May 2020 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services and

Department of Human Services

The members of the Caseload Estimating Conference request that the Executive Office of Health and Human Services and the Department of Human Services provide written answers to the following questions in addition to the presentation of their estimates on April 24, 2020. Please submit the answers no later than close of business April 22, 2020 so that staff can have the opportunity to review the material prior to the meeting.

In addition to the caseload and expenditure estimates, the testimony should include background information supporting each estimate, including (but not limited to) caseload and unit cost trends and key assumptions underlying the projections, as has been provided in the past. The caseload information should also include expenses related to decisions made for temporary rate increases, other program supports or other pending changes during the public health emergency related to COVID-19.

Please also include enrollment/utilization projections for all Medical Assistance programs (including hospitals, nursing homes, pharmacy, in addition to the capitated programs). Please submit a hard copy of any information that is provided as an excel sheet embedded in the documents.

COVID-19 EXPENSES

1) Please fill out the attached excel sheet for changes made during the public health emergency. This should include any new expenses and whether it has been deemed budget neutral.
2) Please identify the mechanism by which these changes are being made (1135 waiver, 1115 waiver, an executive order, FMAP maintenance of effort requirements, or policy decision).

2020 May CEC - COVID-19 & Other I

A complete list of all requested federal authorities is available on EOHHS' website, linked below. The budgetary impact of each is noted throughout testimony. Following testimony, EOHHS will update the attached excel document.

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Summary%20of%20Emergency%20COVID-19%20Federal%20Authorities%20as%20of%204.17.20.pdf

CASH ASSISTANCE

Rhode Island Works

1) Please provide a profile of current 1-parent, 2-parent, and child only cases by demographics (such as age and residence) and by duration of benefits.
2) Please provide a profile of hardship cases by similar criteria as listed above.
3) How many parents are currently without a plan due to:
    a. exemption from employment planning

b. being between plans

c. sanction—by month, the number of parents sanctioned for not complying with work requirements in FY 2020

4) How many child-only cases are included in the estimate for FY 2020 and FY 2021? How many families receive the payment(s)?

5) Please update FY 2020 and FY 2021 TANF block grant estimates. Include the balance of any unspent funds from prior years and report any plans for its use. Please include FY 2020 expenses and identify the other Departments that received funding and the amount.

    a. How much of the TANF funding is being used for UHIP?

6) On a sheet corresponding to the block grant estimates, by Department, please list the services being provided and the caseload figures for each of the programs TANF funding is utilized for.

7) Please indicate how the State will meet its maintenance of effort (MOE) requirement and identify which MOE items are State costs and which are in-kind contributions.

8) Please provide an update on the innovative proposals to test new approaches to improving work participation through the four vendors (Comprehensive Community Action, ResCare, Gateway, and SSTARbirth).

    a. Please provide the metrics, data collected for FY 2018 and FY 2019, targets set for each of the four vendors.

    b. Specifically, please include how many Rhode Island Works participants entered and retained employment and, if available, provide wage/salary information.

    c. Please report the amount of TANF funding provided to each vendor.

9) Please provide the "all families" and "two-parent families" work participation rate for FY 2020 and FY 2021, along with a work participation rate target.

10) Please provide an update on the status of current or potential federal penalties associated with the work participation rate.

11) As of January 1, 2020, the constraint that only allows beneficiaries to receive cash assistance for 24 months within 60 continuous months was eliminated. How has this impacted the number of hardship extensions?

    a. Please provide the profile and number of cases that were granted hardship extensions.

    b. How many individuals will cycle off because of the 24-month time limit?

12) Please provide the underlying assumptions the department is utilizing to assess the impact of COVID-19 in terms of caseload and cost and the subsequent economic contraction will have on the RI Works program.

    a. Please include any information the department has on the relationship between unemployment applications submitted and enrollment in the RI Works program.

    b. How is the department assuming COVID-19 will impact catastrophic expenses?

Child Care Assistance Program

1) How many applications and/or attendance records are processed manually?

2) Please indicate how many providers are being paid manually, including the percentage of total providers.

3) Please provide a monthly accounting of the offline payments for FY 2020.

