Neighborhood members screened for lead by their second birthday. The goal of this QIP is to meet or exceed the national Medicaid 90th percentile for the HEDIS *Lead Screening in Children* measure. Member-Focused Interventions: ▪ Automated voice calls to promote the importance of well visits, immunizations, and lead screening to all families with Medicaid member's two years old and under. ▪ Live Outreach calls conducted to non-compliant members to encourage immunizations and well visits. ▪ Member Newsletter: Article published in the summer iteration of the member newsletter on the importance of well visits and immunizations. ▪ Member Rewards: Neighborhood provided an incentive of $25 to parents of children for completing lead screening by the age of two years. ▪ Member Post Cards: Neighborhood sends lead test reminder postcards monthly to children turning one year old. Provider-Focused Interventions: ▪ Distribution of Provider Gap in Care Reports reminding providers of the importance of lead screening, how they can help and what Neighborhood is doing to help. ▪ Neighborhood shared best practices with low performing providers as well as the HEDIS CAP requirement. MCP-Focused Interventions: ▪ Collaboration with the Rhode Island Department of Health (RIDOH) regarding prevention of lead poisoning, promoting screening and rescreening for high blood lead levels including discussions about lead screening guidelines and laws, exchange of data, sharing of best practices and collaborative efforts around member and provider education. Results: Neighborhood's MY 2020 *Lead Screening* rate did not achieve the QIP's goal rate. The MY 2020 rate was lower than the MY 2015 baseline rate.

Neighborhood's QIP Summaries
QIP 5: Improve Performance for Care for Older Adults **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: Neighborhood aimed to improve performance for care of older adults. Indicators/Goals: HEDIS *Care for Older Adults* 1. *Advanced Care Planning* – The percentage of members 66 years and older who had an advanced care plan in place during the measurement year 2. *Medication Review* – The percentage of members 66 years and older who had a medication review during the measurement year 3. *Functional Status Assessment* – The percentage of members 66 years and older who had a functional status assessment during the measurement year 4. *Pain Assessment* – The percentage of members 66 years and older who had a pain assessment during the measurement year The goals of this PIP were to increase the percentage of members 66 years and older who had: ▪ an advanced care plan to 50%, ▪ a medication review to 81%, ▪ a functional status assessment to 69%, and ▪ a pain assessment to 64%. Member-Focused Intervention: ▪ Generated gaps in care lists of members without advanced care plans and the MCP's Care Management Team worked with the nursing homes to gather this information to be added to the HEDIS supplemental database. Provider-Focused Intervention: ▪ Educated providers on the Care for Older Adults requirements and assistance in improving COA documentation in the provider electronic medical records to facilitate data collection for COA. MCP-Focused Interventions: ▪ Neighborhood's pharmacy team identified an existing pharmacist "license number" reporting field to use for capturing and transferring accurate medication review data. ▪ The MCP's care management team outreached to high-risk members to obtain health risk assessment information. ▪ Neighborhood began utilizing the care management software, Acuity, as a supplemental database for the advanced care plan, functional status assessment, and pain assessment measures. ▪ Implementation of modifications to the health risk assessment well as structural and systematic modifications to the care management software, Acuity, to include the COA measures. Results: Neighborhood's MY rates for *Advanced Care Plan* and *Pain Assessment* exceeded goal rates, while MY 2020 rates for *Medication Review* and *Functional Status Assessment* did not meet goal rates.
QIP 6: Transitions from the Nursing Home Facility to the Community **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: Neighborhood aimed increase the percentage of transitions from the nursing home to the community. Indicators/Goals: 1. The percentage of INTEGRITY MMP members who have transitioned out of a nursing facility to the community under the RTHP.

Neighborhood's QIP Summaries
2. The number of INTEGRITY MMP members who have transitioned out of a nursing facility to the community. The goals are to transition 20 INTEGRITY MMP enrollees eligible for the RTHP from the nursing facility to the community in 2020 and to transition 35% of INTEGRITY MMP members to the community. Member-Focused Interventions: ▪ Provided telephonic education to member and/or members' representative about the services available to them once transitioned. Due to COVID-19, the education was transitioned to telephonic only. ▪ Neighborhood's pharmacy team performed outreach to members listed on a "gap in care" report to ensure safe, quality care was facilitated for nursing facility members who were prescribed antipsychotic medication. Provider-Focused Intervention: ▪ Neighborhood's manager of care management implemented a process whereby nursing staff conducted reassessments every six months as opposed to annually. MCP-Focused Interventions: ▪ Neighborhood obtained access to approximately 55 nursing homes' electronic medical records systems to assist in identifying opportunities for transition through reassessment. ▪ Neighborhood's Nursing Home Measures Quality Withhold Work Group implemented the Nursing Home Incentive Pilot Program, wherein participating nursing facilities submit their staffing metrics to Neighborhood for the calendar year and receive a calculated payment upon passing specific nursing home quality withhold measures. Results: For the *Nursing Home transition to the Community for RTHP eligible*s indicator, Neighborhood reported 19 transitioned members in MY 2020 and did not meet the goal of transitioning 20 members. However, the MY 2020 rate for the *All Transitions from the Nursing Home to the Community* indicator exceeded the goal rate.

Table 16: Tufts Health Public Plan's QIP Summaries, MY 2020

Tufts Health Public Plan QIP Summaries
QIP 1: Promote Doula Program for Maternal and Child Health **Validation Summary:** There were one or more validation findings that indicate a bias in the QIP results.
Aim: Tufts Health Public Plan aimed to promote its doula program for maternal and child health. Indicator/Goal: The MCP did not provide a defined indicator for measuring improvement. The MCP did not establish a target goal. 2020 Member-focused Intervention: ▪ Distributed member materials electronically to increase knowledge of doula program. 2020 Health Plan-focused Interventions: ▪ Established internal doula program workgroup and partnered with Health Equity Committee to identify populations for targeted outreach. ▪ Conducted primary research with both members and prospective members including having in-depth interviews with members who have participated in the doula program to identify value drivers and how to better market this benefit to existing members. ▪ Deployed the Community Relations team to engage current and prospective members through events such as community baby showers.

Tufts Health Public Plan QIP Summaries
Results: There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at-risk were enumerated above.
QIP 2: Member Experience and Retention **Validation Summary:** There were one or more validation findings that indicate a bias in the QIP result
Aim: Tufts Health Public Plan aimed improve its average monthly member attrition rate. Indicator/Goal: The performance indicator and goal are improvement of the monthly member attrition rate by two percentage points from the baseline rate of 8% to 6%. (A lower rate is desired.) 2020 Member-focused Intervention: ▪ Created a new member onboarding content enhancement. 2020 Provider-focused Intervention: ▪ Expanded the provider network to incentivize prospective and current members to select Tufts Health Public Plan's RITogether product. 2020 Health Plan-focused Interventions: ▪ Conducted awareness and acquisition campaigns. ▪ Leveraged Healthsource RI Support to increase awareness of MCP offerings. ▪ Established a community commitment by agreeing to involve the development and construction of two soccer fields in Central Falls. Results: It is unclear how performance in these areas impacted the health outcomes of Tufts Health Public Plan's Medicaid membership. There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at-risk were enumerated above.

Table 17: UHCCP-RI's QIP Summaries, MY 2020

UHCCP RI's QIP Summaries
QIP 1: Improving Effective Acute Phase Treatment for Major Depression **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: UHCCP-RI aimed to increase the percentage of members aged 18 years and older who remain on antidepressant medication during the acute phase of treatment. Indicator/Goal: HEDIS *Antidepressant Medication Management – Effective Acute Phase* 1. Percentage of adults who remained on an antidepressant medication for at least 84 days (12 weeks). The goal was to achieve the national Medicaid 90th percentile. Member-Focused Interventions: ▪ Member flyers were created regarding the Behavioral Health Link resource available in the state and depression medication adherence to be utilized by Clinical practice consultants (CPCs), case managers, community health workers and marketing representatives as hand-outs and for community events. ▪ Related articles were published in the member newsletter. Provider-Focused Interventions: ▪ Related articles were published in the provider newsletter. ▪ Clinical learning seminars offered to physicians.

UHCCP RI's QIP Summaries
▪ Issued an e-mail blast addressing medication adherence for members with schizophrenia and depression. The information was distributed to 1,450 Rhode Island behavioral health practitioners as of December 2020. ▪ UHCCP-RI and Optum joint meetings reconvened to focus on behavioral health quality measures and were attended by additional representatives including quality representatives, Optum behavioral health associates, UHCCP-RI clinical services staff, as well as UHCCP-RI's pharmacist. ▪ Webinars targeted to primary care providers related to Depression and Follow-up after Higher Levels of Care launched for AMM, FUH and FUM measures. ▪ Open Calls were offered and facilitated for providers to provide education on how to use the Live and Work Well website, how to identify providers, and answer any questions providers had regarding behavioral health access, behavioral health in general and to address any concerns. MCP-Focused Interventions: ▪ UnitedHealthcare Clinical Practice Consultants met with Accountable Care Organizations/Accountable Entities and high-volume sites (at least 100 members) to discuss current rates, opportunities for improvement with noncompliant members and share best practices from high performing provider sites. Due to COVID-19, both virtual and in-person meetings were conducted. ▪ Meetings were held monthly throughout the entire year and focused on behavioral health quality measures. The meetings include UnitedHealthcare quality representatives, clinical services representatives, Optum behavioral health associates, as well as the health plan's pharmacist. Data was requested and analyzed to determine trends, including practitioners with poor performance on this measure. Results: UHCCP-RI's MY 2020 rate exceeded the QIP's goal rate.
QIP 2: Developmental Screening in the 1st, 2nd, 3rd Years of Life **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: UHCCP-RI aimed to increase the percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second and third birthdays. Indicators/Goals: National Quality Forum (NQF) *Developmental Screening in the First Three Years of Life* 1. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday. 2. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday. 3. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday. The goals for this QIP were to increase each indicator rate to 50.0% Member-Focused Interventions: ▪ Parents and guardians were targeted for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) interactive voice recordings (IVR) with a reminder to complete a routine check-up for children ages 2-21 years. For calendar year 2020, 18,383 calls were conducted. ▪ Mailed letters were sent to guardians of children in need of developmental screening to educate guardian/parent of the importance of the screening. A total of 2, 133 letters were mailed through December 2020.

UHCCP RI's QIP Summaries
▪ UHCCP-RI mailed a monthly child preventive health letter to identified members, aged 0-20 years, encouraging members to schedule and have a check-up with the primary care physician. A total of 23,601 letters were mailed through December 2020. ▪ Live outreach calls were placed to remind heads of households to seek age-appropriate care for their children. In 2020 a total of 14, 223 calls were conducted. ▪ Monthly mailing to members with an upcoming birthday to emphasize well visits. A total of 6,655 birthday cards have been mailed to members ages 0 through 4 years through December 2020. ▪ Related articles were published in the member newsletter. ▪ The *Developmental Screening in the First Three Years of Life* measure was endorsed as a "Core" (required) measure in the SIM Aligned AEs and Primary Care Measure Sets for 2017 and 2018, meaning that all value-based contracts for these provider groups will include these measures for performance period starting on or after 7/1/2017 for 2017 measure sets and on or after 7/1/2018 for 2018 measure sets. This was a pay-for-reporting measure for each of the AEs contracted with UHCCP-RI. This impacted approximately 70% of the UHCCP-RI membership which is assigned to an AE. Provider-Focused Intervention: ▪ Clinical practice consultants (CPCs) targeted federally qualified health centers (FQHCs), high-volume practices, and practices with low adherence for developmental screening for onsite outreach. Results: UHCCP-RI demonstrated improvement for all three indicators from MY 2019 to MY 2020, and continued to exceeded project goal rates.
QIP 3: Improving Lead Screening in Children **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: UHCCP-RI aimed to increase the percentage of members two years of age who received one or more capillary or venous blood tests for lead poising on or before their second birthday. Indicator/Goal: HEDIS *Lead Screening in Children* 1. The percentage of UHCCP-RI members screened for lead by their second birthday. The goal of this QIP is improve rate of the HEDIS *Lead Screening in Children* measure to 86.62%. Member-Focused Interventions: ▪ Sent an informational flyer to the parents and guardians of children residing in Washington County, Rhode Island and to those identified as needed a lead screening. In September 2019, 93 flyers were mailed. Another flyer was developed that provides information on all the places and items that may have lead. This flyer was distributed by CPCs at practitioner offices and is available at community events for distribution. ▪ Distributed a lead screening flyer at the August 25th, 26th, and 28th, 2020 Back to School event. ▪ Parents and guardians were targeted for EPSDT IVRs with a reminder to complete a routine check-up for children ages 2-21 years. In 2020, 18,383 calls were conducted. ▪ Live outreach calls were made to members identified as being 18-months of age and in need of a lead screening. ▪ Related articles were published in the member newsletter. ▪ The lead screening educational member flyers were made available at a COVID-19 Vaccine event where the Cambodian Society of Rhode Island partnered with Providence Community Health Center in December 2021. Provider-Focused Interventions: ▪ Related articles were published in the provider newsletter.

UHCCP RI's QIP Summaries
▪ UHCCP-RI's CPCs met with AEs and high-volume sites (at least 100 Medicaid members), including sites located in Providence, Rhode Island which was identified as the area with the least compliant members. MCP-Focused Intervention: ▪ Collaborated with the Rhode Island Department of Health (RIDOH) Lead Screening Evaluator and Neighborhood to identify barriers and opportunities for improvement. Results: UHCCP-RI's HEDIS MY 2020 *Lead Screening* in *Children* rate did meet the goal rate. The MY 2020 rate was below the MY 2016 baseline rate. There are no validation findings that indicate that the credibility is at risk for the QIP results.
QIP 4: Improving Breast Cancer Screening **Validation Summary**: There are no validation findings that indicate that the credibility is at risk for the QIP results.
Aim: UHCCP-RI aimed to increase the percentage of women aged 50-74 years who had a mammogram. Indicator/Goal: HEDIS *Breast Cancer Screening* 1. Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. The goal of this QIP is to improve the rate of the HEDIS *Breast Cancer Screening* rate to 69.22%. Member-Focused Interventions: ▪ Live outreach calls were made to members residing in Washington County, Rhode Island and those members identified as needing breast cancer screening. ▪ An informational flyer encouraging members to get a mammogram was mailed to 209 members residing in Washington County, Rhode Island. ▪ Live outreach calls were made to members reminding them complete preventive screenings, to stay up to date with immunizations and to complete well-child visits. A total of 2,791 calls were conducted through March 2020. ▪ Completed monthly birthday card mailings to members reminding them to seek age-appropriate services. ▪ Related articles were published in the member newsletter. ▪ Distributed breast cancer/mammography screening educational member flyer at a COVID-19 Vaccine event where the Cambodian Society of Rhode Island partnered with Providence Community Health Center in December 2021. Provider-Focused Interventions: ▪ Related articles were published in the provider newsletter. ▪ Conducted provider education through the UHCCP-RI on-air program "Working Together to Improve Breast Cancer Screening." MCP-Focused Intervention: ▪ Organized the Health Disparities Work Group which meets quarterly. A Health Disparities Work Plan has been developed to address low performing measures with their Health Equities Team. Results: UHCCP-RI's MY 2020 rate did not meet the project goal rate. The MY 2020 rate was lower than the MY 2017 baseline rate.

Table 18 and **Table 19** display MCP rates for common QIP indicators.

Table 18: NQF Developmental Screening in the First Three Years of Life, MY 2014-MY 2020

Measure/Measurement Period	Neighborhood Results	UHCCP RI Results
Preceding 1st Birthday		
MY 2014[1]	49.64%	41.61%
MY 2015[2]	39.42%	33.29%
MY 2016[1]	55.47%	54.01%
MY 2017[1]	62.77%	57.66%
MY 2018[1]	65.69%	64.23%
MY 2019	69.45%	67.15%
MY 2020	70.35%	79.85%
Preceding 2nd Birthday		
MY 2014[1]	57.66%	48.91%
MY 2015[2]	63.50%	44.38%
MY 2016[1]	72.26%	57.66%
MY 2017[1]	69.34%	57.66%
MY 2018[1]	74.45%	65.69%
MY 2019	68.64%	73.72%
MY 2020	74.65%	80.74%
Preceding 3rd Birthday		
MY 2014[1]	62.04%	43.80%
MY 2015[2]	61.31%	43.41%
MY 2016[1]	64.23%	59.12%
MY 2017[1]	64.23%	56.93%
MY 2018[1]	64.96%	59.85%
MY 2019	62.21%	62.77%
MY 2020	67.36%	80.99%

[1] Rate calculated using the hybrid methodology.
[2] Rate calculated using the administrative methodology.

Table 19: HEDIS Lead Screening in Children, MY 2015-MY 2020

Measurement Period	Neighborhood Results	UHCCP RI Results I
MY 2015	82.90%	Not Available
MY 2016	78.20%	75.89%
MY 2017	79.01%	76.64%
MY 2018	78.79%	74.24%
MY 2019	79.35%	76.89%
MY 2020	77.15%	71.52%

See MCP-level EQR reports for detailed QIP results.

Validation of Performance Measures

Information Systems Capabilities Assessment

The ISCA data collection tool allows the state or EQRO to evaluate the strength of each MCP's information system (IS) capabilities to meet the regulatory requirements for quality assessment and reporting. *Title 42 CFR § 438.242 Health information systems* and *42 CFR § 457.1233 Structure and operation standards (d) Health information*

systems also require the state to ensure that each MCP maintains a health information system that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. While some portions of the ISCA are voluntary, there are some components that are required to support the execution of the mandatory EQR-related activities protocols.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA.

Each MCP contracted with a NCQA-certified HEDIS compliance auditor for HEDIS MY 2020. Auditors assessed the MCP's compliance with NCQA standards in the following designated IS categories as part of the NCQA HEDIS MY 2020 Compliance Audit:

- IS 1.0 Medicaid Services Data: Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0 Enrollment Data: Data Capture, Transfer and Entry
- IS 3.0 Practitioner Data: Data Capture, Transfer and Entry
- IS 4.0 Medical Record Review Processes: Training, Sampling, Abstraction and Oversight
- IS 5.0 Supplemental Data: Capture, Transfer and Entry
- IS 6.0 Data Production Processing: Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
- IS 7.0 Data Integration and Reporting: Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The term "IS" – Information Systems – included the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation included a review of any manual processes used for HEDIS reporting. The compliance auditor determined the extent to which the MCPs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

An MCP meeting all IS standards required for successful HEDIS reporting and submitting HEDIS data to EOHHS according to the requirements in Medicaid model contract were considered strengths during this evaluation. An MCP not meeting an IS standard was considered an opportunity for improvement during this evaluation.

HEDIS Performance Measures

Objectives

EOHHS utilizes performance measures to evaluate the quality and accessibility of services furnished to Medicaid beneficiaries and to promote positive health outcomes. Section 2.12.03.03 of the Contractor requires each MCP to provide performance measure data, specifically HEDIS, to EOHHS within 30 days following the presentation of these results to the MCPs quality improvement committee.

Further, Rhode Island Medicaid MCPs are required to seek and maintain NCQA Accreditation and to provide evidence of the accreditation to EOHHS. As part its accreditation process, HEDIS data reported by the applying MCP to NCQA is used to effectively measure care and service performance.

Title 42 CFR § 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an EQRO must validate the performance measures that were calculated during the preceding 12 months. EOHHS contracted with IPRO to perform this activity for MY 2020.

Technical Methods of Data Collection and Analysis

All MCP submitting HEDIS data to NCQA must undergo a HEDIS Compliance Audit, which may only be performed by licensed organizations and certified auditors. Each MCP independently contracted with Attest Health Care Advisors as its HEDIS Compliance Auditor for HEDIS MY 2020.

In accordance with the 2020 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, Volume 5, the compliance auditor evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCP's IS, as well as criteria that must be met for any manual processes used to report HEDIS information.

The NCQA-certified HEDIS compliance auditor validated the MCP's reported HEDIS rate and produce formal documents detailing the results of the validation. For each MCP, IPRO obtained a copy of the HEDIS MY 2020 FAR and a locked copy of the HEDIS MY 2020) Audit Review Table (ART). The MCP's NCQA-certified HEDIS compliance auditor produced both information sources. IPRO used these audit reports as the foundation for its evaluation.

IPRO's validation of the MCPs' performance measures was conducted in alignment with the CMS EQR *Protocol 2-Validation of Performance Measures*. IPRO evaluated the MCPs' methodology for rate calculation to determine the accuracy of the reported rates using the following approach:

- Review of the HEDIS MY 2020 FAR which includes a summary of findings of the compliance auditor's IS reviews, medical record validation, and rate-level reporting designations.
- Assessment of the accuracy of reported HEDIS MY 2020 rates through appropriate benchmarking, review of trended data, and evaluation of the impact the MCP's QI activities have on health outcomes.

IPRO reviewed the HEDIS MY 2020 FARs and ARTs produced by Attest Health Care Advisors to ensure that the MCPs' calculated its rates based on complete and accurate data using NCQA's established standards and that calculation of these rates also aligned with EOHHS requirements. Specifically, IPRO evaluated the MCPs' IS capabilities that could affect the HEDIS Medicaid reporting set and verified that all performance measures were reportable.

Once the MCP's compliance with NCQA's established standards was examined, IPRO objectively analyzed the MCP's HEDIS MY 2020 results and evaluated current performance levels relative to *Quality Compass 2021* (MY 2020) national Medicaid percentiles.

Unless otherwise noted, benchmarks references in this report derive from NCQA's *Quality Compass 2021* for Medicaid (*National – All Lines of Business [Excluding PPOs and EPOs]*) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2020.

Description of Data Obtained

The FAR included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental, descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable, or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited).

The ART produced by the HEDIS Compliance Auditor displayed performance measure-level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the ART: administrative rate before exclusions; minimum required sample size (MRSS), and MRSS numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

Comparative Conclusions and Findings

Table 20 displays the results of the IS audit for all three MCPs.

Table 20: UHCCP-RI Compliance with Information System Standards

Information System Standard	Neighborhood	Tufts Health Public Plan	UHCCP RI
NCQA HEDIS Auditor	Attest Health Care Advisors	Attest Health Care Advisors	Attest Health Care Advisors
1.0 Medical Services Data	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met

Performance Measure Results

This section of the report explores the utilization of the MCPs' services by examining select measures under the following domains:

- Use of Services – Two measures (three rates) examine the percentage of Medicaid child and adolescent access routine care
- Effectiveness of Care – Five measures (seven rates) examine how well an MCP provides preventive screenings and care for members with acute and chronic illness
- Access and Availability – Three measures (five rates) examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care

Domain/Measures	Neighborhood HEDIS MY 2020	Tufts Health Public Plan HEDIS MY 2020	UHCCP RI HEDIS MY 2020	*Quality Compass* MY 2020 National Medicaid Mean
Use of Services				
Well-Child Visits in the First 30 Months of Life – First 15 Months	76.45%	48.13%	64.98%	52.93%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	85.63%	69.43%	78.34%	71.02%
Child and Adolescent Well-Care Visits	53.46%	42.75%	53.83%	46.12%
Effectiveness of Care				
Cervical Cancer Screening for Women	73.83%	38.93%	65.21%	56.84%
Chlamydia Screening for Women	63.19%	46.98%	60.69%	54.49%
Childhood Immunization Status – Combination 3	80.15%	72.08%	81.27%	67.60%
Childhood Immunization Status – Combination 10	62.31%	49.81%	63.50%	38.88%
Comprehensive Diabetes Care – HbA1c Testing	81.05%	74.80%	80.29%	82.82%
Follow-Up After Hospitalization for Mental Illness – 7 Days	55.92%	53.75%	58.58%	39.36%
Follow-Up After Hospitalization for Mental Illness – 30 Days	73.82%	67.50%	75.21%	58.92%
Access and Availability				
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	78.96%	57.92%	75.42%	74.05%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	87.92%	66.53%	84.24%	82.08%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	93.47%	Small Sample	82.70%	82.43%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	95.86%	66.67%	89.05%	83.82%
Prenatal and Postpartum Care – Postpartum Care	88.08%	60.14%	85.16%	75.07%

IPRO's assessment of strengths and opportunities for improvement related to the performance measures, as well as recommendations to improve **quality**, **timeliness** and **access** are presented in **Section X** of this report.

Rhode Island Performance Goal Program

Objectives

In 1998, the State initiated the Rhode Island Performance Goal Program, an incentive program that established benchmark standards for quality and access performance measures. Rhode Island was the second state in the nation to implement a value-based purchasing incentive for its Medicaid program. In 2020, the Performance Goal Program entered its twentieth year.

The 2005 reporting year marked a particularly important transition for the PGP, wherein the program was redesigned to be more fully aligned with nationally recognized performance benchmarks through the use of new performance categories and standardized HEDIS and CAHPS measures. In addition, superior performance levels were clearly established as the basis for incentive awards. For reporting year 2020, the performance categories were redefined into six categories. For Reporting Year 2020, the following performance categories were used to evaluate MCP performance:

1. Utilization
2. Access to Care
3. Prevention and Screening
4. Women's Health
5. Chronic Care Management
6. Behavioral Health

Technical Methods of Data Collection and Analysis

Within each of the performance categories is a series of measures, including a variety of standard HEDIS and CAHPS measures, as well as state-specific measures for areas of particular importance to the State that do not have national metrics for comparison. Many of the measures are calculated through the MCP's HEDIS and CAHPS data submissions.

Benchmarks referenced in the evaluation of PGP results derive from NCQA's Quality Compass 2020 for Medicaid (National – All Lines of Business [Excluding PPOs and EPOs]) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2019.

Description of Data Obtained

IPRO received a copy of the evaluation reports produced by EOHHS for each MCP included in the PGP for 2020. The evaluation reports include measure descriptive information such as name and corresponding performance category, rates, and numerators and dominators for each measure by Rhode Island Medicaid managed care program.

Comparative Conclusions and Findings

This section of the report evaluates the MCPs' performance on the PGP measures for RY 2019 and RY 2020 for all Medicaid populations. The HEDIS percentiles displayed were derived from the 2020 Performance Goal Program results, in which rates were benchmarked against the NCQA's Quality Compass 2020 for Medicaid.

Tufts Health Public Plan was not included in the Performance Goal Program for 2020 due to small membership.

RI Medicaid Managed Care Performance Goal Program Measures	Neighborhood RY 2020 (MY 2019)	*2020 Quality Compass* (MY 2019) Percentile Met	UHCCP RI RY 2020 (MY 2019)	*2020 Quality Compass* (MY 2019) Percentile Met
Utilization				
Well-Child Visits in the First 15 Months of Life (6 or more visits)	79.17%	90th	74.21%	75th
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	79.00%	66th	80.00%	66.67th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners – 7-11 Years	95.68%	75th	93.20%	66.67th
Children and Adolescents' Access to Primary Care Practitioners – 12-19 Years	94.24%	75th	89.89%	33.33rd
Prenatal and Postpartum Care – Timeliness of Prenatal Care	96.11%	90th	90.27%	50th
Prevention and Screening				
Childhood Immunization Status – Combination 3	78.66%	75th	77.86%	75th
Immunizations for Adolescents – Combination 1	87.35%	75th	86.62%	66.67th
Women's Health				
Cervical Cancer Screening	74.21%	90th	66.91%	66.67th
Chlamydia Screening in Women	69.65%	66th	66.88%	50th
Chronic Care				
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	58.23%	75th	55.47%	66.67th
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	29.87%	95th	32.85%	75th
Tobacco Screening & Cessation	19.6%		19.80%	
HIV Viral Load Suppression	72.4%		8.66%	
Behavioral Health				
Antidepressant Medication Management – Effective Acute Phase Treatment	56.91%	50th	60.87%	75th
Follow-Up After Hospitalization for Mental Illness—7 Days	54.33%	90th	54.38%	90th
Follow-Up After Hospitalization for Mental Illness—30 Days	72.77%	75th	73.85%	90th
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	46.91%	66th	48.65%	75th
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance	56.19%	50th	56.25%	50th
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	80.61%	33rd	77.57%	10th
Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence – 7 Days	11.31%	33rd	14.50%	50th
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	78.20%	95th	69.72%	75th
Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics	66.28%	50th	72.53%	75th
Use of Opioids at High Dosage	6.07%	95th	6.84%	33.33rd
Use of Opioids from Multiple Providers	17.85%	95th	19.19%	50th

Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Title *42 CFR §438.358*, a review must be conducted within the previous 3-year period that determines a plan's adherence to standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards, as well as applicable elements of EOHHS's MMC provider agreement with the plans.

Per *42 CFR § 438.360*, in place of a Medicaid administrative review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization review for determining plan compliance with standards established by the state to comply with these requirements.

Technical Methods of Data Collection and Analysis

EOHHS relies on the NCQA Accreditation standards, review process, and findings, in addition to other sources of information, to ensure MCP compliance with many of the structure and operations standards. The state also conducts an annual monitoring review to assess MCP processes and gather data for the State's Performance Goal Program metrics. Further, EOHHS submitted a crosswalk to CMS, pertaining to comparability of NCQA's accreditation standards to the federal regulatory requirements for compliance review, in accordance with *42 CFR §438.360(b)(4)*. This strategy was approved by CMS, with the most recent version being submitted to CMS in December 2014.

IPRO received the approved crosswalk and the results of the NCQA Accreditation Survey from EOHHS for each MCP. IPRO verified MCP compliance with federal Medicaid standards of *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

Description of Data Obtained

The *Score Summary Overall Results* presented Accreditation Survey results by category code, standard code, review category title, self-assessed score, current score, issues not met, points received and possible points. The crosswalk provided to IPRO EOHHS included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Comparative Conclusions and Findings

Neighborhood's accreditation was granted by NCQA on October 29, 2020. **Table 21** displays the results of Neighborhood's most recent NCQA Accreditation survey. It was determined that Neighborhood was fully compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

Tufts Health Public Plan's accreditation was granted by NCQA on April 29, 2021. **Table 21** displays the results of Tufts Health Public Plan's most recent NCQA Accreditation survey. It was determined that Tufts Health Public Plan was fully compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

UHCCP-RI's accreditation was granted by NCQA on December 3, 2020. **Table 21** displays the results of UHCCP-RI's most recent NCQA Accreditation survey. It was determined that UHCCP-RI was fully compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

Table 21: Evaluation of Compliance with 42 CFR Part 438 Subpart D and QAPI Standards

Part 438 Subpart D and Subpart E 438.330	Neighborhood	Tufts Health Public Plan	UHCCP RI
438.206: Availability of Services	Met	Met	Met
438.207: Assurances of adequate capacity and services	Met	Met	Met
438.208: Coordination and continuity of care	Met	Met	Met
438.210: Coverage and authorization of services	Met	Met	Met
438.214: Provider selection	Met	Met	Met
438.224: Confidentiality	Met	Met	Met
438.228: Grievance and appeal system	Met	Met	Met
438.230: Sub-contractual relationships and delegation	Met	Met	Met
438.236: Practice guidelines	Met	Met	Met
438.242: Health information systems	Met	Met	Met
438.330: Quality assessment and performance improvement program	Met	Met	Met

Validation of Network Adequacy

Objectives

In the absence of a CMS protocol for *42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, IPRO assessed MCP compliance with the standards of *42 CFR § 438.358 Network adequacy standards* and Section 2.09.02 of the state's Medicaid Managed Care Services Contract.

MCPs must ensure that a sufficient number of primary and specialty care providers are available to members to allow for a reasonable choice among providers. This is required by federal Medicaid requirements, state licensure requirements, NCQA accreditation standards, and the state's Medicaid Managed Care Services Contract.

Per section *2.08.01 Network Composition* of the Contract, MCPs are required to "establish and maintain a robust geographic network designed to accomplish the following goals:

1. Offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder and long-term services and supports (including nursing homes and home and community-based care) services for the anticipated number of enrollees in the services area;
2. Maintain providers in sufficient number, mix, and geographic areas; and
3. Make available all services in a timely manner. Pursuant to *42 CFR 438.206(c)(3)*, the Contractor will ensure that its contracted providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities."

Network and appointment timeliness standards included in the State's *Medicaid Managed Care Contract* are displayed in **Table 22**.

Table 22: Rhode Island Medicaid Managed Care Contract Network Standards

Network Standards
Time and Distance
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ Adult Prescribers Within 30 Minutes or 30 Miles
▪ Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours
▪ Routine Care Within 30 Calendar Days
▪ Physical Exam Within 180 Calendar Days
▪ EPSDT Within 6 Weeks
▪ New Member Within 30 Calendar Days
▪ Non-Emergent or Non-Urgent Mental Health or Substance Use Services Within 10 Calendar Days
Member-to-PCP Ratio Standards
▪ No more than 1,500 members to any single PCP
▪ No more than 1,000 members per single PCP within a PCP team
24 Hour Coverage
▪ On a 24 hours a day, 7 days a week basis access to medical and behavioral health services must be available to members either directly through the MCP or PCP
Other
▪ Each Medicaid network should include Patient Centered Medical Homes (PCMH) that serve as PCPs

Technical Methods of Data Collection and Analysis

Neighborhood

IPRO's evaluation was performed using network data submitted by Neighborhood in the *Managed Care Accessibility Analysis* reports as of the end of December 2020. IPRO's evaluation included a comparison of Neighborhood access data to state standards for appointment availability and time and distance. Neighborhood access standards for PCPs is one provider within 20 miles and one provider within 30 miles for OB/GYNs.

Neighborhood's goal is to have 95% of its network of primary care, high-volume, and high-impact providers meet the established distance requirements, as well as to meet provider-to-member ratios. The distance requirements and ratios differ by provider type and county designation.

Tufts Health Public Plan

IPRO's evaluation was performed using network data submitted by Tufts Health Public Plan in the *RI Together Network Access Analysis Report (*printed December 15, 2020) and in the Tufts Health Public Plan *Access Survey Report* for the October-December 2020 timeframe. IPRO's evaluation included a comparison of Tufts Health Public Plan access data to state standards for appointment availability and time and distance. Tufts Health Public Plan's access standards for PCPs is two providers in 30 minutes, and one provider is 30 minutes for OB/GYN providers

UHCCP-RI

IPRO's evaluation was performed using network data submitted by UHCCP-RI in the *Network Accessibility and Availability Adequacy Report, May 2021* and in the UHCCP-RI's *Access Survey Report* for the July 1, 2019 – June 30, 2020, timeframe. IPRO's evaluation included a comparison of UHCCP-RI access data to state standards for appointment availability and time and distance. UHCCP-RI access standards for PCPs are one provider in five miles for large metro regions and one provider in 10 miles for metro regions. For OB/GYN providers, the access standards are one provider in 15 miles for large metro regions and one provider in 30 miles for metro regions

UHCCP-RI's goal is to have 90% of its network of primary care, high-volume, and high-impact providers meet the established distance requirements, as well as to meet provider-to-member ratios. The distance requirements and ratios differ by provider type and county designation.

Description of Data Obtained

Neighborhood

Neighborhood monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes.

Tufts Health Public Plan

Tufts Health Public Plan monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes.

Tufts Health Public Plan monitors its network's ability to provide timely routine and urgent appointments through secret shopper surveys. The data includes the number of providers surveyed, the number of appointments made and not made, the total number of appointments meeting the timeframe standards and appointment rates.

UHCCP-RI

UHCCP-RI monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes.

UHCCP-RI monitors its network's ability to provide timely routine and urgent appointments through secret shopper surveys. The data includes the number of providers surveyed, the number of appointments made and not made, the total number of appointments meeting the timeframe standards and appointment rates.

Comparative Conclusions and Findings

Neighborhood

Table 23 shows the percentage of Neighborhood members for whom the geographic access standards were met. The results of this analysis show that Neighborhood exceeded its geographic accessibility standards for all provider types reported.

Table 23: Neighborhood's GeoAccess Results, December 2020

Provider Type	Access Standard[1]	% of English Speaking Members	% of Spanish Speaking Members
Primary Care Provider (PCP)	1 in 20 miles	100.0%	99.9%
Family Medicine	1 in 20 miles	99.9%	99.9%
Internal Medicine	1 in 20 miles	99.9%	99.9%
Pediatricians	1 in 20 miles	99.9%	99.4%
Cardiology	1 in 30 miles	100.0%	99.9%
Dermatology	1 in 30 miles	100.0%	99.8%
Endocrinology	1 in 30 miles	100.0%	100.0%
Gastroenterology	1 in 30 miles	100.0%	99.7%
Pulmonary	1 in 30 miles	100.0%	99.7%
Oncologists	1 in 30 miles	100.0%	100.0%
Obstetrician/Gynecologists	1 in 30 miles	100.0%	99.8%

[1] The Access Standard is measured in travel time from a member's home to provider offices.
[2] The percentages represent the proportion of members for whom the Access Standards were met.

Table 24 displays the results of the appointment availability survey conducted by the Neighborhood in the fourth quarter of 2020. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 24: Neighborhood's Appointment Availability Results, Fourth Quarter of 2020

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Primary Care					
Routine Appointments					
Family/General Practice	10	0	0.0%	Not Applicable	Not Applicable
Pediatricians	10	2	20.0%	20.0%	9.5
Urgent Appointments					
Family/General/Internal	10	1	10.0%	10.0%	Not reported
Pediatricians	10	0	0.0%	Not Applicable	Not Applicable
Adult Specialty Care					
Routine Appointments					
Cardiology	6	1	16.67%	16.67%	27
Dermatology	6	4	66.67%	66.67%	3.75
Endocrinology	6	1	16.67%	16.67%	1
Gastroenterology	6	2	33.33%	33.33%	6.5
Pulmonary	6	2	33.33%	33.33%	4
Urgent Appointments					
Cardiology	6	1	16.67%	0.0%	2

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Dermatology	6	2	33.33%	0.0%	6
Endocrinology	6	0	0.0%	Not Applicable	Not Applicable
Gastroenterology	6	0	0.0%	Not Applicable	Not Applicable
Pulmonary	6	0	0.0%	Not Applicable	Not Applicable
Pediatric Specialty Care Routine Appointments					
Allergy/Immunology	6	3	50.0%	50.0%	4.6
Gastroenterology	6	1	16.67%	0.0%	58
Neurology	6	0	0.0%	Not Applicable	Not Applicable
Orthopedics	6	1	16.67%	16.67%	7
Otolaryngology/ENT	6	0	0.0%	Not Applicable	Not Applicable
Urgent Appointments					
Allergy/Immunology	6	1	16.67%	16.67%	1
Gastroenterology	6	0	0.0%	Not Applicable	Not Applicable
Neurology	6	1	16.67%	16.67%	1
Orthopedics	6	3	50.0%	50.0%	1
Otolaryngology/ENT	6	1	16.67%	16.67%	1
Behavioral Health Care Routine Appointments					
Adult Behavioral Health	15	2	13.33%	13.33%	3.5

Tufts Health Public Plan

In December 2020, Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.

Table 25 displays Tufts Health Public Plan's performance against the geographic access standards by provider type; while **Table 26** displays the results of the appointment availability survey conducted in the fourth quarter of 2020.

Table 25: Tufts Health Public Plan's GeoAccess Results, December 2020

Provider Type	Access Standard[1]	% of Members with Access
Pediatrics	2 PCPs Within 30 Minutes	100%
Internal Medicine	2 PCPs Within 30 Minutes	100%
Family Practice	2 PCPs Within 30 Minutes	100%
OB/GYN	1 Provider Within 30 Minutes	100%
Licensed Clinical Social Worker	1 Provider Within 30 Minutes	100%
Licensed Medical Health Center	1 Provider Within 30 Minutes	100%
Cardiology	1 Provider Within 30 Minutes	100%
Ophthalmology	1 Provider Within 30 Minutes	97.8%
Orthopedics	1 Provider Within 30 Minutes	100%
Otolaryngology	1 Provider Within 30 Minutes	100%
Dermatology	1 Provider Within 30 Minutes	100%
Gastroenterology	1 Provider Within 30 Minutes	100%
Endocrinology	1 Provider Within 30 Minutes	98.3%
Oncology	1 Provider Within 30 Minutes	100%

Provider Type	Access Standard[1]	% of Members with Access
Pulmonology	1 Provider Within 30 Minutes	100%
Surgery	1 Provider Within 30 Minutes	100%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 26: Tufts Health Public Plan's Appointment Availability Results, Fourth Quarter of 2020

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Primary Care					
Routine Appointments					
Family/General Practice	6	3	50.0%	50.0%	19
Pediatricians	10	1	10.0%	10.00%	15
Urgent Appointments					
Family/General Practice	37	14	37.8%	5.4%	31
Pediatricians	21	5	23.8%	14.3%	5
Adult Specialty Care					
Routine Appointments					
Cardiology	1	0	0%	0%	Not Applicable
Dermatology	1	0	0%	0%	Not Applicable
Endocrinology	1	1	100%	100%	25
Pulmonary	2	2	100%	0%	49
Urgent Appointments					
Cardiology	2	0	0%	0%	Not Applicable
Dermatology	2	1	50.0%	0%	69
Endocrinology	1	0	0%	0%	Not Applicable
Gastroenterology	2	0	0%	0%	Not Applicable
Pulmonary	2	1	50.0%	0%	168
Pediatric Specialty Care					
Routine Appointments					
Allergy/Immunology	1	1	100%	100%	7
Gastroenterology	1	1	100%	100%	Not Provided
Neurology	3	0	0%	0%	Not Applicable
Orthopedics	3	0	0%	0%	Not Applicable
Urgent Appointments					
Neurology	1	1	100%	0%	131
Behavioral Health Care					
Routine Appointments					
Adult Behavioral Health	4	1	25.0%	0%	63

UHCCP-RI

Table 27 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that UHCCP-RI met its geographic accessibility standards for all provider types reported.

Table 27: UHCCP-RI's GeoAccess Results, July 2019-June 2020

Provider Type	Access Standard[1]	% of Members With Access
Large Metro		
Family/General Practice	1 in 5 Miles	99%
Internal Medicine	1 in 5 Miles	100%
Pediatrics	1 in 5 Miles	99%
Total Adult PCP	1 in 5 Miles	100%
Cardiology High Volume, High Impact Specialist	1 in 10 Miles	99%
Orthopedics High Volume	1 in 10 Miles	98%
Oncology High Impact Specialist	1 in 10 Miles	98%
OB/GYN High Volume Specialist	1 in 15 Miles	100%
Metro		
Family/General Practice	1 in 10 Miles	100%
Internal Medicine	1 in 10 Miles	100%
Pediatrics	1 in 10 Miles	99%
Total Adult PCP	1 in 10 Miles	100%
Cardiology High Volume, High Impact Specialist	1 in 20 Miles	100%
Orthopedics High Volume	1 in 20 Miles	100%
Oncology High Impact Specialist	1 in 30 Miles	100%
OB/GYN High Volume Specialist	1 in 30 Miles	100%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 28 displays the results of the appointment availability survey conducted in the fourth quarter of 2020. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 28: UHCCP-RI's Appointment Availability Results, Fourth Quarter of 2020

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Primary Care					
Urgent Appointments					
Family/General/Internal	47	18	38.30%	0%	Not Reported
Pediatricians	10	5	50.00%	0.6%	3
Adult Specialty Care					
Urgent Appointments					
Cardiology	2	0	0.0%	Not Applicable	Not Applicable
Dermatology	2	1	50.00%	0.0%	6
Endocrinology	1	0	0.0%	Not Applicable	Not Applicable
Gastroenterology	1	0	0.0%	Not Applicable	Not Applicable
Pulmonary	1	0	0.0%	Not Applicable	Not Applicable
Pediatric Specialty Care					
Urgent Appointments					
Allergy/Immunology	2	2	100.0%	0.0%	Not Reported
Neurology	3	1	33.33%	0.0%	31
Orthopedics	3	2	66.67%	0.0%	Not Reported
Otolaryngology/ENT	1	0	0.0%	Not Applicable	Not Applicable
Behavioral Health Care					

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Routine Appointments					
Behavioral Health	1	1	100%	0.0%	Not Provided

Administration of Quality of Care Surveys – Member Experience

Objectives

The EOHHS requires contracted health plans to evaluate and report on member satisfaction annually. The MCPs utilize the CAHPS Medicaid Adult Survey to capture such data. The CAHPS survey is a standardized questionnaire that asks enrollees to report on their experiences with care and services from the MCP, the providers, and their staff.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

Each MCP independently contracted with a certified CAHPS vendor to administer the adult and child surveys for MY 2020.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey. The CAHPS Medicaid questionnaire set includes separate versions for the adult and child populations.

HEDIS specifications require that the MCPs provide a list of all eligible members for the sampling frame. Following HEDIS requirements for the adult survey, the MCP included members in the sample frame who were 18 years and older (as of December 31 of the MY) who were continuously enrolled in the plan for at least five of the last six months of the MY. Following HEDIS requirements for the child survey, the MCP included parents and guardians of members 17 years and younger (as of December 31 of the measurement year) who were continuously enrolled in the plan for at least five of the last six months of the measurement year in the sample frame.

Table 29 provides a summary of the technical methods of data collection for the adult and child surveys.

Table 29: CAHPS Technical Methods of Data Collection, MY 2020

Data Collection Elements	Neighborhood	Tufts Health Public Plan	UHCCP RI
Adult CAHPS Survey			
Survey Vendor	SPH Analytics	SPH Analytics	SPH Analytics
Survey Tool	5.1H	5.1H	5.1H
Survey Timeframe	February 2021-May 2021	5.1H	February 2021-May 2021
Method of Collection	Mail	February 2021-May 2021	Mail, Phone
Sample Size	3,375	2,700	1,620
Response Rate	17.05%	8.1%	13.1%
Child CAHPS Survey			

Data Collection Elements	Neighborhood	Tufts Health Public Plan	UHCCP RI
Survey Vendor	SPH Analytics	Not Applicable	SPH Analytics
Survey Tool	5.1H	Not Applicable	5.1H
Survey Timeframe	February 2021-May 2021	Not Applicable	February 2021-May 2021
Method of Collection	Mail	Not Applicable	Mail, Phone
Sample Size - General	1980	Not Applicable	2,310
Response Rate	13.01%	Not Applicable	7.7%

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures the scores were calculated using a 100-point scale. Responses were classified into response categories. **Table 30** displays these categories and the measures which these response categories are used.

Table 30: CAHPS Response Categories, MY 2020

Measures	Response Categories
Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist	0 to 4 (Dissatisfied) 5 to 7 (Neutral) 8 to 10 (Satisfied)
Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures and items; and the Coordination of Care individual item measure	Never (Dissatisfied) Sometimes (Neutral) Usually/Always (Satisfied)

To assess MCP performance, IPRO compared MCP scores to national Medicaid performance reported in the *2021 Quality Compass* (MY 2020) for all lines of business that reported MY 2020 CAHPS data to NCQA.

Description of Data Obtained

IPRO received a copy of the final MY 2020 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCP-level results and analyses.

Comparative Conclusions and Findings

All three MCPs administered the adult Medicaid CAHPS survey for MY 2020, while only two administered the child Medicaid CAHPS survey. **Table 31** displays the results of the MY adult Medicaid CAHPS survey and the MY 2020 national Medicaid for each measure. **Table 32** displays the results of the MY child Medicaid CAHPS survey and the MY 2020 national Medicaid mean for each measure.

Table 31: Adult Member CAHPS Results, MY 2020

Measures	Neighborhood 2021 CAHPS MY 2020	Tufts Health Public Plan 2021 CAHPS MY 2020	UHCCP RI 2021 CAHPS MY 2020	*2021 Quality Compass* (MY 2020) National Medicaid Mean
Rating of Health Plan[1]	90.15%	72.1%	80.6%	78.32%
Rating of All Health Care	82.10%	76.0%	78.6%	77.63%
Rating of Personal Doctor[1]	83.19%	82.3%	82.4%	83.23%
Rating of Specialist[1]	88.36%	80.6%	SS	83.56%
Getting Care Quickly[2]	85.93%	81.2%	82.0%	81.83%
Getting Needed Care[2]	88.14%	77.3%	81.4%	83.58%
Customer Service[2]	89.17%	87.2%	SS	88.94%
How Well Doctors Communicate[2]	92.00%	92.9%	90.6%	92.17%
Coordination of Care[2]	84.32%	82.7%	SS	No Benchmark

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").
[2] Rates reflect responses of "always" or "usually."
SS: Small sample.

Table 32: Neighborhood's Child General Population CAHPS Results, MY 2018-MY 2020

Measures	Neighborhood 2021 CAHPS MY 2020	UHCCP RI 2021 CAHPS MY 2020	*2021 Quality Compass* (MY 2020) National Medicaid Mean
Rating of Health Plan[1]	92.53%	92.4%	86.63%
Rating of All Health Care	84.5%	88.4%	88.91%
Rating of Personal Doctor[1]	90.22%	95.1%	90.53%
Rating of Specialist[1]	SS	97.5%	87.42%
Getting Care Quickly[2]	SS	SS	86.90%
Getting Needed Care[2]	SS	SS	85.65%
Customer Service[2]	SS	SS	88.32%
How Well Doctors Communicate[2]	91.97%	95.6%	94.36%

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").
[2] Rates reflect responses of "always" or "usually."
SS: Small sample.

Administration of Quality of Care Surveys – Provider Satisfaction Survey

Objectives

The EOHHS requires contracted health plans to evaluate and report on provider satisfaction annually. Neighborhood utilizes the annual provider satisfaction survey to capture such data.

The overall objective of the provider satisfaction survey study is to assess and identify opportunities to improve providers' experience with health plan services and operations, with the goal of influencing members' care experience.

Technical Methods of Data Collection and Analysis

Neighborhood

Neighborhood collaborated with the survey vendor SPH Analytics to conduct the MY 2020 provider satisfaction survey. The 50-question 2020 survey instrument is similar to the 2019 instrument, with one exception: the likelihood to recommend survey measure was updated from a binary yes/no choice to a 0-10 Net Promoter Score.

SPH Analytics followed a mail and Internet with phone follow-up survey methodology to administer the provider satisfaction survey from October to December of 2020. The timing of the survey was shifted from spring 2020 to the fourth quarter of 2020 in an effort to lessen the administrative burden on provider offices during the initial surge of the COVID-19 pandemic. Sampling methodology was similar to that of prior years.

A total of 900 PCPs and specialists having a visit with at least 100 or more unique members between March and September 2019 were surveyed. A total of 108 surveys were completed (55 mail, 34 Internet, and 19 phone), yielding a response rate of 13.0%, significantly lower than the 2019 response rate of 23.4%.

Where possible, Neighborhood results are compared to the SPH Analytics 2019 Medicaid Book of Business benchmarks which consists of data from 106 Medicaid health plans representing 30,348 respondents.

Tufts Health Public Plan

Due to the COVID-19 pandemic, three waves of mailings were sent to 608 PCPs and 3,611 specialists on July 20, August 9, and September 7, of 2020. PCPs and specialists who had at least one claim for a RITogether member were eligible for participation in the survey. A total of 196 surveys were completed, resulting in a response rate of 4.6%

UHCCP-RI

The provider satisfaction survey is conducted annually with a 10-point Likert scale with ten being the most favorable and zero being the least favorable.

For MY 2020, providers were mailed the initial survey and given the option to complete the survey by mail or internet. The survey was fielded to 1,700 practices with 34 respondents for a response rate of 2.00%.

General year over year improvement across plans is expected for the top-box (6-10) results. UHCCP-RI's results are trended and compared to the UnitedHealthcare national data.

Description of Data Obtained

Neighborhood

IPRO received a copy of the final study report produced by SPH Analytics for Neighborhood and utilized the reported results to evaluate the administration of the 2020 provider satisfaction survey. The report included detailed descriptions of the survey objectives, methodology, and results.

Tufts Health Public Plan

IPRO received a copy of the final study report produced by Tufts Health Plan Market Research The report summarized the survey objectives and scope, methodology, measures and rates, and key findings.

UHCCP-RI

IPRO received a copy of the 2020 Provider Satisfaction Summary. This document presented the metrics evaluated and performance rates at the state and national levels.

