



Report to the Centers for Medicare and Medicaid Services

Annual Operations Report

Rhode Island Comprehensive

1115 Waiver Demonstration

January 1, 2014 – December 31, 2014

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

August 2016

I. Narrative Report Format

Rhode Island Comprehensive Section 1115 Demonstration

Section 1115 Annual Report Demonstration Reporting

Period: DY 6 January 1, 2014 – December 31, 2014

II. Introduction

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

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

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of: 1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

With those four exceptions, all Medicaid funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration or otherwise, are subject to the requirements of the demonstration. Rhode Island’s previous section 1115 demonstration programs, RItE Care and RItE Share, were subsumed under this demonstration, in addition to the state’s previous section 1915(b) Dental Waiver and the state’s previous section 1915(c) home and community-based services (HCBS) waivers. The state’s title XIX state plan as approved; its title XXI state plan, as approved; and this Medicaid section 1115 demonstration entitled “Rhode Island Comprehensive Demonstration,” will continue to operate concurrently for the demonstration period.

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

- b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid eligibility under RItE Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL. Section X of the STCs details the requirements.
- c. The RItE Share premium assistance component enrolls individuals who are eligible for Medicaid/CHIP, and who are employees or dependents of an employee of an employer that offers a “qualified” plan into the Employer Sponsored Insurance (ESI) coverage.
- d. Effective through December 31, 2013, the Rhody Health Partners component provides Medicaid state plan and demonstration benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance. Effective November 1, 2013, the Rhody Health Options and Connect Care Choice Community Partners component expanded to all qualified aged, blind, and disabled beneficiaries whether they have other health insurance or not. Effective January 1, 2014, the New Adult Group began enrollment in Rhody Health Partners. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.
- e. The Connect Care Choice component provides Medicaid state plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, the STCs, or in demonstration changes implemented using the processes described in section IV of the STCs.
- f. The Home and Community-Based Service component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.
- g. The RItE Smiles Program is a managed dental benefit program for Medicaid eligible children born after May 1, 2000.
- h. Rhody Health Options is a managed care delivery system for Medicaid only and Medicare Medicaid eligibles that integrates acute and primary care and long term care services and supports.
- i. Connect Care Choice Community Partners is an optional delivery system for Adult, Blind and Disabled Medicaid and Medicare Medicaid eligibles that utilizes a community health team and a Coordinating Care Entity to integrate Medicaid benefits.

On December 23, 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes changes to support the state’s implementation of the

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

III. Enrollment Information

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

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

Population Groups (as hard coded in the CMS-64)	Number of Current Enrollees (to date)* 03/31/14	Number of Enrollees That Lost Eligibility in 03/31/14**	Number of Current Enrollees (to date)* 06/30/14	Number of Enrollees That Lost Eligibility in 06/30/14**	Number of Current Enrollees (to date)* 09/30/14	Number of Enrollees That Lost Eligibility in 09/30/14**	Number of Current Enrollees (to date)* 12/31/14	Number of Enrollees That Lost Eligibility in 12/31/14**
Budget Population 1: ABD no TPL	23,691	1,275	22,476	1,404	21,240	1,280	20,088	1,468
Budget Population 2: ABD TPL	24,172	232	25,055	344	26,173	425	26,949	398
Budget Population 3: Rite Care	115,288	2,907	116,632	4,447	118,686	5,955	119,128	6,492
Budget Population 4: CSHCN	11,952	254	12,016	339	12,066	311	12,182	242
Budget Population 5: EFP	246	81	210	43	126	52	99	30
Budget Population 6: Pregnant Expansion	102	9	83	9	64	10	53	12
Budget Population 7: CHIP Children	26,665	278	28,132	532	27,660	946	27,206	1,223
Budget Population 8: Substitute care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 9: CSHCN Alt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 10: Elders 65 and over	1,340	93	1,392	105	1,419	91	1,423	100
Budget Population 11, 12, 13: 217-like group	3,444	71	3,488	96	3,509	47	3,492	80
Budget Population 14: BCCTP	195	17	182	11	161	13	143	17
Budget Population 15: AD Risk for LTC	2,656	0	2,728	0	2,799	1	2,874	1
Budget Population 16: Adult Mental Unins	12,096	208	12,124	25	12,075	46	12,068	7
Budget Population 17: Youth Risk Medic	2,493	176	2,544	189	2,605	200	2,659	185
Budget Population 18: HIV	378	44	304	113	294	87	270	81
Budget Population 19: AD Non-working	38	17	12	11	5	4	0	5
Budget Population 20: Alzheimer adults	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 21: Beckett aged out	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Budget Population 22: New Adult Group	43,493	170	50,052	737	52,953	2,474	59,658	892

***Current Enrollees:**

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

****Number of Enrollees That Lost Eligibility in the Current Quarter:**

Number of enrollees no longer in the eligibility system as of the last day of the month in the quarter on the basis of Medicaid eligibility.

IV. “New”-to-“Continuing” Ratio

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. The ratio of new-to-continuing Medicaid personal care service participants at the close of the each quarter in DY 6 January 1,2014 – December 31, 2014:

Quarter 1: 0.021 (10/481) at the close of the quarter

Quarter 2: 0.015 (7/465) at the close of the quarter

Quarter 3: 0.031 (14/455) at the close of the quarter

Quarter 4: 0.009 (4/459) at the close of the quarter

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during each quarter in 2014 (by category or by type) with an annual total of special purchases expenditures of \$12,747.10.

Quarter 1 2014	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	None			
CUMULATIVE TOTAL				\$0.00

Quarter 2 2014	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	None			
CUMULATIVE TOTAL				\$0.00

Quarter 3 2014	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	24	Massage Therapy		\$1,725.00
	15	Acupuncture		\$1,125.00
	8	Service Dog Training		\$ 370.00
	5	Over the counter medicines	Vitamins, supplements	\$ 666.98
	1	Supplies (non-medical)	Compression stockings, w/c gloves	\$ 107.00
	11	Laundry		\$ 931.00
	1	Newspaper Ad	PCA's employment ads	\$ 105.54
	4	Emergency backup		\$ 887.50
CUMULATIVE TOTAL				\$5,918.02

Quarter 4 2014	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	23	Massage Therapy		\$2,350.00
	15	Acupuncture		\$1,125.00
	8	Service Dog Training		\$ 740.00
	7	Laundry		\$ 743.00
	5	Over the counter medicines	Vitamins, supplements	\$ 814.08

	1	Supplies (non-medical)	Compression stockings, w/c gloves	\$ 107.00
	1	Household equipment	Washer/Dryer	\$ 739.00
	1	Diabetes Nursing	Diabetes Education	\$ 65.00
	2	Strength Training/URI		\$ 96.00
	1	Emergency support equipment	Medicalert	\$ 50.00
CUMULATIVE TOTAL				\$6,829.08

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the quarters during in DY6 January 1, 2014 – December 31, 2014.

Innovative Activities

Integrated Care Initiative

Rhode Island has embarked on an ambitious undertaking to improve the health and health care of individuals who have coverage under both Medicare and Medicaid (the so-called “dual eligibles”). The program is called the **Integrated Care Initiative (ICI)**. The ICI is voluntary on the part of consumers and is being implemented in two phases. In Phase 1, launched in November of 2013, only the individual’s *Medicaid covered services* were affected. In Phase 2, the State will seek approval under the Financial Alignment Demonstration for the full integration of the services covered by **Medicare** (primarily acute care – physician, hospital, diagnostic, and lab services), and **Medicaid** (primarily long term care) under a health plan model.

Care management services are a key ICI feature. Care managers will be available to enrollees and to help physicians and practice staff monitor and coordinate care. They can also address the many non-medical services, such as home and community-based services, transportation and food assistance, often needed by the elderly and persons with chronic conditions.

Under Phase 1, consumers have the option to join one of two new ICI managed care delivery programs:

(1) **Rhody Health Options (RHO)** is a health plan model administered by Neighborhood Health Plan of Rhode Island which manages the consumers’ long term care services, provides care managers and tailors services to meet individual needs.

(2) **Connect Care Choice Community Partners (CCCCP)**, is a primary care case management model and is for consumers who participate in certain participating physician practices. It’s based on the “medical home” model and offers integrated care management services for medical, behavioral and long term care services and the added support of a Community Health Team for non-medical, social support needs.

In Phase 2 of the ICI, scheduled to begin in the spring of 2015, Rhody Health Options (the health plan model) will fully integrate Medicare and Medicaid covered services. A key milestone of Phase 2 is the development and approval of the Memorandum of Understanding (MOU) between the State and CMS. Work has been underway on the MOU development during the quarters with on-going dialogue with CMS. In addition, the State developed a procurement document for Phase 2 potential vendors. The State applied for the Ombudsman Grant opportunity available to state participating in the Financial Alignment Demonstration. Rhode Island received approval on the Ombudsman Grant from CMS, contingent on the approval of the State’s MOU with CMS.

Health Reform/Medicaid Expansion

Rhode Island has made great strides in establishing a state-based marketplace for the purchase of health insurance. On September 19, 2011 Governor Lincoln Chafee signed Executive Order 11-09 which legally established Rhode Island's HealthSource RI. In 2011 Rhode Island was the first state to receive a federal "Level Two" Establishment grant, recognition of the state's planning accomplishments to date. The State has also increased insurance coverage through its decision to expand the Medicaid Program to adults without dependent children living at 133% of the Federal Poverty Level. Both HealthSource RI and EOHHS share the same technology platform for application for insurance coverage and eligibility determinations for insurance affordability programs. This technology solution, called the Unified Healthcare Infrastructure Project (UHIP), will also serve as the automated eligibility tool for Medicaid long-term care, SNAP, TANF, and other work supports.

In January 2014, individuals enrolled in HealthSource RI marketplace insurance and Medicaid New Adult Group became effective. On-going enrollment continued during the reporting periods.

Premium Assistance Program

Rhode Island implemented a Premium Assistance Program to ensure health care coverage for Medicaid adults losing Medicaid eligibility under the RItE Care program and would be eligible to purchase health care coverage through the new marketplace insurance, HealthSource RI. In anticipation of the transition of the Medicaid adults to HealthSource RI, the Rhode Island General Assembly created a fund to assist Medicaid adults to purchase commercial insurance.

As of January 1, income eligibility levels of parents of Medicaid-eligible children receiving RItE Care dropped from 175% of the federal poverty level to 133% of the federal poverty level. Children receiving RItE Care were not impacted by the change; however approximately 6,500 parent would lose RItE Care coverage offered by the Medicaid program.