4) Please provide the number and type (family-based/center-based) of childcare providers within each tier established through the quality rating system and how estimated costs reflect those tiers. If possible, please provide a list of the providers who have changed tiers.

a. Please provide the number of children enrolled in CCAP by provider type, age group, and star rating in the below format:

2020 May CEC - CCAP Enrollment.xls

5) Please provide the percentage of children enrolled in CCAP (by age group, and star rating) that are full-time, half-time, quarter-time, and three-quarters time.

6) Please also provide the cost for each administrative component of the childcare providers contract including: one-time purchase of a home computer for a childcare provider, $100 direct deposit bonus, $500 bonus when receive license as a home provider, $50 annual registration payment, if applicable.

7) Please provide an update on the $250,000 Family Child Care Training and Supports Benefit Fund that is jointly administered by the Department and the Union. What expenses have been made since FY 2016 when the fund was established? Please provide the plan to use the funds and balance of the fund carry forward for FY 2020.

8) The Governor's Budget includes additional funding to expand childcare assistance to include families who require childcare in order to pursue an educational degree. Please identify the number of children that would be impacted by this proposal.

9) As part of the SEIU1199's Collective Bargaining Agreement, effective January 1st, 2020, family home providers received a rate increase of 1.5%. The negotiations also produced new annual registration fees, orientation bonuses, direct deposit bonuses, bonuses for providers who became licensed through DCYF, etc. Please provide the full cost of the amendments to the CBA through the date of the conference, and the department's projections for the remainder of FY 2020 and FY 2021.

10) Please provide an updated on the transfer of the childcare licensing unit from DCYF. Is there a backlog of approvals for new licenses?

11) Please provide an update on all anticipated reconciliation payments from the providers that were overpaid in FY 2017. Are any reconciliation payments anticipated to be recouped in FY 2021?

12) Please provide FY 2020 and FY 2021 CCDF block grant estimates. Include the balance of any unspent funds from prior years and report any plans for its use.

13) What underlying assumptions is the department utilizing to assess the impact that COVID-19 and the subsequent economic contraction will have on the CCAP program?

Supplemental Security Income

1) Please provide the number of SSI recipients in each category (persons, personal needs allowance, assisted living).

    a. Please provide a breakout by category. For category F, please break out the number of individuals in each cohort.

    b. Since the estimate is based on current law, please provide an estimate assuming that the enhanced category F payment only applies to those in managed care.

    c. Please identify the number of individuals receiving the category F payment who are no longer enrolled in Rhody Health Options and are in the fee-for-service system.

        i. Are the individuals still receiving that higher payment?

        ii. If not, in what month did the payment end?

    d. Please also include the number of individuals receiving the State-only payment in each category.

e. Please provide the number of individuals receiving the additional $206 payment for residing in a non-Medicaid funded assisted living facility along with a list of the facilities.

2) How many individuals receive the monthly payment by mail?

a. What are the administrative costs?

b. If receiving federal payment, would that be through a direct deposit?

c. How many receive only the State payment and not the federal payment?

3) What were the moving expenses paid in FY 2019? What is the estimate for FY 2020 and FY 2021?

4) Please provide the underlying assumptions the department is utilizing to assess the impact of COVID-19 in terms of caseload and cost and the subsequent economic contraction will have on the SSI program.

5) Is there an anticipated increase in the administrative fee in FY 2020 or FY 2021?

General Public Assistance

1) Please provide the number of burials and the average cost per burial for FY 2019. What is the estimate for FY 2020 and FY 2021?

2) Please provide the underlying assumptions the department is utilizing to assess the impact of COVID-19 in terms of caseload and cost.

See DHS responses.

MEDICAL ASSISTANCE

1) Please provide, where possible, excel spreadsheets/tables with details/explanation for your narrative testimony related to expenditures, eligibility, growth factors and methodology for projections. Please include notes/comments within on any related adjustments or factors that are relevant to the estimate.

*Refer to **May 2020 CEC – Workbook.***

2) Please update the attached file (or provide a similar file) showing average caseload and average capitation rates for all managed care product lines to reflect the Executive Office's revised estimates for FY 2020 and FY 2021, Please update FY 2019 Final and FY 2020 and FY 2021 November adopted figures, as necessary.