Comparative Conclusions and Findings

Neighborhood

The MY 2020 provider survey results for all the reported rates showed an increase in comparison to the rates reported in MY 2019. Neighborhood's rate for the provider satisfaction measure *Overall Satisfaction* for MY 2020 was 73% which demonstrated a 21-percentage point increase in comparison to MY 2019. **Table 33** displays the survey questions and results for MY 2019 and MY 2020.

Table 33: Provider Satisfaction Performance Summary, MY 2019 and MY 2020

Measures	Summary Rate Definition	Neighborhood Summary Rate MY 2019	Neighborhood Summary Rate MY 2020	2019 SPHA Medicaid Book of Business Summary Rate
Overall Satisfaction[1]	Well / Somewhat Above Average	52%	73%	68%
Finance Issues		19%	32%	30%
Utilization and Quality management		25%	38%	32%
Network/Coordination of Care		21%	28%	29%
Pharmacy		11%	24%	23%
Health Plan Call Center Staff[2]		35%	51%	37%
Provider Relations		16%	24%	35%

[1] Proportions represent percentage Completely or Somewhat Satisfied.

Tufts Health Public Plan

Tufts Health Public Plan's MY 2020 score for the *Overall Satisfaction with Tufts Health Public Plan* measure was statistically significantly higher than the MY 2019 score. **Table 34** and **Table 35** display MY 2019 and MY 2020 survey results.

Table 34: Provider Satisfaction Survey Summary, MY 2019 and MY 2020

Measures	Tufts Health Public Plan Summary Rate MY 2019	Tufts Health Public Plan Summary Rate MY 2020
Overall Satisfaction[1]	61.1%	75.6% ▲
Collaboration[2]	69.2%	74.4%
Collaboration in a Crisis[2]		78.4%

[1] Proportions represent percentage of providers that are Completely/Very/Somewhat Satisfied

[2] Proportions represent percentage of providers that Agree/Agree Strongly

Table 35: Provider Satisfaction Survey Individual Attribute Scores, MY 2019 and MY 2020

Measures	Tufts Health Public Plan Summary Rate MY 2019	Tufts Health Public Plan Summary Rate MY 2020
Provider Communication, Education and Support		
Tufts Health Public Plan informs providers about new/revised plan policies and procedures[1]	80.0%	81.8%
Tufts Health Public Plan provided clear comm. re: policy procedure changes due to COVID-19[1]		74.7%
Tufts Health Public Plan provided timely comm. re: policy/procedure changes due to COVID-19[1]		74.2%
I understand Tufts Health Public Plan's payment policies[1]	67.5%	75.2%
I understand the Tufts Health Public Plan product[1]	70.0%	71.9%
Utilization Management Programs		
Tufts Health Public Plan's medical necessity guidelines make it easy for me/my staff to determine which procedures require priori authorization[1]		78.6%
It is easy to locate Tufts Health Public Plan's medical necessity guidelines on the website		78.3%
Financial Reimbursement		
Tufts Health Public Plan's contract arrangement has had a positive impact on my practice[1]	60.0%	68.5%
Provider Payment Dispute Process		
The payment dispute process is conducted in a fair and complete manner[1]	70.8%	74.3%
The payment dispute process is conducted in a timely manner[1]	68.8%	69.8%
It is easy to access information regarding the payment dispute process[1]	65.5%	60.9%
Member Education		
It is easy to determine which plan members are on by looking at the member's identification card[1]	72.3%	82.6%
Tufts Health Public Plan provides me with useful tools/information to assist me when patients ask questions[1]	60.7%	69.7%
Information/Technology		
Tufts Health Public Provider Connect is easy to navigate[1]		86.2%
Tufts Health Public Plan's technology options make transactions more efficient for my practice[1]	77.1%	83.1%
Overall, Tufts Health Public Plan's website provides useful information for my practice[1]	85.7%	79.4%
I often use Tufts Health Public Provider Connect to complete administrative tasks[1]	68.2%	73.3%

[1] Percentage of providers that agree or strongly agree with individual statements

▲ Indicates statistically significant improvement from previous year at the 95% confidence level.

UHCCP-RI

Table 36 displays the provider survey metrics and results for MY 2020. Two of the 12 metrics presented performed above the UnitedHealthcare national performance rates.

Table 36: Provider Satisfaction Survey Results, MY 2020

Metrics	UHCCP RI MY 2020	UnitedHealthcare National MY 2020
Ease of Credentialing	28%	38%
Ease of Contracting	21%	36%
Quality of the Network	48%	44%
Availability of Specialists to Accommodate Referrals	41%	43%
Quality of Incentive-Based Programs	11%	28%
Accuracy of Claims Processing on First Submission	17%	34%
Ease of Appeals	39%	26%
Ease of Accessing Information	19%	33%
Timeliness of Information Provided by Primary Care Physicians	38%	42%
Overall Satisfaction With UHC	12%	39%
Easy to Get Answers to Questions	15%	33%
Policies are Aligned with the Latest Evidence Based Best Practices	16%	32%

VIII. NCQA Accreditation

Objectives

NCQA's Health Plan Accreditation program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals.

Technical Methods of Data Collection and Analysis

The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

Beginning with Health Plan Accreditation 2020 and the 2020 HEDIS reporting year, the Health Plan Ratings and Accreditation were aligned to improve consistency between the two activities and to simplify the scoring methodology for Accreditation. An aggregate summary of MCP performance on these two activities in summarized in the NCQA Health Plan Report Cards.

To earn NCQA Accreditation, each MCP must meet at last 80% of applicable points in each standards category, submit HEDIS and CAHPS during the reporting year after the first full year of Accreditation, and submit HEDIS and CAHPS annually thereafter. The standards categories include quality management, population health management, network management, utilization management, credentialing and recredentialing, and member experience.

To earn points in each standards category, MCPs are evaluated on the factors satisfied in each applicable element and earn designation of 'met,' partially met' or 'not met' for each element. Elements are worth one or two points and are award to the based on the following:

- Met = Earns all applicable points (either 1 or 2 points)
- Partially Met = Earns half of applicable points (either 0.5 or 1 point)
- Not Met = Earns no points (0 points)

Within each standards category, the total number of points is added. MCPs achieve one of three accreditation levels based on how they score on each standards category. **Table 37** displays the accreditation determination levels and points needed to achieve each level.

Table 37: NCQA Accreditation Levels and Points

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with Provisional Status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55%^ of applicable points

To distinguish quality among the accredited MCPs, NCQA calculates an "overall rating" for each MCP as part of its *Health Plan Ratings* program. The "overall rating" is the weighted average of a MCP's HEDIS and CAHPS measure

ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

Overall ratings are recalculated annually and presented in the *Health Plan Ratings* that is released every September. However, in response to COVID-19's impact to health plans and the changes to HEDIS and CAHPS for MY 2019, NCQA did not calculate the *Health Plan Ratings 2020*.

The *Health Insurance Plan Ratings 2021* methodology used to calculate an "overall rating" is based on MCP performance on dozens of measures of care and is calculated on a 0–5 scale in half points, with five being the highest. Performance includes these three subcategories (also scored 0–5 in half points):

1. Patient Experience: Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).
2. Rates for Clinical Measures: The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. NCQA Health Plan Accreditation: For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounded to the nearest half point and displayed as stars. A plan with an Interim status receives 0.15 bonus points added to the overall rating before rounded to the nearest half point and displayed as stars.

The rating scale and definitions for each are displayed in **Table 38**.

Table 38: NCQA Health Plan Star Rating Scale

Ratings	Rating Definition
5	The top 10% of health plans, which are also statistically different from the mean.
4	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean.
3	The middle one-third of health plans and health plans that are not statistically different from the mean.
2	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean.
1	The bottom 10% of health plans, which are also statistically different from the mean.

For 2021 only, NCQA implemented a special "Overall Rating Policy" for NCQA-accredited plans. The *Health Plan Ratings 2021* displays the better of the overall rating score between the *Health Plan Ratings 2019* and *Health Plan Ratings 2021*, for plans with accredited, provisional, and interim status as of June 30, 2021. Individual measures, sub composites and composites continued to be scored and displayed using *Health Plan Rating 2021* performance (i.e., MY 2020 data) for all plans.

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website to review the *Health Plan Report Cards 2021* for Neighborhood. For each MCP, star ratings, accreditation status, plan type and distinctions were displayed. At the MCP-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall. The data presented here was as of June 30, 2021.

Comparative Conclusions and Findings

All MCPs ere compliant with the state's requirement to achieve and maintain NCQA Accreditation.

Table 39 displays each MCP's overall health plan star ratings, as well as the ratings for the three overarching categories (patient experience, prevention, and treatment) and their subcategories under review.

Table 39: MCP NCQA Rating by Category, 2020

Performance Measure/Area	Neighborhood's Rating	Tufts Health Public Plan's Rating	UHCP RI's Rating
Overall Rating (Highest Possible Star Rating is 5 Stars)	**4.5 stars**	**Partial Data Reported, No Overall Rating**	**4.5 Stars**
Patient Experience	3.5 stars	**Insufficient Data**	**Insufficient Data**
Getting Care	4 stars	No Credit	Insufficient Data
Satisfaction with Plan Physicians	3.5 stars	No Credit	4 Stars
Satisfaction with Plan Services	5 stars	No Credit	4 Stars
Prevention	5 stars	**Insufficient Data**	**4.5 Stars**
Children and Adolescent Well Care	5 stars	No Credit	4.5 Stars
Women's Reproductive Health	5 stars	No Credit	4.5 Stars
Cancer Screening	4.5 stars	No Credit	4 Stars
Other Preventive Services		No Credit	4 Stars
Treatment	4 stars	**Insufficient Data**	**3.5 Stars**
Asthma	5 stars	No Credit	2 Stars
Diabetes	4 stars	No Credit	3.5 Stars
Heart Disease	2 stars	No Credit	4 Stars
Mental and Behavioral Health	4.5 stars	No Credit	3.5 Stars

Note: Getting Need Care includes two measures; Satisfaction with Plan Physicians includes four measures; Satisfaction with Plan Services includes one measure; Children and Adolescent Well-Care includes four measures; Women's Reproductive Health includes two measures; Cancer Screening includes two measures; Other Preventive Services includes two measures; Asthma includes one measure; Diabetes includes five measures; Heart Disease includes five measures; and Mental and Behavioral Health includes 10 measures; and Other Treatment Measures which is not included in the table includes nine measures.

IX. MCP Responses to the 2019 EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO. PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 40** displays the assessment categories used by IPRO to describe MCP progress towards addressing the to the 2019 EQR recommendations. Respectively, **Table 41**, **Table 42** and **Table 43** display's Neighborhood's, Tufts Health Public Plan's and UHCCP-RI's progress related to the *Annual External Quality Review Technical Report, Reporting Year 2019*, as well as IPRO's assessment of Neighborhood's response.

Table 40: MCP Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
MCP's quality improvement response resulted in demonstrated improvement.
Partially Addressed
MCP's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
MCP's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Table 41: IPRO's Assessment of Neighborhood's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCP Response
To improve timeliness and access, Neighborhood should continue monitoring the access and availability of routine and urgent care appointments. In 2019, all provider types surveyed had an appointment rate at or below 50%, Neighborhood should re-educate network providers of appointment standards and request providers submit a plan of correction should standards continue to not be met.	Partially Addressed
The QIPs were comprised of multi-faceted intervention strategies that targeted members, providers, and Health Plan systems and processes. Opportunities for improvement remain for all of the QIPs, as the Health Plan did not achieve the established project goals for some of the indicators. Neighborhood should continuously monitor the effectiveness of the interventions implemented for the QIPs. Many of the interventions are passive in nature (i.e., automated messaging, newsletters, etc.). The Health Plan should consider developing and initiating more active interventions. The Health Plan should also include additional provider focused interventions.	Addressed

Table 42: IPRO's Assessment of Tufts Health Public Plan's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCP Response
Tufts Health Public Plan should focus on improving health outcomes of its Medicaid membership by improving the quality of care members have access to and promoting member accountability for the status of their health.	Partially Addressed
Tufts Health Public Plan should continue to monitor its provider network and address inadequacies related to the quality and size of the network. Tufts Health Public Plan should re-educate network providers of appointment standards and request plans of correction should standards continue to not be met.	Partially Addressed
Tufts Health Public Plan should continue the QIP aiming to decrease attrition by improving member experience, the quality improvement strategy should be updated to address the issues members experience, or perceive, when attempting to access care.	Partially Addressed

Table 43: UHCCP-RI's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCP Response
As UHCCP-RI demonstrated improvement in the Living with Illness domain of the NCQA Accreditation survey, UHCCP-RI should continue with the improvement strategy described in the Health Plan's response to the previous year's recommendation. The Health Plan should continue to include strategies that target the Getting Better domain. *(repeat recommendation)*	Addressed
To improve timeliness and access, UHCCP-RI should continue monitoring the access and availability of routine and urgent care appointments. With 10 of the 26 provider types surveyed having an appointment rate at or below 50%, UHCCP-RI should re-educate network providers of appointment standards and request providers submit a plan of correction should standards continue to not be met.	Partially Addressed
The four contractually mandated QIPs comprised multi-faceted intervention strategies that targeted members, providers, and Health Plan systems and processes. Opportunities for improvement remain for all of the four QIPs, as the Health Plan did not achieve the established project goals.	Partially Addressed

X. Strengths, Opportunities and 2020 Recommendations Related to Quality, Timeliness and Access

MCP's strengths and opportunities for improvement identified during IPRO's EQR of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of and **access** to care are presented. These three elements are defined as:

- **Quality** is the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

The strengths and opportunities for improvement based on the MCP's 2020 performance, as well recommendations for improving **quality**, **timeliness,** and **access** to care are presented in **Table 44, Table 45** and **Table 46** for Neighborhood, Tufts Health Public Plan and UHCCP-RI, respectively. In this table, links between strengths, opportunities, and recommendations to **quality**, **timeliness** and **access** are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading). Unless otherwise noted, the benchmarks referenced in this table derive from NCQA's *Quality Compass 2021* for Medicaid (National – All Lines of Business [Excluding PPOs and EPOs]) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2020.

Table 44: Neighborhood's Strengths, Opportunities and Recommendations for Improvement, 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Neighborhood maintained NCQA accreditation in 2020.	X	X	X
QIPS – General	Six of six QIPs pass PIP validation.			
QIPS – Developmental Screening	All performance indicators exceeded the goal rate in MY 2020.	X	X	X
Performance Measures	Neighborhood met all IS and validation requirements to successfully report HEDIS data to EOHHS and NCQA.			
	Neighborhood reported MY 2020 HEDIS rates that exceeded the national MY 2020 Medicaid mean for all three Use of Services rates, six Effectiveness of Care rates and all five Access and Availability rates.	X	X	X
Compliance with Medicaid Standards	Neighborhood is fully compliant with the federal Medicaid standards.	X	X	X
Network Adequacy	Neighborhood's appointment availability for network providers met the state standard for number of days to		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	schedule an urgent pediatric care (all specialties) and behavioral health appointment.			
Quality of Care Surveys – Member Satisfaction	Six adult MY 2020 CAHPS scores exceeded the national Medicaid mean.	X		X
Quality of Care Surveys – Provider Satisfaction	Of the seven rates reported in the provider satisfaction survey, all reported rates in MY 2020 demonstrated an increase in comparison to the rates reported in MY 2019.			
Opportunities for Improvement				
QIPs	Of the six QIPS conducted by Neighborhood, five QIPs had one or more indicators that did not meet the benchmark goal.	X	X	X
Performance Measures	One of Neighborhood's MY 2020 HEDIS rates related to diabetes care did not meet the national Medicaid MY 2020 mean and performed at the 25th percentile national Medicaid mean.	X	X	X
Quality of Care Surveys – Member Satisfaction	Two adult MY 2020 CAHPS scores benchmarked below the national Medicaid 50th percentile. Three child MY 2020 CAHPS scores benchmarked below the national Medicaid 50th percentile.	X		X
Quality of Care Surveys – Provider Satisfaction	Satisfaction with provider relations was identified as an area need improvement.			
Network Adequacy	Neighborhood's reported mean number of days to an appointment for urgent adult specialty care did not meet the 24-hour standard for any specialty evaluated.		X	X
Recommendations to Neighborhood to Address Quality, Timeliness and Access				
QIPs	Neighborhood should investigate opportunities to improve the current interventions as five of the six QIPs did not achieve the goal rates. Neighborhood should continue to monitor the effectiveness of their multi-faceted intervention strategies, including member-focused, provider-focused and MCP-focused interventions.	X	X	X
Performance Measures	Neighborhood should investigate opportunities to improve the health of members with diabetes.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	Neighborhood should investigate opportunities to improve adult access to urgent care as none of the specialties reported met the 24-hour standard.		X	X
Quality of Care Surveys – Member Satisfaction	Neighborhood should evaluate the adult and child CAHPS scores to identify opportunities to improve member experience with the MCP.	X		X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Quality of Care Surveys – Provider Satisfaction	Neighborhood should monitor the effectiveness of the planned interventions outlined in the 2020 Provider Satisfaction Survey Summary and modify interventions as needed.			

Table 45: Tufts Health Public Plan's Strengths, Opportunities and Recommendations for Improvement, MY 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
QIPS	None.			
Performance Measures	Tufts Health Public Plan met all IS and validation requirements to successfully report HEDIS data to EOHHS and NCQA.			
	Tufts Health Public Plan reported MY 2020 HEDIS rates that exceeded the national MY 2020 Medicaid mean for two measures related to childhood immunizations and for two rates related to behavioral health care. One childhood immunization rate benchmarked at the national Medicaid MY 2020 75th percentile.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan was fully compliant with the federal Medicaid standards. Tufts Health Public Plan achieved NCQA Accreditation.	X	X	X
Network Adequacy	Tufts Health Public Plan's time standards for PCPs and OB/GYNs exceeds the states standards.		X	X
	Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.		X	X
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan's score for *How Well Doctors Communicate exceeded the National Medicaid Mean* and performed at 50th percentile.	X		X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan's MY 2020 score for *Provider Overall Satisfaction with Tufts Health Public Plan* was statistically significantly higher than the MY 2019 score.			
Opportunities for Improvement				
Annual Quality Strategy/Annual Evaluation	The 2020 Quality Improvement Plan did not include sufficient data to track Tufts Health Public Plan's performance towards its goals. Specifically, there were no defined indicators, performance rates, or target rates made available in the 2020 Quality Improvement Plan.	X	X	X
QIPs	Tufts Health Public Plan's conduct of QIP 1 and QIP 2 did not meet all standards related to topic selection, data collection, and interpretation of study results.	X	X	X
Performance Measures	Ten (10) of Tufts Health Public Plan's MY 2020 HEDIS rates related to child and adult access to primary care, women's preventive screenings, and prenatal and postpartum care did not meet the national Medicaid MY 2020 mean. Two rates met the 33.33rd percentile, one rate met the 25th	X	X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	percentile, and seven rates performed at or below the 10th percentile.			
Compliance with Medicaid Standards	None.			
Network Adequacy	Tufts Health Public Plan's reported mean number of days to an appointment for urgent adult and pediatric primary care did not meet the 24-hour standard for any specialty evaluated.		X	X
	Tufts Health Public Plan's reported mean number of days to an appointment for routine adult behavioral health care did not meet the 10-calendar day standard.		X	X
Quality of Care Surveys – Member Satisfaction	Seven of nine Tufts Health Public Plan CAHPS scores declined in MY 2020 from MY 2019. Of the eight measures with national Medicaid MY 2020 benchmarks, none of Tufts Health Public Plan scores for these measures achieved the 75th percentile.	X		X
Quality of Care Survey – Provider Satisfaction	The provider payment dispute process was a key area identified as needing improvement, as were communications around Tufts Health Public Plan's COVID-19 response.			
Recommendations to Tufts Health Public Plan to Address Quality, Timeliness and Access				
Annual Quality Strategy/Annual Evaluation	Consider enhancing the annual quality strategy with linking objectives to goals and goals to quantifiable indicators.	X	X	X
QIPs	To ensure future QIP methodologies are effectively designed and managed, Tufts Health Public Plan staff should complete QIP trainings, consult the CMS protocol to ensure QIPs meet all validation requirements, and fully address issues identified by the EQRO.	X	X	X
Compliance with Medicaid Standards	None.			
Performance Measures	The MCP should investigate opportunities to improve the HEDIS measures that performed below the national Medicaid mean.	X	X	X
Network Adequacy	The MCP should investigate opportunities to improve members access to urgent care, primary care, and behavioral health providers.		X	X
Quality of Care Survey – Member Satisfaction	The MCP should evaluate the adult CAHPS scores to identify opportunities to improve member experience with the MCP.	X		X

Table 46: UHCCP-RI's Strengths, Opportunities and Recommendations for Improvement, MY 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	UHCCP-RI maintained NCQA accreditation in 2020.	X	X	X
QIPs – General	Four of four QIPs pass PIP validation.			
QIPs	Of the four QIPs conducted by UHCCP-RI, the goal was met for two of these QIPs namely, *Developmental Screening in 1st, 2nd and 3rd years of life* and *Improving Effective Acute Phase Treatment for Major Depression*.	X	X	X
Performance Measures	UHCCP-RI met all IS and validation requirements to successfully report HEDIS data to EOHHS and NCQA.			
	UHCCP-RI reported MY 2020 HEDIS rates that exceeded the national MY 2020 Medicaid mean for all three Use of Services measures, six Effectiveness of Care measures and all five Access and Availability measures.	X	X	X
Compliance with Medicaid Standards	UHCCP-RI is fully compliant with the federal Medicaid standards.	X	X	X
Network Adequacy	UHCCP-RI met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.		X	X
Quality of Care Survey – Member Satisfaction	For the adult CAHPS survey, scores for the following three measures performed above the national Medicaid mean: *Rating of Health Plan*, *Rating of All Health Care* and *Getting Care Quickly*.	X	X	X
	For the child CAHPS survey, UHCCP-RI's scores performed at 95th percentile of the national Medicaid means for *Rating of Personal Doctor* and *Rating of Specialist*. UHCCP-RI's score for *Rating of Health Plan* performed at 90th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	UHCCP-RI reported two of 12 rates that performed above the UnitedHealthcare national rate.			
Opportunities for Improvement				
QIPs	UHCCP-RI did not meet its goals for *Improving Lead Screening in Children* and *Improving Breast Cancer Screening* QIPs.	X	X	X
Performance Measures	UHCCP-RI's MY 2020 rates for *Comprehensive Diabetes Care – HbA1c Testing* and *Adults' Access to Preventive/Ambulatory Health Services – 65+ Years* performed below the national Medicaid 50th percentile.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	UHCCP-RI's reported mean number of days to an appointment for urgent adult and pediatric primary care and specialty care did not meet the 24-hour standard for any specialty evaluated.		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	Appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	UHCCP-RI achieved four MY 2020 adult CAHPS score that performed below the national Medicaid 50th percentile. These measures were *Rating of Personal Doctor*, *Getting Care Quickly*, *Getting Needed Care*, and *How Well Doctors Communicate*.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI reported 10 of 12 rates that did not meet the UnitedHealthcare national rate.	X		X
Recommendations to UHCCP-RI to Address Quality, Timeliness and Access				
QIPs	Opportunities of improvement remain for two of the four QIPs, as UHCCP-RI did not achieve the established project goals for these QIPs. UHCCP-RI should continue to monitor the effectiveness of the intervention strategy, and identify opportunities to make enhancements.	X	X	X
Performance Measures	UHCCP-RI should investigate opportunities to improve the health of members with diabetes.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	UHCCP-RI should investigate opportunities to improve member access to care.		X	X
Quality of Care Surveys – Member Satisfaction	UHCCP-RI should evaluate low performing areas of the adult and child CAHPS surveys to identify opportunities to improve member perception around the quality of, timeliness of and access to care.	X		X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI should identify best practices used at other UnitedHealthcare organizations that aim to improve provider satisfaction.			

Appendix A: NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	
C.1 Data Sources.	

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):
_The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCQA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction
If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.

[ ] Once a year
[ ] Twice a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Once a week
[ ] Once a day
[ ] Continuous
[ ] Other (list and describe):
_Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007

Data Analysis Cycle.

[ ] Once a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Continuous
[ ] Other (list and describe):

C.5 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- **I.** Measure and time period covered
- **II.** Type of change
- **III.** Rationale for change
- **IV.** Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- **V.** Any introduction of bias that could affect the results

Section II: Data/Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 UM nurses" as opposed to "hired UM nurses"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

Appendix B: Rhode Island Medicaid Managed Care Quality Strategy, 2019-2022

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RHODE ISLAND
MEDICAID MANAGED CARE QUALITY STRATEGY

Rhode Island Executive Office of Health and Human Services

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July 31, 2019

Section 1: RI Medicaid Managed Care Overview

Section 1.1 Overview

For over 25 years, Rhode Island (RI) has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. Most RI Medicaid members are enrolled in managed care for at least acute care, including behavioral health services, and most children are enrolled in both a managed care organization (MCO) and in the dental Prepaid Ambulatory Health Plan (PAHP). Similar to the state's rationale for managed medical and behavioral health services, the managed dental program (RIte Smiles) was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and better manage Medicaid expenditures for oral health care.

To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, over time Rhode Island has increasingly transitioned from functioning simply as a payer of services to becoming a purchaser of medical, behavioral, and oral health delivery systems. Among other responsibilities, the contracted managed care entities (MCEs) program are charged with:

- ensuring a robust network beyond safety-net providers and inclusive of specialty providers,
- increasing appropriate preventive care and services, and
- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with three MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).[1] RI Medicaid operates a Medicaid-Medicare Plan with one of its MCOs to serve dually-eligible members in managed care. In addition, RI Medicaid contracts with one dental plan. Rhode Island does not contract with any Prepaid Inpatient Health Plans (PIHP).

RI Medicaid's Managed Care Quality Strategy is required by the Medicaid Managed Care rule, 42 CFR 438 Subpart E.[2] This strategy focuses on RI Medicaid's oversight of MCO and PAHP compliance and quality performance to monitor the quality of care provided to Medicaid and CHIP members.[3] RI Medicaid will work with CMS to ensure that the Quality Strategy meets all content requirements set forth in 42 CFR 438.340 (c)(2).

Throughout this document, the MCOs and the PAHP will be collectively referred to as Managed Care Entities (MCEs), unless otherwise noted. Demonstrating compliance with federal managed care rules, this revised Quality Strategy reflects RI Medicaid's objective to transition to a state-wide collaborative framework for quality improvement activities, including measurement development, data collection, monitoring, and evaluation.

[1] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

[2] This Quality Strategy incorporates CMS guidance from its initial "Quality Considerations for Medicaid and CHIP programs," communicated by CMS in its November 2013 State Health Official Letter and the Quality Strategy Toolkit for States.

[3] Throughout this document, reference to Medicaid managed care programs and members also includes CHIP members served under the same managed care programs and contracts.

Rhode Island contracts with IPRO, a qualified External Quality Review Organization (EQRO) to conduct external quality reviews (EQRs) of its MCEs in accordance with 42 CFR 438.354.

Section 1.2 Rhode Island Medicaid and CHIP

The Executive Office of Health and Human Services (EOHHS) is the single state agency for Rhode Island's Medicaid program and, as such, is responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State's Medicaid program, the EOHHS also serves as the CHIP State Agency under Federal and State laws and regulations.

In 2019, over 317,000 Rhode Island residents are covered by Medicaid under one of the following eligibility categories:

- Adults with incomes up to 138 percent of poverty,
- Pregnant women with household incomes up to 253 percent of poverty,
- Children with household incomes up to 261 percent of poverty, and
- Persons eligible under categories for persons who are aged, blind, or those with a disability.

After the state expanded Medicaid eligibility under the Affordable Care Act, Rhode Island's total Medicaid population increased rapidly, and its uninsured rate dropped to less than four percent. Today, Medicaid is the state's largest health care purchaser covering one out of four Rhode Islanders in a given year. The Medicaid Program constitutes the largest component of the state's annual budget, State General Revenue expenditures are expected to reach $2.9 billion in State Fiscal Year (SFY) 2018.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).[4]

Section 1.3 History of Medicaid Managed Care Programs

The State's initial Medicaid and CHIP managed care program, RIte Care, began in 1994. As shown in Table 1 below, in the 25 years since, there has been a steady increase in the managed care populations and services, including carving in behavioral health services and serving populations with more complex needs.

[4] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

Table 1 Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	RIte Care SCHIP
2000	Children in Substitute Care RIte Share
2003	Children with Special Needs RIte Smiles
2008	Rhody Health Partners
2014	Medicaid Expansion Behavioral Health carved in to managed care
2015	Accountable Entities Pilot
2016	Medicare-Medicaid Plan (MMP)
2018	MCO-Certified Accountable Entities APMs

Today, RI Medicaid and CHIP beneficiaries enrolled in managed care entities include children and families; children in substitute care;[5] children with special health care needs; aged, blind, and disabled adults; low-income adults without children; adults with dual Medicare and Medicaid coverage; and adults who need long-term services and supports (LTSS).

This increase in Medicaid managed care population and services has led RI Medicaid to progressively transition from a fee-for-service claims payer to a more active purchaser of care. Central to this transition has been the state's focus on improved access to and quality of care for Medicaid beneficiaries along with better cost control. Rhode Island Medicaid is committed to managed care as a primary vehicle for the organization and delivery of covered services to eligible Medicaid beneficiaries.

[5] Under the provisions of Rhode Island's 1115 waiver, enrollment in managed care is mandatory for each of these populations except for children in legal custody of the State Department of Children, Youth and Families referenced as Children in Substitute Care.

Section 1.4 Medicaid and CHIP Managed Care in 2019

Approximately 90 percent of Medicaid and CHIP members are enrolled in managed care entities for acute care and/or for dental services. Currently, RI Medicaid contracts with three MCOs and one managed dental health plan. These risk-based managed care contractors are paid per member per month (PMPM) capitation arrangements and include the following MCEs:

- MCOs: Rhode Island's three MCOs include: Neighborhood Health Plan of Rhode Island (Neighborhood); United Healthcare Community Plan of Rhode Island (UHC-RI), and Neighborhood Health Public Plan (Neighborhood). Neighborhood and UHC-RI began accepting Medicaid members in Rhode Island's initial managed care program in 1994. Neighborhood began accepting RI Medicaid members in July 2017. MCOs enroll Medicaid beneficiaries in the following lines of business (LOBs):
    - RIte Care Core (children and families)
    - RIte Care Substitute Care (children in substitute care)
    - RIte Care CSHCN (children with special healthcare needs)
    - Rhody Health Expansion (low-income adults without children)
    - Rhody Health Partners (aged, blind, disabled adults)
- Dental MCE: The state contracts with United Healthcare Dental to manage the RIte Smile dental benefits for children enrolled in Medicaid. Enrollment in United Healthcare Dental began in 2006 for children born on or after May 1, 2000.

For RI Medicaid beneficiaries that are determined eligible, long-term services and supports (LTSS) are offered through a variety of delivery systems. RI Medicaid programs for persons dually eligible for Medicare and/or meeting high level of care determinations, including eligibility for LTSS include:

- Medicare-Medicaid Plan (MMP) Duals: EOHHS, in partnership with CMS and Neighborhood launched an innovative program in 2016 that combined the benefits of Medicare and Medicaid into one managed care plan to improve care for some of the state's most vulnerable residents. Enrollment in MMP duals is voluntary and covered benefits include Medicare Part A, B, and D, and Medicaid Services (including LTSS for those who qualify). (Dental Care and transportation are covered out-of-plan).
- Program for All Inclusive Care for the Elderly (PACE) is a small voluntary program for qualifying eligible individuals over age 55 who require a nursing facility level of care. PACE provides managed care through direct contracts with PACE providers rather than through MCEs.

Table 2 displays MCO and PAHP enrollment in RI Medicaid managed care as of January 2019.

Table 2: Enrollment in Medicaid and CHIP Managed care as of January 2019

Managed Care Program	Members Enrolled in Program	Eligible MCEs
RIte Care Core (children and families)	157,376	Neighborhood Neighborhood UHC-RI
RIte Care Substitute Care (children in substitute care)	2,631	Neighborhood
RIte Care CSHCN (children with special healthcare needs)	6,967	Neighborhood Neighborhood UHC-RI
Rhody Health Expansion (low income adults without children)	71,456	Neighborhood Neighborhood UHC-RI
Medicare/Medicaid Plan	15,777	Neighborhood
Grand Total MCO Members	264,841	
Dental PAHP Members Rite Smiles	114,101	United Healthcare

Section 2: Guiding Principles, Goals and Objectives

Section 2.1 Medicaid Guiding Principles and Accountable Entities

Rhode Island's Medicaid managed care program is dedicated to improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life.

In 2015, Governor Gina Raimondo established the "Working Group to Reinvent Medicaid," tasked with presenting innovative recommendations to modernize the state's Medicaid program and increase efficiency. The Working Group established **four guiding principles**:

- pay for value, not volume,
- coordinate physical, behavioral, and long-term health care,
- rebalance the delivery system away from high-cost settings, and
- promote efficiency, transparency and flexibility.

Rhode Island's vision, as expressed in the Reinventing Medicaid report is for "…a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population."

In alignment with its guiding principles, RI Medicaid developed the AE program as a core part of its managed care quality strategy. AEs are Rhode Island's version of an accountable care organization. AEs represent interdisciplinary

partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. Medicaid MCOs are required to enter into Alternative Payment Model (APM) arrangements with certified AEs. As of early 2019, RI Medicaid has certified six Comprehensive AEs as part of its Health System Transformation Project (HTSP).

RI Medicaid created the AE Initiative to achieve the following goals in Medicaid managed care:[6]

1. transition Medicaid from fee for service to value-based purchasing at the provider level
2. focus on Total Cost of Care (TCOC)
3. create population-based accountability for an attributed population
4. build interdisciplinary care capacity that extends beyond traditional health care providers
5. deploy new forms of organization to create shared incentives across a common enterprise, and
6. apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

The state's MCO contracts stipulate that only Rhode Island residents who are not eligible for Medicare and are enrolled in Medicaid managed care plans are eligible to participate in the AE Program. In early 2019, qualified

[6] RI Medicaid Accountable Entity Roadmap http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/AEroadmap041117v6.pdf

APM contracts were in place between five AEs and two Medicaid MCOs. Combined, close to 150,000 RI Medicaid managed care members are attributed to an AE. These RI Medicaid members include participants in the following programs: RIte Care, Rhody Health Partners, and the Rhody Health Expansion Population. RI Medicaid contracts directly with the MCO, certifies the AEs and works closely with the dyads to improve quality as outlined in the 1115 waiver. More information on AEs is included in *Section 7: Delivery System Reform*.

Section 2.2 Quality Strategy Goals

Evolving from the state's guiding principles, RI Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022 as depicted in Table 3 below.

Table 3: Managed Care Quality Strategy Goals
1. Maintain high level managed care performance on priority clinical quality measures
2. Improve managed care performance on priority measures that still have room for improvement (i.e., are not 'topped out')
3. Improve perinatal outcomes
4. Increase coordination of services among medical, behavioral, and specialty services and providers
5. Promote effective management of chronic disease, including behavioral health and comorbid conditions
6. Analyze trends in health disparities and design interventions to promote health equity
7. Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice
8. Reduce inappropriate utilization of high-cost settings

This strategic quality framework will be used as a tool for RI Medicaid to better facilitate alignment of agency- wide initiatives that assess managed care progress to date and identify opportunities for improvement to better serve RI Medicaid and CHIP managed care populations in a cost-effective manner. Each of the eight managed care goals is aligned with one or more quality objectives outlined in **Section 1.7**

In its managed care programs, RI Medicaid employs standard measures that have relevance to Medicaid- enrolled populations. Rhode Island has a lengthy experience with performance measurement via collecting and reporting on HEDIS©[7] measures for each managed care subpopulation it serves. RI Medicaid also requires its managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS)[8] 5.0 surveys. During this quality strategy period, RI Medicaid will focus on strengthening its current MCE measurement and monitoring activities and benchmarks to continually improve performance and achieve the goals of Medicaid managed care. RI Medicaid will also implement and continually improve AE performance measurement specifications, benchmarks and incentives, consistent with the goals of the AE initiative and this Quality Strategy.

[7] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[8] CAHPS surveys are developed by the Agency for Healthcare Research and Quality (AHRQ), a government organization and administered by qualified vendors. https://www.ahrq.gov/cahps/index.html

Section 2.3 Quality Strategy Objectives

To support achievement of the Quality Strategy goals, RI Medicaid has established specific objectives as identified in Table 3 below. The state has developed objectives to focus state, MCE and other activities on interventions likely to result in progress toward the eight managed care goals. The right column of the table depicts how each objective aligns with one or more referenced managed care goals as numbered in **Section 2.2**.

Table 3: Managed Care Quality Objectives	**Aligned with Goal #**
A. Continue to work with MCEs and the EQRO to collect, analyze, compare and share clinical performance and member experience across plans and programs.	1-8
B. Work collaboratively with MCOs, AEs, OHIC and other stakeholders to strategically review and modify measures and specifications for use in Medicaid managed care quality oversight and performance incentives. Establish consequences for declines in MCE performance.	1
C. Create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.	1,2
D. Review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time.	1-5
E. Work with MCOs and AEs to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.	3, 6, 8
F. Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.	3, 4, 5, 6, 8
G. Increase communication and the provision of coordinated primary care and behavioral health services in the same setting for members attributed to AEs.	4,5,8
H. Monitor and assess MCO and AE performance on measures that reflect coordination including: follow up after hospitalization for mental health and data from the new care management report related to percentage/number of care plans shared with PCPs.	4,5,8
I. Develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.	5,8
J. Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens.	6
K. Share and aggregate data across all RI HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	6
L. Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCO CAHPs survey results with the MCAC.	7
M. Explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs.	7
N. Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.	7

Section 3: Development and Review of Quality Strategy

Section 3.1 Quality Management Structure

The EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island, with responsibility for coordinating the organization, financing, and delivery of services and supports provided through the State's Department of children, Youth and Families (DCYF), the Department of Health (DOH), the Department of Human Services (DHS) including the divisions of Elderly Affairs and Veterans Affairs, and the Department of Mental Healthcare, Developmental Disabilities and Hospitals (BHDDH). Serving as the State's Medicaid agency, EOHHS has responsibility for the State's Comprehensive 1115 Demonstration.

RI Medicaid oversees and monitors all contractual obligations of the MCEs to further enhance the goals of improving access to care, promote quality of care and improve health outcomes while containing costs. RI Medicaid also provides technical assistance to MCEs and when necessary takes corrective action to enhance the provision of high quality, cost- effective care.

Medicaid Quality functions include:

1. measurement selection and/or development,
2. data collection,
3. data analysis and validation,
4. identification of performance benchmarks,
5. presentation of measurement and analysis results, including changes over time, and
6. quality improvement activities.

The above functions are conducted at different levels including: RI Medicaid program level, the MCE level, the AE level, and the provider level, where appropriate and feasible. The cadence of each activity aligns with federal guidelines and best practices. The RI Medicaid managed care quality strategy demonstrates an increase in alignment of priorities and goals across state agencies and Medicaid MCEs. This quality strategy will continue to evolve in the next few years to increase the strategic focus and measurement linked to state objectives for managed care.

RI Medicaid conducts oversight and monitoring meetings with all managed care entities. These monthly meetings are conducted separately with each of the MCEs. Meeting agendas focus on routine and emerging items accordingly. The following content areas are addressed on at least a quarterly basis:

- managed care operations
- quality measurement, benchmarks, and improvement
- managed care financial performance
- Medicaid program integrity

RI Medicaid utilizes a collaborative approach to quality improvement activities at the State level. RI Medicaid coordinates with state partners across health and human services agencies. On a routine basis, representatives from DCYF, BHDDH, DOH join RI Medicaid in routine oversight activities to lend their expertise related to subject matter and populations served. This collaborative approach has proven to be sustainable and efficient.

As part of the 2019-2022 Quality Strategy, the 1115 Quality and Evaluation Workgroup with state partners will be crucial to monitoring various quality improvement efforts occurring within the broad array of Medicaid programming, sharing lessons learned, and discussing quality and evaluation efforts on the horizon.

In addition to managed medical care, there is also state oversight of the managed dental care provided to Medicaid managed care members. The focus of the RI Medicaid dental quality strategy continues to be on ensuring access to preventive dental services for members under age 21 and effective collaboration between state partners. Along with the RI Medicaid dental contract oversight, the DOH regulates the utilization review and quality assurance, or quality management (UR/QA) functions of all licensed Dental Plans, including Rite Smiles. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

Section 3.2 Review and Update of the Quality Strategy

RI Medicaid will conduct an annual review of the Medicaid Managed Care Quality Strategy and complete an update to its quality strategy as needed but note less frequently than every three years. As part of the review, RI Medicaid and its contracted MCEs will meet with interested parties, state partners, and consumer advisors to share annual EQRO results and other data to assess the strategy's effectiveness.

To obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final, the State put the proposed Medicaid Managed Care Quality Strategy on the March 2019 agenda of the Medical Care Advisory Committee (MCAC) for discussion. In April 2019, Rhode Island will post the final draft Medicaid Managed Care Quality Strategy on the RI EOHHS Website for 30 days for public comment. After public comments are received and reviewed, the Quality Strategy will be finalized, and copies will be forwarded to CMS Central and Regional Offices. EOHHS will post the most recent version of the Quality Strategy on its website.

In accordance with 42 CFR 438.204(b)(11), Rhode Island has defined what constitutes a "significant change" that would require revision of the Quality Strategy more frequently than every three years. Rhode Island will update its Quality Strategy whenever any of the following significant changes and/or temporal events occur:

a. a new population group is to be enrolled in Medicaid managed care;
b. a Medicaid managed care procurement takes place
c. substantive changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level, or
d. significant changes in managed care membership demographics or provider network as determined by EOHHS.

Section 3.3 Evaluating the Effectiveness of the Quality Strategy

Rhode Island engages in regular activities to assess the effectiveness of its Medicaid managed care quality strategy including:

- routine monitoring of required MCE reports and data submissions that are due to the state according to a contractually-defined reporting calendar

- collection and analysis of key performance indicators to assess MCE progress toward quality goals and targets at least annually.
- annual review of EQR reports to assess the effectiveness of managed care program in providing quality services in an accessible manner.
- annual strategy review conducted by internal stakeholders for each type ofmanaged care program: acute MCO (including AEs), managed dental, and managed LTSS/Duals.

As MCE, EQR, and other quality reports are reviewed, opportunities may be identified for additional reporting requirements to ensure RI Medicaid is meeting the mission statement assuring access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders.

Internal and external stakeholders provide input to the development of Rhode Island's Medicaid quality programs, and to the Medicaid Managed Care Quality Strategy itself. Through committees, work groups and opportunities for comment, stakeholders identify areas that merit further discussion to ensure the advancement of person-centered, integrated care and quality outcomes for Medicaid managed care members. For example, in 2019, EOHHS convened a series of stakeholder meetings with the AEs and MCOs to discuss the implementation of the AE Total Cost of Care quality measures, pay-for-performance methodology, and the outcome measures and incentive methodology to ensure measures and methodology met the intended program goals. Similarly, RI Medicaid also convened an MCO and AE workgroup to discuss further refinement of the Social Determinants of Health screening measure.

Section 4: Assessment of Managed Care

Section 4.1 State Monitoring of Managed Care Entities

To assess the health care and services furnished by Medicaid MCEs, RI Medicaid has a managed care monitoring system which addresses all aspects of the MCE program consistent with 42 CFR 438.66. For example, the state's oversight and monitoring efforts include assessing performance of each MCE to contract requirements in the following areas:

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services, including the activities of the beneficiary supportsystem.
- finance, including new medical loss ratio (MLR) reporting requirements,
- Information systems, including encounter data reporting,
- marketing,
- medical management, including utilization management and case management.
- program integrity,
- provider network management, including provider directory standards,
- availability and accessibility of services, including network adequacy standards,
- quality improvement, and
- for MMPs, areas related to the delivery of LTSS not otherwise included above and as applicable to the MMP contract.

RI uses data collected from its monitoring activities to improve the performance of its MCE programs. For example, the state MCE oversight includes reviewing:

- enrollment and disenrollment trends in each MCE and other data submitted by the RI Medicaid enrollment broker related to MCE performance
- member grievance and appeal logs,
- provider complaint and appeal logs,
- findings from RI's EQR process,
- results from enrollee and provider satisfaction surveys conducted by the State/EQRO or MCE,
- MCE performance on required quality measures,
- MCE medical management committee reports and minutes,
- the annual quality improvement plan for each MCE.
- audited financial and encounter data submitted by each MCE,
- the MLR summary reports required by 42 CFR 438.8.
- customer service performance data submitted by each MCE, and
- for the MMP contract, other data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

Section 4.2 Specific MCE Oversight Approaches Used by RI Medicaid

Rhode Island Medicaid has detailed procedures and protocols to account for the regular oversight, monitoring, and evaluation of its MCEs in the areas noted above. As part of its managed care program, RI Medicaid employs a variety of mechanisms to assess the quality and appropriateness of care furnished to all MCO and PAHP members including:

1. Contract management - All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions and oversight activities. Contracts include requirements for quality measurement, quality improvement, and reporting. Active Contract Management is a crucial tool in RI Medicaid's oversight. Routine reporting allows RI Medicaid to identify issues, trends and patterns early and efficiently to mitigate any potential concerns. Another key part of its contract management approach are monthly oversight meetings that RI Medicaid directs with each MCE. One topic that may be included in contract oversight meetings, for example, is mental health parity. The state may use this meeting as a forum to address compliance issues or questions related to the updated MCO Contract language related to mental health parity:
    - *The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Qualitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA*

policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.

2. State-level data collection and monitoring – RI Medicaid collects data to compare MCE performance to quality and access standards in the MCE contracts. At least annually, for example, Rhode Island collects HEDIS and other performance measure data from its managed care plans and compares plan performance to national benchmarks, state program performance, and prior plan performance. In addition, the state monitors MCE encounter data to assess trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

RI Medicaid's enhanced Reporting Calendar tool helps MCOs and the state better track, manage, and assess a comprehensive series of standing reports used for oversight and monitoring of the State's managed care programs. MCO reports are submitted monthly, quarterly and annually depending on the reporting cadence on a variety of topics specified by the state, such as:

- Care Management
- Compliance
- Quality Improvement Projects
- Access, secret shopper, provider panel
- Grievances and Appeals
- Financial Reports
- Informal Complaints
- Pharmacy Home

See Appendix C for an abbreviated copy of the MCO Reporting Attestation Form developed by RI Medicaid. The scheduled MCE reports allow RI Medicaid to identify emerging trends, potential barriers or unmet needs, and/or quality of care issues for managed care beneficiaries. The findings from the MCE reports are analyzed by the state and discussed with contracted health plans during monthly MCE Oversight and Monitoring meetings. During this Quality Strategy period, RI Medicaid will expand the enhanced Reporting Calendar tool to apply to the dental PAHP and to the MMP.

In addition, MCEs are required to submit information for financials, operations, and service utilization through the encounter data system. RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions.

3. Performance Incentives - Within the contract for RIte Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). MCOs can earn financial incentives for achieving specified benchmarks for measures in the following domains: utilization, access to care, prevention/screening, women's health, and chronic care management, and behavioral health. The contract for the MMP requires performance measures that are tied to withholds. The plan can earn the withhold payment by meeting benchmarks as outlined in the contract. The PAHP has one required performance measure that is calculated using a HEDIS methodology.

   To create more meaningful consequences for MCE performance in the future, RI Medicaid will develop and more actively utilize a combination of financial and non-financial incentives for contracted MCEs to meet or exceed performance expectations. To make a stronger business case for MCEs to invest in improved performance on behalf of members, RI Medicaid may amend its MCE policies and contracts to specifically require more transparency on performance and to specify financial penalties on MCEs performing below state-defined minimum benchmarks for certain key measures.

4. Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects (PIPs) annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. RI Medicaid MCOs are contractually obligated to conduct 4 PIPs annually. The dental plan has two contractually required PIP(s). The MMP is also required to perform one additional PIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required quality improvement project.

5. Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the RI Medicaid's goals and objectives. RI Medicaid contracts with an EQRO to perform an independent annual review of each Medicaid MCE. The state's EQRO is involved in reviewing the MCE quality plans as part of its broader role in performing the external quality review of each managed care entity and program.

6. Accreditation Compliance Audit- As part of the annual EQR, the EQRO conducts an annual accreditation compliance audit of contracted MCOs. The compliance review is a mandatory EQR activity and offers valuable feedback to the state and the plans. Based on NCQA rankings, RI's Medicaid health plans continue to rank in the top percentiles of Medicaid plans nationally. The state and the EQR reinforces the State's requirement that participating MCOs maintain accreditation by the NCQA. The state reviews and acts on changes in any MCO's accreditation status and has set a performance "floor" to ensure that any denial of accreditation by NCQA is considered cause for termination of the RI Medicaid MCO Contract. In addition, MCO achievement of no greater than a provisional accreditation status by NCQA requires the MCO to submit a Corrective Action Plan within 30 days of the MCO's receipt of its final report from the NCQA.

RI Medicaid conducts monthly internal staff meetings to discuss MCE attainment of performance goals and standards related to access, quality, health outcomes, member services, network capacity, medical management, program integrity, and financial status. Continuous quality improvement is at the core of RI Medicaid's managed care oversight and monitoring activities. The state conducts ongoing analysis of MCE data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance. When MCE compliance and/or performance is deemed to be below the established benchmark or contractual

requirement, RI Medicaid will impose a corrective action, provide technical assistance and will potentially impose financial penalties as necessary.

In addition to the MCE oversight and monitoring mechanisms detailed in this section, RI Medicaid may make modifications or additions to metric development and specification, performance incentives, and data and reporting requirements as necessary, e.g., as part of a contract amendment, a new procurement, or with the implementation of new managed care programs.

The remainder of Section 4 summarizes components of the RI Medicaid Managed Care Quality Strategy related to oversight of:

- appropriateness of care in managed care (Section 4.3),
- MCE performance levels and targets (Section 4.4) and
- The External Quality Review (Section 4.5).

Section 4.3 Appropriateness of Care in Managed Care

RI Medicaid's oversight of appropriateness of care for Medicaid managed care members includes a variety of state requirements and processes, including early identification and swift treatment, consideration of persons with special health care needs, cultural competency and considerations to measure and address health disparities. This section summarizes key components of the Quality Strategy related to appropriateness of care.

1. EPSDT: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Appropriateness of care begins with early identification and swift treatment. As part of its MCE oversight, RI Medicaid monitors provision of Early Periodic Screening, Diagnosis and Treatment (EPSDT) to managed care members. The *State's CMS 416: Annual EPSDT Participation Report* is produced annually. Medicaid beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or receive services in a fee-for-service delivery system. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Rhode Island uses findings from the CMS 416 Report as part of its Medicaid Quality Strategy to monitor trends over time, differences across managed care contractors, and to compare RI results to data reported by other states. RI Medicaid will share the 416 report results with the MCEs annually, discuss opportunities for improvement and modifications to existing EPSDT approaches as necessary. For example, the CMS 416 report includes but is not limited to the following measures:

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services
- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth
- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

2. Persons with Special Health Care Needs

A critical part of providing appropriate care is identify Medicaid beneficiaries with special health care needs as defined in the MCE contracts. Each MCE must have mechanisms in place to assess enrollees identified as having *special health care needs.* Rhode Island defines children with special health care needs (CSHCN) as: persons up to the age of twenty-one who are blind and/or have a disability and are eligible for Medical Assistance on the basis of SSI; children eligible under Section 1902(e) (3) of the Social Security Administration up to nineteen years of age ("Katie Beckett"); children up to the age of twenty-one receiving subsidized adoption assistance, and children in substitute care or "Foster Care". The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

For each enrollee that the managed care program deems to have special health care needs, the MCE must determine ongoing treatment and monitoring needs. In addition, for members including but not limited to enrollees with special health care needs, who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. Access to Specialists is monitored through a monthly report from the managed care entity.

