November 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 October 22, 2020. Please submit the answers no later than close of business October 20, 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 the State's COVID-19 response.

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.

MEDICAL ASSISTANCE

All tables requested by these questions are consolidated into one Excel workbook (emailed as an attachment along with the questions). References to each tab are included throughout this document.

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.

   See testimony.

2) Please update Tab 1 of 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 estimates for FY 2021 and FY 2022. Please update FY 2020 Final and May adopted figures, as necessary.

   See testimony.

COVID-19 Impact and Expenses

1) Within each program, please include EOHHS assumptions regarding the following COVID-19 impacts and how each assumption is factored into FY 2021 and FY 2022 estimates. Please note any changes in such assumptions since the May conference.

   a. Impact on enrollment, rates, and program costs. Please include a separate discussion of redeterminations and assumptions regarding the enhanced FMAP.

      For impact on enrollment and assumptions regarding redeterminations and enhanced FMAP see ***Major Developments*** *section.*

   b. Impact due to regulatory changes.

      The EOHHS testimony assumes that the regulatory changes made for the COVID-19 pandemic have no fiscal impact in FY 2021.

   c. Potential COVID surge in winter.

Moody's economic forecast, referenced in EOHHS' testimony, assumes that a COVID-19 surge and/or lack of federal stimulus would lead to the more severe economic outlook nationally and contribute to rising unemployment and Medicaid enrollment. EOHHS' testimony aligns with Moody's baseline model which assumes no such surge and does assume a federal stimulus.

d. Potential federal aid (unemployment benefits, aid to states or businesses, etc.)

The EOHHS testimony assumes a federal stimulus passes in early CY 2021 and/or the absence of a severe economic downturn.

e. Anticipation of a COVID-19 vaccine

EOHHS' testimony does not assume that the efficacy of a vaccine will directly impact Medicaid enrollment.

f. Limitation or closure of in-person learning

EOHHS' testimony does not assume changes to in-person will directly impact Medicaid enrollment.

2) Please describe the interaction between Rhode Island unemployment rates and Medicaid enrollment from March 2020 through September 2020 by program.

As written in Health Affairs[1], in terms of national trends, the correlation between employment and enrollment among eighteen expansion states studied was −0.252 (p = 0.313) which is not statistically significant. Notably,

> *Medicaid enrollment may lag job losses and applications for other safety-net programs. Enrollment changes for March 1–June 1, 2020 might not capture the full extent of coverage changes resulting from the pandemic and should be interpreted as preliminary evidence of enrollment changes. It is possible that a clearer relationship between job losses and Medicaid enrollment will emerge in the coming months as more people lose employer-sponsored insurance, move off of COBRA, or resume using health care services. The share of nonelderly adults with Medicaid coverage continued to increase through 2010 and 2011, well after the end of the Great Recession. It will be important for researchers to investigate these dynamics as more data become available.*

*See **Major Developments** for further information and Rhode Island specific data.*

a. Please note any lag observed between filing for unemployment, eligibility determination, and Medicaid enrollment (i.e. time from filing to enrollment). Are there any sectors that have seen higher unemployment rates during the pandemic that have protections in place that limit or prolong the transition to Medicaid, such as union protections?

The 2008 Recession trends suggest there was a lag between filing for unemployment and enrollment in Medicaid, as enrollment did not immediately increase as unemployment rose, but began to in FY09. It is not clear that such a lag would be the same in this recession given it is of a different type, as outlined in the testimony, e.g., it is impacting lower income earners (suggesting a shorter lag is possible), people may be delaying healthcare utilization (suggesting a longer lag is possible).

According to the same Health Affairs article cited above

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[1] Frenier et al. "COVID-19 Has Increased Medicaid Enrollment, But Short-Term Enrollment Changes Are Unrelated To Job Losses." *Health Affairs* 39 No. 10. Internet: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00900 (Accessed: October 20, 2020)

several states with relatively large increases in unemployment and relatively small increases in Medicaid enrollment (such as Washington, Michigan, and New Jersey) also happen to have relatively high levels of unionization; unions may protect temporarily laid-off workers from losing their insurance. Furthermore, many people who are Medicaid eligible might not enroll until they have an immediate need for health services, and such needs may be postponed because of the cancellation of nonessential procedures or concerns related to health care use during the pandemic.