*Refer to **Table 1-12** in **Major Developments** section of testimony and **May 2020 CEC – Workbook**. Summarized below:*

Product	FY 2019 Final		FY 2020 Nov CEC		FY 2020 May CEC		FY 2021 Nov CEC		FY 2021 May CEC	
	Caseload	PMPM	Caseload	PMPM	Caseload	PMPM	Caseload	PMPM	Caseload	PMPM
Managed Care										
RIte Care	155,716	$244.96	*150,074*	*$269.51*	*148,981*	$269.20	*147,303*	*$278.92*	*169,511*	$278.80
RIte Care CSHCN	9,636	$970.46	*9,571*	*$1,002.67*	*9,696*	$1,001.28	*9,390*	*$1,037.85*	*10,598*	$1,088.58
RIte Care SOBRA	4,470	$11,316.00	*4,308*	*$12,469.27*	*4,254*	$12,469.27	*4,182*	*$12,905.69*	*4,861*	$12,905.69
RIte Share	4,525	$51.67	*4,776*	*$50.86*	*3,252*	$55.20	*5,742*	*$52.50*	*3,005*	$57.67
RIte Smiles	113,291	$19.12	*112,795*	*$19.28*	*112,474*	$19.27	*114,503*	*$19.71*	*130,544*	$19.70
Expansion										
Expansion	71,658	$505.46	*70,184*	*$548.32*	*70,630*	$558.39	*69,385*	*$567.56*	*80,130*	$632.71
Expansion SOBRA	507	$11,316.00	*592*	*$12,469.27*	*573*	$12,469.27	*576*	*$12,905.69*	*652*	$12,905.69
Rhody Health Partners	14,677	$1,462.45	*14,603*	*$1,612.09*	*14,709*	$1,609.70	*14,488*	*$1,668.13*	*15,690*	$1,783.71
Rhody Health Options										
Integrity	14,721	$719.87	*14,401*	*$813.57*	*13,980*	$830.60	*14,328*	*$842.37*	*14,296*	$816.37
PACE	304	$3,738.64	*352*	*$3,839.09*	*337*	$3,870.64	*365*	*$3,970.28*	*361*	$3,988.27
Transportation	298,088	$8.63	*285,831*	*$14.01*	*286,470*	$8.11	*279,289*	*$13.48*	*318,921*	$7.90

3) There was a recent $3.6 million settlement with NHPRI for outstanding claims for newborns that was paid from general revenues. EOHHS indicated that this was to resolve a dispute around alleged underpayments due to issues with UHIP. EOHHS assumed the payment to be $7.6 million, including $3.6 million from general revenues and accrued that amount in SFY 2019. The final settlement was lower, and the payment was processed as state-only due to concerns regarding demonstrating compliance with the two-year timely filing window to CMS. What changed from when the total was booked, assuming that Medicaid funds would be claimed, to when it was paid using only general revenues? Is the entire amount outside of the two-year claiming window?

Out of concerns regarding demonstrating compliance with the two-year timely filing window, this payment was made using state-only funds. The settlement was entered to resolve a dispute regarding UHIP system issues that resulted in alleged underpayment for newborns. The basis of the payment was plan-provided financial records and not EOHHS accepted encounters. A review of the plan-submitted data, approximately $1.0 million of the total $3.6 million is for the period prior to June 2018.

Given that the final settlement amount agreed to by the parties was under the initial estimate of the liability included in the accrual, EOHHS felt it was prudent to make this payment as state-only, thus avoiding a future federal audit finding.

4) Please provide a summary of how the COVID-19 emergency situation is projected to impact enrollment and rates across the programs and how that is factored into your caseload estimates. Please also provide any data limitations used for related estimates.

*Please see **Caseload Growth and Trend Development** section of **Major Developments** in testimony. Additional information provided in **May 2020 CEC – Workbook**.*

5) As part of the COVID-19 response, Congress passed, and the President signed into law, the Families First Coronavirus Response Act (FFCRA). FFCRA provides a temporary 6.2 percentage point increase to each qualifying state and territory's FMAP effective January 1, 2020 and extends through the last day of the calendar quarter in which the public health emergency terminates. Please discuss your assumptions around inclusion of the enhanced FMAP within your estimates for FY 2020 and FY 2021. Please clarify how long you anticipate receiving the enhanced FMAP and for which programs apply.