For populations determined to have special healthcare needs, continuity of care and subsequent planning is crucial. As such, Medicaid MCOs are required to continue the out-of-network coverage for new enrollees for a period of up to six months, and to continue to build their provider network while offering the member a provider with comparable or greater expertise in treating the needs associated with that member's medical condition. See Appendix A for a copy of RI Medicaid's currently proposed Transition of Care (TOC) Policy. This TOC policy is being finalized simultaneously with this Quality Strategy.

3. Cultural Competency

At the time of enrollment, individuals are asked to report their race and ethnicity and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

4. Health Disparity Analysis

MCOs are required to submit their annual HEDIS submission stratified by Core RIte Care only and for All Populations, including special needs population such as Rhody Health Partners. As part of Rhode Island's External Quality Review process, analysis is completed to identify differences in rates between the Core RIte Care only group and those including All Populations. (The Health Plans utilize internal quality and analytic tools such as CAHPS which is provided in both English and Spanish as well as informal complaints to identify and monitor for potential health disparities.)

In addition, since 2014, (for CY 2013) the Health Plans have provided the following four HEDIS measures stratified by gender, language, and SSI status:

- *Controlling high blood pressure (CBP)*
- *Cervical cancer screening (CCS)*
- *Comprehensive diabetes care HbA1c Testing (CDC)*
- *Prenatal and Postpartum care: Postpartum care rate (PPC)*

With assistance from the EQRO, the state and MCOs are assessing trends in the disparities shown in these disparity-sensitive national performance measures over time. The state and MCEs are also working to design quality improvement efforts to address social determinants of health and hopefully improve health equity. As part of this Managed Care Quality Strategy, RI Medicaid will support these efforts by:

- working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens, and
- developing a statewide workgroup to resolve barriers to data-sharing and increase the sharing and
- aggregating of data across all state Health and Human Service agencies to better address determinants.

Section 4.4 MCE Performance Measures and Targets

The development of quality measures and performance targets is an essential part of an effective Medicaid program. RI Medicaid identifies performance measures specific to each managed care program or population served across different types of measurement categories. The State works with its MCEs and its EQRO to collect, analyze, and compare MCE and program performance on different types of measures and measure sets that include both clinical performance measures and member experience measures. The MCE measure sets described in this section and the MCO performance measures in **Appendix B** provide quantifiable performance driven objectives that reflect state priorities and areas of concern for the population covered.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. The RI Medicaid staff work collaboratively with MCOs, AEs, the Office of the Health Insurance Commissioner OHIC and other internal and external stakeholders to strategically review and where needed modify, measures and specifications for use in Medicaid managed care quality oversight and incentive programs.

RI Medicaid has employed use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF). Rhode Island collects and voluntarily reports on most CMS Adult and Child Core Measure Set performance measures.[9] In 2019, Rhode Island reported on 20 measures from the Adult Core Set and 17 measures from the Child Core Set, with measurement reflecting services delivered to Medicaid beneficiaries in CY2017. RI Medicaid also opts to report on some CMS Health Home core measures.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. For example, the Child and Adult Core Measure Sets inform the measures used in RI Medicaid's MCO Performance Goal Program (PGP). In addition, all applicable PGP measures are benchmarked on a national level using the Quality Compass©. Historically, the

[9] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf and https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf

MCO PGP has provided financial incentives to the health plans for performing in the 90th and 75th national Medicaid percentiles according to Quality Compass rankings.

As RI Medicaid moves forward with new performance measures, specifications and incentive approaches with its AE program, the state also intends to re-visit the MCO performance measures, specifications, and incentives used to support and reward quality improvement and excellence. Similarly, as the state prepares to re-procure its managed dental program, RI Medicaid intends to review the performance measures, expectations, and incentives for future dental plan contractors.

RI Medicaid consults with its EQRO in establishing and assessing CAHPS survey requirements and results for MCEs. All MCEs are required to conduct CAHPS 5.0 member experience surveys and report to RI Medicaid and its EQR on member satisfaction with the plan. RI Medicaid is exploring the use of additional member satisfaction surveys to assess AE performance in the future. For example, Rhode Island will explore the future use of a statewide CAHPS survey to assess consumer satisfaction with members in AEs, such as the potential use of the Clinician Group CG-CAHPS version survey for adults and children receiving primary care services from AEs.

Rhode Island Medicaid has historically relied heavily on HEDIS and NCQA to identify measures and specifications. This has proven to be a crucial component of the success of RI's MCOs as evidenced by their high NCQA rankings. However, recently there have been significant changes in RI's managed care delivery system that may require a more customized approach to at least some managed care performance measures and targets. The catalyst for this shift is inherently connected to the AE program and the future vision of RI Medicaid. With behavioral health benefits carved in and the addition of the AE program, a vast array of managed care services and providers are or will be involved in collecting and reporting on quality data in a new way. RI Medicaid is working to ensure that contracted MCEs, their AE provider partners and behavioral health network providers are equipped to adequately collect and report on quality measures. RI Medicaid has required the MCEs to support provider readiness related to quality. As part of its managed care quality strategy. RI Medicaid will continue to monitor MCE, AE, and provider progress via a variety of oversight and reporting activities.

RI Medicaid has obtained technical assistance from experts in quality to support state efforts and ensure RI Medicaid has a mechanism to track and achieve its goals. RI Medicaid now has some additional capacity to develop measures, collect data, analyze findings and enforce accountability (penalties/incentives). Over the next three years, RI Medicaid will look to include state custom measures into managed care oversight activities. The states modifications to its managed care performance measures and specifications over time will be deigned to ensure that the MCE and AE programs are capturing accurate data to reflect activities related to the state's unique approaches to achieving its quality goals.

Rhode Island Medicaid works to ensure that its performance measures tie back to the agency's goals, objectives, and mission. Measures are chosen that align with the State's commercial partners which lessens provider burden and streamlines expectations. Clinical and non-clinical measures that represent key areas of interest are chosen accordingly. Many MCO performance measures belong to the CMS Adult and Child Core Measure Sets and the measurement domains for AEs are closely aligned with the MCO measures.

To assess MCE performance and establish targets across areas of member experience, clinical performance and monitoring measures, MCE rates are compared to appropriate regional, national, or state benchmarks as available and applicable. As is currently the practice at RI Medicaid, many of these performance benchmarks will be obtained from the NCQA's Medicaid Quality Compass, from performance comparison across MCEs and, when feasible, from the state's OHIC or its all-payer claims database. Where external benchmarks are not available, EOHHS will use

baseline performance and targets established through initial or historical performance (e.g., for new or emerging measures).

Alongside efforts to create new AE performance benchmarks, targets, and quality incentives to support its delivery system reform efforts, during 2019, RI Medicaid will re-examine its MCE performance benchmarks, targets, and consider modifications to financial and non-financial MCO performance incentives. EOHHS shall also consider refinements to the measures used in the Total Cost of Care Program and Medicaid Infrastructure Incentive Program for AEs.

Section 4.5 External Quality Review

As required by 42 CFR 438.350, an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. IPRO is under contract with RI Medicaid to conduct the EQR function for the State. Rhode Island's current Medicaid managed care EQR contract with IPRO runs from January 2019 through January 2020. The contract period for this effort begins on January 1, 2019 through December 31, 2021, with the potential for up to three one-year extensions.

In accordance with 42 CFR Part 438, subpart E, the EQRO performs, at minimum, the mandatory activities of the annual EQR. RI Medicaid may ask the EQRO to perform optional activities for the annual EQR. The EQRO provide technical guidance to MCOs/PAHP on the mandatory and optional activities that provide information for the EQR. These activities will be conducted using protocols or methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352Activities- the EQRO must perform the following activities for each MCO/PAHP:

1. Performance Improvement Projects - Validation of PIPs required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months. Currently, MCOs are required to complete at least four PIPs each year. Additionally, the contract for the MMP requires at least one more PIP. The PAHP is required to complete at least two performance improvement projects each year.
2. Performance Goal Program - Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months.
3. Access -Validation of MCO and PAHP network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 438.14(b)(1) and state standards established in the respective MCE contracts as summarized in Section 5. Validation of network adequacy will include, but not be limited to a secret shopper survey of MCO and dental PAHP provider appointment availability in accordance with contractual requirements established by the state.
4. Accreditation Compliance Review - A review, conducted within the previous three-year period, to determine each MCO's and PAHP's compliance with the standards set forth in 42 CFR Part 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330. Within the contracts for Rite Care, Rhody Health Partners Rhody Health Expansion, Rhody Health Options, and Medicare Medicaid Plan the state requires the MCOs to be accredited by the National Committee for Quality Assurance as a Medicaid Managed Care organization. The PAHP is accredited by the Utilization Review Accreditation Commission (URAC).
5. Special enhancement activities as needed. In addition, the State reserves the option to direct the EQRO to conduct additional tasks to support the overall scope of this EQR work in order to have flexibility to bring on additional technical assistance and expertise in a timely manner to perform activities which require similar expertise and work functions as those described in 1 to 4 above. One example of this may be the

EQRO's future assistance in conducting a CAHPs satisfaction survey for Medicaid members attributed to an AE.

6. The EQRO is responsible for the analysis and evaluation of aggregated information on quality outcomes, timeliness of, and access to the services that a managed care entity or its contractors furnish to Medicaid enrollees. The EQRO produces an annual detailed technical report that summarizes the EQR findings on access and quality of care for MCEs including:
    - A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
    - For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.
    - An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
    - Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
    - An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
    - An evaluation of the effectiveness of the State's quality strategy and recommendations for updates
    - based on the results of the EQR.

Concurrently, each MCE is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by RI Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, each MCO must make a presentation outlining the MCO's response to the feedback and recommendations made by the EQRO to the State formally.

The EQRO presents clear and concrete conclusions and recommendations to assist each MCO, PAHP, and RI Medicaid in formulating and prioritizing interventions to improve performance and to consider when updating the State's managed care quality strategy and other planning documents. A recent EQR can be found here: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/2016AggregateEQRTechnicalReport.pdf

Each MCO and PAHP is required to respond the EQRO's recommendations and to state any improvement strategies that were implemented. The MCO and PAHP responses to previous recommendations are included in the report. Recommendations for improvement that are repeated from the prior year's report are closely monitored by the EQRO and RI Medicaid. The EQRO produces a technical report for each MCO and PAHP and one aggregate report for RI Medicaid. The aggregate report includes methodologically appropriate comparative information about all MCEs. The EQRO reviews the technical reports with the State and MCEs prior to the State's submission to CMS and posting to the State's website; however, the State or MCEs may not substantively revise the content of the final EQR technical report without evidence of error or omission.

In conjunction with the State's annual continuous quality improvement cycle, findings from the annual EQR reports are presented to RI Medicaid's Quality Improvement Committee for discussion by the State's team which oversees the MCEs. The information provided as a result of the EQR process informs the dialogue between the EQRO and

the State. Rhode Island incorporates recommendations from the EQRO into the State's oversight and administration of RIte Care, Rhody Health Partners, RIte Smiles and the Medicare-Medicaid Dual Demonstration program.

Section 5: State Standards

Section 5.1 RI Managed Care Standards

Rhode Island's Medicaid managed care contracts have been reviewed by CMS for compliance with the Medicaid managed care rule and the 2017 version of the *"State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval."*[10] The State is concurrently amending its dental plan contract to clarify the contractor's requirement to specifically comply with all applicable PAHP requirements in 42 CFR 438 per CMS feedback. RI Medicaid is also preparing to make additional changes to its managed dental program when it re- procures its dental contract prior to July 2020. The state seeks to contract with two qualified, statewide Medicaid dental plans by mid-2020.

All RI Medicaid MCEs are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.68 and 42 CFR 438.206-438.210.

For example, in accordance with the standards in 42 CFR 438.206 RI Medicaid ensures that services covered under MCE contracts are accessible and available to enrollees in a timely manner. Each plan must maintain and monitor a network of appropriate providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the MCE contract. The RI Medicaid MCE contracts require plans to monitor access and availability standards of the provider network to determine compliance with state standards and take corrective action if there is a failure to comply by a network provider(s).

Section 5.2 MCO Standards

In the contracts for RIte Care, Rhody Health and Partners Rhody Health Expansion the state has specified time and distance standards for adult and pediatric primary care, obstetrics and gynecology, adult and pediatric behavioral health (mental health and substance use disorder), adult and pediatric specialists, hospitals, and pharmacies.

[10] https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

Table 4 below includes time and distance standards for contracted Medicaid MCOs:

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	**Time and Distance Standard Provider office is located within the lesser of**
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

The RI Medicaid MCO contract, (Section 2.09.04 Appointment Availability) also includes the following state standards. The contracted MCOs agree to make services available to Medicaid members as set forth below:

Table 5: MCO Timeliness of Care Standards	
Appointment	**Access Standard**
After Hours Care Telephone	**24 hours 7 days a week**

Table 5: MCO Timeliness of Care Standards	
Appointment	**Access Standard**
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	30 calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 10 calendar days

Among other federal and state requirements, MCE contract provisions related to availability of services require RI Medicaid MCEs to:

- offer an appropriate range of preventive, primary care, and specialty services,
- maintain network sufficient in number, mix, and geographic distribution to meet the needs of enrollees,
- require that network providers offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to Medicaid fee-for-service patients if the provider does not see commercial patients,
- ensure female enrollees have direct access to a women's health specialist,
- provide for a second opinion from a qualified health care professional,
- adequately and timely cover services not available in network,
- provide the state and CMS with assurances of adequate capacity and services as well as assurances and documentation of capacity to serve expected enrollment,
- have evidence-based clinical practice guidelines in accordance with 42 CFR §438.236, and
- comply with requests for data from the EOHHS' EQRO.

Section 5.3 MMP Standards

In the contracts for Rhody Health Options and Medicare Medicaid Plan the state has specified time and distance standards for long-term services and supports.

MMP standards are included in the RI Medicaid MCO contract with Neighborhood and are specific to members who are dually eligible for Medicare and Medicaid and enrolled in this managed care plan. Network requirements, including network adequacy and availability of services under the State's MMP contract are similar to those for managed medical and behavioral health care but also take into account Medicare managed care standards and related federal requirements for plans serving dual-eligibles. Although methods and tools may vary, each long-term service and supports (LTSS) delivery model is expected to ensure that, for example:

- an individual residing in the community who has a level of care of "high" or "highest" will have, at a minimum, a comprehensive annual assessment,
- an individual residing in the community who has a level of care of "high" or "highest" will have, at a minimum, an annual person-centered care/service plan,
- Covered services provided to the individual is based on the assessment and service plan,
- providers maintain required licensure and certification standards,

- training is provided in accordance with state requirements,
- a critical incident management system is instituted to ensure critical incidents are investigated and substantiated and recommendations to protect health and welfare are acted upon, and
- providers will provide monitoring, oversight and face-to-face visitation per program standards.

Section 5.4 Dental PAHP Standards

In the Medicaid managed dental contract, Rhode Island has specified time and distance standards for pediatric dental. RI Medicaid network adequacy and availability of service requirements under the State's managed dental care contract are broadly similar to those for managed medical and care but focused on covered dental services for Medicaid enrollees under age 21. The Dental Plan is contractually required to establish and maintain a geographically accessible statewide network of general and specialty dentists in numbers sufficient to meet specified accessibility standards for its membership. The Dental Plan is also required to contract with all FQHCs providing dental services, as well as with both hospital dental clinics in Rhode Island, and State-approved mobile dental providers.

For example, the Dental PAHP is required to make available dental services for Rite Smiles members within forty-eight (48) hours for urgent dental conditions. The Dental Plan also is required to make available to every member a dental provider, whose office is located within twenty (20) minutes or less driving distance from the member's home. Members may, at their discretion, select a dental provider located farther from their homes. The Dental plan is required to make services available within forty-eight (48) hours for treatment of an Urgent Dental Conditions and to make services available within sixty (60) days for treatment of a non-emergent, non- urgent dental problem, including preventive dental care. The Dental Plan is also required to make dental services available to new members within sixty (60) days of enrollment.

Section 6: Improvement and Interventions

Section 6.1 Improvement and Interventions

Improvement strategies described throughout this RI Medicaid Quality Strategy document are designed to advance the quality of care delivered by MCEs through ongoing measurement and intervention. To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related the vision and mission, RI Medicaid engages in multiple interventions. These interventions are based on the results of its MCE assessment activities and focus on the managed care goals and objectives described in Section 2.

RI Medicaid's ongoing and expanded interventions for managed care quality and performance improvement include:

1. Ongoing requirements for MCEs to be nationally accredited

RI Medicaid MCOs will continue to be required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status. As NCQA increases and modifies its Medicaid health plan requirements over time based on best practices nationally, the standards for RI Medicaid plans are also updated. Loss of NCQA accreditation, or a change to provisional accreditation status will continue to trigger a corrective action plan requirement for RI Medicaid plans and may result in the state terminating an MCO contract. As previously noted, the dental PAHP is accredited by URAC which similarly offers ongoing and updated dental plan utilization review requirements over time. In addition, RI Medicaid uses its EQRO to conduct accreditation reviews of its MCE plans.

During its upcoming re-procurement of the managed dental contract, RI Medicaid will explore modifications to its existing plan accreditation requirements, as well as modifications to contract language related to consequences for loss of sufficient accreditation for its dental plans.

2. Tracking participation in APMs related to value-based purchasing (pay for value notvolume)

Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including:

a. Alternate Payment Methodology (APM) Data Report
b. Value Based Payment Report and
c. Accountable Entity-specific reports.

RI Medicaid will review these reports internally and with contracted MCEs and AEs to determine how the progress to date aligns with the goals and objectives identified in this Medicaid managed care Quality Strategy. This APM data and analysis will also inform future state, MCE, AE and work group interventions and quality improvement efforts.

3. Pay for Performance Incentives for MCEs and AEs

As noted in the Managed Care Quality Strategy Objectives in Section 2, RI Medicaid intends create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.

In addition, as part of this Quality Strategy, RI Medicaid will review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time. RI Medicaid will also consider modifications to AE measures and incentives over time based on results of its MCO and AE assessments and its managed care goals and objectives.

Finally, as part of its upcoming managed dental procurement, RI Medicaid intends to both strengthen its model contract requirements related to dental performance, transparency of performance, and consider the use of new or modified financial and/or non-financial performance incentives for its managed dental plans in the future.

4. Statewide collaboratives and workgroups that focus on quality of care

RI Medicaid will continue to work with MCEs and the EQRO to collect, analyze, compare and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement. EOHHS convenes various collaborative workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to the development of improvement projects and program services. Examples of these workgroups include:

- Accountable Entity Advisory Committee
- Behavioral Health Workgroup for Children
- Behavioral Health Workgroup for Adults
- 1115 waiver Demonstration Quality Workgroup
- Integrated Care Initiative Implementation Council
- Governor's Overdose Taskforce
- Long-term Care Coordinated Council

During the period of this Quality Strategy, RI Medicaid will consider how the work of these groups can better align with and support the goals and objectives identified in this Medicaid managed care Quality Strategy. In addition, as noted in **Section 2,** the State will develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.

5. Soliciting member feedback through a variety of forums and mechanisms: empowering members in their care

As previously noted, MCEs and the EQRO are involved in administering and assessing performance and satisfaction surveys sent to Medicaid managed care participants and/or their representatives. RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement. In addition, as part of its managed care objectives, RI Medicaid will explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs. RI Medicaid is also considering the use of managed care focus groups to better identify improvement opportunities and develop measures and strategies to ensure better outcomes that matter to members.

Section 6.2 Intermediate Sanctions

Rhode Island's Medicaid MCO Contracts clearly define intermediate sanctions, as specified in CFR 438.702 and 438.704, which EOHHS will impose if it makes any of the following determinations or findings against an MCO from onsite surveys, enrollee or other complaints, financial status or any other source:

1. EOHHS determines that a Medicaid MCO acts or fails to act as follows:
   a. Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of discrimination.
   b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater.
   c. Acts to discriminate among enrollees on the basis of their health status or need for health care services; the limit is $15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice, subject to an overall limit of $100,000.
   d. Misrepresents or falsifies information that it furnishes to CMS or to EOHHS; EOHHS may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation.
   e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation.
   f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in CFR 422.208 and 422.210 EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.
   g. EOHHS determines whether the Contractor has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by EOHHS or that contain false or materially misleading information. EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.

h. EOHHS determines whether Contractor has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

In addition to any civil monetary penalty levied against a Medicaid MCE as an intermediate sanction, EOHHS may also: a) appoint temporary management to the Contractor; b) grant members the right to disenroll without cause; c) suspend all new enrollment to the Contractor; and/or d) suspend payment for new enrollments to the Contractor. As required in 42 CFR 438.710, EOHHS will give a Medicaid MCE written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeals rights.

Section 6.3 Health Information Technology

Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop and maintain a central repository of membership, medical, behavioral health and pharmacy claims from all commercial insurers, the self-insured, Medicare, and Medicaid. The purpose of APCD is to build a robust database that helps identify areas for improvement, growth, and success across Rhode Island's health care system. The production of actionable data and reports that are complete, accessible, trusted, and relevant allow for meaningful comparison and help inform decisions made by consumers, payers, providers, researchers, and state agencies. As a co-convener of APCD, EOHHS was one of the drivers of the project, and continues to be actively involved in its implementation. EOHHS has access to, and the ability to analyze APCD data including Medicaid and Medicare data in the APCD via a business intelligence tool supported by the APCD analytic Vendor. APCD data will be able to be used to report quality measures derived from claims data across the various Medicaid delivery systems.

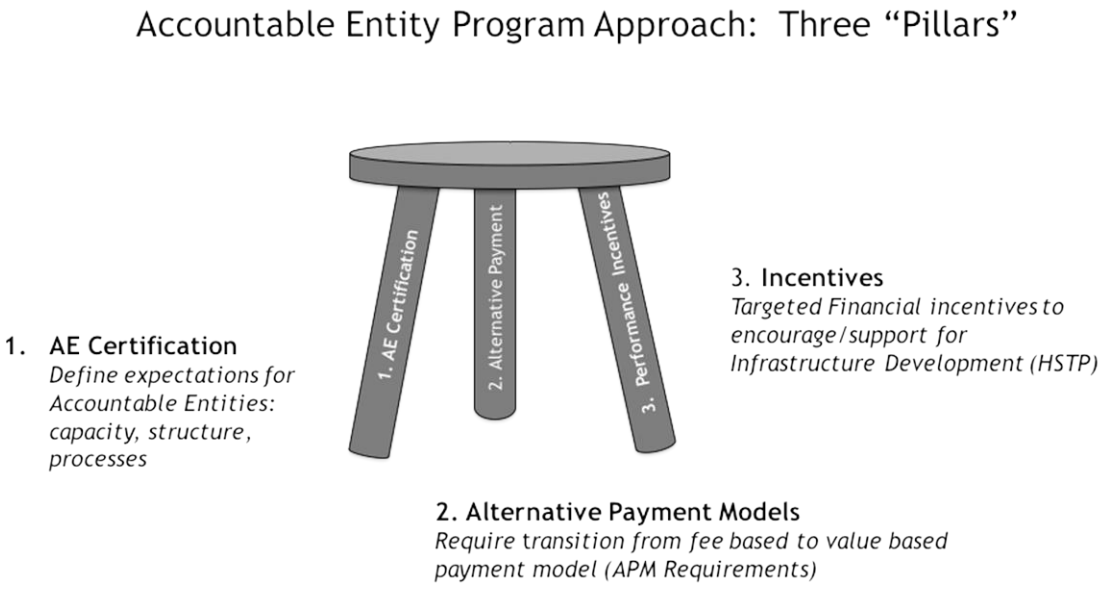
Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health and Human Service agencies have partnered to share information and collaborate towards achieving positive health outcomes and reducing disparities. This has culminated with the development of an eco-system that collects data from each HHS agency that can be shared within each agency. The ecosystem is still in its infancy but is expected to be a promising tool used in quality reporting and active contract management.

The Rhode Island Department of Health (DOH) also provides oversight functions related to the State's HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- KIDSNET Childhood Immunization Registry
- Syndromic Surveillance Registry
- Electronic Lab Reporting
- Prescription Drug Monitoring Program (PDMP)

Section 7: Delivery System Reform

AEs represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model, including but not limited to, behavioral health and social support services. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.



In late 2015, RI Medicaid provisionally certified Pilot AEs and in late 2017, CMS approved the state's AE Roadmap outlining the State's AE Program, Alternative Payment Methodologies (APMs) and the Medicaid Infrastructure Incentive Program (MIIP). The MIIP consists of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program.

EOHHS certifies Accountable Entities which are then eligible to enter into EOHHS-approved alternative payment model contractual arrangements with the Medicaid MCOs. To date, six Comprehensive Accountable Entities have been certified, and qualified APM contracts are in place between five AEs and Medicaid MCOs. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.

To secure full funding, AEs must earn payments by meeting metrics defined by EOHHS and its MCO partners and approved by CMS. Actual incentive payment amounts to AEs will be based on demonstrated AE performance.

Shared priorities are being developed through a joint MCO/AE working group that includes clinical leadership from both the MCOs and the AEs using a data driven approach. RI Medicaid is actively engaged in this process for identifying performance metrics and targets with the MCOs and the AEs.

Below is the initial list of AE performance measures as developed by RI Medicaid. The state identified these AE performance metrics after examining the Medicaid MCO measures, Adult and Child Core Measure Sets, and the OHIC standardized measures for commercial insurers developed as part of Healthy RI. The state's quality strategy for AEs, as with MCEs, continues to include alignment with other payers in the market and regionally to reduce

confusion and administrative burden at the provider level where possible, while continuing to focus efforts on performance improvement.

Initial AE Performance Measures	Steward
Breast Cancer Screening	NCQA
Weight Assessment & Counseling for Physical Activity, Nutrition for Children and Adolescents	NCQA
Developmental Screening in the 1st Three Years of Life	OHSU
Adult BMI Assessment	NCQA
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA
Controlling High Blood Pressure	NCQA
Follow-up after Hospitalization for Mental Illness (7 days & 30 days)	NCQA
Screening for Clinical Depression & Follow-up Plan	CMS
Social Determinants of Health (SDOH) Screen	RI EOHHS

As part of its ongoing quality strategy for MCOs and AEs, RI Medicaid will examine these AE performance metrics annually to determine if and when certain measures will be cycled out, perhaps because performance in some areas have topped out in Rhode Island and there are other opportunities for improvement on which the state wants MCOs and AEs to focus. For example, for AE performance year three, RI Medicaid is removing Adult BMI Assessment from the measure slate and moving the tobacco use measure to "reporting only." For the same time period, RI Medicaid will add two new AE HEDIS measures: Adolescent Well Care Visits and Comprehensive Diabetes Care: Eye Exam.

Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its Medicaid managed care members. Our goals include improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well- being, independence and quality of life.

We are excited by the progress in our AE program and the collaboration between RI Medicaid our contracted MCOs and the state-certified AEs. Today, close to 150,000 RI Medicaid MCO members are attributed to an AE. Consistent with our overall managed care approach, RI Medicaid is developing and refining an AE performance measure set and detailed measure specifications to assess AE performance over time as part of a joint workgroup with the state, the MCOs and their contracted AEs.

While strides have been made in Medicaid managed care accountability and value-based purchasing, Rhode Island continues to work towards a focus on accountability for health outcomes inclusive of population health and social determinants. Rhode Island is on the forefront of a shift from a fee for service model to a value-based payment system; this paradigm shift requires collaboration across delivery systems and stakeholders. There is also limited capacity within Medicaid managed care to address broader social needs, which often overshadow and exacerbate members' medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence. These issues are particularly problematic when serving the most complex Medicaid populations. In the future, RI Medicaid

anticipates taking lessons learned from its AE initiative and its care management initiatives as part of its efforts to improve cost-effective, quality care for the most complex Medicaid populations, including those with long-term care needs.

Appendix C: Interim Evaluation Report

NORC at the University of Chicago

INTERIM EVALUATION REPORT

December 2022

Rhode Island Comprehensive Demonstration

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Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
ACS	American Community Survey
AE	Accountable Entity
AMI	Acute Myocardial Infarction
APM	Alternative Payment Mechanism
BH	Behavioral Health
BHDDH	Behavioral Healthcare, Developmental Disabilities, and Hospitals
BVCHC	Blackstone Valley Community Health Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFO	Chief Financial Officer
CHC ACO	Community Health Care ACO
CMS	The Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DSHP	Designated State Health Programs
ED	Emergency Department
EOHHS	Executive Office of Health & Human Services
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HCBS	Home- and Community-Based Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HSTP	Health System Transformation Project
IHH	Integrated Health Home
IHP	Integrated Healthcare Partners
IMD	Institution of Mental Disease
IT	Information Technology
MCO	Managed Care Organization

MH	Mental Health
NHPRI	Neighborhood Health Plan of Rhode Island
OUD	Opioid Use Disorder
PCHC	Providence Community Health Centers
PCP	Primary Care Provider
PHSRI	Prospect Health Services Rhode Island
PRS	Peer Recovery Specialists
PVI	Pandemic Vulnerability Index
RI	Rhode Island
ROI	Return on Investment
SDOH	Social Determinants of Health
SNAP	Supplemental Nutrition Assistance Program
SOR	State Opioid Response
SSI	Supplemental Security Income
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TCOC	Total Cost of Care
TIA	Transient Ischemic Attack

Executive Summary

Approximately one-third of all Rhode Islanders are enrolled in Rhode Island's Medicaid program. Medicaid program expenditures are the largest item in the state's annual budget and have continued to increase in recent years.[1,2] Since Medicaid serves a large proportion of the population and is a fundamental economic driver for the state, Medicaid reform is a central component in driving innovation across Rhode Island's health care system. The state of Rhode Island designed their Comprehensive section 1115(a) Medicaid Demonstration ("the Demonstration") in 2013 to reinvent Medicaid, leveraging the key principles and goals outlined in **Exhibit ES.1**. The Demonstration allowed for more flexibility for the state to provide more cost-effective and high-quality care.

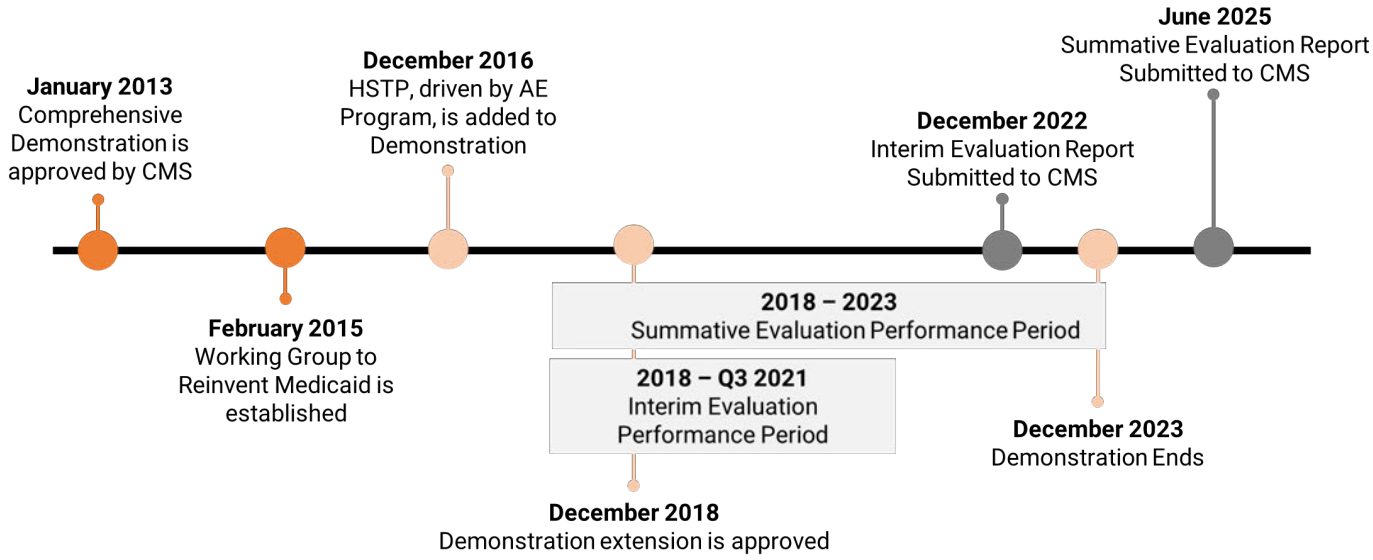
Exhibit ES.1. Key Principles and Goals from Working Group to Reinvent Medicaid

Principle 1: Pay for value, not volume
• GOAL 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes, and total cost of care for their members. • GOAL 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments. • GOAL 3: Maintain and expand on our record of excellence – including our #1 ranking – on delivering care to children.
Principle 2: Coordinate physical, behavioral, and long-term health care
• GOAL 4: Maximize enrollment in integrated care delivery systems • GOAL 5: Implement coordinated, accountable care for high-cost/high-need populations • GOAL 6: Ensure access to high-quality primary care • GOAL 7: Leverage health information systems to ensure quality, coordinated care
Principle 3: Rebalance the delivery system away from high-cost settings
• GOAL 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings • GOAL 9: Encourage the development of accountable entities for integrated long-term care
Principle 4: Promote efficiency, transparency, and flexibility
• GOAL 10: Improve operational efficiency

SOURCE: Report of the Working Group to Reinvent Medicaid

Exhibit ES.2 provides an overview of the Rhode Island Demonstration timeline, from design to expiration.[3] The amendment, approved in December 2016, incorporated goals and initiatives from the Reinventing Medicaid Act of 2015, aiming to shift toward value-based care in the Medicaid program.[3]

Exhibit ES.2. Rhode Island Demonstration Implementation and Evaluation Timeline



In December 2018, CMS authorized Designated State Health Programs (DSHP) funds to maintain federal matching funding for two key health system components: 1) health workforce development, and 2) vital state health programs. This funding released additional funds to help the state implement the Health System Transformation Project (HSTP), primarily through the development of Accountable Entities (AEs). AEs are integrated provider organizations responsible for the total cost of care and health care outcomes for attributed populations, and are the key mechanisms by which Rhode Island is aiming to achieve the greater accountability and value-based care as laid out in the Reinventing Medicaid Act. The four primary principles of the Demonstration are:

- Pay for value, not volume
- Improve coordination of physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings
- Promote efficiency, transparency, and flexibility

Extension of Rhode Island's Comprehensive Demonstration

The 2018 five-year extension of the Demonstration, which is the focus of this evaluation, reflects the four aforementioned principles. The extension included changes in eligibility, demonstration benefits, delivery system, and financing, including:

- **Changes to Medicaid eligibility** to streamline the member liability collection process, codify needs-based criteria for service options available to adults with developmental and intellectual disabilities, and create a new eligibility pathway for children with disabilities to receive care in a residential treatment facility.
- **Changes in Demonstration benefits** to improve access to a range of programs and cover more services, including members with substance use disorders (SUDs), homebound individuals, and adults in need of home- and community-based support services.

- **Delivery system enhancements,** including a pilot project that will allow Medicaid dental providers to bill for time related to improving appointment compliance, care coordination, motivational interviewing, and patient education.
- **Changes in Demonstration financing,** including: 1) an alternative payment methodology (APM) for personal care and homemaker services; 2) an extension of the Designated State Health Programs (DSHP) authority, which funds the HSTP, through December 31, 2020; and 3) waiving the IMD exclusion to improve access to substance use treatment.

The Demonstration extension also includes nine new programs and additional benefits for members. This interim evaluation report will focus on five of these new programs, as described in **Exhibit ES.3.** Chapters 3 through 7 include more information on each program, their eligibility criteria, and key design features.

Exhibit ES.3. Rhode Island Comprehensive Demonstration Programs

Accountable Entities (AE) Program	• Implemented in 2018. The primary driver for health care system transformation for Rhode Island Medicaid's program. • AEs function as integrated provider organizations and are financially responsible for the cost of care, quality, and outcomes. • Alternative payment models are established between MCO health plans and AEs through value-based contracts. • By the beginning of PY4, EOHHS had certified seven AEs serving 190,995 attributed Medicaid members.
Behavioral Health Link (BH Link)	• Began in 2019. Includes triage center and hotline for crisis stabilization and short-term treatment for behavioral health needs. • Seeks to reduce ED visits related to mental health conditions and provide treatment services to improve outcomes. • Treatments provided include physician services, medication treatment, skilled nursing care, services from mental health professionars, comprehensive assessment and triage, and crisis stabilization.
Piloting Dental Case Management (DCM)	• Conducted in 2019. Permitted six Rhode Island dental practices to participate in demonstration of impact of four new dental case management CPT codes. • New codes address appointment compliance barriers, care coordination, motivational interviewing, and patient education. • Aims to address the social determinants of health and improve member and provider experience and oral health outcomes.
Institutions of Mental Disease (IMD) Exclusion	• Demonstration funding for IMO services for SUD treatment began in July 2019. • Waives the exclusion individuals aged 22-64 years old residing in IMDs and aims to allow RI to maintain and enhance member access to substance use disorder treatment in appropriate settings.
Peer Recovery Specialist (PRS) & Family/Youth Support Partners (FYSP) Programs	• Secured additional federal matching funds in 2019 • PRS aims to provide individuals who are experiencing/at risk for hospitalization, overdose, or homelessness, or were recently released from institutions with a support system to develop and learn healthy living skills. • FYSP offers services to help stabilize children under 21 with behavioral health disorder(s) or developmental disabilities and promote well-being of the child and family.

Key Demonstration Stakeholders. The Rhode Island Executive Office of Health and Human Services (EOHHS) is the single state agency for administering the Rhode Island Medicaid program, which includes three Medicaid managed care organizations (MCOs) that provide services directly to Rhode Island Medicaid members and collaborate with AEs to implement value-based care initiatives. The Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) works closely with EOHHS to provide services to approximately 50,000 Rhode Islanders who are living with mental

illness and/or substance use disorders, developmental disabilities, or who require long-term acute care at a state hospital.[4]

Evaluation Overview & Goals

The goal of this interim evaluation is to: 1) assess the performance of each of the five Demonstration programs, 2) describe successes and challenges related to implementation, and 3) present high-level findings on the Demonstration's impact on Medicaid spending, hospitalizations, all-cause readmissions, emergency department visits, annual wellness visits, and other key outcomes relevant to each Demonstration program. This evaluation directly assesses three of the four demonstration principles (pay for value, not volume; improve coordination of physical, behavioral, and long-term health care; rebalance the delivery system away from high-cost settings), and indirectly assesses the fourth principle (promote efficiency, transparency, and flexibility) as it is outside the scope of this evaluation.

To evaluate the Demonstration, we first conducted descriptive analyses for all five Demonstration programs, focusing on characterizing the members in each program and trends in unadjusted and risk-adjusted spending, utilization, and quality outcomes. The AE Program, the program with the largest number of members attributed in each quarter, is the only Demonstration program for which it was feasible to conduct an impact analysis with both a comparison group and a baseline period. Due to the program design and number of members in each of the four remaining programs, it was not feasible to construct either a meaningful baseline period (Behavioral Health [BH] Link, Dental Case Management [DCM]) or an appropriate comparison group (Peer Recovery Specialist [PRS] and Family/Youth Support Partners [FYSP] Programs, Institutions of Mental Disease [IMD] Exclusion Waiver). Considering these limitations, we conducted additional descriptive analysis to characterize performance on spending and utilization outcomes[†] and performed either cross-sectional analyses in the performance period or a pretest-posttest analysis to examine the Demonstration programs' performance. **Exhibit ES.4** provides a program-level overview of the periods of performance included this interim evaluation, whether we evaluated each program's impact on the treatment group against a comparison group, and our analytic approaches evaluating each program.

Exhibit ES.4. Analytic Approach for Demonstration Programs

Program	Performance Period	Baseline Period	Comparison Group	Analytic Approach
AE Program	Q3 2018 – Q3 2021	Q3 2014 – Q3 2016	RI Medicaid-only members in expansion, Rite Care, and RHP population, who were **never attributed to an AE during the performance period**.	Difference-in-differences

[†] For the AE program, we were able to conduct impact analyses; see Section 2.4 for more details.

Program	Performance Period	Baseline Period	Comparison Group	Analytic Approach
BH Link	Q1 2020 – Q3 2021	N/A	18+ Medicaid members with one or more BH conditions or diagnosed SUDs who were **not treated through the BH Link triage center.**	Cross-sectional analyses
DCM Pilot	CY 2019	N/A	18+ RI Medicaid members **seen by participating providers** and who **did not receive services under the 4 dental case management CPT codes**.	Cross-sectional analyses
IMD Exclusion	Q3 2019 – Q2 2021	Q3 2017 – Q2 2019	N/A	Pretest-posttest analyses
PRS/FYSP	Q3 2019 – Q2 2021	Q3 2017 – Q2 2019	N/A	Pretest-posttest analyses

High-Level Summary of Findings

This report details interim evaluation findings across five of the Demonstration projects. Chapter 1 provides an overview of the Demonstration, Chapter 2 summarizes the evaluation methodology, and Chapters 3 through 7 detail the methods and key findings for each of the five programs. Throughout this report, we describe the trends in member attribution or participation in Demonstration programs, the sociodemographic characteristics of the members attributed to the program compared to the characteristics of comparison group members (where applicable), and unadjusted and risk-adjusted trends in core and program-specific outcomes.

For the AE program, we measured impact of the program using a difference-in-differences analysis and examined subgroups by AE and race. Due to the limitations discussed above, for the other four programs, we assessed impact using either cross-sectional analyses (BH Link and DCM) or pretest-posttest analyses (IMD Exclusion Waiver, PRS/FYSP Programs). When considering outcomes for these Demonstration programs, it is important to consider that they were operating in large part during the COVID-19 pandemic, a period that saw unprecedented drops in health care utilization and drastic shifts in care-seeking patterns.[5,6,7] Due to the nature of our analyses (i.e., most programs' performance periods overlapped completely with the pandemic) and the widespread impact of the COVID-19 pandemic, we are unable to quantify the effect of the COVID-19 pandemic on observed declines even when accounting for individual-level COVID-19 diagnoses and county-level pandemic statistics. Readers should interpret these results with caution.

Below we provide high-level findings from the interim evaluation, organized by key research questions domains. All differences noted for utilization and spending outcomes are statistically significant at $p<0.05$.

Member Attribution and Participation in Demonstration Programs

- Member attribution to the **AE Program** rose steadily over the course of the performance period (July 2018 – September 2021). By September 2021, 209,188 Rhode Island Medicaid members were attributed to AEs, representing 68% of Rhode Island's total eligible Medicaid population (i.e., Medicaid members in an MCO). A total of 199,154 AE-attributed members met the inclusion criteria for our analyses (enrolled in Medicaid and AE-attributed in all months of a calendar quarter).
- There was relatively steady usage of the BH Link program, with approximately 200-250 members each quarter accessing BH Link services.
- Participation in the DCM Pilot Program was very limited (25 total unique members) due to challenges in recruiting and enrolling target dental practices. Due to this small sample size, spending and utilization estimates may be unreliable and we are limited in our ability to generalize results beyond this small population.
- Use of the IMD Exclusion Waiver also remained relatively constant, with approximately 1,000-1,100 Medicaid members receiving SUD treatment in a residential IMD setting each quarter.
- Uptake of PRS/FYSP services was slow (fewer than 100 members per quarter) until mid-2020, when usage spiked. Since this program is designed to attract service providers who may have no prior experience with Medicaid, the slow uptake in early quarters was likely related to challenges in setting up new systems for Medicaid billing and reimbursement with those new providers.

Acute Care Utilization

- The **AE Program** had a mixed impact on acute care utilization, with an increase in hospitalizations (7.4 per 1,000 members) and a decrease in readmissions (26.4 per 1,000 members), with no impact on ED visits.
- Due to low enrollment and the emphasis of the pilot on dental services, no acute care utilization outcomes are meaningful for the DCM Pilot.
- Risk-adjusted averages of acute care utilization for white members attributed to the AE Program are lower than that of non-white members in the AE performance period.
- BH Link users had higher rates of risk-adjusted acute care utilization, including hospitalizations (278.4 per 1,000 members), all-cause readmissions (96.4 per 1,000 members), ED visits (1,236 per 1,000 members), IMD service use (270.0 per 1,000 members), and ED visits for BH services (1,037.1 per 1,000 members), relative to comparison members.
- Rhode Island Medicaid members covered by the Demonstration's IMD Exclusion Waiver had a higher hospitalization rate (40.9 per 1,000 members) per quarter in the performance period (July 2019 – September 2021) than the baseline period (July 2017 – June 2019).
- Members using PRS/FYSP services had a steep decline in ED visits (1,545.7 per 1,000 members) after the program's inception in July 2019; however, this decline should be interpreted in the context of broader decreased service utilization during the COVID-19 pandemic, as most members received services after the start of the pandemic.

Ambulatory and Preventative Care Utilization

- Members attributed to the **AE Program** showed an increase in 7-day follow-up after hospitalization for mental illness (29.8 per 1,000 members), but a decrease in 30-day follow-up for the same measure (68.6 per 1,000 members). This may indicate that AEs' increased focus on care coordination is concentrated on the time immediately after an acute event.
- The AE Program showed increased rates of breast cancer screening (26.8 per 1,000 members), which is consistent with MCO quality performance tracking data.
- BH Link users had higher 30-day follow-up after an ED visit for mental illness (117.0 per 1,000 members), potentially driven by the connections to follow-up services in the community that BH Link can provide to members.
- DCM Pilot participants had a slightly higher unadjusted number of dental health services (1.9 per member, compared to 1.6 per member for the comparison group); however, due to the small number of participants in the program (25 members), we were unable to estimate risk-adjusted averages for the groups.
- Members accessing PRS/**FYSP** services showed a steep decline in use of preventative and ambulatory care services (3,597.5 per 1,000 members) after the program's inception in July 2019; however, this decline should be interpreted in the context of broader decreased service utilization during the COVID-19 pandemic, particularly for nonurgent or preventative care.

Total Medicaid Spending for Demonstration Programs

- Reflecting the mixed impact on acute care and ambulatory utilization, the **AE Program** showed no impact on total Medicaid spending, relative to the comparison group.
- Risk-adjusted average spending during the AE performance period was lower for white AE-attributed members than non-white members. A DID analysis to assess whether the impact of the AE program differs for race subgroups is planned for the Summative Evaluation Report (sample size permitting).
- BH Link users had higher observed average risk-adjusted spending relative to the comparison group, likely driven by higher acute care utilization (hospitalizations, all-cause readmissions, ED visits, IMD service use, and ED visits for BH services).
- Members accessing IMD services under the IMD Exclusion Waiver had higher quarterly risk-adjusted spending ($1,486 per member), driven in part by the increase in hospitalizations.
- Members using PRS/FYSP services showed lower annual risk-adjusted spending in the two years after program implementation, driven by decreases in ED visits and ambulatory health services in the baseline period. We were unable to determine the extent to which these decreases were attributable to the PRS/FYSP since the majority of the performance period overlapped with the COVID-19 pandemic, which drove declines in care in all settings.

Next Steps

We will produce a Summative Final Evaluation Report, expanding upon the initial findings presented in this Interim Evaluation Report with subsequent evaluation findings through the entire Demonstration

period (2018 – 2023). The extended evaluation timeframe will allow us to consider more rigorous evaluation designs, such as including additional timepoints in the pretest-posttest analyses. In addition to updates on the topics addressed in the Interim Evaluation Report, the Summative Final Evaluation Report will include implications of the final evaluation results for future initiatives, and a discussion of the extent to which specific elements of the Demonstration were sustained after the Demonstration programs' conclusion.

Chapter 1: Introduction

Rhode Island's Medicaid program, administered by the Executive Office of Health and Human Services (EOHHS), provides essential services and works to "ensure access to high-quality and cost-effective services that foster health, safety, and independence of all Rhode Islanders." As the single state agency for Medicaid, EOHHS contracted with NORC in 2018 to conduct an independent evaluation of the state's section 1115 demonstration, the "Rhode Island Comprehensive Demonstration," which currently runs through December 31, 2023. The evaluation began in 2018 and will conclude in 2025, culminating with a Summative Evaluation Report. This report, the Interim Evaluation Report, presents interim evaluation findings using Medicaid data through September 2021. The report includes an introduction to the Demonstration and evaluation approach (Chapter 1), a detailed description of the evaluation methodology (Chapter 2), evaluation findings for each of five Demonstration programs (Chapters 3–7), and future plans for analysis and evaluation (Chapter 8).

Approximately one-third of all Rhode Islanders are enrolled in Rhode Island's Medicaid program, and Medicaid program expenditures are the largest item in the state's annual budget and have continued to increase in recent years.[1] This number has increased in recent years due to the Medicaid eligibility expansion in 2014 under the Affordable Care Act (ACA), as well as the federal rules implemented via the Families First Coronavirus Response Act (FFRCA), which allows states that provide continuous enrollment to Medicaid members as of March 18, 2020, to receive additional federal funding.[2,8] In 2020, approximately 88 percent of Medicaid members were covered under managed care plans, with the remaining 12 percent in fee-for-service (FFS) Medicaid.[9] Currently, EOHHS contracts with three managed care organizations (MCOs) that serve Rhode Island Medicaid members: 1) the Neighborhood Health Plan of Rhode Island (NHPRI; approximately 185,000 members), 2) UnitedHealthcare (approximately 96,000 members), and 3) Point32Health (formerly Tufts Health Plan; approximately 16,000 members).[9,10] Both NHPRI and UnitedHealthcare have been in Rhode Island's Medicaid managed care program since its inception in 1994; Tufts Health Plan joined as an MCO in 2016.[11]

1.1 Delivery System Reform in Rhode Island

As in many states, Rhode Island's history of providing care for Medicaid members does not incentivize the provision of whole-person care due to inherent limitations of the fee-for-service (FFS) model, which is focused on medical care for specific health conditions. Although the system provides high-quality care across settings for discrete services, it is organized such that no single provider has purview over care integration or overall health outcomes. This often leads to fragmented care and missed opportunities for intervention, as well as acute care needs (e.g., emergency department visits) that may have been prevented by more-coordinated care. Lack of care integration poses particular challenges for Medicaid members with complex health issues, who account for a disproportionate share amount of claims expenditures. For instance, in state fiscal year 2019, nine percent of all Rhode Island Medicaid members were considered high-cost members (i.e., members who incur more than $15,000 in claims expenditures in a year); those nine percent of members accounted for 73 percent of Medicaid claims

expenditures. In Rhode Island, nearly half of claims expenditures for high-cost members occur in residential and rehabilitation services for persons with developmental disabilities and in nursing facilities for members with disabilities or who are older adults.[12] Among Medicaid members incurring high costs who reside in the community (approximately 40%), the majority have multiple comorbidities that would greatly benefit from an integrated approach to treatment.[13]

Because Medicaid serves one out of three Rhode Islanders, Medicaid reform is a central component in driving innovation across Rhode Island's health care system. In 2015, Governor Gina Raimondo established the "Working Group to Reinvent Medicaid" to identify progressive, sustainable savings initiatives to transform the state's Medicaid program. The Working Group conducted a comprehensive review of the state's Medicaid program and submitted a final report that included recommendations for a multi-year transformation of the Medicaid program and state-financed health care in Rhode Island.[14] The plan identified the four high-level principles and 10 goals to guide Rhode Island's path toward a reinvented Medicaid program (**Exhibit 1.1.1**).