It is possible that a clearer relationship between job losses and Medicaid enrollment will emerge in the coming months as more people lose employer-sponsored insurance, move off of COBRA, or resume using health care services. The share of nonelderly adults with Medicaid coverage continued to increase through 2010 and 2011, well after the end of the Great Recession. It will be important for researchers to investigate these dynamics as more data become available.

By sector information on unemployment for all states including RI can be tracktherecovery.org, as site maintained by Harvard and Brown.

3) Please provide an updated impact of the delay in termination activity since the enhanced FMAP has been extended beyond what was anticipated at the May conference.

The Public Health Emergency has been extended, presumably until January 2021. Assuming we follow the conditions stated below, we can claim the enhanced FMAP through the end of the quarter in which the PHE ends (March 31, 2021). EOHHS is maintaining the same trend observed since February 2020 through the end of March 2021 to account for the moratorium on termination activity and uncertain enrollment surges. A summary of the growth is presented below:

*See **Major Developments** for further information.*

	Actual Enrollment Growth Between Feb-20 and Sep-20	Estimate Enrollment Growth Sep-20 and Mar-21	Additional Member Months between Oct-20 and Mar-21
Rite Care Core	9,832	8,566	29,753
Rite Care CSHCN	292	233	808
Expansion	14,873	15,363	52,498
Rhody Health Partners	82	99	347
Rhody Health Options (ICI)	-249	224	560
PACE	8	7	24
Overall	25,559	25,259	87,023

a. How many individuals are in the pool of potential terminations that are on hold?

Eligibility & Held Terminations

By suppressing nearly all terminations, the Medicaid program has shielded just under 17,000 members from being terminated through early October. Approximately 3,000 have since regained eligibility for a net 14,000 members who remain in the Medicaid program.

It is important to note that total only represents members who self-reported a change in income through the client web portal or where a worker updated a client record with a member-reported change that would have resulted in termination, but for the PHE. It does not include members who may have been identified as ineligibly through renewal or post-eligibility verification of income because these processes have not been run since the start of the PHE.

Backlog of Renewals

Through the end of September, there are 62,000 members who have had their renewal date pushed (53K MAGI/9K complex) back because of the PHE. This number will continue to grow now that the PHE has been extended. Once the PHE ends, these members will be moved through the renewal process. In terms of the share of those renewals that may result in termination, on average approximately 16% of Complex/MPP/LTSS renewals end up being terminated. For MAGI, roughly 7% of renewals are terminated. In the current environment those totals may end up being lower. For Complex Renewals, the termination rate is higher than MAGI because EOHHS requires every recertification packet to be signed and returned. The MAGI population goes through Passive Renewal and most individuals are passively renewed. PEV could also be a factor as these individuals are not flagged throughout the year, just at the annual renewal.

Post Eligibility Verification (PEV)

PEV runs the entire population of MAGI every month, excluding cases that have recertifications due within 90 days. Once the PHE ends, the entire MAGI population will be run through the PEV process. For comparison purposes, from March through November of calendar year 2019, just over 21,000 members (or approximately 10%) were flagged as over-income through the PEV process and sent termination notices (including an opportunity to dispute the findings and retain eligibility). These members were not all terminated, as some provided additional documentation to demonstrate a change in income compared to what was captured by the PEV (for example, they have since been terminated, or their hours were reduced, or the size of their household changed and it was not updated in Bridges, etc.).

b. What is the timeline for terminating these cases once the public health emergency ends?

EOHHS interprets this question to mean, "what is the timeline for redetermining eligibility for these cases," as not all will be terminated. Once redeterminations can resume EOHHS aims to complete them all within three months, but this may take longer as the size of the backlog grows.

c. How many individuals have voluntarily terminated Medicaid enrollment?

The following chart shows terminations effectuated by month, as of 10/5/2020 for each category where terminations are still permitted.

Termination Reason	1/31/2020	2/29/2020	3/31/2020	4/30/2020	5/31/2020	6/30/2020	7/31/2020	8/31/2020	9/30/2020	10/31/2020	Total
Deceased	251	210	257	337	408	229	158	84	55	15	2,004
Residency	154	123	166	58	63	84	159	97	117	84	1,105
Withdrawal	529	580	551	337	297	426	426	432	552	360	4,490
Total	934	913	974	732	768	739	743	613	724	459	7,599

d. Please provide a monthly breakdown of activity for these individuals, including how many are added to the pool each month or voluntarily terminate.

See response to (c) above.

4) Please describe how caseload estimates typically account for seasonality (i.e. influenza season and increased utilization) and how EOHHS anticipates COVID-19 will affect the typical impact on Medicaid expenditures.