*Please see **Enhanced FMAP Rate** section of **Major Developments** in testimony.*

6) Please provide any limitation in the data used for estimates related to UHIP challenges.

No limitations resulting from the data assumed in development of estimates.

7) Please update the attached file, provided to conferees at the November CEC, based on final audited expenditures for FY 2019.

We will share an updated workbook with the Conferees after testimony.

FY 2021 Budget Initiatives

1) The attached workbook includes a spreadsheet that lists items in the Governor's recommended budget that should and should not be included in the EOHHS' testimony. There is also a sheet that was included in the November conference estimate describing the status of current initiatives and the action taken for FY 2020. Please update the sheets for May.

2020 May CEC - Initiatives.xlsx

Budget initiatives will be rebased once the Conferees adopt a budget estimate. At that time we will also update the attached with the various state/federal authorities that are needed along with the associated timeline. See attachment 2A for an update of FY 2020 budget initiatives..

Also include a reconciliation of which FY 2021 initiatives are reflected in the caseload estimate and which initiatives are not included because they require legislative or policy change. For each item, we ask that EOHHS testimony include updated information regarding the necessity of: waiver amendments that would have previously qualified as Category II or III changes; State Plan Amendments; or changes to State rules and regulations governing the Medicaid program. If any of these actions are required, please include information regarding the anticipated timeframe for approval and the steps taken thus far to initiative the process.

EOHHS testimony incorporates the UHIP Optimizations savings for FY 2020 and FY 2021.

Non-Emergency Medical Transportation Services

Please provide the FY 2020 revised and FY 2021 estimates by program compared to the FY 2020 November estimate. How has the COVID-19 directions by EOHHS impacted this program? How many beneficiaries have access to their own vehicles and do not need to use MTM?

EOHHS provided direction in an April 3, 2020 memo to the managed care plans: "Members will not be allowed to take mass transit if he/she has been referred to a COVID-19 testing by a PCP or the Rhode Island Department of Health. Members are highly encouraged to utilize the gas mileage reimbursement (GMR) option if they have a vehicle or someone is willing to transport them to the testing facility. EOHHS welcomes creative solutions from MCOs to support members to utilize GMR".

EOHHS instructed MTM to temporarily discontinue the use of multi-load trips.

MTM agreed to provide transport to all eligible members to COVID-19 testing sites in addition to pre-existing approved destinations.

There has been a 66% decline in transportation provider trips due to closure of facilities and non-essential medical visits being canceled

EOHHS does not know how many of its members have access to their own vehicles; however, the utilization of NEMT services is low with fewer than 10% of all Medicaid recipients ever utilizing the benefit.

2) Ambulance Rates:

- Do you project a rebased impact based on the contract amendments?

No. EOHHS is not directing MTM to adjust the 8/19/20 NEMT provider rates shown in the table below.

Services	Prior Rates	Rates in effect 8/19	Increase	% change
Basic Life Support	$ 71.50	$ 147.67	$ 76.17	107%
Advanced Life Support	$ 71.50	$ 177.20	$ 105.70	148%

3) Please provide a breakdown of types of transportation usage including ambulance, RIPTA, wheelchair van, ride share, and other allowable modes of transportation. How does the COVID-19 memo and use of transportation services impact the breakdown by type of service?

The table below details non-emergency medical transport modes and COVID-19 impact as of 4/20/2020.

Transport Type	**Change**
Trip Legs (Public Transit)	No change
Trip Legs (Ambulatory)	Decreased approximately 50%
Trip Legs (Paralift)	Decreased approximately 50%
Trip Legs (Stretcher/Ambulance)	Decreased approximately 35%

Trip Legs (Gas Reimbursement)	Increased approximately 30%

4) Has the use of ambulance services increased as a result of social distancing?

No. Ambulance transport has decreased approximately 35% from previous months.

5) Has there been a reduction in overall services because some non-essential medical visits have been cancelled?

Yes. Daily transportation provider trip volume has decreased from approximately 6,000 trips to 2,000 trips

6) Please provide most recent performance/complaint report.

Please see the file attached below.