Exhibit 1.1.1. Key Principles and Goals from Working Group to Reinvent Medicaid

Principle 1: Pay for value, not volume
• GOAL 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes, and total cost of care for their members.
• GOAL 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.
• GOAL 3: Maintain and expand on our record of excellence – including our #1 ranking – on delivering care to children.
Principle 2: Coordinate physical, behavioral, and long-term health care
• GOAL 4: Maximize enrollment in integrated care delivery systems
• GOAL 5: Implement coordinated, accountable care for high-cost/high-need populations
• GOAL 6: Ensure access to high-quality primary care
• GOAL 7: Leverage health information systems to ensure quality, coordinated care
Principle 3: Rebalance the delivery system away from high-cost settings
• GOAL 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings
• GOAL 9: Encourage the development of accountable entities for integrated long-term care
Principle 4: Promote efficiency, transparency, and flexibility
• GOAL 10: Improve operational efficiency

SOURCE: Report of the Working Group to Reinvent Medicaid

Through these principles and goals, the Working Group, in partnership with the General Assembly and community partners, passed the Reinventing Medicaid Act of 2015 and developed a plan to achieve over $70 million in annual Medicaid savings by redesigning the system to promote high-quality and holistic care for members without reducing benefits or eligibility.[15] This vision for Rhode Island's Medicaid program has guided reforms and initiatives over the subsequent seven years.

1.2 Rhode Island's Comprehensive Demonstration

Rhode Island's Comprehensive section 1115(a) Medicaid Demonstration ("the Demonstration") began in 2013 and allowed for greater flexibility for the state to provide more cost-effective and high-quality care than previous CMS guidance.[16] All services provided by Rhode Island's Medicaid program were covered under this waiver, with the exception of disproportionate share hospitals, administrative expenses, phased Part D contributions, and payments to local education agencies for services provided in school-based settings. This Demonstration was initially approved through December 31, 2018.

In May 2016, EOHHS requested an amendment to the existing Demonstration that incorporated goals and initiatives from the Reinventing Medicaid Act of 2015, aiming to shift toward value-based care in the Medicaid program.[3] This amendment was approved in December 2016 and established the Designated State Health Program (DSHP) and the Health System Transformation Plan (HSTP),[3] permitting approximately $160 million for approved use of funds. DSHP funding was authorized by CMS to maintain funding for two key health system components: 1) health workforce development, via partnerships with Rhode Island secondary education institutions, and 2) vital state health programs (e.g., tuberculosis clinics, the Center for Acute Infectious Disease Epidemiology). This funding allocation released additional funds that the state could use to implement the HSTP, primarily through the development of Accountable Entities (AEs). AEs are integrated provider organizations responsible for total cost of care and health care outcomes for attributed populations and are the key drivers through which Rhode Island aims to achieve the greater accountability and value-based care laid out in the Reinventing Medicaid Act. MCOs contract with AEs through value-based purchasing strategies. The goal of coordination between MCOs and AEs is to enable improved case management and other member support resources to promote integrated, focused, and timely care that meets multi-faceted needs of members.

Three key components of Rhode Island's Health System Transformation Plan:

- Encouraging provider accountability
- Developing the next generation of managed care
- Building a robust health care workforce

In July 2018, EOHHS requested a 5-year extension of the existing Demonstration to further support and expand on the four principles of Medicaid reinvention.[17] Approved by CMS on December 20, 2018, the extension includes the following changes in the areas of eligibility, demonstration benefits, delivery system, and financing:

- **Medicaid eligibility** changes will streamline the beneficiary liability collection process, codify the needs-based criteria for service options available to adults with developmental and intellectual disabilities, and create a new eligibility pathway for children with disabilities to receive care in a residential treatment facility.
- **Changes in demonstration benefits** will improve access to a range of programs and cover more services, including members with substance use disorders, homebound individuals, and adults in need of home- and community-based support services.

- **Delivery system enhancements** include a pilot project which will allow Medicaid dental providers to bill for time related to improving appointment compliance, care coordination, motivational interviewing, and patient education. The pilot will address social determinants of health that affect compliance with appointments and treatment recommendations, improving oral health outcomes, and improving member experience.
- **Demonstration financing** changes include the following: 1) an alternative payment methodology (APM) for personal care and homemaker services; 2) an extension of the DSHP authority, which funds the HSTP, through December 31, 2020; and 3) waiving the IMD exclusion to improve access to substance use treatment.

Since approval of the extended Demonstration in December 2018, CMS has approved a number of amendments requested by EOHHS, including updates to expenditure authorities, approval of federal financial participation (FFP) for home stabilization services and telephonic psychiatric consultation,[18] and considerations for Demonstration changes as a result of the COVID-19 pandemic.[19]

Goals of the Demonstration

Building off the work completed by Rhode Island's Working Group to Reinvent Medicaid as described above, Rhode Island's Comprehensive Demonstration seeks to address service gaps and other issues identified by the Working Group by improving coordinated, cost-effective, person-centered health care. The four main goals of the Demonstration align with the principles identified by the Working Group and are described in more detail below.

Pay for value, not volume. The Demonstration promotes the principle of "pay for value, not volume" by transitioning Rhode Island's Medicaid program away from FFS models toward value-based care, establishing Medicaid-wide population health targets tied to payments, and maintaining and expanding excellence in program design and outcomes. AEs are the primary vehicle driving these changes via a population health approach and facilitation of partnerships among MCOs, providers, and Rhode Island Medicaid. **Exhibit 1.2.1** presents specific strategies identified by EOHHS for working towards each goal under this principle.

AEs shift care to **value based payment**, increase focus on **total cost of care**, create **new forms of organization** to incentivize common enterprise, improve **care integration,** build **interdisciplinary capacity,** and integrate **advanced data**

Exhibit 1.2.1. Goals and Strategies for Principle 1 (Pay for Value, Not Volume)[20]

GOAL 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes, and total cost of care for their members.

- Strategy 1: Increase the percent of members attributed to AEs
- Strategy 2: Continue to support HSTP to move towards greater provider accountability

GOAL 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.

- Strategy 3: Support AE measure development and tracking

GOAL 3: Maintain and expand on our record of excellence – including our #1 ranking – on delivering care to children.
• Strategy 4: Pilot a dental case management program
• Strategy 5: Cover family home visiting programs to improve birth and early childhood outcomes
• Strategy 6: Continue support for children's dental care through RIte Smiles
• Strategy 7: Support the education and training of the health care workforce to ensure those providing care to Medicaid members are adequately prepared

SOURCE: 1115 Waiver Driver Diagram (EOHHS)

Coordinate physical, behavioral, and long-term health care. The Demonstration aims to increase access to critical levels of care for opioid use disorder (OUD) and other substance use disorders (SUD), increase the use of evidence-based and SUD specific patient placement criteria, and set state-wide standards for residential treatment provider qualifications.[21] The extension seeks to improve coordination of health care by maximizing enrollment in integrated care delivery systems, implementing coordinated accountable care for high-cost/high-need populations, ensuring access to high-quality primary care, and leveraging health information systems. In the extension, the state also received authority for several critical programs to improve access to cost-effective, high-quality, "whole person" integrated care. **Exhibit 1.2.2** shows strategies identified by EOHHS as potential drivers of transformation to coordinate physical, behavioral, and long-term care.

Exhibit 1.2.2. Goals and Strategies for Principle 2 (Coordinate Physical, Behavioral, and Long-Term Health Care)

GOAL 4: Maximize enrollment in integrated care delivery systems
• Strategy 1: Incentivize the establishment, growth, and participation of AEs through HSTP funding opportunities
GOAL 5: Implement coordinated, accountable care for high-cost/high-need populations
• Strategy 2: Address gaps in treatment for adults with special health care needs by covering home-based therapeutic services, life skills training, and other evidence-based practices
• Strategy 3: Support parents and youth navigating behavioral health challenges through coverage of Peer Support Services
• Strategy 4: Better support primary care physicians by allowing psychiatric consultation in primary care settings
GOAL 6: Ensure access to high-quality primary care
• Strategy 5: Provide access to care for homebound individuals by reimbursing home-based primary care services
GOAL 7: Leverage health information systems to ensure quality, coordinated care
• Strategy 6: Support AEs in HIT development/interoperability through HSTP funding sources

SOURCE: 1115 Waiver Driver Diagram (EOHHS)

Rebalance the delivery system away from high-cost settings. To facilitate the shift away from high-cost institutional settings and to community-based care, EOHHS designed a long-term services and supports (LTSS) Alternative Payment Methodology (APM) Program focused specifically on the home and community-based services needed to prevent the Medicaid-eligible population from needing institutional LTSS.[21] The Program aims to encourage and enable LTSS eligible and aging populations

to live successfully in their communities, improve and ensure equitable access to home and community-based services (HCBS) that prevent LTSS eligible populations from needing institutional LTSS, and foster a sustainable network of high quality HCBS providers that are equipped to meet the diverse needs of LTSS members. The LTSS APM will launch in July 2022 as an 18-month pilot program. The full Program is expected to launch in January 2024, and run for four years, through December 2027.

EOHHS anticipates that the LTSS APM will ultimately be integrated with the Comprehensive AEs to better provide an integrated and accountable care network for members. **Exhibit 1.2.3** shows strategies identified by EOHHS as potential drivers of transformation to rebalance the delivery system away from high-cost settings.

Exhibit 1.2.3. Goals and Strategies for Principle 3 (Rebalance the Delivery System Away from High-Cost Settings)

GOAL 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings
• Strategy 1: Provide BH crisis services to divert ED visits and ensure members are connected to appropriate levels of care
• Strategy 2: Streamlined/expedited eligibility for LTSS to expand the array of Home and Community-Based Services offered to members with an institutional level of care, or those at risk of needing an institutional level of care
• Strategy 3: Modernize Home- and Community-Based Services (HCBS)benefit package and service definitions
• Strategy 4: Expand the types of covered non-recurring, set-up expenses to improve transitions between care settings
• Strategy 5: Support and expand self-directed models of care
• Strategy 6: Promote socialization, long-term recovery, wellness, self-advocacy, and community connections for individuals with chronic conditions through the services of peer recovery specialists
• Strategy 7: Allow MCOs the flexibility to provide additional, value-add services
GOAL 9: Encourage the development of accountable entities for integrated long-term care
• Strategy 8: Develop alternative payment methodologies for home care providers

SOURCE: 1115 Waiver Driver Diagram (EOHHS)

Promote efficiency, transparency, and flexibility. Establishing an environment that promotes flexibility and transparency within the systems and structures delivering health care in Rhode Island is an essential component of reform (**Exhibit 1.2.4**). Improving operational efficiency will include the development of resources and capacity within state government to adequately oversee its health care system partners and drive system change.

Exhibit 1.2.4. Goals and Strategies for Principle 4 (Promote Efficiency, Transparency, and Flexibility)

GOAL 10: Improve operational efficiency
• Strategy 1: Collect member liability directly from the member to reduce provider burden and improve program integrity
• Strategy 2: Shortened application for expedited eligibility for LTSS

SOURCE: 1115 Waiver Driver Diagram (EOHHS)

New Demonstration Benefits and Programs

The 2018 extension for Rhode Island's Comprehensive Demonstration includes several new programs and benefits for members, which will be the focus of this evaluation. Nine new programs, described briefly below, were slated for implementation in the Demonstration. Of these, five have been implemented to date and will be included in this interim evaluation report. Four of the programs are not a focus of the interim evaluation because they have not been implemented or, in the case of the Home- and Community-Based Services Benefit Package, no new services were established under CMS' approved language. If any of these four programs are funded under the Demonstration in future years, they will be included in the Summative Evaluation Report.

Accountable Entities Program. The Accountable Entities (AE) Program is a critical aspect of Rhode Island's HSTP, which was implemented in 2018 and is the primary driver for health system transformation for Rhode Island Medicaid's program. AEs function as integrated provider organizations that are financially responsible for the total cost of care, health care quality, and outcomes among their attributed populations. Alternative payment models are established between MCO health plans and AEs through the development of value-based contracts. By September 2021, EOHHS had certified seven AEs serving 209,188 attributed Medicaid members. The process by which Medicaid members are attributed to AEs is described in more detail in Chapter 3. Recognizing that success hinges on having the appropriate workforce in place, AEs also leverage the state's Health Workforce Transformation project, which supports the establishment of AEs and the development of education and training programs to build career pathways to AEs and capacities for AEs. See Chapter 3 for additional information and evaluation findings for the AE Program.

Behavioral Health Link (BH Link). The BH Link Program began in 2019, incorporating a triage center and hotline to provide immediate assistance and support to patients seeking crisis stabilization and short-term treatment for behavioral health needs, including mental health and substance use disorders. It seeks to reduce ED visits related to mental health conditions by Rhode Island Medicaid members and to provide responsive treatment services from BHDDH-licensed Behavioral Healthcare Organization staff to improve outcomes. Beginning on January 29, 2020, the triage center began billing using a CMS-approved bundled rate billing methodology that can be billed once daily per member. Treatments provided include but are not limited to physician services, medication treatment, skilled nursing care, services from mental health professionals, comprehensive assessment and triage, and crisis stabilization. See Chapter 4 for additional information and evaluation findings for BH Link.

Piloting Dental Case Management (DCM). The DCM Pilot Program was conducted in 2019 and was modeled after similar programs that had positive outcomes in other states. It permitted six Rhode Island dental practices, including private practices, hospital-based clinics, and federally qualified health centers (FQHCs), to participate in a demonstration of the impact of four new dental case management Current Procedural Terminology (CPT) codes. The new codes address appointment compliance barriers, care coordination, motivational interviewing, and patient education to improve oral health literacy. The goals of the program were to address the social determinants of health that affect compliance, as well as to improve member experience, member oral health outcomes, and provider

experience (e.g., fewer no-shows and broken appointments, greater chance of improvement to oral health). See Chapter 5 for additional information and evaluation findings for the DCM Pilot Program.

Promoting Access to Appropriate, High-Quality Substance Use Treatment by Waiving the Institutions of Mental Disease (IMD) Exclusion. The IMD exclusion was implemented under the Demonstration in 2019. Previously, federal financial participation excludes individuals aged 22-64 years old residing in IMDs. This exclusion has resulted in 1) Medicaid enrollees being treated in hospital emergency departments, which are more expensive and less prepared for mental health/substance abuse; 2) undermined continuity of care efforts; 3) limited access to substance use treatment programs and constrained Medicaid-funded services and supports; and 4) parity concerns. This program waives this IMD exclusion, with the goal of allowing RI to maintain and enhance member access to SUD services in appropriate settings. See Chapter 6 for additional information and evaluation findings for the IMD exclusion.

Peer Recovery Specialist (PRS) and Family/Youth Support Partners (FYSP) Programs. The PRS and FYSP programs, which secured additional federal matching funds in 2019, aim to provide individuals with an enhanced support system to develop healthy living skills. As part of the programs, a PRS or FYSP works with members to offer the skillset and unique vantage point of someone who has succeeded in managing a serious behavioral health condition or developmental disability, or is an adult with personal experience caring for a child or other family member with a similar mental illness and/or substance use disorder. The key objective of the PRS program is to provide individuals who are experiencing or at risk for hospitalization, overdose, or homelessness, or were recently released from institutions (e.g., hospital, prison) with a support system to develop and learn healthy living skills. Interventions promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community. The FYSP program offers services to children under 21 years of age and their caregivers to help stabilize the child with behavioral health disorder(s) or developmental disabilities and promote the well-being of the child and family. Target outcomes include improved socialization, long-term recovery, wellness self-advocacy, and connection to the community. Additional target outcomes include the treatment of mental health and/or substance use disorders and residing in the community rather than being institutionalized. See Chapter 7 for additional information and evaluation findings for the PRS/FYSP programs.

Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes *(not included in this report)*. Although not yet implemented as funded under this Demonstration, this program targets Medicaid-eligible pregnant women, and children younger than five years old, who are at-risk for adverse health, behavioral, and educational outcomes to be provided evidence-based home visiting services. Evidence-based tools will be used to identify risk for poor outcomes, and families with multiple risk factors for poor outcomes will be prioritized for services. The home visits are designed to improve maternal and child health outcomes, encourage positive parenting, and promote child development and school readiness. Because this program has not yet been implemented, findings are not included in this evaluation report.

Supporting Home- and Community-Based Therapeutic Services for the Adult Population (*not included in this report)*. Although not yet implemented pending additional funding support, this

program is intended to provide home- and community-based therapeutic services to Medicaid members aged 21 or older with at least one of the following: 1) a chronic condition, 2) a behavioral health diagnosis, 3) a neurological diagnosis, or 4) a significant impairment in functioning level determined by a validated screening tool. This program aims to address the treatment gaps that exist due to Rhode Island's fragmented system of population-specific treatment services between child- and adult-eligible services. Expanding eligibility to include adults will help young adults transition from the child system to the adult system. The program may improve outcomes for children and increase access to support services for 16- to 25-year-olds at risk for developing a serious mental health or substance use condition. Because this program has not yet been implemented, findings are not included in this evaluation report.

Improving Access to Care for Homebound Individuals (*not included in this report)*. Although not yet implemented, this program will pay for home-based primary care services for Medicaid-eligible individuals who are homebound, have functional limitations that make it difficult to access office-based primary care, or for whom routine office-based primary care is not effective due to their complex medical, social, and/or behavioral health conditions. This program aims to increase access and utilization of primary care services by those individuals who are homebound. At the present time, there are no plans to implement this program. Because this program has not yet been implemented, findings are not included in this evaluation report.

Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package (*not included in this report)*. Because of an increase in the aging population and continued increase in total expenses for nursing homes, this program is intended to redesign home- and community-based services (HCBS) coverage. The proposed plan included four key parts: 1) eliminating selected HCBS that are no longer needed as they are now State Plan benefits, 2) broadening the range of needs-based Preventive and Core HCBS, 3) updating definitions of the existing benefits, and 4) instituting authority to cap the amount or duration of Preventive HCBS based on need and mandating cost-sharing for Preventive HCBS. This program was not ultimately implemented, as there were no new services under transitions that EOHHS will add given the language in the CMS-approved waiver.

Key Demonstration Components Addressing Substance Use Disorder

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) oversees substance use disorder (SUD) treatment services across the continuum of care in Rhode Island, including:

- Outpatient services
- Intensive outpatient care
- Medication-assisted treatment (MAT)
- Residential and inpatient care
- Medically supervised withdrawal management

BHDDH also oversees prevention and recovery-oriented services such as Peer Recovery Specialist services and grant-funded Recovery Centers and Housing. Rhode Island has made great progress in serving individuals with SUD and Opioid Use Disorder (OUD) through these services; however, the continuing opioid crisis in the state calls for greater access to prevention and treatment. The Rhode Island Overdose Prevention and Intervention Task Force created an action plan to address the state's overdose crisis focused on prevention, rescue, treatment and recovery, and public education/outreach to reduce stigma; however, work remains to ensure that Medicaid beneficiaries with SUD and mental health (MH) conditions receive the full continuum of care. Priority activities addressed in the waiver include:

- Increasing access to peer recovery specialists,
- Establishing Behavioral Health Link triage centers,
- Hotline and mobile outreach,
- Waiving the Institutions of Mental Disease (IMD) rule for SUD to increase capacity at residential facilities.

The SUD Implementation Plan details the strategic approach and project implementation activities associated with achieving the following milestones:

- **Milestone #1. Access to critical levels of care for OUD and SUD** including outpatient and intensive outpatient services, medication-assisted treatment (MAT), residential and inpatient settings, medically supervised withdrawal management
- **Milestone #2. Widespread use of evidence-based, SUD-specific patient placement criteria** including consistent, evidence-based assessment of SUD treatment needs and utilization management approaches
- **Milestone #3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications** including implementing a state process for reviewing providers to assure compliance and requiring residential treatment facilities offer MAT on-site or facilitate off-site access
- **Milestone #4. Sufficient provider capacity at each level of care, including MAT,** informed by an assessment of the availability of and gaps among providers enrolled in Medicaid and accepting new patients in critical levels of care
- **Milestone #5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD**, including implementation of opioid prescribing guidelines, expanded coverage of and access to naloxone for overdose reversal, and implementation of strategies to improve prescription drug monitoring programs
- **Milestone #6. Improved care coordination and transitions between levels of care**, including implementation of policies to ensure residential and inpatient facilities link members with community-based services and supports following facility stays.

Impact of COVID-19 on Rhode Island's Medicaid Program and the Demonstration

Over 79 million Americans have contracted COVID, with approximately 973,451 deaths as of March 2022.[22] As of April 2022, Rhode Island has experienced 362,000 total positive cases and over 3,500 deaths.[23] The pervasive impact of COVID-19 on the nation's health care system and individuals' quality of life has been unprecedented. Negative impacts from COVID-19 have been disproportionately borne by some racial and ethnic minority groups due to underlying health and social inequities.[24] The importance of public health and social measures and community engagement in limiting the transmission of COVID-19 and reducing poor health and mortality outcomes has been well-established.[25]

Throughout the pandemic, the Medicaid program has monitored testing, case identification, hospitalizations and death among Medicaid members compared to the general population. The primary purpose of this initiative is to be sure that Medicaid members are being adequately tested and that positive cases are being referred to appropriate treatment. Overall, the adequacy of testing and case identification among Medicaid members has been comparable to the general population. However, Medicaid members have experienced a disproportionate share of hospitalizations and deaths. In addition, vaccinations in Medicaid have lagged behind the general population.[26]

The Rhode Island Department of Health proactively established various policies and developed responsive resources to promote education, prevention, and treatment of COVID-19 in the community. For instance, a COVID-19 Informational Hotline was established to complement the department's dedicated COVID-19 website, which hosts relevant information and resources on topics such as vaccination requirements and treatment.[27] Rhode Island also demonstrated its commitment to equitable COVID-19 prevention and treatment across all individuals and communities. For instance, the state implemented a 'Hard-Hit Community Vaccination Strategy' to address disparities in vaccination rates in certain geographies and developed a COVID-19 Risk Assessment Protocol based on CDC guidance to measure risk on a county basis.

In March 2020, EOHHS submitted a request for an amendment to the existing Comprehensive Demonstration to ensure that Medicaid members continued to receive medically indicated Medicaid-covered services while minimizing COVID-19 exposure for patients and staff. Overarching goals of the waiver included: limiting in-person meetings for person-centered care to reduce transmission; facilitating access to necessary institutional and home- and community-based care; and increasing access to COVID-19 testing and treatment. The goals and elements of this Demonstration amendment are described in more detail below.[28]

- Prevent transmission of COVID-19 to workers and vulnerable Medicaid members by a) limiting in-person meetings and care, b) extending level of care authorizations, and c) modifying level of care determination assessment procedures.
- Facilitate access to COVID-19 testing and treatment while reducing exposure to health care workers and beneficiaries by covering telephone triage for COVID-19 treatment.

- Utilize limited staff resources to focus on the most medically fragile members by a) extending the time for 12-month reviews of person-centered plans, and b) limiting non-emergency medical transportation (NEMT) to only appointments that are critical to the member's health.

During the COVID-19 pandemic, EOHHS continued normal processes for the Medicaid under the Demonstration, resources permitting. However, shifts in priorities and staffing occurred due to the required work to address the pandemic and its effect on the Medicaid program. Across the state, resources were redirected to address the pandemic and support state public health efforts. The COVID-19 pandemic also had discernible impacts on several Demonstration programs, including: 1) delaying meetings or activities, 2) shifting state public health communication priorities, and 3) affecting SUD technical assistance and training content for providers to include a primary focus on COVID-19. As of March 18, 2020, Rhode Island reimbursed for clinically appropriate, medically necessary covered services to be provided via telehealth, including behavioral health services under fee-for service and managed care. These reimbursable telehealth services included services provided by phone as well as non-HIPAA compliant videoconferencing services (e.g., Apple FaceTime, Google Hangouts) to enable greater access to care during the pandemic.[29] Due to the widespread impact of the COVID-19 pandemic on individuals, providers, health care systems, and communities, it is not possible to assess the direct impact of COVID-19 on Demonstration goals or individual outcome measures. In our evaluation, we highlight the importance of understanding contextual factors and incorporate consideration of the impact of COVID-19 on communities, individuals, and providers in the interpretation of our findings. Given the disproportionate share of the disease burden among Medicaid patients, extensive oversight and monitoring initiatives were implemented with the MCO to address service gaps in the Medicaid population. See Chapter 2 for additional methodological updates we made to account for the COVID-19 pandemic.

1.3 Overview of Independent Evaluation

In the years since the approval of the Demonstration's extension to 2023 and the renewed focus on the four principles set forth in the Reinventing Medicaid Act of 2015, Rhode Island has continued to focus on the principles and goals outlined in its initial vision. This is a pivotal time for Rhode Island and one which highlights the critical importance of a rigorous and comprehensive evaluation. An evaluation provides the tools to enable ongoing feedback that informs improvements to the program and fosters sustainability for the long-term benefit of the State and its population.

5 Demonstration Programs are Included in NORC's Interim Evaluation Report:

- Accountable Entities Program
- Behavioral Health Link
- Dental Case Management Pilot
- Waiver of the Institutions of Mental Disease Exclusion
- Peer Recovery Specialist and Family/Youth Support Partners Programs

The evaluation of this Demonstration waiver extension is primarily focused on assessing three of the four principles of transformation upon which this Demonstration is based:

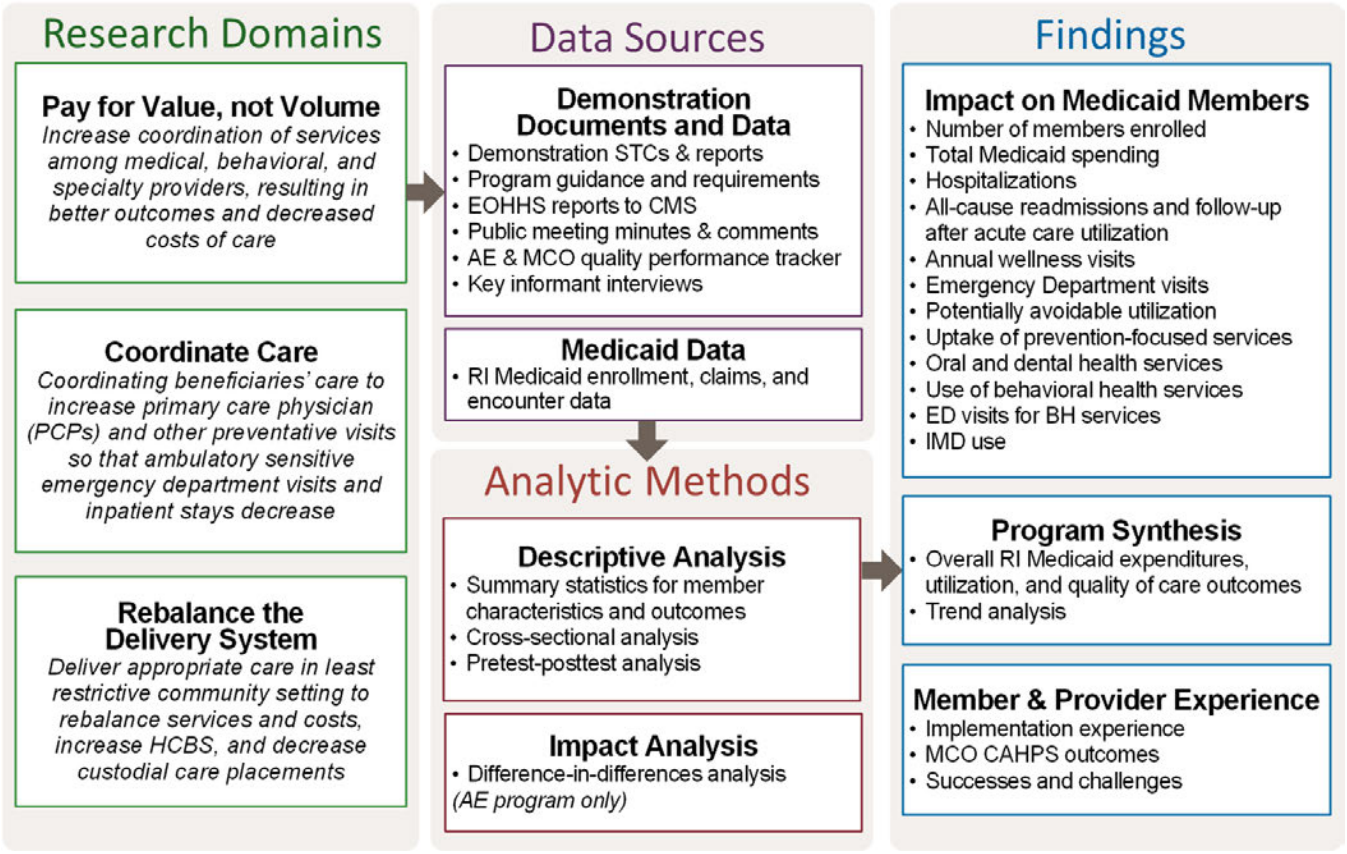
- Pay for value, not volume
- Improve coordination of physical, behavioral, and long-term health care

- Rebalance the delivery system away from high-cost settings.

The fourth principle (promote efficiency, transparency, and flexibility) is outside the scope of NORC's evaluation. These three principles guide the framing of the research questions and the selection of data sources, measures, analytic approaches, and other aspects of this evaluation design plan. We will indirectly address the state's goal to promote efficiency, transparency, and flexibility by assessing the three primary outcome domains.

Rhode Island submitted a draft evaluation design for the overall Demonstration to CMS in June 2019 and received CMS comments in October 2019. Rhode Island responded to comments and submitted revised versions of the evaluation design to CMS in November 2019. This was followed by one additional round of CMS feedback (received January 2020) and submission of a revised evaluation design (February 2020). The final evaluation design, which was approved by CMS on April 15, 2020, can be accessed directly through the Medicaid website.[30] **Exhibit 1.3.1** presents an overview our evaluation approach to addressing these three research domains, including data sources, analyses, and categories of key findings.

Exhibit 1.3.1. Evaluation Approach Overview



Evaluation Questions

Exhibit 1.3.2 presents evaluation hypotheses and research questions aligned with each Demonstration principle. Program-specific evaluation hypotheses and research questions, alongside additional information about the programs such as program-specific goals, relevant performance metrics, and descriptions of the target population, can be found in each program's dedicated chapter (Chapters 3-7).

Exhibit 1.3.2. Evaluation Hypotheses and Research Questions, by Demonstration Principle

Principle 1: Pay for value, not volume	
Evaluation Hypothesis	*The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for RI Medicaid members*
Research Questions	• What is the scale of participation in Demonstration programs? • What are the trends in spending, utilization, and quality of care for members in Demonstration programs? • What is the experience of care for members receiving services under the Demonstration? Are they satisfied with their care?
Principle 2: Improve coordination of physical, behavioral, and long-term health care	
Evaluation Hypothesis	*The Demonstration will increase coordination among different care types, leading to better health outcomes for RI Medicaid members*
Research Questions	• To what extent has the Demonstration integrated BH and SUD care into medical care? How has this affected health outcomes and BH/SUD treatment uptake for RI Medicaid members? • What are the trends in ED visits and IMD service use for members accessing behavioral health services? • Does better care integration reduce high-cost care for members?
Principle 3: Rebalance the delivery system away from high-cost settings	
Evaluation Hypothesis	*The Demonstration will shift care away from high-cost settings (e.g., the ED), reducing spending while increasing utilization in lower-cost settings.*
Research Questions	• Does the Demonstration increase uptake of prevention-focused resources into routine medical care for high-cost/high-need RI Medicaid members? • Has the expansion of covered home- and community-based services impacted rates of institutionalization and/or home-based care? • To what extent has the demonstrations integrated BH and SUD care into medical care? How has this affected health outcomes and BH/SUD treatment uptake for RI Medicaid members?

Evaluation Methods

We used secondary data to capture the characteristics of the demonstration programs, characteristics of members served, and the impact on health and quality outcomes. First, we conducted extensive document reviews, using waiver documentation, program documents (where available), and benchmark data from EOHHS to understand the complex demonstration programs that were funded and implemented in this waiver. We also conducted a limited number of in-person and virtual interviews with the EOHHS, BHDDH, and other relevant AE administrators to provide an overview of the state's existing programs and initiatives, including implementation challenges and facilitators. The goals of these interviews were to review progress on established SUD milestones, determine the priorities of

each initiative, and contextualize SUD implementation activities within the broader health care environment.

To assess the demonstration programs' impact on cost, quality, and utilization, we used Rhode Island Medicaid eligibility files, claims, and encounter data. Impacts on key outcomes were measured at the program level as well as across the Demonstration. We also integrated EOHHS' MCO/AE quality performance tracker data and MCO-level CAHPS findings to identify contextual trends beyond what is captured in claims and encounter data. Although we used a similar process to evaluate each of the five waiver programs, we tailored the evaluations to reflect the specific attributes of each program as described in the Methodology section. The interim evaluation resulted in a synthesis of findings across programs including an analysis of overall trends in Medicaid spending, utilization, and quality of care before and after the waiver implementation dates, which takes into consideration the sum effect of all programs on Rhode Island Medicaid.

1.4 Overview of Interim Evaluation Report

This Interim Evaluation Report provides an overview of the evaluation methodology as well as detailed results across the five programs assessed. Chapter 2 provides a detailed description of the methodology applied to evaluate the Rhode Island Comprehensive Demonstration programs, including: 1) quantitative and qualitative data sources, 2) measurement time points and quasi-experimental approaches applied, 3) analytic approaches to produce descriptive and impact assessment findings, and 4) project limitations. Chapters 3 through 7 present program-specific evaluation design information and findings, including evaluation hypotheses and outcomes, analytic strategy, empirical results, and a discussion of the results and implications contextualized broadly within the waiver program. Chapter 8 describes our future plans for the evaluation of Rhode Island's Comprehensive Demonstration, to be presented in the Summative Evaluation Report.

Chapter 2: Evaluation Methodology

In this chapter, we discuss NORC's evaluation approach, including data sources, analytic populations, descriptive assessments, impact assessments, evaluation measures, and limitations associated with our evaluation design. Throughout this report, we draw on data from the waiver documentation and associated data sources, claims and encounter datasets, and semi-structured in-person and virtual interviews with key informants. The report's evaluation approach is based on three key Demonstration principles (described in more detail in Chapter 1) that the Executive Office of Health and Human Services (EOHHS) has established as priorities, including:

- Pay for value, not volume
- Coordinate physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings

These principles guide the framing of the research questions and the selection of data sources, measures, analytic approaches, and other aspects of NORC's evaluation of this waiver extension. The team also seeks to indirectly address a fourth principle: the state's goal to promote efficiency, transparency, and flexibility through the three key principles above. **Exhibit 2.1** provides a summary of the evaluation hypotheses and research questions, along with relevant outcome measures and analytic approaches, grouped under each of the three Demonstration principles that guide this evaluation.

Exhibit 2.1. Research Questions, Outcome Measures, and Analytic Approach

	Research Question	Outcome Measures	Analytic Approach
Demonstration Principle 1: Pay for value, not volume			
Evaluation Hypothesis 1: The demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members			
1	What percentage of Medicaid members are attributed to each waiver program?	• Percent of RI Medicaid members enrolled	• Descriptive analysis
2	What are the trends in spending, utilization, and quality of care for Medicaid members in each Demonstration program?	• Total Medicaid spending • Hospitalizations • Readmissions • ED Visits	• Descriptive trend analysis • Pretest-posttest analysis • Cross-sectional analysis
3	What are the trends in spending, utilization, and quality of care for all Medicaid members in the Demonstration?	• Total Medicaid spending • Hospitalizations • Readmissions • ED Visits	• Descriptive trend analysis • Difference-in-differences analysis

	Research Question	Outcome Measures	Analytic Approach
4	What is the impact on spending, utilization, and quality of care for AE-attributed members?	• Spending, utilization, and quality measures	• Difference-in-differences
5	What is the experience of care for AE-attributed members? Are they satisfied with their care?	• MCO CAHPS measures	• Descriptive analysis
Demonstration Principle 2: Coordinate physical, behavioral, and long-term care ***Evaluation Hypothesis: The demonstration will increase coordination among different care types, leading to better health outcomes for RI Medicaid members.***			
6	Does better care integration reduce high-cost care for members?	• Potentially avoidable ED use • ED use among members with mental illness • MCO CAHPS measures	• Descriptive analysis • Difference-in-differences • Pretest-posttest analysis • Cross-sectional analysis
7	To what extent has the demonstrations integrated BH and SUD care into medical care? How has this affected health outcomes and BH/SUD treatment uptake for Medicaid members?	• Ambulatory health services • Use of BH services • ED visits for BH services • Follow-up after ED visit for mental illness	• Descriptive analysis • Pretest-posttest analysis • Cross-sectional analysis
8	Does the demonstration increase uptake of prevention-focused resources into routine medical care for high-cost/high-need Medicaid members?	• Frequency of dental case management code usage • Dental services	• Descriptive analysis • Cross-sectional analysis
Demonstration Principle 3: Rebalance the delivery system away from high-cost settings ***Evaluation Hypothesis: The demonstration will shift care away from high-cost settings, reducing spending while increasing utilization in lower-cost settings.***			
9	What are the trends in ED visits and IMD service use for members accessing behavioral health services?	• IMD service use • Use of BH services • ED visits for BH services	• Descriptive analysis • Pretest-posttest analysis • Cross-sectional analysis

NOTES: AE = Accountable Entity; BH = Behavioral Health; CAHPS = Consumer Assessment of Healthcare Providers and Systems ; ED = Emergency Department; IMD = Institutions of Mental Disease; MCO = Managed Care Organization; OUD = Opioid Use Disorder; SUD = Substance Use Disorder.

2.1 Data Sources

For this evaluation, we used three main data sources: Demonstration documentation and data, Medicaid claims and encounter data, and key informant interviews (**Exhibit 2.1.1**). Each of these sources are described in more detail below.

Exhibit 2.1.1. Evaluation Data Sources and Uses

Source	Uses
Demonstration documentation and data	• Identify Demonstration aims, drivers, implementation strategies, and areas of focus for Demonstration programs • Characterize Demonstration programs and participants • Assess AE and MCO quality performance over time • Provide context for claims-based findings
Medicaid claims and encounter data	• Identify Rhode Island Medicaid members participating in waiver programs • Describe sociodemographic characteristics for Medicaid members • Assess claims-based outcomes of cost, utilization, and quality
Key informant interviews	• Understand early implementation of the AE program • Conduct a mid-point assessment of Rhode Island's SUD programs included in the Demonstration • Identify challenges associated with piloting the AE program and behavioral health/SUD programs • Provide context for claims-based findings

Demonstration Documentation & Data

Demonstration documents detail state authority and program commitments for each program. Regulatory documents are available publicly on CMS' Medicaid page dedicated to the Rhode Island Comprehensive Demonstration, and AE program resources are publicly available on EOHHS' website.[31,32] The sources we identified included:

- Special Terms and Conditions (STCs) for Rhode Island's Comprehensive Section 1115 Demonstration (2013-2018)
- EOHHS' request Health System Transformation Program Demonstration Application (June 2016) and approval (April 2017)
- Rhode Island's Demonstration extension application (July 2018), approval (December 2018), and technical corrections (November 2019)
- Quarterly and annual operations reports submitted to CMS by EOHHS
- Quarterly budget neutrality reports submitted to CMS by EOHHS
- Demonstration amendments responding to the COVID-19 pandemic
- AE applications and application instructions
- AE documentation (attribution guidance, certification standards, incentive program requirements, total cost of care requirements, technical guidance, quality and outcome implementation manual)
- AE Implementation Manual and Roadmap
- AE pilot recommendation report
- AE guidance on social determinants of health

- Agendas and minutes from AE Stakeholder meetings and Health System Transformation Plan (HSTP) AE Advisory Committee meetings
- MCO CAHPS data, 2020-2021
- Quality performance tracking data for AEs, 2018-2020
- Public comments submitted in response to AE Roadmap and requirements documents
- Public presentations made by EOHHS and the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)
- Public documentation of behavioral health/SUD program resources and services

The NORC team conducted a comprehensive document review of these Demonstration documents to develop a better understanding of the aims, drivers, implementation strategies; areas of focus of each Demonstration program; characterizations of the programs and participants; additional context on AE quality performance over time, and context for the claims-based findings. Our extensive document review provided a deeper understanding of the state's ongoing efforts and implementation of the Demonstration programs evaluated in this report.

Medicaid Claims & Encounter Data

NORC used Rhode Island's Medicaid enrollment, claims, and encounter data to assess the Demonstration's impact on health outcomes. This report uses data from July 2014 through September 2021, although the evaluation of each Demonstration program applied a timeline specific to that program (see Chapters 3 through 7 for additional details).

Key Informant Interviews

As part of the evaluation work, NORC conducted two sets of key informant interviews. For each set of interviews, NORC collaborated with EOHHS and other Rhode Island agencies to develop the list of key informants and semi-structured interview guides for each stakeholder. **Exhibit 2.1.2** summarizes the stakeholders with which we conducted key informant interviews.

Exhibit 2.1.2. Stakeholder Interviewees

Agency	Stakeholders
Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)	• Behavioral Health (BH) Division Director • BH and Substance Use Disorder (SUD) Administrator • Peer Recovery Specialist Project Manager • Director of Healthcare Workforce Transformation • Associate Director of Strategy and Financing • Administrator of Research, Data Evaluation and Compliance • Chief Human Services Policy & Systems Specialist

Agency	Stakeholders
Executive Office of Health and Human Services (EOHHS)	• Medicaid Director • Medicaid Accountable Entity Program Director • Director of Managed Care • Director of Policy & Delivery System Reform • Associate Chief Financial Officer (CFO) • Director of Community Investments • Executive Director • Project Manager • HSTP Consultant
Rhode Island Department of Health (RIDOH)	• Communications Manager

The first set of interviews, conducted in February 2019 with EOHHS leadership and the AE program team, focused on the early implementation experience of HTSP program activities, particularly for AEs. These interviews focused on establishing an overview of the development of the HSTP and its goals, the program structure (e.g., AE certification requirements, population-based accountability, and value-based purchasing), and key implementation challenges.

The second set of interviews, conducted from March to May 2020, focused specifically on implementation progress for the Demonstration's SUD programs, and were conducted with key staff at EOHHS, BHDDH, and other relevant stakeholders. Interviews were conducted both in-person and virtually (either via telephone or on Zoom, depending on the preference of the interviewee). The goals of each interview were to review progress on established milestones, determine the priorities of each initiative, and contextualize SUD implementation activities within the broader health care environment.

2.2 Analytic Populations

In this report, we evaluated select measures of Medicaid spending, utilization, and access to care. More information on the timeline and treatment and comparison group construction by program can be found below.

Baseline & Performance Periods

The baseline (pre-intervention) and performance period (post-intervention) varied based on the program. **Exhibit 2.2.1** provides an overview of the baseline and performance period by program.

Exhibit 2.2.1. Baseline and Performance Years for Demonstration Programs

	2014	2015	2016	2017	2018	2019	2020	2021
AE Program		**Baseline** *Q3 2014 – Q2 2016*		**AE Pilot Period** *Q3 2016 – Q2 2018*		**Performance** *Q3 2018 – Q3 2021*		
DCM Pilot						**Performance** *2019*		
BH Link							**Performance** *Q1 2020 – Q3 2021*	
PRS/FYSP					**Baseline** *Q3 2017 – Q2 2019*		**Performance** *Q3 2019 – Q2 2021*	
IMD Excl. Waiver					**Baseline** *Q3 2017 – Q2 2019*		**Performance** *Q3 2019 – Q3 2021*	

NOTES: AE = Accountable Entity; DCM = Dental Case Management; BH = Behavioral Health; PRS = Peer Recovery Specialists; FYSP = Family/Youth Support Partner; IMD = Institutions of Mental Disease. The AE Program is analyzed using a difference-in-differences design; BH Link and the DCM Pilot are analyzed using a cross-sectional design (performance period only), and PRS/FYSP and the IMD Exclusion Waiver are analyzed using a pretest-posttest design (no comparison group).

Treatment Group Identification

The identification of the treatment group is an important first step in the analysis of each program. Using each program's attribution rules and/or target population definitions, we defined program-specific treatment group members in the evaluation as participants who were enrolled in the corresponding program for each performance quarter and year. For the AE program, we used the MCO-provided flags in the Medicaid enrollment data, which indicate which of their members are attributed to an AE, to identify the AE treatment group. For all other programs, Rhode Island Medicaid members who received services from a particular program were identified from the claims based on documentation (e.g., diagnosis codes, visits to participating providers) provided by EOHHS. More details on the treatment groups by program and baseline or performance year can be found in **Exhibit 2.5**, and in each Demonstration program's dedicated chapter.

Comparison Group Construction

Based on sample size and target populations, it was possible to construct comparison groups for three of the five Demonstration programs in this report (the AE Program, BH Link, and the Dental Case Management pilot). To define inclusion and exclusion criteria for these program-specific comparison groups, we considered factors including sample size, data availability, and the comparability of the proposed comparison group to the target population based on observable characteristics. Due to the limited scope, broadly defined eligibility criteria, and the small number of participating enrollees the evaluation team, NORC, in collaboration with EOHHS, determined that comparison groups for the PRS and IMD exclusion waiver were not feasible. Additional details on the comparison group construction by program can be found in **Exhibit 2.2.2**.

Exhibit 2.2.2. Treatment and Comparison Group Definitions, by Demonstration Program

Program	Baseline Years	Performance Years
AE Program		
Treatment Group	• Rhode Island Medicaid-only members flagged as being in an AE by an MCO. • Limited to members in expansion, Rite Care, and RHP populations, who were **attributed to an AE during the performance period**.	
Comparison Group	• Rhode Island Medicaid-only members in managed care, limited to members in expansion, Rite Care, and RHP population, who were **never attributed to an AE during the performance period**. • Members enrolled in Rhody Health Options and who were ever attributed to an AE are excluded. Members treated by AE providers but not attributed to an AE are included.	
Dental Case Management		
Treatment Group	N/A	• Adult (ages 18+) Rhode Island Medicaid members in the FFS Medicaid dental delivery system, seen by participating providers in the performance period who received services under the 4 dental case management Current Procedural Terminology (CPT) codes.
Comparison Group	N/A	• Adult (ages 18+) Rhode Island Medicaid members in the FFS Medicaid dental delivery system, seen by participating providers in the performance period and who did not receive services under the 4 dental case management CPT codes.
BH Link		
Treatment Group	N/A	• Adult (ages 18+) Medicaid members **treated through the Behavioral Health Link triage center** during the performance period.
Comparison Group	N/A	• Adult (ages 18+) Medicaid members with one or more behavioral health conditions or diagnosed SUDs who were **not treated through the BH Link triage center** during the performance period.
PRS/FYSP Programs		
Treatment Group	▪ Medicaid members who accessed PRS or FYSP services during the performance period.	• Medicaid members accessing PRS or FYSP services during the performance period.
IMD Exclusion Waiver		
Treatment Group	▪ Medicaid members ages 21 to 64 years accessing IMDs for SUD treatment during the baseline period.	• Medicaid members ages 21 to 64 years accessing IMDs for SUD treatment during the performance period.

Addressing Selection Bias. Because enrollment in Demonstration programs is non-random, we assumed that members in the treatment group may be systematically different from those in the comparison group, a phenomenon known as selection bias. To obtain unbiased estimates from our analyses with comparison groups (the AE Program, BH Link, and the DCM Pilot), we addressed selection bias using propensity score weighting. First, we estimated the propensity score as the predicted probability of a member being in the treatment group using a logit model. Next, we computed propensity score weights for members in the treatment and comparison groups as the relative predicted probability of a member being in the treatment group. Members in the treatment group received a weight of $1/PS_i$, and members in the comparison group received a weight of $1/(1-PS_i)$, where PS_i is the predicted probability of the member being in the treatment group, given a set of observed covariates. The propensity score model included member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden. **Exhibit 2.3.2** summarizes the propensity score covariates used in each program's evaluation. In the Summative Evaluation Report, we will consider inclusion of additional covariates, including a variable indicating homelessness/housing status of Medicaid members.

Exhibit 2.2.3. Covariates Used to Estimate Propensity Scores and Risk-Adjusted Models

Variable	Definition	Source	AE	BH Link	DCM
Age	Member age	RI Medicaid enrollment data	X	X	X
Sex	Member self-reported sex	RI Medicaid enrollment data	X	X	X
Race/ethnicity	Member race/ethnicity	RI Medicaid enrollment data	X	X	X
Diabetes flag	Member diagnosis of diabetes in prior year	RI Medicaid claims and encounter data	X	X	X
Stroke/Transient Ischemic Attack (TIA) flag	Member diagnosis of stroke/TIA in prior year	RI Medicaid claims and encounter data	X	X	X
Acute Myocardial Infarction (AMI) flag	Member diagnosis of AMI in prior year	RI Medicaid claims and encounter data	X	X	X
Median household income	Median household income in member's zip code	ACS	X	X	X
Less than high school education	Percentage of member's zip code with less than a high school education	ACS	X	X	X
Percent under 100% federal poverty line	Percentage of member's zip code living below the federal poverty line	ACS	X	X	X
Receipt of SSI, TANF, SNAP in the Last 12 Months	Percent of households in member's zip code receiving SSI, SNAP, or Cash Public Assistance in the last 12 months	ACS	X	X	X

Variable	Definition	Source	AE	BH Link	DCM
Unemployment rates	Percentage of enrollee's zip code that is currently unemployed	ACS	X	X	X
COVID-19 cases	Average number of cases in county per 1,000 (2020-2021 only)	PVI	X	X	X
COVID-19 deaths	Total number of deaths in county per 1,000 (2020-2021 only)	PVI	X	X	X
PVI score	Average PVI score in county (2020-2021 only)	PVI	X	X	X
Case fatality rate	Average case fatality rate in county (2020-2021 only)	PVI	X	X	X
Vaccinated rate	Percentage of county population vaccinated (2021 only)	PVI	X	X	X
BH diagnosis	Flag for behavioral health diagnosis	Medicaid claims and encounter data	X		
MCO	Categorical indicator for MCO enrollment	Medicaid claims and encounter data	X		
Line of business	Categorical indicator for Medicaid line of business	Medicaid claims and encounter data	X		
Integrated health home enrollment	Flag for enrollment in an integrated health home^	Medicaid claims and encounter data	X	X	
SUD diagnosis	Flag for SUD diagnosis	Medicaid claims and encounter data		X	

NOTES: ACS = American Community Survey; PVI = Pandemic Vulnerability Index; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families. ^The integrated health home flag does not include Medicaid members receiving assertive community treatment (ACT), which is provided for members with the most acute behavioral health conditions, outside of an integrated health home. Since only approximately one percent of Medicaid members in an integrated health home were also receiving ACT, this flag may not capture members with the most acute behavioral health needs.

2.3 Descriptive Assessments

To evaluate Rhode Island's Comprehensive Demonstration, the NORC team first conducted descriptive analyses for all five waiver programs, focusing on characterizing members in each program (and each program's comparison group and/or baseline period, as applicable), as well as trends in unadjusted (raw) spending, utilization, and quality outcomes. Summary statistics (e.g., means, frequencies) between the groups were compared using chi-squared tests for categorical variables and t-tests for continuous variables. The summary statistics characterize the members in each Demonstration program and informed the development of our impact analyses.

For BH Link, the DCM Pilot Program, the IMD Exclusion Waiver, and the PRS/FYSP Programs, we conducted additional descriptive analysis to characterize the performance on spending and utilization

outcomes.‡ For these programs, we concluded that based on the program design and number of members in each program, it was not feasible to construct either a meaningful baseline period (BH Link, DCM) or an appropriate comparison group (PRS/FYSP program, IMD exclusion waiver). Due to these limitations, we performed cross-sectional analysis in the performance period or conducted a pretest-posttest analysis to explore the performance of the Demonstration programs. Each analysis was conducted in a risk-adjusted framework, accounting for key sociodemographic, health status, and area-level covariates. The methods used to conduct these analyses are summarized in **Exhibit 2.3.1** and described below. Results of our descriptive analyses are presented in tables and visuals in Chapters 3 through 7 for each program. All analyses were conducted using R version 4.1.2 and Stata version 17.0.

