Article 12: Relating to Medical Assistance

This article modifies the financing and delivery of the medical assistance (Medicaid) program. The article also includes a joint resolution authorizing the Executive Office of Health and Human Services (EOHHS) to undertake various reforms within the Medicaid program that require amendments to the State's 1115 waiver, Medicaid State Plan, rules and regulations, or managed care contracts. Specifically, the article:

- Modifies existing Long Term Services and Supports (LTSS) programs to shift the State's long-term care options away from institutional settings and towards home- and community-based services.
- Eliminates the supplemental outpatient upper payment limit (UPL) and Graduate Medical Education (GME) payments to hospitals.
- Reduces the risk margin built into the State's managed care rates from 1.5 percent to 1.25 percent.
- Adds Medicaid coverage for the Department of Health's First Connections and Parents as Teachers programs.
- Changes the deadline for the annual Medicaid expenditure report from March 15 to September 15 of each year.
- Adds Medicaid coverage and reimbursement for community health workers.
- Adds Medicaid coverage for perinatal doula services, which provide individual supports for expectant mothers before, during, and after birth.
- Includes provisions to support transitioning patients from Eleanor Slater Hospital into clinically appropriate settings in the community.
- Expands child dental benefits to include an additional type of cavity treatment.
- Makes a number of technical corrections to Medicaid enabling statutes to reflect current practice.
- Allows the Executive Office to pursue any changes in the Medicaid program which may offset State costs or improve access, quality, or effectiveness.

FISCAL IMPACT

The initiatives included in this article result in a net $8.4 million in general revenue expenditure savings ($17.7 million all funds) relative to the November 2020 Caseload Estimating Conference (CEC) adopted estimates for FY2022.

Article 12 Expenditure Impact

Initiative	General Revenue	All Funds
LTSS Resiliency and Rebalancing	($4,545,226)	($8,870,459)
Hospital Payments	(3,158,639)	(6,941,280)
Managed Care Risk Margin	(1,244,186)	(3,952,244)
RIDOH Programs	701,293	2,362,338
Medicaid Expenditure Report	(138,000)	(276,000)
Community Health Workers	(115,082)	(340,313)
Perinatal Doula Services	112,252	278,022
Total	**($8,387,588)**	**($17,739,936)**

Several initiatives also impact revenue collections from the 2.0 percent insurance premium tax on health insurers and 5.5 percent nursing home provider tax. The Governor's Budget accounts for a net $600,000 revenue loss, accordingly.

ANALYSIS AND BACKGROUND

Article 12 includes two primary components. First, Article 12 amends current law to make the statutory changes necessary to implement Medicaid budget initiatives where required. However, many aspects of the Medicaid program are not codified in statute, as they are primarily governed by separate documents submitted to the federal government, such as the State Plan and Section 1115 waiver, as well as State rules and regulations and certain contractual agreements. State law requires that the Executive Office of Health and Human Services (EOHHS) seek authority from the General Assembly in order to pursue any significant, non-statutory changes to the Medicaid program by submitting a joint resolution. Article 12 also includes the joint resolution authorizing EOHHS to amend the Medicaid State Plan, submit formal amendments to the special terms and conditions of Rhode Island's Section 1115 waiver, update State rules and regulations, and/or modify the terms of managed care contracts. The combined authority from the statutory changes and joint resolution included in Article 12 enables EOHHS to undertake all actions required to realize the funding levels included in Article 1.

Analyst Note: There is a proposal included in Article 15 to amend the reporting requirements of Medicaid's RIte Share program. It appears that the proposal should also be included in the resolution because it requires amending Medicaid regulations as well as potential amendments to the State Plan or 1115 waiver, but it is not included in Article 12. The Governor submitted an identical proposal in FY2021 and included it in the resolution.