Under a creative partnership between the Executive Office of Health and Human Services (EOHHS), HealthSource RI and Neighborhood Health Plan of Rhode Island, parents affected by the change in eligibility were offered voluntary enrollment in the Neighborhood Health Plan of Rhode Island VAULE silver level product through the new marketplace, HealthSource RI. EOHHS paid for the first month of the premium utilizing the funds made available by the General Assembly. This initiative guaranteed coverage as of January 1, 2014, ensuring continuation of healthcare services.

State Innovative Model

Rhode Island was awarded a State Innovative Model grant from CMS to develop a statewide state health care innovation plan to transform the delivery of healthcare in Rhode Island. The plan was submitted to CMS in December of 2013. The goals articulated in the Rhode Island

State Health Care innovation Plan are as follows:

Rhode Island aims to create a system of care that meets four key elements: lifelong support of health and wellness, a focus on population health, coordinated models of care and payment transformation. The purpose of this system would be to improve the health of Rhode islanders, while at the same time “bending the cost curve” of health care in Rhode Island and improving the care experience for Rhode Islanders. By implementing the reforms outlined in this State health Care Innovation Plan (SHIP), the state expects to achieve these goals across five years.¹

The Rhode Island State Health Care Innovation Plan is a guide map with the objective to fundamentally change Rhode Island’s health care system for one based on episodic care of illness and injury and supported by a volume driven business model, to a system based on population health and supported by a business model rooted in value. This plan is designed to set the guideposts, to identify those steps that Rhode Island could take to maximize the opportunity for change in today’s health care system. Each of the steps identified in the plan will require intense and detailed implementation planning. As such, this plan provides strategies for transforming the state’s health care system, the context for those strategies and suggested tactics to bring the strategies to fruition. This plan should not be seen as the implementation blueprint, but rather a holistic model with the need for further debate and discussion on program details.²

In advance of the second round of funding, work continued during the reporting quarters to strengthen the payment and delivery system reforms under way in Rhode Island and continued to build the infrastructure for data, analysis and change.

Patient Centered Medical Home

Rhode Island’s Patient Centered Medical Home initiative, Chronic Care Sustainability Initiative (CSI) has developed a pilot Community Health Team to develop, test and evaluate intensive care management strategies that can be focused on patients who are identified as high risk/high cost/high impact in a targeted geographic region. The goals of the initiative are to demonstrate directional improvement in health and total costs outcomes for identified high risk cohort versus comparison group in the South County and Pawtucket target areas. The Community Health Team pilots are being financially funded to provide intensive care management for patients that are identified by the Health Plan and by the CSI practices as high risk. Community Needs Assessment results have identified that patients with mental health issues need to be included in the target population.

¹ Rhode Island State Health Care Innovation Plan, page 55
<http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf>

² Rhode Island State Health Care Innovation Plan, page 4
<http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf>

High Utilizer Strategy

Rhode Island has begun to develop a focused strategy to assess service delivery options for Medicaid high utilizers. Efforts have been underway to analyze the utilization data, review current programs with potential to inform the strategy, inventory common themes from other states and to develop short, medium and long term strategies. Key consideration must address strategies for real-time data sharing between involved parties, mental health and substance abuse diagnoses that are predominant in high utilizer populations and traditional non-medical issues such as housing and food.

Non-Emergency Medical Transportation Broker

Effective May 1, 2014, the Executive Office of Health and Human Services implemented a new Non-Emergency Medical Transportation management broker contract. The vendor, **LogistiCare**, began coordinating transportation services for Medicaid beneficiaries and individuals over the age of 60 who do not have access to transportation for critical appointments and services. This change to the transportation system is for Non-Emergency Medical Transportation only. The broker provides member services, eligibility verification for transportation services, schedules appointments with contracted transportation providers, quality assurance and monitoring and program reporting. Activities that occurred are outlined below.

- Executed the contract with LogistiCare
- Developed and implemented internal and external communications and training
- Monitored readiness and implementation of the Non-Emergency Medical Transportation broker services
- Assisted with problem resolution for transportation services

PCMH- Kids

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI), established in 2008, has distinguished itself as a successful innovative all-payer adult medical home demonstration project. Building on the successes of CSI for adult patients, and the successes of similar pediatric PCMH projects around the country, Rhode Island developed CSI-Kids, or PCMH-Kids, an equally innovative all-payer medical home demonstration project for children and their families. The vision for PCMH-Kids is that all Rhode Island children grow well to become healthy productive adults. Rhode Island child health providers and families raising children are active partners in an effective, affordable, integrated, community system of health, developmental and education services.

The mission of PCMH-Kids is to lead the transformation of children's primary care in Rhode Island in the context of an integrated health care system. PCMH-Kids brings together payers, providers, parents, educators and other leaders to develop, finance and sustain high quality community medical homes as a critical component of a system to support healthy development of all Rhode Island kids.

Family-centered medical homes for pediatrics differ from their adult counterparts due to the “Five D’s” – five issues of focus that are unique to children and adolescents.

1. Development: children grow and develop, adding cognitive skills as they age, as well as physical skills (habilitative), which all means that pediatric care coordination and family coordination needs change over time.
2. Dependency: children are dependent on adults at home (parents) and community (i.e. teachers, coaches, civic leaders) for their care, which means that the pediatric team based approach includes a broad team.
3. Differential Epidemiology: children are primarily healthy, which means that prevention is the critical piece of medical home care (i.e. obesity, asthma, mental health) and chronic conditions are rare, so pediatric coordination programs should be generalized rather than disease-specific.
4. Demographic Patterns: children and adolescents have disproportionately high rates of poverty which means that medical home care coordination must also address pediatric social determinants of health as well as racial/ethnic and socioeconomic disparities.
5. Dollars: children and adolescents’ overall healthcare costs are small compared to the adult population and the lifetime dividends from well-invested child healthcare result in huge savings, and yet, historically pediatric healthcare is disproportionately funded compared to adult healthcare costs. This means that a pediatric medical home initiative must also address the financing disparities between pediatric and adult medical care.³

The Executive Office of Health and Human Services is a key partner in the PCMH-Kids project. The EOHHS participated in the planning for the project and identified the need to hire dedicated staff to support the implementation of the PCMH-Kids program.

Medicaid Case Management System

In April of 2014, the Executive Office of Health and Human Services launched a Case Management System for the Medicaid Program. The system, Atlantes, provides a Medical Case Management portal under the MMIS platform. The Atlantes portal provides the nurse care managers an electronic case management system to improve operational and administrative efficiencies. Activities conducted during the reporting quarters are outlined below.

- Developed and implemented the training and testing of the Atlantes system
- Launched the implementation of Atlantes
- Monitored the implementation and utilization of the Atlantes case management system
- Explored opportunities to expand the utilization of Atlantes to additional case managers working with Medicaid beneficiaries

³ Rhode Island Patient/Family Centered Medical Home – Kids Recommendations to SIM Planning Grant Team, May 13, 2013

Transforming State LTSS Access Programs and Functions into a No Wrong Door System for All Populations and All Payers

EOHHS applied for the grant funding to transform to develop a three-year plan to design and implement a “No Wrong Door” (NWD) system to help all Rhode Islanders, regardless of age, disability, or income status access needed Long-Term Services and Supports (LTSS). The planning grant will be administered by the EOHHS that includes the major agencies that provide or coordinate LTSS. The Providence Veterans Administration Medical Center (VAMC) has committed support to this important endeavor. The goal of this grant is to develop a three-year plan that enables the State to implement a statewide NWD system that provides timely and accurate information about LTSS to consumers. The objectives of the grant are to: Develop a planning document that will address the needs of those consumers who must inform and educate themselves about LTSS options for themselves or their loved ones. The grant will: (1) Involve all stakeholders in the planning process to ensure that the NWD system reflects the needs of the State and is utilized to its fullest capacity; (2) Develop a three-year plan that: a) results in streamlined, coordinated, and integrated access to LTSS during the intake, assessment, counseling and enrollment processes for all Rhode Islanders; and b) adheres to the principles of a person-centered options counseling approach for all consumers. Activities conducted during the quarter are outlined below.

- Convened a cross-departmental workgroup to apply for the grant funding and agency leads
- Conducted an environmental scan of the LTSS access processes and opportunities
- Initiated the development of the No Wrong Door grant proposal

Outreach Activities

Rhode Island has continued to execute the State’s comprehensive communications strategy to inform stakeholders (consumers and families, community partners, and State and Federal agencies) about the 1115 Demonstration Waiver.

- Convened meetings with the 1115 Waiver Task Force on 01/27/2014, 02/16/2014, 04/28/2014, 05/19/14, 06/23/2014, 07/28/2014, 10/27/2014 and 12/15/2014
- Conducted the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 03/05/2014, 06/04/2014, 09/03/2014 and 12/03/2014
- Conducted bi-monthly Children and Family Consumer Advisory Committee meetings on 01/09/2014, 03/13/2014, 05/08/2014, 07/10/2014, 09/11/2014 and 11/13/2014
- Convened the Monthly Integrated Care Initiative Consumer Advisory Committee meetings in collaboration with the Lt. Governor’s Long Term Care Coordinating Council on 01/15/2014, 02/11/2014 and 03/05/2014, 04/02/2014, 05/07/2014 and 06/04/2014, 07/02/2014, 09/03/2014, 10/01/2014 and 11/05/2014

- Continued monthly mailings to adult beneficiaries eligible for the Integrated Care Initiative and managed care programs
- Mailed letters to RIte Care parents regarding payment assistance for commercial health insurance coverage
- Update the EOHHS website with the approved 1115 Waiver Extension and the Technical Correction to the 1115 Wavier Extension
- Updated the EOHHS website information on the Integrated Care Initiative for Medicare and Medicaid Beneficiaries
- Conducted numerous community and provider trainings on the Integrated Care Initiative
- Updated the EOHHS website information on Health Reform, Medicaid coverage and the Premium Assistance Program, including the letters that were sent to parents
- Updated the EOHHS website information on Non-Emergency Medical Transportation, Medicaid Renewals, Early Intervention Program, and public comments received on the Section 1115 Comprehensive Quality Strategy
- Posted the following reports to the EOHHS websites:
 - An Assessment of the Rhode Island Medicaid Adult Dental Program, January 2014
 - Long Term Care Transition Report, January – December 2014
 - 1115 Demonstration Waiver Quarterly Report April - June 2013, March 2014
 - 1115 Demonstration Waiver Quarterly Report July - September 2013, March 2014
 - Medicaid Report to RI Senate, July - September 2013, March 2014
 - 1115 Demonstration Waiver Quarterly Report October – December 2013, May 2014
 - Medicaid Report to RI Senate, October – December 2013, June 2014
 - Health Indicator Data Book, A Comparison of Access and Quality Measures for Rhode Islanders ,65 years old by Health Insurance Coverage-Trends 2000-2012, June 2014
 - Sherlock Plan Report, August 2014
 - Rhode Island Annual Medicaid Expenditure Report (SFY2013), August 2014

- Rhode Island's Medicaid Managed Care Program: Annual External Quality Review, November 2014
 - Sherlock Plan Report, December 2014
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- Posted Monthly Provider Updates in January- December 2014
 - Posted public notice on rule, regulations and procedures for EOHHS
 - Posted information on the RItE Care and RItE Share renewals
 - Posted a Guide for Caregivers, July 2014
 - Posted presentation Bending the Cost Curve in Healthcare, December 2014
 - Continued refinements to the new EOHHS website to improve communications and transparency

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the quarters in DY6 January 1, 2014 –December 31, 2014.