Exhibit 2.3.1. Descriptive Assessment Methods for Four Demonstration Programs

Program	Analysis Method	Level
BH Link	Cross-sectional analysis with treatment and propensity score-weighted comparison group	Member-quarter
DCM	Cross-sectional analysis with treatment and propensity score-weighted comparison group	Member-year
PRS/FYSP Programs	Pretest-posttest analysis (no comparison group)	Member-year
IMD Exclusion Waiver	Pretest-posttest analysis (no comparison group)	Member-quarter

For each Demonstration program, we assessed six core outcomes: 1) percent of members participating, 2) total Medicaid spending, 3) hospitalizations, 4) annual wellness visit, 5) emergency department visits, and 6) all-cause readmissions. Additionally, we assessed a selected number of program-specific outcomes determined in collaboration with EOHHS. We synthesized findings from these analyses with additional findings from our review of Demonstration documents and data, key informant interviews, and quality performance data provided by EOHHS to contextualize the claims-based outcomes and discussed the overall impact of the Demonstration programs.

Cross-Sectional Analysis

For BH Link and the DCM pilot Demonstration programs, we conducted cross-sectional analyses to assess core and program-specific outcomes for the treatment and comparison groups in the performance (post-intervention) period. For BH Link, the performance period is from January 2020 through September 202; for the DCM pilot, the performance period is only calendar year 2019. For BH Link, the sample size allowed us to conduct quarterly cross-sectional analyses in the performance period (i.e., a serial cross-sectional analysis). Due to the small sample size in the DCM treatment group and the limited span of the performance period (one year), we were only able to conduct analysis aggregated to the member-year level.

‡ For the AE program, we were able to conduct impact analyses; see Section 2.4 for more details.

Average outcomes in the performance period were estimated with a multivariate model, allowing comparisons between the treatment and comparison groups. We used multivariate generalized linear model regressions to describe changes in each outcome measure for the demonstration populations using the following equation:

$$g[(Y_{ijk})] = \beta_0 + \beta_1 Treat_j + \gamma Member_{ijk} + \pi Area_k$$

Where:

- Y_{ijk} is the outcome for the member *i* in treatment or comparison group *j*, in area *k* in the treatment or comparison group g *t*. We modeled Y_{ijk} with the appropriate distributional form and link function g(●), based on the distribution indicated by the Modified Park Test.
- $Treat_j$ is the binary indicator for the treatment group. The coefficient β_1 captures the mean of the difference between the treatment and comparison groups in the performance period.
- $Member_{ijk}$ and $Area_k$ are sets of member-level and area-level characteristics with coefficient sets γ and π, respectively.

Pretest-Posttest Analysis

For the PRS/FYSP programs and IMD exclusion waiver, we conducted a pretest-posttest analysis that allowed us to observe the outcomes among members in each program in a two-year baseline period (July 2017 through June 2019) before these Demonstration programs went into effect. No comparison groups are included in the pretest-posttest analyses. Pretest-posttest analyses allow us to compare the outcomes for members covered under the PRS/FYSP programs and the IMD Exclusion waiver program before and assess improvements in performance over those time periods. We used multivariate generalized linear model regressions to characterize changes in each outcome measure using the following equation:

$$g[(Y_{ikt})] = \beta_0 + \beta_1 Post_t + \gamma Member_{ikt} + \pi Area_k$$

Where:

- Y_{ikt} is the outcome for the member *i* in area *k* and time period (baseline or performance) *t*. We modeled Y_{ijt} with the appropriate distributional form and link function g(●), based on the distribution indicated by the Modified Park Test.
- $Post_j$ is the binary indicator for the performance (post-intervention) time period. The coefficient β_1 captures the mean of the difference between the baseline and performance periods for the treatment group.
- $Member_{ijkt}$ and $Area_k$ are sets of member-level and area-level characteristics with coefficient sets γ and π, respectively.

2.4 Impact Assessments

The AE Program, the program with the largest number of members attributed each quarter, is the only Demonstration program for which it was feasible to conduct an impact analysis. After conducting descriptive analyses for the AE Program, we assessed its impact using a difference-in-differences (DID) design, focusing on the six core Demonstration measures as well as five additional outcomes that align with the AE Program's goals. The DID analysis was conducted in a risk-adjusted framework, accounting for key sociodemographic, health status, and area-level covariates. Additional details on the DID methodology are described below.

Difference-in-Differences Analysis

We used a DID model to conduct impact analyses for the AE Program. The DID design adjusts for time-invariant characteristics of intervention and control groups, or factors that vary over time and affect both groups in the same manner. For each outcome measure, we chose the appropriate model specification based on the observed distribution of the outcome, using the modified Park test.[33] Next, we used generalized linear models to estimate the impact of AEs, including relevant covariates based on our empirical model of causality, and adjusting standard errors to account for clustering of observations within AEs. We used DID regressions to estimate the effect of the AE Program on each outcome measure using the following equation:

$$g[(Y_{ijkt})] = \beta_0 + \beta_1 AE_j + \delta_t Quarter_t + \theta AE_j \bullet Quarter_t \bullet Post + \gamma Member_{ijkt} + \pi Area_k$$

Where:

- Y_{ijt} is the outcome for the member *i* in AE or comparison group *j*, in area *k* and quarter *t*. We modeled Y_{ijt} with the appropriate distributional form and link function g(●), based on the distribution indicated by the Modified Park Test.
- AE_j is the binary indicator for a member attributed to an AE in either a baseline or performance quarter. The coefficient β_1 captures the mean of the difference between the AE and comparison group that remains constant over time.
- $Quarter_t$ represents fixed effects for calendar quarter. The coefficients δ_t capture changes in the AE and comparison group over time, before and after the implementation of the AE Program. For the AE Program analysis, the pilot period (July 2016 – June 2018) is considered an implementation ramp-up period and is excluded from both baseline and performance periods.
- The coefficient θ represents the DID estimate for the $AE_j \bullet Quarter_t \bullet Post$, the binary indicator for a member who is in the AE group in a given performance (post-intervention) quarter.
- $Member_{ijkt}$ and $Area_k$ are sets of member- and area-level characteristics with coefficient sets γ and π, respectively.

Examining Parallel Trends for the DID Model. An assumption of the DID approach is that the impact of the treatment can be inferred because the treatment and comparison group in the baseline had constant and parallel trajectories. In other words, the rate of change observed in the baseline is the

same for the AE and comparison groups and would hold constant in the post period in the absence of the intervention. To address these challenges, we employed a flexible DID framework that allowed groups to have differing baseline trends for outcomes. The flexible DID framework allowed us to relax the parallel trends assumption that is required for producing unbiased DID impact estimates. Instead, this approach assumes that the differential trends in the baseline period take a linear form and that they would have continued to persist in the absence of the AE Program.

Sensitivity Analyses. To test the robustness of the total Medicaid spending impact estimate, we conducted a sensitivity analysis that accounts for the cap on total cost of care for an individual member in a single year included in the AE Program's TCOC methodology. For this sensitivity analysis, the total Medicaid spending outcome is capped at the following values, based on state fiscal year (SFY):

- SFY 2019 (July 1, 2018 – June 30, 2019): $104,800
- SFY 2020 (July 1, 2019 – June 30, 2020): $109,800
- SFY 2021 (July 1, 2020 – June 30, 2021): $113,500
- SFY 2022 (July 1, 2021 – June 30, 2022): $119,600

Subgroup Analyses. Individual responses to the AE Program may differ from the average treatment effect for a variety of reasons; therefore, it is important to examine whether the effect of a program varies across member subgroups. We used multivariate generalized linear models to estimate the risk-adjusted means for spending and utilization outcomes in the performance period for subgroups of AE and race/ethnicity, which allows us to descriptively assess the performance of the AE program across these groups.

2.5 Evaluation Measures

Using Rhode Island Medicaid claims and encounter data, we constructed measures to describe the Demonstration program member populations and assess the Demonstration's impact on cost, utilization, and quality of care outcomes. To estimate the impact of the Demonstration program, we assessed a standard set of six core measures for each program, as well as additional program-specific measures as data and resources allowed.

Descriptive Measures

We used Rhode Island's Medicaid enrollment, claims, and encounter data to characterize members and outcomes in each of the Demonstration programs. **Exhibit 2.5.1** lists the descriptive measures in three domains (sociodemographic characteristics, zip code-level characteristics, and COVID-19 county-level characteristics) that we assessed for each program, contingent on data availability and sample size.

Exhibit 2.5.1. Descriptive Measures Used to Assess Demonstration Programs

Sociodemographic Characteristics	Health Status

• Age
• Sex
• Race/ethnicity
  – White, not Hispanic
  – Black, non-Hispanic
  – Hispanic
  – Multiple/other non-Hispanic
  – Unknown
	• COVID-19 diagnosis
	• Chronic conditions^
	  – Diabetes
	  – Stroke/transient ischemic attack
	  – Acute myocardial infarction

Zip Code-Level Characteristics	
• Under 100% of federal poverty level • Less than a high school education • Unemployment rate • Median household income	• Receiving supplemental security income, temporary assistance for needy families, or supplemental nutrition assistance program
COVD-19 County-Level Characteristics	
• Number of cases per 1,000 population • Average case fatality rate per 1,000 population • Total percentage of population vaccinated	• Number of deaths per 1,000 population • Average Pandemic Vulnerability Index score

NOTE: ^Selected based on priority conditions identified by EOHHS. A broader set of chronic conditions will be included in the Summative Evaluation Report (pending data availability).

Outcome Measures

Using Rhode Island Medicaid claims and encounter data, we constructed seventeen outcome measures to assess the Demonstration's impact on cost, utilization, and quality of care outcomes for members in the five Demonstration programs (**Exhibit 2.5.2**). We developed a standard set of six core measures applied across programs (highlighted in orange), with eleven additional program-specific measures relevant to key Demonstration program goals.

Exhibit 2.5.2. Claims-Based Outcome Measures and Specifications

Number of members enrolled	
Description	Number of Rhode Island Medicaid members enrolled and/or engaged in each of the Demonstration programs (definition of enrolled will vary by program criteria)
Programs	All
Total Medicaid spending	
Description	Total Medicaid spending per Rhode Island Medicaid member. Includes all Medicaid medical spending on all claims and encounter data through attribution end date and excludes spending on prescription drugs.
Programs	All

Hospitalizations	
Description	Number of all-cause acute care inpatient stays per 1,000 Rhode Island Medicaid members. In the case of a hospital-to-hospital transfer, only one stay is counted.
Programs	All
Annual Wellness Visit	
Description	Number of annual wellness visits with providers per 1,000 Rhode Island Medicaid members. Members must have been continuously enrolled for the entire year to be included in this measure.
Programs	All
Emergency Department visits	
Description	Number of emergency department (ED) visits and observation stays per 1,000 Rhode Island Medicaid members not resulting in a short-term inpatient hospitalization. The ED admission date in a baseline or performance year determines inclusion in this outcome.
Programs	All
All-cause readmissions	
Description	Occurrences of unplanned hospitalization within 30 days of discharge from hospital, per 1,000 Rhode Island Medicaid members. This analysis will be done only for members with an index hospitalization, as those *without* an index hospitalization cannot subsequently have a 30-day readmission.
Programs	All
Potentially avoidable ED visits	
Description	Count of potentially avoidable ED visits per 1,000 Rhode Island Medicaid members, calculated using the "patched" NYU algorithm[34]
Programs	AE Program
Breast cancer screening	
Description	Number of Rhode Island Medicaid members 50-64 years of age who had a mammogram to screen for breast cancer, per 1,000 members.^
Programs	AE Program
Follow-up after hospitalization for mental illness	
Description	Number of follow-up visits with a mental health provider within 7 and 30 days after hospitalization for selected mental illness conditions, per 1,000 Rhode Island Medicaid members.[35]
Programs	AE Program
Dental case management code use	
Description	Number of dental claims for Rhode Island Medicaid members that include new dental case management codes (D9991, D9992, D9993, D9994), seen at participating Pilot providers.
Programs	DCM
Dental services	
Description	Number of dental services per 1,000 Rhode Island Medicaid adult (18+) members enrolled in fee-for-service Medicaid.[36]
Programs	DCM

Preventative/Ambulatory health services	
Description	Number of Rhode Island Medicaid members who had an ambulatory or preventative care visit, per 1,000 members.[37]
Programs	PRS/FYSP
Use of Behavioral health (BH) Services	
Description	Number of Rhode Island Medicaid members using behavioral health services, per 1,000 members.
Programs	PRS/FYSP, BH Link, IMD Exclusion
Emergency department (ED) visits for behavioral health (BH) services	
Description	Number of ED visits related to behavioral health (mental health, substance use disorder, or opioid use disorder), per 1,000 Rhode Island Medicaid members
Programs	BH Link, IMD Exclusion
Follow-up after ED visit for mental illness	
Description	Number of Rhode Island Medicaid members with a follow-up visit to a provider within 7 or 30 days of an ED visit with a primary diagnosis of mental health condition or an alcohol/drug dependence, per 1,000 members.
Programs	PRS/FYSP, IMD Exclusion
IMD Service Use	
Description	Number of Rhode Island Medicaid members who received services in a residential IMD for substance use disorder, per 1,000 members.
Programs	PRS/FYSP, BH Link, IMD Exclusion

NOTE: The timeframe for each measure depends on the level of analysis for each program; see **Exhibit 2.3.1**. ^Because the AE population does not include Medicaid members 65 years and older, this outcome only measures breast cancer screening for that age range.

2.6 Limitations

There are several important limitations to our analyses. First the initial set of claims-based findings are limited by the partial implementation period for each program, which ranges from one year to three years. As such, our evaluation reflects only the timeframes for which claims and administrative data were available, and not the entirety of the Demonstration. Results may change as Demonstration programs continue and/or more data become available, as state agencies and participating providers have additional time to implement each program and refine their operations.

In addition to a limited implementation period, the small number of members participating in some of the Demonstration programs limited our ability to conduct impact assessments. For instance, the Dental Case Management program served less than 70 Rhode Island Medicaid members in its entire performance period, making it difficult to interpret any findings about members receiving those services. Similarly, use of PRS/FYSP program services has increased starting in late 2020, but prior to that, fewer than 85 members utilized those services in each quarter. Due to these small sample sizes, conducting a quarterly analysis for these two programs was not feasible; for both, we aggregated data to the year-level and conducted an annual analysis (for the Dental Case Management pilot, this meant

there was only one time point in the cross-sectional analysis). Our team heavily relied upon descriptive assessments for measures to gain a better understanding of outcomes in these two programs.

The COVID-19 pandemic also posed challenges for conducting key informant interviews about implementation the Demonstration's behavioral health programs (BH Link, PRS/FYSP, and the IMD Exclusion Waiver) in Spring 2020, potentially leading to an incomplete picture of the current state of implementation of these programs. State agencies, health care systems, and MCOs understandably focused their attention and priorities on quickly responding to Medicaid members' needs in the pandemic environment. Interviewees from EOHHS, BHDDH, and RIDOH noted that the state's resources were being redirected to address the pandemic and support state public health efforts. After discussion with EOHHS, the decision was made to not reach out to MCO representatives for interviews, as their efforts were focused on the statewide COVID-19 response at that time. Additionally, the scope and timeframe for our key informant interviews were limited to two narrow topics (early AE program implementation progress in 2019; implementation updates on behavioral health programs in Spring 2020), which does not capture updates current to the date of report submission, or the broader scope of this Demonstration evaluation.

As such, while we have developed an overall understanding of existing program implementation and noted in the program-specific chapters when activities have shifted to focus on COVID-19, we were not able to assess the impact of COVID-19 on the Demonstration overall. We were also unable to distinguish any mechanisms of action through which COVID-19 affected the evaluation outcomes. Due to the myriad factors that contribute to the impact of COVID-19 in Rhode Island at the individual and community levels, we are unlikely to fully capture the impact of the COVID-19 pandemic on Demonstration programs, even when accounting for individual-level COVID-19 diagnoses and county-level pandemic statistics. Where possible, we have attempted to consider drivers of Demonstration program outcomes in light of the ongoing COVID-19 pandemic.

Chapter 3: Accountable Entity Program

3.1 Accountable Entity Program Background

Building off work by the Working Group to Reinvent Medicaid, Rhode Island received funding under the 2013 Comprehensive Demonstration, and subsequently under the 2018 Demonstration extension, to implement the Health System Transformation Project (HSTP) to support the transformation of the Medicaid program. Since that time, Rhode Island has been working diligently to implement the HSTP to advance the state's "path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees."[38] The core component of the HSTP is the creation of Accountable Entities (AEs), the integrated provider organizations responsible for the total cost of care, health care quality, and outcomes among an attributed population. This new infrastructure builds on the strengths of the current managed care organization (MCO) model to create partnerships between AEs and MCOs, enhancing MCO capacity to serve high-risk populations by increasing delivery system integration and improving information exchange and clinical integration across the continuum.

AEs serve as the main driver and coordinator of long-term health system transformation in Rhode Island. Two distinct AE programs were developed: the Comprehensive AE Program and a "specialized" AE program, the Long-Term Services and Supports Alternative Payment Methodology (LTSS APM) Program. The Comprehensive AE Program promotes change in alignment with the Demonstration's transformation activities by encouraging interdisciplinary partnerships of providers centered around primary care. The Comprehensive AE program began as a limited pilot (the "AE Coordinated Care Pilot Program") in July 2016; this pilot was a precursor to the full, statewide AE Program, which was launched in July 2018 and is expected to run through June 2024.[39] The LTSS APM, which is set to launch in July 2022, aims to help eligible and aging populations reside in their communities, improve equitable access to home and community-based services to prevent institutional LTSS, and foster a sustainable network of high-quality home- and community-based providers.[40] In both the Comprehensive AE Program and the LTSS APM program, the providers will be accountable for members' care and are "expected to enhance MCO capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum."[38]

Goals, Objectives, and Priorities

The partnership between AEs and MCOs in the HSTP provides the framework for restructuring the state's Medicaid program, moving from fee-for-service (FFS) at the point of delivery to value-based purchasing and increased focus on total cost of care (TCOC). In the spring of 2019, EOHHS began a strategic planning process to formulate a set of strategic goals to govern Rhode Island's Medicaid managed care program and the AE Program that are specified in the state's Medicaid Program Accountable Entity Roadmap document for Program Year 5. As noted in the roadmap, the goals and priorities of the AE Program include:

Partnerships and collaboration between MCOs and AEs are a key feature of the AE program's design.

MCOs are responsible for **identifying members** who are attributed to AEs, **establishing AE benchmarks** (in partnership with EOHHS), and **executing shared savings** contracts.

AEs are responsible for **coordination and management of care** for their attributed population, via implementation of **population health approaches**.

- Maintaining and expanding on Rhode Island Medicaid's record of excellence in delivering high-quality care
- Substantially transitioning the Medicaid payment system away from FFS to alternative payment models
- Structuring delivery system accountability with the goals of enhancing quality, increasing member satisfaction, improving health outcomes, and reducing TCOC
- Improving care delivery for individuals with complex health care needs and enabling vulnerable populations to live successfully in the community
- Developing provider relationships that apply data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs
- Improving health equity and efforts to address and incorporate social determinants of health and behavioral health into care
- Ensuring access to high-quality primary care and encouraging interdisciplinary care coordination

Anticipated AE Program effects on health care costs and utilization include:

- Decreased readmission rates, hospitalizations, and emergency department (ED) visits
- Improvements in the balance of long-term care utilization and expenditures, away from institutional and into community-based care
- Improved coordination of medical, social, and behavioral health services
- Increased numbers of Medicaid members who choose or are assigned to a primary care practice that functions as a patient-centered medical home
- Targeted reductions in expenditures related to high and rising risk populations by increasing delivery system integration and improvement of information exchange/clinical integration.

Phases of AE Program Implementation

The AE Program is being implemented in a phased approach, with the Comprehensive AE and LTSS APM programs implemented independently in discrete phases (**Exhibit 3.1.1**). This evaluation includes findings for the Comprehensive AE program only, as LTSS APM Program implementation was initiated on July 1, 2022. More details about the two programs and their phases are included in the following sections.

Exhibit 3.1.1. Timeline for Comprehensive AEs and LTSS APM

AE Program	Pilot	Full Program
Comprehensive AE Program	July 2016 – June 2018	July 2018 – June 2024
LTSS APM Program	July 2022 – December 2023	January 2024 – December 2027

Phase 1: Comprehensive AE Program

The Comprehensive AE is an interdisciplinary partnership of providers with a strong primary care base that ensures coordinated access to other services including specialty care, behavioral health care, and social support services. The AE Pilot was designed to function as an initial starting point prior to the initiation of the full Comprehensive AE Program under HSTP. During the two-year pilot, providers gained experience working under a value-based payment model and were able to test the experience of participating in the AE Program without concern related to potential financial penalties. Many AEs participated in the AE Pilot to prepare for the full program, and five out of six initial pilot AEs applied for and became Comprehensive AEs under the full program in 2018.

AEs **integrate behavioral and physical health** care and **address social determinants of health** by applying a population health approach that is:

- Population-based
- Data-driven
- Evidence-based

The Comprehensive AE Program launched on July 1, 2018. To participate in the program, prospective Comprehensive AEs were required to demonstrate that they met the AE Certification Standards issued by EOHHS. The AE certification standards and the corresponding application and approval process were intended to promote the development of new forms of organization, care integration, payment equity, and accountability.[41] Certification standards for Comprehensive AEs are organized into two categories and eight domains (**Exhibit 3.1.2**). To receive certification from EOHHS, AEs were required to demonstrate specific compliance in each domain or identify how they would achieve compliance and provide a timeline for doing so.

Exhibit 3.1.2. Comprehensive AE Program Certification Domains

Category 1: Readiness
Domain 1: Breadth and Characteristics of Participating Providers
An AE is required to have a minimum number of partner or affiliated providers in relation to the population that the AE serves. This group of providers must be interdisciplinary in nature to provide the care required of the AE in addressing the following categories: primary care, behavioral health, substance use services, and social determinants of health.
Domain 2: Corporate Structure and Governance
The intent of these requirements is: • To ensure multi-disciplinary providers are actively engaged in a shared enterprise and have a stake in both financial opportunities and decision-making of the organization • To ensure that assets and resources intended to support Rhode Island Medicaid are appropriately allocated, protected, and retained in Rhode Island • To ensure that the mission and goals of the new entity align with the goals of EOHHS and the needs of the Medicaid population • To ensure a structured means of accountability to the population served.
Domain 3: Leadership and Management
The AE should have a clear organizational framework that allows them to both address the key operational and management areas required of them; and model how the AEs structure will foster a coordinated system of care.
Category #2: System Transformation
Domain 4: IT Infrastructure – Data Analytic Capacity and Deployment
The AE will utilize comprehensive health assessment and evidence-based systems that integrate patient information to forge system connections that go beyond traditional medical claims and eligibility systems.
Domain 5: Commitment to Population Health and System Transformation
The AE will have a clearly defined strategy on how it proposes to impact care and health outcomes from a population health and system transformation perspective. In particular, the AE will describe how it plans to organize resources to address all subpopulations and the most complex needs within the state.
Domain 6: Integrated Care Management
The AE will demonstrate its approach to integrating care across life domains, particularly for at-risk populations, to address clinical, behavioral, and social determinants of health across the care continuum.
Domain 7: Member Engagement and Access
The AE must have defined strategies to maximize effective member contact and engagement, including the ability to effectively outreach to and connect with hard-to-reach, high-need target populations.
Domain 8: Quality Management
The AE will maintain an ongoing Quality Committee that reports to the Governing Board of a multiple entity AE or to the Governing Committee of a single entity AE.

Once certified, AEs must be re-certified by EOHHS annually. In the initial years of the program, AEs focused on fulfillment of the AE Certification Standards in the Readiness category (Domains 1 – 3). As AEs mature and grow in later program years, they will concentrate progressively more on System Transformation advancements (Domains 4 – 8). As a part of the application and/or re-certification process, EOHHS requires that AEs submit certification applications including project plans that identify

specific activities and performance milestones to help AEs achieve system transformation under Domains 4 – 8.[38]

Five Comprehensive AEs were certified and entered into contracts with MCOs in Program Year 1 (July 2018 – June 2019); by Program Year 4, there were seven AEs in total. **Exhibit 3.1.3** presents the AEs, their networks, the year that they joined as a Comprehensive AE, and the number of attributed members. In total, 190,995 Medicaid members were attributed to AEs as of the beginning of PY4 (August 2021).[42] In PY4, all AEs have contracts with one or both of Rhode Island's two MCOs participating in the AE Program, Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare Community Plan (UHCCP-RI). Tufts Health Public Plans (currently Point32Health) participated in the AE Program in PY2 only, with three AEs. As of August 2021, approximately 63 percent of all AE-attributed members are enrolled in NHPRI, with 37 percent enrolled in UHCCP-RI.

Exhibit 3.1.3. Participation among Comprehensive AEs, Program Years 1 Through 4

AE Name	MCO Contracts	Type	Year Joined	Attributed Members as of PY4
Blackstone Valley Community Health Care	• NHPRI	Federally Qualified Health Center (FQHC)	PY1 (2018)	13,707
Coastal Medical	• NHPRI • UHCCP-RI • Tufts^	Physician group	PY2 (2019)	13,859
Integra Community Care Network	• NHPRI • UHCCP-RI • Tufts^	Network of hospital systems and medical practices	PY1 (2018)	50,577
Integrated Healthcare Partners	• NHPRI • UHCCP-RI	FQHCs and community mental health centers	PY1 (2018)	29,092
Prospect Health Services Rhode Island	• NHPRI • UHCCP-RI • Tufts^	Network of hospital systems and medical practices	PY1 (2018)	20,817
Providence Community Health Centers	• NHPRI • UHCCP-RI	FQHC	PY1 (2018)	52,547
Thundermist Health Center	• NHPRI • UHCCP-RI	FQHC	PY4 (2021)	24,103

NOTE: NHPRI = Neighborhood Health Plan of Rhode Island; UHCCP-RI = United Healthcare Community Plan of Rhode Island. ^Tufts Health Plan only participated in the AE Program in PY2.

Phase 2: Specialized AE: LTSS APM Program

The LTSS APM Program aims to:

- Encourage and enable LTSS eligible and aging populations to live successfully in their communities
- Improve and ensure equitable access to home- and community-based services (HCBS) that prevent LTSS eligible populations from needing institutional LTSS
- Foster a sustainable network of high quality HCBS providers that are equipped to meet the diverse needs of LTSS members

The specialized focus of the LTSS APM program required that EOHHS actively involve stakeholders in the design, refinement, and implementation of the model. Initially, EOHHS held a series of stakeholder meetings in the spring and summer of 2017 that began informing the development of the program. Planning continued through 2019 but was interrupted due to the COVID-19 pandemic. Throughout the summer and fall of 2021, EOHHS reconvened stakeholders in discussions to inform the program design for the LTSS APM model, including publishing a Request for Comment answered by Neighborhood Health Plan of Rhode Island and UnitedHealthcare Community Plan of Rhode Island. Following those conversations and additional feedback from CMS, EOHHS published the LTSS APM Program Requirements for Program Year 1 on December 15, 2021. EOHHS will continue to seek public input and comment on the LTSS APM model throughout the program development and implementation process. In the Summative Evaluation Report, we will report on progress for the LTSS APM program and, if sample size permits, estimate the impact of the program relative to a similar comparison group.

In July 2020, EOHHS received an extension of its Medicare-Medicaid Program through 2023, and also executed contracts with two Dual Eligible Special Need Plans. Both programs are managed care programs targeted for the dually eligible population. EOHHS has an opportunity to pilot the LTSS APM Program through the Medicare-Medicaid Program and, depending on initial results, extend the pilot offering to Dual Eligible Special Need Plans in Rhode Island. Currently, the pilot program will only be available through EOHHS integrated managed care programs for dual eligible members through the Medicare-Medicaid Program. Home care agencies providing homemaker and certified nursing assistant services are eligible to participate in the LTSS APM pilot program. Any home care agency contracted with participating managed care programs can enter into an agreement with that managed care entity to participate in the LTSS APM. There is no minimum membership threshold for participating agencies.

MCO Reporting Standards and Quality Performance Measurement

EOHHS has developed a series of quality metrics and reporting standards for the Comprehensive AE Program to 1) ensure compliance with AE Program guidelines, 2) monitor the extent to which AEs are providing coordinated care, and 3) determine whether AEs' efforts have led to improvements in population health. **Exhibit 3.1.4** describes the type and frequency of reporting to EOHHS that must be completed by MCOs for each Comprehensive AE with which they contract.[38] In order to monitor the

quality of care that AE-attributed members are receiving from MCOs, EOHHS requires MCOs to provide annual reports with quality performance data on the AE Common Measure Slate.[§]

Exhibit 3.1.4. MCO Reporting Requirements for Comprehensive AE Program

Reported by MCO	Description	Frequency
AE population extract	List of all Medicaid MCO members attributed to each AE	Monthly
AE provider roster	List of current practitioners in the AE's provider network	Monthly
AE quality measure report	Results for the set of clinical and quality outcomes used to determine the quality multiplier for TCOC	Annual
Clinical data exchange implementation reports	Status of clinical data exchange efforts with each AE	Monthly
MCO/AE milestone performance reports	Demonstrate compliance with MCO and AE incentive reward programs	Quarterly
Outcome metric reports	Performance data on three identified outcome measures; used to calculate HSTP incentive amount	Quarterly & Annual
TCOC historical base data	Data to support the development of the TCOC benchmark for the subsequent PY	Annual
TCOC performance report	Data to support the development of TCOC report	Quarterly & Annual
AE base contract checklist	Confirmation of elements required in the AE-MCO contract	Annual
Final return on investment (ROI) project report	Documentation of findings for "ROI Project" through which adding funds can be earned (available to FQHCs only)	Annual

Attribution Methodology

The overall population eligible for attribution to a comprehensive AE consists of Medicaid-only members enrolled in managed care, and members may only be attributed to a single AE. Attribution occurs in two steps. The first step is member selection or assignment by the MCO to a primary care provider (PCP) affiliated with an AE at the time of member's enrollment with the MCO. The second step is quarterly attribution reconciliation based on claims-based utilization analysis and member-requested changes to an assigned PCP. This reconciliation is done based on member use of qualifying primary care services and associated AEs. While MCOs are required to use EOHHS-approved methodology to attribute members to AEs, PCP assignment methods vary slightly across MCOs. Additionally, on a

[§] Quality performance data are collected for the following measures: breast cancer screening, adult BMI assessment (through PY3 only), weight assessment and counseling for nutrition and physical activity (through PY4 only)developmental screening in the first three years of life, adult BMI assessment, child and adolescent well-care visits (12-17 years; 18-21 years; total 12-21 years), tobacco use screening and cessation intervention, comprehensive diabetes care (HbA1c control; eye exam), controlling high blood pressure, follow-up after hospitalization for mental illness (7 and 30 days), screening for clinical depression and follow-up plan, social determinants of heath (SDOH) infrastructure development (through PY3 only), SDOH screening.

monthly basis, MCOs submit electronic lists of attributed members to AEs and EOHHS, so that AEs can review the members they are accountable for and track changes in member Medicaid eligibility, member PCP requests, and quarterly reconciliation. HSTP incentive fund pools for each AE are developed using an estimate of the number of months that members will be attributed to each AE, based on prior numbers of AE-attributed MCO members in the preceding performance year. Annual incentive fund pools are determined based on attribution of members to an AE in April of the year preceding the start of the next state fiscal year/program year, quality performance measurement is based on attribution of members to an AE in December of the quality performance year, and total cost of care (TCOC) analyses are measured based on attribution for each member in that member's final month of Medicaid managed care during the state fiscal year.[43]

Total Cost of Care Methodology

One of the key innovations of the AE Program is the application of a TCOC methodology to evaluate quality and performance and to inform the distribution of shared savings. EOHHS established the following goals for its Comprehensive AE TCOC methodology:

- Provide opportunity for a sustainable business model
- Create financial flexibility for AEs
- Be fiscally responsible for all participating parties
- Specifically recognize and address the challenge of small populations
- Incorporate quality metrics related to increased access and improved member outcomes
- Require timely data exchange and performance improvement reporting between MCOs and AEs
- Define and establish a progression toward meaningful AE risk

The TCOC methodology uses a projected historical baseline cost of care, adjusted to the relative market average to calculate a TCOC expenditure target for the performance period. The TCOC expenditure target is compared to actual costs during the performance period to determine a potential shared savings or risk pool. The shared savings pool is then adjusted based on an overall quality score, generated through an assessment of the AE's performance relative to a set of quality measures. Additionally, certain qualified AEs must demonstrate a progression towards meaningful downside shared risk within three years of program participation. Downside risk incentivizes AEs to invest in care management and other services to address member needs and reduce duplication of services, which is expected to yield better health outcomes and lower costs.[44,45]

AE Program Design Modifications in response to COVID-19

To respond to the impacts of the COVID-19 pandemic on the health care system, EOHHS adjusted program requirements for the AE program, making several changes with effects on total cost of care, quality performance, and capacity for quality reporting. Key design modifications are described in **Exhibit 3.1.5**.

Exhibit 3.1.5. AE Program Modifications in Response to the COVID-19 Pandemic

Total Cost of Care Methodology
• Removed the requirement for downside risk for non-FQHC AEs in PY3. • Maintained the requirement for AEs taking on downside risk in PY3 to complete the Risk-Based Provider Organization certification process with the Rhode Island Office of the Health Commissioner.
Quality Performance Measurement
• Extended re-certification deadlines for PY3 for AEs from March 20, 2020, to April 17, 2020. • Used the PY2 Quality Score methodology instead of PY 3 methodology, except for those measures that are common to both PY2 and PY3 for MCOs. • Recommended that MCOs use the best outcomes from measures common to both PY2 and PY3 (i.e., where PY2 performance is better, MCOs use PY2 and where PY3 performance is better, MCOs use PY3). • Required that MCOs must report performance on new PY3 measures to EOHHS, but do not need to include the results in the Overall Quality Score calculation.
Incentive Funding
• Required AEs to submit an updated pandemic safety and preparedness plan that addresses health equity, social determinants of health, and use of technology such as telehealth. This milestone was worth 5% of Incentive Funds and was due August 3, 2020. • AEs had the opportunity to earn 10% of Incentive Funds by either providing evidence of risk-based provider organization certification per the Office of the Health Insurance Commissioner or executing an EOHHS-qualified APM contract with an MCO (which need not include downside risk). • Incentive payments for outcome measure reporting implemented on a pay-for-reporting basis, contingent on AEs submitting a description and self-evaluation of implemented plans to improve each of the three measures: All-Cause Readmissions, Potentially Avoidable ED Visits, and ED Utilization for Individuals Experiencing Mental Illness.

3.2 Evaluation Hypotheses and Outcomes

AE performance will be evaluated with a focus on efforts towards meeting the established goals of the program and improving relevant performance metrics. As described in the **Exhibit 3.2.1**, the evaluation design examines whether the demonstration reduces utilization and overall Medicaid spending while maintaining quality of care and whether the demonstration increases coordination among different care types and lead to better health outcomes for RI Medicaid enrollees. The two evaluation hypotheses will be tested by addressing several targeted research questions examining the percentage of Medicaid patients attributed to the program, trends in and impact of the program on spending, utilization, and quality of care, the experience of care for members, and whether care integration reduces high-cost care.

Exhibit 3.2.1. Overview of AE Program Goals, Evaluation Hypotheses, Research Questions, Target Population, and Metrics

Goals	• Transition the Medicaid payment system away from FFS to alternative payment models • Drive delivery system accountability to improve quality, member satisfaction and health outcomes, while reducing cost of care • Develop targeted provider partnerships that apply emerging data capabilities to refine and enhance care management, pathways, coordination, and responsiveness to emergent needs • Improve health equity and address social determinants of health and behavioral health by building on a strong primary care foundation to develop interdisciplinary care capacity that extends beyond traditional health care providers • Enable vulnerable populations to live successfully in the community
Target Population	• The population eligible for attribution to an AE consists of Medicaid-only members enrolled in managed care; members may only be attributed to a single AE.
Evaluation Hypotheses	• The AE Program will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members • The AE Program will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members
Research Questions	• What percentage of Medicaid members are attributed to an AE? • What are the trends in spending, utilization, and quality of care for AE-attributed members? • What is the impact on spending, utilization, and quality of care for AE-attributed members? • What is the experience of care for AE-attributed members? Are they satisfied with their care? • Does better care integration reduce high-cost care for members?
Performance Metrics	• All-cause readmissions • ED utilization among members with mental illness • Potentially avoidable ED visits • Breast cancer screening • Follow-up after hospitalization for mental illness

3.3 Analytic Approach

The below section details our approach to evaluating the AE Program's impact, including baseline and performance periods, identification of treatment and comparison groups, key outcomes, and our analytic approach. All analyses for the AE Program are conducted with Rhode Island Medicaid members in an MCO who received full Medicaid benefits for all three months in the calendar quarter.

Baseline and Performance Periods. The baseline period for the AE Program analysis is July 2014 – June 2016, and the performance period is July 2018 – September 2021. We excluded data from the period during which the Comprehensive AE Pilot was implemented (July 2016 – June 2018), as that was considered an implementation ramp-up period for

Baseline Period for AE Program analysis
July 2014 – June 2016

Performance Period for AE Program analysis
July 2018 – September 2021

the full program implementation and inclusion of those years may attenuate the observable impacts of the AE Program in a difference-in-differences framework. For this report, we analyzed data through September 2021 based on current availability of complete data for that period; in the Summative Evaluation Report, we will analyze data through the end of the AE program period (currently June 2024).

Treatment Group Identification. To identify members who were enrolled in an AE in the performance period, we used the flags in Medicaid enrollment data from MCOs that indicate members who were attributed to an AE on a monthly basis. Members who were indicated as enrolled in an AE for all three months of the calendar quarter were considered attributed for that quarter of the analysis. To identify AE members in the baseline, we included all members who were attributed to an AE in any quarter of the performance period.

Comparison Group Identification. The comparison group for the AE Program analyses comprises Medicaid-only members who are in an MCO but were *not* attributed to an AE during the performance period. In discussions with EOHHS, we determined that this was the most appropriate comparison group because these are members who are eligible to be attributed to an AE and may be in the future. Thus, spending and utilization patterns among these groups are likely to be similar in the baseline period (i.e., before AEs were implemented), and the key difference in the performance period is that some members are attributed to an AE, which may be driving differences we see in the observed impacts from our analyses. To identify comparison group members in the baseline, we included members that were never attributed to an AE during the performance period and who were younger than 65 years and not dually eligible for Medicare.

Outcomes. For the AE Program, we focused our analysis on six core claims-based metrics (i.e., metrics that are measured for each demonstration program) as well as four additional metrics that are specific to the AE Program and its mechanisms of transformation (**Exhibit 3.3.1**). Additionally, we assessed aggregate metrics from AE quality performance data and MCO Consumer Assessment of Healthcare Providers and Systems (CAHPS) data in order to provide context for the claims-based outcomes.

Exhibit 3.3.1. AE Program Outcomes for Evaluation

Core Demonstration Outcomes
• Number of members attributed to an AE
• Hospitalizations
• Emergency department visits
• Annual wellness visit
• All-cause readmissions
• Total Medicaid spending
AE Program Outcomes
• ED utilization among members with mental illness
• Potentially avoidable ED visits
• Follow-up after hospitalization for mental illness
• Breast cancer screening

Analytic Approach. We conducted the following analyses to characterize the AE-attributed members and estimate the impact of the AE program:

- **Descriptive analyses of member characteristics** to understand the members that AEs are serving, and how many members they are serving over time

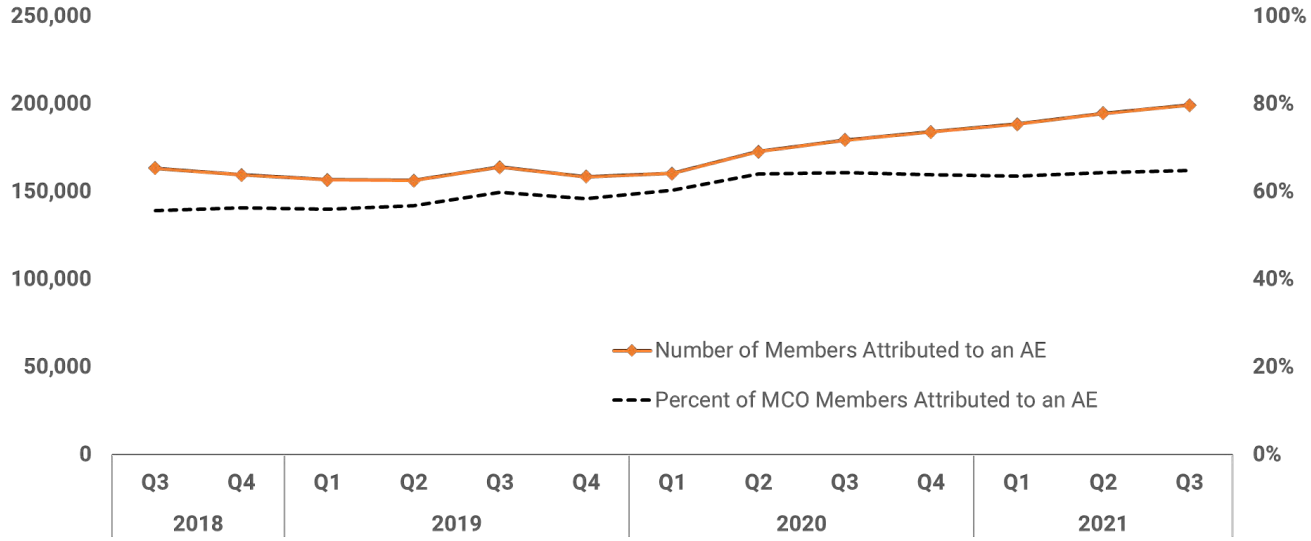
- **Descriptive analyses of AE quality performance data and MCO CAHPS data** to provide additional context to the claims-based outcomes we observe
- **Unadjusted analyses of outcomes** to identify trends in the nine key outcomes in the baseline and performance periods, for the AE and comparison groups
- **Risk-adjusted difference-in-differences (DID) analyses** to compare the experience of members in the AE and comparison groups in the baseline and performance period, which will allow us to estimate the impact of the AE program on each of the nine outcomes. DID analyses control for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden.

3.4 Findings

Descriptive Assessments

Member attribution. Over the course of the AE Program, 270,092 unique Rhode Island Medicaid members have been attributed to an AE. As shown in **Exhibit 3.4.1**, the number of members attributed to AEs has risen over time, from 163,125 in July 2018 (55.6 percent of Medicaid members in MCOs) to 199,154 in September 2021 (64.7 percent of Medicaid members in MCOs). Member attribution to AEs stayed relatively constant from July 2018 to March 2020, with slight fluctuations in the number of attributed members from quarter to quarter. Starting in April 2020, the number of members attributed to an AE has risen every quarter while the percent of AE-attributed among eligible members (i.e., members in an MCO) has remained steady. This reflects the overall increase in Medicaid enrollment due to the Medicaid continuous enrollment requirement enacted in the Families First Coronavirus Response Act, wherein CMS requires state Medicaid agencies to retain members enrolled in the Medicaid program from January 2020 through the end of the declared public health emergency.[8]

Exhibit 3.4.1. Members Attributed to AEs (July 2018 – September 2021)



SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.

Sociodemographic characteristics. Sociodemographic and area-level characteristics of both the AE-attributed and propensity-weighted comparison groups were similar and consistent across the baseline and performance periods (**Exhibit 3.4.2**). Most AE-attributed and comparison members in the performance period were female (53.2 percent for both groups) and white** (40.4 percent and 40.5 percent, respectively), and slightly over one-quarter in both groups were Hispanic.††

** Race and ethnicity are measured separately, therefore there is overlap between the white and Hispanic groups.

†† The decrease in the "Unknown" race category during the performance period reflects increased efforts around collecting and recording race/ethnicity data for Medicaid members in recent years.

Exhibit 3.4.2 Sociodemographic Characteristics of AE-Attributed and Comparison Members, Baseline (July 2014 – June 2016) and Performance (July 2018 – September 2021) Periods

	Baseline Period (July 2014 – June 2016)		Performance Period (July 2018 – September 2021)		
	AE-Attributed Members	Comparison Group	AE-Attributed Members	Comparison Group	Difference
Unique members	100,704	219,533	270,092	233,178	N/A
Sociodemographic Characteristics					
Age (%)					
<18 years	41.4	41.3	39.7	39.8	-0.13
18-34 years	26.4	26.7	27.3	27.4	0.17
35-54 years	22.8	22.8	22.6	22.6	-0.05
55-64 years	9.3	9.1	10.2	10.2	-0.15*
65+ years	0.1	0.0	0.2	0.0	N/A
Female (%)	53.5	53.6	53.2	53.2	0.13
Race/Ethnicity (%)					
White, not Hispanic	27.2	26.8	40.4	40.5	-0.46***
Black, not Hispanic	6.3	6.4	9.4	9.5	-0.07
Hispanic	16.9	16.9	26.8	26.7	0.15
Multiple/Other, not Hispanic	3.8	3.7	7.1	7.0	-0.09*
Unknown	45.9	46.3	16.3	16.3	0.47***
Chronic conditions (%)†					
Diabetes	5.3	5.4	5.6	5.6	0.09
Stroke/TIA	0.6	0.6	0.7	0.7	0.03

	Baseline Period (July 2014 – June 2016)		Performance Period (July 2018 – September 2021)		
AMI	0.1	0.1	0.2	0.2	0.00
Any COVID diagnosis (%)	N/A	N/A	0.8	0.8	N/A
Zip Code-Level Characteristics					
Median household income	$50,524	$50,429	$59,079	$59,043	-$59
Less than a high school education (%)	81.2	81.2	85.0	85.0	0.01
Under 100% of federal poverty line (%)	18.4	18.4	16.3	16.3	0.01
Receiving SSI, TANF, or SNAP (%)	63.2	63.2	48.7	48.7	0.00
Unemployment rate (%)	10.1	10.1	6.4	6.4	0.01
COVID County-Level Characteristics					
Average # cases	N/A	N/A	12.9 per 1,000 residents	12.9 per 1,000 residents	-0.01
Total # deaths	N/A	N/A	0.2 per 1,000 residents	0.2 per 1,000 residents	0.00
Average PVI score	N/A	N/A	0.3	0.3	0.00
Average case fatality rate	N/A	N/A	11.5 per 1,000 residents	11.5 per 1,000 residents	-0.02
Total population vaccinated (%)	N/A	N/A	11.8	12.0	-0.20

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. † Selected based on priority conditions identified by EOHHS. Zip code-level characteristics represent the average across all zip code tabulation areas where Rhode Island Medicaid members in the group reside. County-level characteristics represent the average across all counties where Rhode Island Medicaid members in the group reside; data is from March 2020 onward. Difference column represents the standardized difference between the four groups. AMI = Acute Myocardial Infarction; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families; TIA = Transient Ischemic Attack; PVI = Pandemic Vulnerability Index.

Unadjusted trends in spending and utilization outcomes. Exhibit 3.4.3 outlines the unadjusted outcomes from the baseline and performance periods for the AE-attributed group and comparison members. Before adjusting for covariates and in both periods, total Medicaid spending and all-cause readmissions were slightly lower in the AE group than the comparison group, and hospitalizations and ED visits were slightly higher for the AE group. Both the AE and comparison groups showed an increase in 30-day follow-up after hospitalization for mental illness.

Exhibit 3.4.3. Unadjusted Means for Spending and Utilization Outcomes for AE-Attributed and Comparison Members, Baseline (July 2014 – June 2016) and Performance (July 2018 – September 2021) Periods

	Baseline Period		Performance Period	
	AE	Comparison	AE	Comparison
Core Demonstration Outcomes				
Total Medicaid spending	$1,794	$1,858	$1,243	$1,303
Hospitalizations	35.5	31.9	30.5	28.1
All-cause readmissions	196.7	219.7	205.6	224.9
ED visits	262.8	220.0	257.6	206.9
Annual wellness visits	114.1	109.1	124.6	117.8
AE Program Outcomes				
Potentially avoidable ED visits	88.4	62.5	87.4	65.1
Breast cancer screening	92.9	101.1	104.3	98.3
7-day follow-up after hospitalization for mental illness	62.4	56.0	51.8	91.1
30-day follow-up after hospitalization for mental illness	156.2	147.9	166.2	188.8

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Total Medicaid spending is presented per member per quarter; all other outcomes are presented as per 1,000 members per quarter.

Risk-adjusted performance of the AE Program across individual AEs. Looking at the risk-adjusted means in outcomes across AEs in the performance period, we observe a great deal of AE-specific variation that is contributing to the overall impact estimates (**Exhibit 3.4.4**).[⌗⌗] Total quarterly Medicaid spending ranges from $1,177 (BVCHC) to $1,404 (Coastal); however, there is no clear utilization driver among the Core Demonstration or AE Program outcomes to which this difference may be attributed. Coastal had the lowest rates of ED visits (99.9 per 1,000 members), hospitalizations (17.3 per 1,000), potentially avoidable ED visits (51.1 per 1,000 members), and the highest rates of annual wellness visits (175.6 per 1,000) and breast cancer screening (152.5 per 1,000 members).

[⌗⌗] We are unable to estimate impact using a DID model for each AE because comparison beneficiaries lack assignment to an AE, which would be required in the DID framework.

Exhibit 3.4.4. Risk-Adjusted Means for Spending and Utilization Outcomes for AE-Attributed and Comparison Members in the Performance Period (July 2018 – September 2021), by AE

	Risk-Adjusted Mean and Standard Error						
	BVCHC	Coastal	IHP	Integra	PCHC	Prospect	Thundermist
Core Demonstration Outcomes							
Total Medicaid spending	$1,177 ($19)	$1,404 ($26)	$1,237 ($9)	$1,354 ($11)	$1,271 ($13)	$1,265 ($13)	$1,210 ($39)
Annual wellness visits	90.4 (0.7)	175.6 (1.2)	93.3 (0.4)	137.9 (0.4)	105.5 (0.4)	142.0 (0.8)	92.2 (2)
Hospitalizations	21.7 (0.4)	17.3 (0.4)	21.9 (0.2)	20.0 (0.2)	24.4 (0.2)	19.5 (0.3)	21.7 (0.9)
All-cause readmissions	93.0 (7.1)	97.4 (8.4)	105.3 (2.7)	114.2 (3.5)	126.4 (3.9)	93.1 (4.3)	119.1 (14.1)
ED visits	119.0 (1.2)	99.9 (1.5)	141.4 (0.8)	122.4 (0.7)	139.1 (0.9)	133.2 (1.2)	144.2 (3.5)
AE Program Outcomes							
Potentially avoidable ED visits	59.7 (0.6)	51.1 (0.8)	69.4 (0.3)	62.3 (0.4)	65.3 (0.3)	67.8 (0.5)	70.1 (1.8)
Breast cancer screening	98.6 (3.4)	152.5 (4.3)	93.3 (1.5)	107.3 (1.8)	100.5 (1.8)	114.5 (2.1)	82 (6.8)
7-day follow-up after hospitalization for mental illness	71.8 (38.8)	N/A	88.9 (15.9)	93.3 (22.4)	107.2 (19.2)	78.1 (29.5)	118.5 (98.7)
30-day follow-up after hospitalization for mental illness	91.3 (42.9)	N/A	176.2 (21.7)	208.9 (30.9)	216 (26.3)	238.4 (48.6)	135.2 (101.9)

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Total Medicaid spending is presented per member per quarter; all other outcomes are presented as per 1,000 members per quarter. Sample size for Coastal would not allow analysis for follow-up after hospitalization for mental illness. Risk-adjusted means were estimated using a multivariate generalized linear model regression.

Risk-adjusted performance of the AE Program across white and non-white members. Except for all-cause readmissions, we observe that white members attributed to AEs had lower spending and utilization in the performance period than non-white members attributed to AEs (**Exhibit 3.4.5**). The largest difference among acute outcomes is for ED visits (125.5 per 1,000 for white members; 140.9 per 1,000 for non-white members). The adjusted means do not reflect the impact of the AE Program for white and non-white members; a DID analysis for race subgroups is planned for the Summative Evaluation Report if sample size allows.