EOHHS estimates of enrollment trends do not typically explicitly account for influenza season as we have relied upon past enrollment trends or national or regional benchmarks in our recent forecasts.

In terms of utilization, EOHHS' FY 2020 close was impacted by decreased utilization driven by the shutdown. For FY 2021, our MCO rates include a downward acuity adjustment that reflects the

increased enrollment since February 2020 and that the enrollment surge is expected to continue into the fiscal year.

It is important to note that this is an area of great uncertainty. Our certifying actuaries believe our rates are funded appropriately and so while we are not budgeting any risk share payments, the risk corridors will offer protection to the state in the event the rates are overfunded and utilization remains low and will offer protection to the plans if the rates are underfunded and utilization rebounds quickly.

In terms of FFS spending, each section of testimony outlines the utilization assumptions.

5) Does EOHHS have analysis or research regarding how other assistance programs, such as SNAP, interact with Medicaid enrollment?

Several national studies have examined this topic. A summary of results and links to these studies are below.

- *In 2013, the Urban Institute released a study which found that in Rhode Island 35% of children, 23% of nonelderly parents, and 5% of nonelderly, non-parent adults were eligible for both CHIP/Medicaid and SNAP. The study identified state variations due to eligibility rules and poverty rates but noted that the overlap between SNAP and Medicaid was expected to increase after the passage of the ACA. A 2016 article published in Health Economics Review examined the effects of the ACA, noting that Medicaid expansion led to small, but significant effects on SNAP enrollment.*
- *More recently, in August 2020, the Kaiser Family Foundation (KFF) released a report on food insecurity and health which noted the overlap in eligibility requirements between the Medicaid and SNAP programs. However, KFF also noted that less than half of Medicaid enrollees were enrolled in SNAP in 2018. Like the Urban Institutes findings, KFF noted that Medicaid beneficiaries' participation in SNAP varied by income, race, ethnicity, and health status. Populations with higher SNAP participation included African Americans, Native Americans and Alaskan natives, and those with fair or poor health status, and low incomes.*
- *Several papers and CMS guidance have explored ways to coordinate SNAP and Medicaid enrollment. A 2016 report form the Center on Budget and Policy Priorities (Center) noted that about three-quarters of SNAP beneficiaries at least one member receiving Medicaid and CHIP coverage. The Center issued a 2017 report which expanded on its SNAP discussion by examining 17 federal program to determine linkages that streamline enrollment in public benefits programs. CMS guidance to Medicaid directors issued in 2013, provided targeted enrollment strategies, which included enrolling individuals into Medicaid based on SNAP eligibility. In a 2015 follow-up letter to Medicaid Directors, CMS further expanded on its original recommendation to use SNAP eligibility to enroll Medicaid-eligible individuals, and noted that six states had successfully used SNAP enrollment information to process Medicaid enrollment.*

6) Please describe the impact of COVID-19 on the managed care risk/gain share payments in FY 2020 and how EOHHS anticipates the pandemic will impact these payments in FY 2021. Please also provide a breakdown of the latest risk/gain share projections.

SFY 2020

Based solely on plan reporting, utilization changes attributable to COVID-19 reduced the preliminary SFY 2020 risk share payment by $32M from all funds. A comparison of the

preliminary risk share settlement included in the EOHHS accrual to what was adopted at the May CEC is shown below.

As of July 2020	RITE CARE	CSN	RHP	EXPANSION	RITESMILES	TOTAL
SFY 2020 Risk Share (Recoup)/ Payment	$ (568,082)	$ 3,588,401	$ 12,389,218	$ 14,192,491	$ (4,443,408)	$ 25,158,620
May CEC Adopted - SFY 2020	$ 7,655,050	$ 5,030,325	$ 3,041,597	$ 16,415,474		$ 32,142,446
(Surplus)/Deficit to May Adopted - SFY 2020 Only	*$ (8,223,132)*	*$ (1,441,924)*	*$ 9,347,621*	*$ (2,222,983)*	*$ (4,443,408)*	*$ (6,983,826)*

It is important to note that these figures are preliminary and based on plan reporting and will not be finalized until August 2021 to allow time for 12-months of claims run-out. Additionally, prior to final payment or recoupment EOHHS will audit the plans reporting through a reconciliation between claims submitted to MMIS and plan reporting.