PerformanceCompl
aintReport.doc.docx

Reconciliation Payments and Recoupments

1) Please fill out the attached excel sheet to show the advancements, recoupments and the outstanding balance by facility since November. For each facility, how many applications does this balance represent?

*Please see the spreadsheet below and included see **May 2020 CEC - Workbook**.*

Nursing home information represents 4,038 applications. Applications can be counted in multiple "case status" fields as the recoupment processes is completed and claims are paid after eligibility is determined.

May_CEC Interim
Payment Excel_mk_D

2) Please provide any and all information on monthly collections and recent changes to collection plans.

Due to the COVID19 State of Emergency period, the EOHHS has suspended collections on contingency payments through May 2020. At this time, EOHHS will evaluate the effects of the State of Emergency Period and determine when collections will resume.

3) For the balance that remains, please note the advances that are becoming time sensitive for claiming opportunities and, if not cleared, will impact the state's ability to leverage Medicaid. Please include this information by month and facility.

The two-year timely filling window which limits the state's ability to claim federal match begins at the time of claim submission. The state then has two years to draw down federal funds. For contingency payments that do not have a claim paid, there is no risk to the state's ability to claim federal match, and the state is not yet working to recoup the advance. For contingency payments for which a claim has been paid, the federal match has been drawn down for that claim.

The potential budgetary impact of a contingency payment remaining state-only is driven by the state's ability to recoup the contingency payment, and not by the state's ability to leverage federal funding on a given claim. For example, if the state is unable to recoup the contingency payment due to the application being denied and the provider being entitled to retain the funding, pursuant to stature, then there could be a negative budgetary impact if, in the aggregate, these unrecoverable amounts exceed the 10% figure that EOHHS has been budgeting for as uncollectable

4) Please provide a 3-year history (FY 2017 through FY 2019) by facility of advances that could not be matched or recouped. Please also include a comparison of these actual expenses to the prior assumptions used when estimating these impacts.

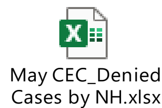
Please refer to the "Nursing Home Interim Payments and Recoupments," located in the "Major Developments" section of our testimony.

Un-recoupable advances to-date are associated with denied cases. Advances for denied claims through April total $2.9 million. Additionally, there are 651 cases pending eligibility determination worth $12.7 million in outstanding contingency payments that could be denied, and unable to be recouped and/or matched.

Note that at FY 2019 fiscal close, the EOHHS paid out $136 million in contingency payments, and assumed that $13.6 million, or ten percent, would be unrecoverable. Any uncollectable amounts from contingency payments made in FY 2020 and FY 2021 are in addition to the $13.6 M assumed for FY 2019 and earlier.

The spreadsheet below sums denied claims by nursing home from March 2017 through April 2020.

*Please see **May 2020 CEC - Workbook**.*



Redeterminations

1) Please provide the current schedule of redeterminations and plan to clear the backlog.

Due to the COVID-19 emergency, Medicaid has stopped sending out recertification packets for all programs. All Complex Medicaid/LTSS/MPP renewals due for 4/30/20 have been pushed out by six months to 10/31/20. All MAGI/Complex Medicaid/LTSS/MPP renewals due for 5/31/20 have been pushed out by six months to 11/30/20. At this point in time, CMS has not provided an end date for the COVID-19 emergency period. The processing of Medicaid renewals is contingent on CMS providing an end date to the emergency period. Each month of the emergency period will delay the processing of current and backlogged renewals.

In order to clear the backlog of renewals, a data script was developed that will consider several factors when determining where to redistribute these renewals. The logic considers:

- *When the latest renewal notice was sent to the customer;*
- *The most recent application date (to account for any reapplication scenarios); and,*
- *The latest recertification task closure date*

If one or more of the above data points occurred within the last 12 months, EOHHS will take the most recent data point and add 12 months to determine the new recertification date. Checks will also be performed to ensure that the new date does not fall mid current recertification cycle. If it does, it will be placed in the next recertification cycle accordingly.