Integrated Care Initiative

The Integrated Care Initiative (ICI) in Rhode Island has been established to coordinate the Medicare and Medicaid benefits for program eligible beneficiaries. The overall goal is to improve care for Rhode Island's elder and people with disabilities to improve quality of care; maximize the ability of members to live safely in their homes and communities; improve continuity of care across settings and promote a system that is person-centered and helps members attain or maintain personal health goals. Rhode Island is implementing the ICI in two phases. Phase 1 commenced in November 2013 with the enrollment of eligible individuals into managed care for their Medicaid funded services, including long-term services and supports (LTSS). Phase 2 is expected to start in April of 2015. Phase 2 will be a partnership between the Rhode Island Medicaid program, CMS and a managed care organization under the Financial Alignment Demonstration opportunity. Activities conducted during the reporting quarters in DY6 January 1, 2014 – December 31, 2014 are outlined below.

Phase 1 of the ICI

- Mailed ICI enrollment letters to 17,178 new eligible beneficiaries from January 1, 2014 – December 31, 2014
- Enrolled 22,109 eligible beneficiaries in the ICI as of December 31, 2014
- Conducted ICI trainings for stakeholders including consumers, advocates and providers
- Presented at the ICI Consumer Advisory Committee meetings in April, May, June, July, September, October and November of 2014
- Continued readiness reviews and operational oversight of the ICI contracted vendors
- Monitored the Enrollment Help Line activities, including re-training of staff
- Processed enrollment opt-out requests and mailed confirmation of ICI program opt-out
- Provided guidance to providers regarding enrollment opt-out procedures and billing procedures
- Identified and resolved systems issues
- Continued to develop the Medicare Data Use Agreement application
- Refined reporting templates for the ICI initiative

Phase 2 of the ICI

- Continued to develop the Memorandum of Understanding (MOU) for the three-way contract under the Financial Alignment Demonstration

- Incorporated CMS comments on the draft MOU
- Continued to analyze data for the Phase 2 rate development and continued the rate negotiation with CMS
- Convened workgroup to develop draft procurement document for the CMS Ombudsman Grant for Phase 2 with funding contingent upon approval of the MOU
- Issued the procurement document for the Phase 2 potential bidders
- No bids were received for the Phase 2 ICI initiative
- Provided information to internal and external stakeholder on the Phase 2 ICI initiative
- Commenced drafting of the three-way contract for the Financial Alignment Demonstration
- Convened workgroup to develop a proposal for the enhanced ADRC/SHIP funding available to states participating in the Financial Alignment Demonstration
- Participated in the Center for Health Care Strategies initiative, Implementing New Systems of Care for Dually Eligible Enrollees, known as INSIDE, made possible by The SCAN Foundation and The Commonwealth Fund
- Began the development of the systems modifications needed to support the Financial Alignment Demonstration
- Commenced the planning for the call center operation requirements under the Financial Alignment Demonstration
- Commenced the development of the marketing and member materials for the Financial Alignment Demonstration

Health Reform/New Adult Group (Medicaid Expansion)

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

- Continued on-going enrollment
- As of December 31 2014, enrollment in Medicaid through HealthSource RI was 59,658
- Continued oversight of the managed care organizations
- Continued systems modifications to support enrollment of the New Adult Group
- Convened workgroups focused on specific issues related to behavioral health, HIV/AIDS and Corrections
- Monitored enrollment of newborns into Medicaid and QHPs
- Conducted trainings and presentation for stakeholders
- Worked with customer service staff from the state and HealthSource RI to resolve enrollment issues

Premium Assistance Program

Rhode Island has established a Premium Assistance Program to assist parents, no longer eligible for Medicaid, afford quality health insurance. In addition to the federal tax credits available for individuals with income between 133 and 175% FPL, parents may be eligible for state assistance to help pay for coverage. Parents must complete the premium assistance application and must choose a silver plan to qualify for the State Assistance Program and federal cost-sharing reductions. EOHHS continued to monitor the processing of premium assistance program applications.

Patient Centered Medical Home/High Utilizers Strategy

Rhode Island's Patient Chronic Care Sustainability Initiative (CSI-RI) brings together key health care stakeholders, including Medicaid, to promote care for patients with chronic illness through the patient-centered medical home model. CSI-RI's mission is to lead the transformation of primary care in Rhode Island. CSI-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care. A pilot has been developed to address barriers to CSI practice sites success in meeting utilization targets for all cause hospitalization and all cause emergency use through the use of a Community Health Team. This effort aligns with Medicaid high utilizers' strategy. During the reporting quarters, the following activities have occurred.

- Implemented the plan to develop, test and evaluate intensive care management strategies focused on patients who are identified as high risk/high cost/high impact in a targeted geographic region
- Analyzed data to identify high utilizers
- Implemented the strategy to define high utilizers, establish "real time" patient registry of high risk patients to generate lists of high risk patients with "impactable" high cost conditions
- Conducted an environmental scan of the utilization of "real time" patient registries of high risk patients
- Continued to explore opportunities to align efforts with current *care*, the statewide Health Information Exchange
- Identified Community Health Team activities underway to ensure alignment and efficient resource allocation

Medicaid Adult Quality Grant

Rhode Island received a Medicaid Adult Quality Grant in December 2013. Funding under this grant was to assist states with the implementation of the twenty-six (26) Medicaid Adult Core Set Measures. Grantees were required to implement two quality improvement projects tied to one of the Medicaid Adult Core Set Measures and maintain implementation of the Quality Improvement

Projects (QIPs) over the two-year grant period. Since the grant award, Rhode Island faced delays in implementing grant activities due to constraints in hiring staff and securing contractors. Progress has been made with both the hiring of the staff and awarding of contracts for the grant activities. The following work has been achieved on the quality improvement projects.

- Continued learning collaborative between participating hospitals and provider to identify areas for improving care transitions
- Examined current practices around information transfer
- Convened technical experts to discuss opportunities to enhance information transfer following hospital discharge
- Continued conducting a series of meeting to discuss patterns of readmissions
- Specified tools and methods to track monthly best practice date for Medicaid patients, as well as captured contextual variables to inform the type and reason for gaps in the information exchange
- Identified barriers to information transfer, including misinterpretation regarding HIPAA
- Planned to developed a “training aid job” to map how the regulations/laws regarding Mental Health law and state law intersect to reduce barriers to information transfer
- Implemented strategy to improve information transfer to PCPs for patients with behavioral health
- Implement plan to produce MMIS data for analysis by the University of Rhode Island College of Pharmacy to develop anti-depression medication management QIP
- Convened a meeting to discuss MCO adherence with anti-depressant medication to review lessons learned and ensure alignment
- Commissioned a state-wide environmental scan of anti-depressant medication adherence related initiatives, results and materials of interventions to improve depression outcomes
- Applied for and received a no-cost extension through December 2015
- Established goals in the areas of Capacity Building, Measure Calculation, Transitions of Care and Antidepressant Medication QIPs, and an EHR Project
- Established a fully staffed and functioning Analytic and Evaluation Unit that informs program evaluation efforts across EOHHS departments. A 2TB server blade and storage space was purchased in October 2014. Laptop computers and TOAD analytic software were ordered in late December 2014
- Developed file structures that can link claims from all data sets into more manageable analytical files for measurement construction across payers/health plans within Medicaid.
- Researched then identified an appropriate CAHPS survey tool and a vendor for Rhode Island’s statewide CAHPS project
- Transitions of Care QIP vendor, Healthcentric Advisors, convened EOHHS, commercial, and Medicaid plans, and the Office of Health Insurance Commissioner to align expectations around Safe Transitions Best Practice expectations, and met with the Department of Health to discuss QIP alignment with mandated Continuity of Care expectations, Meaningful Use, Joint Commission regulations, and HBIPS regulations
- Healthcentric Advisors convened a second session with EOHHS, commercial and Medicaid plans, the Office of Health Insurance Commissioner, and all hospitals to review

expectations around Safe Transitions Best Practice expectations, and completed an initial round of chart audits in participating practice sites to collect transfer information receipt and completeness. They also conducted the first Learning Session for participating hospitals and practices.

- The University of Rhode Island - College of Pharmacy, the State's vendor for the Antidepressant Medication QIP, developed an algorithm to identify eligible AMM population, and began data integration and operationally defining measure components.
- The University of Rhode Island - College of Pharmacy, determined measure rates for managed care versus FFS populations for CY 2013, solidified concepts for intervention with providers and the pharmacy community, and calculated per-provider rates for the acute phase and chronic phase measure.
- Brown University School of Public Health, the State's vendor for the EHR initiative, worked with the Analytics and Evaluation team to refine attribution methodology, and conducted first round qualitative interviews with providers/nurses/medical assistants at all three participating clinics to investigate patient flow and clinical staff use of EHRs.
- Brown University School of Public Health met with quality analysts at two sites to discuss processes of EHR data extraction for quality measurement and met with EHR trainers at two sites to begin training on manual EHR data extraction, and worked with participating clinical sites to generate lists of Medicaid patients meeting certain criteria for comparison with EOHHS-generated lists. They also conducted detailed comparisons of clinical sites' patient lists and EOHHS' patient lists, to develop, refine, and evaluate preliminary attribution algorithms.