SFY 2021

EOHHS has not included a risk share payment in its estimated expenditures for SFY 2021, consistent with how EOHHS approached November CEC. EOHHS makes this assumption because the certified rates are considered "actuarially sound." Actual medical expenditures will vary but at this point we do not have enough information from which to make a projection. The SFY 2021 draft rates (pending legislative changes) are 7.8% higher in composite than the SFY 2020 rates. Additionally, the rates continue to be risk adjusted, so that that the plan with more acute membership will see a rate increases of approximately 10% composite year/year.

7) Please delineate COVID-19 expenses relevant to the Medicaid program that have been allocated to the Coronavirus Relief Fund (CRF) to date, including funds that may be encumbered or planned but have not yet been spent. Note: these expenses may be incurred in Central Management but impact Medicaid providers, such as the LTSS Resiliency Fund or HAPP.

   a. Please provide additional details for the LTSS Resiliency Fund and HAPP, including the amounts paid to each provider.

   Please see spreadsheet below for all CRF-funded EOHHS programs. Separate tabs are included providing a breakout by provider. The summary sheet also includes the approved budget for each program and to-date expenditures.

CRF Funded Program

   b. Please identify any specific program change using the LTSS Resiliency Fund that will have an impact on the Medicaid program when the funds are spent. For example, any programs that expand capacity, such as shared living, will have a fiscal impact.

   As of October 14th, only $5.3 million of the $22.7 million has been expended. It is too early to determine the fiscal impact; however, spending in the HCBS sector will likely increase and spending on LTSS institutional settings will likely decrease. A larger goal of the LTSS Resiliency Fund and associated programs has been to re-orient the delivery of care in nursing facilities and expand home and community-based service (HCBS) options to enable Rhode Islanders to remain in the community, through home-based workforce incentives, training and support. EOHHS anticipates that many of the LTSS Resiliency Fund programs will be budget neutral due to shifting expenditures from LTSS institutional care to HCBS supports, given the difference in average costs between institutional and HCBS settings

   c. What is the impact of the Resiliency Fund on nursing home census, particularly in the NF Transformation Program?

EOHHS understands the question is referring to the initiative known as "Program Support and Change for Nursing Facilities." EOHHS anticipates that the Resiliency Fund will maintain over time the post-COVID nursing home census. The agency remains focused on fostering a more balanced, sustainable and responsible continuum of LTSS programs that emphasize person-centered principles promoting choice, community integration, and opportunity for Rhode Islanders. Nursing facilities will be a part of this continuum of care; however, with a combination of financial incentives, policy and regulatory changes and new programs, EOHHS seeks to reduce RI's reliance on institutional care, and move our state toward the national average for nursing home utilization. "Program Support and Change for Nursing Facilities" is designed to fund nursing facilities that wish to develop new business models, diversify revenue streams and/or develop specialized care models.

d. Please provide data on all program metrics and outcomes assessed to date.

Program metrics, where available, are included in the spreadsheet in our response to question 4A.

8) Are there other potential uses for federal stimulus funds that may be available to provide general revenue relief or to enhance provider stability?

In addition to the funds outlined in earlier questions, CMS FAQs also outline two main additional pathways that Medicaid funds can be used to enhance provider stability:

- *In fee- for-service, retainer payments:*
  - *Typically, CMS does not allow states to "pay providers directly for the time when care is not provided to beneficiaries." However, retainer payments for habilitation and personal care services is an option in an Appendix K, an Emergency Preparedness and Response Addendum to a 1915(c) waiver.*
  - *A retainer payment in this instance is a payment made to a provider in FFS Medicaid when an individual is unable to access the service due to COVID (i.e., a stay at home order, or hospitalization) AND their service plan indicates that the individual needed the service. Providers are only allowed to bill for 30 days of absences for a given individual per CMS guidance.*
  - *We have CMS approval for Medicaid adult day and BHDDH, budgeted as FY20 expenses*
- *In managed care, directed payments:*
  - *This is an option even without the PHE and would direct the MCOs to give rate increases to providers; it can be used to target provider groups in need of additional support due to the pandemic.*
  - *This requires CMS approval of a "pre-print" to revise its MCO contracts.*
  - *EOHHS is not presently pursuing this option.*

FY 2020 Closing

1) Please provide a FY 2020 closing analysis by program (in the same format that has been used for prior November testimony) with a separate column identifying any variance to the preliminary closing.

   a. Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position.

   Please see Excel file below.

2) Please include a column for FY 2020 closing figures in the summary tables within each section of your testimony.

   See each section of the testimony.