For cases where none of the three data points mentioned are within the last 12 months, EOHHS will place these into the next available recertification cycle or distribute them amongst a number of upcoming months if the case load is too high. The script is currently on hold due to the COVID-19 emergency. Once the emergency period ends, the script will be operationalized and will run just before the next renewal cycle. Based upon the current number of backlogged renewals, we anticipate a four to six-month period of redistribution for Complex Medicaid, LTSS and MPP cases. This will ensure field workers are able to manage the volume of recertification packets in each month. MAGI Medicaid cases are passively renewed and do not require as much manual intervention. Therefore, these cases can be redistributed at a higher volume throughout the upcoming months.

Independent Provider Model

1) Please provide an update for the Independent Provider Model and any potential costs outside of the conference estimate. The statute includes the provision that: 3 (d) The secretary's authority in § 40-8.14-4 shall be subject to the state's obligations to meet and negotiate under § 40-8.15-3 and chapter 7 of title 28, as modified and made applicable to individual providers under §40-8.15-3, and to agreements with any exclusive representative of 16 individual providers, as authorized by § 40-8.15-3. Except to the extent otherwise provided by law, the secretary shall not undertake activities in subsections (c)(3) and (c)(4) of this section, prior to October 1, 2019, unless included in a negotiated agreement and an appropriation has been provided by the legislature to the secretary.

Regarding medical benefits, EOHHS assumes that any benefits spending for the IP model will be budget neutral compared spending on home care. Additional spending on the fiscal intermediary and service advisor is offset by a reduction in the unit cost of the direct home care services.

Regarding non-medical benefit costs, the Department of Labor and Training will support training costs through October 2020. The FY 21 Governor's recommendation for EOHHS contains $200,000, including $100,000 in general revenue, to finance training expenses. The MMIS system changes have been instituted to ensure that participating providers can bill the state. This will be monitored as the program continues. EOHHS anticipates additional expenses for translation of learning materials as non-English and non-Spanish speaking individuals participate in the program. The Registry will continue to be provided in a manual fashion between the Fiscal Intermediary and EOHHS thus incurring no additional costs at this time.

Hepatitis C

1) Please provide a detailed comparison of the FY 2020 and FY 2021 estimates for Hepatitis C coverage. If any of the underlying assumptions have changed since November (utilization, price, case mix, State share, etc.), please explain why.

    a. How many individuals have utilized the treatment through April 2020?

Health plan reporting is available only through January 2020. EOHHS estimates annualizes this reporting without applying any inflation factor for potential unmet demand.

The number of people being treated across the plans is averaging approximately 50 members in treatment per month based on a review of current claims data. This is a decline from the 92 members treated per month treated in FY 2021 (and a total of 625 distinct members in treatment during the full year) or the 125 members per month in treatment during the first half of FY 2020, immediately following the change in EOHHS' Hepatitis C policy.

    b. Please provide final FY 2019 numbers for Hepatitis C coverage.

*Please refer to **Section D** within **Major Developments** of testimony for comparison of current to prior estimates and FY 2019 final.*

Behavioral Healthcare Services

1) How many individuals are receiving treatment through either IHH or ACT? What is the PMPM for the services? How many are dual eligibles?

Following table includes eligibility for EOHHS' various behavioral health related health homes. The actual utilization, predominately paid within the managed care contracts, will be marginally less. Approximately one-third of health home users are dual eligible for Medicare and Medicaid services.

	MA Only	Dual	Grand Total
2019	**6,829**	**3,607**	**10,437**
Assertive Community Treatment (ACT)	589	542	1,132
Integrated Health Home (IHH)	3,618	2,738	6,357
Centers of Excellence (CoE)	187	21	208
Opioid Treatment Program (OTP)	2,434	306	2,741
2020	**7,129**	**3,616**	**10,744**
Assertive Community Treatment (ACT)	652	555	1,206
Integrated Health Home (IHH)	3,842	2,746	6,588
Centers of Excellence (CoE)	151	14	164
Opioid Treatment Program (OTP)	2,484	302	2,785

The PMPM for ACT is $1,267 and for IHH it is $420. These rates have not changed since July 2016.

*Please see **May 2020 CEC - Workbook**.*

All Programs – Rate and Caseload Changes

1) Please fill out the attached spreadsheet for the specific rate and caseload changes that impact the separate programs so that the totals can be shown in the aggregate and by program.