Long-Term Services and Supports (LTSS) Resiliency and Rebalancing

Article 12 contains a number of initiatives designed to work in tandem to rebalance the State's array of long-term care programs by shifting away from institutional settings and towards home- and community-based services (HCBS). This includes reforming program eligibility, modifying rates, and establishing a wage pass-through program for direct care workers, among other targeted investments. The Governor's Budget assumes that these investments will in turn reduce nursing home admissions, which are significantly more expensive than HCBS, thereby resulting in net savings to the State. According to the Executive Office, this initiative will result in an estimated reduction of 101,070 nursing home bed days in FY2022, resulting in $8.9 million in general revenue savings ($19.6 million all funds) in FY2022. The nursing home savings are offset by a number of investments, totaling $4.3 million from general revenues ($10.8 million all funds), as follows:

LTSS Resiliency and Rebalancing	General Revenue	Federal Funds	All Funds
Nursing Home Reductions	($8,894,050)	($10,730,950)	($19,625,000)
Maintenance of Need	2,433,630	2,936,251	5,369,881
Assisted Living Rates	1,121,262	2,108,461	3,229,722
Home Care Wages	662,244	799,018	1,461,263
Supplemental Security Income	(208,747)	-	(208,747)
Implemetation - Contract and Staff	180,723	326,883	507,606
Shared Living Rates	123,181	191,029	314,210
Nursing Home Rates	36,531	44,075	80,606
Total	**($4,545,226)**	**($4,325,232)**	**($8,870,459)**

- **Maintenance of Need:** The article raises the HCBS Maintenance of Need allowance from 100.0 percent of the federal poverty level plus $20 per month ($1,093 per month) to 300.0 percent of the federal standard for supplemental security income ($2,382 per month) to enable individuals to retain more of their income while receiving services in their homes.

  Medicaid does not cover room and board expenses when individuals receive services in home- or community-based living arrangements. To ensure that beneficiaries opting for care in these settings have adequate resources to meet these and other personal needs, the State allows individuals in HCBS programs to retain part of their income. This is known as the Maintenance of Need. By increasing the allowance, individuals will be able to retain more of their income to cover more of their expenses at

home. This will reduce the likelihood that individuals need to move into institutional settings because staying home is cost prohibitive. The increase in the allowance also means that individuals will contribute less towards their cost of care. The Budget adds $2.4 million from general revenues ($5.4 million all funds) to recognize the corresponding increase in the cost to the State for these services.

Analyst Note: The Governor's Budget adds the funding to the Medicaid program; however, approximately half is for the population of individuals with intellectual or developmental disabilities whose services are funded through the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The Governor's Budget Amendment dated April 12, 2021, shifts half of the additional costs from EOHHS to BHDDH, which reduces the impact within the Medicaid program but is budget neutral to the State.

- **Assisted Living Rates:** The article increases assisted living rates in both fee-for-service and managed care. Currently, assisted living facilities are reimbursed at $69.00 per day for all beneficiaries. The rate does not compensate facilities for the difference in costs to provide care for higher-need patients; this creates a disincentive for assisted living providers to care for patients with higher acuity. The Governor's Budget establishes a tiered rate structure to reimburse assisted living based on residents' acuity as follows:

Assisted Living Tiered Reimbursement

Tier	Description	Population	Rate	*Increase*
A	Basic	57.1%	$78.00	*13.0%*
B	Enhanced care and transition services	40.5%	$98.00	*42.0%*
C	Serious cognitive decline and co-morbidities that may require skilled care or stablization services	2.4%	$121.00	*75.4%*

The Budget adds $1.1 million from general revenues ($3.2 million all funds) to fund the rate increases, representing a composite rate increase of 23.0 percent based on the share of assisted living residents expected to be assigned to each tier. The tiered structure is effective October 1, 2021.

Analyst Note: The Governor's Budget Amendment dated April 12, 2021, increases the general revenue portion of the tiered reimbursement rates by $612,225 to $1.7 million. There is no accompanying federal funds change. The Governor's Budget originally included $612,225 in general revenue savings attributable to the elimination of the State-only Category F Supplemental Security Income payment within the assisted living budget line. These initiatives are related, as the savings are reinvested in higher assisted living rates; however, Category F is budgeted separately in DHS. The amendment shifts the savings to DHS, leaving a higher amount in EOHHS. The Category F changes are described in more detail below.