Exhibit 3.4.5. Risk-Adjusted Means for Spending and Utilization Outcomes for AE-Attributed and Comparison Members in the Performance Period (July 2018 – September 2021), by Race

	Risk-Adjusted Mean and Standard Error		
	White	**Non-White**	**Difference**
Core Demonstration Outcomes			
Total Medicaid spending	$1,234 ($6)	$1,344 ($9)	-$110 ($11)***
Annual wellness visits	117.1 (0.3)	118.5 (0.3)	-1.4 (0.4)**
Hospitalizations	20.7 (0.1)	22.9 (0.2)	-2.1 (0.2)***
All-cause readmissions	109.9 (2.0)	109.3 (2.9)	0.6 (3.6)
ED visits	125.5 (0.5)	140.9 (0.7)	-15.4 (0.9)***
AE Program Outcomes			
Potentially avoidable ED visits	62.2 (0.2)	68.8 (0.3)	-6.6 (0.3)***
Breast cancer screening	101.0 (1)	110.0 (1.5)	-9.0 (1.9)***
7-day follow-up after hospitalization for mental illness	86.9 (11.3)	93.8 (16.2)	-6.8 (20.3)
30-day Follow-up after hospitalization for mental illness	162.5 (15.1)	230.4 (23.6)	-67.8 (29.3)**

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. Difference is calculated relative to white members; a negative value indicates a lower level for white members. Total Medicaid spending is presented per member per quarter; all other outcomes are presented as per 1,000 members per quarter. Risk-adjusted means were estimated using a multivariate generalized linear model regression. Hispanic ethnicity was measured separately and is not reflected in these subgroup analyses.

Impact Assessments

Risk-adjusted impact of the AE Program. Considering the AE Program relative to the baseline period and the comparison group with a difference-in-differences model adjusted for key covariates,[§§] we observed no significant impact on total Medicaid spending, and varying effects for utilization outcomes (**Exhibit 3.4.6**). In DID models, the AE Program is associated with a 26.4 fewer all-cause readmissions per 1,000 members, 29.8 more 7-day follow-ups after hospitalization for mental illness per 1,000 members, and 26.8 more breast cancer screenings per 1,000 members, potentially driven by the increased focus on care coordination and population health by AEs. However, AE-attributed members also saw an increase of 7.4 hospitalizations per 1,000 members and an increase of 4.6 potentially avoidable ED visits per 1,000 members, as well as a decrease of 68.6 30-day follow-up after hospitalization for mental illness per 1,000 members.

[§§] We adjusted the DID models for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden. See **Exhibit 2.3.2** for additional details about covariates.

Results of the sensitivity analysis in which total Medicaid spending was capped for individual members (see Chapter 2 for capped dollar amounts for each year) were very similar to the main analysis, showing an estimated non-significant increase of $9 (95% confidence interval -$11, $29).

Exhibit 3.4.6. Risk-Adjusted Impact of AE Program on Spending and Utilization Outcomes

	Risk-Adjusted DID Estimate	95% Confidence Interval
Core Demonstration Outcomes		
Total Medicaid spending	$37	-$45, $119
Annual wellness visits	12.6	-3.8, 28.9
Hospitalizations	7.4***	5.6, 9.3
All-cause readmissions	-26.4***	-32.3, -20.5
ED visits	3.1	-6.1, 12.2
AE Program Outcomes		
Potentially avoidable ED visits	4.6*	0.1, 9.2
Breast cancer screening	26.8***	16.7, 36.9
7-day follow-up after hospitalization for mental illness	29.8***	13.8, 45.8
30-day follow-up after hospitalization for mental illness	-68.6***	-97.4, -39.8

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. Total Medicaid spending is presented per member per quarter; all other outcomes are presented as per 1,000 members per quarter.

3.5 Discussion

Since the inception of the AE Program in July 2018, member attribution to AEs has grown from 163,125 to 199,154 members as of September 2021[***], representing 64.7 percent of the eligible population (i.e., Medicaid members in MCOs). During the COVID-19 pandemic, attribution to AEs increased proportionally to the overall increase in Rhode Island Medicaid members.

Overall, we did not observe a statistically significant impact of the AE Program on total Medicaid spending in our risk-adjusted DID analyses. Both the AE and comparison groups saw reductions in total spending between the baseline and performance periods. The overall effect of the AE Program on quality and utilization metrics was mixed. AE-attributed members saw lower rates of all-cause readmissions and improved rates of 7-day follow-ups after hospitalizations for mental illness. However, AE-attributed members also saw increases in hospitalizations and potentially avoidable ED visits and

[***] Measured quarterly; limited to members with full Medicaid enrollment each quarter.

lower rates of 30-day follow-ups after hospitalizations for mental illness, compared to their non-AE counterparts. Both the AE and comparison groups saw reductions in total spending between the baseline and performance periods; this likely reflects national trends in declines in utilization during the COVID-19 pandemic.[5,7,46]

It is important to note that the total spending measure presented here differs from the AE TCOC methodology in several ways, including differing approaches to risk adjustment, different populations (NORC's spending measure includes only member-quarters with three months of Medicaid coverage), and included costs (e.g., prescription drugs are included in TCOC but not the analysis here); the full technical guidance for TCOC calculations can be found on EOHHS' website.[32] In TCOC data for PY3 obtained from EOHHS, AE-specific spending trends differ from patterns observed in the DID results for total Medicaid spending. TCOC ranged from $993.27 per member-quarter (BVCHC) to $1,532.07 per member quarter (IHP). For all AEs, TCOC expenditures remained below the risk-adjusted targets in PY3. PY3 TCOC expenditures for AE members ranged from 7.2% to 10.5% below the risk-adjusted targets for UHCCP-RI and 3.7% to 16.2% below targets for NHPRI. Expenditures for non-AE enrollees ranged from 3.5% below the risk-adjusted target for the UHCCP-RI and 5.7% below target for NHPRI. With one exception, AEs saw larger savings percentages the non-AE groups for both payers. However, the overall trends for AE and non-AE members were similar to DID estimates. Across all AEs, quarterly TCOC expenditures were $1,205.85 per member, compared to $1,326.38 for non-AE members.

Our finding that the AE Program was associated with increased rate of preventative care like breast cancer screening is consistent with MCO quality reporting. To provide additional context to the Interim Evaluation findings, we obtained quality performance tracking data for AEs from 2018 through 2020 collected for two of the three MCOs (NHPRI and UHCCP-RI). The AEs that partnered with these two MCOs reported increases in most measures between the CY 2018 performance year, and the first reporting period (CY 2019). For both NHPRI and UCCHP-RI, the AEs on average experienced a minor increase in members receiving a breast cancer screening, weight assessment and counseling for nutrition for adolescents, developmental screening in the first three years, screening and cessation intervention for tobacco use, and HbA1c control for diabetes care. Both MCOs experienced larger average increases in weight assessment and counseling for physical activity for adolescents (12.61% for NHPRI and 12.67% for UHCCP-RI), and UHCCP-RI AEs experience a significant increase in adult BMI assessments (11.98%) and controlling high blood pressure (16.49%). The only measures where MCOs on average experienced a steady increase from CY 2018 through the second reporting period (CY 2020) were developmental screening in the first three years, screening and cessation intervention for tobacco use, and follow-up after hospitalization for mental illness within 7 or 30 days. Finally, UHCCP-RI AEs also experienced a slight increase over time in screening for clinical depression and follow-up planning.

The 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for all three MCOs indicate that most Medicaid adult members report that they usually or always receive needed care right away and scheduled check-up/routine appointments and specialist appointments as soon as needed. Most adult members also reported that their doctors always or usually communicated about care, listened, and showed them respect, that customer service treated them with courtesy and respect and coordination of care. For child Medicaid members in two of the MCOs (NHPRI and

UHCCP-RI), CAHPS survey results indicated that most participants report that their doctors usually or always explained things, listened carefully, and showed respect. These rates for both adult and child Medicaid members generally align with national and regional benchmarks.[47,48,49,50]

Finally, we observed notable variation across subgroups of AE-attributed members, including AE-specific variation and variation between white and non-white members. Among non-white members, higher rates of all-cause ED visits coupled with the higher rate of potentially avoidable ED visits may indicate a higher level of unmet need and fewer ambulatory/preventative care options for this population. We aim to include further exploratory analyses assessing this variation in The Summative Evaluation Report.

Chapter 4: Behavioral Health Link

4.1 BH Link Overview

In response to rising overdose deaths and in acknowledgement of the high percentage of emergency department visits attributable to mental health conditions among Rhode Island Medicaid members, the Executive Office of Health and Human Services (EOHHS) developed the Behavioral Health Link (BH Link) Program. The program's goal is to provide better support and treatment for patients with mental health and substance use (misuse) concerns and provide an alternative to the emergency department offering specialized emergency behavioral health services.[30] As part of the 1115 Demonstration Extension Request, EOHHS requested the authority for the BH Link program, incorporating the BH Link Triage Center and the BH Link Hotline. Both the triage center and the hotline operate 24 hours a day, 7 days a week, with the goal of providing immediate assistance to individuals in crisis.

Primary Components of BH Link:
- BH Link Onsite Triage Center
- Mobile Outreach
- BH Link Hotline

BH Link began in January 2019 with the opening of the BH Link Triage Center, a 24/7 triage center designed to support crisis stabilization and short-term treatment for individuals experiencing mental health and/or substance use crises. The BH Link Triage Center is a licensed behavioral health care facility staffed by nurses, licensed physicians, certified peer recovery specialists, case managers, psychiatric clinical nurse specialists, psychiatrists, and qualified mental health professionals. The BH Link triage center provides services consistent with a licensed community mental health center, including comprehensive screening and evaluations, treatment, and crisis intervention. Services include:

- Physician services
- Medication prescription and management
- Skilled nursing
- Comprehensive assessment and triage
- Case management
- Discharge coordination, including warm hand-offs to community providers.

All services are available from staff on-site or via telemedicine. Additionally, to increase referrals to BH Link facilities and address areas not covered by the BH Link Triage Center, BH Link employs mobile outreach liaisons from community health centers to provide care throughout the community.

BH Link also incorporates the BH Link Hotline, which holds the contract for the Rhode Island National Suicide Hotline and incorporates other relevant call lines for the treatment center to serve as a one-stop, statewide 24/7 call-in center. The BH Link Hotline delivers telephonic triage services and information to connect people to relevant community services.

Reimbursement. At the time of the initial implementation of the program, BH Link services were reimbursed using existing traditional fee-for-service (FFS) codes. Beginning on January 29, 2020, CMS approved bundled rate billing for BH Link services. The bundled rate may be billed once daily per Medicaid member, and there are no restrictions on the number of times per month the bundled rate may be billed. **Exhibit 4.1.1** outlines the components of the bundled rate and provides a sample calculation for a bundled rate that might be billed for a member. [51] The methodology defined in **Exhibit 4.1.1** shows an average number of units expected per stay, but individual stays may have higher or lower numbers of units. As a result, when providers submit claims for the bundled rates, they must provide service-level details documenting how many units of each service were delivered. To trigger payment, providers must perform a crisis assessment, which is typically followed by additional services such as case management, monitoring, and potential psychiatric evaluation and medication management.

While the bundled rate is calculated by combining the projected costs for each service, the claim is paid at a single level, such that the individual component services do not receive a separate reimbursement. The bundled rate was established by EOHHS based on similar FFS rates paid to current community health centers and providers. The BH Link bundled rate will be continually reviewed and recalculated by EOHHS and approved by CMS as necessary to maintain efficiency and effectiveness of the program.

Exhibit 4.1.1. BH Link Triage Center Rate Composition, Sample Calculation[13]

	Rate/Unit	Duration	Projected Average Number of Units	Projected Average Total time	Cost
Service	Fixed Estimates		Variable Estimates Based on Patient Encounter		Calculated
Crisis Assessment	$150.00	60 minutes	1 unit	60 minutes	$150.00
Nursing/monitoring	$7.50	5 minutes	24 units	120 minutes	$180.00
Case Management	$21.25	15 minutes	7 units	105 minutes	$150.50
Psychiatrist (E&M)	$118	25 minutes	1 unit	25 minutes	$118.00
Total Bundled Rate for the Sample Patient					**$598.50**

SOURCE: Demonstration Special Terms & Conditions, Attachment CC (Behavioral Health Link Payment Methodology)
NOTES: E&M = Evaluation and Management

4.2 Evaluation Hypotheses and Outcomes

The BH Link Program was developed with the goal of delivering and expanding access to high-quality, more appropriate, and more affordable care and guidance for individuals in behavioral health and/or substance use crises. **Exhibit 4.2.1** lays out the explicit goals and target population of the BH Link Program, as well as the associated evaluation hypotheses, research questions, and performance metrics for the evaluation.

Exhibit 4.2.1. Overview of BH Link Goals, Evaluation Hypotheses, Research Questions, Target Population, and Metrics

Goals	• Move to billing bundled rate for BH Link services on a per-member basis
Target Population	• Rhode Island Medicaid members who are in crisis due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders
Evaluation Hypotheses	• The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members • The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members • The Demonstration will shift care away from high-cost settings (e.g., the ED), reducing spending while increasing utilization in lower-cost settings.
Research Questions	• What percentage of Rhode Island Medicaid members are attributed to this Demonstration program? • What are the trends in spending, utilization, and quality of care? • To what extent has the Demonstration integrated BH and SUD care into medical care? How has this affected health outcomes and BH/SUD treatment uptake for Rhode Island Medicaid members? • What are the trends in ED visits and Institution of Mental Disease (IMD) service use for members accessing behavioral health services?
Performance Metrics	• Access to physical health care • Use of BH services • ED visits for BH services • Follow-up after ED visit for mental illness • IMD service use

4.3 Analytic Approach

The below section details our approach to evaluating the BH Link Program, including identification of treatment and comparison groups in the performance period, key outcomes, and our analytic approach. All analyses are conducted with adult (ages 18 and older) Rhode Island Medicaid members who received full Medicaid benefits for each month in the calendar quarter and were eligible for treatment in the BH Link triage center during the performance period.

Performance Period for BH Link analysis

January 2020 – September 2021

Performance Period. The performance period for the BH Link Program analysis is January 2020 – September 2021. Although BH Link started in January 2019, we identified members using BH Link services with the bundled billing code that was established in January 2020, so we are only able to capture Medicaid members who received services through BH Link after that time. Thus, our performance period is the timeframe in which we saw claims for BH Link encounters for Medicaid members after BH Link started providing services. We excluded a baseline period from our analyses, as it was not feasible to construct a meaningful baseline period. In this report, we analyze data through September 2021 based on current availability of complete data for that period; in the Summative Evaluation Report, we will analyze data through the end of the Demonstration (currently December 2023).

Treatment Group Identification. To identify members who were treated through the BH Link triage center in the performance period, we used the BH Link bundled rate billing Healthcare Common Procedure Coding System (HCPCS) code S9485, which indicates a per-diem BH Link encounter. Any member who received a service from BH Link in a quarter was flagged for inclusion in that quarter's analysis, and considered part of the treatment group for our cross-sectional analysis.

Comparison Group Identification. The comparison group for the BH Link Program analyses consists of all Medicaid-only members with one or more behavioral health conditions but who were *not* treated through the BH Link triage center during the performance period. Using Medicaid claims data, the team identified any beneficiaries with flags for substance use disorder (SUD) or serious mental illness diagnosis. Thus, the key difference in the performance period is that members in the treatment group received services from the BH Link triage center, which may indicate they may need more acute crisis care. This key distinction may be driving differences in outcomes we see between the treatment and comparison group.

Outcomes. For BH Link, we focused our analysis on six core claims-based metrics (i.e., metrics that are measured for each demonstration program) as well as four additional metrics that are specific to the BH Link program and its mechanisms of transformation (**Exhibit 4.3.1**).

Exhibit 4.3.1. BH Link Outcomes for Evaluation

Core Demonstration Outcomes
• Number of members using BH Link services
• Hospitalizations
• Emergency department visits
• Annual wellness visit
• All-cause readmissions
• Total Medicaid spending
BH Link Outcomes
• Use of behavioral health services
• Follow-up after ED visit for mental illness
• Institutions for Mental Disease service use
• ED visits for BH services

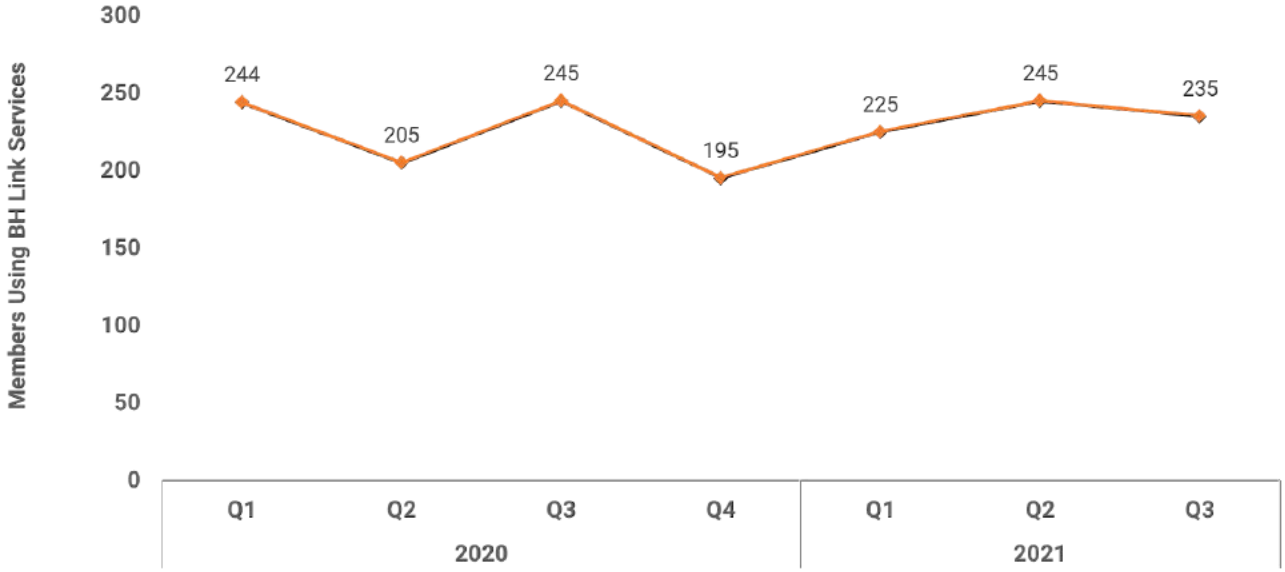
Analytic Approach. We conducted the following analyses to characterize the members who received services from the BH Link triage center and estimate the impact of the BH Link program:

- **Descriptive analyses of member characteristics** to understand the members that the BH Link triage center is serving, and how many members they are serving over time
- **Unadjusted analyses of outcomes** to compare differences in the means of the nine key outcomes in the performance period (January 2020 – September 2021), for the BH Link and comparison groups
- **Risk-adjusted cross-sectional analysis** to compare the experience of members in the BH Link program and comparison groups in the performance period, which will allow us to descriptively assess the effect BH Link program had on each of the nine outcomes. The cross-sectional analyses were adjusted for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden.

4.4 Descriptive Findings

Member participation. Since BH Link started in January 2020, 1,232 unique Rhode Island Medicaid members have used BH Link triage center services. As shown in **Exhibit 4.4.1** below, the number of members using BH Link services has stayed relatively constant from the beginning of the program to September 2021, with slight (10-50 member) fluctuations in quarterly attribution.

Exhibit 4.4.1. Members Using BH Link Services (January 2020 – September 2021)



SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.

Sociodemographic characteristics. Exhibit 4.4.2 presents the characteristics of members using BH Link services alongside the characteristics of the propensity score-weighted comparison member group, which consists of adult Rhode Island Medicaid members with one or more behavioral health conditions or diagnosed SUDs who were not treated through the BH Link triage center during the performance period. The majority of BH Link users were female (54.9 percent) and non-Hispanic white (57.5 percent), similar to the comparison group. More members who used BH Link services were Hispanic (24.8 percent), relative to the comparison group (16.3 percent). Five percent of BH Link users had a COVID diagnosis during the performance period, which was significantly higher than comparison members (2.9 percent). Overall, BH Link users lived in areas where a smaller percentage of the population was receiving Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits.

Exhibit 4.4.2. Sociodemographic Characteristics of Members Using BH Link Services and Comparison Group, Performance Period (January 2020 – September 2021)

	Members Using BH Link Services	Comparison Group Members	Difference
Unique members	1,232	87,030	N/A

	Members Using BH Link Services	Comparison Group Members	Difference
Sociodemographic Characteristics			
Age (%)			
18-34 years	36.7	35.5	1.05
35-54 years	36.4	39.5	0.88
55-64 years	15.0	16.9	0.87
65+ years	11.9	8.1	1.53
Female (%)	54.9	59.2	0.84
Race/Ethnicity (%)			
White, not Hispanic	57.5	61.3	0.85
Black, not Hispanic	7.2	8.1	0.89
Hispanic	24.8	16.3	1.70**
Multiple/Other, not Hispanic	5.1	6.3	0.80
Unknown	5.4	8.1	0.65***
Chronic conditions (%)†			
Diabetes	13.3	14.4	0.91
Stroke/TIA	2.1	2.5	0.82
AMI	0.1	0.5	0.28*
Any COVID diagnosis (%)	5.0	2.9	1.79***
Zip Code-Level Characteristics			
Median household income	$62,118	$61,775	$343
Less than a high school education (%)	86.5	86.4	0.14
Under 100% of federal poverty line (%)	14.5	14.9	-0.46
Receiving SSI, TANF, or SNAP (%)	29.9	31.8	-0.02*
Unemployment rate (%)	6.0	6.0	-0.01
COVID County-Level Characteristics			
Average # cases per 1,000	25.0 per 1,000 residents	22.6 per 1,000 residents	2.45
Total # deaths per 1,000	0.45 per 1,000 residents	0.4 per 1,000 residents	0.04
Average PVI score	0.50	0.51	0.01*
Average case fatality rate	21.2 per 1,000 residents	20.4 per 1,000 residents	0.79
Total population vaccinated (%)	19.8	21.3	-0.02

SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. † Selected based on priority conditions identified by EOHHS. Zip code-level characteristics represent the average across all zip code tabulation areas where Rhode Island Medicaid members in the group reside. County-level characteristics represent the average across all counties where Rhode Island Medicaid members in the group reside; data is from March 2020 onward. AMI = Acute Myocardial Infarction; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families; TIA = Transient Ischemic Attack; PVI = Pandemic Vulnerability Index

Unadjusted trends in spending and utilization outcomes. As shown in **Exhibit 4.4.3**, unadjusted outcomes indicate that members using BH Link services are higher utilizers of acute care, particularly for mental and behavioral health conditions, as aligns with BH Link's target population. Members using BH Link services had higher quarterly Medicaid spending than comparison members, which is likely driven by acute care; members using BH Link had higher rates of hospitalizations, hospital readmission rates, ED visits (total and BH-specific), and IMD service use. These differences, while unadjusted, show that members accessing BH Link services have a high need for acute services, even when compared to other Medicaid members with behavioral health conditions.

Exhibit 4.4.3. Unadjusted Means for Spending and Utilization Outcomes for Members Using BH Link Services and Comparison Members, Performance Period (January 2020 – September 2021)

	Unadjusted Mean and Standard Error	
	Members Using BH Link Services	**Comparison Members**
Core Demonstration Outcomes		
Total Medicaid spending	$9,347 ($503)	$4,654 ($20)
Hospitalizations	504.7 (69.8)	100.8 (8.3)
All-cause readmissions	407.9 (33.5)	222.4 (3.6)
ED visits	1,292.2 (90.1)	297.3 (1.8)
Annual wellness visit	50.4 (10.8)	62.6 (4.3)
BH Link Outcomes		
Use of behavioral health services	974.5 (2.8)	--
Follow-up after ED visit for mental illness	78.9 (26.5)	73.0 (4.4)
IMD service use	112.8 (9.1)	21.8 (0.3)
ED visits for BH services	1,034.7 (86.4)	146.9 (1.4)

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Use of behavioral health services was used to construct the comparison group, so is not a relevant metric for the comparison group. Total Medicaid spending is presented per member per quarter; utilization outcomes are presented per 1,000 members per quarter.

Risk-adjusted means for spending and utilization outcomes. When considering health outcomes for BH Link users, adjusting for key member- and area-level characteristics[†††] and comparing outcomes to Medicaid members with behavioral health conditions, it is clear that BH Link users are complex patients with acute health care needs (**Exhibit 4.4.4**). Among Core Demonstration outcomes, members using BH Link services have higher acute care utilization overall, including for hospitalizations (278.4 per 1,000 members), readmissions (96.4 per 1,000 members), total ED visits (1,236.0 per 1,000

[†††] We adjusted the DID models for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden. See **Exhibit 2.3.2** for additional details about covariates.

members), ED visits related to BH (1,037.1 per 1,000 members), and IMD service use (270.0 per 1,000 members) than comparison members. This more frequent use of acute care also led to higher total Medicaid spending ($14,353 vs. $4,870 per member). However, members using BH Link services saw significantly higher rates of 30-day follow-up for mental health-related ED visits (276.3 vs. 159.3 per 1,000 members).

Exhibit 4.4.4. Risk-Adjusted Means for Spending and Utilization Outcomes for BH Link Users and Comparison Members, Performance Period (January 2020 – September 2021)

	Risk-Adjusted Mean			
	BH Link	Comparison	Difference	95% CI
Core Demonstration Outcomes				
Total Medicaid spending	$14,353	$4,870	$9,483***	$8,695, $10,270
Hospitalizations	402.8	124.4	278.4***	255.2, 301.6
All-cause readmissions	222.9	126.5	96.4***	71.2, 121.6
ED visits	1,493.2	257.2	1,236.0***	1,080.2, 1,391.8
Annual wellness visit	45.8	55.2	-9.4	-19.6, 0.9
BH Link Outcomes				
30-day follow-up after ED visit for mental illness	276.3	159.3	117.0***	61.2, 172.9
7-day follow-up after ED visit for mental illness	100.1	75.8	24.3	-10.8, 59.5
IMD service use	333.9	63.9	270.0***	248.6, 291.3
ED visits for BH services	1,179.3	142.2	1,037.1***	901.5, 1,172.6

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data. NOTES: *p<0.05; **p<0.01; ***p<0.001. Total Medicaid spending is presented per member per quarter; utilization outcomes are presented per 1,000 members per quarter.

4.5 Discussion

Despite numerous challenges since its January 2019 debut, BH Link has made substantial progress filling gaps in Rhode Island's mental health and substance use crisis care services, serving just over 1,200 members since January 2020. From our descriptive analyses, we observe that members accessing BH Link services also receive a high level of acute care, particularly for behavioral health conditions and SUD treatment. This is the population for which BH Link was designed, and the differences between BH Link users and the comparison members (all of whom also have one or more behavioral health conditions) indicate that BH Link is serving the most acute patients in need of crisis care. These differences are driving the overall increase in spending and acute care utilization seen in our risk-adjusted analyses; BH Link users overall incurred almost $10,000 more than the comparison group in a quarter when they access BH Link services. These higher levels of Medicaid spending and utilization among BH Link users may reflect both an increased need for these services, as well as increased service utilization as a direct result of seeking help from BH Link, since a key component of

BH Link is to connect users directly to other types of care. The connections to follow-up care services in the community that BH Link can provide may be driving the higher rates of 30-day follow-up for BH-related ED visits relative to the comparison group. These findings are consistent with previous studies of similar initiatives, where increased utilization was seen after engagement in behavioral health-focused care management programs.[52,53]

Our evaluation of BH Link is limited by a number of factors, including our inability to construct a relevant baseline against which to measure spending and utilization outcomes, inability of the descriptive design to assess causality, and the near-complete overlap of the COVID-19 pandemic with the performance period. Additionally, as noted above, we captured BH Link users in this analysis at a particularly high-acuity and high-need time, which led to higher observed spending and utilization relative to the comparison group. While we weighted the comparison group to be similar to the members seeking BH Link services during the performance period, we were only able to account for *observable* characteristics that we can capture from Medicaid enrollment, claims, and encounter data. There may be additional differences in disease severity and use of services prior to the performance period which might contribute to the differences between BH Link users and comparison members. For instance, we were unable to capture many of the individual-level factors (e.g., access to and awareness of BH Link, familial support or lack thereof, concerns related to COVID-19) that drive individuals' behavior and are likely more central in care-seeking decisions than sociodemographic and area-level characteristics that are included in our propensity weighting model.

Additionally, our evaluation is limited to members receiving services through the BH Link triage center and appearing in claims and encounter data under the HCPCS bundled rate code. This may contribute to the observed higher level of acuity of members using BH Link, as we are not capturing members needing lower-acuity services who access the BH Link Hotline or receive services from the BH Link Mobile Outreach program. In the Summative Evaluation Report, we hope to be able to conduct a deeper assessment of service utilization across all three primary components of BH Link, including the BH Link Hotline and the mobile outreach services.

Chapter 5: Dental Case Management Pilot Program

5.1 Dental Case Management Pilot Overview

Rhode Island's Medicaid program faces a number of challenges in providing adequate dental care to enrollees, including: 1) the small number of participating dental providers (19 percent as of 2018); 2) concerns from providers, including insufficient fee-for-service (FFS) reimbursement rates, high number of missed appointments among Medicaid patients, and patient non-compliance; and 3) the continued high costs of care and frequent use of the emergency department for dental health conditions.[54] Additionally, an increasingly diverse Rhode Island population is driving the need for more interpreters and expanded translation services, and Rhode Island's aging public transportation infrastructure renders public transit an increasingly unreliable option for patients who depend on it to travel to appointments. Given these challenges, Rhode Island implemented a program that aimed to increase provider participation in the adult Medicaid FFS dental program, increase dental service use by adult Medicaid members, and reduce costs to the Medicaid program overall. The program is designed to achieve these aims by creating mechanisms to offer more value to providers and members, and to improve the provider-patient relationship. Rhode Island's pilot builds on similar dental care management/coordination programs conducted in Vermont, New Jersey, Ohio, Georgia, Indiana, and Minnesota, all of which achieved positive outcomes.

In 2019, EOHHS implemented the Dental Case Management (DCM) Pilot, a year-long program that incentivized dental practices to offer case management services to Rhode Island adults enrolled in FFS Medicaid. The case management services in the DCM pilot were furnished via use of four Current Procedural Terminology (CPT) codes aimed at improving the social determinants of health (SDOH) that affect compliance, improve enrollee experience and oral health outcomes, and provider experience:[55]

- **D9991: Addressing Appointment Compliance Barriers.** Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers.
- **D9992: Care Coordination.** Assisting in a patient's decisions regarding the coordination of oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems.
- **D9993: Motivational Interviewing.** Patient-centered, personalized counseling using methods such as Motivational Interviewing to identify and modify behaviors interfering with positive oral health outcomes.
- **D9994: Patient Education to Improve Oral Health Literacy.** Individual, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral

health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions, and language preferences.

To participate in the DCM Pilot, providers were first required to attend the "Improving the Quality of Oral Healthcare through Case Management" webinar developed in collaboration with the Medicaid/Medicare CHIP Services Dental Association (MSDA).[56] Once their training completion was approved by the Executive Office of Health and Human Services (EOHHS) and the practice was officially enrolled in the pilot, providers were able to bill for reimbursement using the case management codes.[‡‡‡] In order to receive reimbursement, providers were required to submit the DCM Progress and Outcomes Data Collection Form to EOHHS, as well as documentation of each patient's progress, challenges, and follow-up appointments.[13] EOHHS tracked data on code uptake and performance measures, stratified by provider and code use. Performance measures included: 1) broken appointments, 2) preventive dental services, 3) restorative dental services, 4) completed treatment plans, 5) utilization of emergency department for dental-related conditions, and 6) scores for health literacy and patient experience. EOHHS used these data from the DCM Pilot to help determine the utility and effectiveness of these additional case management codes, and whether positive behavior changes for patients were driven by the provision of case management services.[13]

Providers in the pilot received FFS Medicaid payments for these services at $22 per claim. Practices not participating in the DCM Pilot were not able to submit these codes for Medicaid reimbursement. This pilot was designed to be implemented in up to six dental practices across the state; however, due to challenges with practice recruitment only three practices had providers who completed the training.[13] At the end of the pilot, EOHHS determined they would not be extending the program beyond December 2019.

5.2 Evaluation Hypotheses and Outcomes

The DCM Pilot Program was implemented as a delivery system enhancement aligned with Principle 1 of the Demonstration (pay for value, not volume), with the objective of providing higher-quality and more coordinated care to Rhode Island Medicaid members. **Exhibit 5.2.1** lays out the explicit goals and target population of the DCM Pilot, as well as the associated evaluation hypotheses, research questions, and performance metrics for the evaluation.

Exhibit 5.2.1. Overview of DCM Pilot Goals, Evaluation Hypotheses, Research Questions, Target Population, and Metrics

Goals	• Increase use of preventive services • Decrease broken appointments • Improve the social determinants of health that affect compliance, member experience, health outcomes, and provider experience

[‡‡‡] If a participating practice is a Federally Qualified Health Center (FQHC) and bills a case management service with another Medicaid-covered dental services, it will be covered by the typical prospective payment to the FQHC. For case management services provided by an FQHC over the phone, EOHHS reimburses the FQHC at $22 for each code billed on a FFS basis.

Target Population	• Rhode Island Medicaid members ages 18 and over in the traditional fee-for-service dental delivery system, seen at participating dental practices
Evaluation Hypotheses	• The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members • The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members
Research Questions	• What percentage of Rhode Island Medicaid patients are attributed to this waiver program? • What are the trends in spending, utilization, and quality of care? • Does the Demonstration increase uptake of prevention-focused resources into routine medical care for high-cost/high-need Rhode Island Medicaid members?
Performance Metrics	• Frequency of use of dental case management codes at the participating dental practices • Rate of broken appointments • Dental services

5.3 Analytic Approach

The below section details our approach to evaluating the DCM Pilot's impact, including the performance period, identification of treatment and groups, key outcomes, and our analytic approach. All analyses are conducted with adult (ages 18 and older) Rhode Island Medicaid members who received full Medicaid benefits for each month in the calendar quarter and were enrolled in Medicaid's fee-for-service dental coverage plan.

Performance Period for DCM analysis
January 2019 – December 2019

Performance Period. The performance period for the DCM Pilot is January 2019 – December 2019. It was not feasible to construct a meaningful baseline period, as these services were not covered by Medicaid in previous years. Due to the small sample size in the DCM treatment group and the limited timespan of the performance period (one calendar year), we were only able to conduct analysis aggregated to the member-year level. In this report, we analyze data through December 2019, the end of the pilot program period. Because the DCM Pilot was time-limited to 2019 and was not extended, we will not conduct any further analysis on this program in the Summative Evaluation Report

Treatment Group Identification. To identify members who participated in the DCM Pilot, we first identified providers who completed training and officially enrolled in the pilot, and who were eligible to submit claims for dental case management services to Medicaid members, throughout 2019. Any member enrolled in the Medicaid FFS dental plan and received dental case management services (CPT codes D9991 – D9994) in 2019 from a provider enrolled in the pilot were considered members of the treatment group for the member-year analysis.

Comparison Group Identification. The comparison group for the DCM Pilot analysis is comprised of members who were enrolled in the Medicaid FFS dental plan and were seen by providers enrolled in the DCM Pilot, but who did *not* receive services under the four dental case management CPT codes.

Outcomes. For the DCM Pilot, we focused our analysis on six core claims-based metrics (i.e., metrics that are measured for each Demonstration program), as well as two additional metrics that are specific to the DCM pilot and its mechanisms of transformation (**Exhibit 5.3.1**).

Analytic Approach. We conducted the following analyses to characterize the members receiving eligible services under the DCM Pilot assess performance for members receiving services under the program:

- **Descriptive analyses of providers participating in the DCM Pilot** to understand uptake of the pilot program, characteristics of providers, and patterns in use of dental case management codes.
- **Descriptive analyses of member characteristics** to understand the members served by the DCM Pilot, and how many members the pilot is serving over time.
- **Unadjusted analyses of outcomes** to compare differences in the mean outcomes in the performance period, for the DCM Pilot treatment and comparison groups.
- **Risk-adjusted member-year level cross-sectional case study analysis** to descriptively compare the experience of members in the DCM Pilot and comparison groups in the performance period. The serial cross-sectional analyses adjusted for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden.

Exhibit 5.3.1. DCM Pilot Outcomes for Evaluation

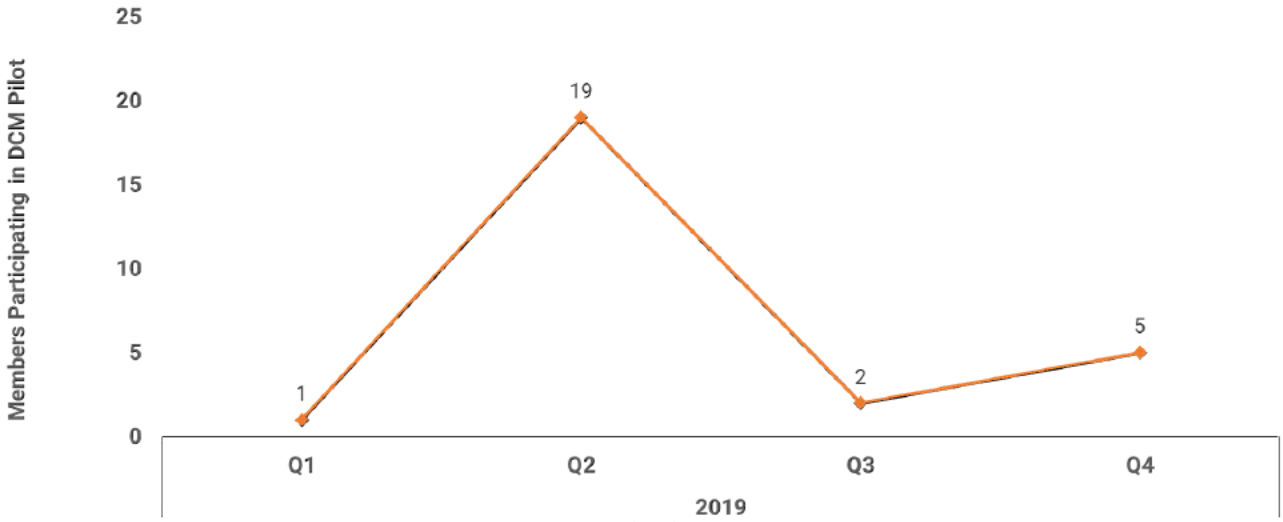
Core Demonstration Outcomes
• Number of members receiving DCM
• Hospitalizations
• Emergency department visits
• Annual wellness visit
• All-cause readmissions
• Total Medicaid spending
DCM Pilot Outcomes
• Use of dental case management codes
• Dental services

5.4 Descriptive Findings

Provider and practice participation. As described above, providers must be trained and certified by EOHHS to provide dental case management services to members to participate in the pilot. Over the course of DCM Pilot in 2019, 20 providers from three Rhode Island dental practices completed training and were enrolled in the program to provide dental case management services to Medicaid members. Although four dental practices completed the required training, only two remained enrolled throughout the entire pilot year and submitted claims for dental case management codes. Most providers at the two participating practices were trained in the first two quarters of the year, with only three providers trained in the second half of the year. No new practices were added after the second quarter of 2019.

Member participation. As summarized in **Exhibit 5.4.1** below, member participation in the DCM Pilot was limited, with only 25 total unique members participating in the pilot during the year-long performance period of January 2019 – December 2019. In Q1 2019, only one member received dental case management services under the pilot program. The highest number of members participated in the pilot during Q2 2019, when 19 members participated. Participation in the pilot dropped to two members in Q3 2019; five members were enrolled in the final quarter of the pilot in Q4 2019.

Exhibit 5.4.1. Members Participating in the DCM Pilot (January – December 2019)



SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.

Sociodemographic characteristics. The unique 25 DCM Pilot participants were compared to the propensity score-weighted comparison group of 4,689 Rhode Island Medicaid members enrolled in the FFS dental delivery system who did not receive DCM services. **Exhibit 5.4.2** outlines the sociodemographic characteristics of members participating in the DCM Pilot alongside the comparison group. Both groups were majority female, non-Hispanic white, and ages 18 to 34 years. The only significant difference observed between the two groups is that DCM Pilot participants lived in areas with a slightly higher unemployment rate (7.2 percent vs. 6.3 percent).

Exhibit 5.4.2. Sociodemographic Characteristics of Members Participating in the DCM Pilot and Comparison Members, Performance Period (January – December 2019)

	DCM Pilot Participant Characteristics	Comparison Group Characteristics	Difference
Unique members	25	4,689	N/A
Sociodemographic Characteristics			
Age (%)			
<18 years	35.2	42.9	0.72
18-34 years	31.1	36.0	0.80
35-54 years	22.9	13.5	1.90

	DCM Pilot Participant Characteristics	Comparison Group Characteristics	Difference
55-64 years	10.8	7.6	1.48
Female (%)	54.0	58.7	0.83
Race/Ethnicity (%)			
White, not Hispanic	42.8	47.0	0.84
Black, not Hispanic	6.6	8.8	0.74
Hispanic	28.2	23.8	1.26
Multiple/Other, not Hispanic	13.9	8.2	1.82
Unknown	8.5	12.3	0.66
Chronic conditions (%)†			
Diabetes	8.7	14.0	0.59
Stroke/TIA	0.0	1.9	N/A
AMI	0.0	0.3	N/A
Zip Code-Level Characteristics			
Median household income	$55,664	$59,588	-$3,924
Less than a high school education (%)	83.2	85.4	-2.20
Under 100% of federal poverty line (%)	17.0	15.7	1.39
Receiving SSI, TANF, or SNAP (%)	63.5	67.7	-0.04
Unemployment rate (%)	7.2	6.3	0.92*

SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. † Selected based on priority conditions identified by EOHHS. Zip code-level characteristics represent the average across all zip code tabulation areas where Rhode Island Medicaid members in the group reside. County-level characteristics represent the average across all counties where Rhode Island Medicaid members in the group reside; data is from March 2020 onward. AMI = Acute Myocardial Infarction; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families; TIA = Transient Ischemic Attack.

Use of dental case management codes. Over the course of the DCM Pilot in 2019, dental case management codes were rarely used (**Exhibit 5.4.3**). A total of 76 claims were recorded with the four pilot codes; 68 of those instances occurred in the second quarter of the year. Code D9994, Patient Education to Improve Oral Health Literacy, was used most often (60 out of the 76 code usages). No provider used code D9991, Addressing Appointment Compliance Barriers, during the DCM Pilot period, and only eight claims were recorded for both D9992 (Care Coordination) and

Exhibit 5.4.3. Dental Case Management Code Usage in the DCM Pilot Performance Period (January – December 2019)

	2019 Q1	2019 Q2	2019 Q3	2019 Q4
D9991	0	0	0	0
D9992	0	8	0	0
D9993	0	8	0	0
D9994	0	52	3	5

SOURCE: Annual Operations Report Rhode Island Comprehensive 1115 Waiver Demonstration, January 1, 2019 – December 31, 2019 (EOHHS)

D9993 (Motivational Interviewing). One provider (St. Joseph's Hospital) recorded the vast majority of claims with dental case management codes (68 of 76).

Unadjusted trends in spending and utilization outcomes. As highlighted in **Exhibit 5.4.4**, unadjusted outcomes from the DCM Pilot participants show marked differences in the outcomes of comparison members, some of which may be attributable to the small sample size. DCM Pilot participants overall had lower Medicaid spending and hospitalizations, but a higher rate of ED visits, annual wellness visits, and dental health services. One of the main goals of the DCM Pilot was to reduce barriers to dental care for patients; however, due to the small sample size we cannot determine if the DCM Pilot is driving the small increase we see in that measure.

Exhibit 5.4.4. Unadjusted Means for Spending and Utilization Outcomes for DCM Pilot Participants and Comparison Members, Performance Period (January – December 2019)

	Unadjusted Mean and Standard Error	
	DCM Pilot Participants	**Comparison Members**
Core Demonstration Outcomes		
Total Medicaid spending	$1,980 ($702)	$10,371 ($198)
Hospitalizations	44.6 (45.0)	73.2 (4.2)
All-cause readmissions	N/A	265.7 (41.7)
ED visits	310.8 (121.1)	266.7 (9.0)
Annual wellness visit	131.8 (84.1)	83.1 (3.1)
DCM Pilot Outcomes		
Dental health services	1,918.8 (196.1)	1,557.1 (10.4)

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Total Medicaid spending is presented per member per year; utilization outcomes are presented per 1,000 members per year.

Risk-adjusted means for spending and utilization outcomes. When considering outcomes for DCM Pilot participants and other adult Medicaid members seen in participating dental practices, we see much lower utilization and spending for DCM Pilot participants (**Exhibit 5.4.5**). Members in the DCM Pilot had significantly lower spending ($1,824 versus $22,744 per member), hospitalization (21.9 versus 79.2 per 1,000 members), and ED visit (329.1 versus 501.5 per 1,000 member) rates in the year than the comparison group after adjusting for key member- and area-level covariates.[§§§] Due to the small number of members who participated in the DCM Pilot, we were unable to compare the adjusted differences in dental services, which may be most relevant to this pilot program.

[§§§] We adjusted the cross-sectional models for member-level sociodemographic characteristics and health status indicators, zip code-level community characteristics, and county-level COVID-19 burden. See **Exhibit 2.3.2** for additional details about covariates.

Exhibit 5.4.5 Risk-Adjusted Means for Spending and Utilization Outcomes for DCM Pilot Participants and Comparison Members in the Performance Period (January – December 2019)

	Risk-Adjusted Mean			
	DCM Pilot	Comparison	Difference	95% CI
Core Demonstration Outcomes				
Total Medicaid spending	$1,824	$22,744	-$20,919***	-$29,998, -$11,841
Hospitalizations	21.9	79.2	-57.2***	-88.3, -26.2
ED visits	329.1	501.5	-172.4*	-344.1, -0.7
Annual wellness visit	134.9	138.0	-3.1	-93.8, 87.5

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data
NOTES: No results are shown for all-cause readmissions and dental services because those models did not converge due to sample size limitations. Total Medicaid spending is presented per member per year; utilization outcomes are presented per 1,000 members per year.

5.5 Discussion

EOHHS' goals for the DCM Pilot were broad and included: 1) increasing the use of preventative services, 2) decreasing the number of broken appointments, and 3) mitigating SDOH barriers for members. The limited scope of implementation of this pilot program (25 unique members) made it difficult to evaluate whether the Pilot made progress on these goals. The DCM Pilot was designed to make care more accessible to members who typically had barriers to accessing care, which may be reflected in the large gaps we see in utilization between the treatment and comparison groups. While we did observe that members receiving dental case management services under the Pilot incurred more unadjusted claims for dental services in the year, we cannot determine whether that was a result of the DCM Pilot activities. Unfortunately, due to the small sample size, we were not able to estimate the difference in risk-adjusted average dental services across the DCM Pilot participants and comparison members. In their 2019 Annual Operations Report to CMS,[57] EOHHS identified key challenges with the DCM Pilot that led to its limited uptake:

- **Low financial incentives for practices and providers to enroll and participate in the Pilot.** Providers participating in the pilot were compensated just $22 per claim with a dental case management code, reimbursed on a fee-for-service basis. EOHHS reported that this reimbursement rate was too low to incentivize providers to join this pilot program.
- **Insufficient resources to successfully market the DCM Pilot to practices.** EOHHS reported that despite multi-pronged practice recruitment strategies, their resources were limited and, ultimately, could not reach the goal of enrolling six practices in the DCM Pilot.
- **Lack of enrollment, especially among non-FQHC practices.** With only two practices participating fully in this pilot program, the sample size was too small for EOHHS to make determinations on programmatic success for the few individuals receiving services.

Additionally, with so few patients receiving services under the dental case management codes, it was not possible to conduct rigorous analyses on changes in outcomes in patients receiving this care. The reporting requirements were also sparingly reported; in EOHHS' 2019 Annual Operations Report, only one outcome metric (percent change in broken appointments) was included, and only for one practice. The practice reported decreases in the number of broken appointments among adult members in two quarters (four percent and three percent, respectively). However, claims data show that the practice also reported fewer than five instances of dental case management in those quarters, so it is not possible to assess whether that improvement is causally linked to the DCM Pilot. Per the Demonstration agreement, CMS also requires EOHHS to stratify outcomes by the four dental case management codes, which was not feasible due to the low uptake overall.

Providers may have found the additional reporting requirements for the DCM Pilot burdensome, [58] as they were required to submit multiple types of documentation to EOHHS beyond what could be captured in claims data:

- The DCM Progress and Outcomes Data Collection Form (online or paper)
- Scoring of patient behavior difficulty to assess progress over time
- Data on performance measures stratified by case management code
  - Number and percent of broken appointments
  - Preventive dental services
  - Ratio of preventive to restorative dental services
  - Number and percentage of completed treatment plans
  - Change in ED utilization for dental-related reasons

To reduce systemic barriers and observe a change in care utilization and billing practices, initiatives may need to be broader in scope and implemented for a longer duration than one calendar year.

Chapter 6: Institutions of Mental Disease Exclusion Waiver

6.1 IMD Exclusion Waiver Overview

As part of the Demonstration, the Executive Office of Health and Human Services (EOHHS) in collaboration with the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), requested a waiver (the "IMD exclusion waiver") of Section 1905(a)(29)(B) of the Social Security Act. This waiver would allow Medicaid coverage and federal financial participation for residential treatment services for Medicaid members with opioid use disorders (OUDs) and substance use disorders (SUDs) in Institutions for Mental Disease (IMD).[****] In Rhode Island, IMDs are defined as facilities with 16 or more beds and that are "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases," regardless of whether the facility is specifically licensed as such.[59] Facilities that primarily provide services for individuals with intellectual disabilities are not considered IMDs. Historically, federal financial participation excluded Medicaid coverage for adults under the age of 65 receiving inpatient OUD/SUD treatment in IMDs, even when an IMD was the most appropriate treatment location.[††††] This exclusion led to many complications for Medicaid members seeking care for OUD/SUDs, including: 1) Medicaid members being treated in hospital emergency departments (ED), which are more expensive and less prepared for mental health diagnoses and SUDs, 2) undermining continuity of care efforts, 3) limiting access to SUD treatment programs, and 4) constraining Medicaid-funded services and supports.

The Comprehensive Demonstration waives this IMD exclusion for OUD/SUD treatment and adds OUD/SUD treatment services provided in IMDs, including short-term residential services, to the benefits that Rhode Island Medicaid members receive. This allows Rhode Island to receive federal financial participation matching for members receiving OUD/SUD treatment services in IMDs who would otherwise be eligible for matching if they received those services in a non-IMD setting. In the Comprehensive Demonstration agreement, the target for average IMD length of stay was extended from 15 days in previous Section 1115 waivers to 30 days in the Comprehensive Demonstration to allow for additional flexibility in treatment courses and increase the probability of treatment success.

[****] EOHHS also requested that the IMD Exclusion Waiver be extended to members with mental health diagnoses; however, CMS only approved the waiver for members with SUD but not those with mental health diagnoses. According to Kaiser Family Foundation's Medicaid Waiver Tracker, as of April 2022, 32 states have an approved IMD Exclusion Waiver for SUD treatment (5 states pending), while 8 states have an approved IMD Exclusion Waiver for mental health conditions (8 states pending).

[††††] Rhode Island uses the American Society of Addiction Medicine's criteria for treatment settings and placement for patients needing treatment for addiction. ASAM levels 3.1 through 3.5 reflect the levels of treatment indicated for an IMD placement.

