Report to the Centers for Medicare and Medicaid

Services Quarterly Operations Report

Rhode Island

Comprehensive 1115

Waiver Demonstration

DY15 Annual

January 1, 2023 – December 31, 2023

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

Submitted ____March 20, 2024___________

I. Narrative Report Format

Rhode Island Comprehensive Section 1115

Demonstration Section 1115 Quarterly Report

Demonstration Reporting

Period: DY 15 January 1, 2023 – December 31, 2023

II. Introduction

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

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

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

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

The Rhode Island Comprehensive demonstration includes the following distinct components:

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

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

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

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

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

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

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

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

- Health System Transformation Project:
    - In Q1, all Accountable Entities were certified for the Program Year

beginning July 1, 2023.
    - In Q2, AE Project Plans were finalized.
    - In Q3, Outcome Performance Year 5 Outcome Metric results were finalized and shared with AEs and Quality program metrics were established for PY7. All seven AE contracts with managed care organizations were signed, and the Rhode to Equity learning and action collaborative concluded its final year.
    - In Q4, all seven AEs were fully re-certified for PY6 and six AEs took on downside risk.
- Modernizing Health and Human Services Eligibility Systems:
    - In Q1, the Medicaid Systems team and Deloitte implemented four (4) software releases to address 48 data fixes and 22 software enhancements for the RI Bridges eligibility system.
    - In Q2, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 86 data fixes and 29 software enhancements for the RI Bridges eligibility system.
    - In Q3, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 84 data fixes and 17 software enhancements for the RI Bridges eligibility system.
    - In Q4, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 79 data fixes and 17 software enhancements for the RI Bridges eligibility system.
- Home and Community-Based Services Conflict-Free Case Management:
    - In Q1, the statewide team posted a summary of stakeholder feedback on the draft strategic plan along with the State's responses, as well as an updated CFCM strategic plan. The team drafted a request for information (RFI) to assess provider capacity. On March 22, 2023, the State received CMS approval of the Corrective Action Plan (CAP) to outline the state's plan to achieve full compliance.
    - In Q2, the State team posted an updated CFCM strategic plan and CFCM fact sheet to the EOHHS website for stakeholder review and comment and held stakeholder engagement meetings on the strategic plan. The CAP was posted publicly on May 24. The General Assembly enacted the FY2024 budget, including the legislative authority to promulgate rule changes as well as funding to support the State's implementation of CFCM for the fiscal year beginning July 1.
    - In Q3, based on feedback from the RFI, the state decided to use certification standards rather than a procurement/RFP process to qualify CFCM providers. The state began monthly stakeholder meetings on CFCM.
    - In Q4, the state posted draft CFCM certification standards for public comment and worked to review and respond to public comment.
- Home and Community-Based Services Quality Improvement:
    - In Q1, the Quality Improvement Team completed an outline for HCBS Common Provider Training requirements and requested that each

program office develop a data collection procedural document for their Service Plans and Health and Welfare measures. The Critical Incidents Subgroup finalized and shared a critical incident FAQ document in English, Spanish, and Portuguese; and proposed and received CMS approval for the restrictive intervention measure, which will be reflected in the June data call, covering Q1 data. The Data Analytics Subgroup completed the CY2022 Q3 data call in a timely manner, and results were aggregated by the EOHHS data team and presented at the February meeting using the data dashboard. The data team submitted counts to CMS for the unduplicated number of individuals who received HCBS services in CY2022, as well as the projected individual counts for CY2023.

  - In Q2, the team received approval from CMS regarding the removal of an Administrative Authority measure and confirmed their ability to track the new measures. The state submitted the HCBS Quality Annual Critical Incident Report and HCBS Quality Annual Deficiency Report to CMS by the June 30 deadline. The CY2023 Q1 data call was received in a timely manner and results were aggregated by the EOHHS data team and presented at the May meeting using the data dashboard.
  - In Q3, the project governance team completed individual check ins with each agency. Due to the success of the past year, the team determined it did not need an additional year of technical assistance support from New Editions, whose TA contract ended in August. The QIS team continues to meet monthly, to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups.
  - In Q4, the Project Governance Team developed a recommendation to use the National Core Indicators-Aging and Disability (NCI-AD) survey for the Elders and Adults with Disabilities (EAD) population and sent a contract to CMS for review and approval. The team also posted the state's core HCBS Provider Training, pursuant to HCBS quality assurance requirements. The State is requiring annual completion of this training for anyone working directly with HCBS participants. The QIS team identified the connection between RI's implementation of CFCM and QIS Performance Measure data collection. The QIS team also reviewed the Q2 data and addressed changes in each performance area. The CY2023 Q2 data call was received in a timely manner and results were aggregated by the EOHHS data team and presented at the November meeting using the data dashboard.

- LTSS System Modernization:
  - In Q2, the State submitted an updated Implementation Advance Planning Document (IAPD) and CMS approved it. BHDDH amended the contract with Wellsky.
  - In Q3, the state team identified a revised timeline for full Wellsky implementation in light of interdependencies with other state systems.
  - In Q4, the state continued to collaborate with Wellsky, with the aim of

rolling out Phase II capabilities in March 2024.

- State Plan Amendments:
    - In Q1, CMS approved four (4) SPAs.
    - In Q2, CMS approved six (6) SPAs.
    - In Q3, CMS approved two (2) SPAs.
    - In Q4, CMS approved four (4) SPAs.
- Other Programmatic Changed Related to the 1115 Waiver:
    - In Q2, EOHHS submitted a request to CMS to update the rate methodology for HCBS DD services, proposed to be effective 7/1/23.
    - In Q3, the State began making changes needed to transition approximately 60 participants from the Independent Provider program into the Personal Choice program, consistent with recent State legislation directing EOHHS to merge its two self-directed programs, Personal Choice and Independent Provider, into one program effective July 1.
    - In Q3, the State FY2024 Budget as Enacted, effective July 1, included $14.4 million (all funds) to support the State's implementation of person-centered planning and conflict-free case management.
    - In Q4, EOHHS submitted a request to CMS to update the rate methodology for HCBS case management services to support the transition to CFCM.
    - In Q4, EOHHS completed the transition of participants from the Independent Provider self-directed program to the Personal Choice self-directed program.

III. Enrollment Information

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

Note:

Enrollment counts should be participant counts, not participant months.

Summary:

The number of current enrollees as of the last day of the month in the reported quarter (December 31, 2023) with eligibility for full benefits is **344,658**. This count does not include another 2,619 members with full benefits but are eligible under Rhode Island's separate CHIP program (and not reflected in **Table III.1**). Nor does it include an additional **12,198** members with only limited Medicaid coverage.

This represents a 4.8% decrease in Medicaid enrollment (full benefits) over prior quarters. The decrease is due to the Rhode Island Unwinding of the continuous coverage requirement in place since the start of the of the Public Health Emergency in March 2020.

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

	DY13	DY14	DY15				
	Dec-21	Dec-22	Mar-23	Jun-23	Sep-23	Dec-23	Quarter Δ
01: ABD no TPL	15,633	15,526	15,809	16,018	16,248	16,075	-173
02: ABD TPL	34,486	36,854	37,141	37,334	36,770	34,708	-2,062
03: Rite Care	138,831	143,998	144,813	146,329	146,982	147,795	813
04: CSHCN	12,247	12,440	12,603	12,701	12,638	11,519	-1,119
05: Family Planning	1,369	1,104	1,082	1,038	991	955	-36
06: Pregnant Expansion	56	96	97	91	97	107	10
07: CHIP Children	33,617	33,924	34,746	34,037	34,616	35,365	749
10: Elders 65+ - OHA Copay	1,590	1,165	1,186	1,184	1,195	1,194	-1
14: BCCPT	87	93	96	97	72	49	-23
15: ORS CNOM	74	100	117	131	112	94	-18
17: Early Intervention	1,781	1,482	1,633	1,638	1,639	1,642	3
18: HIV	847	820	755	749	745	763	18
21: 217-like	4,705	5,141	5,284	5,493	5,561	5,527	-34
22: New Adult Group	103,750	112,592	115,020	114,937	109,029	93,513	-15,516
27: Undocumented Immigrants	59	55	74	73	64	47	-17
Grand Total	**349,132**	**365,390**	**370,456**	**371,850**	**366,759**	**349,353**	**-17,406**
Full Benefits Only	343,412	360,664	365,609	367,037	362,013	344,658	-17,355
Partial Benefits	5,720	4,726	4,847	4,813	4,746	4,695	-51

Notes to Table III.1:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the two prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. "03: Children with Special Healthcare Needs (CHSCN)" includes Budget Populations, "08: Substitute Care" and "09: CSHCN Alt."
3. "07: CHIP Children" includes members eligible under CMS 64.21U and CMS 21. The former reflects the state's CHIP Expansion program for low-income children, whereas the later includes pregnant women and unborn children who are eligible under the Separate CHIP program. Only the CMS 64.21U eligible members are eligible under the Rhode Island's 1115 financial reporting and so included above. Details on the members excluded from this Budget Population for purposes of calculating Rhode Island's Budget Neutrality PMPM are shown in Table III.1b.
4. "10: Elders 65+" includes members eligible under the (a) Office of Health Aging (OHA) CNOM program to assist elders paying for medically necessary Adult Day and Home Care services, and (b) Medicare Premium Payment (MPP) Only (i.e., QMB Only, SLMB, and Qualifying Individuals). The MPP Only subgroup, however, are excluded for purposes of calculating PMPM b/c these costs are invoiced in aggregate and only reported under "02: ABD TPL." Details on this Budget Population are shown in Table III.2.
5. "Hypothetical 03: IMD SUD" are reported here for informational purposes. The expenditures (for Budget Services 11 per the Rhode Island's 1115 Waiver) for such members are reported under the member's underlying eligibility group. Where these members appear for purposes of calculating Rhode Island's Budget Neutrality PMPM are shown in Table III.3.
6. "22: New Adult Group" and "Low-Income Adults" are used interchangeably.

Table III.2. Medicaid-Eligible members excluded for 1115 Budget Neutrality Calculations

	DY13	DY14	DY15					
			Mar-23	Jun-23	Sep-23	Dec-23	Quarter Δ	YTD Δ
07: Separate CHIP Children	2,277	2,912	3,039	3,200	3,314	2,619	-695	-293
10: Elders 65+ - MPP Only	7,373	7,069	7,033	7,071	7,239	7,503	264	434
99: Base	3	2	5	8	8	129	121	127

Notes to Table III.2:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the two prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. "07: CHIP Pregnant & Unborn" are members eligible under Rhode Island's Separate CHIP program. Their expenditures are reported under form CMS 21 and not included in the 1115 waiver reporting. These members are not included in **Table III.1**.
3. "10: Elders 65+ MPP Only" includes members eligible exclusively for support with their Medicare premium payments (i.e., QMB Only, SLMB, and Qualifying Individuals). The MPP Only subgroup is included in **Table III.1** but are excluded for purposes of calculating PMPM b/c these costs are invoiced in aggregate and only reported under "02: ABD TPL."

Table III.3. Medicaid-Eligible members receiving IMD SUD Services (Budget Services No. 11)

	DY13	DY14	DY15					
			Mar-23	Jun-23	Sep-23	Dec-23	Δ Quarter	Δ YTD
01: ABD no TPL	106	90	73	87	91	81	-10	-9
02: ABD TPL	19	5	7	8	6	10	4	5
03: Rite Care	59	54	40	37	41	37	-4	-17
04: CSHCN	2	7	7	2	3	2	-1	-5
21: 217-like	1		0	0	0	0	0	0
22: New Adult Group	487	391	338	342	383	345	-38	-46
Grand Total	**674**	**547**	**465**	**476**	**524**	**475**	**-49**	**-63**

Notes to Table III.3:

Notes to Table III.3:

1. "Snapshot" reporting includes members enrolled as of December 31 for each of the two prior Demonstration Years (DY) and last day of reported quarter(s) within the current DY.
2. Members using IMD SUD Budget Services meet the following criteria within the quarter:
   - Full Medicaid benefits
   - Aged between 21 and 64 years old inclusive.
   - Have at least one residential stay for SUD purposes at a state designated IMD within the fiscal quarter. Current list of IMDs providing with 16+ beds for SUD-related services include: The Providence Center, Phoenix House, MAP, Bridgemark, Adcare, and Butler Hospital
3. These counts will be updated (and increase) as more claims are paid and submitted to EOHHS thereby identifying more individuals with an IMD SUD related claim.

Number of Enrollees that Lost Eligibility

The number of enrollees eligible in the prior quarter who had lost eligibility for full Medicaid benefits as of the last day in the current quarter is **26,196**.

The cumulative count of terminations among those with full Medicaid benefits in the current demonstration year is **44,262**.

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

	DY13	DY14	DY15				
			Mar-23	Jun-23	Sep-23	Dec-23	YTD
01: ABD no TPL	632	778	167	183	214	565	978
02: ABD TPL	2,545	1,626	433	374	863	1,977	3,517
03: Rite Care	4,795	4,679	1,234	1,791	1,810	2,758	6,337
04: CSHCN	419	700	121	111	91	258	555
05: Family Planning	86	77	12	13	33	28	83
06: Pregnant Expansion	2	0	1	4	2	3	9
07: CHIP Children	1,087	1,013	271	417	291	377	205
10: Elders 65+ MPP Only			59	75	138	285	495
10: Elders 65+ OHA Copay	113	493	52	57	43	55	140
14: BCCPT	3	2			21	19	38
15: ORS CNOM	62	62	59	73	80	75	89
17: Early Intervention	1,020	1,036	225	276	268	218	863
18: HIV	82	92	85	25	28	18	127
21: 217-like	371	279	76	52	92	206	414
22: New Adult Group	4,301	4,225	1,175	3,450	9,394	19,990	32,084
27: Undocumented Immigrants	125	39	33	49	54	44	36
Grand Total	**15,643**	**15,101**	**4,003**	**6,950**	**13,422**	**26,876**	**45,970**
Subtotal - Full Medicaid	**14,202**	**13,926**	3,596	6,456	12,839	26,196	44,262

Notes to Table III.4:

1. Loss of Eligibility reflects complete the loss of Medicaid eligibility between subsequent reporting periods (i.e., member was eligible on March 31 but no longer eligible on June 30). Members who move from one eligibility group to another are not reported herein; nor are members who gained and lost eligibility within the same quarter.
2. Annual counts of members losing eligibility compares subsequent December 31 snapshots. Only those that lost all eligibility are counted. Members who lost eligibility and regained eligibility prior to end of DY would not be included; nor are members who gained and lost eligibility within the same DY.
3. Within current DY, YTD refers to number who have lost eligibility between December 31 of prior fiscal year and end of the most recent quarter. Members who regained eligibility in a quarter would not be counted.