	FY2022 Governor		As Amended	
Assisted Living Rates - Medicaid	**General Revenue**	**Federal Funds**	**General Revenue**	**Federal Funds**
Medicaid Population	$1,145,480	$1,393,261	$1,145,480	$1,393,261
Remove Category F	(612,225)	-	-	-
Reinvest Category F in Tiered Rates	588,007	715,199	588,007	715,199
Total	**$1,121,262**	**$2,108,460**	**$1,733,487**	**$2,108,460**

- **Home Care Wages:** The article establishes a targeted wage pass-through program for home care workers to bolster the State's ability to provide services to individuals in their homes.
  - **Shift Differential:** Article 12 increases the shift differential rate modifier for Personal Care and Combined Personal Care/Homemaker services delivered by Certified Nursing Assistants (CNAs). The modifier grants extra pay to CNAs that deliver direct care services during non-standard hours (evenings, nights, weekends, and holidays). The Budget increases the existing modifier from $0.38 per 15 minutes ($1.50 per hour) to $0.56 per 15 minutes ($2.25 per hour) effective July 1, 2021. The intent is to increase the number of staff that can care for individuals in their homes during off-hours, thereby reducing the need for 24-hour residential care. The rate modifier is paid to HCBS providers (employers) through the Medicaid reimbursement rate, but the article requires that 100.0

percent of the modifier be passed directly to CNAs and imposes reporting requirements on employers to confirm that the wage is passed through. The Budget includes $274,684 from general revenues to fund the shift modifier.

- **Behavioral Health Enhancement:** Article 12 also adds a new behavioral healthcare rate enhancement of $0.39 per 15 minutes ($1.55 per hour) for Personal Care, Combined Personal Care/Homemaker, and Homemaker Only services for providers with at least 30.0 percent of staff with behavioral healthcare training. The enhancement applies to CNAs who have completed a required behavioral health certificate training program, effective January 1, 2022. Similar to the shift differential noted above, the rate enhancement provides extra pay for CNAs that specialize in behavioral healthcare. The article requires that 100.0 percent of the enhancement be passed directly to CNAs and imposes reporting requirements on employers to confirm that the wage is passed through. The Budget includes $469,127 from general revenues to fund the behavioral health enhancement.

Analyst Note: A portion of home care expenses are incurred by the Department of Human Services' Office of Healthy Aging for the Home and Community Care Co-Pay program. There should be funds added to DHS to account for the modifiers. All costs for the direct care wage enhancements are accounted for in EOHHS in the Governor's Budget.

- **Supplemental Security Income:** The article eliminates the Supplemental Security Income (SSI) Category F payment and part of the Category D payment.
  - **Category F:** Category F is an enhanced SSI payment for certain individuals in assisted living facilities. The payment assists with room and board expenses, but is State-only because the federal government does not provide matching funds for room and board outside of institutional settings. The Governor's Budget eliminates the Category F payment in Article 12. Individuals are not allowed to retain the payment for personal use and therefore will not be impacted by its elimination. Assisted living facilities, which benefit from the payment, will also receive a rate increase, noted above, effectively building the Category F payment into the federally-matched rates. The Budget includes $208,747 in general revenue savings within the Department of Human Services by eliminating the State-only Category F payment.
  - **Category D:** Category D is a subset of assisted living residents who receive SSI but reside in an assisted living facility that is not eligible to receive Medicaid. The State makes supplemental $206 payments per month to assisted living facilities for these beneficiaries. Current law includes a provision for the $206 payment for Category D individuals living in assisted living facilities financed by the Rhode Island Housing and Mortgage Financing Corporation (RI Housing). Article 12 strikes the language as it relates to $206 payments to RI Housing facilities. The Budget does not appear to remove the funding associated with this population.