Length of stay will continue to be assessed via quarterly monitoring reports to CMS, as well as in this evaluation. Rhode Island's key goals for the IMD Exclusion Waiver are:

- Allow Rhode Island providers to maintain and enhance Medicaid members' access to substance use treatment in the settings deemed clinically appropriate
- Increase the use of evidence-based, SUD-specific patient placement criteria
- Set standards for residential treatment providers to help mitigate barriers to accessing care, particularly for members who require residential treatment[13]

Under the IMD Exclusion Waiver, all Medicaid members have coverage for high-quality, evidence-based OUD/SUD treatment services during short-term residential treatment and inpatient stays in IMDs, including medication-assisted treatment (MAT), medically supervised withdrawal management, care coordination for physical and behavioral health diagnoses, and peer recovery services. As of the submission of BHDDH's SUD Implementation Plan as part of the Comprehensive Demonstration, there were 280 residential beds for SUD treatment in Rhode Island (186 men-only, 48 women-only, and 46 for men or women), with approximately 100 patients waiting for placement.[13] BHDDH anticipates that the greater potential for residential treatment reimbursement under the IMD Exclusion Waiver, along with targeted funding outside of the Demonstration, will attract new residential providers, increase the number of available beds, address the disparity in gender-specific beds, and eliminate or greatly decrease the waitlist for residential treatment in Rhode Island.

6.2 Evaluation Hypotheses and Outcomes

The IMD Exclusion Waiver and extended length of stay guidance in the Comprehensive Demonstration is one of the many delivery system enhancements intended to create better access to higher-quality and more appropriate SUD treatment services for all Medicaid members, regardless of the setting where a member received those services. **Exhibit 6.2.1** lays out the explicit goals and target population of the IMD Exclusion Waiver, as well as the associated evaluation hypotheses, research questions, and performance metrics for the evaluation.

Exhibit 6.2.1. Overview of IMD Exclusion Waiver Goals, Evaluation Hypotheses, Research Questions, Target Population, and Metrics

Goals	• Allow Rhode Island to maintain and enhance member access to behavioral health services in appropriate settings
Target Population	• Rhode Island Medicaid members aged 21 to 64 years with substance use disorders and a clinical need for residential treatment and the services and supports required to make a transition back into the community
Evaluation Hypotheses	• The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members • The Demonstration will shift care away from high-cost settings, reducing spending while increasing utilization in lower-cost settings.

Research Questions	• What percentage of Rhode Island Medicaid members are attributed to this Demonstration program? • What are the trends in spending, utilization, and quality of care? • What are the trends in ED visits and IMD service use for members accessing behavioral health services?
Performance Metrics	• Use of BH services • Follow-up after ED visit • IMD service use • ED visits for BH services

6.3 Analytic Approach

The below section details our approach to evaluating the IMD Exclusion Waiver's impact, including identification of the treatment group in the baseline and performance periods, key outcomes, and our analytic approach. All analyses are conducted with adult Rhode Island Medicaid members ages 21-64 who received full Medicaid benefits for each month in the calendar quarter.

Baseline Period for IMD Exclusion analysis
July 2017 – June 2019

Performance Period for IMD Exclusion analysis
July 2019 – September 2021

Baseline and Performance Periods. The baseline period for the IMD Exclusion Waiver analysis is July 2017 – June 2019, and the performance period is July 2019 – September 2021. In this report, we analyze data through September 2021 based on current availability of complete data for that period; in the Summative Evaluation Report, we will analyze data through the end of the Demonstration (currently December 2023).

Treatment Group Identification. We used Medicaid claims and encounter data to indicate which members were between the ages of 21 and 64 years and accessed IMDs for residential SUD treatment during the baseline and/or performance period.

Comparison Group Identification. Due to the limited scope, broadly defined eligibility criteria, and the small number of participating enrollees in the IMD Exclusion Waiver, it was not feasible to identify an appropriate comparison group for the IMD Exclusion Waiver analysis. We instead conducted a pretest-posttest analysis of members receiving IMD services for residential SUD treatment before and after the Demonstration implementation period.

Exhibit 6.3.1. IMD Exclusion Waiver Outcomes for Evaluation

Core Demonstration Outcomes
• Number of members covered by IMD exclusion waiver
• Hospitalizations
• Emergency department visits
• Annual wellness visit
• All-cause readmissions
• Total Medicaid spending
IMD Exclusion Waiver Outcomes
• Use of BH services
• Follow-up after ED visit
• IMD service use
• ED visits for BH services

Outcomes. For the IMD Exclusion Waiver, we focused our analysis on the six core claims-based metrics (i.e., metrics that are measured for each demonstration program) as well as four additional metrics that are specific to the IMD Exclusion Waiver and its mechanisms of transformation (**Exhibit 6.3.1**).

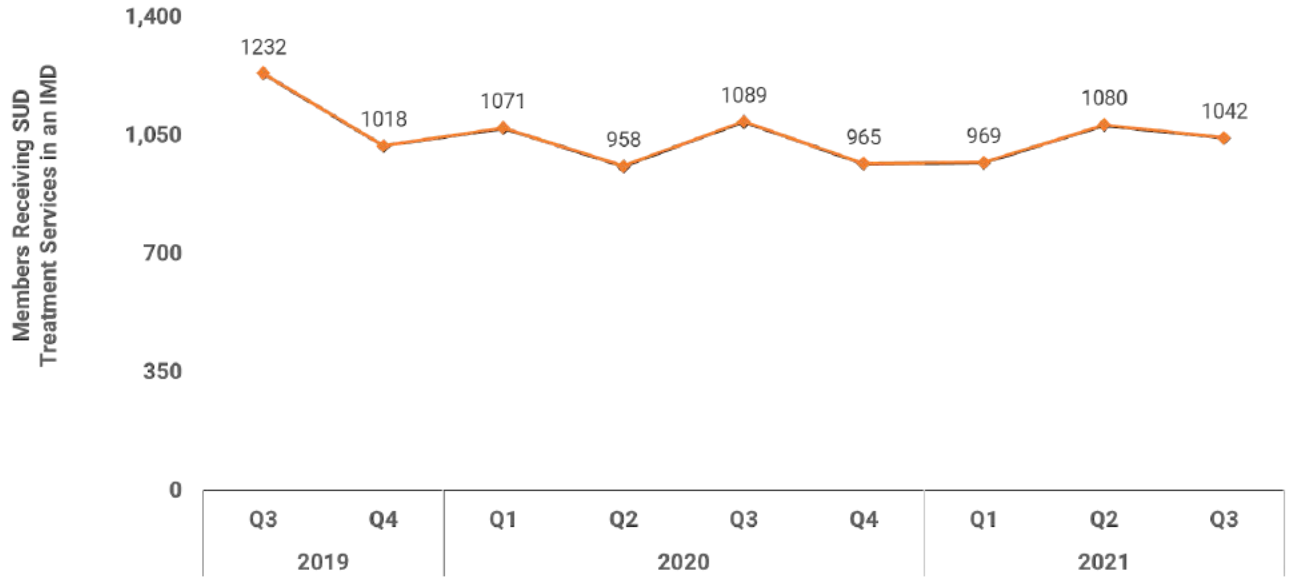
Analytic Approach. We conducted the following analyses to characterize the members who received residential treatment services for OUDs and SUDs in an IMD and estimate the impact of the IMD Exclusion Waiver:

- **Descriptive analyses of member characteristics** to understand the members aged 21 to 64 years who are accessing IMDs for SUD treatment, and how many members IMDs are serving over time
- **Unadjusted analyses of outcomes** to identify trends in the nine key outcomes in the baseline and performance periods, for Rhode Island Medicaid members using IMD services.
- **Risk-adjusted one-group pretest-posttest analyses** to compare the experience of members covered under the IMD Exclusion Waiver program in the baseline and performance period, which compares the outcomes for the IMD population before and after implementation. This approach, while adjusted for observable member- and area-level characteristics, does not permit a causal interpretation.

6.4 Descriptive Findings

Member participation. Over the course of this Demonstration, 4,895 unique Rhode Island Medicaid members received services under the IMD Exclusion Waiver. As displayed in **Exhibit 6.4.1**, the number of members using IMD services had a slight decrease from 1,232 members in Q3 to 1,018 in Q4 2019, then remained relatively constant over the rest of performance period, ending with 1,042 members using IMD services in Q3 2021. The number of members fluctuated slightly from Q4 2019 to Q3 2021, with a small amount of quarterly variation.

Exhibit 6.4.1. Members Using IMD Services in the Performance Period (July 2019 – September 2021)



SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.

Sociodemographic characteristics. Exhibit 6.4.2 summarizes the sociodemographic characteristics of members receiving residential SUD services in an IMD in the baseline and performance periods. A total of 5,136 unique members received these services in the baseline period, compared to 4,895 members in the performance period. The baseline and performance groups for this analysis are not mutually exclusive; 1,855 unique members received residential SUD services in an IMD in both the baseline and performance periods. Overall, the majority of members using IMD services in the performance period were male (65.0 percent) and non-Hispanic white (65.0 percent), and approximately half were 35-54 years of age. The overall sociodemographic and health characteristics of members accessing residential SUD service in an IMD did not change significantly between the baseline and performance periods.

Exhibit 6.4.2. Sociodemographic Characteristics of Members Receiving Residential SUD IMD Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Baseline Period (July 2017 – June 2019)	Performance Period (July 2019 – September 2021)
Unique members	5,136	4,895
Sociodemographic Characteristics		
Age (%)		
18-34 years	40.8	38.3
35-54 years	48.5	49.6
55-64 years	10.7	12.1
Female (%)	34.3	35.0

	Baseline Period (July 2017 – June 2019)	Performance Period (July 2019 – September 2021)
Race/Ethnicity (%)		
White, not Hispanic	61.1	65.0
Black, not Hispanic	7.9	8.3
Hispanic	10.2	10.0
Multiple/Other, not Hispanic	6.0	6.6
Unknown	14.8	10.1
Chronic conditions (%)†		
Diabetes	7.4	8.4
Stroke/TIA	1.9	2.5
AMI	0.5	0.7
Any COVID diagnosis (%)	N/A	5.3
Zip Code-Level Characteristics		
Median household income	$59,822	$62,212
Less than a high school education (%)	14.4	13.3
Under 100% of federal poverty line (%)	15.5	14.5
Receiving SSI, TANF, or SNAP (%)	68.5	40.4
Unemployment rate (%)	6.9	6.0
COVID County-Level Characteristics		
Average # cases	N/A	16.3 per 1,000 residents
Total # deaths	N/A	0.3 per 1,000 residents
Average PVI score	N/A	0.4
Average case fatality rate	N/A	16.2 per 1,000 residents
Total population vaccinated (%)	N/A	15.7

SOURCE: NORC analysis of Rhode Island Medicaid enrollment data.
NOTES: † Selected based on priority conditions identified by EOHHS. Zip code-level characteristics represent the average across all zip code tabulation areas where Rhode Island Medicaid members in the group reside. County-level characteristics represent the average across all counties where Rhode Island Medicaid members in the group reside; data is from March 2020 onward. AMI = Acute Myocardial Infarction; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families; TIA = Transient Ischemic Attack; PVI = Pandemic Vulnerability Index.

Unadjusted trends in spending and utilization outcomes. As shown in **Exhibit 6.4.3**, unadjusted outcomes for members using IMD services show increased utilization and spending during the performance period, as compared to the baseline period. Members using IMD services in the performance period had total Medicaid spending and acute care utilization (hospitalizations, readmissions, ED visits, behavioral health services, and IMD service use). In the performance period, more members received follow-up services after an ED visit for a mental illness, and slightly fewer had an ED visit for BH services.

Exhibit 6.4.3. Unadjusted Means for Spending and Utilization Outcomes for Members Using Residential SUD IMD Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Unadjusted Quarterly Mean	
	Baseline Period (July 2017 – June 2019)	Performance Period (July 2019 – September 2021)
Core Demonstration Outcomes		
Total Medicaid spending	$12,091	$13,620
Hospitalizations	794.1	926.9
All-cause readmissions	188.5	193.4
ED visits	1,431.1	1,355.9
IMD Exclusion Waiver Outcomes		
Use of behavioral health services	18,967.2	22,526.1
7-day follow-up after ED visit for mental illness	75.3	84.8
30-day follow-up after ED visit for mental illness	5.6	185.4
IMD service use	4,680.1	6,291.6
ED visits for BH services	1,213.4	1,202.8

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Medicaid spending is presented per member per quarter; utilization outcomes are presented per 1,000 members per quarter.

Risk-adjusted means for spending and utilization outcomes. In risk-adjusted pretest-posttest analyses, we observed statistically significant higher hospitalizations among members accessing residential SUD treatment services in an IMD (40.9 per 1,000 members more than baseline; **Exhibit 6.4.4**). This may be driving the higher total Medicaid spending per member ($12,121.38 in the baseline and $13,607.55 in the performance period). There were no statistically significant differences between the baseline and performance periods among the other utilization outcomes.

Exhibit 6.4.4. Risk-Adjusted Means for Spending and Utilization Outcomes for Members Using Residential SUD IMD Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Risk-Adjusted Mean			
	Baseline	Performance	Difference	95% CI
Core Demonstration Outcomes				
Total Medicaid spending	$12,121	$13,608	$1,486***	$875, $2,097
Hospitalizations	489.9	530.8	40.9***	18.3, 63.5

	Risk-Adjusted Mean			
	Baseline	Performance	Difference	95% CI
All-cause readmissions	191.6	191.1	0.4	-34.5, 34.1
ED visits	1,372.4	1,416.4	44.0	-36.5, 124.5
Annual wellness visit	57.5	53.5	-4.0	-14.5, 6.6
IMD Exclusion Waiver Outcomes				
7-day follow-up after ED visit for mental illness	77.3	83.6	6.2	-5.7, 7.0
30-day follow-up after ED visit for mental illness	201.3	192.0	-9.4	-10.7, 8.8
ED visits for BH services	1,200.7	1,215.5	14.8	-65.5, 95.0

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. Total Medicaid spending is presented per member per quarter; utilization outcomes are presented per 1,000 members per quarter. The 7- and 30-day outcome measures are limited to the population of members who had an ED visit for mental illness during a quarter.

6.5 Discussion

The changes to IMD reimbursement policies and length-of-stay guidelines under the Demonstration are designed to help address the increased need for SUD treatment services. However, the state still faces several challenges in providing appropriate and timely SUD/OUD care. For example, Rhode Island has seen a significant decrease in State Opioid Response (SOR) funding, which has resulted in the termination of funding for several projects. Further, while the state is working to increase capacity and use SOR funding to help new residential facilities open, they are unable to use federal grant funds for brick-and-mortar infrastructure. While there is political interest in developing these additional residential treatment facilities, there has historically been a lack of funding for those types of investments. However, in early 2022, the Rhode Island Attorney General announced settlement deals with four major opiate manufacturers and distributors for a total of $250 million over the next 18 years, as restitution for the companies' roles in driving the opioid epidemic.[60,61] These funds, distributed both to cities and towns as well as allocated for statewide initiative administered by EOHHS, will go directly to opioid use disorder prevention, treatment, and recovery.[62] With these funds, EOHHS may be able to provide more appropriate and timely care for Medicaid members accessing SUD/OUD care.

The IMD Exclusion Waiver is just one tool in Rhode Island's plan to address rising rates of SUD, which includes a wide range of other services and programming that focus on the prevention and treatment of SUD. A more comprehensive discussion of the role of Rhode Island's 1115 Demonstration in addressing the SUD crisis, including challenges related to the IMD Exclusion Waiver, can be found in the Rhode Island Substance Use Disorder Mid-Point Assessment.

In discussions, stakeholders noted that IMDs in Rhode Island have been seeing an increased demand for services, particularly for SUD. This increase is reflected in our descriptive analyses. While the total number of members accessing IMD services declined slightly (from 5,136 in the baseline to 4,895 in the

performance period), the number of members accessing services in each quarter remained relatively stable, and members accessed more residential SUD services in IMDs in the performance period (4,680.1 residential SUD services per 1,000 members in the baseline compared to 6,291.6 per 1,000 members in the performance period). In our risk-adjusted analyses, we also observed a $1,486 increase in total Medicaid spending per member per quarter driven in part by a corresponding increase in inpatient hospitalizations.

The descriptive findings in this Interim Report should be interpretated with caution. Due to the lack of an appropriate comparison group, this analysis was limited to a pretest-posttest design and these results cannot be interpreted causally. In the Summative Evaluation Report, we will further explore patterns in the usage of residential SUD services in Rhode Island's IMDs by including additional timepoints in the analyses and assessing the feasibility of an interrupted time series design to characterize the impacts of the program.

Chapter 7: Peer Recovery Specialist and Family/Youth Support Partners Programs

7.1 PRS/FYSP Program Overview

As part of Rhode Island's ongoing efforts to coordinate physical and behavioral health care and rebalance the delivery system away from high-cost settings, the Comprehensive Demonstration allows Rhode Island to receive federal funding for two initiatives designed to provide more holistic and less costly care to Medicaid members with complex mental illnesses and/or substance use disorders (SUDs). The Peer Recovery Specialist (PRS) and Family/Youth Support Partners (FYSP) Programs, administered by the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) and the Rhode Island Department of Children, Youth, and Family (DYCF), respectively, aim to provide a peer support system for Medicaid members with behavioral and/or mental health conditions, developmental disabilities, and SUDs.[13,‡‡‡‡] These programs are "intended to inspire hope in individuals that recovery is not only possible but probable,"[63] and to mentor individuals through challenges drawing from the lived experience of the PRS/FYSP. Services for Medicaid members under the Comprehensive Demonstration began in late 2019, once the Medicaid billing certification process was finalized.

A PRS is a non-clinical "credentialed behavioral health care professional… who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community" for individuals experiencing or at high risk for hospitalization, overdose, or homelessness, as well as individuals who were recently released from institutions (e.g., hospitals, prisons).[64] Similarly, a FYSP offers peer support services to children (under 21 years) with behavioral health or developmental disabilities and their caregivers or families, with the goal of the child continuing to live in a community-based setting with supports instead of in a residential treatment facility or inpatient setting. Both PRSs and FYSPs aim to "provide individuals with a support

Supports provided by peers in the PRS/FYSP program include:

- Using lived experience to help patients understand and develop the skills to address behavioral health conditions
- Serving as a key member of a patient's recovery and wellness team
- Providing tools and education to focus on health, wellness, and recovery
- Navigating state and local systems of care
- Fostering encouragement of personal responsibility and self-determination
- Growing skills to engage and communicate with providers and systems of care
- Educating and encouraging patients to be active advocates for themselves and for needed services
- Assisting in transitioning into and staying in the workforce

‡‡‡‡ The PRS program was introduced as an amendment to Rhode Island's Comprehensive Demonstration which was approved by CMS in February 2018. The FYSP program was included in the Comprehensive Demonstration as part of the waiver extension request approved in December 2018.

system to develop and learn healthy skills" and help stabilize patients in the community to keep out of more acute settings when possible.[13]

The PRS/FYSP program is designed to fill a gap in care coordination and management, drawing on the unique experience of individuals who have been successful at facing similar challenges in their lives. For instance, a parent who helped their child successfully addressed complex behavioral health challenges may serve as a FYSP to another parent in a similar situation, helping to navigate various health care and legal systems (e.g., psychiatric care, child welfare, juvenile justice) and provide direct support to tackle challenges.[13] Both PRS and FYSP peers are required to be certified by the Rhode Island Certification Board and/or DYCF[65] and work under a licensed health care provider.[§§§§] They must have a history of or currently be receiving treatment for a mental illness, addiction, chronic illness, or intellectual or developmental disability. Family members with experience navigating these conditions are also able to become a PRS or FYSP. The PRS/FYSP program takes a "Recovery Oriented Systems of Care" approach, which focuses on a patient's strengths and has a primary goal of achieving "sustained recovery and restoration."[13]

As of April 2020, there were 150 active PRS-certified individuals and six provider groups certified to provide services through the PRS/FYSP Programs, with only two provider groups billing Medicaid for PRS services. However, BHDDH has required each of the six community recovery centers in Rhode Island to become certified to bill for PRS services, with the aim of increasing opportunities to enroll and train PRS/FYSP peers.[66]

7.2 Evaluation Hypotheses and Outcomes

The PRS/FYSP Programs are two of the many delivery system enhancements intended to lead to better access to higher-quality and more appropriate SUD treatment services for all Medicaid members, coordinate physical and behavioral health care, and redirect patients away from acute care settings where possible. **Exhibit 7.2.1** lays out the explicit goals and target population of the PRS/FYSP Programs, as well as the associated evaluation hypotheses, research questions, and performance metrics for the evaluation.

[§§§§] A PRS may also work under the supervision of a non-clinical PRS Supervisor who is certified as a PRS and has at least two years of experience providing PRS services.

Exhibit 7.2.1. Overview of PRS/FYSP Program Goals, Evaluation Hypotheses, Research Questions, Target Population, and Metrics

Goals	• To provide peer-to-peer mentoring supports that go beyond recovery navigation • Provide individuals with a support system to develop and learn healthy living skills. • Teaching families the skills necessary to improve coping abilities and positive parenting skills • Developing and linking children, youth, and parents/caregivers with formal and informal support • Helping families to secure basic needs, and access health insurance or social service benefits • Improving socialization, long-term recovery, self-advocacy, connection to the community, and treatment of mental health and/or substance use disorders
Target Population	• PRS: Medicaid-eligible individuals experiencing or at risk of, hospitalization, overdose, homelessness or are in the hospital after an overdose, are homeless or are in a detox setting, or recently released from institutions such as hospitals and prison. • FYSP: Parents and youth covered by Rhode Island Medicaid with complex behavioral health needs who are at risk of having to leave the home due to child welfare or juvenile justice involvement, or may need extended residential psychiatric treatment
Evaluation Hypotheses	• The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for Rhode Island Medicaid members • The Demonstration will increase coordination among different care types, leading to better health outcomes for Rhode Island Medicaid members • The Demonstration will shift care away from high-cost settings, reducing spending while increasing utilization in lower-cost settings.
Research Questions	• What percentage of Rhode Island Medicaid members are attributed to these Demonstration programs? • What are the trends in spending, utilization, and quality of care? • To what extent have the Demonstrations integrated BH and SUD care into medical care? How has this affected health outcomes and BH/SUD treatment uptake for Rhode Island Medicaid members? • What are the trends in Emergency Department (ED) visits and Institution of Mental Disease (IMD) use for members accessing behavioral health services?
Metrics	• Preventative/ambulatory health services • Use of BH services • Follow-up after ED visit for mental illness • IMD service use

7.3 Analytic Approach

The below section details our approach to evaluating the PRS/FYRP Programs' impact, including baseline and performance periods, identification of treatment group, key outcomes, and our analytic approach. All analyses are conducted with Rhode Island Medicaid members who received full Medicaid benefits for each month in the calendar quarter.

Baseline and Performance Periods. The baseline period for the PRS/FYRP program analysis is July 2017 – June 2019, and the performance period is July 2019 – June 2021. In this report, we aggregated data to the year-level due to small sample size in each calendar quarter; thus, the analyses include data through only June 2021. In the Summative Evaluation Report, we will analyze data through the end of the Demonstration (currently December 2023).

Baseline Period for PRS/FYRP Program:
July 2017 – June 2019

Performance Period for PRS/FYRP Program:
July 2019 – June 2021

Treatment Group Identification. To identify members who accessed PRS or FYRP services in both the baseline and performance periods, we used Medicaid claims and encounter data to indicate which members accessed PRS or FYRP services during performance period (July 2019 – June 2021) and identified those same members in the baseline period (July 2017 – June 2019) to construct the baseline treatment group.

Comparison Group Identification. Due to the limited scope, broadly defined eligibility criteria, and the small number of participating enrollees in the PRS/FYRP Programs, the identification of a comparison group for the PRS/FYRP program analysis was not feasible.

Outcomes. For the PRS/FYRP Programs, we focused our analysis on six core claims-based metrics (i.e., metrics that are measured for each demonstration program) as well as four additional metrics that are specific to the PRS/FYRP Programs and their mechanisms of transformation (**Exhibit 7.3.1**).

Exhibit 7.3.1. PRS/FYSP Program Outcomes for Evaluation

Core Demonstration Outcomes
• Number of members receiving PRS/FYSP services
• Hospitalizations
• Emergency department visits
• Annual wellness visit
• All-cause readmissions
• Total Medicaid spending
PRS/FYSP Outcomes
• Preventative/ambulatory health services
• Use of BH services
• Follow-up after ED visit for mental illness
• IMD service use

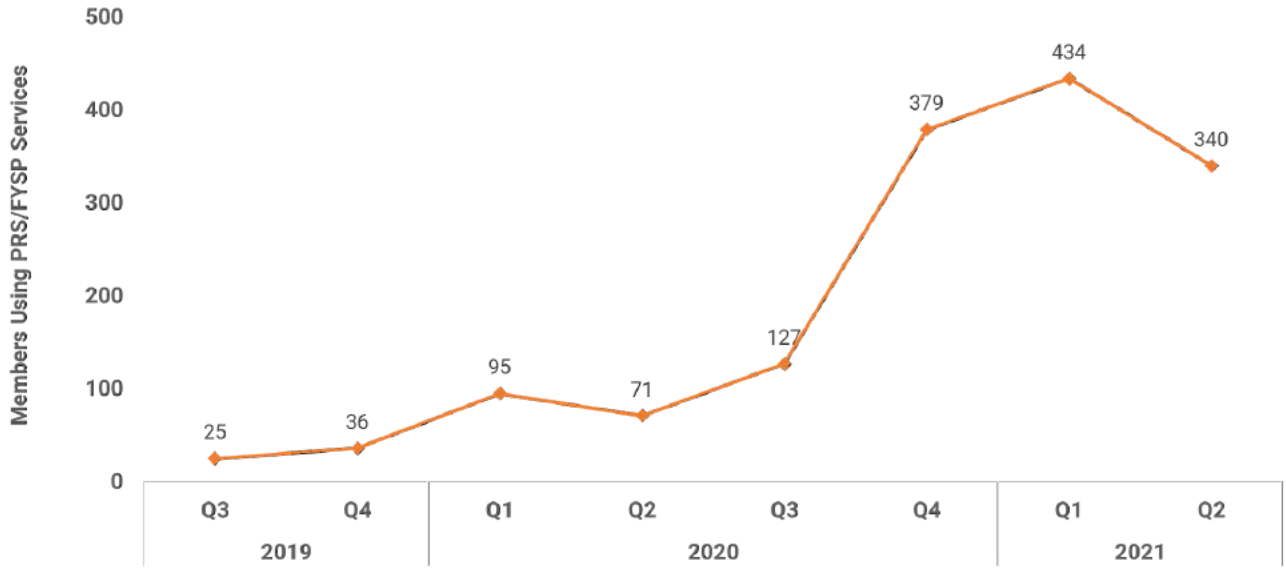
Analytic Approach. We conducted the following analyses to characterize the members who accessed PRS or FYRP services and estimate the impact of the PRS/FYRP Programs:

- **Descriptive analyses of member characteristics** to understand the members that are accessing PRS or FYPR services, and how many members PRS/FYRP are serving over time
- **Unadjusted analyses of outcomes** to identify trends in the nine key outcomes in the baseline and performance periods, for Rhode Island Medicaid members using PRS/FYSP services.
- **Risk-adjusted one-group pretest-posttest analyses** to compare the experience of members covered under the PRS/FYRP Programs in the baseline and performance period, comparing outcomes for the study population before and after implementation of the PRS/FYRP. This approach compares member outcomes prior to and after receiving PRS services and does not permit a causal interpretation.

7.4 Descriptive Findings

Member participation. Over the course of the Demonstration, 917 unique Rhode Island Medicaid members have received services under the PRS/FYSP Programs. As shown in **Exhibit 7.4.1**, the number of members using PRS/FYP services rose steadily from an initial number of 25 members in Q3 2019 to a peak of 434 members in Q1 2021. After Q1 2021, the number of enrolled members decreased slightly to 340 in Q2 2021, the final quarter in the evaluation analysis.

Exhibit 7.4.1. Members Using PRS/FYSP Services (July 2019 – June 2021)



SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.

Sociodemographic characteristics. Most members using PRS/FYSP services were majority male (58.9 percent) and non-Hispanic white (63.6 percent), and approximately half were 35 to 54 years of age (**Exhibit 7.4.2**). A relatively small percentage of members using PRS/FYSP services had diabetes (11.9 percent), stroke/TIA (3.2 percent), or AMI (0.8 percent). On average, members lived in areas where 16.5 percent of the community is below the federal poverty line, and approximately 40 percent of the community received Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits.

Exhibit 7.4.2. Sociodemographic Characteristics of Members Using PRS/FYSP Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Performance Period (July 2019 – September 2021)
Unique members	917
Sociodemographic Characteristics	
Age (%)	
<18 years	0.1

	Performance Period (July 2019 – September 2021)
18-34 years	32.4
35-54 years	51.4
55-64 years	15.3
>65 years	0.9
Female (%)	41.1
Race/Ethnicity (%)	
White, not Hispanic	63.6
Black, not Hispanic	9.6
Hispanic	10.8
Multiple/Other, not Hispanic	6.2
Unknown	9.8
Chronic conditions (%)	
Diabetes	11.4
Stroke/TIA	3.2
AMI	0.8
Any COVID diagnosis (%)	6.9
Zip Code-Level Characteristics	
Median household income	$58,632
Less than a high school education (%)	14.9
Under 100% of federal poverty line (%)	16.5
Receiving SSI, TANF, or SNAP (%)	37.6
Unemployment rate (%)	6.4
COVID County-Level Characteristics	
Average # cases	26.2 per 1,000 residents
Total # deaths	0.4 per 1,000 residents
Average PVI score	0.5
Average case fatality rate	14.0 per 1,000 residents
Total population vaccinated (%)	28.9

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data
NOTES: † Selected based on priority conditions identified by EOHHS. The baseline period consists of the same members as the performance period and are thus not included in this table. Zip code-level characteristics represent the average across all zip code tabulation areas where Rhode Island Medicaid members in the group reside. County-level characteristics represent the average across all counties where Rhode Island Medicaid members in the group reside; data is from March 2020 onward.
AMI = Acute Myocardial Infarction; PVI = Pandemic Vulnerability Index; SNAP = Supplemental Nutrition Assistance Program; SSI = Social Security Income; TANF = Temporary Assistance for Needy Families; TIA = Transient Ischemic Attack.

Unadjusted trends in spending and utilization outcomes. Exhibit 7.4.3 shows the unadjusted means for members who accessed PRS/FYSP services in the two years before the programs started (July 2017 – June 2019) and two years after the programs were implemented (July 2019 – June 2021). Due to the low number of members the PRS/FYSP Programs served during the performance period, we aggregated outcomes to the year level.

Unadjusted outcomes for members using PRS/FYSP services generally show decreased utilization and spending during the performance period, as compared to the baseline period. Members using PRS/FYSP services had lower total annual Medicaid spending and lower acute care utilization (hospitalizations, ED visits, and IMD service use), as well as lower use of preventative/ambulatory care. However, members using PRS/FYSP services had slightly higher rates of readmissions in the performance period, and also used more behavioral health services.

Exhibit 7.4.3. Unadjusted Means for Spending and Utilization Outcomes for Members Using PRS/FYSP Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Unadjusted Mean	
	Baseline Period (July 2017 – June 2019)	**Performance Period (July 2019 – June 2021)**
Core Demonstration Outcomes		
Total Medicaid spending	$12,887	$10,541
Hospitalizations	606.2	556.0
All-cause readmissions	170.7	197.2
ED visits	1,957.4	1,316.7
PRS/FYSP Outcomes		
Preventative/ambulatory health services	5,537.7	4,843.0
Use of behavioral health services	21,376.6	23,708.0
IMD service use	1,706.4	1,467.7

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: Total Medicaid spending is presented per member per year; utilization outcomes are presented per 1,000 members per year.

Risk-adjusted means for spending and utilization outcomes. Exhibit 7.4.4 shows the risk-adjusted means for members who accessed PRS/FYSP services in the two years before the programs started (July 2017 – June 2019) and two years after the programs were implemented (July 2019 – June 2021). As with the unadjusted numbers above, we aggregated outcomes to the year level due to the low number of members the PRS/FYSP Programs served during the performance period. Members using PRS/FYSP services had significantly lower average annual Medicaid spending in the performance period ($8,603 versus $24,740 per member), driven by decreases in ED visits (1,456.1 versus 3,001.8 per 1,000 members) and ambulatory health services (5,096.4 versus 8,693.9 per 1,000 members) in

the baseline period. However, because most of the performance period coincided with the COVID-19 pandemic, which drove declines in care in all settings, we are unable to determine the extent to which these decreases are due to the supports provided under the PRS/FYSP Programs.

Exhibit 7.4.4. Risk-Adjusted Means for Spending and Utilization Outcomes for Members Using PRS/FYSP Services, Baseline (July 2017 – June 2019) and Performance (July 2019 – June 2021) Periods

	Risk-Adjusted Mean			
	Baseline	Performance	Difference	95% CI
Core Demonstration Outcomes				
Total Medicaid spending	$24,740	$8,603	-$16,137**	-$2,8127, $4,147
Hospitalizations	369.9	277.5	-92.4	-208.7, 23.9
ED visits	3,001.8	1,456.1	-1,545.7***	-2,167.2, -924.1
Annual wellness visit	166.4	73.4	-93.0*	-179.6, -6.4
PRS/FYSP Outcomes				
Preventative/ambulatory health services	8,693.9	5,096.4	-3,597.5***	-4,614.8, -2,580.2
IMD service use	4,361.5	1,653.8	-2,707.8***	-4,195.7, -1,219.8

SOURCE: NORC analysis of Rhode Island Medicaid enrollment, claims, and encounter data.
NOTES: *p<0.05; **p<0.01; ***p<0.001. No results are shown for all-cause readmissions or 7- and 30-day follow-up for behavioral health ED visits because those models did not converge due to sample size limitations. Total Medicaid spending is presented per member per year; utilization outcomes are presented per 1,000 members per year.

7.5 Discussion

Looking across the baseline and performance periods, members using PRS/FYSP services showed decreased spending and utilization in the time after the PRS/FYSP Programs were implemented. However, most of the period when members were receiving PRS/FYSP services overlapped with the COVID-19 pandemic, which drove declines in service delivery and utilization across care settings, but particularly for behavioral health services.[6] Based on previous research, we hypothesize that members who more fully integrate peer and family support specialists into their care teams, develop meaningful relationships with their PRS, and who engage with their PRS more often will receive greater benefits from this program;[67,68] however, because we were unable to capture the intensity of engagement with program supports for individual members based on Medicaid claims and encounter data, we are limited in our ability to test that hypothesis. Relatedly, our evaluation of the PRS/FYSP Programs is also limited by our inability to conduct an impact assessment or determine causality on the fact that the COVID-19 pandemic overlaps almost completely with the measured performance period.

In our interviews with key stakeholders about the PRS/FYSP Programs, a number of key challenges emerged with implementation. First, because the PRS/FYSP Programs target providers in new service areas (i.e., peer support services) who may be new to Medicaid, some of the provider agencies and

organizations had little experience billing Medicaid for services or using electronic medical records. While BHDDH worked closely with practices to establish the Medicaid billing certification process, it was a lengthy exercise which initially delayed broader uptake of the program.[69] Stakeholders noted that this was an especially challenging barrier for smaller providers with more limited funding and staffing resources to complete the administrative requirements for participation. To mitigate some of these concerns, BHDDH collected feedback from providers about this process and revised the trainings to directly address some of the challenges in future rounds of training.

Like many behavioral health programs, the PRS/FYSP has limited staff and resources to oversee them programs, particularly around the onset of the COVID-19 pandemic when many staff re-focused on mitigating the pandemic's effects. The COVID-19 pandemic also delayed some of the required in-person practical experience required for peer specialists trying to participate in the PRS/FYSP Programs, which posed a challenge during a time when even more supports were needed for members.

Some managed care organizations (MCOs) were already implementing a similar program to pay for peer recovery services, which may or may not be captured in claims. However, these plans are not restricted by the state's certification standards for the PRS/FYSP Programs, and may differ in some of the details of implementation. In the future, BHDDH is hoping to collaborate with the MCO programs to streamline and standardize program requirements and benefits.

Finally, stakeholders noted that the attitudes and understanding about the PRS/FYSP roles have posed challenges for integrating them into members' care networks and care teams. While there is little published evidence on the impact of these types of peer navigators and in what contexts their services are most effective, BHDDH is collecting data on how they are interacting with members and when members may be most open to engaging with a PRS/FYSP. Stakeholders reported reluctance on the part of patients to connect with a designated peer after an overdose or crisis situation, and BHDDH noted that they were exploring approaches to integrate peers into the care team at the hospital to ensure that patients are offered the services from the very beginning of their care and/or recovery journey. BHDDH noted that, in their own follow-up analyses, patients who engaged with a peer support were more likely to enter treatment than those who did not.

Chapter 8: Future Analysis & Evaluation

The Summative Evaluation Report, the final draft of which will be submitted to CMS in October 2025, will cover the entire Demonstration period (January 2019 through December 2023). The Summative Evaluation will build on the findings presented in this Interim Evaluation Report, applying similar methodology for each of the Demonstration programs and assessing similar outcomes over the full Demonstration period. In addition to the five programs evaluated in this report, we will also include any programs that are implemented and funded under the Demonstration in the future. This includes the second phase of the AE Program, the LTSS APM Program, which is planned to be implemented as a pilot program from July 2022 through December 2023, and then as a full program from January 2024 through December 2027. Data from the LTSS APM pilot will be included in the Summative Evaluation Report, as well as all data from the full program performance period that is available for analysis at the time of the report.

The Demonstration programs assessed in this Interim Evaluation Report were in the early stages of implementation during the period evaluated. The findings presented here represent an opportunity to assess the early trends in outcomes observed under each program. However, because most of the performance period for the five Demonstration programs overlapped entirely or meaningfully with the COVID-19 pandemic, we were limited in our ability to assess the effects of the program relative to the drastic shifts in care-seeking behavior and service utilization that occurred during the pandemic. In the longer evaluation timeframe allowed by the Summative Evaluation Report, we will be able to better assess the impact of the Demonstration programs in the “new normal” of health care service delivery.

In the Summative Evaluation Report, we will also consider an expanded set of analyses and additional measures. The extended evaluation timeframe will allow us to consider more rigorous evaluation designs, such as including additional timepoints in pretest-posttest analyses. The availability of additional data will allow for the addition of new covariates, including housing status variables from Rhode Island’s Homeless Management Information System. We will also assess the feasibility of additional exploratory analyses, including assessing Accountable Entity (AE)-specific variation and effects by member subgroups.

Finally, we will carry out an additional set of sensitivity analyses for the Summative Report. One such sensitivity analysis will include testing the robustness of our findings under different attribution methodologies for AE-enrolled members. In primary analyses we will use the attribution lists generated by the MCOs, as we did for this Interim Report. In the Summative Report sensitivity analyses, we will apply a retrospective attribution algorithm based on utilization and compare the characteristics of the attributed populations and results from impact models to those in the primary models.

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Appendix D: Budget Neutrality Methodology

The budget neutrality projections of future costs are based on informed assumptions. Actual spending will vary to the extent that experience differs from our assumptions.

Appendix E contains the budget neutrality worksheets. The text below describes the methodology as required by CMS.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Data

Rhode Island's historical data reflects the following Regular and Hypothetical Medicaid Eligibility Groups (MEG) contained within its current 1115 Demonstration:

- Regular MEGs:
  - Adults no TPL
  - Adults TPL
  - Rite Care
  - Children with Special Healthcare Needs
- Hypothetical MEGs:
  - 217-like Group
  - Family Planning Group
  - Substance Use Disorder (SUD) Institutes for Mental Disease (IMD)
  - Low-Income Adult

Data is provided for five calendar years (CY), from 2017 through 2021, and includes all FFS claims (including supplemental payments to hospitals) and payments to MCOs less any rebates made by Rhode Island's EOHHS for Medicaid-eligible services, consistent with the terms of Rhode Island's global 1115 waiver. The expenditure data is from Rhode Island's CMS-64 submissions. Technical re-allocations of certain expenditures to specific MEGs have been made to the underlying financial data where errors in original reporting were discovered (see *Appendix E* for details). The corresponding member months and their categorization by MEG is from the State's MMIS.

The historical data does not include disproportionate share hospital (DSH) payments; EOHHS' Medicaid-funded central management expenses; payments made on behalf of children that meet the requirements of section 2103 of the Social Security Act and are delivered under Rhode Island's Separate CHIP program[89]; Medicare Part D clawback payments; payments to local education agencies; all claiming or spending associated with the Health Systems Transformation Program (HSTP)[90]; or any state-only payments.

[89] Payments made under the section 2103 of the Social Security Act consistent with the Medicaid expansion model for CHIP that allows Rhode Island to cover CHIP-eligible children under its Medicaid program are included, however.

[90] Although any HSTP-related expenditures are subject to Budget Neutrality within the current Demonstration, it is not appropriate for inclusion when establishing a without waiver baseline for the subsequent Demonstration.

Additionally, within our historical reporting, we have treated the Hypothetical SUD IMD MEG as an expenditure service rather than a separate MEG.[91] This is consistent with how a member's underlying eligibility for Medicaid is determined (i.e., eligibility does not consider whether a person has or is expected to have SUD IMD service utilization). As a result, SUD IMD expenditures may be included in all MEGs except the Family Planning Group; however, over 70% of members utilizing SUD IMD services within a quarter are within the Low-Income Adult Hypothetical MEG.

For purposes of the current renewal, we propose eliminating our Hypothetical MEGs given the availability of reliable experience. Further, to reflect the expected variances in spending Rhode Island amends its existent categorization for the following MEGs:

- ABD no TPL (Non LTSS)
- ABD with TPL (Non LTSS)
- ABD LTSS
- Rite Care
- Children with Special Healthcare Needs
- Expansion
- Family Planning

B. Bridge Period (from end of historical data to beginning of waiver renewal on January 1, 2024).

The bridge is January 1, 2022, through December 31, 2023 (24 months).

C. Without-Waiver Per Member Per Month (PMPM) Costs and Member Months with Justification

For all populations, EOHHS developed its annual without-waiver trends rates for eligible members, by MEG, based on the historical data (CY 2017 – 2021) reallocated to the proposed MEGs where necessary. Rhode Island's without-waiver (WOW) costs are obtained on a per capita basis (as opposed to aggregate basis).

For PMPM cost trend, we adjusted the observed 5-year average annual trends for the following:

- increased costs to account for the acuity impact of changes in enrollment due to the national health emergency in January 2020 (and its related maintenance-of-eligibility requirement) and subsequent unwinding of the PHE during the Bridge Period as assumed in CMS' latest report on National Health Expenditures[92] (+6.7% for all populations, applied to the bridge period)

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[91] This treatment of SUD IMD expenditures is consistent with how EOHHS has been reporting expenditures on the CMS-64 through June 30, 2022. Although there are approximately 500 distinct members per month and 700 distinct members per quarter have SUD IMD utilization, EOHHS is only able to identify these members through a retroactive analyses of claims data. Further, this logic cannot be applied at level of the financial transaction as needed for contemporaneous CMS-64 reporting. It should be noted that EOHHS report extensively on this population to CMS as part of its well-established SUD monitoring protocol.

[92] Centers for Medicare & Medicaid Services. (2022, April 27). National Health Expenditure Data: Projected. Retrieved September 15, 2022, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

- the greater of observed trend or the prospective Medicaid-specific price trend reflected in CMS' most recent National Health Expenditures report[93] (+4.8% for all populations)
- increased costs to account for the unprecedented (yet temporary) decline in nursing home spending as a result of Covid-19 related mortality and the change in beneficiary behavior[94] (+2.5% to ABD LTSS, annually for 3 years)
- increased costs to account for full implementation of recommendation of federal consent decree for Rhode Island's I/DD population (+2.5% for ABD LTSS, annually for 3 years)
- increased costs if existing cost-effective waiver services were to be eliminated, including elimination of home and community-based services provided in lieu of Medicaid nursing home benefits[95] and health home services for members with complex BH needs[96] (+1.0% ABD no TPL and ABD TPL; +2.5% ABD LTSS; +0.5% New Adult Group)
- increased costs if managed care programs were replaced with FFS[97] (+3.0% to ABD no TPL, Rite Care, CSHCN, and Expansion; +1% for ABD TPL cumulative over 3 years)
- increased costs for HRSN expenditures in Rite Care (+1%) and Expansion (+1%) populations

The composite impact of these adjustments to the trends apparent in the Historical Data results in annual trends ranging from 7.8% to 15% per annum across the different enrollment groups during the first 3 years and between 4.8% and 6.5% for each of the final two years of the Demonstration.

Additional information on adjustments is included in *Appendix E*.

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[93] Centers for Medicare & Medicaid Services. (2022, April 27). National Health Expenditure Data: Projected. Retrieved September 15, 2022, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

[94] Between the pre-COVID era (i.e., CY 2019) and CY 2021 there was a decline in the average daily census of Nursing Facilities (including Hospice beds) of nearly 1,000 Medicaid recipients adjusting the ratio of Institutional to Community LTSS members. With a PMPM cost differential of approximately $6,500 Institutional to $2,500 HCBS, the change in the blend of LTSS setting contributed negatively to observed trends that will likely revert absent intervention. A reversion to pre-Covid ratio will increase PMPM by 7.5% that assume will be realized over the 3 years.

[95] Approximately 30% of HCBS members (not including I/DD members) have a need for the highest level of care and would otherwise be eligible for nursing home care. Further, some proportion of those who have avoided needing the highest level of care under our existing waiver authority will experience a more rapid deterioration of their independence in the absence of such home-based services and thereby become eligible for institutional level of care. Assuming that 50% ABD LTSS current receiving HCBS will see their average cost fall from $2,500 to approximately $700 (for cross over activity and Medicare premium payments only) but the average cost of the remaining HCBS members will see a greater than 2x increase in their PMPM, we assume this net impact will increase the PMPM by 7.5% realized over the 3 years.

[96] In 2016, Rhode Island's Medicaid Reinvent assumed savings of 6.0% against the total cost of care of members enrolled in health home. These savings were achieved over the course of 18 months. While these savings were applied against a portion of each MEG, the savings were greatest against the SSI and SPMI subpopulations with the ABD no TPL and Expansion groups. Applied against the entire MEG these savings are equivalent to 1.0% for ABD no TPL and 0.5% for Expansion.

[97] The savings assumption of 3.0% is equivalent to the savings set by Rhode Island EOHHS and CMS for the Medicare Medicaid Program Demonstration program. Managed care enrollment is mandatory and so applying the same savings against the WOW is reasonable; the savings ABD TPL and ABD LTSS is less as only 1/3rd of these MEGs are enrolled in managed care.

Our member months estimates assume an initial reduction in enrollment during the Bridge Period, following resumption of Medicaid redetermination activities with the "unwinding" of the PHE, after which a stable enrollment growth is modeled. This approach is consistent with EOHHS' forecasting methodology for its biannual caseload estimating conference to the State legislature.

Rhode Island's member months and resulting estimate of its overall costs are based on EOHHS' best forecast as of September 2022 and therefore should be considered illustrative only.

D. With-Waiver PMPM Cost and Member Month Projections and Justification

In determining the trend for our with-waiver (WW) PMPM, we considered the impact of the major modifications being pursued in Rhode Island's 1115 waiver renewal with the historic actuals, based on information in our and other states' waiver submissions. The cumulative impact of the adjustments is reflected in the trend rates included in *Appendix E*. The adjustments are grouped into 3 main categories as described below:

1. Items in historical actuals:

In estimating our WW PMPM costs, we did not make any adjustments to our historical spend for the following waiver services:

- Telephonic HCBS Assessments
- Parents as Caregivers

However, we adjusted the PMPM cost trends for the following:

- Managed Care
- Accountable Entities

We estimate the savings attributed to managed care to be 3.0% consistent with savings attributed assumed under the CMS Demonstration for Medicare Medicaid Program and accountable entities program to be 1.0% reflecting realized shared savings reported within the program and not included in subsequent rating periods.

2. Items expanding benefits:

We project that PMPM costs will increase because of modifications intended to increase access to existing services and/or as a result of utilization of the new services for which we are pursuing new authority. However, these increases will be partially offset by savings on other Medicaid service expenditures, for an increase in PMPM that is moderated compared to the marginal cost of the new services.

Overall, we anticipate the additional costs of equivalent to less than 2.0% for each budget population.

Table 1. New Benefits and Impacted Population

	ABD TPL	ABD NO TPL	ABD LTSS	RITE CARE	CSHCN	EXPANSION
HOME STABILIZATION	✓	✓				✓

MEDICAL RESPITE	✓	✓				✓
HEALTH EQUITY ZONES	✓	✓		✓	✓	✓
I/DD REPORT SUPPORTS			✓			
MANAGED DENTAL FOR ADULTS		✓	✓	✓		✓
ALTERNATIVE MEDICINE		✓	✓	✓		✓
FAMILY VISITATION SERVICES[98]				✓		

3. Item expanding coverage:

Extending Medicaid coverage to incarcerated Rhode Islanders during the month preceding their release from the custody of Rhode Island's Department of Corrections will add marginal member months and marginal costs for associated supports.

Additionally, compared to our existing authority, the postpartum 12-month extension would contribute to additional member months in Rite Care and a reduction in the number of members eligible under the limited-benefits Family Planning Group MEG. However, we anticipate this impact is fully reflected in the historical data given the PHE-related maintenance-of-eligibility requirements and the proposed change to our existing waiver during the Bridge Period.

The impact of these modest expansions to eligibility will be primarily across the following population groups:

Table 2. Newly Covered Budget Population

	ABD TPL	ABD NO TPL	ABD LTSS	RITE CARE	CSHCN	EXPANSION
OUTREACH & PRE-RELEASE SUPPORTS				✓		✓
POSTPARTUM 12-MONTHS				✓		

Overall, we assume a With-Waiver cost trend of 6.1%. This reflects the 4.6% long term cost trend forecast of CMS in its most recent National Health Expenditure report. The cost savings

[98] Family visitation services will be codified as a state plan service and therefore not a waiver program request. However, However, this is a new cost that is not yet implemented and therefore it is not in the historical data.

and efficiencies achieved by our health plan partners – that are routinely ranked among the top 10 Medicaid managed care plans in the nation – are already reflected in the historical experience. One and a half additional percentage points are added to the trend to reflect the potential costs of the new service provisions included in the renewal.

II. Cost Projections for New Populations

There are no new populations being sought in this 1115 renewal.

However, we are seeking to amend out general eligibility criteria for Medicaid in a manner that will have a marginal impact on existing populations by extending postpartum eligibility form 60 days to 12 months and allowing outreach and pre-release supports for the incarcerated. Overall, we anticipate an impact of fewer than 15,000 member months among existing Budget Populations, including 2,000 member months in the Adult Expansion MEG for incarcerated members receiving outreach and pre-release supports and 10,000 member months moving from Family Planning Group to Rite Care as a result of the postpartum extension.

This costs and member month impact of these changes are reflected in the “With-Waiver PMPM Cost and Member Month Projections.” The overall cost projection for these new member months is estimated to be less than $5,000,000 per annum or less than 0.1% of our Without Waiver cost estimate.

III. Disproportionate Share Hospital Expenditure Offset

Not applicable.

IV. Summary of Budget Neutrality

See D.2 Budget Neutrality Tables.