IV. New"-to-"Continuing" Ratio

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. As of September 30, 2023, a total of **2,111** Medicaid-eligible members were in a self-directed HCBS program, including 1,025 in a program administered by EOHHS and 1,201 in a program for I/DD members and administered by Rhode Island's Department of Behavioral Health Developmental Disabilities & Hospitals (BHDDH).

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

	DY12	DY13	DY14	DY15				
				Mar-23	Jun-23	Sep-23	Dec-23	YTD Avg.
New	98	262	227	68	68	95	75	77
Continuing	437	464	631	835	885	930	987	910
Subtotal - EOHHS	**535**	**726**	**858**	**903**	**953**	**1,025**	**1,062**	**986**
Subtotal - BHDDH			**1,071**	**1,102**	**1,151**	**1,201**	**1,239**	**1,173**
Grand Total			**1,929**	**2,006**	**2,105**	**2,226**	**2,301**	**2,159**

Notes to Table IV.1:

1. Self-Directed includes Personal Choice and Independent Provider models as administered by Medicaid.
2. Additional self-directed members with an I/DD are administered by the Department of Behavioral Health, Developmental Disabilities, and Hospital, but are not reported herein.
3. "New" is defined as a member eligible for services on the last day of the quarter and not previously eligible for services on the last day of the prior quarter. "Continuing" means that the member was eligible for services across subsequent quarters.
4. For prior demonstration data, the counts reflect the average of the quarter-ending results within the year.

For figure for the BHDDH Self-Directed program for I/DD members represent total quarter-end snapshot only.

V. Special Purchases

The Rhode Island 1115 Comprehensive Demonstration Waiver includes a self-direction component. Below are the special purchases approved during DY15 January 1, 2023 – December 31, 2023 (by category or by type) with a total of **$22,620.21** for special purchases expenditures.

Q1 2023	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter medications		$ 301.48
	3	Acupuncture		$1,080.00
	12	Service Dog Training		$1,500.00
	4	Massage Therapy		$ 340.00
	7	Massage Float Therapy		$ 665.00
	4	Health Supplements		$ 1,186.32
	1	Adaptive Mobility Equipment		$ 1,319.13
	1	Membership Renewal – Medic Alert		$ 74.99
	CUMULATIVE TOTAL			**$ 6,466.92**

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

Q3 2023	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	1	Over the counter medications		$ 503.91
	2	Acupuncture		$ 600.00
	11	Service Dog Training		$1,375.00
	9	Massage Therapy		$ 765.00
	8	Massage Float Therapy		$ 505.00
	4	Supplements		$ 466.83
	1	Personal Hygiene		$ 149.98
	CUMULATIVE TOTAL			**$4,365.72**

Q4 2023	# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
	3	Acupuncture		$ 850.00
	11	Service Dog Training		$1,375.00
	1	Service Dog	Purchase - Final Payment	$2,500.00
	6	Massage Therapy		$ 570.00
	1	Massage Float Therapy		$ 95.00
	5	Supplements		$1,297.74
	1	Apple Watch Subscription		$ 63.23
	CUMULATIVE TOTAL			**$6,750.97**

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for January 1, 2023 – December 31, 2023.

Innovative Activities

Health System Transformation Project

On October 20, 2016, CMS approved the state's 1115 Waiver request to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain delivery system reform efforts. The RI HSTP proposes to foster and encourage this critical transformation of RI's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities. During Q1, the following activities occurred.

Accountable Entities (AEs)

Q1 2023

- All AEs applied for PY6 re-certification and have all been certified without conditions pending review of PY6 HSTP Project Plans, due 5/8/2023.
- The AEs continued working towards their PY5 HSTP Project Plan targets.
- The MCOs completed and shared OPY5 Q3 AEIP Quarterly Outcome Metrics with EOHHS.
- EOHHS continued to work with Bailit Health on the AE/MCO Quality Work Group and have developed proposed changes for the quality measure slate, the methodology used to set targets, and measure specification for the upcoming performance year (i.e., OPY7/QPY7). We will be reviewing the proposed changes with the AE/MCO Quality Work Group at the next two meetings 5/8 and 6/13 to gather feedback.
- The PCF and CPO Health Equity Zones (HEZs) that were given Participatory Budgeting grants created committees of community members called "budget delegates and change agents" who have been meeting on a weekly basis, to further develop ideas collected from their respective communities and turn those ideas into full-fledged project proposals.
- The Rhode to Equity (R2E) learning and action collaborative began to plan and develop their second and final year Bi-Annual Conference, where the cross-sector teams will come together to reflect on their projects and lessons learned over the course of the R2E program and discuss and explore new and sustainable ways to further create community linkages prospectively.

Q2 2023

- The review of all PY6 AE Project Plans that were submitted have been finalized and all communications were sent to the MCOs and AEs pertaining to approval.

- The AEs continued working towards their PY5 HSTP Project Plan targets.

- The MCOs completed and shared OPY5 Q4 AEIP Quarterly Outcome Metrics with EOHHS and communications were sent to the AE's pertaining to their performance.

- EOHHS continued to work with Bailit Health on the AE/MCO Quality Work Group and have developed proposed changes for the quality measure slate, the methodology used to set targets, and measure specification for the upcoming performance year (i.e., OPY7/QPY7). We will be reviewing the proposed changes with the AE/MCO Quality Work Group at the next two meetings 5/8 and 6/13 to gather feedback.

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

- The Rhode to Equity (R2E) learning and action collaborative held their second and final year Bi-Annual Conference, where the cross-sector teams came together to reflect on their projects and lessons learned over the course of the R2E program and discuss and explore new and sustainable ways to further create community linkages prospectively.

Q3 2023

- All 7 AE PY6 contract agreements have been signed.

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

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

- The PCF and CPO Health Equity Zones (HEZs) that were given Participatory Budgeting grants finalized the ideas collected from their respective communities and turned them

into formal project proposals with associated budgets. Community members from Pawtucket/Central Falls and Central Providence were then able to vote on which finalized projects they would like to see implemented in their community. Winning projects will now start the implementation process.

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

Q4 2023

- All seven AEs have been fully re-certified for PY6, with six taking on downside risk.

- Planning for Program Year (PY)7 has been completed and the Accountable Entity PY7 Roadmap and Sustainability Plan and all required Resource documents were posted for public comment and submitted to CMS.

- The MCOs completed and shared OPY6 Q2 AEIP Outcome Metrics with EOHHS and a communication was sent to the AE's pertaining to their performance.

- AE Quality Performance for PY5 (2022) was submitted to EOHHS from the MCOs in October 2023.

DSHP State Spending Analysis

No federal matching funds for support of DSHPs were claimed in SFY 2023.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in DY 15 January 1, 2023 – December 31, 2023.

Modernizing Health and Human Services Eligibility Systems

DY15 Q1

Between January 1 and March 30, 2023, the Medicaid Systems team and Deloitte implemented four (3) software releases to address 48 data fixes and 22 software enhancements for the RI Bridges eligibility system. These releases improved services for Medicaid Eligibility & Enrollment, Asset Verification System (AVS), Long Term Services and Supports, as well as functionality improvements to our mobile app (HealthyRhode) and our customer/worker interfaces. No significant program development or issues were identified.

DY15 Q2

Between April 1 and June 30, 2023, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 86 data fixes and 29 software enhancements for the RI Bridges eligibility system. These releases improved services for Medicaid Eligibility & Enrollment for Unwinding, Appeals Process Improvements, Human Services Programs Applications, Long Term Services and Supports, Returned Mail Operations, as well as functionality improvements to our customer/worker interfaces. No significant program development or issues were identified.

DY15 Q3

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

DY15 Q4

Between October 1 and December 31, 2023, the Medicaid Systems team and Deloitte implemented three (3) software releases to address 79 data fixes and 17 software enhancements for the RI Bridges eligibility system. These releases improved services for Medicaid Eligibility & Enrollment, Program Applications, Long Term Services and Supports, as well as functionality improvements to our customer/worker interfaces. No significant program development or issues were identified.

HCBS Conflict-Free Case Management

EOHHS is leading an interagency initiative to establish a statewide conflict-free case management (CFCM) program to serve Medicaid long-term services and supports (LTSS) beneficiaries who participate in the State's home and community-based services (HCBS) programs. A core

component of this initiative is the establishment of a contractual network of qualified CFCM entities with the capacity to serve approximately 11,000 Rhode Island HCBS participants who have a varying and changing array of LTSS needs.

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

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

DY15 Q1

In January, February, and March 2023, the statewide team continued to develop the CFCM implementation plan and communication strategy. Most notably:

- The Governor's FY2024 budget proposal was released in January, including the legislative authority and funding to support the State's implementation of CFCM. The General Assembly will continue to debate and revise this proposal until June, for an effective date of July 1, 2023. The interagency team continues to identify materials that will need to be updated upon approval, such as regulations.
- In February, EOHHS posted a summary of stakeholder feedback on the draft strategic plan along with the State's responses. An updated CFCM strategic plan was posted in February.
- In February, the State drafted a request for information (RFI) to assess provider capacity, which was released in March and closes April 7, 2023.
- In early February, following previous discussions with CMS regarding the State's compliance with CMS' CFCM regulations, EOHHS submitted a draft Corrective Action Plan (CAP) to outline the plan to achieve full compliance. The CAP was revised in early March, and on March 22, 2023, the State received CMS approval of the CAP.
- The State continues to hold small and large group sessions with external stakeholders to ensure that the process informed by all stakeholders, although stakeholder engagement was paused while the RFI was open.

DY15 Q2

In April, May, and June 2023, the statewide team continued to meet regularly to develop the CFCM implementation plan and communication strategy. Most notably:

- After receiving CMS approval on March 22, 2023, the State continued to implement its corrective action plan (CAP) for CFCM and provide monthly progress updates to CMS.
- Throughout Q2, the interagency team worked to develop a training

schedule and curriculum for case managers as well as fact sheets and other informational materials for participants and stakeholders to explain the new CFCM process. The team also developed initial training and phase-in plans to transition participants to CFCM.
    - The team also began development of a pilot program through a contract with the Paul V. Sherlock Center on Disabilities whereby business processes and training materials will be tested on a sample population in late CY 2023 before full implementation in CY 2024.
    - The State team posted an updated CFCM strategic plan and CFCM fact sheet to the EOHHS website for stakeholder review and comment on April 17. On May 11 and May 30, the interagency team held stakeholder engagement meetings to seek feedback and discuss updates to the strategic plan. The CAP was also posted publicly on May 24.
    - The General Assembly enacted the FY2024 budget on June 15, including the legislative authority to promulgate rule changes as well as funding to support the State's implementation of CFCM for the fiscal year beginning July 1.

DY15 Q3

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

    - **CAP Updates:** The State continued to implement its corrective action plan (CAP) for CFCM and provide monthly progress updates to CMS.

- **Moved from RFP to certification standards**: EOHHS reviewed feedback from the State's RFI and determined that it would pursue certification standards instead of an RFP. This new approach presents the greatest opportunity and flexibility for RI to meet CFCM capacity requirements. EOHHS began drafting the certification standards in Q3, to be posted for a 30-day public comment period in October.
- **Began monthly stakeholder webinars**: In August, EOHHS began monthly stakeholder meetings to gather feedback and share regular updates on key activities. EOHHS will hold monthly CFCM stakeholder meetings from August through December. During the State's first two meetings, it covered:
    - Updates to the CFCM implementation timeline;
    - Key policy changes;
    - An outline of the State's approach to stakeholder engagement;
    - An overview of roles and responsibilities under CFCM; and
    - The process for becoming a CFCM entity.
- **Posted additional stakeholder materials**: The team posted additional materials to support stakeholder education including a conflict-of-interest fact sheet, a CFCM fact sheet, and a flyer for participants. These documents are posted on the CFCM webpage.
- **Continued to design the State's case management system**: The team continued its work with WellSky, the vendor selected to provide the State's case management system.

DY15 Q4

In October, November, and December 2023, the interagency redesign team continued to meet regularly to develop the CFCM implementation plan and communication strategy. Most notably:

- **CAP Updates:** The State continued to implement its corrective action plan (CAP) for CFCM and provide monthly progress updates to CMS.

- **Certification Standards:** The State posted the draft EOHHS CFCM certification standards for public comment in October. The redesign team reviewed and responded to the comments and adjusted the certification standards accordingly. The response to comments, final certification standards, and application for certification will be posted in early 2024.
- **Stakeholder Engagement:** The State continues to hold targeted stakeholder meetings for HCBS participants and families, as well as HCBS providers and interested case management agencies. The State will continue to meet with providers and participants to disseminate information in a timely manner and ensure a smooth transition to conflict-free case management. An interagency communications team was developed to ensure the communications are streamlined and in plain language.
  - The State continues to post new documents and communications on the RI EOHHS CFCM webpage.
- **Continued to design the State's case management system**: The team continued its work with WellSky, the vendor selected to provide the State's case management system.

HCBS Quality Improvement

DY15 Q1

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

- **Project Governance Team:** In addition to overall project planning and leadership, the project governance team primarily focused on updating EOHHS' ISAs with its sister agencies. This work is ongoing and will continue into CY2023 as the team identifies areas to clarify partner expectations on items such as data sharing, group participation, and responding to inquires in a timely manner. The team also continues to update the HCBS Work Plan and identify the ongoing areas of focus for the remainder of CY2023.