Analyst Note: As noted above, the Governor's Budget Amendment dated April 12, 2021, shifts additional savings to DHS to account for the Category F elimination. The Governor's Budget included $612,225 in general revenue savings within EOHHS related to Category F. This represents the proper total associated with Category F; it is unclear why the Governor's Budget also removed $208,747 from DHS. The amendment adds $612,225 back to EOHHS and shifts approximately $400,000 to DHS to reflect the total savings in the proper budget. It does not appear that the Governor's Budget accounts for savings by eliminating the Category D payment for individuals in RI Housing facilities.

- **Implementation:** The Governor's Budget adds 2.0 Implementation Director of Policy and Program FTE positions within the Executive Office of Health and Human Services to administer and oversee the various programmatic changes associated with the LTSS Resiliency and Rebalancing initiative. These positions are funded 50/50 between general revenues and federal funds. The Budget includes $107,508 from general revenues and $107,508 from federal funds, assuming an October 1, 2021, start date. The Budget also includes $73,215 from general revenues and $219,375 from federal funds for

contracted IT support to provide the necessary system upgrades to implement the home care rate modifiers and tiered reimbursement rates for assisted living facilities.

- **Shared Living:** The article authorizes a 10.0 percent rate increase for shared living caregiver stipends beginning July 1, 2021. Currently, shared living providers are paid rates ranging from $24.23 per day to $48.11 per day. Approximately 200 individuals utilize shared living arrangements. EOHHS anticipates that increasing shared living rates will provide an incentive for willing caregivers to utilize shared living as an alternative to more intensive options. The Budget includes $123,181 from general revenues ($314,210 all funds) to fund the rate increase.

- **Nursing Home Rates:** The article allows the Executive Office of Health and Human Services to revise the methodology used to determine nursing home rates by re-weighting rates towards behavioral healthcare effective October 1, 2021. The resolution increases the acuity-based rates for beneficiaries with behavioral health symptoms and cognitive performance diagnoses by 10.0 percent to recognize the additional staff time needed for behavioral health patients and adds $516,871 from general revenues ($1.1 million all funds) to fund the increase. The Budget simultaneously reduces rates for all other diagnoses categories by approximately 1.0 percent, reducing general revenues by $480,340 ($1.0 million all funds).

Analyst Note: This part of the LTSS Resiliency and Rebalancing initiative is supposed to be budget neutral per the Executive Office's request. The Budget updated the cost associated with the behavioral health increase, but did not update the savings associated with the rate reduction for other diagnoses, leaving residual funding. The Governor's Budget Amendment dated April 12, 2021, corrects the reduction for other diagnoses categories such that there is no net impact from this change.

Hospital Payments

Article 12 reduces general revenue payments to hospitals by $3.2 million ($6.9 million all funds) relative to the November 2020 caseload estimate by eliminating two supplemental payments.

- **Outpatient Upper Payment Limit:** Upper Payment Limit (UPL) payments compensate hospitals for the difference between what hospitals receive for Medicaid services and what they are paid under Medicare reimbursement principles. These payments are authorized, but not required, by federal law. A portion of the payments are eligible for the favorable Expansion federal match rate; the State pays approximately one-third of the total cost. Currently, the State only makes UPL payments for outpatient services; the inpatient portion was eliminated in the FY2020 Enacted Budget. Article 12 eliminates the outpatient portion.

  The November 2020 CEC estimate includes a total of $4.9 million for outpatient UPL payments in FY2022, of which $1.7 million is from general revenues. The Governor's Budget removes funding for the UPL payment in FY2022; however, the Budget applies an incorrect federal match and takes more general revenues than were included in the estimate. The Budget includes $2.2 million in general revenue savings, which is overstated by $418,808.