Money Follows the Person Demonstration Grant

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

- Received 451 referrals for Nursing Home Transitions
- Transitioned 117 individuals to the community, of which forty-four (44) individuals qualified under the MFP program.
- Submitted and received approval of the revisions to the Rhode to Home Operational Protocol
- Continued to monitor the MFP activities under the managed care Integrated Care Initiative (ICI)
- Continued to directly manage the MFP activities in the Medicaid Fee For Service program
- Continued to develop the MFP claiming methodology under a capitation payment arrangement
- Continued to develop relationships with housing authorities to improve capacity for community-based housing for individuals transitioning from nursing facilities

Health Homes

Rhode Island continues to operate three programs under the Health Home opportunity. Rhode Island is planning to develop a Health Home model for the Connect Care Choice Community Partners program. Efforts are underway to implement the Opioid Treatment Health Home SPA. Activities conducted are outlined below.

- Developed a draft of the Health Home Connect Care Choice Community Partners State Plan Amendment
- Participated in Health Home Learning Technical Assistance calls
- Continued the implementation and oversight of the Opioid Treatment Health Home SPA
- Continued to pursue Data Use Agreement to capture Medicare claims data for reporting
- Submitted, then withdrew, SPA amendment for the children's health home
- Continued to monitor the children's health home

Home and Community Base Services (HCBS) Final Rules

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

- Continued to plan for the implementation of the final rules
- Conducted legal review of the impact to the EOHHS programs of the Fair Labor Standards Act rules
- Explored opportunities and challenges under the new HCBS guidelines
- Communicated with Stakeholders planning efforts

Community First Choice

With the promulgation of the new HCBS rules, Rhode Island began to fully explore the opportunity afforded under the Community First Choice State Plan option. The activities conducted are outlined below.

- Examined relationship of the State Plan Amendment and 1115 Waiver authority related to the implementation of the Community First Choice program
- Documented the HCBS services provided under the authority of the 1115 waiver and the State Plan to identified services that would qualify under the Community First Choice program
- Convened discussions with CMS Community First Choice program staff and 1115 Waiver staff to discuss Rhode Island's authority questions
- Requested and was granted approval for HCBS Technical Assistance
- Continue to analyze utilization data to identify Maintenance of Effort (MOE) requirements

- Continued cross-department planning of the Community First Choice State Plan Amendment opportunity
- Analyzed utilization data, level of care eligibility, service and setting requirements
- Documented current HCBS delivery system policies and procedures, including self-direction programs
- Met with CMS to discuss authority issues
- Determined that federal authority requirements would need to include areas that would present a challenge to meeting the MOE requirements and would require RI to restructure the approved 1115 Demonstration Waiver Renewal authority
- Determined the Community First Choice opportunity would not be pursued

Personal Choice Program Advisement Agency Certification Standards

The Personal Choice Program is a participant (service recipient) directed program designed to provide in-home services and supports to adults with disabilities and elders utilizing Cash and Counseling model. The ‘Cash’ portion of the model refers to the cash allowance each participant is offered to purchase and manage his/her personal assistance services. ‘Counseling’ refers to services provided to participants to enable them to make informed decisions that work best for them, are consistent with their needs and reflect their individual preferences. In order to broaden participation the Personal Choice Program, Rhode Island established certification standards. Activities conducted are outlined below.

- Published the solicitation of interested Personal Choice Program Advisement Agency vendors
- Certified a new Personal Choice provider
- Monitored the one of the Personal Choice providers that was experiencing financial difficulty
- Conducted on-site reviews, fiscal monitoring and provided technical assistance to ensure the delivery of service to beneficiaries
- Non-compliance with Personal Choice program standards resulted in the termination of the Personal Choice vendor in July 2014
- Transitioned members to other Personal Choice providers

Hospital Presumptive Eligibility

Beginning March 1, 2014, Rhode Island hospitals were permitted to conduct ‘presumptive’ determinations of Medicaid eligibility for certain individuals who were likely to be eligible. Eligibility under Hospital Presumptive Eligibility (HPE) is temporary and is effective from the date of application to the end of the following month. At that time, a full complete application was required to be completed in order for eligibility to continue. In order for hospitals to participate in HPE, they needed to attend training and take a test to become certified and must comply with all RI State and Federal laws, regulations, policies and procedures or forfeit HPE authorization. EOHHS monitored the HPE activities to ensure compliance.

RItE Smiles Program

The RItE Smiles program is Rhode Island's managed care dental program for children who have Medicaid coverage and were born on or after May 1, 2000. The program was implemented in 2006 and designed to increase access to dental service, promote preventive and primary dental treatment and reduce the need for high cost restorative and emergency dental procedures. The State began the re-procurement for a dental benefit manager. Activities conducted are outlined below.

- Convened the Evaluation Team to review the proposal responses to the procurement
- Recommend proposal awards
- Drafted contract documents
- Commenced systems modification design
- Convened implementation and readiness activities
- Two vendors were initially selected, one vendor withdrew
- Executed contract with existing vendor effective July 1, 2014

Comprehensive Quality Strategy

The Rhode Island Quality Strategy has been in place since 2005. In 2012, Rhode Island's Quality Strategy was updated to include Rhody Health Partners, RItE Smiles and Connect Care Choice and was approved in 2013. With the approval of the 1115 Wavier renewal, updates to the State's Comprehensive State Quality Strategy were required. Activities conducted are outlined below.

- Obtained, reviewed and included public comments on the draft Comprehensive Quality Strategy
- Submitted the Comprehensive Quality Strategy for review and approval by CMS
- Posted public comments on the EOHHS website
- Received comments from CMS on areas for further modifications to the Comprehensive Quality Strategy prior to its submission to CMS

State Innovative Model

Rhode Island was awarded a State Innovative Model grant from CMS to develop a statewide state health care innovation plan to transform the delivery of healthcare in Rhode Island. The plan was submitted to CMS in December of 2013. The goals articulated in the Rhode Island State Health Care innovation Plan are as follows:

Rhode Island aims to create a system of care that meets four key elements: lifelong support of health and wellness, a focus on population health, coordinated models of care and payment transformation. The purpose of this system would be to improve the health of Rhode islanders, while at the same time "bending the cost curve" of health care in Rhode Island and improving the care experience for Rhode Islanders. By implementing the reforms outlined in this State health Care Innovation Plan (SHIP), the state expects to

achieve these goals across five years.⁴

The Rhode Island State Health Care Innovation Plan is a guide map with the objective to fundamentally change Rhode Island's health care system for one based on episodic care of illness and injury and supported by a volume driven business model, to a system based on population health and supported by a business model rooted in value. This plan is designed to set the guideposts, to identify those steps that Rhode Island could take to maximize the opportunity for change in today's health care system. Each of the steps identified in the plan will require intense and detailed implementation planning. As such, this plan provides strategies for transforming the state's health care system, the context for those strategies and suggested tactics to bring the strategies to fruition. This plan should not be seen as the implementation blueprint, but rather a holistic model with the need for further debate and discussion on program details.⁵

In advance of the second round of funding, work continued to strengthen the payment and delivery system reforms under way in Rhode Island and continued to build infrastructure for data, analysis and change. By early 2014, Rhode Island had completed the work of Round One through an extensive stakeholder engagement process and with the technical assistance of The Advisory Board of Nashville, Tennessee. The model design was set forth in the "Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost." In July 2014, Rhode Island applied for the second round of SIM awards in order to test its model design. As part of Round Two, 32 awardees received \$660 million. Rhode Island received a \$20 million award to test its health care payment and service delivery reform model over the next four years.

The vision statement articulated in the SIM model design process reads as follows:

"Healthy Rhode Island aims to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care. We plan to transition from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric."

This vision statement will be operationalized through a "value-based care" paradigm. This paradigm integrally includes patient care quality measurements and strategies for engaging patients in their own health care. As part of SIM Round Two, the value-based care paradigm includes the following six components:

1. Developing a population health plan (Rhode Island baseline measures);
2. Developing and refining clinical outcome measures;
3. Expanding the state's health information technology infrastructure;
4. Establishing multi-disciplinary teams of health care providers to link provider practices with the communities that they treat (creating more effective relationships);
5. Identifying effective strategies for actively engaging patients in their own health care;

⁴ Rhode Island State Health Care Innovation Plan, page 55
<http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf>

⁵ Rhode Island State Health Care Innovation Plan, page 4
<http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf>

6. Achieving alternatives to fee-for-service arrangements, such that by the end of the grant period, 80% of insured Rhode Islanders will be in health insurance arrangements that link payment to value or quality of care.

The governance model for SIM Round Two includes the following:

Healthy Rhode Island Steering Committee: This Steering Committee is the governing body of SIM Round Two. The Committee is composed of state officials, hospitals, long-term care providers, behavioral health practitioners, health insurers, primary care practice organizations, advocates, and consumers. This Committee is setting the strategic direction and policy goals of SIM Round Two.

Contractual support: EOHHS intends to enter into a competitive bid process for: 1) project management, 2) evaluation and monitoring, and 3) data management /analytics contractual support.

Internal working group of state staff: SIM Round Two is a collaborative effort that includes staff representation from the following state agencies: Office of the Governor, Office of the Lt. Governor, EOHHS, Department of Health (DOH), Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), Office of the Health Insurance Commissioner (OHIC), Department of Administration (HealthSource RI and the State Employee Health Plan).

Medicaid Eligibility System

EOHHS and HealthSource RI share the same technology platform for application for insurance coverage and eligibility determinations for insurance affordability programs. This technology solution, called the Unified Healthcare Infrastructure Project (UHIP), became operational in October 2013 serving Medicaid Rite Care and the New Adult Group (Expansion) in addition to the marketplace insurance offered under HealthSource RI. Under Phase 2, UHIP will also serve as the automated eligibility tool for Medicaid long-term care, SNAP, TANF, and other work supports. The following activities have occurred.

- Identified the internal stakeholders for the planning and design of the eligibility system to support the specialized programs
- Commenced the design of the UHIP Phase 2 eligibility system
- Convened planning and design for the connectivity with the MMIS system

High Utilizer Strategy

Rhode Island has begun to develop a focused strategy to assess service delivery options for Medicaid high utilizers. Efforts have been underway to analyze the utilization data, review current programs with potential to inform the strategy, inventory common themes from other states and to develop short, medium and long term strategies. Key consideration must address strategies for real-time data sharing between involved parties, mental health and substance abuse

diagnoses that are predominant in high utilizer populations and traditional non-medical issues such as housing and food. The high utilizer strategy aligns with the PCMH activities. Activities conducted are outlined below.