- **Quality Improvement Team:** The full QIS team continued to convene biweekly to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups. The QIS team completed an outline for HCBS Common Provider Training requirements. The team will continue to work with leadership to determine the best methods to develop, implement and

maintain the trainings for current and new HCBS providers. Additionally, the team made progress with the development of a project charter by requesting each program office develop a data collection procedural document for their Service Plans and Health and Welfare measures. The purpose of these process documents is to ensure the data collection methodology is consistent each quarter, allowing accurate data comparisons across quarters and years and ensuring data can be collected in the future if there are changes in staff. The documents are maintained in a common HCBS QIS Teams space to be reviewed bi-annually.

- **Critical Incidents Subgroup:** The Critical Incident subgroup continued to meet monthly. First, the team finalized and shared a critical incident FAQ document with its members in English, Spanish, and Portuguese. The purpose of the document is to educate program participants about abuse, neglect, and exploitation and where to report incidents if they occur. The document will serve as starting point for each program and can be used as a supplement for education already in place. The document was provided in preparation for agencies to begin reporting out data on the Educating Families measure. The team also discussed and put forth a new proposal for the restrictive intervention measure and received approval from CMS on March 21, 2023. The new measure will be reflected in the June data call, covering Q1 data.

- **Data Analytics Subgroup:** The CY2022 Q3 data call, which was sent to program offices in December, was received in a timely manner by January 17. The results were aggregated by the EOHHS data team and presented at the February meeting using the data dashboard. The data team also submitted counts to CMS for the unduplicated number of individuals who received HCBS services in CY2022, as well as the projected individual counts for CY2023. Due to changes in which programs classify as HCBS, the previous unduplicated counts were revised to reflect the change in the baseline CY2022 metric. The data team continues to prepare for future changes in data collection measures once the WellSky system is implemented; this system will serve as a single data source across all state agencies. A member of the data team continues to participate in WellSky development meetings to ensure a smooth transition. On March 8, the CY2022 Q4 data template was sent to the program offices, to be returned in April.

DY15 Q2

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

- **Project Governance Team:** In addition to overall project planning and leadership, the project governance team focused on reviewing and updating the HCBS Work Plan. The governance team received approval from CMS regarding the removal of an Administrative Authority measure in June. The team is also reviewing potential new measures to begin tracking the settings requirements and standards. The team determined the benefit to individual check-ins with each agency, the purpose was shared with the greater quality

improvement team and meetings will be held in August. The team continues to follow the HCBS Work Plan and will continue to address items outlined for the remainder for CY2023.

- **Quality Improvement Team:** The full QIS team continued to convene biweekly to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups. Going forward, the team will meet monthly in CY2023 Q3 and beyond. The team also provided confirmation on their ability to track the new measures, which they will report on in the CY2023 Q3 templates. In the June meeting the team reviewed the CMS Proposed Access Rules and provided feedback as part of the comments Rhode Island submitted to CMS. Next steps will include developing a smooth implementation plan with input from each agency.

- **Critical Incidents Subgroup:** The Critical Incident subgroup continued to meet monthly. The subgroup supplemented data requests related to critical incidents. The group also took the lead on completing the HCBS Quality Annual Critical Incident Report to CMS; the report was submitted by the June 30 deadline. The team also completed the HCBS Quality Annual Deficiency Report, also submitted by the June 30 deadline. The group began collecting agency processes around their utilization of the critical incident FAQ document, which was finalized and shared with the quality improvement group in March. The group continues to review the performance measures and will make updates as the need arises.

- **Data Analytics Subgroup:** The CY2022 Q4 data call, which was sent to program offices in March, was received in a timely manner by April 17. The results were aggregated by the EOHHS data team and presented at the May meeting using the data dashboard. The presentation included a review of CY2022 Q4 data, as well as a Year Over Year Comparison of CY2022 and CY2023. A secondary May meeting provided an overview of the two new measures agencies will begin reporting on in CY2024 Q4, as well as information on how to document the measures within the reporting template. The data team also sent out reports of critical incidents without finalized actions to agencies to provide updates, these were received by June 30. The data team continues to prepare for future changes in data collection measures once the WellSky system is implemented; this system will serve as a single data source across all state agencies. A member of the data team continues to participate in WellSky development meetings to ensure a smooth transition. On June 16, the CY2023 Q1 data template was sent to the program offices, to be returned in July.

<u>DY15 Q3</u>

In July, August, and September 2023, the standing project governance team, quality improvement team, and Data Analytics subgroup continued to meet regularly.

- **Project Governance Team:** In addition to overall project planning and leadership, the project governance team focused on reviewing and updating the HCBS Work Plan. The

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

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

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

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

DY15 Q4

In October, November, and December 2023, the standing project governance team, quality improvement team, and Data Analytics subgroup continued to meet regularly.

- **Project Governance Team:** In addition to overall project planning and leadership, the project governance team focused on reviewing and updating the HCBS Work Plan. The governance team researched various experience of care tools to address standards in the HCBS Final Rule and Proposed Access Rule. The State currently uses the National Core Indicators-Intellectual and Developmental Disabilities (NCI-IDD) survey for participants receiving I/DD services through the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH). A memo was shared with leadership to utilize the National Core Indicators-Aging and Disability (NCI-AD) survey for the Elders and Adults with Disabilities (EAD) population. The memo was approved, and a contract was developed and sent to CMS for review. After receiving approval, the team will work to identify a survey vendor. The governance team also finalized and posted our core HCBS Provider Training, pursuant to the HCBS quality assurance requirements under 42 C.F.R. § 441.302 for all Rhode Island Medicaid HCBS providers and direct support professionals. The State is requiring annual completion of this training for anyone working directly with HCBS participants. The team continues to follow the HCBS Work Plan and will continue to address items outlined for CY2024.

- **Quality Improvement Team:** The full QIS team adjusted its cadence to a monthly meeting. This meeting still serves as a time to discuss highlights, areas for improvement, and to serve as a resource to work through concerns that arise in the Critical Incident and Data Analytics subgroups. The team identified the connection between of RI's implementation of conflict free case management (CFCM) and data collect of the QIS Performance Measures. In the November meeting, the team reviewed the Q2 data and addressed changes in each performance area.

- **Critical Incidents Subgroup:** The Critical Incident subgroup has paused the regular meeting cadence and convenes on an as needed basis. The group continues to review the performance measures and will make updates as the need arises. The group intends to restart regular meetings upon the official roll out of the Proposed Access rule and adjust the performance measures as needed.

- **Data Analytics Subgroup:** The CY2023 Q2 data call, which was sent to program offices in September, was received in a timely manner by October 16. The results were aggregated by the EOHHS data team and presented at the November meeting using the data dashboard. The data team continues to prepare for future changes in data collection measures once the WellSky system is implemented; this system will serve as a single data source across all state agencies. A member of the data team continues to participate in WellSky development meetings to ensure a smooth transition. On December 15, the CY2023 Q3 data template was sent to the program offices, to be returned in January.

LTSS System Modernization

<u>**DY15 Q2**</u>

Rhode Island continues to make progress towards implementing a true No Wrong Door System to improve the consumer experience with LTSS, reduce historic agency silos, and ensure compliance with the HCBS Final Rule. The State submitted an updated Implementation Advance Planning Document (IAPD) request on June 30, 2023. It was approved by CMS on August 9, 2023, allowing the State to utilize a 90/10 match for LTSS IT system modernization design, development, and implementation (DDI) activities not covered by HCBS E-FMAP. Additionally, our sister agency, BHDDH, successfully amended the contract with Wellsky. During Q4 the oversight of the Wellsky system was shifted to the State's Systems/IT team. The Systems/IT team has identified several interdependencies with Wellsky, the State's current eligibility system (RI Bridges), and the Medicaid claims system (MMIS) that might impact the implementation timeline.

DY15 Q3

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

DY15 Q4

The State continues to collaborate with the vendor Wellsky to develop and implement the single case management system for all HCBS participants. This system will require interfacing ability with the State's eligibility system, RI Bridges, and the MMIS billing system. This multi-phase project is currently in Phase II, with an anticipated rollout of Phase II capabilities in March.

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during the period of January 1, 2023 – December 31, 2023.

DY15 Q1

Request Type	Description	Date Submitted	CMS Action	Date
SPA	22-0018 Nursing Facility Rate Increase	11/18/22	Approved	2/8/23
SPA	22-0019 Nursing Facility Add-on Rate	11/18/22	Approved	2/8/23
SPA	22-0020 Children's Group Home Rate Increase	11/18/22	Approved	2/7/23

Request Type	Description	Date Submitted	CMS Action	Date
SPA	23-0001 DR SPA Emergency Case Management	1/30/23	Approved	2/8/23
SPA	23-0002 DR SPA RIte Smiles to 26	1/30/23	Withdrawn	2/15/23
SPA	23-0003 Nursing Facility Rate Methodology	1/30/23	Approved	4/24/23
SPA	23-0004 Former Foster Care Youth	3/31/23	Approved	6/15/23
SPA	23-0005 MNIL SSP Annual Update	3/31/23	Approved	5/18/23

DY15 Q2

Request Type	Description	Date Submitted	CMS Action	Date
SPA	21-0007 Psychiatric Residential Treatment Facilities (PRTF)	6/29/21	Approved	7/14/23
SPA	22-0024 Postpartum Coverage for 12 months	12/28/22	Approved	4/19/23
CHIP SPA	22-0025 Postpartum Coverage for 12 months	12/29/22	Approved	4/19/23
CHIP SPA (HSI)	22-0026 Postpartum Coverage for 12 months (conception to birth)	12/29/22	Approved	4/19/23
SPA	23-0006 Medicare Premium Payment Program	6/30/23	Approved	9/22/23

DY15 Q3

Request Type	Description	Date Submitted	CMS Action	Date
SPA	23-0007 First Connections Temporary Rate Increase	8/15/23	Approved	10/18/23
SPA	23-0008 Personal Needs Allowance	9/18/23	Approved	11/6/23
SPA	23-0009 DCYF Group Home Rate Increase	9/18/23	Approved	11/17/23
SPA	23-0010 Cedar Rates	9/20/23	Approved	12/11/23

DY15 Q4

Request Type	Description	Date Submitted	CMS Action	Date
SPA	23-0011 Ticket to Work	12/20/23	Pending	
SPA	23-0012 Ticket to Work	12/20/23	Pending	
SPA	23-0013 Clinician Services	12/27/23	Approved	2/14/24
SPA	23-0014 Vaccine Coverage	12/27/23	Approved	2/1/24

Rate Increases

DY15 Q2
On 4/6/23, EOHHS Submitted a request to CMS to update the rate methodology for HCBS DD services. These changes are proposed to be effective July 1, 2023.

DY15 Q3
The FY2024 Budget as Enacted, effective July 1, included $14.4 million (all funds) to support the State's implementation of person-centered planning and conflict-free case management.

DY15 Q4
On 11/21/23, EOHHS submitted a request to CMS to update the rate methodology for HCBS case management services to support the transition to CFCM. The State will consolidate a variety of codes and billing units into a single monthly rate of $170.87 for CFCM services.

Other Programmatic Changes Related to the 1115 Waiver

DY15 Q3
In June, the Governor signed legislation (2023-H-5991Aaa and 2023-S-1030Aaa) directing EOHHS to merge its two self-directed programs, Personal Choice and Independent Provider, into one program effective July 1. In Q3, EOHHS began making the program and policy changes needed to transition approximately 60 participants from the Independent Provider program into the Personal Choice program. EOHHS anticipates that the merger will be complete by October 2023.

DY15 Q4
EOHHS completed the transition of participants from the Independent Provider self-directed program to the Personal Choice self-directed program in October. EOHHS worked to draft new self-directed regulations, which were posted for public comment from November 8 through December 8, 2023. One comment was received. The response to comments and regulatory language will be finalized in early 2024.

Annual Public Forum

On October 31, 2023 at 8:30am, EOHHS hosted a Public Forum in order to afford the public an opportunity to provide comment on the progress of the Demonstration. The Forum took place

at 3 West Road in Cranston, RI. EOHHS posted the Annual Demonstration Monitoring Report for CY2022 on the EOHHS website in advance of the Forum.

EOHHS received four public comments during the Forum.

One commenter encouraged EOHHS to pursue opportunities to fund e-consults (professional consultations between, e.g., a primary care provider and a specialist). This commenter also encouraged EOHHS to fund “collaborative care codes,” including in the managed care context and to fund efforts to improve transitions of care when children “age out” of pediatric care and need to transition to an adult primary care provider.

Another commenter expressed support for the Community Health Worker benefit in the Medicaid state plan and encouraged EOHHS to consider whether the rates are adequate. Accountable Entities have been using HSTP funds to supplement the rates but will not be able to do so long-term due to the limited nature of that funding. This commenter also raised the point that Home Stabilization housing support specialists, authorized through the Demonstration, may be a more efficient route than CHWs for appropriate activities.

A third commenter encouraged EOHHS to explore options to enhance maternal health equity using peer-to-peer services and to maximize use of Moms PRN. This commenter encouraged EOHHS to maximize engagement in perinatal quality work.

The final commenter encouraged EOHHD to explore use of the Demonstration for workforce support, such as through loan repayment.

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

There were no significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for DY 15 January 1, 2023 – December 31, 2023 or allotment neutrality and CMS-21 reporting for the quarter. The Budget Neutrality Report can be found in Attachment E-XII., Enclosures –Attachments, Attachment 1: Rhode Island Budget Neutrality Report.

IX. Consumer Issues

January 1, 2023 – December 31, 2023

The Rhode Island Executive Office of Health and Human Services (RI EOHHS) employs procedures to monitor consumer issues across the managed care delivery system. These procedures include tracking, investigating and remediating Medicaid managed care consumer issues. Quarterly, the Managed Care Organizations (MCO) submit Prior Authorization (PA) requests, PA request denials, Appeals and Grievance reports to EOHHS. The State reviews reports to identify emerging consumer issues, trends and recommend actions to mitigate and/or improve member satisfaction. The Appeals and Grievances charts can be found in Section XII. Enclosures – Attachments - Attachment 2 – Appeals, Grievances and Complaints.