Outpatient UPL

Hospital	FY2022 Adopted
Butler	-
Kent	488,429
Women and Infants	526,493
Care New England	**$1,014,923**
Bradley	-
Miriam	550,548
Newport	160,290
Rhode Island Hospital	2,247,859
Lifespan	**$2,958,696**
Roger Williams	346,164
St. Joseph's	220,956
Prospect - CharterCARE	**$567,120**
Landmark	149,008
South County	119,590
Westerly	36,232
Rehabilitation	6,670
Other	**$311,500**
Total	**$4,852,239**
General Revenue	*$1,739,831*

- **Graduate Medical Education:** Article 12 eliminates the Graduate Medical Education (GME) payment to Rhode Island Hospital in FY2022. The GME program, created in 2014, provides funding for

academic Level I trauma center hospitals that have a minimum of 25,000 inpatient discharges and provide training for at least 250 interns and residents per year. Rhode Island Hospital is the only hospital that qualifies for this funding. The payment is made in June of each year.

In prior years, Rhode Island Hospital received a State-only payment because the federal government did not allow a match for GME. However, the State applied for and received approval for federal Medicaid matching funds for the program in October 2019. The approval document authorizes $548,800 in federal matching funds in FY2022 to supplement the State's $1.0 million general revenue payment. The November 2020 CEC included $1.5 million from all funds based on this approval document. The Executive Office applied for and expects approval for a full federal match of $1.2 million for the FY2021 and FY2022 payments, although this has not yet been approved. Because caseload estimates are based on current law, the FY2022 estimate only includes the $548,800 federal match. The Governor's Budget removes $1.0 million from general revenues and $1.2 million from federal funds for the GME payment in FY2022 based on the Executive Office's expectations; however, this exceeds the caseload estimate and overstates the federal funds savings by $629,375.

Analyst Note: The following table summarizes the amounts included in the November 2020 CEC estimate for supplemental hospital payments in FY2022. The Governor's Budget should include a total of $2.7 million in general revenue savings ($6.4 million all funds) by eliminating these payments.

Supplemental Payments	General Revenue	Federal Funds	All Funds
Outpatient UPL	$1,739,831	$3,112,408	$4,852,239
Graduate Medical Education	1,000,000	548,800	1,548,800
Total	**$2,739,831**	**$3,661,208**	**$6,401,039**

Both payments, along with the savings associated with their elimination, will be readjusted at the May 2021 CEC, though these errors could also be corrected via a budget amendment.

Managed Care Risk Margin

Most Medicaid beneficiaries are enrolled in managed care programs, whereby the State pays a health plan a per member per month capitation rate to provide comprehensive coverage. Managed care is the alternative to fee-for-service, where the State pays providers directly based on the services each member actually uses. The managed care structure is similar to a private insurance arrangement, where beneficiaries pay a premium regardless of whether or not services are actually used. Rhode Island operates its managed care programs using risk-based managed care organizations (MCOs).

Federal actuarial soundness requirements mandate that states account for risk in managed care arrangements. Rhode Island does so by including a risk adjustment within the monthly capitation rates, which allows the State and Medicaid managed care organizations to share in aggregate gains or losses associated with insuring Medicaid beneficiaries. The arrangement provides financial protection by addressing potential claims volatility that MCOs may face by covering an array of different Medicaid coverage groups, particularly high-need populations. The margin recognizes that rates are developed prospectively and that the actual expense of providing care may vary. Federal requirements do not set the margin; according to EOHHS, most states' use margins ranging from 0.5 percent to 2.5 percent of monthly capitation rates. Rhode Island Medicaid currently uses a 1.5 percent margin.

The resolution allows EOHHS to execute contract amendments with the MCOs in order to reduce the margin from 1.5 percent to 1.25 percent in FY2022. The Governor includes $1.2 million in general revenue savings ($4.0 million all funds) to reflect a reduction in the rates paid by the State to the MCOs. The Medicaid savings are offset by a $79,045 revenue loss from the 2.0 percent insurance premium tax.

RIDOH Programs

The resolution authorizes the State to modify two programs at the Department of Health (RIDOH).