*Please see **May 2020 CEC - Workbook**.*

2) Include hospital and nursing home October 1 increases, home care rate increase, and policy adjustor as well as managed care plan changes.

*Please see **May 2020 CEC - Workbook**.*

Long Term Care (including the Integrated Care Initiative)

1) Applications and Payments.

    a. Provide number of pending applications and the backlog including those past 90 days.

2) Current and anticipated caseload trends for both Rhody Health Options.

    a. Provide a table of FY 2020 and FY 2021 Neighborhood capitation rates for Rhody Health Options (per member per month payments from the state to NHP). Please include FY 2019 final rates as a point of comparison.

    b. If the rates for FY 2020 have changed since November, please provide an explanation.

*Refer to **Rhody Health Options** section of testimony.*

3) How is FY 2021 impacted by the end of the contract with Neighborhood Health to operate the program on December 31, 2020? What is the assumption for continuation of the current contract?

*The current estimate reflects continuation of the CMS Demonstration through at least the end of FY 2021. If the program were to cease operations at the end of CY 2020 (i.e. Demonstration Year 4) then the members would be transitioned to fee-for-service. The current expenditures would shift from Rhody Health Options to the existing Fee-for-Service lines with most expenditures residing in **Nursing and Hospice Care** or **Home and Community Care**.*

4) Please provide the enrollment and capitation rate information for the PACE program.

*Refer to **Table IX-3** and **Table IX-4** in the **Home and Community Care** section of the testimony.*

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share, and fee-for-service for FY 2020 and FY 2021. Please delineate those aspects of managed care programs not covered under a payment capitation system.

*Refer to **Table II-1** in **Managed Care** section of testimony.*

2) For the Managed Care Line Expenditure Detail sheet provided in previous testimony, please include the FY 2019 actual expenditures for each item (RIte Care, RIte Share, RIte Smiles, NICU) so estimators can compare current estimate to prior year spending.

*Refer to **Table II-1** in **Managed Care** section of testimony.*

3) Please provide the monthly capitation rate(s) for RIte Care. If different from the rates assumed in the November 2019 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.

*Refer to **Table II-4** and **Table II-5** in **Managed Care** section of testimony.*

4) Please provide the projected CHIP funding for FY 2020 and FY 2021.

*Refer to **Table II-7** in **Managed Care** section of testimony.*

Rhody Health Partners

1) How many beneficiaries are enrolled in Rhody Health Partners?

    a. Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Partners.

    b. If different from prior cap rate, please document the change according to: contributing factors such as medical expense trends, risk/claims adjustment assumptions and administrative costs.

*Refer to **Rhody Health Partners** section of testimony.*

Hospitals

1) Please provide separate inpatient and outpatient hospital estimates for FY 2020 and FY 2021.

*Refer to **Hospitals** section of the testimony.*

Pharmacy

1) Please provide separate estimates for pharmacy expenditures and rebates for FY 2020 and FY 2021.

*Refer to **Pharmacy** section of the testimony.*

Other Medical Services

1) Please provide an updated estimate of receipts for the Children's Health Account and expenditures for all Other Medical Services by service.

*Refer to **Other Medical Services** section of testimony.*

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2020 and FY 2021.

*Please see **May 2020 CEC - Workbook**.*

3) Are there any state-only costs in FY 2020 and FY 2021?

*There are no state-only expenditures within **Other Medical Services**. Expenditures with a non-Regular FMAP are presented in the section, however.*

Affordable Care Act

1) Please provide updated caseload and expenditure estimates (with associated methodology) for FY 2020 and FY 2021 for the ACA-based Medicaid expansion population.

*Refer to **Medicaid Expansion** section of testimony.*

2) What are the five-year projections for the Medicaid expansion program?

    a. What is the updated number of potential individuals who are eligible to enroll?

*Refer to **Medicaid Expansion** section of testimony.*

3) Please provide a current estimate of the cost and number of participants of the Exchange premium support program (the "Affordability Assistance Program").

    a. Has the program now been automated through HSRI? If not, when is this expected?

*The premium assistance program is included in the **Managed Care** section of the testimony.*

Presently an average of 145 members are in the premium support program each month at an annual cost less than $100,000. This program has not yet been automated and it not presently scheduled for immediate implementation.