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

Appendix E: Budget Neutrality Worksheets

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED**						
4							
5	**Pop 1. ABD no TPL**	**HY 1 (CY 2017)**	**HY 2 (CY 2018)**	**HY 3 (CY 2019)**	**HY 4 (CY 2020)**	**HY 5 (CY 2021)**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 268,476,462	$ 283,334,689	$ 330,133,616	$ 304,925,667	$ 344,478,759	$ 1,531,349,192
7	**ELIGIBLE MEMBER MONTHS**	179,647	177,761	173,815	172,667	171,765	
8	**PMPM COST**	$ 1,494.47	$ 1,593.91	$ 1,899 34	$ 1,765.98	$ 2,005 52	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		5.53%	16 52%	-7.64%	12 97%	6.43%
12	ELIGIBLE MEMBER MONTHS		-1.05%	-2 22%	-0.66%	-0 52%	-1.12%
13	PMPM COST		6.65%	19.16%	-7.02%	13 56%	7 63%
14							
15	**Pop 2. ABD TPL**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
16	**TOTAL EXPENDITURES**	$ 269,885,976	$ 250,546,864	$ 219,410,648	$ 190,132,028	$ 216,926,304	$ 1,146,901,820
17	**ELIGIBLE MEMBER MONTHS**	287,270	297,535	288,025	290,451	303,876	
18	**PMPM COST**	$ 939.49	$ 842.08	$ 761.78	$ 654.61	$ 713 86	
19	**TREND RATES**						**5-YEAR**
20				**ANNUAL CHANGE**			**AVERAGE**
21	TOTAL EXPENDITURE		-7.17%	-12.43%	-13.34%	14 09%	-5.31%
22	ELIGIBLE MEMBER MONTHS		3.57%	-3 20%	0.84%	4 62%	1.41%
23	PMPM COST		-10.37%	-9 54%	-14.07%	9 05%	-6.64%
24							
25	**Pop 3. ABD LTSS**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
26	**TOTAL EXPENDITURES**	$ 724,033,942	$ 745,167,513	$ 820,733,227	$ 783,326,661	$ 803,607,144	$ 3,876,868,487
27	**ELIGIBLE MEMBER MONTHS**	176,684	177,507	178,549	173,328	166,371	
28	**PMPM COST**	$ 4,097.90	$ 4,197.96	$ 4,596 68	$ 4,519.33	$ 4,830 21	
29	**TREND RATES**						**5-YEAR**
30				**ANNUAL CHANGE**			**AVERAGE**
31	TOTAL EXPENDITURE		2.92%	10.14%	-4.56%	2 59%	2 64%
32	ELIGIBLE MEMBER MONTHS		0.47%	0 59%	-2.92%	-4 01%	-1.49%
33	PMPM COST		2.44%	9 50%	-1.68%	6 88%	4 20%
34							
35	**Pop 4. Rite Care**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
36	**TOTAL EXPENDITURES**	$ 515,019,502	$ 523,900,737	$ 584,755,268	$ 540,281,451	$ 661,604,382	$ 2,825,561,340
37	**ELIGIBLE MEMBER MONTHS**	2,069,454	2,021,958	1,937,553	1,934,573	2,074,006	
38	**PMPM COST**	$ 248.87	$ 259.11	$ 301 80	$ 279.28	$ 319 00	
39	**TREND RATES**						**5-YEAR**
40				**ANNUAL CHANGE**			**AVERAGE**
41	TOTAL EXPENDITURE		1.72%	11 62%	-7.61%	22.46%	6.46%
42	ELIGIBLE MEMBER MONTHS		-2.30%	-4.17%	-0.15%	7 21%	0 05%
43	PMPM COST		4.11%	16.48%	-7.46%	14 22%	6.40%
44							
45	**Pop 5. CSHCN**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
46	**TOTAL EXPENDITURES**	$ 170,107,095	$ 168,132,484	$ 167,369,332	$ 169,999,309	$ 182,811,295	$ 858,419,514
47	**ELIGIBLE MEMBER MONTHS**	147,208	147,761	143,051	145,585	147,024	
48	**PMPM COST**	$ 1,155.56	$ 1,137.87	$ 1,170 00	$ 1,167.70	$ 1,243.41	
49	**TREND RATES**						**5-YEAR**
50				**ANNUAL CHANGE**			**AVERAGE**
51	TOTAL EXPENDITURE		-1.16%	-0.45%	1.57%	7 54%	1 82%
52	ELIGIBLE MEMBER MONTHS		0.38%	-3.19%	1.77%	0 99%	-0.03%
53	PMPM COST		-1.53%	2 82%	-0.20%	6.48%	1 85%
54							
55	**Pop 6. Expansion**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
56	**TOTAL EXPENDITURES**	$ 479,099,781	$ 451,290,490	$ 475,460,073	$ 545,106,889	$ 765,644,669	$ 2,716,601,902
57	**ELIGIBLE MEMBER MONTHS**	962,548	936,990	897,870	985,547	1,193,095	
58	**PMPM COST**	$ 497.74	$ 481.64	$ 529 54	$ 553.10	$ 641.73	
59	**TREND RATES**						**5-YEAR**
60				**ANNUAL CHANGE**			**AVERAGE**
61	TOTAL EXPENDITURE		-5.80%	5 36%	14.65%	40.46%	12.43%
62	ELIGIBLE MEMBER MONTHS		-2.66%	-4.18%	9.76%	21 06%	5 51%
63	PMPM COST		-3.24%	9 95%	4.45%	16 02%	6 56%
64							
65	**Pop 7. Family Planning**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
66	**TOTAL EXPENDITURES**	$ 53,490	$ 116,238	$ 359,192	$ 406,225	$ 245,689	$ 1,180,834
67	**ELIGIBLE MEMBER MONTHS**	12,183	13,138	17,700	21,044	18,163	
68	**PMPM COST**	$ 4.39	$ 8.85	$ 20 29	$ 19.30	$ 13 53	
69	**TREND RATES**						**5-YEAR**
70				**ANNUAL CHANGE**			**AVERAGE**
71	TOTAL EXPENDITURE		117.31%	209 01%	13.09%	-39 52%	46.40%
72	ELIGIBLE MEMBER MONTHS		7.84%	34.72%	18.89%	-13 69%	10.50%
73	PMPM COST		101.51%	129 37%	-4.88%	-29 93%	32.49%
74							
75	**Other Populations & CNOMS**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
76	**TOTAL EXPENDITURES**	$ 9,176,311	$ 9,399,975	$ 9,839,671	$ 8,397,342	$ 8,152,058	$ 44,965,356
77	**ELIGIBLE MEMBER MONTHS**	53,953	55,061	55,361	52,925	52,394	
78	**PMPM COST**	$ 170.08	$ 170.72	$ 177.74	$ 158.66	$ 155 59	
79	**TREND RATES**						**5-YEAR**
80				**ANNUAL CHANGE**			**AVERAGE**
81	TOTAL EXPENDITURE		2.44%	4 68%	-14.66%	-2 92%	-2.92%
82	ELIGIBLE MEMBER MONTHS		2.05%	0 54%	-4.40%	-1 00%	-0.73%
83	PMPM COST		0.38%	4.11%	-10.73%	-1 94%	-2.20%

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
2											
3											
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
5	GROUP	RATE 1	OF AGING	DY 15 (CY 2023)	RATE 2	DY 16 (CY 2024)	DY 17 (CY 2025)	DY 18 (CY 2026)	DY 19 (CY 2027)	DY 20 (CY 2028)	WOW
6											
7	Pop 1. ABD no TPL										
8	Pop Type:	Medicaid									
9	Eligible Member Months	0.00%	24	171,765	1.2%	173,826	175,912	178,023	180,159	182,321	
10	PMPM Cost	7.63%	24	$ 2,323.24	7.1%	$ 2,488.89	$ 2,666.35	$ 2,856.46	$ 3,060.13	$ 3,278.32	
11	Total Expenditure					$ 432 634 241	$ 469 043 212	$ 508 515 691	$ 551 310 927	$ 597 707 327	$ 2 559 211 398
12											
13	Pop 2. ABD TPL										
14	Pop Type:	Medicaid									
15	Eligible Member Months	-1.31%	24	295,967	1.3%	299,903	303,892	307,933	312,029	316,179	
16	PMPM Cost	6.70%	24	$ 812.73	6.0%	$ 861.49	$ 913.18	$ 967.97	$ 1,026.05	$ 1,087.61	
17	Total Expenditure					$ 258 363 397	$ 277 507 791	$ 298 070 317	$ 320 157 293	$ 343 879 359	$ 1 497 978 157
18											
19	Pop 3. ABD LTSS										
20	Pop Type:	Medicaid									
21	Eligible Member Months	2.47%	24	174,691	1.6%	177,486	180,326	183,211	186,143	189,121	
22	PMPM Cost	6.70%	24	$ 5,499.14	9.2%	$ 6,007.26	$ 6,562.33	$ 7,168.69	$ 7,831.08	$ 8,554.67	
23	Total Expenditure					$ 1,066,206,289	$ 1,183,359,181	$ 1,313,384,924	$ 1,457,698,125	$ 1,617,867,324	$ 6,638,515,842
24											
25	Pop 4. Rite Care										
26	Pop Type:	Medicaid									
27	Eligible Member Months	-0.75%	24	2,043,013	1.1%	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811	
28	PMPM Cost	8.11%	24	$ 372.84	6.6%	$ 397.60	$ 424.00	$ 452.15	$ 482.17	$ 514.19	
29	Total Expenditure					$ 821,155,887	$ 885,224,221	$ 954,285,145	$ 1,028,736,172	$ 1,109,010,473	$ 4,798,411,899
30											
31	Pop 5. CSHCN										
32	Pop Type:	Medicaid									
33	Eligible Member Months	-0.55%	24	145,411	1.0%	146,923	148,451	149,995	151,555	153,131	
34	PMPM Cost	6.70%	24	$ 1,415.61	6.0%	$ 1,500.55	$ 1,590.58	$ 1,686.01	$ 1,787.17	$ 1,894.40	
35	Total Expenditure					$ 220 465 992	$ 236 123 924	$ 252 893 669	$ 270 855 098	$ 290 092 280	$ 1 270 430 963
36											
37	Pop 6. Expansion										
38	Pop Type:	Expansion									
39	Eligible Member Months	-3.62%	24	1,108,278	-0.1%	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852	
40	PMPM Cost	9.01%	24	$ 762.58	6.7%	$ 813.67	$ 868.19	$ 926.36	$ 988.43	$ 1,054.65	
41	Total Expenditure					$ 901,051,467	$ 960,657,326	$ 1,024,202,754	$ 1,091,954,365	$ 1,164,177,906	$ 5,142,043,818
42											
43	Pop 7. Family Planning										
44	Pop Type:	Medicaid									
45	Eligible Member Months	-0.64%	24	17,931	1.5%	18,195	18,462	18,734	19,009	19,289	
46	PMPM Cost	32.49%	24	$ 23.74	4.8%	$ 24.88	$ 26.07	$ 27.32	$ 28.63	$ 30.00	
47	Total Expenditure					$ 452 688	$ 481 313	$ 511 805	$ 544 230	$ 578 656	$ 2 568 692
48											
49	Other Populations & CNOMS										
50	Pop Type:	Medicaid									
51	Eligible Member Months	0.00%	24	52,394	1.2%	53,023	53,659	54,303	54,955	55,614	
52	PMPM Cost	6.70%	24	$ 177.14	4.8%	$ 185.64	$ 194.55	$ 203.89	$ 213.68	$ 223.94	
53	Total Expenditure					$ 9,843,139	$ 10,439,359	$ 11,071,820	$ 11,742,687	$ 12,454,199	$ 55,551,204

	A	B	C	D	E	F	G	H	I
1	DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION COVERAGE COSTS FOR POPULATIONS								
2									
3									
4				DEMONSTRATION YEARS (DY)					TOTAL WW
5	ELIGIBILITY GROUP	DY 15 (CY 2023)	DEMO TREND RATE	DY 16 (CY 2024)	DY 17 (CY 2025)	DY 18 (CY 2026)	DY 19 (CY 2027)	DY 20 (CY 2028)	
6									
7	Pop 1. ABD no TPL								
8	Pop Type	Medicaid							
9	Eligible Member Months	171,765	1.2%	173,826	175,912	178,023	180,159	182,321	
10	PMPM Cost	$ 2,323 24	6.1%	$ 2,464.96	$ 2,615.32	$ 2,774.85	$ 2,944.12	$ 3,123.71	
11	Total Expenditure			$ 428,474,581	$ 460,066,418	$ 493,987,231	$ 530,410,645	$ 569,518,642	$ 2,482,457,516
12									
13	Pop 2. ABD TPL								
14	Pop Type	Medicaid							
15	Eligible Member Months	295,967	1.3%	299,903	303,892	307,933	312,029	316,179	
16	PMPM Cost	$ 812.73	6.1%	$ 862.31	$ 914.91	$ 970.72	$ 1,029.93	$ 1,092.76	
17	Total Expenditure			$ 258,609,318	$ 278,033,523	$ 298,917,134	$ 321,367,965	$ 345,507,681	$ 1,502,435,620
18									
19	Pop 3. ABD LTSS								
20	Pop Type	Medicaid							
21	Eligible Member Months	174,691	1.6%	177,486	180,326	183,211	186,143	189,121	
22	PMPM Cost	5,499	6.1%	$ 5,834.59	$ 6,190.50	$ 6,568.12	$ 6,968.78	$ 7,393.88	
23	Total Expenditure			$ 1,035,559,731	$ 1,116,308,538	$ 1,203,353,721	$ 1,297,187,302	$ 1,398,337,615	$ 6,050,746,908
24									
25	Pop 4. Rite Care								
26	Pop Type	Medicaid							
27	Eligible Member Months	2,043,013	1.1%	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811	
28	PMPM Cost	$ 372 84	6.1%	$ 395.58	$ 419.71	$ 445.31	$ 472.47	$ 501.29	
29	Total Expenditure			$ 816,984,019	$ 876,267,589	$ 939,848,984	$ 1,008,040,689	$ 1,081,187,616	$ 4,722,328,897
30									
31	Pop 5. CSHCN								
32	Pop Type	Medicaid							
33	Eligible Member Months	145,411	1.0%	146,923	148,451	149,995	151,555	153,131	
34	PMPM Cost	$ 1,415 61	6.1%	$ 1,501.96	$ 1,593.58	$ 1,690.79	$ 1,793.93	$ 1,903.36	
35	Total Expenditure			$ 220,673,154	$ 236,569,278	$ 253,610,647	$ 271,879,612	$ 291,464,338	$ 1,274,197,030
36									
37	Pop 6. Expansion								
38	Pop Type	Medicaid							
39	Eligible Member Months	1,108,278	-0.1%	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852	
40	PMPM Cost	$ 762 58	6.1%	$ 809.10	$ 858.46	$ 910.83	$ 966.39	$ 1,025.34	
41	Total Expenditure			$ 895,990,687	$ 949,891,024	$ 1,007,032,465	$ 1,067,605,980	$ 1,131,823,993	$ 5,052,344,149
42									
43	Pop 7. Family Planning								
44	Pop Type	Medicaid							
45	Eligible Member Months	17,931	1.5%	18,195	18,462	18,734	19,009	19,289	
46	PMPM Cost	$ 23.74	6.1%	$ 25.19	$ 26.73	$ 28.36	$ 30.09	$ 31.93	
47	Total Expenditure			$ 458,328	$ 493,498	$ 531,288	$ 571,984	$ 615,883	$ 2,670,980
48									
49	Other Populations & CNOMS								
50	Pop Type	Medicaid							
51	Eligible Member Months	52,394	1.2%	53,023	53,659	54,303	54,955	55,614	
52	PMPM Cost	$ 177.14	6.1%	$ 187.95	$ 199.41	$ 211.57	$ 224.48	$ 238.17	
53	Total Expenditure			$ 9,965,622	$ 10,700,141	$ 11,488,866	$ 12,336,196	$ 13,245,586	$ 57,736,411
54									
55									
56									
57	NOTES								
58	For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.								

	A	B	C	D	E	F	G
1	**Panel 1: Historic DSH Claims for the Last Five Fiscal Years:**						
2	**RECENT PAST FEDERAL FISCAL YEARS**						
3		**20__**	**20__**	**20__**	**20__**	**20__**	
4	State DSH Allotment (Federal share)						
5	State DSH Claim Amount (Federal share)						
6	DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -	
7							
8	**Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
9	**FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS**						
10		**FFY 00 (20__)**	**FFY 01 (20__)**	**FFY 02 (20__)**	**FFY 03 (20__)**	**FFY 04 (20__)**	**FFY 05 (20__)**
11	State DSH Allotment (Federal share)						
12	State DSH Claim Amount (Federal share)						
13	DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
14							
15	**Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
16	**FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS**						
17		**FFY 00 (20__)**	**FFY 01 (20__)**	**FFY 02 (20__)**	**FFY 03 (20__)**	**FFY 04 (20__)**	**FFY 05 (20__)**
18	State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
19	State DSH Claim Amount (Federal share)						
20	Maximum DSH Allotment Available for Diversion (Federal share)						
21	Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
22	DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
23	DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
24							
25	**Panel 4: Projected DSH Diversion Allocated to DYs**						
26	**DEMONSTRATION YEARS**						
27			**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**
28	DSH Diversion to Leading FFY (total computable)						
29	FMAP for Leading FFY						
30							
31	DSH Diversion to Trailing FFY (total computable)						
32	FMAP for Trailing FFY						
33							
34	Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

	A	B	C	D	E	F	G
1	**Budget Neutrality Summary**						
2							
3	**Without-Waiver Total Expenditures**						
4		**DEMONSTRATION YEARS (DY)**					**TOTAL**
5		**DY 16 (CY 2024)**	**DY 17 (CY 2025)**	**DY 18 (CY 2026)**	**DY 19 (CY 2027)**	**DY 20 (CY 2028)**	
6	**Medicaid Populations**						
7	**Pop 1. ABD no TPL**	$ 432,634,241	$ 469,043,212	$ 508,515,691	$ 551,310,927	$ 597,707,327	$ 2,559,211,398
8	**Pop 2. ABD TPL**	$ 258,363,397	$ 277,507,791	$ 298,070,317	$ 320,157,293	$ 343,879,359	$ 1,497,978,157
9	**Pop 3. ABD LTSS**	$ 1,066,206,289	$ 1,183,359,181	$ 1,313,384,924	$ 1,457,698,125	$ 1,617,867,324	$ 6,638,515,842
10	**Pop 4. Rite Care**	$ 821,155,887	$ 885,224,221	$ 954,285,145	$ 1,028,736,172	$ 1,109,010,473	$ 4,798,411,899
11	**Pop 5. CSHCN**	$ 220,465,992	$ 236,123,924	$ 252,893,669	$ 270,855,098	$ 290,092,280	$ 1,270,430,963
12	**Pop 6. Expansion**	$ 901,051,467	$ 960,657,326	$ 1,024,202,754	$ 1,091,954,365	$ 1,164,177,906	$ 5,142,043,818
13	**Pop 7. Family Planning**	$ 452,688	$ 481,313	$ 511,805	$ 544,230	$ 578,656	$ 2,568,692
14							
15	**DSH Allotment Diverted**	$ -	$ -	$ -	$ -	$ -	$ -
16							
17	**Other WOW Categories**						
18	**Other Populations & CNOMS**	$ 9,843,139	$ 10,439,359	$ 11,071,820	$ 11,742,687	$ 12,454,199	$ 55,551,204
19							$ -
20							
21							
22	**TOTAL**	$ 3,710,173,101	$ 4,022,836,326	$ 4,362,936,125	$ 4,732,998,897	$ 5,135,767,524	$ 21,964,711,973
23							
24	**With-Waiver Total Expenditures**						
25		**DEMONSTRATION YEARS (DY)**					**TOTAL**
26		**DY 16 (CY 2024)**	**DY 17 (CY 2025)**	**DY 18 (CY 2026)**	**DY 19 (CY 2027)**	**DY 20 (CY 2028)**	
27	**Medicaid Populations**						
28	**Pop 1. ABD no TPL**	$ 428,474,581	$ 460,066,418	$ 493,987,231	$ 530,410,645	$ 569,518,642	$ 2,482,457,516
29	**Pop 2. ABD TPL**	$ 258,609,318	$ 278,033,523	$ 298,917,134	$ 321,367,965	$ 345,507,681	$ 1,502,435,620
30	**Pop 3. ABD LTSS**	$ 1,035,559,731	$ 1,116,308,538	$ 1,203,353,721	$ 1,297,187,302	$ 1,398,337,615	$ 6,050,746,908
31	**Pop 4. Rite Care**	$ 816,984,019	$ 876,267,589	$ 939,848,984	$ 1,008,040,689	$ 1,081,187,616	$ 4,722,328,897
32	**Pop 5. CSHCN**	$ 220,673,154	$ 236,569,278	$ 253,610,647	$ 271,879,612	$ 291,464,338	$ 1,274,197,030
33	**Pop 7. Family Planning**	$ 458,328	$ 493,498	$ 531,288	$ 571,984	$ 615,883	$ 2,670,980
34							
35	**Expansion Populations**						
36	**Pop 6. Expansion**	$ 895,990,687	$ 949,891,024	$ 1,007,032,465	$ 1,067,605,980	$ 1,131,823,993	$ 5,052,344,149
37							
38							
39	**Excess Spending From Hypotheticals**						$ -
40							
41	**Other WW Categories**						
42	**Other Populations & CNOMS**	$ 9,965,622	$ 10,700,141	$ 11,488,866	$ 12,336,196	$ 13,245,586	$ 57,736,411
43	**Category 4**						$ -
44							
45	**TOTAL**	$ 3,666,715,440	$ 3,928,330,010	$ 4,208,770,336	$ 4,509,400,373	$ 4,831,701,353	$ 21,144,917,511
46							
47	**VARIANCE**	$ 43,457,662	$ 94,506,316	$ 154,165,789	$ 223,598,524	$ 304,066,170	$ 819,794,461
48							
49							

Appendix F: Formal Public Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

PUBLIC NOTICE OF PROPOSED RHODE ISLAND COMPREHENSIVE 1115 DEMONSTRATION WAIVER EXTENSION REQUEST

In accordance with 42 CFR 431.408 and Rhode Island General Laws Chapter 42-35, notice is hereby given that the Rhode Island Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1) through December 31, 2028.

This notice provides details about the waiver extension request and serves to formally open the thirty (30) day public comment period, which will conclude on November 1, 2022. During the public comment period, the public is invited to provide written comments to EOHHS via US postal service or electronic mail, as well as make comments verbally during several public hearings that will be hosted at geographically diverse locations around the state. Specifically, notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold three (3) public hearings, as detailed below, at which time and place all interested persons therein will be heard on the above-mentioned matter. Public hearings will be held on the following dates, times, and locations:

Public Hearing #1	Public Hearing #2	Public Hearing #3
October 12, 2022 5:30-7:00 p.m. Pawtucket Public Library 13 Summer Street Pawtucket, RI 02860 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/85040776334?pwd=WlMvRHNLZnBkYkxETTBOcDN6aWo5QT09 Zoom Dial-In: 888 788 0099 Meeting ID: 850 4077 6334 Passcode: 226735	October 25, 2022 3:00-4:30 p.m. Peace Dale Library 1057 Kingstown Road Peace Dale, RI 02879 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/87616533965?pwd=NFFpWnJFQkVnekp4NnlicG54Z2JUZz09 Zoom Dial-In: 888 788 0099 Meeting ID: 876 1653 3965 Passcode: 867253	October 27, 2022 5:30-7:00 p.m. Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/81549811005?pwd=WG9ySDZBMXVuYllrMWJ1Y3FjUzNDUT09 Zoom Dial-In: 888 788 0099 Meeting ID: 815 4981 1005 Passcode: 132667

In addition to the above public hearings, EOHHS will also accept public comment on the proposed extension request during the Health System Transformation Project (HSTP) Accountable Entity (AE) Advisory Committee Meeting on **October 18, 2022, 8:30am** at **3 West Road, Virks Building 1st Floor Training Room, Cranston, RI 02920.** Also available for virtual participation:
Zoom link: https://us02web.zoom.us/j/84460354854?pwd=R1BydGE1ZlN4ZVNpNkxFUTd4cHR4dz09.
Zoom Dial-In: 888 788 0099
Meeting ID: 844 6035 4854
Passcode: 311195

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

The proposed extension request is accessible for public review on the EOHHS website at Medicaid 1115 Waiver Extension | Executive Office of Health and Human Services (ri.gov). In addition, the draft documents are also available in hard copy, located at the Security Desk on the 1st floor of the Virks Building at 3 West Road, Cranston, RI 02920.

Interested persons should submit comments to EOHHS on the proposed extension on or before November 1, 2022. Comments can be submitted via email to OHHS.RIMedicaidWaiver@ohhs.ri.gov or by mail to Amy Katzen, Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

The Pawtucket Public Library, Peace Dale Public Library, Woonsocket Public Library, and the Virks Building are all accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Executive Office at OHHS.RIMedicaidWaiver@ohhs.ri.gov or (401) 462-6222 (hearing/speech impaired, dial 711) at least three (3) business days prior to the public hearing so arrangements can be made to provide such assistance at no cost to the person requesting.

To request interpreter services at any of these events, please notify the Executive Office at OHHS.RIMedicaidWaiver@ohhs.ri.gov at least five (5) business days in advance. Interpreter services will be made available at no cost to the person requesting.

Si necesita servicios de interpretación en cualquiera de estos eventos, por favor solicítelos a la Oficina Ejecutiva al correo electrónico OHHS.RIMedicaidWaiver@ohhs.ri.gov con al menos cinco (5) días hábiles de antelación. Los servicios de interpretación están a disposición de los solicitantes de forma gratuita.

Para solicitar serviços de intérprete em qualquer um destes eventos, por favor, notifique o Gabinete Executivo através do endereço OHHS.RIMedicaidWaiver@ohhs.ri.gov com, pelo menos, cinco (5) dias úteis de antecedência. Os serviços de intérprete serão disponibilizados sem custo para a pessoa que solicita.

Program Description

Rhode Island is submitting an extension request for its 1115 waiver. Section 1115 waivers are utilized to implement experimental, pilot, or demonstration projects found to be likely to assist in promoting the objectives of the Medicaid program. Rhode Island's 1115 waiver (hereinafter "the Demonstration") has been in place since 2009. Rhode Island's entire Medicaid program is operated under the Demonstration. The Demonstration offers a complete array of services, including medical, behavioral health, and Home and Community-Based Services (HCBS), to multiple eligibility groups. The state has tested a number of cutting-edge pilots and transformative projects under the Demonstration such as the Health System Transformation Program and the Accountable Entities initiative. While the Demonstration has changed greatly since its inception, the State's intent to utilize this waiver to improve the lives of Rhode Island Medicaid beneficiaries has not. Utilizing a global waiver structure that captures all aspects of the

Medicaid program into one (1) authorizing document allows the State to take a holistic approach to serving Medicaid beneficiaries. Equity and access have remained at the forefront of all renewals and amendments of the waiver.

The State sees this waiver extension as an opportunity to continue to build upon its foundational aims while implementing new focused enhancements targeted at behavioral health, social determinants of health, and long-term services and supports. The State has also utilized this waiver renewal to request a number of administrative enhancements to the waiver that will promote efficiency, transparency, and flexibility. All existing beneficiaries covered by the waiver will be impacted by the extension.

Goals and Objectives

Four (4) foundational principles have guided the Demonstration since 2015, and continue to guide the program as a whole:

- Pay for value, not volume;
- Coordinate physical, behavioral, and long-term healthcare;
- Rebalance the delivery system away from high-cost settings; and
- Promote efficiency, transparency, and flexibility.

Rhode Island also seeks to align this Demonstration extension with the larger vision and values of EOHHS. The vision of EOHHS is to support resilient, equitable, and just communities nurturing the health, safety, wellbeing, and independence of all Rhode Islanders. To achieve this vision, EOHHS has elected to center on the key values of voice, choice, and equity. Rhode Island has approached this waiver extension with those values in mind.

The State has identified a number of goals it seeks to achieve during this extension period. The goals are:

Goal 1: Health Equity Improve health equity through strong community-clinical linkages that support beneficiaries in addressing social determinants of health, including ensuring access to stable housing.
Goal 2: Behavioral Health Continue to ensure expanded access to high-quality integrated behavioral healthcare that is focused on prevention, intervention, and treatment.
Goal 3: Long-Term Services & Supports (LTSS) Continue progress toward rebalancing LTSS toward home and community-based services (HCBS).
Goal 4: Maintain and Expand on Our Record of Excellence Streamline administration of the Demonstration to strengthen current services and processes, while supporting continued progress towards our state's goals of improving healthcare quality and outcomes for Medicaid beneficiaries.

It is with these goals in mind that we submit this waiver extension.

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

Eligibility, Cost Sharing, Delivery Systems, and Benefits

Eligibility

All eligibility groups presently covered by Rhode Island Medicaid are included within the Demonstration, including all eligibility categories in the Medicaid State Plan. The underlying authority for the State's current eligibility groups include: (i) categorically eligible groups (mandatory and optional) as described in the Medicaid State Plan; (ii) the medically needy (mandatory and optional) as described in the Medicaid State Plan; (iii) groups that could be covered under the Medicaid State Plan but are currently only covered under the Demonstration; and (iv) groups that have eligibility via Demonstration authority only.

The State is requesting several eligibility expansions in this waiver extension. If approved, pre-release supports for incarcerated individuals will be expanded to cover individuals in prison or jail thirty (30) days before their release. Additionally, the State will extend Medicaid coverage for pregnant members from sixty (60) days postpartum to twelve (12) months postpartum. This Demonstration extension request also seeks to expand the income limit for Budget Population 15, HCBS waiver-like services for adults with disabilities, from 300% to 400% of the Supplemental Security Income (SSI) federal benefit rate. Finally, the State seeks to document a technical correction in the waiver to remove two (2) budget populations that are no longer active.

Cost Sharing

In 2019, Rhode Island revised the Cost-Sharing Requirements specified in the State Plan to reflect that the State does not charge cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. This Demonstration does not seek to impose cost sharing.

Delivery Systems

All Medicaid benefits and programs, including LTSS, behavioral health services, and other unique components of Rhode Island's Medicaid program, are available under the Demonstration. The Demonstration contains the following components:

- Managed Care. 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. Benefits are provided through comprehensive mandatory managed care delivery systems.

- Family Planning. The Extended Family Planning component provides access to family planning and referrals to primary care services for postpartum beneficiaries 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 postpartum period.

- Premium Assistance. 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.

- Rhody Health Partners. Rhody Health Partners is a comprehensive, risk-based program that provides acute and primary care services to older adults and individuals with disabilities who are not enrolled in Connect Care Choice. 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.

- HCBS Program. 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.

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

Under this Demonstration extension, the waiver delivery system will remain the same except for enhancements to dental services. Rhode Island is seeking to provide all dental benefits for adults through managed care. Like how children's dental benefits are provided today, adults will also receive dental services through a pre-paid ambulatory health plan rather than through a fee-for-service arrangement.

Benefit Coverage

Rhode Island seeks to remove authority for the Dental Case Management, Healthy Behaviors Incentives, and Recovery Navigation programs. These programs are either not active or not having a measurable effect on beneficiary outcomes. However, the State is requesting approval for a variety of new services and pilots, including enhancing access to home stabilization, operating a medical respite pilot, providing several new HCBS services, and expanding access to complimentary alternative medicine.

Summary of Proposed Changes

The program enhancements and technical revisions requested in this Demonstration extension are each summarized below.

Program Enhancements
Home Stabilization Expansion: EOHHS seeks to expand the pool of qualified providers, expand the targeted population for home stabilization benefits, and add coverage for one (1) time transition costs.
Recuperative Care (Medical Respite) Pilot: EOHHS is seeking authority to establish a pilot program to provide short term residential care to individuals experiencing homelessness in a Recuperative Care Center to allow individuals the opportunity to rest and recover from illness or injury in a safe environment while accessing medical care and other supportive services.
Health Equity Zone (HEZ): EOHHS plans to use several managed care strategies to drive additional funding and support to the fund HEZs in its upcoming MCO procurement, and to use the Demonstration to evaluate the benefits of HEZ investment to support future federal support for HEZ expenditures.
Pre-Release Supports for Incarcerated Individuals: EOHHS is seeking federal authority to provided Medicaid coverage, including enrollment in managed care, to incarcerated individuals thirty (30) days before release to support reintegration and improve access to care upon release.

HCBS Enhancements: EOHHS seeks to permanently continue many of the HCBS flexibilities allowed during the COVID public health emergency, including expanding access to telephonic HCBS assessments, adding remote supports service, and allowing parents to be paid to provide services to adults with disabilities.
Accountable Entities (AE): As federal funding phases out, EOHHS requests removal of the AE related sections of the demonstration but reaffirms continued state commitment to the AEs and furthering value-based payment models in Medicaid.
Managed Dental Benefits for Adults: EOHHS seeks to carve adult dental benefits into the existing RIte Smiles managed care program.

Technical Revisions
Eligibility Revisions
• Expand postpartum coverage to 12 months
• Use inclusive pregnancy language in formal documentation
• Remove Populations 16 and 23, which are no longer active eligibility categories
• Expand financial limits for Budget Population 15 from 300 to 400% of SSI benefit rate
Benefit Revisions
• Clarifying the distinction between Family/Youth Support Partners and Peer Recovery Specialists benefits
• Expanding access to complimentary alternative medicine to individuals with certain behavioral health conditions
• Codifying family home visiting services as a state plan service
Removing Inactive Programs
• Dental Case Management
• Healthy Behaviors Incentives
• Recovery Navigation
HCBS Benefit Clarity: EOHHS seeks to make technical revisions to the demonstration documentation to update service definitions to support transparency and benefit clarity.

Enrollment and Expenditures

Enrollment and expenditure data for the waiver can be found in the table below.

	Base Year	Waiver Period				
	DY 15 (2023)	DY 16 (2024)	DY 17 (2025)	DY 18 (2026)	DY 19 (2027)	DY 20 (2028)
PMPM						
Pop 1 ABD no TPL	$2,323	$2,453	$2,591	$2,736	$2,889	$3,051
Pop 2 ABD TPL	$813	$858	$906	$957	$1,011	$1,067
Pop 3 ABD LTSS	$5,499	$5,807	$6,132	$6,476	$6,838	$7,221
Pop 4 Rite Care	$366	$386	$408	$431	$455	$481
Pop 5 CSHCN	$1,416	$1,495	$1,579	$1,667	$1,760	$1,859
Pop 6 Expansion	$749	$791	$835	$882	$931	$983
Pop 7 Family Planning	$24	$25	$26	$28	$30	$31
Other Populations & CNOMS	$177	$187	$198	$209	$220	$233
Enrollment - Member Months						
Pop 1 ABD no TPL	171,765	173,826	175,912	178,023	180,159	182,321
Pop 2 ABD TPL	295,967	299,903	303,892	307,933	312,029	316,179
Pop 3 ABD LTSS	174,691	177,486	180,326	183,211	186,143	189,121
Pop 4 Rite Care	2,043,013	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811
Pop 5 CSHCN	145,411	146,923	148,451	149,995	151,555	153,131
Pop 6 Expansion	1,108,278	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852
Pop 7 Family Planning	17,931	18,195	18,462	18,734	19,009	19,289
Other Populations & CNOMS	52,394	53,023	53,659	54,303	54,955	55,614
Total Expenditures						
Pop 1 ABD no TPL		$426,454,720	$455,740,740	$487,037,211	$520,483,866	$556,227,424
Pop 2 ABD TPL		$257,388,713	$275,417,016	$294,707,684	$315,348,927	$337,438,794
Pop 3 ABD LTSS		$1,030,678,858	$1,105,811,758	$1,186,421,334	$1,272,906,853	$1,365,697,230
Pop 4 Rite Care		$798,148,653	$852,028,313	$909,541,487	$970,938,169	$1,036,476,931
Pop 5 CSHCN		$219,632,936	$234,343,991	$250,040,758	$266,788,869	$284,659,175
Pop 6 Expansion		$875,470,717	$923,755,355	$974,704,117	$1,028,465,178	$1,085,186,230
Pop 7 Family Planning		$456,145	$488,697	$523,607	$561,148	$601,223
Other Populations & CNOMS		$9,918,431	$10,599,799	$11,327,587	$12,105,387	$12,936,928

Hypotheses and Evaluation Parameters

Rhode Island will conduct an independent evaluation to measure and monitor the outcomes of the Demonstration. The State proposes to evaluate this extension of the Demonstration utilizing the following questions, hypotheses, and measures. Evaluators will assess the Home Stabilization benefit, Medical Respite program, pre-release enrollment functions, and the impact of Health Equity Zones.

Home Stabilization

Hypotheses	Example Research Questions	Example Measures and Data Source
The Home Stabilization program will increase community living and reduce	How many members receiving services under the Home Stabilization program have obtained housing in the community? How many have	• Number of members living in the community (Program Data) • Homelessness status (Ecosystem Homeless Management Information

unnecessary institutionalization for participants.	maintained community housing for six months or more? Do these trends vary by race or ethnicity?	System (HMIS) data linked to Medicaid population grid) • Number of members accessing homelessness services (Ecosystem HMIS data linked to Medicaid population grid) • Types of homelessness services used by members (Ecosystem HMIS data linked to Medicaid population grid) • IMD admissions for SUD and, if feasible, for non-SUD conditions (Medicaid claims)
	What are the trends in members receiving services under the Home Stabilization program accessing homeless services? Does this vary by type of homelessness service, or by race or ethnicity?	
	What are the trends in Institutions for Mental Diseases (IMD) use among members receiving services under the Home Stabilization program? Does this vary by race or ethnicity?	
The Home Stabilization program will identify and address participants' social determinants of health.	What types of barriers to successful tenancy do members receiving Home Stabilization services report? Does this differ by race or ethnicity?	• Housing assessments (Program Data • Current social needs and housing retention barriers (Housing support and crisis plans—document review) • How do Home Stabilization Providers try to address social determinants of health (SDOHs)? Where are the gaps in service provision? (Interviews with Home Stabilization Providers)
	What are the social needs and barriers to housing retention experienced by members receiving services under the Home Stabilization program? Do these differ by race or ethnicity?	
	How did Home Stabilization providers use data on social needs and barriers to housing retention provided by members?	
	What were successes in and barriers to Home Stabilization providers addressing members' social needs and housing retention barriers?	
The Home Stabilization program will improve health	What are the trends over time in utilization (inpatient hospitalization, emergency department (ED) visits,	• Inpatient hospitalization (Medicaid claims) • ED visits and potentially avoidable ED visits (Medicaid claims)

outcomes for participants.	nursing home admission, behavioral health (BH) facility admission, IMD admission) for members using Home Stabilization services? Does this differ by race or ethnicity?	• Nursing home admission (Medicaid claims) • BH facility admission (Medicaid claims) • IMD admissions for SUD and, if feasible, for non-SUD conditions (Medicaid claims)
The Home Stabilization program will decrease Medicaid spending for participants after successful home placement.	What are the trends over time in total Medicaid spending for members using Home Stabilization services? Does this differ by race or ethnicity?	• Total Medicaid spending (Medicaid claims)

Medical Respite

Hypotheses	**Example Research Questions**	**Example Measures and Data Source**
The Medical Respite program will improve healthcare utilization for participants.	What are the trends over time in utilization (primary care/preventative services, inpatient hospitalization, ED visits) for members using Medical Respite services? Do trends differ by race or ethnicity?	• Primary care & preventative services (Medicaid claims) • MH & SUD/OUD services (Medicaid claims) • Inpatient hospitalization, rehospitalization (Medicaid claims) • ED visits and potentially avoidable ED visits (Medicaid claims) • Inpatient length of stay (Medicaid claims) • Referrals for specialists, BH services, and/or SUD/OUD services (Program data, if available)
	How many referrals (specialists, BH services, substance use disorder/opioid use disorder (SUD/OUD) services, community organizations) are made through the Medical Respite program?	
The Medical Respite program will decrease Medicaid spending for participants.	What are the trends over time in spending (total Medicaid, inpatient, ED, outpatient) for members using Medical Respite services? Does this differ by race or ethnicity?	• Total Medicaid spending (Medicaid claims) • Medicaid spending for inpatient visits (Medicaid claims) • Medicaid spending for ED visits (Medicaid claims) • Medicaid spending for outpatient visits (Medicaid claims)
The Medical Respite program will improve housing status and	How many members receiving services under the Medical Respite program	• Homelessness status (Ecosystem HMIS data linked to Medicaid population grid)

access to social services for participants.	have obtained housing in the community? How many have maintained community housing for six months or more? Do these trends vary by race or ethnicity?	• Housing supports appointments (Program data, if available) • Health-related social needs screenings (Program data, if available) • Social services referrals (number, type) (Program data, if available) • Number of clients approved for SSI/SSDI (Program data, if available)
	What are the trends in members receiving services under the Medical Respite program accessing homeless services? Does this vary by type of service, or by race or ethnicity?	
	What are the trends in members receiving services under the Medical Respite program accessing social services? Does this vary by type of social service, or by race or ethnicity?	
	What are the trends in Supplemental Security Income/ Social Security Disability Insurance (SSI/SSDI) enrollment among members receiving services under the Medical Respite program? Does this vary by race or ethnicity?	

Pre-Release Enrollment

Hypotheses	**Example Research Questions**	**Example Measures and Data Source**
Pre-release enrollment will improve access to medical care for recently incarcerated members.	How many previously incarcerated individuals enroll in Medicaid through the Pre-Release Enrollment program over time?	• Number of previously incarcerated individuals enrolling in Medicaid (Medicaid population grid, Ecosystem Rhode Island Department of Corrections (RIDOC) data) • Number of previously incarcerated individuals accessing primary care services (Medicaid population grid, Medicaid claims, Ecosystem RIDOC data)
	How many previously incarcerated individuals enrolled in Medicaid through the Pre-Release Enrollment program access primary care services within one year of release?	

Pre-release enrollment will improve health outcomes for recently incarcerated members	What are the trends in utilization (as measured by primary care and preventative services, mental health and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members enrolled through the Pre-Release Enrollment program?	• Primary care & preventative services (Medicaid claims, Ecosystem RIDOC data) • MH & SUD/OUD services (Medicaid claims, Ecosystem RIDOC data) • Inpatient hospitalization, rehospitalization (Medicaid claims, Ecosystem RIDOC data) • ED visits and potentially avoidable ED visits (Medicaid claims, Ecosystem RIDOC data)

Health Equity Zones

Hypotheses	**Example Research Questions**	**Example Measures and Data Source**
Residing in Health Equity Zones will improve health utilization overall for Medicaid members.	What are the trends in community rates of services utilization (as measured by primary care and preventative services, mental health and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members living in a Health Equity Zone?	• Primary care & preventative services (Medicaid claims) • MH & SUD/OUD services (Medicaid claims) • Inpatient hospitalization, rehospitalization (Medicaid claims) • ED visits and potentially avoidable ED visits (Medicaid claims)
	What are the trends in racial/ethnic disparities in utilization (as measured by primary care and preventative services, mental health and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members living in a Health Equity Zone?	
Residing in Health Equity Zones will improve housing status for Medicaid members.	How many members residing in a Health Equity Zone have obtained housing in the community? How many have maintained community housing for six months or more? Do these trends vary by race or ethnicity?	• Homelessness status (Ecosystem HMIS data linked to Medicaid population grid)

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

Waiver and Expenditure Authorities

Except as otherwise noted below, Rhode Island is seeking to continue all existing waiver and expenditure authorities currently documented in the approved special terms and conditions.[1]

In addition, the State is requesting the following waiver and expenditure authorities to implement the new and enhanced programs and services under this Demonstration extension.

Waiver Authorities		
New Recuperative Care/Medical Respite Pilot	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B); Freedom of Choice Section 1902(a)(23)(A)
Allow Use of Telephonic HCBS Assessments	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Addition of Remote Supports Benefit	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Allow Parents to be Service Providers	Benefits	Self-Direction 1902(a)(32)
Managed Dental	Finance and Expenditure Authority	Freedom of Choice Section 1902(a)(23)(A)
Expenditure Authorities		
Reimbursement of HEZ Services	Finance and Expenditure Authority	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Provide Coverage for Incarcerated Individuals 30 Days Prior to Release	Eligibility	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
New Recuperative Care/Medical Respite Pilot	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)

Additionally, the State is requesting removal of the following expenditure authorities for programs and authorities which are no longer active.

- Health System Transformation Project-Accountable Entity Incentive and Hospital and Nursing Home Incentive. Expenditures for performance-based incentive payments to providers who participate in the Hospital and Nursing Home Incentive Program and to providers who participate as a certified Accountable Entity.

[1] The current waiver and expenditure authorities are listed on pages 1 through 9 of the Rhode Island Comprehensive Demonstration, as amended on February 6, 2020, available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf.

- Expenditures for Healthy Behaviors Incentives. Expenditures for incentives to individuals who adopt healthy behaviors such as a gift card for health-related goods.

- Expenditures for Recovery Navigation Program (RNP). Expenditures to deliver a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services, with the necessary level of detox, treatment, and recovery services within a less-intensive and less-costly level of care than is furnished in an inpatient hospital setting.

Appendix G: Abbreviated Public Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

ABBREVIATED PUBLIC NOTICE OF PROPOSED RHODE ISLAND COMPREHENSIVE 1115 DEMONSTRATION WAIVER EXTENSION REQUEST

In accordance with 42 § CFR 431.408 and Rhode Island General Laws Chapter 42-35, notice is hereby given that the Rhode Island Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1) through December 31, 2028.

Program Description

Rhode Island is submitting an extension request for its 1115 waiver. Section 1115 waivers are utilized to implement experimental, pilot, or demonstration projects found to be likely to assist in promoting the objectives of the Medicaid program. Rhode Island's 1115 waiver (hereinafter "the Demonstration") has been in place since 2009. Rhode Island's entire Medicaid program is operated under the Demonstration. The Demonstration offers a complete array of services, including medical, behavioral health, and Home and Community-Based Services (HCBS), to multiple eligibility groups.

The State sees this waiver extension as an opportunity to continue to build upon its foundational aims while implementing new focused enhancements targeted at behavioral health, social determinants of health, and long-term services and supports. The State has also utilized this waiver renewal to request a number of administrative enhancements to the waiver that will promote efficiency, transparency, and flexibility. All existing beneficiaries covered by the waiver will be impacted by the extension.

This abbreviated notice serves to formally open the thirty (30) day public comment period, which will conclude on **November 1, 2022**. During the public comment period, the public is invited to provide written comments to EOHHS via US postal service or electronic mail, as well as make comments verbally during several public hearings that will be hosted at geographically diverse locations around the state. Specifically, notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold three (3) public hearings, as detailed below, at which time and place all interested persons therein will be heard on the above-mentioned matter. Public hearings will be held on the following dates, times, and locations:

Public Hearing #1	Public Hearing #2	Public Hearing #3
October 12, 2022 5:30-7:00 p.m. Pawtucket Public Library 13 Summer Street Pawtucket, RI 02860 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/85040776334?pwd=WlMvRHNLZnBkYkxETTBOcDN6aWo5QT09	October 25, 2022 3:00-4:30 p.m. Peace Dale Library 1057 Kingstown Road Peace Dale, RI 02879 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/87616533965?pwd=NFFpWnJFQkVnekp4NnlicG54Z2JUZz09	October 27, 2022 5:30-7:00 p.m. Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/81549811005?pwd=WG9ySDZBMXVuYllrMWJ1Y3FjUzNDUT09

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

Zoom Dial-In: 888 788 0099 Meeting ID: 850 4077 6334 Passcode: 226735	Zoom Dial-In: 888 788 0099 Meeting ID: 876 1653 3965 Passcode: 867253	Zoom Dial-In: 888 788 0099 Meeting ID: 815 4981 1005 Passcode: 132667

In addition to the above public hearings, EOHHS will also accept public comment on the proposed extension request during the Health System Transformation Project (HSTP) Accountable Entity (AE) Advisory Committee Meeting on **October 18, 2022, 8:30am** at **3 West Road, Virks Building 1st Floor Training Room, Cranston, RI 02920.** Also available for virtual participation:
Zoom link: https://us02web.zoom.us/j/84460354854?pwd=R1BydGE1ZlN4ZVNpNkxFUTd4cHR4dz09.
Zoom Dial-In: 888 788 0099
Meeting ID: 844 6035 4854
Passcode: 311195

The proposed extension request is accessible for public review on the EOHHS website at Medicaid 1115 Waiver Extension | Executive Office of Health and Human Services (ri.gov). In addition, the draft documents are also available in hard copy, located at the Security Desk on the 1st floor of the Virks Building at 3 West Road, Cranston, RI 02920.

Interested persons should submit comments to EOHHS on the proposed extension on or before November 1, 2022. Comments can be submitted via email to OHHS.RIMedicaidWaiver@ohhs.ri.gov or by mail to Amy Katzen, Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

The Pawtucket Public Library, Peace Dale Public Library, Woonsocket Public Library, and the Virks Building are all accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Executive Office at OHHS.RIMedicaidWaiver@ohhs.ri.gov or (401) 462-6222 (hearing/speech impaired, dial 711) at least three (3) business days prior to the public hearing so arrangements can be made to provide such assistance at no cost to the person requesting.

To request interpreter services at any of these events, please notify the Executive Office at OHHS.RIMedicaidWaiver@ohhs.ri.gov at least five (5) business days in advance. Interpreter services will be made available at no cost to the person requesting.

Si necesita servicios de interpretación en cualquiera de estos eventos, por favor solicítelos a la Oficina Ejecutiva al correo electrónico OHHS.RIMedicaidWaiver@ohhs.ri.gov con al menos cinco (5) días hábiles de antelación. Los servicios de interpretación están a disposición de los solicitantes de forma gratuita.

Para solicitar serviços de intérprete em qualquer um destes eventos, por favor, notifique o Gabinete Executivo através do endereço OHHS.RIMedicaidWaiver@ohhs.ri.gov com, pelo menos, cinco (5) dias úteis de antecedência. Os serviços de intérprete serão disponibilizados sem custo para a pessoa que solicita.

Appendix H: Tribal Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

September 22, 2022

Autumn leaf Spears
Narragansett Indian Health Center
4533 South County Trail
Charlestown, RI 02913

Dear Director Spears,

In accordance with the requirements of our Tribal Consultation Policy, this is to notify you that the Rhode Island Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1) through December 31, 2028.

The Demonstration provides federal authority for EOHHS to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery system that improve care, increase efficiency, and reduce costs. Rhode Island's 1115 waiver (hereinafter "the Demonstration") has been in place since 2009. Rhode Island's entire Medicaid program is operated under the Demonstration. The Demonstration offers a complete array of services, including medical, behavioral health, and Home and Community-Based Services (HCBS), to multiple eligibility groups.

The state sees this waiver extension as an opportunity to continue to build upon its foundational aims while implementing new focused enhancements targeted at behavioral health, social determinants of health, and long-term services and supports. The state has also utilized this waiver renewal to request a number of administrative enhancements to the waiver that will promote efficiency, transparency, and flexibility. All existing beneficiaries covered by the waiver will be impacted by the extension. The proposed extension request outlines the specific authorities being requested from CMS.

The Secretary will hold three (3) public hearings, as detailed below, at which time and place all interested persons therein will be heard on the above-mentioned matter. Public hearings will be held on the following dates, times, and locations:

Public Hearing #1	**Public Hearing #2**	**Public Hearing #3**
October 12, 2022 5:30-7:00 p.m. Pawtucket Public Library 13 Summer Street Pawtucket, RI 02860 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/85040776334?pwd=WlMvRHNLZnBkYkxETTBOcDN6aWo5QT09	October 25, 2022 3:00-4:30 p.m. Peace Dale Library 1057 Kingstown Road Peace Dale, RI 02879 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/87616533965?pwd=NFFpWnJFQkVnekp4NnlicG54Z2JUZz09	October 27, 2022 5:30-7:00 p.m. Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895 **Also available for virtual participation**: Zoom link: https://us02web.zoom.us/j/81549811005?pwd=WG9ySDZBMXVuYllrMWJ1Y3FjUzNDUT09

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In addition to the above public hearings, EOHHS will also accept public comment on the proposed extension request during the Health System Transformation Project (HSTP) Accountable Entity (AE) Advisory Committee Meeting on **October 18, 2022,** at **8:30am** at **3 West Road, Virks Building 1st Floor Training Room, Cranston, RI 02920.**

If you have specific questions regarding this proposed extension request or would like to schedule a tribal consultation to discuss the contents of the waiver extension, please contact Amy Katzen via email at amy.katzen@ohhs.ri.gov or via phone at 401-462-6222.

Sincerely,

[redacted]

Kristin Sousa
Medicaid Program Director
Rhode Island Executive Office of Health and Human Services