Currently there are three (3) medical MCOs and one (1) dental Prepaid Ambulatory Health Plan (PAHP) that are contracted with RI EOHHS to provide care to RI Medicaid eligible people enrolled in Managed Care:

- Neighborhood Health Plan of RI (NHPRI)*****,
- Tufts Health Public Plan RITogether (THRIT),
- United Healthcare Community Plan (UHCP-RI),
- United Healthcare Dental RIte Smiles (RIte Smiles)******.

***NHPRI** continues to be the only managed care organization that services the RIte Care for Children in Substitute Care populations.

****United Healthcare RIte Smiles** *RIte Smiles* is the dental plan for children and young adults who are eligible for Rhode Island Medicaid who were born after May 1, 2000.

Each Managed Care Organization (MCO) monitors consumer appeals, complaints, and tracks trends and/or emerging consumer issues through a formal Appeals and Grievance process. Additionally, all Grievance, Complaint, and Appeal reports are submitted to RI EOHHS on a quarterly basis.

Data is disaggregated according to Medicaid cohort:

- RIte Care
- Rhody Health Partners (RHP),
- Rhody Health Expansion, (RHE)
- Children with Special Health Care Needs (CSN),
- Children in Substitute Care (Sub Care). NHPRI ONLY

Consumer reported grievances are grouped into six (6) categories:

- access to care,

- quality of care,
- environment of care,
- health plan enrollment,
- health plan customer service
- billing Issues.

Consumer appeals are disaggregated into nine (9) categories:

- medical services,
- prescription drug services,
- radiology services,
- durable medical equipment,
- substance use disorder residential services,
- partial hospitalization services,
- detoxification services,
- opioid treatment services
- behavioral health services (non-residential).

Where appropriate, appeals and grievances directly attributed to Accountable Entities (AE) are indicated as a subcategory for each cohort and included in the total data.

In addition to the above, RI EOHHS monitors consumer issues reported by RIte Smiles. Consumer reported issues are grouped into three (3) categories:

- general dental services,
- prescriptions drug services
- dental radiology
- orthodontic services

The quarterly reports are reviewed by the RI EOHHS Compliance Officer and/or designee. Upon review, any concerning trends or issues of non-compliance identified by EOHHS are forwarded to the respective MCO. The Plan is then required to investigate the issue(s) and submit a report to EOHHS Medicaid Managed Care Oversight team within thirty (30) days of notification and, if appropriate, monthly at the EOHHS/MCO Oversight meeting. EOHHS Compliance department reviews submitted A&G quarterly reports for trends in member service dissatisfaction, including but not limited to, access to services, balance billing and quality of care.

Q1 2023

In Q1-2023 the appeals and grievance data reviews continue to remain an area of focus, particularly because of encounter data issues with the MCOs. However, to date and during q1, none have resulted in EOHHS implementing any corrective actions.

Given the previous (Q3 & Q4) performance in outpatient Behavioral Health (BH) care and

neuropsychological testing across all three (3) managed care organizations, EOHHS will continue to monitor these issues during oversight meetings. EOHHS required each MCO to submit their current Network Adequacy plan and provide in network contracting strategies to address current lack of in-network BH service access. EOHHS continued to build on its work related to Network Adequacy and oversight. Specifically, EOHHS directed Tufts to provide a full report including their outreach efforts and planning activities related to network adequacy and appropriate access to behavioral health services. Additionally, EOHHS requested THPP to begin collect BH drug utilization data during January of Q1 2023 to monitor trends as they related to BH drugs and in the context of Tuft's pharmacy benefit manager transition from CVS to OptumRX. There was nothing significant in the BH utilization that would warrant a concern.

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

Of note, EOHHS reviews for any increases in issues of dissatisfaction specifically attributed to Accountable Entities (AE).

NHPRI covers approximately 65% of Medicaid eligible members with UHCCP covering approximately 25% and RIT approximately 10% of Medicaid eligible members.

EOHHS Compliance is currently conducting an annual MCO/PAHP Appeals and Grievances audit. Anticipated to be completed at the end March 2023 due to a staffing transition.

DY15 Q1

MCO Prior Authorization and Denials Summary

NHPRI Q1-2023: Prior Authorizations and Denials: NHPRI reported twenty-two thousand and fifty-nine (22,059) PAs (across all cohorts) of which one thousand six hundred and eighty-one (1,681) PAs were denied representing an 7.62% denial rate. There is no substantive change in PA requests or denials from Q4-2022 (8.02%) to Q1 2023. Representing less than 1% increase in denial rate.

UHCCP Q1-2023: Prior Authorizations and Denials: UHCCP-RI reported seventeen thousand eight hundred and twelve (17,812) PAs (across all cohorts) of which three thousand seven hundred and twenty-nine (3,729) PAs were denied representing a 20.94% total denial rate. Representing an approximate increase of 2.94% in denial rate. Despite the fact that, UHCCP only makes up approximately 25% of the market share, their RIte Care PA requests made up 45% between them and NHPRI. EOHHS has requested that UHCCP Optum share their PA policies Radiology and pharmacy represent approximately 66.74% of all prior authorizations and 94.29% denials respectively. EOHHS is currently finalizing its annual Appeals and Grievance audit, causation for this anomaly will be reviewed and addressed during the audit process.

THRIT Q1-2023: Prior Authorizations and Denials: THRIT reported one thousand two hundred and nine (1,209) PAs (across all cohorts) of which one hundred and forty-five (145) PAs were denied representing 11.99% denial rate. There is no substantive change in PA requests or denials from Q4 2022 (12.13%) to Q1 2023. Representing less than 1% decrease in denial rate.

Dental (RIte Smiles) Q1-2023: Prior Authorizations and Denials: RIte Smiles reported a total of three thousand four hundred and sixty-two (3,462) PAs of which one thousand four hundred and seventy-three (1,473) PAs were denied representing 42.55% total denial rate. Requests for orthodontic services represent 45.49% denial rate which represents an additional decrease of more than .89% from Q4.

MCO Q1-2023: Appeals and Overturn Rate Summary

NHPRI Q1-2023: NHPRI reported a total of three hundred and sixty-seven (367) standard internal appeals, twenty (20) expedited internal appeals and one hundred and forty-six (146) state fair external hearings across all cohorts. Of the five hundred and thirty-three (533) total appeals, two hundred and three (203) appeals were overturned representing 38.09% overturn rate. Of the one hundred and forty-six (146) external appeals, forty-five (45), appeals, 31.03% were overturned.

UHCCP Q1-2023: UHCCP reported a total of one hundred and twenty-eight (128) standard internal appeals, one hundred (100) expedited internal and zero state fair- external hearings across all cohorts. Of the two hundred and twenty-eight (228) total appeals, one hundred and sixty-three (163) were overturned representing 71.49% overturn rate. There were no external appeals this quarter.

THRIT Q1-2023: THRIT reported a total of four (4) standard internal appeals, seven (7) expedited internal appeals and zero state fair – external hearings across all cohorts. Of the eleven (11) total appeals six (6) were overturned representing 54.55% overturn rate. There were no external appeals in Q1.

Dental (RIte Smiles) Q1-2023: RIte Smiles reported a total of forty-three (43) standard internal appeals and twelve (12) expedited state fair -external hearings. Of the fifty-five (55) total appeals eight (8) appeals were overturned representing 14.54% overturn rate. Denials for orthodontic services represented 100% of appeal requests. EOHHS is currently reviewing trends to ensure that members are fully aware to initiate an appeal given this trend.

MCO Q1-2023 Grievances and Complaints Summary

NHPRI Q1-2023: Grievances and Complaints: NHPRI reported a total of total of one hundred and six (106) Grievances and Complaints; fifty-four (54) Grievances and fifty-two (52) Complaints; eighteen (18) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the fifty-four (54) Grievances, thirty-four (34) represented quality of care issues, twenty (20) to access of care and zero (0) customer service issues. Access to care issues were related to in-network BH provider availability. There was a slight decrease (less than 1%) in

grievances/complaints from Q1 over Q4. This is being monitored during oversight and flagged as a part of the provider enrollment screening process related to the 21st Century CURES ACT.

UHCCP Q1-2023:_Grievances/Complaints: UHCCP-RI reported a total of seventeen (17) Grievances and Complaints; five (5) Grievances and twelve (12) Complaints; ten (10) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the seventeen (17) Grievances, four (4) represented quality of care issues. UHCCP comparatively receives more complaints regarding balance billing than the other two (2) MCOs. After meeting with UHCCP and reviewing the complaints, it appears provider offices confuse the Medicaid product with their commercial product. UHCCP educates those providers identified and ensures members are reimbursed where appropriate. There was a significant decrease in balance billing complaints in both Q1 and Q2, and no balance billing issue complaints in Q3 and Q4. EOHHS is monitoring this issue closely and will monitor/track and resolve any additional unforeseen risks/issues that may result due to this oversight.

THRIT Q1-2023: Grievances and Complaints: THRIT reported zero Grievances and zero Complaints in Q1-2023.

RIte Smiles (Dental) Q1-2023: Grievances and Complaints: RIte Smiles reported a total of zero consumer Grievance and two (2) Complaints in Q1-2023.

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

Q2 2023

In Q2-2023 the appeals and grievance data reviews continue to remain an area of focus, particularly because of encounter data issues with the MCOs. However, to date and during q1, none have resulted in EOHHS implementing any corrective actions.

An area of focus has continued to be Network Adequacy. EOHHS has continued to require each MCO to submit their current Network Adequacy plan and provide in network contracting strategies to address any lack of in-network BH service access. EOHHS continued to build on its work related to Network Adequacy and oversight. Specifically, EOHHS directed Tufts to provide a full report including their outreach efforts and planning activities related to network adequacy and appropriate access to behavioral health services. It is worth noting that THPP remained on a Corrective Action Plan for mainstreaming throughout Q2.

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

Of note, EOHHS evaluates trends in issues of dissatisfaction specifically attributed to Accountable

Entities (AE).

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

EOHHS Compliance is currently conducting an annual MCO/PAHP Appeals and Grievances audit. Anticipated to be completed at the end March 2023 due to a staffing transition.

DY15 Q2

MCO Prior Authorization and Denials Summary

NHPRI Q2-2023: Prior Authorizations and Denials: NHPRI reported twenty-one thousand nine hundred and twenty-three (21,923) PAs (across all cohorts) of which two thousand two hundred and twenty-eight (2,228) PAs were denied representing an 10.16% denial rate. There was slight increase in denials from Q1-2023 (7.62%) to Q2 2023. Representing a 2.54% increase in denial rate.

UHCCP Q2-2023: Prior Authorizations and Denials: UHCCP-RI reported seventeen thousand four hundred and seventy-five (17,475) PAs (across all cohorts) of which three thousand six hundred and forty-one (3,641) PAs were denied representing a 20.84% total denial rate. There was no substantive change in PA or denials from Q1 2023 (20.94%) to Q2 2023 representing less than 1% in the denial rate. Despite the fact that, UHCCP only makes up approximately 25% of the market share, their RIte Care PA requests made up 45% between them and NHPRI. EOHHS has requested that UHCCP Optum share their PA policies Radiology and pharmacy represent approximately 66.74% of all prior authorizations and 94.29% denials respectively.

THRIT Q2-2023: Prior Authorizations and Denials: THRIT reported one thousand two hundred and seventy-nine (1,279) PAs (across all cohorts) of which one hundred and sixty-one (161) PAs were denied representing 12.59% denial rate. There is no substantive change in PA requests or denials from Q1 2023 (11.99%) to Q2 2023. Representing less than 1% increase in denial rate.

Dental (RIte Smiles) Q2-2023: Prior Authorizations and Denials: RIte Smiles reported a total of three thousand one hundred and fifty-eight (3,158) PAs of which one thousand three hundred and thirty-nine (1,339) PAs were denied representing 42.40% total denial rate. Requests for orthodontic services represent 46.38% denial rate which represents an additional increase of more than .89% from Q1.

MCO Q2-2023: Appeals and Overturn Rate Summary

NHPRI Q2-2023: NHPRI reported a total of four hundred (400) standard internal appeals, four (4) expedited internal appeals and seventy-nine (79) state fair external hearings across all cohorts. Of the four hundred and eighty-three (483) total appeals, two hundred and six (206) appeals

were overturned representing 42.65% overturn rate. Of the seventy-nine (79) external appeals, twenty (20), appeals, 25.32% were overturned.

UHCCP Q2-2023: UHCCP reported a total of ninety-eight (98) standard internal appeals, ninety-six (96) expedited internal and zero state fair- external hearings across all cohorts. Of the one hundred and ninety-four (194) total appeals, one hundred and thirty-three (133) were overturned representing 68.56% overturn rate. There were no external appeals this quarter.

THRIT Q2-2023: THRIT reported a total of six (6) standard internal appeals, five (5) expedited internal appeals and zero state fair – external hearings across all cohorts. Of the eleven (11) total appeals five (5) were overturned representing 45.45% overturn rate. There were no external appeals in Q2.

Dental (RIte Smiles) Q2-2023: RIte Smiles reported a total of forty-six (46) standard internal appeals and thirteen (13) expedited state fair -external hearings. Of the fifty-nine (59) total appeals seven (7) appeals were overturned representing 11.86% overturn rate. Denials for orthodontic services represented 100% of appeal requests. EOHHS is currently reviewing trends to ensure that members are fully aware to initiate an appeal given this trend.

MCO Q2-2023 Grievances and Complaints Summary

NHPRI Q2-2023: Grievances and Complaints: NHPRI reported a total of total of ninety-seven (97) Grievances and Complaints; fifty-four (54) Grievances and forty-three (43) Complaints; sixteen (16) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the fifty-four (54) Grievances, thirty-nine (39) represented quality of care issues, fifteen (15) to access of care and zero (0) customer service issues. Access to care issues were related to in-network BH provider availability. There was a slight decrease (less than 1%) in grievances /complaints from Q2 over Q1. This is being monitored during oversight and flagged as a part of the provider enrollment screening process related to the 21st Century CURES ACT.