- **Family Home Visiting:** The Family Home Visiting program provides pregnant women and families with services to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, promote child development, and improve school readiness. The program is funded by the Department of Health; coordinated along with the Departments of Children, Youth, and Families (DCYF) and Human Services (DHS); and administered by local, community-based agencies.

  Family Home Visiting encompasses three sub-programs: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. These programs are currently supported by a federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) formula grant. Federal grant funding will be reduced in FY2022 and RIDOH will need to reduce capacity from 1,400 to 1,150 families. The Governor proposes establishing a costs not otherwise matchable (CNOM) program in order to maintain Family Home Visiting services at the current capacity. CNOMs are programs that cover populations that are not mandatory under federal Medicaid rules, but for which the federal government authorizes Medicaid reimbursement. Rhode Island establishes its CNOM programs in the Section 1115 waiver. Two of the home visiting sub-programs—Healthy Families America and Nurse-Family Partnership—are already included in the waiver as a CNOM program but are not funded as such. The Medicaid resolution in Article 12 authorizes the State to amend the 1115 waiver to add Parents as Teachers to the CNOM in the 1115 waiver so that the full array of home visiting services are reflected. The Budget adds $605,538 from general revenues ($1.4 million all funds) to fund the CNOM.

Analyst Note: The additional funding is not limited to Parents as Teachers and encompasses all three programs, as they are not funded as discrete items in the Budget. Note that the Budget could fund the CNOM for the other two programs without the authority in Article 12 since they are already in the waiver.

- **First Connections:** The First Connections program is a referral-based home visiting program that works to connect families with services such as food assistance, behavioral healthcare services, child care, long-term family home visiting, Early Intervention (EI), and other community-based services and supports. Services are delivered through a multidisciplinary team that includes a maternal child health nurse, a social worker, and a community health worker. The goal of the program is to ensure that at-risk families are engaged and connected to appropriate services in order to reduce poor outcomes for children. Currently, families are referred to the First Connections program after a screening at birth. Children up to age three may also be referred by a primary care provider, DCYF, or another source. Article 12 authorizes an expansion of the program to pregnant women who meet the income requirements for Medicaid eligibility in order to identify and address risk factors earlier on. The resolution authorizes this new coverage as a CNOM program. The Budget includes a general revenue increase of $95,755 ($226,800 all funds) to fund the expansion for an estimated 60 women in FY2022. The funding would provide for 30 visits per person per year at a cost of $126 per visit.

Medicaid Expenditure Report

RIGL 42-7.2-5 requires that the Executive Office of Health and Human Services submit an annual, comprehensive overview of all Medicaid expenditures, outcomes, administrative costs, and utilization rates for each fiscal year. The Medicaid report includes spending and trends by population and major service area, including populations served by other departments within the Secretariat.

Under current law, the report is due by March 15 of each year. According to EOHHS, because of the timing and requirements of the report as is, State staff do not compile the report in-house. It is completed by a contractor, Milliman, which already provides other claims data analysis and rate setting support for the Medicaid program. The report is generated at an annual expense of $138,000 from general revenues and $138,000 from federal funds.

Article 12 shifts the deadline for the annual Medicaid report from March 15 to September 15 of each year. This would shift the next deadline from March 15, 2022, to September 15, 2022. As a result, a report would

not be completed during FY2022 and the next report would be submitted during FY2023. The Governor's Budget removes funding for the report in FY2022, accordingly.

Analyst Note: This report has not been completed since September 2019, when it was submitted six months late. It is unclear why EOHHS has continued funding this portion of the Milliman contract since then.

Community Health Workers

The resolution adds Medicaid coverage for care management services provided by community health workers. Care management refers to a comprehensive set of services and activities that support patients in managing their health conditions or risks by coordinating healthcare and connecting patients with other resources outside of the healthcare system. There is a growing evidence base which shows that addressing patients' holistic needs has significant potential to yield cost savings in Medicaid and the healthcare system generally. A study published in Health Affairs in February 2020 showed a return on investment of $2.47 for every dollar invested in community health workers. By covering community health worker services under Medicaid, EOHHS anticipates a $2.25 annual return on investment (ROI).