- Analyzed utilization data to target actionable interventions for specific populations
- Convened cross-departmental meetings and to review current programs and inventory common themes and best practices
- Developed short, medium and long term strategies
- Reviewed behavioral health proposal for an Emergency Department diversion project
- Developed a strategy to identify a uniform definition of a “high utilizer”
- Convened Health Plan meetings to understand and align “high utilizer” strategies
- Convened inventory of efforts underway in PCMH/PCHM-Kids and Community Health Team pilots

Medicaid Renewals for RItE Care and RItE Share

EOHHS/Medicaid reinstated the redetermination of eligibility for RItE Care and RItE Share members. Letters were mailed to beneficiaries starting in June 2014. The process continued into November 2014. Approximately 20,000 individuals or 7,000 family/cases were affected monthly. EOHHS/Medicaid and DHS worked with community partners, the HSRI Contact Center, Navigators to get the word out and help families renew their coverage. Members have two months to renew their coverage but were encouraged to sign up in 30 days. The HealthSource RI Contact Center received training on the renewal process from June 18-20, 2014. The HealthSource RI Contact Center and DHS helped families recertify. On-going Medicaid renewals for the RItE Care and RItE Share programs were conducted.

Non-Emergency Medical Transportation

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

- EOHHS held weekly meetings oversight and monitoring with LogistiCare to review operational, system & financial functional areas, transportation provider network access, along with Quality Improvement activities
- EOHHS and LogistiCare addressed complaint issues with missed rides for appointment and transportation provider network capacity
- EOHHS and LogistiCare worked together to resolve transition issues with the implementation of the transportation broker contract

- EOHHS and LogistiCare routinely report to several external committees and/or multi-agency groups including: the Alliance for Better Long Term Care and the Lt. Governor’s Long Term Care Coordinating Council

Behavioral Health Delivery System Redesign

The Rhode Island General Assembly transferred all Medicaid-funded behavioral health services to EOHHS on July 1, 2014. EOHHS and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) began meeting to plan for the transition and re-design. EOHHS and BHDDH convened stakeholder input into the re-design of the current adult behavioral health benefit, with the goal of integrating the behavioral health benefits with the physical health benefits. For those enrolled in managed care programs, all benefits would be integrated into the health plan benefit package. For those enrolled in fee-for-service or Connect Care Choice/Connect Care Choice Community Partners the benefits would be integrated into the fee-for-service covered services. EOHHS and BHDDH were seeking feedback on how the integration could be optimally achieved. The objective of behavioral health system re-design would produce an equitable, evidence-based, cost-effective, efficient and flexible system that is responsive to the individual and family needs. The target implementation date for the behavioral health benefit package delivered in managed care was set for April 1, 2015. EOHHS and BHDDH planning efforts continued to meet the target date.

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the CY 6 period January 1, 2014 – December 31, 2014.

Request Type	Description	Date Submitted	CMS Action	Date
SPA	Nursing Home Payment Methodology	06/13/13	Pending	
SPA	2101(f) Children	12/31/13	Approved	01/06/14
SPA	Reasonable Classification of Individuals under 21	01/02/14	Approved	01/10/14
SPA	MAGI Based Eligibility Groups	12/12/13	Approved	01/10/14
SPA	MAGI Income Methodology	12/12/13	Approved	02/07/14
SPA	Alternative Benefit Program	12/12/13	Approved	02/12/14

Request Type	Description	Date Submitted	CMS Action	Date
SPA	MAGI Residency	12/12/13	Approved	02/14/14
SPA	MAGI Single State Agency	12/12/13	Approved	02/28/14
SPA	CHIP Non-Financial Eligibility	12/12/13	Approved	03/05/14
SPA	CHIP Establish 2101(f) Group	12/12/13	Approved	03/07/14
SPA	CHIP XXI Medicaid Expansion	12/12/13	Approved	03/07/14
SPA	MAGI Eligibility Process	12/12/13	Approved	03/11/14
SPA	MAGI Citizenship and Immigration Status	12/12/13	Approved	03/11/14
SPA	CHIP Eligibility Process	12/12/13	Approved	03/26/14
SPA	CHIP MAGI Eligibility & Methods	12/12/13	Approved	04/11/14
SPA	FMAP for Expansion Population	02/03/14	Approved	05/02/14
SPA	Hospital Presumptive Eligibility	03/28/14	Pending	
SPA	Benzos/Barbiturates/Smoking Cessation	03/31/14	Approved	06/09/14
SPA	MNIL	03/31/14	Approved	06/26/14
SPA	State Supplementary Payments	03/31/14	Approved	05/09/14
SPA	Home Equity for LTC	03/31/14	Approved	05/09/14
SPA	Transportation Broker	04/11/14	Approved	07/17/14
SPA	Annual DSH update	06/23/14	Approved	09/12/14
SPA	Change to CEDARR Payment Methodology	7/24/2014	Withdrawn	09/26/2014
SPA	In-patient UPL	9/25/2014	Withdrawn	10/27/14
SPA	Change in the CEDARR benefit	12/02/2014	Pending	

VIII. Financial/Budget Neutrality Developments/Allotment Neutrality Developments/Issues

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the quarters, or allotment neutrality and CMS-21 reporting for the quarters. The Budget Neutrality Report is can be found in Attachment E- XII., Enclosures – Attachments, Attachment 1 Rhode Island Budget Neutrality Report.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the DY6 January 1, 2014 – December 31, 2014. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

The summary of the consumer issues during DY6 January 1, 2014 – December 31, 2014 are outlined below.

Consumer Issues

EOHHS monitors consumer issues to ensure our Medicaid enrollees have access and receive high quality services. The State administers both managed care⁶ and primary care case management⁷ delivery systems. The procedures for tracking, investigating and remediating consumer issues differ slightly between the capitated managed care and the PCCM delivery system models.

The State requires that all Health Plans collect consumer issue data, submit a quarterly Summary of Informal Complaints report, and present their findings at quarterly RI EOHHS oversight and administration meetings. NHPRI and UHCP-RI must disaggregate their quarterly reports according to Medicaid enrollment cohort, such as RItE Care for Children with Special Health Care Needs, Rhody Health Partners, New Adult Group (ACA Expansion)⁸, and Core RItE Care. The report focuses on the types of issues most commonly identified by consumers broken out into seven (7) categories: Access to Care, Quality of Care, Environment of Care, Health Plan Enrollment, Health Plan Customer Service, Billing Issues, and Transportation. Each Health Plan also convenes an internal quality improvement committee to review consumer issues, trends, and strategies for taking preventive action. The State has implemented this reporting format for the Primary Care Case Management Model, Connect Care Choice Community Partners program. The contracted Coordinating Care Entity, in concert with the State reviews the consumer issues, trends and strategies for preventing other occurrences.

This reporting methodology and concurrent participation in internal plan committees and the RI EOHHS' oversight and administration meetings facilitate the identification of trends and exploration of strategies to prevent future occurrence if possible. An example pertains to enrollees' complaints associated with non-emergency medical transportation, which is an "out of Health Plan" benefit. When the EOHHS implemented its informal complaint reporting requirements in 2006, specific types of complaints (such as "reckless driving", "pick-up was late", et cetera) were to be delineated in association with various modes of transportation (such as cab service, bus, or ambulance). Based on the EOHHS' analysis, the Summary of Informal Complaints report made clear that, in most years, the number of transportation related issues increases during the winter months. Through investigation and discussion at committee

⁶ The State's capitated managed care programs are: RItE Care, RItE Care for Children with Special Health Care Needs, RItE Care for Children in Substitute Care, Rhody Health Partners, RItE Smiles, Rhody Health Options, and Rhody Health Expansion.

⁷ The State's PPCM programs are Connect Care Choice and Connect Care Choice Community Partners.

⁸ The New Adult Group cohort became Medicaid eligible in conjunction with the implementation of the Affordable Care Act (ACA).

meetings and the oversight and administration meetings it was determined that this uptick is related to seasonality (i.e., cycles of inclement weather in New England.) For on-going analysis, transportation-related complaints will continue to be documented by the Health Plans and monitored by the RI EOHHS in conjunction with the transition of RI Medicaid's non-emergency medical transportation services to a transportation broker, effective on 05/01/2014.

In addition to meeting the State's contract requirements, submitting quarterly reports, and participating in quarterly oversight and administration meetings, RI EOHHS requires NHPRI and UHCP-RI to maintain National Committee for Quality Assurance (NCQA) accreditation and adhere to the NCQA's standards that pertain to members' rights and responsibilities. Adherence to this standard in particular ensures the Plans:

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

RI EOHHS utilizes Summary of Informal Complaints reports and participation in internal Health Plan committees and State oversight and administration meetings to identify consumer issue trends and develop strategies to prevent future occurrence. One such trend pertains to non-emergency medical transportation, an "out of Health Plan" benefit. After considerable investigation and discussion, RI EOHHS transitioned RI Medicaid's non-emergency medical transportation services to a transportation broker. This transition became effective 05/01/2014. Initial data show that after an uptick in consumer-reported transportation issues during the initial transition to a transportation broker, the number of transportation related issues has begun to decline. RI EOHHS continued to monitor these issues closely during this transition phase. The transportation broker has instituted a four-tiered Complaint Resolution and Tracking Process which provides more detailed data about types of complaints and their disposition. A new Complaint Resolution and Tracking Process developed by EOHHS and LogistiCare provides more detailed data such as complaints as a percentage of all trip reservations (<1%), and percentage of complaints by source (enrollee 65%, provider 25%, facility 10%) and by issue (late 29.7%, rider no-show 22.6%, provider no-show 21.5%, provider general complaint 15%, LogistiCare issue 6%).

Both plans reported a decrease in the number of complaints from Q2 to Q3 and from Q3 to Q4 and that the majority of complaints are unsubstantiated. The highest percentages of complaints were made by Rhody Health Partners members and the expansion population.

EOHHS established a special procedure to monitor and resolve any enrollment issues for our New Adult Group population that began receiving services in January 2014. Consumer issues related to enrollment in the Rhody Health Expansion Medicaid program are tracked directly by RI EOHHS via a dedicated and continuously monitored log. System edits are then employed as needed. Once enrolled, consumer issues brought forth by these newly eligible Medicaid members are monitored following the procedure for all Health Plans described above. In addition, RI EOHHS requires monthly reports for Rhody Health Expansion and Rhody Health

Options to be transmitted electronically. These reports are also presented each quarter in a face-to-face session with the EOHHS by each Health Plan during the oversight and administration meetings that focus on Operations. EOHHS and our vendor, Deloitte, have collaborated to develop a process to triage and resolve expansion population enrollment issues more efficiently. The changes to the triage and resolution process for expansion population enrollment issues have resulted in fewer accounts with errors. By the end of December 2014 of all members enrolled, approximately 280 cases are being worked for various issues. A trend in the reduction in the number of accounts with errors under this new system was observed. Once enrolled, consumer issues brought forth by these newly eligible Medicaid members are monitored following the procedure for all Health Plans described above. In addition, RI EOHHS requires monthly reports for Rhody Health Expansion and Rhody Health Options to be transmitted electronically. These reports are also presented each quarter in a face-to-face session with the EOHHS by each Health Plan during the oversight and administration meetings that focus on Operations.