UHCCP Q2-2023: Grievances/Complaints: UHCCP-RI reported a total of thirty-three (33) Grievances and Complaints; sixteen (16) Grievances and seventeen (17) Complaints; twenty-six (26) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the thirty-three (33) Grievances, eight (8) represented quality of care issues and fourteen (14) represented balance billing issues. UHCCP comparatively receives more complaints regarding balance billing than the other two (2) MCOs. After making progress at the end of 2022, UHCCP has reported a significant increase in balance billing in Q1 and Q2 and trending upwards. This will be addressed in the monthly Oversight meetings.

THRIT Q2-2023: Grievances and Complaints: THRIT reported zero Grievances and zero Complaints in Q2-2023.

RIte Smiles (Dental) Q2-2023: Grievances and Complaints: RIte Smiles reported a total of zero consumer Grievance and three (3) Complaints in Q2-2023.

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

Q3 2023

In Q3-2023 the appeals and grievance data reviews continue to remain an area of focus, which is further demonstrated by the Annual Appeal and Grievance Audit for 2022, which officially commenced in Q3 2023.

An additional and continuing area of focus has continued to be Network Adequacy within the managed care. EOHHS has continued to require each MCO to submit their current Network Adequacy plan and provide in network contracting strategies to address any lack of in-network BH service access. EOHHS continued to build on its work related to Network Adequacy and oversight.

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

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

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

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

DY15 Q3

MCO Prior Authorization and Denials Summary

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

UHCCP Q3-2023: Prior Authorizations and Denials: UHCCP-RI reported fourteen thousand seven

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

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

Dental (RIte Smiles) Q3-2023: Prior Authorizations and Denials: RIte Smiles reported a total of two thousand eight hundred and seventy-one (2,871) PAs of which one thousand one hundred and eighty-one (1,181) PAs were denied representing 41.14% total denial rate. Requests for orthodontic services represent 46.23% denial rate which represents a decrease of more than .15% from Q2.

MCO Q3-2023: Appeals and Overturn Rate Summary

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

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

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

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

MCO Q3-2023 Grievances and Complaints Summary

NHPRI Q3-2023: Grievances and Complaints: NHPRI reported a total of total of one hundred and four (104) Grievances and Complaints; forty-eight (48) Grievances and fitty-four (56) Complaints;

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

UHCCP Q3-2023:_Grievances/Complaints: UHCCP-RI reported a total of forty-one (41) Grievances and Complaints; thirty-nine (39) Grievances and two (2) Complaints; twenty-three (23) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the thirty-nine (39) Grievances, two (2) represented quality of care issues and sixteen (16) represented balance billing issues. UHCCP comparatively receives more complaints regarding balance billing than the other two (2) MCOs. After making progress at the end of 2022, UHCCP has reported a slight increase in balance billing in Q2 and Q3 and trending upwards. A cursory review has determined this is largely due to Accountable Entities. his will once again be addressed in the monthly Oversight meetings with a request for the MCOs to provide additional analyses.

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

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

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

DY15 Q4

In Q4-2023 the appeals and grievance data reviews continue to remain an area of focus, which is further demonstrated by the Annual Appeal and Grievance Audit for 2022, which officially commenced in Q3 2023.

EOHHS has continued to require each MCO to submit their current Network Adequacy plan and provide in network contracting strategies to address any lack of in-network BH service access. EOHHS continued to build on its work related to Network Adequacy and oversight.

During Q34 Tufts remains on a Corrective Action Plan (CAP) related to network adequacy, specifically “mainstreaming.” EOHHS recently re-directed Tufts to provide an updated and detailed analysis regarding their o further their outreach efforts and planning activities related to network adequacy in all areas but with an emphasis both primary care and appropriate access to behavioral health services. The bulk of this effort was focused on mainstreaming the networks between commercial and Medicaid lines of business.

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

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

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

DY15 Q4

MCO Prior Authorization and Denials Summary

NHPRI Q4-2023:_Prior Authorizations and Denials: NHPRI reported nineteen thousand one hundred and ninety-seven (19,197) PAs (across all cohorts) of which one thousand six hundred and sixty-seven (1,667) PAs were denied representing an 8.69% denial rate. There was a slight increase (less than 1%) in denials from Q3-2023 to Q4 2023.

UHCCP Q4-2023: Prior Authorizations and Denials: UHCCP-RI reported fourteen thousand six hundred and seven (14,607) PAs (across all cohorts) of which three thousand two hundred and twenty-two (3,222) PAs were denied representing a 22.06% total denial rate. There was a slight increase (1%) in denials from Q3 2023 to Q4 2023.

THRIT Q4-2023: Prior Authorizations and Denials: THRIT reported four hundred and three (403) PAs (across all cohorts) of which forty-eight (48) PAs were denied representing 11.91% denial rate. There was a slight change in PA requests and denials from Q3 2023 to Q4 2023. Representing 1.12% increase in denial rate.

Dental (RIte Smiles) Q4-2023: Prior Authorizations and Denials: RIte Smiles reported a total of two thousand two hundred and ninety-five (2,295) PAs of which one thousand two hundred and forty-four (1,244) PAs were denied representing 42.53% total denial rate. Requests for orthodontic services represent 45.58% denial rate which represents a decrease of more than .65% from Q3.

MCO Q4-2023: Appeals and Overturn Rate Summary

NHPRI Q4-2023: NHPRI reported a total of three hundred and twelve (312) standard internal appeals, fourteen (14) expedited internal appeals and ninety (90) state fair external hearings across all cohorts. Of the four hundred and sixteen (416) total appeals, one hundred and sixty (160) appeals were overturned representing 38.46% overturn rate. Of the eighty-nine (89) external appeals, twenty-three (23) appeals or 25.84% were overturned.

UHCCP Q4-2023: UHCCP reported a total of thirty-five (35) standard internal appeals, eighty-one (81) expedited internal one (1) expedited external and zero state fair- external hearings across all cohorts. Of the one hundred and seventeen (117) total appeals, seventy (70) were overturned representing 59.83% overturn rate. There was one (1) external appeal in Q4.

THRIT Q4-2023: THRIT reported a total of four (4) standard internal appeals, fourteen (14) expedited internal appeals and zero state fair – external hearings across all cohorts. Of the eighteen (18) total appeals thirteen (13) were overturned representing 72.22% overturn rate. There were no external appeals in Q4.

Dental (RIte Smiles) Q4-2023: RIte Smiles reported a total of forty (40) standard internal appeals and eight (8) expedited state fair-external hearings. Of the forty-eight (48) total appeals nine (9) appeals were overturned representing 18.75% overturn rate. Denials for orthodontic services represented 66.67% of appeal requests. EOHHS is currently reviewing trends to ensure that members are fully aware to initiate an appeal given this trend. Additionally, EOHHS is working with Dental to ensure that continuity of care is taken into account when members in active ortho treatment churn off RIte Smiles due to the existence of commercial dental.

MCO Q4-2023 Grievances and Complaints Summary

NHPRI Q4-2023: Grievances and Complaints: NHPRI reported a total of total of seventy-nine (79) Grievances and Complaints; thirty-nine (39) Grievances and forty (40) Complaints; seventeen (17) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the thirty-nine (39) Grievances, thirty-one (31) represented quality of care issues, six (6) to access of care and zero (0) customer service issues. Access to care issues were related to in-network BH provider availability. There was a significant decrease (24.04%) in grievances/complaints from Q4 over Q3. This is being monitored during oversight and flagged as a part of the provider enrollment screening process related to the 21st Century CURES ACT.

UHCCP Q4-2023: Grievances/Complaints: UHCCP-RI reported a total of thirty-two (32) Grievances and Complaints; thirty-two (32) Grievances and zero Complaints; thirty (30) were directly attributed to Accountable Entities (AE). (AEs included in totals). Of the thirty-two (32) Grievances, one (1) represented quality of care issues and nine (9) represented balance billing issues. UHCCP comparatively receives more complaints regarding balance billing than the other two (2) MCOs. After making progress at the end of 2022, UHCCP has reported a slight increase in balance billing in Q2/Q3 and with a slight decrease in Q4. A cursory review has determined this is largely due to Accountable Entities. his will once again be addressed in the monthly Oversight meetings with a request for the MCOs to provide additional analyses.

THRIT Q4-2023: Grievances and Complaints: THRIT reported two (2) Grievances and zero Complaints in Q4-2023.

RIte Smiles (Dental) Q4-2023: Grievances and Complaints: RIte Smiles reported a total of zero

consumer Grievance and zero Complaint in Q4-2023.

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

EOHHS also participates in two advisory groups, the long-standing Consumer Advisory Committee (CAC) and the Integrated Care Initiative's ICI Implementation Council. CAC stakeholders include individuals who are enrolled in RIte Care, and representatives of advocacy groups, health plans, the Department of Human Services (DHS), and EOHHS. The CMS Regional Officer participates in these meetings as her schedule permits. The CAC met six (6) times in DY 15 January 1, - December 31, 2023:

January meeting agenda

- Welcome and Introductions
- Review of Minutes & Approval
- MAPCO Results
- Cover All Kids
- PHE Unwinding/Return to Pre-Pandemic Redeterminations
- Policy Update - SPAs
- Data Reports – Enrollment & Auto Assignment

March meeting agenda

- Welcome and Introductions
- Review of Minutes & Approval
- Return to Annual Medicaid Redeterminations/Renewals (also called “unwinding”)
- Cover All Kids Update
- Data Reports – Enrollment & Auto Assignment

May meeting agenda

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

July meeting agenda

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

September meeting agenda

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

November meeting agenda

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

The EOHHS Transportation Broker, Medical Transportation Management (MTM), reported on transportation related complaints. The following charts reflect the number of complaints compared to the transportation reservations and the top five complaint areas during DY 15 January 1, 2023 – September 30, 2023.

NEMT Analysis	Q1 2023	Q2 2023	Q3 2023	Q4 2023	DY15 YTD	
All NEMT & Elderly Complaints	271	292	309	329	1,201	
All NEMT & Elderly Trip Reservations	565,241	575,718	577,880	542,206	2,261,045	
Complaint Performance	0.05%	0.05%	0.05%	0.06%	0.05%	
Top 5 Complaint Areas						
Transportation Provider No Show	85	88	105	90	368	**1**
Transportation Broker Processes	29	39	45	45	158	**3**
Transportation Provider Behavior	37	42	35	36	150	**4**
Transportation Provider Late	45	51	44	56	196	**2**
Transportation Broker Client Protocols	20	11	20	32	83	
Driver Service/Delivery	19	24	25	29	97	**5**

X. Marketplace Subsidy Program Participation

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 142% and 179% of the Federal Poverty Level (FPL), who are not Medicaid eligible themselves, can apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. To obtain assistance, applicants must submit a request to EOHHS. Applications are available at the HeathSource RI Contact Center, online at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Application_for_State_Assistance_Program.pdf, or can be requested by calling RIte Share at (401) 462-0311. The application requires applicants to provide demographic information and information regarding enrollment in a Qualified Health Plan (QHP) through HealthSource RI.

For this quarter, the average monthly participation was 70 enrollees. The average subsidy was $29.60 per individual, with an average total of $2,072 per month.

Month	Marketplace Subsidy Program Participation	Change in Marketplace Participation	Average Subsidy per Enrollee	Total Subsidy Payments
January	123	6	$40.62	$4,996
February	83	(39)	$41.70	$3,461
March	81	(2)	$41.56	$3,366
April	53	(21)	$39.00	$2,067
May	61	8	$40.56	$2,474
June	66	5	$39.70	$2,620
July	62	(4)	$38.08	$2,361
August	60	(1)	$38.57	$2,314
September	50	(10)	$38.02	$1,901
October	51	1	$38.96	$1,987
November	101	50	$19.16	$1,935
December	58	(43)	$39.55	$2,294

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in DY 15, January 1, 2023 – December 31, 2023.

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

Monthly Oversight Review

Monthly, the RI EOHHS leads oversight and administration meetings with the State's four (4) Medicaid-participating managed care organizations (MCOs): NHPRI, UHCCP-RI, Tufts Health Public Plans (THPP) and UHC Dental. These monthly meetings are conducted separately with each MCO during the EOHHS MCO Oversight meetings; agenda items focus upon both standing areas of focus as well as emerging items related to quality assurance and oversight activities.

Areas of focus addressed during Q1:

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 1 (Q1) of 2023, the third quarter of State Fiscal Year (SFY) 2023:

Active Contract Management (ACM)

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

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

MCOs.
    - Support provider financial solvency efforts to critical services including MCO financial oversight, enhance APMs, CMS pre-prints as appropriate

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

MCOs focused on decreasing preventable ED utilization and increase COVID-19 vaccination rates for both boosters and newly eligible populations.

COVID-19 Public Health Emergency (PHE) Response Effort

During Q4, EOHHS and the three (3) medical MCOs, including NHPRI, UHCCP-RI, and THPP, continued to partner with EOHHS, RIDOH, school departments, faith-based organizations, provider offices, pediatrician and pediatric dentist offices, and accountable entities (AEs) to establish and align plans for disseminating the most important, updated vaccine-related information and the importance of parents and any other eligible household members to get vaccinated and boosters given the winter months and holidays which increase exposure and risk in Q4. MCOs executed upon their continuously evolving member and provider outreach plans. Member-specific outreach (and follow-up, as necessary) included but was not limited to phone calls, text messages, emails, direct mailings, and website and social media posts.

General Updates

- EOHHS continued work with MCOs concerning outreach and care coordination efforts to enhance provision of Early Intervention Services for members.
- EOHHS completed Wave 4 of 4, for Provider Screening – 21st Century Cures Act enrollment

requirements. Letters were mailed to providers on December 16, 2023. EOHHS is providing oversight to external vendor (Gainwell Technologies) re: compliance with the enrollment requirements with the 3 MCOs, and Dental plan. Meetings with both the vendor and MCOs are held on a weekly basis to ensure adherence with the project plan. Given the intense oversight and research related to compliance with the CURES ACT, compliance with the ACT has improved. However, there remains a discrepancy between the MCE's self-reported compliance rates and the rates reported by Gainwell. During edit testing it was discovered that the definitions of "in-network" differed between the MCEs and EOHHS. EOHHS helped to address this by refining a compendium that included clear guidance and definitions. EOHHS has hired a new compliance officer, who will started during Q1 2023. The compliance officer has worked to streamline the entire process and has created a path to escalate accordingly. Progress has been made and EOHHS continues to assess.