Based on prior year care management data, an estimated 2,000 high-risk Medicaid members will utilize community health workers each year under the new coverage group. Assuming that each community health worker can provide care management services for 55 members, this initiative requires 36 full-time community health workers per year. At an hourly rate of $48.50, this requires annual funding of $3.6 million, including $1.2 million from general revenues.

Community Health Workers	**FY2022**	**Out-Years**
Total CHWs Needed	36	36
Medicaid Rate - Hourly per CHW	$48.50	$48.50
Months Paid	9	12
Annual Cost	**$2,722,500**	**$3,630,000**
General Revenue	*920,653*	*1,227,537*
ROI Assumption	$1.125	$2.25
Annual ROI	**($3,062,813)**	**($8,167,500)**
General Revenue	*(1,035,735)*	*(2,761,959)*
Net Impact	**($340,313)**	**($4,537,500)**
General Revenue	*(115,082)*	*(1,534,422)*

The Budget assumes a three-quarter impact from this initiative in FY2022, with the coverage and reimbursement effective October 1, 2021. The Budget also assumes a $1.125 return on investment in the first year of implementation to reflect that it may take some time to see the full return on investment. The Budget adds $920,653 from general revenues ($2.7 million all funds) to fund the 36 community health workers in FY2022. The investment is offset by an anticipated $1.0 million in general revenue savings ($3.1 million all funds) via the return on investment. The net impact to the state is a $115,082 general revenue savings ($340,313 all funds). In future years, the net general revenue savings is expected to grow to $1.5 million ($4.5 million all funds).

Perinatal Doula Services

The resolution allows EOHHS to submit a State Plan Amendment in order to add Medicaid coverage for perinatal doula services. The Governor includes $112,252 from general revenues ($278,022 all funds) to cover $850 per birth for these services. This investment would generate an additional $5,560 from the 2.0 percent insurance premium tax.

Doulas are non-medical professionals trained in childbirth who provide women with continuous physical, emotional, and informational support before, during, and after birth. During childbirth, doulas provide breathing techniques, massages, advice, and advocacy. Studies show that one-on-one support during labor and delivery is associated with improved outcomes, particularly in communities of color, including shorter labor periods, reduced risk for costly C-section procedures and premature births, and a reduction in the use of pain medication. EOHHS anticipates that doula coverage will reduce the likelihood of higher-cost interventions in labor and delivery within Medicaid populations.

The Governor's Budget assumes that 10.0 percent of Medicaid births, or 456 births, will be assisted by a doula. Studies show that doulas reduce the incidence of C-section births by 40.4 percent. The Governor's

Budget assumes that providing doula services would result in 52 fewer C-section births for savings of $109,578, offset by an increase of $387,600 to cover the additional cost of providing doula services for 456 women. This would result in a net expenditure increase of $278,022 in FY2022, including $112,252 from general revenues.

Eleanor Slater Hospital Transitions

The resolution includes two provisions related to the effort to transition patients from the State-run Eleanor Slater Hospital (ESH) into clinically appropriate settings.

- **Mental Health Psychiatric Rehabilitative Residential (MHPRR) Program:** A Mental Health Psychiatric Rehabilitative Residence (MHPRR) is a congregate licensed residential program with 24-hour staffing. MHPRRs serve individuals with developmental disabilities, addiction, and mental health issues and other individuals who cannot be treated in the community through outpatient supports. MHPRRs provide discharge planning, medical and/or psychiatric treatment, and reduce barriers that prevent transitions to less restrictive settings. MHPRR services are currently reimbursed by Medicaid at a per diem rate of either $125 or $175. Article 12 authorizes a $350 rate increase. MHPRRs are less costly than ESH, and the savings attributable to these transitions are included in BHDDH's budget. However, once patients leave ESH, the cost of their care is transferred to EOHHS and the Budget does not include any associated funding for the rate change in EOHHS.
- **Nursing Home Rates:** The resolution authorizes EOHHS to modify nursing home rates to assist in Eleanor Slater Hospital transitions. Specifically, it increases rates for patients on ventilators and establishes a behavioral health add-on to per diem nursing home rates. It appears that these rate modifications are targeted at existing Eleanor Slater Hospital patients; however, the language applies to all nursing home rates and will impact other individuals. The scope of the impact to other Medicaid beneficiaries is unclear. Supporting documentation indicates that the behavioral health add-on refers to the $175 per day noted above, but the increase is not limited to MHPRR patients. The Budget does not add funding to EOHHS to increase the rates.