The State also participates in two advisory groups, the long-standing Consumer Advisory Committee (CAC) and the Integrated Care Initiative's CAC (ICI-CAC). CAC stakeholders include individuals who are enrolled in RItE Care, and representatives of advocacy groups. The CMS Regional Officer participates in these meetings, as her schedule permits. Topics discussed at the meetings included:

- Contact center call volume
- Rhody Health Options opt-out rates
- Potential changes to adult dental program
- Newborn enrollment
- Expansion enrollment issues
- Transition issues for youth aging out of foster care
- Status of Medicaid renewal process
- Rhode Island Health Coverage Project outreach to Rhode Islanders about RItE Care
- Enrollment report
- Transition of BHDDH clients to the health plans
- Transportation issues
- Rhode Island Health Coverage Project flyer and webinar
- Legislature/budget update
- Department of Corrections expansion Issues
- Premium Assistance

The ICI-CAC is chaired by Rhode Island's Lieutenant Governor. This group includes individuals who are Medicaid-enrolled and receive Long-term Services and Supports in Phase 1 of RI's Integrated Care Initiative and representatives of Health Plans and community groups. The ICI-CAC topics discussed at the meetings included:

- Enrollment and opt-out trends
- Phase II procurement process
- ICI and people with developmental disabilities and SPMI
- Budget updates

- Public comment/consumer access to neutral help when contemplating signing up for ICI
- Voices for Better Health – RI introductory presentation
- Marketing and Outreach Subcommittee meeting update
- ICI and people with developmental disabilities and/or SPMI
- Engaging Already Enrolled ICI Consumers
- Budget Article 18 overview
- Appeals Dashboard report

X. Marketplace Subsidy Program Participation

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

The following chart identifies the marketplace subsidy program participation during the CY 6 January 1, 2014 – December 31, 2014.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy Received by Enrollee	Actual Costs
<u>January</u>	2	N/A	\$33.50	\$67.00
<u>February</u>	35	33	\$158.60	\$5,551.00
<u>March</u>	124	89	\$59.62	\$7,393.00
<u>April</u>	163	39	\$47.11	\$7,679.00
<u>May</u>	259	96	\$49.00	\$10,921.00
<u>June</u>	243	-16	\$49.00	\$10,511.00
<u>July</u>	241	-2	\$40.67	\$9,802.00
<u>August</u>	219	-22	\$42.31	\$9,265.00
<u>September</u>	216	-3	\$43.41	\$9,377.00
<u>October</u>	203	-13	\$43.59	\$8,849.00
<u>November</u>	176	-27	\$42.88	\$7,546.00
<u>December</u>	80	-96	\$44.39	\$3,551.00
<u>Total</u>				\$90,512.00

Summary of Marketplace Activities for the DY 6 January 1, 2014 – December 31, 2014

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 133% and 175% of the Federal Poverty Level (FPL), who are not Medicaid eligible themselves, could apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HealthSource RI Contact Center, online at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Application_for_State_Assistance_Program.pdf

f, or could be requested by calling the RItE Care InfoLine at (401) 462-5300. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI. Based off a list of families previously enrolled in Medicaid and who met the Premium Assistance Program's FPL guidelines, EOHHS was able to identify and contact potential members. Along with letter generation, a notice was also posted on the EOHHS website.

All potential Premium Assistance members who have submitted an application are confirmed with a monthly report provided by Deloitte. The report lists individuals who meet the income and Medicaid-related provisions governing the RI Affordable Health Care Coverage Assistance Program (AHCCA). Along with these requirements, a Premium Assistance applicant must also be confirmed in the report as having paid (on-time) for their Silver Plan in order to be eligible for reimbursement.

As of December 2014, the monthly report has been automated and is available in UHIP. The report is run on the 24th of the previous month, and aims to ensure that potentially eligible members have *fully* paid for next month's Silver Plan coverage by the due date specified by their insurer. Since premiums for Silver Plan coverage are submitted on a month-to-month basis, the highest number of eligible individuals are likely to be seen in January and February 2015. Likewise, it is expected enrollment will decrease throughout the mid-year months, as families have a harder time meeting payment deadlines.

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in the quarters in DY6.

The following report is represents the major evaluation, quality assurance and monitoring during the reporting quarters in DY6 January – December 2014.

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

On a monthly basis, the RI EOHHS leads oversight and administration meetings with the State’s three (3) Medicaid participating Plans, NHPRI, UHC Dental, and UHCP-RI. These monthly meetings are conducted separately with each Health Plan; agenda items focus upon both standing areas of focus as well as emerging items. Each of the following content areas is addressed on a cyclic, quarterly basis: a) Medicaid managed care operations (January/April/July/October); b) Quality improvement, compliance, and program integrity (March/June/September/December); & c) Medicaid managed care financial performance (February/May/August/November).

Specific to quality improvement, compliance, and program integrity, the following areas of focus were addressed during the cycle of oversight and administration meetings that were conducted during CY 2014:

- Feedback from NHPRI and UHCP-RI pertaining to the annual External Quality Review Technical Reports, which were prepared by IPRO, Incorporated (Rhode Island’s External Quality Review Organization) in December 2013⁹
- Health Plans’ processes for ensuring members’ access to a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of their enrollees¹⁰
- A presentation by each Plan (NHPRI, UHC Dental, and UHCP-RI) of one of its internal audits that was conducted in CY 2013
- A presentation of each Health Plan’s informal complaints, grievances, and appeals as well as care management reporting, including a discussion of emerging trends and overview of how they are using this information to drive program and/or policy change.
- A presentation and discussion of each Health Plan’s Compliance Dashboard
- Each Health Plan (NHPRI and UHCP-RI) provided an update on their EPSDT programs, including but not limited to provider and member engagement and education, observed utilization trends, whether an audit of EPSDT services has been conducted to determine

⁹ Subsequently, the Health Plans’ January 2014 presentations were analyzed by the State’s EQRO during the first quarter of 2014, in order to produce feedback to the RI EOHHS for quality improvement purposes. As a result of this feedback loop, separate addenda were prepared, which provided the EQRO’s independent review of the Health Plans’ response to the recommendations that were made in the December 2013 annual EQR technical reports. The Health Plan-specific Addenda, which were issued in March 2014, also presented the EQRO’s assessment of the quality improvement projects (QIPs).

¹⁰ “Enrollees” include the Health Plan’s Core RItE Care, RItE Care for CSHCN, RItE Care for Children in Substitute Care (if the Health Plan serves this enrollment cohort) and Rhody Health Partners membership, as well as the New Adult Group (ACA Expansion enrollees.)

whether all components of a full EPSDT screening were provided, and how each Plan works with members starting at the latency stage to transition to adult services.

- Each Health Plan (NHPRI and UHCP-RI) provide an overview of how they are monitoring access to primary care, specialty and behavioral health services, including but not limited to conducting a snapshot (point in time) telephone survey with the Plan's top five high volume practices (medical and behavioral health), monitoring member to PCP ratios, and the completion of a closed panel reporting mechanism.
- UHC Dental presented an overview of their provider network access monitoring, including Geo-Access and ongoing recruitment. UHC Dental also presented their findings on a Sealant study and Orthodontia utilization, specifically among younger age cohorts.
- A presentation of each Health Plan's informal complaints, grievances, and appeals, communities of care and pain management, care management and pharmacy (generics utilization) reporting, including a discussion of emerging trends and overview of how they are using this information to drive program and/or policy change.
- Each Health Plan's updated reporting specific to Medicaid Expansion, including but not limited to member services metrics such as distribution of ID cards and member handbooks within 10 days of enrollment, welcome calls, call answer and abandonment rate and initial health risk assessment completion rate. In addition, information and data was presented on preventive care utilization (annual physical rate) and prior authorization and access to care for behavioral health.
- UHC Dental presented on their strategy to incorporate quality measures developed by the Dental Quality Alliance. In addition, a presentation was provided on the utilization of orthodontia among the seven to ten year old age cohort.
- Each Health Plan (NHPRI and UHCP-RI) presented their HEDIS® and Performance Goal Program Opportunities and Progress to date, including specific areas of focus identified for more in depth root cause analysis. In addition, each Health Plan presented their current process and strategy on high utilizers, including but not limited to the definition of a "high-utilizer", the processes in place to identify high utilizers, and alignment with the communities of care program and patient centered medical home efforts.
- Both Health Plans (NHPRI and UHCP-RI) presented the results of their 2014 CAHPS survey, response to the findings from the External Quality Review Evaluation Report, 2014 Quality Improvement Project outcomes and next steps, and their improvement plan for the state specific measures included within Rhode Island's Performance Goal Program.
- UHC Dental presented their Quality Improvement work plan as well as the outcome of an analysis completed on an orthodontia evaluation process, which included specific recommendations for Rhode Island.

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

Section 1115 Waiver Quality and Evaluation Work Group

Rhode Island's Section 1115 Quality and Evaluation Work Group, which includes Medicaid enterprise-wide representation, was established in 2009 and was responsible for the development of the 1115 Waiver's initial draft *Evaluation Design*. This work group has met regularly since the implementation of the Demonstration Waiver to analyze the findings from on-going quality monitoring activities that span the areas of focus as delineated in the Waiver's Special Terms and Conditions, STC # 123 (*State Must Separately Evaluate Components of the Demonstration*). The following table outlines the areas of focus that were addressed during the reporting periods by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

The following table outlines the areas of focus that were addressed during Q-1 of CY 2014 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
01/10/2014	An Overview of the RItE @ Home (Shared Living Program)
02/14/2014	Presentation of the proposed draft <i>Comprehensive Quality Strategy</i> for the State's 1115 Demonstration
03/14/2014	Hospitalizations for Prevention Quality Indicators (PQIs): 2005 - 2012

The following table outlines the areas of focus that were addressed during Q-2 of CY 2014 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
04/11/2014	Review and discuss CMS Memo (Modifications to HCBS 1915(C) Quality Measures & 1115 Waiver Quality & Evaluation STC's
05/16/2014	Medicaid EHR Incentive Program and Meaningful Use Measure Update
06/13/2014	Overview of the EOHHS Office of Policy & Innovation DEA Home & Community Care Audit Results

The following table outlines the areas of focus that was addressed during Q-3 of CY 2014 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
08/08/2014	Pediatric Respite Audit Process: Oversight and Monitoring

The following table outlines the areas of focus that was addressed during Q-4 of CY 2014 by Rhode Island's Section 1115 Demonstration Quality and Evaluation Work Group.