- EOHHS reviewed results of QIP Reports with each MCO and collected data to share with the EQRO
- MCOs continued to address any outstanding retro-payments related to reimbursement rates for children services including Early Intervention, which were increased retroactively to July 1, 2022.This work was scheduled to be completed by December 31,2022 but is not completed. EOHHS made this an agenda item for each respective plan until compliance is achieved. During Q1, this was achieved.
- EOHHS received confirmation from CMS that PHE would end on May 11, 2023. EOHHS has worked internally and with its MCO's to begin planning activities relative to redeterminations and eligibility. EOHHS continues to explore creative ways to mitigate the risk for fraud and abuse, as well as treatment disruption for members.

Specific to the unique details of Q1 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI informed EOHHS that they are switching specialty pharmacy from CVS as the PBM, to NHPRI acting as lead PBM and contracting with 3 pharmacies. EOHHS dedicated two meetings in Q3 and two in Q4 to ensure NHPRI had adequately planned for the transition, and to ensure that no member would be negatively impacted. NHPRI provided EOHHS with sufficient documentation that evidenced appropriate planning. NHPRI implemented the new specialty PBM during Q1 with no disruption for consumers or providers.
    - NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.

UnitedHealthcare Community Plan (UHCCP-RI)

- During Q1UHCCP oversight largely focused on subcontractor management related to their behavioral health vendor processing authorization for service and adjudicating claims. As noted in previous Q's, there were recent rate changes that required remediation and retroactive reimbursement. UHCCP/Optum reported that there was an issue with claims' denials that required a manual edit. Because the resolution process was manual, it required more time

which equated to monies owed to providers. EOHHS continues to monitor their progress towards completion as well as UHCCP's ability to adequately oversee their subcontractor. EOHHS has kept Optum Oversight as a standing agenda item during Q1.

- UHCCP case managers continued targeted outreach to members in areas with low COVID- 19 vaccination rates.

Tufts Health Public Plans (THPP)

- As noted on previous Q's EOHHS monitored THPP's transition to OptumRX from CVS as their pharmacy benefit manager. EOHHS oversaw the project planning and milestones very closely to adequately prepare for any unforeseen issues that may impact the implementation. Despite this, there was a significant disruption during January 2023, that resulted in issues with: members access, subcontractor oversight and the mainstreaming clause within the MCO contract. Due to the above infractions, THPP was placed on three

    (3) separate Corrective Action Plans (CAP) that included civil monetary penalties. THPP has been cooperative throughout the CAP process and despite issues in the beginning of Q1, progress was made in February and March 2023. By the end of the Q4. THPP had effectively closed two of their three corrective action plans.
- THPP continued to make progress to address encounter claims submission and has worked with EOHHS' data team accordingly.
    - THPP has also attended the provider enrollment meetings related to the 21st Century CURES Act and continued to be a solid partner.

      EOHHS continues to delve deeper into THPP's network adequacy given recent trends by member requests to change plans. EOHHS will continue to monitor THPP's Network Adequacy very closely and if necessary, will impose a plan to address. EOHHS is seeking to make Network Adequacy a formal Active Management Project in future Q's.

UnitedHealthcare-Dental (UHC Dental)

- EOHHS continued to monitor UHC Dental's availability for providers to offer services given the pandemic. UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to staffing shortages and pent-up demand. UHC Dental made great strides in establishing relationships with provider offices such that providers feel more supported and heard. Additionally, during Q1 EOHHS hired a new contract manager to oversee UHC dental.
- EOHHS continues to monitor adherence to the 21st Century CURES Act.

<u>Areas of focus addressed during Q2:</u>

Specific to quality improvement and compliance, the following areas of focus were addressed

during the cycle of oversight and administration meetings conducted during Quarter 2 (Q2) of 2023, the fourth quarter of State Fiscal Year (SFY) 2023:

Active Contract Management (ACM)

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

- **Goal 1**: Members receive quality care within all managed care delivery systems.
  - Integrate NEMT Member No-Show ACM Project to reduce member no-shows and increase coordination for at-risk members with handoff between vendors. Streamline work directly between MCOs and NEMT vendor.
  - Improve access to behavioral care services for both children and adults with BHDDH and DCYF.
  - Improve integration with medical MCOs and UHC Dental. Increase childhood P-DENT by 10% by end of CY22.
- **Goal 2**: Enhance financial & data analytic oversight of MCOs.
  - Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. Review and provide feedback to FDCR to promote better financial oversight and accountability). Resubmit missing/incomplete encounter data by January 1, 2022.
  - Increase oversight of MCO interventions concerning utilization such as avoidable ED usage and reduced health care diagnostic screenings from 2021 benchmarks. Provide MCOs high-utilizers to provide direct care interventions.
  - Establish 6-month error free operations/financial reporting goal for MCOs.
  - Support provider financial solvency efforts to critical services including MCO financial oversight, enhance APMs, CMS pre-prints as appropriate.
- **Goal 3**: Implement and oversee COVID-19 testing, treatment and vaccination.
  - Implement successful COVID-19 vaccination plan, with focus on addressing SDOH among all Medicaid populations to promote greater health equity. Establish 85% vaccination goal for Medicaid members by end of CY22.
  - Establish and streamline MCOs member outreach efforts to prevent duplications for members in coordination with RIDOH.
  - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
  - Support youth vaccination efforts, with a goal of 90% vaccination by end of CY22 for youth aged 5-17.
- **Goal 4**: Integrate development of Accountable Entities in Managed Care Oversight
  - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
  - MCOs to provide strategic plan to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery model.
  - Implementation of race, ethnicity, and language (REL) data collection process

    to identify gaps in care.
  - Support oversight efforts of MCO implementation of AE program, with a focus on program sustainability.

MCOs focused on decreasing preventable ED utilization and increase COVID-19 vaccination rates for both boosters and newly eligible populations.

General Updates

- EOHHS continues to make progress for Provider Screening – 21st Century Cures Act enrollment requirements. EOHHS has enlisted its vendor to manage the project from a technical perspective. EOHHS is providing oversight to external vendor (Gainwell Technologies) re: compliance with the enrollment requirements with the 3 MCOs, and Dental plan. Meetings with both the vendor and MCOs continue to be held on a weekly basis to ensure adherence with the project plan. Given the intense oversight and research related to compliance with the CURES ACT, compliance with the ACT has improved. However, there remains a discrepancy between the MCE's self-reported compliance rates and the rates reported by Gainwell. During edit testing it was discovered that the definitions of "in-network" differed between the MCEs and EOHHS. EOHHS helped to address this by refining a compendium that included clear guidance and definitions. EOHHS has hired a new compliance officer, who will started during Q1 2023. The compliance officer has worked to streamline the entire process and has created a path to escalate accordingly. Progress has been made and EOHHS continues to assess.
- EOHHS reviewed results of QIP Reports with each MCO and collected data to share with the EQRO.
- EOHHS received confirmation from CMS that PHE would end during Q2 on May 11, 2023. EOHHS has worked internally and with its MCO's to begin planning activities relative to redeterminations and eligibility. EOHHS continues to explore creative ways to mitigate the risk for fraud and abuse, as well as treatment disruption for members. The MCOs have offered to assist within federal guidelines and their efforts have proven to be helpful.

Specific to the unique details of Q2 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.

UnitedHealthcare Community Plan (UHCCP-RI)

- During Q2, UHCCP oversight largely focused on subcontractor management related to their behavioral health vendor processing authorization for service and adjudicating claims. As noted in previous Q's, there were recent rate changes that required remediation and retroactive reimbursement. UHCCP/Optum reported that there was an issue with claims' denials that required a manual edit. Because the resolution process was manual, it required more time which equated to monies owed to providers. EOHHS continues to monitor their progress towards completion as well as UHCCP's ability to

adequately oversee their subcontractor. EOHHS has kept Optum Oversight as a standing agenda item during Q2.

- UHCCP case managers continued targeted outreach to members in areas with low COVID-19 vaccination rates.

Tufts Health Public Plans (THPP)

- As noted on previous Q's EOHHS monitored THPP's transition to OptumRX from CVS as their pharmacy benefit manager. EOHHS oversaw the project planning and milestones very closely to adequately prepare for any unforeseen issues that may impact the implementation. Despite this, there was a significant disruption during January 2023, that resulted in issues with: members access, subcontractor oversight and the mainstreaming clause within the MCO contract. Due to the above infractions, THPP was placed on three (3) separate Corrective Action Plans (CAP) that included civil monetary penalties. THPP has been cooperative throughout the CAP process and despite issues in the beginning of Q1, progress was made throughout Q2.
- THPP continued to make progress to address encounter claims submission and has worked with EOHHS' data team accordingly.
- THPP has attended the provider enrollment meetings related to the 21st Century CURES Act and continued to be a solid partner. EOHHS continues to delve deeper into THPP's network adequacy given recent trends by member requests to change plans. EOHHS will continue to monitor THPP's Network Adequacy very closely and if necessary, will impose a plan to address. EOHHS is seeking to make Network Adequacy a forma Active Management Project in future Q's.

UnitedHealthcare-Dental (UHC Dental)

- EOHHS continued to monitor UHC Dental's availability for providers to offer services given the pandemic. UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to staffing shortages and pent-up demand. UHC Dental made great strides in establishing relationships with provider offices such that providers feel more supported and heard. Additionally, during Q2 EOHHS new contract manager has fully integrated in the oversight role and has taken over the monthly meetings.
- EOHHS is currently working with UHC Dental to ensure adherence to CURES ACT. During Q2, UHC Dental has done a remarkable job with enrolling and screening providers. They are significantly further along than their counterparts.

<u>Areas of focus addressed during Q3:</u>

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 3 (Q3) of 2023, the fourth quarter of State Fiscal Year (SFY) 2023:

Active Contract Management (ACM)

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

- **Goal 1**: Members receive quality care within all managed care delivery systems.
    - Integrate NEMT Member No-Show ACM Project to reduce member no-shows and increase coordination for at-risk members with handoff between vendors. Streamline work directly between MCOs and NEMT vendor.
    - Improve access to behavioral care services for both children and adults with BHDDH and DCYF.
    - Improve integration with medical MCOs and UHC Dental. Increase childhood P-DENT by 10% by end of CY22.
- **Goal 2**: Enhance financial & data analytic oversight of MCOs.
    - Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. Review and provide feedback to FDCR to promote better financial oversight and accountability).
    - Increase oversight of MCO interventions concerning utilization such as avoidable ED usage and reduced health care diagnostic screenings from 2021 benchmarks. Provide MCOs high-utilizers to provide direct care interventions.
    - Establish 6-month error free operations/financial reporting goal for MCOs.
    - Support provider financial solvency efforts to critical services including MCO financial oversight, enhance APMs, CMS pre-prints as appropriate.
- **Goal 3**: Implement and oversee COVID-19 testing, treatment and vaccination.
    - Implement successful COVID-19 vaccination plan, with focus on addressing SDOH among all Medicaid populations to promote greater health equity. Establish 85% vaccination goal for Medicaid members by end of CY22.
    - Establish and streamline MCOs member outreach efforts to prevent duplications for members in coordination with RIDOH.
    - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
    - Support youth vaccination efforts, with a goal of 90% vaccination by end of CY22 for youth aged 5-17.
- **Goal 4**: Integrate development of Accountable Entities in Managed Care Oversight
    - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
    - MCOs to provide strategic plan to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery model.
    - Implementation of race, ethnicity, and language (REL) data collection process to identify gaps in care.
    - Support oversight efforts of MCO implementation of AE program, with a focus on program sustainability.

MCOs focused on decreasing preventable ED utilization and increase COVID-19 vaccination rates for both boosters and newly eligible populations.

General Updates

- EOHHS continues to make gains towards compliance for Provider Screening – 21st Century Cures Act enrollment requirements. EOHHS has enlisted its vendor to manage the project from a technical perspective. EOHHS is providing oversight to external vendor (Gainwell Technologies) re: compliance with the enrollment requirements with the 3 MCOs, and Dental plan. Meetings with both the vendor and MCOs continue to be held on a weekly basis to ensure adherence with the project plan. Given the intense oversight and research related to compliance with the CURES ACT, compliance with the ACT has improved. However, there remains a discrepancy between the MCE's self-reported compliance rates and the rates reported by Gainwell. During edit testing it was discovered that the definitions of "in-network" differed between the MCEs and EOHHS. EOHHS helped to address this by refining a compendium that included clear guidance and definitions. This effort is being monitored closely with completion date of 2/1/2024. y 1, 2023.
- EOHHS reviewed results of QIP Reports with each MCO and collected data to share with the EQRO.
- EOHHS received confirmation from CMS that PHE would end during Q2 on May 11, 2023. EOHHS has worked internally and with its MCO's to begin activities related to redeterminations and eligibility. To date, Rhode Island's "Return To Normal Operations" has proven to be a multi-agency collaborative effort with much success. EOHHS continues to explore creative ways to mitigate the risk for fraud and abuse, as well as treatment disruption for members. The MCOs have assisted within federal guidelines and their efforts have proven to be helpful.

Specific to the unique details of Q4 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.

UnitedHealthcare Community Plan (UHCCP-RI)

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

- UHCCP case managers continued targeted outreach to members in areas with low COVID-19 vaccination rates.