Analyst Note: The Governor's Budget Amendment dated April 12, 2021, adds $5.9 million from general revenues to the Medicaid program to reflect the additional caseload related to the transition of patients from ESH into community-based settings paid by Medicaid. The amendment adds $2.9 million from general revenues ($6.9 million all funds) to reflect the additional Medicaid expenses associated with patients discharged from ESH. The estimate accounts for the rate increases for MHPRRs, behavioral health patients, and ventilators that are included in Article 12. The amendment also includes $2.9 million from general revenues ($7.0 million all funds) to reflect that the proposed rate increases will also affect existing, non-ESH populations that may also be discharged to community-based settings as a result of the rate increases.

Dental Benefits for Children

The resolution authorizes Medicaid coverage for dental caries (cavity) arresting treatments using Silver Diamine Fluoride (SDF) within the RIte Smiles program, which provides dental benefits for children up to age 21. The Budget does not include funding associated with this proposal. EOHHS' budget request noted that the gross cost of the benefit for the population is approximately $30,000 from all funds, but that a variety of research indicates that the addition of the benefit results in a net reduction to costs. The Executive Office only requested the authority to provide the benefit, without associated funding.

Cavities are typically treated by drilling into tooth surfaces and filling the defects with restorative materials (amalgam, ceramic, etc.) and usually involves the use of local anesthesia. Unlike traditional restorative treatment, SDF application takes about one minute and does not require the removal of carious tissue. SDF is applied topically by brushing, which eliminates the need for needles and anesthesia. Additionally, unlike traditional fillings, SDF application remineralizes the tooth and kills bacteria, helping to prevent future cavities. The treatment costs about $1 per patient, compared to several hundred for a filling. This cost

differential is the basis for the assumption that this new benefit will be at least cost neutral, but it is likely that providing SDF coverage will produce savings.

Technical Corrections

Section 2 amends current law to make two technical corrections that do not have a budget impact.

- **Medicaid Co-Pays:** RIGL 40-8-4 currently authorizes the State to charge nominal co-pays for certain hospital services and prescription drugs by promulgating regulations to impose cost sharing. However, Rhode Island does not actually require cost sharing from Medicaid beneficiaries. Article 12 strikes the current language to clarify that the Medicaid program does not charge co-pays and to remove the potential that the existing language could be used to impose co-pays in the future.
- **Federally Qualified Health Centers (FQHCs):** The federal government imposes special payment rules for FQHCs, which are safety net organizations that provide comprehensive and affordable care to vulnerable populations in underserved areas. State Medicaid programs must reimburse FQHCs at a minimum rate per encounter, known as a prospective payment system (PPS). States also have the option to establish higher rates under an alternative payment methodology (APM). Rhode Island opted to establish APM rates through a document known as the FQHC Principles of Reimbursement. FQHCs may opt into the APM if they agree to certain additional obligations; if they opt out, they are reimbursed under the PPS. Current law only recognizes PPS reimbursement. Article 12 amends RIGL 40-8-26 to recognize the APM and clarify that it is established by the Principles of Reimbursement.

Federal Financing Opportunities

The resolution allows EOHHS to pursue any changes to the Medicaid program which improve quality, access, and cost-effective delivery, so long as the changes do not have an adverse impact on beneficiaries or increase expenditures beyond appropriations for FY2022.