DATE	AGENDA
10/10/14	PACE Quality Oversight Update
11/14/14	HIV Program Quality Management & Evaluation

Child and Family Health Quality Improvement Committee

Rhode Island Medicaid’s Child and Family Health Quality Improvement Committee was established in 2006 and meets on a regularly-scheduled basis. Areas of focus include the following: access; health status indicators; service utilization; member/participant satisfaction; internal operational performance; and health outcomes and program impacts. Committee membership include program and management staff who serve Medicaid-enrolled Children with Special Health Care Needs, adults and children with disabilities who are enrolled in Rhody Health Partners and in RItE Care for CSHCN, as well as children born on or after 05/01/2000 who are enrolled in RItE Smiles. During the DY6 January 1, 2014 – December 31, 2014, the CFH Quality Improvement Committee discussed the following reports.

During Q-1 of CY 2014, the CFH Quality Improvement Committee discussed the following reports.

DATE	AGENDA
01/16/2014	The External Quality Review Organization’s Aggregate Technical Report & Potential Areas of Focus for Quality Improvement Projects (QIPs) for the Health Plans that Participate in RItE Care and Rhody Health Partners
03/13/2014	Rhode Island’s Early Intervention State Annual Performance Report & Outcomes for Children in Rhode Island Who Are Served Through IDEA

During Q-2 of CY 2014, the CFH Quality Improvement Committee discussed the following reports.

DATE	AGENDA
05/15/2014	CMS 416 EPSDT Report for FFY 2013
07/17/2014	Preliminary HEDIS® and CAHPS® findings from Rhode Island’s 2014 Performance Goal Program

During Q-3 of CY 2014, the CFH Quality Improvement Committee discussed the following report.

DATE	AGENDA
07/17/2014	Preliminary HEDIS® and CAHPS® findings from Rhode Island’s 2014 Performance Goal Program

During Q-4 of CY 2014, the CFH Quality Improvement Committee discussed the following report.

DATE	AGENDA
11/13/14	External Quality Review Findings and Recommendations

Development of the State’s proposed Section 1115 Comprehensive Quality Strategy

In concert with the development of the proposed Section 1115 Comprehensive Quality Strategy, the EOHHS has analyzed the draft Evaluation Design which was submitted to CMS in July 2009. Based on the synthesis of feedback that the EOHHS has received from stakeholders in response to the proposed Section 1115 Comprehensive Quality Strategy, further modifications to the draft Evaluation Design are anticipated prior to its submission to CMS.

The draft Evaluation Design will include a discussion of the goals, objectives, and evaluation questions specific to the Comprehensive Demonstration. The following will be addressed:

- Outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval
- The adequacy and appropriateness of the benefit coverage
- The data sources and sampling methodology to be used
- The proposed analytic plan
- The party that will conduct the evaluation

In addition, separate components of the Demonstration must be evaluated, including but not limited to the following:

- LTC Reform, including the HCBS-like and PACE-like programs
- Rite Care
- Rite Share
- The 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:
 - Children and Families in Managed Care and Continued eligibility for Rite Care parents when kids are in temporary state custody
 - Children with Special Health Care Needs
 - Elders 65 and Over
 - HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth
 - Uninsured adults with mental illness/substance abuse problems
 - Coverage of detection and intervention services for at risk young children
 - HIV Services

The State's current Quality Strategy was approved by CMS on 04/25/2013. During the DY6, significant efforts were conducted to obtain stakeholder feedback on the proposed revision to the State's current Quality Strategy. The proposed revision is based on the following three (3) major policy initiatives:

- The implementation of Phase One of Rhode Island's program for Medicare and Medicaid Eligible (MME) individuals who are eligible for full Medicaid benefits, as approved by CMS for implementation, which began 11/01/2013. Phase One implementation is the incorporation of home and community based services for Medicaid eligibles and MMEs into a managed care delivery system.

- The enrollment in Medicaid, beginning on 01/01/2014, of adults who are age 19 or older and under 65 who are at or below the Federal Poverty Level based on household income using the application of a modified adjusted gross income (MAGI) who are not pregnant; not entitled to or enrolled in Medicare; and not eligible for mandatory coverage under the State's Medicaid Plan. (This group is referred to as Rhode Island's Affordable Care Act Adult Expansion population.)
- CMS' renewal on 12/23/2013 of the State's Comprehensive 1115 Demonstration (Project Number 11-W-00242/1)¹¹ and the Demonstration's associated Special Terms and Conditions (STCs), which include STC 128 (Comprehensive Quality Strategy).

To fulfill the requirements of 42 CFR 438.202(b) and the Waiver's associated Special Terms and Conditions (STC) a stakeholder feedback process was implemented. In February, March and April 2014 presentations were made to the State's Quality and Evaluation workgroup (2/14/14), the EOHHS Consumer Advisory Committee (3/13/2014), State's Integrated Care Initiative Consumer Advisory Committee (ICI-CAC) (04/02/2014), and a tribal notice was sent on 3/28/2014. The proposed Section 1115 Comprehensive Quality Strategy was also sent to the EOHHS' Medical Care Advisory Committee. Relevant public notices were posted on 03/28/2014 for a thirty-day review period. The State received comments from several community based organization and trade associations. Following the close of the thirty-day public comment solicitation period on 04/28/2014, the feedback from respondents was analyzed and further clarifications were made to Quality Strategy as appropriate. A formal response to the public comments was posted to the EOHHS website on 5/28/2014. The Comprehensive Quality Strategy was formally submitted to CMS on 6/18/14.

On September 9, 2014, EOHHS had a conference call with CMS to discuss the submission of the Quality Strategy. After a thoughtful discussion, several areas of opportunity were identified and explored further with a specific focus on the provision of additional detail and breadth of quality measurement and improvement across Medicaid programs. On December 10, 2014 a revised Comprehensive Quality Strategy was formally submitted to CMS.

Development of a Draft Evaluation Design for the Section 1115 Demonstration

In concert with the development of the proposed Section 1115 Comprehensive Quality Strategy, the EOHHS has analyzed the draft Evaluation Design which was submitted to CMS in July 2009. Based on the synthesis of feedback that the EOHHS has received from stakeholders in response to the proposed Section 1115 Comprehensive Quality Strategy, further modifications to the draft Evaluation Design are anticipated prior to its submission to CMS.

Rhode Island was one of 26 states CMS awarded an Adult Medicaid Quality (AMQ) grant. One goal of the grant was to build internal State capacity around analytics to inform program development and evaluation efforts across EOHHS. An Analytics and Evaluation unit was established in May 2014. At that time staff began familiarizing themselves with the various initiatives and ongoing services provided through the 1115 Demonstration, as well as the myriad of data sources and performance measurement activities taking place across Medicaid.

¹¹ CMS subsequently issued technical corrections to the Demonstration's Special Terms and Conditions on 02/25/2014.

In the meantime, an initial Evaluation Design was drafted, primarily through external resources. Upon review of that draft, along with discussions regarding the Quality Strategy development, Rhode Island chose to take the opportunity to create a more comprehensive Evaluation Design that not only is better aligned with ongoing efforts around data analysis, quality measurement, and reporting, but also takes a broader perspective. Our planned evaluation of Demonstration activities will not only cover the three dimensions of value in health care (cost, effectiveness, and efficiency), but also examine outcomes both proximal (for Medicaid eligible) and distal (for the RI population as a whole).

As with the existing draft design, the modified Evaluation Design will include a discussion of the goals, objectives, and evaluation questions specific to the Comprehensive Demonstration. The following will be addressed:

- Outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval
- The adequacy and appropriateness of the benefit coverage
- The data sources and sampling methodology to be used
- The proposed analytic plan

The modified Evaluation Design will focus on the following components of the Demonstration and the team will explore the necessity to include additional components:

- LTC Reform, including the HCBS-like and PACE-like programs
- RItE Care
- RItE Share
- The 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:
 - Children and Families in Managed Care and Continued eligibility for Rite Care parents when kids are in temporary state custody
 - Children with Special Health Care Needs
 - Elders 65 and Over
 - HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth
 - Uninsured adults with mental illness/substance abuse problems
 - Coverage of detection and intervention services for at risk young children
 - HIV Services

An Evaluation Design team was formed in Q4, CY 2014 to modify the draft Evaluation Design, and began meeting in November 2014. Based on synthesis of feedback that EOHHS received from stakeholders in response to the 1115 Comprehensive Quality Strategy and the team's analysis of current analytic resources and capabilities, the team is developing modifications to the draft Evaluation Design. It is anticipated that an Evaluation Design Strategy will be submitted to CMS Q1 CY2015

During Q4, CY2014, EOHHS also began preliminary discussions with two local academic institutions to develop an Analytics and Evaluation collaborative. Initial plans are to establish open, ongoing contractual relationships between EOHHS and at least two universities in Rhode

Island that would facilitate routine as well as “as needed” support for evaluation activities. Additionally, this development period coincides with Rhode Island being awarded a State Innovation Model Test Grant. Staff involved in the 1115 Demonstration Evaluation Design will also be involved in SIM analytic development and evaluation activities, enabling cross-fertilization and alignment of evaluation efforts.

Attachment J: FQHC Annual Report

Beginning in 2014, as part of each annual report, the state must collect and report data on the use of the payments for uninsured populations to FQHCs, (payments described in STC 81). The state must report on the costs associated with these individuals by provider, as outlined in Attachment J. In the report, the state must include information about the uninsured people being served by FQHCs including, but not limited to the following:

- The number of FQHC uninsured encounters
- Costs of FQHC uninsured encounters
- Number of uninsured people in the state
- General description of who the uninsured are, such as individuals who are difficult to enroll due to homelessness, individuals who report finding coverage cost prohibitive as the reason for lack of coverage, etc.

As indicated in section XIV of the STCs, the state assures that the payments made to FQHCs do not exceed the cost of delivering services to the uninsured. The state must report annually data associated with the services and costs delivered by the FQHCs to any uninsured individuals following the chart below. The methodology for the encounter rate is defined in the Medicaid State plan.