Tufts Health Public Plans (THPP)

- As noted on previous Q's EOHHS monitored THPP's transition to OptumRX from CVS as their pharmacy benefit manager. EOHHS oversaw the project planning and milestones very closely to adequately prepare for any unforeseen issues that may impact the implementation. Despite this, there was a significant disruption during January 2023, that resulted in issues with: members access, subcontractor oversight and the mainstreaming clause within the MCO contract. Due to the above infractions, THPP was placed on three (3) separate Corrective Action Plans (CAP) that included civil monetary penalties. THPP has been cooperative throughout the CAP process and despite issues in the beginning of Q1, progress was made throughout Q2 and Q3, with only one CAP remaining.
- THPP continued to make progress to address encounter claims submission and has worked with EOHHS' data team accordingly.
- THPP has attended the provider enrollment meetings related to the 21st Century CURES Act and continued to be a solid partner. EOHHS continues to delve deeper into THPP's network adequacy given recent trends by member requests to change plans. EOHHS will continue to monitor THPP's Network Adequacy very closely and if necessary, will impose a plan to address. EOHHS is seeking to make Network Adequacy a formal Active Contract Management Project in future Q's.

UnitedHealthcare-Dental (UHC Dental)

- EOHHS continued to monitor UHC Dental's availability for providers to offer services given the pandemic. UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to staffing shortages and pent-up demand. UHC Dental made great strides in establishing relationships with provider offices such that providers feel more supported and heard. Additionally, during Q2 EOHHS new contract manager has fully integrated in the oversight role and has taken over the monthly meetings.
- EOHHS is currently working with UHC Dental to ensure adherence to CURES ACT. During Q4, UHC Dental has continued to make progress and remains significantly further along than their counterparts.

Areas of focus addressed during Q4:

Specific to quality improvement and compliance, the following areas of focus were addressed during the cycle of oversight and administration meetings conducted during Quarter 4 (Q4) of 2023, the fourth quarter of State Fiscal Year (SFY) 2023:

Active Contract Management (ACM)

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

- **Goal 1**: Members receive quality care within all managed care delivery systems.
  - Integrate NEMT Member No-Show ACM Project to reduce member no-shows and increase coordination for at-risk members with handoff between vendors. Streamline work directly between MCOs and NEMT vendor.
  - Improve access to behavioral care services for both children and adults with BHDDH and DCYF.
  - Improve integration with medical MCOs and UHC Dental. Increase childhood P-DENT by 10% by end of CY22.
- **Goal 2**: Enhance financial & data analytic oversight of MCOs.
  - Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. Review and provide feedback to FDCR to promote better financial oversight and accountability).
  - Increase oversight of MCO interventions concerning utilization such as avoidable ED usage and reduced health care diagnostic screenings from 2021 benchmarks. Provide MCOs high-utilizers to provide direct care interventions.
  - Establish 6-month error free operations/financial reporting goal for MCOs.
  - Support provider financial solvency efforts to critical services including MCO financial oversight, enhance APMs, CMS pre-prints as appropriate.
- **Goal 3**: Implement and oversee COVID-19 testing, treatment and vaccination.
  - Implement successful COVID-19 vaccination plan, with focus on addressing SDOH among all Medicaid populations to promote greater health equity. Establish 85% vaccination goal for Medicaid members by end of CY22.
  - Establish and streamline MCOs member outreach efforts to prevent duplications for members in coordination with RIDOH.
  - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
  - Support youth vaccination efforts, with a goal of 90% vaccination by end of CY22 for youth aged 5-17.
- **Goal 4**: Integrate development of Accountable Entities in Managed Care Oversight
  - Identify and improve on gaps in care that should be reduced through MCO-AE intervention strategies, such as case management referrals to high utilizers.
  - MCOs to provide strategic plan to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery model.
  - Implementation of race, ethnicity, and language (REL) data collection process to identify gaps in care.
  - Support oversight efforts of MCO implementation of AE program, with a focus on program sustainability.

MCOs focused on decreasing preventable ED utilization and increase COVID-19 vaccination rates for both boosters and newly eligible populations.

General Updates

- EOHHS continues to make gains towards compliance for Provider Screening – 21st Century Cures Act enrollment requirements. EOHHS is providing oversight to external vendor (Gainwell Technologies) re: compliance with the enrollment requirements with the 3 MCOs, and the children's Dental plan. Meetings with both the vendor and MCOs continue to be held on a weekly basis to ensure adherence with the project plan. Given the intense oversight and research related to compliance with the CURES ACT, compliance with the ACT has improved. EOHHS helped to address this by refining a compendium that included clear guidance and definitions. This effort is being monitored closely with completion date of 2/1/2024.
- EOHHS reviewed results of QIP Reports with each MCO and collected data to share with the EQRO.
- EOHHS has contiued to work internally and with its MCO's related to redeterminations and eligibility.
    - To date, Rhode Island's "Return To Normal Operations" has proven to be a multi-agency collaborative effort with much success. EOHHS continues to explore creative ways to mitigate the risk for fraud and abuse, as well as treatment disruption for members. The MCOs have assisted within federal guidelines and their efforts have proven to be helpful.

Specific to the unique details of Q4 oversight, pertaining to each MCO, see below:

Neighborhood Health Plan of Rhode Island (NHPRI)

- NHPRI continued to work with RIDOH to obtain vaccination data for NHPRI members.
- NHPRI also reported that they were transitioning from their sub-contracted care management vendor and taking on that work internally. They are currently in the process of transition planning.

UnitedHealthcare Community Plan (UHCCP-RI)

- During Q4, UHCCP oversight largely focused on subcontractor management related to their behavioral health vendor processing authorization for service and adjudicating claims. As noted in previous Q's, there were recent rate changes that required remediation and retroactive reimbursement. UHCCP/Optum reported that there was an issue with claims' denials that required a manual edit. Because the resolution process was manual, it required more time which equated to monies owed to providers. EOHHS continues to monitor their progress towards completion as well as UHCCP's ability to adequately oversee their subcontractor.
- UHCCP case managers continued targeted outreach to members in areas with low COVID-19 vaccination rates.

Tufts Health Public Plans (THPP)

- As noted on previous Q's EOHHS monitored THPP's transition to OptumRX from CVS as their pharmacy benefit manager. EOHHS oversaw the project planning and milestones very closely to adequately prepare for any unforeseen issues that may impact the implementation. Despite this, there was a significant disruption during January 2023, that resulted in issues with: members access, subcontractor oversight and the mainstreaming clause within the MCO contract. Due to the above infractions, THPP was placed on three (3) separate Corrective Action Plans (CAP) that included civil monetary penalties. THPP has been cooperative throughout the CAP process and despite issues in the beginning of Q1, progress was made throughout Q2 and Q3, with only one CAP remaining.
- THPP continued to make progress to address encounter claims submission and has worked with EOHHS' data team accordingly.
- THPP has attended the provider enrollment meetings related to the 21st Century CURES Act and continued to be a solid partner. EOHHS continues to delve deeper into THPP's network adequacy given recent trends by member requests to change plans. EOHHS will continue to monitor THPP's Network Adequacy very closely and if necessary, will impose a plan to address. EOHHS is seeking to make Network Adequacy a formal Active Contract Management Project in future Q's.

UnitedHealthcare-Dental (UHC Dental)

- EOHHS continued to monitor UHC Dental's availability for providers to offer services given the pandemic. UHC Dental continued to regularly meet with provider offices across Rhode Island to understand and monitor the current status of network capacity, access barriers due to staffing shortages and pent-up demand. UHC Dental made great strides in establishing relationships with provider offices such that providers feel more supported and heard. Additionally, during Q2 EOHHS new contract manager has fully integrated in the oversight role and has taken over the monthly meetings.
- EOHHS is currently working with UHC Dental to ensure adherence to CURES ACT. During Q4, UHC Dental has continued to make progress and remains significantly further along than their counterparts.

XII. Enclosures/Attachments

Attachment 1: Rhode Island Budget Neutrality Report

Table A1.1 MEMBER MONTHS (ACTUALS)

	Historical:		Current:				
	DY 13	DY 14			DY 15		
Medicaid Eligibility Group (MEG)	2021	2022	31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	186,735	187,749	47,352	48,056	48,734	48,503	192,645
ABD TPL	389,246	429,626	111,220	111,924	111,021	106,371	440,536
RIte Care	2,050,133	2,105,658	537,611	541,162	544,220	549,036	2,172,029
CSHCN	146,946	147,992	37,581	38,018	38,003	34,962	148,564
217-like Group	54,812	59,217	15,673	16,301	16,637	16,616	65,227
Family Planning Group	18,159	14,185	3,268	3,148	3,038	2,882	12,336
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Low-Income Adult	1,192,867	1,300,472	343,123	347,235	335,934	295,369	1,321,661
Additional Populations & CNOMS	56,713	47,065	11,242	11,272	11,240	11,255	45,009
Average Count of Members with Full Benefits	*335,062*	*352,560*	*364,187*	*367,565*	*364,850*	*350,286*	*361,722*

Notes to Member Months (Actuals)

1. RIte Care includes: 03: Rite Care, 06: Pregnant Expansion, 07: CHIP Children
2. SUD IMD member months reallocated to their underlying eligibility group. Approximately, 70% are reported within the Low-Income Adult Group.
3. Additional Populations & CNOMS include Early Intervention Only, ORS CNOM, Elders 65+.

Table A1.2 WITHOUT WAIVER PMPM

Medicaid Eligibility Group (MEG)	Historical: DY 13 2021	Historical: DY 14 2022	Current: DY 15 31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 3,576	$ 3,730	$ 3,891	$ 3,891	$ 3,891	$ 3,891	$ 3,891
ABD TPL	$ 4,043	$ 4,217	$ 4,398	$ 4,398	$ 4,398	$ 4,398	$ 4,398
RIte Care	$ 650	$ 683	$ 719	$ 719	$ 719	$ 719	$ 719
CSHCN	$ 3,789	$ 3,978	$ 4,177	$ 4,177	$ 4,177	$ 4,177	$ 4,177
217-like Group	$ 4,488	$ 4,627	$ 4,770	$ 4,770	$ 4,770	$ 4,770	$ 4,770
Family Planning Group	$ 27	$ 28	$ 30	$ 30	$ 30	$ 30	$ 30
SUD IMD	$ 4,411	$ 4,649	$ 4,900	$ 4,900	$ 4,900	$ 4,900	$ 4,900
Low-Income Adult	$ 1,097	$ 1,153	$ 1,212	$ 1,212	$ 1,212	$ 1,212	$ 1,212
Composite PMPM for Members with Full Benefits	*$ 1,414*	*$ 1,492*	*$ 1,563*	*$ 1,565*	*$ 1,566*	*$ 1,555*	*$ 1,562*

Table A1.3 WITHOUT WAIVER TOTAL EXPENDITURES

Medicaid Eligibility Group (MEG)	Historical: DY 13 2021	Historical: DY 14 2022	Current: DY 15 31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 667,828,363	$ 700,327,330	$ 184,223,945	$ 186,962,872	$ 189,600,645	$ 188,701,934	$ 749,489,396
ABD TPL	$ 1,573,594,779	$ 1,811,521,997	$ 489,125,444	$ 492,221,509	$ 488,250,278	$ 467,800,419	$ 1,937,397,650
RIte Care	$ 1,331,874,962	$ 1,439,080,183	$ 386,528,075	$ 389,081,150	$ 391,279,771	$ 394,742,348	$ 1,561,631,345
CSHCN	$ 556,764,673	$ 588,764,263	$ 156,985,967	$ 158,811,434	$ 158,748,775	$ 146,045,698	$ 620,591,874
Subtotal - Without Waiver	**$ 4,130,062,777**	**$ 4,539,693,774**	**$ 1,216,863,431**	**$ 1,227,076,965**	**$ 1,227,879,469**	**$ 1,197,290,400**	**$ 4,869,110,265**
217-like Group	$ 245,983,259	$ 273,990,162	$ 74,765,177	$ 77,760,936	$ 79,363,763	$ 79,263,586	$ 311,153,462
Family Planning Group	$ 487,646	$ 401,117	$ 97,309	$ 93,736	$ 90,460	$ 85,815	$ 367,320
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
New Adult Group	$ 1,308,675,527	$ 1,499,490,362	$ 415,810,277	$ 420,793,364	$ 407,098,357	$ 357,940,056	$ 1,601,642,054

Budget Neutrality Tables II

Table A1.4 HYPOTHETICALS ANALYSIS

Medicaid Eligibility Group (MEG)	Historical: DY 13 2021	Historical: DY 14 2022	Current: DY 15 31-Mar-23	Current: DY 15 30-Jun-23	Current: DY 15 30-Sep-23	Current: DY 15 31-Dec-23	Current: DY 15 YTD
Without Waiver Expenditure Baseline	$ 246,470,905	$ 274,391,279	$ 74,862,486	$ 77,854,672	$ 79,454,223	$ 79,349,401	$ 311,520,781
With Waiver Expenditures (Actuals):							
217-like Group	$ 213,980,940	$ 249,615,556	$ 51,113,045	$ 50,912,205	$ 53,488,719	$ 57,195,674	$ 212,709,644
Family Planning Group	$ 245,689	$ 167,696	$ 40,713	$ 29,420	$ 28,054	$ 26,838	$ 125,025
SUD IMD	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal - Actuals	**$ 214,226,629**	**$ 249,783,252**	**$ 51,153,758**	**$ 50,941,625**	**$ 53,516,773**	**$ 57,222,512**	**$ 212,834,669**
Excess Spending: Hypotheticals	$ (32,244,276)	$ (24,608,027)	$ (23,708,728)	$ (26,913,047)	$ (25,937,450)	$ (22,126,889)	$ (98,686,112)

Table A1.5 LOW INCOME ADULT ANALYSIS

Medicaid Eligibility Group (MEG)	Historical: DY 13 2021	Historical: DY 14 2022	Current: DY 15 31-Mar-23	Current: DY 15 30-Jun-23	Current: DY 15 30-Sep-23	Current: DY 15 31-Dec-23	Current: DY 15 YTD
Without Waiver Expenditure Baseline	$ 1,308,675,527	$ 1,499,490,362	$ 415,810,277	$ 420,793,364	$ 407,098,357	$ 357,940,056	$ 1,601,642,054
With Waiver Expenditures (Actuals)	**$ 749,543,250**	**$ 772,853,442**	**$ 163,087,393**	**$ 158,493,794**	**$ 141,525,261**	**$ 150,333,130**	**$ 613,439,578**
Excess Spending: New Adult Group	$ (559,132,277)	$ (726,636,920)	$ (252,722,884)	$ (262,299,570)	$ (265,573,096)	$ (207,606,926)	$ (988,202,476)

Table A1.6 WITH WAIVER TOTAL ANALYSIS

Medicaid Eligibility Group (MEG)	Historical: DY 13 2021	DY 14 2022	Current: DY 15 31-Mar-23	30-Jun-23	30-Sep-23	31-Dec-23	YTD
ABD no TPL	$ 512,917,727	$ 429,616,225	$ 87,162,461	$ 82,165,600	$ 86,598,295	$ 99,678,816	$ 355,605,172
ABD TPL	$ 713,173,265	$ 716,972,584	$ 145,695,680	$ 163,598,142	$ 158,221,608	$ 155,526,213	$ 623,041,642
RIte Care	$ 716,613,141	$ 640,551,514	$ 185,559,336	$ 130,289,952	$ 142,843,739	$ 147,152,717	$ 605,845,744
CSHCN	$ 177,986,526	$ 195,422,916	$ 62,407,810	$ 43,712,957	$ 40,182,360	$ 49,175,395	$ 195,478,521
Excess Spending: Hypotheticals	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending: New Adult Group	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DSHP - Health Workforce & AIE Payments	$ 18,928,491	$ 19,150,124	$ 3,886,751	$ 3,216,661	$ 5,069,002	$ 4,390,787	$ 16,563,202
CNOM Services	$ 8,152,058	$ 10,175,765	$ 1,132,963	$ 968,892	$ 3,744,548	$ 1,428,669	$ 7,275,073
TOTAL	**$ 2,147,771,207**	**$ 2,011,889,127**	**$ 485,845,001**	**$ 423,952,204**	**$ 436,659,552**	**$ 457,352,597**	**$ 1,803,809,354**
Favorable / (Unfavorable) Variance	$ 1,982,291,570	$ 2,527,804,647	$ 731,018,430	$ 803,124,761	$ 791,219,917	$ 739,937,803	$ 3,065,300,910
Cumulative Budget Neutrality Variance	$ 14.97 B	$ 17.50 B	$ 18.23 B	$ 19.03 B	$ 19.82 B	$ 20.56 B	$ 20.56 B

Notes to With Wavier Analysis

1. Excess Spending: Hypotheticals and New Adult Group reflects spending, if any, that exceeds the Without Waiver benchmark. Any savings against the Hypothetical populations (i.e., IMD SUD, 217-like and Family Planning groups) do not contribute to Budget Neutrality Variance.
2. Favorable/(Unfavorable) Variance compares actual spending on base MEGs and any excess spending on Hypotheticals or New Adult Group and any spending on CNOM services or DSHP investments to the Without Waiver expenditure limit (calculated in Table A1.3 as the product of the actual member months multiplied PMPM benchmark).
3. The Cumulative Budget Neutrality variance considers total "savings" relative to Without Waiver limit.

ATTACHMENT 2 – Appeals, Grievances and Complaints – Quarterly Report Q3-2023

Attachment A2.1: NHPRI Q4-2023 Prior Authorization Requests

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	7,692	7,334	6,897	6,935	28,858
Prior Authorization Denials	673	912	731	692	3,008
RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

CSN	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	1,084	1,182	1,231	1,095	4,592
Prior Authorization Denials	47	40	39	49	175
CSN AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	3,361	3,335	3,135	3,108	12,939
Prior Authorization Denials	211	227	208	231	877
			0		
RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RHE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	9,641	9,820	8,849	7,804	36,114
Prior Authorization Denials	740	1,039	787	687	3,253
RHE AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

SubCare** (NHP Only)	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	281	252	173	255	961
Prior Authorization Denials	10	10	12	8	40

NHPRI Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	9%	12%	11%	10%
CSN	4%	3%	3%	4%
RHP	6%	7%	7%	7%
RHE	8%	11%	9%	9%
Subcare	4%	4%	7%	3%

Attachment A2.2: UHCCP Q4-2023 Prior Authorization Requests

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	6,331	6,071	5,194	5,253	22,849
Prior Authorization Denials	1,343	1,278	1,160	1,149	4,930
RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	255	338	306	251	1,150
Prior Authorization Denials	16	12	12	11	51

CSN	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	451	429	123	433	1,436
Prior Authorization Denials	62	16	0	60	138
CSN AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	37	39	35	47	158
Prior Authorization Denials	2	2	4	2	10

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	3,051	3,025	2,601	2,677	11,354
Prior Authorization Denials	579	594	503	597	2,273
RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	87	103	89	95	374
Prior Authorization Denials	5	12	3	4	24

RHE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	7,979	7,950	6,871	6,244	29,044
Prior Authorization Denials	1,745	1,707	1,453	1,416	6,321
RHE AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	278	330	248	209	1,065
Prior Authorization Denials	16	23	18	12	69

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

UHCCP Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	21%	21%	22%	22%
CSN	14%	14%	30%	14%
RHP	19%	20%	19%	22%
RHE	22%	21%	21%	23%
Subcare	N/A	N/A	N/A	N/A

Attachment A2.3: THRIT Q4-2023 Prior Authorization Requests

RIte Care	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	402	434	411	294	1,541
Prior Authorization Denials	45	44	36	44	169
RIte Care AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	70	67	74	0	211
Prior Authorization Denials	3	8	5	0	16

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

RHP	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	807	845	784	109	2,545
Prior Authorization Denials	100	117	93	4	314
RHP AE	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	181	178	184	0	543
Prior Authorization Denials	18	29	21	0	68

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

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

THRIT Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	11%	10%	9%	15%
CSN	0%	0%	0%	0%
RHP	12%	14%	12%	4%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Attachment A2.4: RIte Smiles Q4-2023 Prior Authorization Requests

Dental	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	2,341	2,208	2,011	1,997	8,557
Prior Authorization Denials	803	718	635	677	2,833
RX	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0

RAD	Q1	Q2	Q3	Q4	YTD
Prior Authorization Requests	0	0	0	0	0
Prior Authorization Denials	0	0	0	0	0
Orthodontic	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Prior Authorization Requests	1,121	950	860	928	3,859
Prior Authorization Denials	670	621	546	567	2,404

RIte Smiles Prior Authorizations and Denial Rates

Quarter over Quarter 2023 – Denial Rates				
	Q1	**Q2**	**Q3**	**Q4**
Dental	34%	33%	32%	34%
Orthodontic	60%	65%	63%	61%

Attachment A2.5 NHPRI Q4-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	105	149	110	112	476
Overturned	42	68	38	49	197
Expedited	5	3	5	4	17
Overturned	4	1	2	2	9

Appeals External - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	39	28	40	17	124
Overturned	12	6	15	7	40
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - CSN	Q1	Q2	Q3	Q4	YTD
Standard	10	12	11	11	44
Overturned	2	4	2	6	14
Expedited	0	0	2	3	5
Overturned	0	0	2	2	4

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

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	88	49	49	61	247
Overturned	27	22	21	26	96
Expedited	5	0	2	4	11
Overturned	4	0	2	3	9

Appeals External - RHP	Q1	Q2	Q3	Q4	YTD
Standard	52	22	14	20	108
Overturned	17	7	6	8	38
Expedited	0	0	0	24	24
Overturned	0	0	0	0	0

Appeals Internal - RHE	Q1	Q2	Q3	Q4	YTD
Standard	159	189	164	127	639
Overturned	70	90	82	47	289
Expedited	10	1	2	3	16
Overturned	8	1	1	2	12

Appeals External - RHE	Q1	Q2	Q3	Q4	YTD
Standard	46	28	0	26	100
Overturned	13	7	0	8	28
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - SubCare	Q1	Q2	Q3	Q4	YTD
Standard	5	1	0	1	7
Overturned	1	0	0	0	1
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

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

Quarter over Quarter 2023_Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	40%	46%	35%	44%
CSN	20%	33%	18%	55%
RHP	31%	45%	43%	43%
RHE	44%	48%	50%	37%
Subcare	20%	0%	0%	0%

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	80%	33%	40%	50%
CSN	0%	0%	100%	67%
RHP	80%	0%	100%	75%
RHE	80%	100%	50%	67%
Subcare	0%	0%	0%	0%

Quarter over Quarter 2023_External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	31%	21%	38%	41%
CSN	33%	0%	22%	0%
RHP	33%	32%	43%	18%
RHE	28%	25%	36%	31%
Subcare	33%	0%	0%	0%

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

Attachment A2.6 UHCCP Q4-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	45	31	18	15	109
Overturned	24	21	9	9	63
Expedited	26	30	31	26	113
Overturned	22	22	21	19	84

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

Appeals Internal - CSN	Q1	Q2	Q3	Q4	YTD
Standard	3	5	1	2	11
Overturned	2	1	0	0	3
Expedited	5	2	3	4	14
Overturned	4	1	3	3	11

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

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	16	20	5	1	42
Overturned	10	13	4	0	27
Expedited	27	16	5	22	70
Overturned	21	13	4	9	47

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

Appeals Internal - RHE	Q1	Q2	Q3	Q4	YTD
Standard	64	42	26	17	149
Overturned	48	26	16	10	100
Expedited	42	47	44	29	162
Overturned	32	36	30	19	117

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

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

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

Quarter over Quarter 2023_Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	53%	68%	50%	60%
CSN	67%	20%	0%	0%
RHP	63%	65%	80%	0%
RHE	75%	62%	62%	59%
Subcare	N/A	N/A	N/A	N/A

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	85%	73%	68%	73%
CSN	80%	50%	100%	75%
RHP	78%	81%	80%	41%
RHE	76%	77%	68%	66%
Subcare	N/A	N/A	N/A	N/A

Quarter over Quarter 2023_External Appeals

External Standard Appeal Overturn Rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	0%	0%	0%	0%
CSN	0%	0%	0%	100%
RHP	0%	0%	0%	0%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

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

Attachment A2.7 THRIT Q4-2023 Appeals and Overturn Rates

Appeals Internal - RIte Care	Q1	Q2	Q3	Q4	YTD
Standard	0	1	4	1	6
Overturned	0	0	1	1	2
Expedited	2	2	3	3	10
Overturned	2	2	2	2	8

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

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

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

Appeals Internal - RHP	Q1	Q2	Q3	Q4	YTD
Standard	4	5	3	3	15
Overturned	3	1	0	2	6
Expedited	5	3	3	11	22
Overturned	1	2	3	8	14

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

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

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

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

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

Quarter over Quarter 2023 Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	0%	0%	25%	100%
CSN	0%	0%	0%	0%
RHP	75%	20%	0%	67%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Internal Expedited Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
RIte Care	100%	100%	67%	67%
CSN	0%	0%	0%	0%
RHP	20%	67%	100%	73%
RHE	0%	0%	0%	0%
Subcare	N/A	N/A	N/A	N/A

Quarter over Quarter 2023 External Appeals

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

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

Attachment A2.8 RIte Smiles Q4-2023 Appeals and Overturn Rates

Appeals Internal - Dental	Q1	Q2	Q3	Q4	YTD
Standard	0	0	1	13	14
Overturned	0	0	0	3	3
Expedited	0	0	0	0	0
Overturned	0	0	0	0	0

Appeals Internal - Orthodontics	Q1	Q2	Q3	Q4	YTD
Standard	43	46	64	27	180
Overturned	7	6	16	6	35
Expedited	12	13	12	8	45
Overturned	1	1	1	0	3

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

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

Quarter over Quarter 2023_Internal Appeals

Internal Standard Appeal overturn rates:				
	Q1	**Q2**	**Q3**	**Q4**
General Dental	0%	0%	0%	23%
Orthodontic	16%	13%	25%	22%

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

Quarter over Quarter 2023_External Appeals

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

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

Attachment A2.9 NHPRI Q4-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	15	22	11	15	63
CSN	3	1	0	0	4
RHP	12	15	20	15	62
RHE	24	16	18	18	76
SubCare (NHP only)	0	0	0	0	0
Total Number of Grievances					205
AE	12	13	5	5	35

Number of Complaints	Q1	Q2	Q3	Q4	YTD
RIte Care	17	16	15	11	59
CSN	5	0	1	1	7
RHP	12	15	15	20	62
RHE	18	12	24	24	78
SubCare (NHP only)	0	0	1	1	2
Total Number of complaints					208
AE	6	3	5	5	19

Attachment A2.10 UHCCP Q4-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	3	6	11	7	27
CSN	0	1	0	0	1
RHP	0	3	5	4	12
RHE	2	6	23	21	52
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of Grievances					92
AE	3	13	22	30	68

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

Attachment A2.11 THRIT Q4-2023 Grievances and Complaints

Number of Grievances	Q1	Q2	Q3	Q4	YTD
RIte Care	0	0	0	0	0
CSN	0	0	0	0	0
RHP	0	0	1	2	3
RHI	0	0	0	0	0
SubCare (NHP only)	N/A	N/A	N/A	N/A	0
Total Number of Grievances					3
AE	0	0	0	0	0

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

Attachment A2.12 RIte Smiles Q4-2023 Grievances and Complaints

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

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

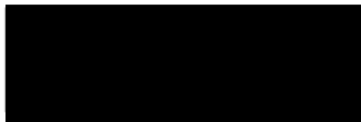
Attachment 3: Statement of Certification of Accuracy of Reporting of Member Months

Statement of Certification of Accuracy of Reporting Member Months

As the Executive Office of Health and Human Services Deputy Director, Medicaid Finance and Policy, I certify the accuracy of reporting member months for demonstration population under the 1115 Comprehensive Demonstration Waiver for the purpose of monitoring the budget neutrality agreement.

Name: Kimberly Pelland

Title: Deputy Director, Medicaid Finance and Policy

Signature: 

Date: March 19, 2024

XIII. State Contact(s)

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Kristin.Sousa@ohhs.ri.gov

XIV. Date Submitted to CMS

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