In 2014, there were 56,800 uninsured individuals in Rhode Island. The remaining group of uninsured is comprised primarily of 1) individuals who are difficult to enroll due to homelessness, 2) undocumented individuals and families, or 3) individuals who find coverage cost prohibitive or who refuse to pay monthly premiums, however small, as they are still able to receive services on a sliding fee scale even without coverage. The FQHCs used the funds to support activities to increase coverage and improve care to their uninsured populations. These activities include the following:

- Partnered with the health insurance exchange to engage uninsured residents at various events.
- Social Workers provided outreach activities to increase the community's awareness of available health care services to uninsured/low income populations at schools, faith based organizations, social service centers, and community case management programs.
- Outreach to patients that have been recently assigned to a PCP at the FQHC but have not received care from the provider.
- Development of distinct referral mechanisms in order to identify at-risk individuals and provide immediate access to care.

Attachment J: List of FQHCs

FQHC	Medical Encounter Rate¹²	Uninsured Encounters	Overall Uninsured Cost
Blackstone Valley Community Health Care Inc.	\$ 194.04	10,932	\$ 2,121,245.28
Comprehensive Community Action Program	\$ 203.47	8,926	\$ 1,816,173.22
East Bay Community Action Program	\$ 202.66	7,980	\$ 1,617,226.80
WellOne	\$ 170.76	4,210	\$ 718,899.60
Providence Community Health Centers	\$ 184.00	19,340	\$ 3,558,560.00
Thundermist Health Center	\$ 153.30	33,403	\$ 5,120,679.90
Tri-Town Community Action Agency	\$ 153.25	1,901	\$ 291,328.25
Wood River Health Services	\$ 179.26	8,872	\$ 1,590,394.72

¹² FQHCs operate on varying fiscal years. Therefore the Medical Encounter Rates for each FQHC change at different points during the calendar year. The Medical Encounter Rate reported here and utilized in the above calculations are those rates which were in effect as of December 31, 2014.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Budget Neutrality Table I

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	DY 6 1st Qtr. CY 2014	DY 6 2nd Qtr. 2014	DY 6 3rd Qtr. 2014	DY 6 4th Qtr. 2014	DY 6 2014 YTD
ABD Adults No TPL	\$ 150,104,288	\$ 133,368,833	\$ 133,472,862	\$ 132,136,480	\$ 549,082,463
ABD Adults TPL	\$ 262,061,723	\$ 272,489,910	\$ 272,782,430	\$ 273,777,601	\$ 1,081,111,664
Rlte Care	\$ 185,341,835	\$ 194,761,413	\$ 199,023,008	\$ 197,954,537	\$ 777,080,793
CSHCN	\$ 96,548,376	\$ 96,626,364	\$ 96,986,719	\$ 98,105,435	\$ 388,266,894
TOTAL	\$ 694,056,223	\$ 697,246,519	\$ 702,265,020	\$ 701,974,052	\$ 2,795,541,814

With Waiver Total Expenditures

Medicaid Populations	DY 6 1st Qtr. CY 2014	DY 6 2nd Qtr. 2014	DY 6 3rd Qtr. 2014	DY 6 4th Qtr. 2014	DY 6 2014 YTD
ABD Adults No TPL	\$ 100,872,889	\$ 92,525,925	\$ 124,517,540	\$ 93,320,120	\$ 411,236,474
ABD Adults TPL	\$ 192,696,806	\$ 170,826,529	\$ 197,808,727	\$ 170,714,392	\$ 732,046,454
Rlte Care	\$ 123,538,800	\$ 83,229,925	\$ 109,926,234	\$ 145,268,070	\$ 461,963,029
CSHCN	\$ 44,909,415	\$ 40,380,805	\$ 44,520,658	\$ 46,131,678	\$ 175,942,556
Excess Spending: Hypotheticals	\$ 10,258,284	\$ (16,415,303)	\$ 50,171,174	\$ (12,868,598)	\$ 31,145,557
CNOM Services	\$ 4,714,775	\$ 4,547,779	\$ 2,631,321	\$ 1,900,643	\$ 13,794,518
TOTAL	\$ 476,990,969	\$ 375,095,660	\$ 529,575,654	\$ 444,466,305	\$ 1,826,128,588
Favorable / (Unfavorable) Variance	\$ 217,065,254	\$ 322,150,859	\$ 172,689,366	\$ 257,507,747	\$ 969,413,227
Budget Neutrality Variance (DY 1 - 5)	\$ 2,786,961,150				
Cumulative Bud. Neut. Variance	\$ 3,004,026,404	\$ 3,326,177,264	\$ 3,498,866,629	\$ 3,756,374,377	\$ 3,756,374,377

Budget Neutrality Table I

HYPOTHETICALS ANALYSIS

Without Waiver Total Exp.	1st Qtr. 2014	2nd Qtr. 2014	3rd Qtr. 2014	4th Qtr. 2014	2014 YTD
217-like Group	\$ 37,233,540	\$ 37,233,540	\$ 37,687,165	\$ 37,785,148	\$ 149,939,393
Low-Income Adults (Expansion)	\$ 75,632,639	\$ 111,795,125	\$ 121,475,404	\$ 131,508,944	\$ 440,412,112
Family Planning Group	\$ 17,615	\$ 13,346	\$ 8,865	\$ 6,346	\$ 46,171
TOTAL	\$ 112,883,794	\$ 149,042,011	\$ 159,171,434	\$ 169,300,438	\$ 590,397,676

With-Waiver Total Exp.	1st Qtr. 2014	2nd Qtr. 2014	3rd Qtr. 2014	4th Qtr. 2014	2014 YTD
217-like Group	\$ 38,879,379	\$ 40,180,931	\$ 41,737,517	\$ 42,729,275	\$ 163,527,102
Low-Income Adults (Expansion)	\$ 84,239,542	\$ 92,427,724	\$ 167,590,444	\$ 113,684,777	\$ 457,942,487
Family Planning Group	\$ 23,156	\$ 18,053	\$ 14,647	\$ 17,788	\$ 73,644
TOTAL	\$ 123,142,077	\$ 132,626,708	\$ 209,342,608	\$ 156,431,840	\$ 621,543,233

Excess Spending	1st Qtr. 2014	2nd Qtr. 2014	3rd Qtr. 2014	4th Qtr. 2014	2014 YTD
217-like Group	\$ 1,645,839	\$ 2,947,391	\$ 4,050,352	\$ 4,944,127	\$ 13,587,709
Low-Income Adults (Expansion)	\$ 8,606,903	\$ (19,367,401)	\$ 46,115,040	\$ (17,824,167)	\$ 17,530,375
Family Planning Group	\$ 5,541	\$ 4,707	\$ 5,782	\$ 11,442	\$ 27,473
TOTAL	\$ 10,258,284	\$ (16,415,303)	\$ 50,171,174	\$ (12,868,598)	\$ 31,145,557

Budget Neutrality Table II

Without-Waiver Total Expenditure Calculation

Actual Member Months	DY 6 1st Qtr. CY 2014	DY 6 2nd Qtr. 2014	DY 6 3rd Qtr. 2014	DY 6 4th Qtr. 2014	DY 6 2014 YTD
ABD Adults No TPL	56,273	49,999	50,038	49,537	205,847
ABD Adults TPL	86,900	90,358	90,455	90,785	358,498
Rlte Care	407,121	427,812	437,173	434,826	1,706,932
CSHCN	35,902	35,931	36,065	36,481	144,379
217-like Group	10,260	10,260	10,385	10,412	41,317
Low-Income Adult Group	97,843	144,625	157,148	170,128	569,744
Family Planning Group	916	694	461	330	2,401

Without Waiver PMPMs	DY 6 1st Qtr. CY 2014	DY 6 2nd Qtr. 2014	DY 6 3rd Qtr. 2014	DY 6 4th Qtr. 2014	DY 6 2014 YTD
ABD Adults No TPL	\$ 2,667	\$ 2,667	\$ 2,667	\$ 2,667	\$ 2,667
ABD Adults TPL	\$ 3,016	\$ 3,016	\$ 3,016	\$ 3,016	\$ 3,016
Rlte Care	\$ 455	\$ 455	\$ 455	\$ 455	\$ 455
CSHCN	\$ 2,689	\$ 2,689	\$ 2,689	\$ 2,689	\$ 2,689
217-like Group	\$ 3,629	\$ 3,629	\$ 3,629	\$ 3,629	\$ 3,629
Low-Income Adult Group	\$ 773	\$ 773	\$ 773	\$ 773	\$ 773
Family Planning Group	\$ 19	\$ 19	\$ 19	\$ 19	\$ 19

Without Waiver Expenditures	DY 6 1st Qtr. CY 2014	DY 6 2nd Qtr. 2014	DY 6 3rd Qtr. 2014	DY 6 4th Qtr. 2014	DY 6 2014 YTD
ABD Adults No TPL	\$ 150,104,288	\$ 133,368,833	\$ 133,472,862	\$ 132,136,480	\$ 549,082,463
ABD Adults TPL	\$ 262,061,723	\$ 272,489,910	\$ 272,782,430	\$ 273,777,601	\$ 1,081,111,664
Rlte Care	\$ 185,341,835	\$ 194,761,413	\$ 199,023,008	\$ 197,954,537	\$ 777,080,793
CSHCN	\$ 96,548,376	\$ 96,626,364	\$ 96,986,719	\$ 98,105,435	\$ 388,266,894
217-like Group	\$ 37,233,540	\$ 37,233,540	\$ 37,687,165	\$ 37,785,148	\$ 149,939,393
Low-Income Adult Group	\$ 75,632,639	\$ 111,795,125	\$ 121,475,404	\$ 131,508,944	\$ 440,412,112
Family Planning Group	\$ 17,615	\$ 13,346	\$ 8,865	\$ 6,346	\$ 46,171

Attachment 2: Statement of Certification of Accuracy of Reporting of Member Months

Statement of Certification of Accuracy of Reporting Member Months

As the Executive Office of Health and Human Services Chief Financial Officer, I certify the accuracy of reporting member months for demonstration population under the 1115 Comprehensive Demonstration Waiver for the purpose of monitoring the budget neutrality agreement.

A handwritten signature in cursive script that reads "Robert B. Farley". The signature is written in black ink and is positioned above the printed name.

Name: Robert Farley

Title: EOHHS Chief Financial Officer

Signature:

Date: June 3, 2016

XIII. State Contact(s)

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Cranston, RI 02920

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XIV. Date Submitted to CMS

Enter the date submitted to CMS in the following format: (06/03/2016).