FY 2021 Budget

1) Please discuss the impact of the FY 2021 budget delay on the Executive Office's ability to pursue savings initiatives that were included in the Governor's recommendation for FY 2021. In Tab 2 of the attached file, please categorize each initiative by whether it is fully, partially, or not achievable in FY 2021 and rebase the values for those that are still achievable to some extent.

   See table below for whether each initiative is fully, partially or not achievable in FY21. EOHHS will provide rebasing following the submission of these materials.

	May CEC		
	GR	AF	Comment
MCO full risk	5,995,029	17,727,858	EOHHS not pursuing due to COVID
NICU	(1,351,819)	(2,926,648)	EOHHS not pursuing due to COVID
Hospital Rate Freeze	(7,010,217)	(20,901,072)	Can be partially achieved despite budget delays. EOHHS will rebase at 3/4 of a year because although public comment posted July 1, effective day can be first day of quarter we submit SPA to CMS. Assumes budget passes by December 31.
Eliminate Outpatient UPL	(1,511,145)	(4,642,402)	Can be partially achieved despite budget delays. EOHHS will rebase at 3/4 of a year because although public comment posted July 1, effective day can be first day of quarter we submit SPA to CMS. Assumes budget passes by December 31.
Nursing Home Rate - 1% increase	(2,362,385)	(5,145,687)	Can be partially achieved despite budget delays. EOHHS will rebase at 3/4 of a year because although public comment posted July 1, effective day can be first day of quarter we submit SPA to CMS. Assumes budget passes by December 31.
Pharmacy	(552,079)	(1,733,891)	Achieved
Ambulance Rate Increase	790,395	2,217,436	Full cost
SNF Diversions	(401,725)	(869,723)	EOHHS can fullly achieve due to decline in census.
Rite Share	(5,627,570)	(19,000,000)	Savings not achievable due to delay in budget authority and COVID-related loss of ESI.
Co-pays	(3,855,387)	(16,243,471)	EOHHS not pursuing due to COVID and PHE/FFCRA
FFS High Utilizers	(2,098,560)	(6,148,142)	EOHHS not pursuing due to COVID
Doula	94,802	226,750	If enacted in budget, we will post those changes for public comment and submit to CMS. In this case, the changes will only be able to be effective as of the day after the public comment is posted. We assume this will be December so are budgeting 1/2 of the cost.
GME Increase	-	1,200,000	Payment made at year-end, so assuming SPA would be accepted for full amount even if submitted in December though EOHHS is exploring this with CMS.
Total	(17,890,661)	(56,238,992)	

   a. What planning actions have been taken with regards to each initiative to expedite the federal approval process upon the passage of the budget? For example, the State already submitted SPAs to freeze hospital rates, limit the nursing home COLA, etc. prior to legislative action.

For potential reductions, we have submitted for public comment the SPAs that are in line with the Governor's budget proposal. However, we have not officially submitted these to CMS as we do not have legislative authorization to do so.

If a FY 2021 budget passes that contains the proposals already posted for public comment, EOHHS will formally submit State Plan amendments to CMS. The effective date will be the first day of the quarter in which EOHHS submits the changes; therefore, EOHHS will not be able to achieve savings back to July 1, 2020. If the General Assembly passes a FY 2021 budget with different State Plan changes, EOHHS will post the specific amendments for public comment and submit them to CMS after the State's regulatory process completes. These changes will only be effective the day following the posting for public comment. If the State Plan changes are not posted for public comment within the applicable quarter, then the earliest effective date would be the first day of the quarter in which the requested changes are submitted to CMS

b. If enacted, will rate changes be made retroactive? Does a retroactive rate freeze require recouping funds from providers?

If the enacted rate changes are those we have already posted for public comment, the changes will be made retroactively to be effective the first day of the quarter in which the budget is enacted.

If the enacted rate changes are different than those we have posted for public comment, we will post the SPA for public comment as soon as feasible after budget passage and the rate changes will be effective retroactively as of the day after the public comment is posted, unless it is not submitted within the applicable quarter, in which case the earliest effective date would be the first day of the quarter in which it is submitted to CMS.

A retroactive rate freeze does not require recouping funds from the provider as EOHHS has not increased rates for nursing homes, hospitals, or home care/hospice despite RIGL and federal authorities directing us to do so, as OMB has cited RIGL subjecting us to the lower of the FY 2020 Revised Enacted Budget or the FY 2021 Governor's Recommended Budget.

Of note, EOHHS believes that it will need to give the rate increase as outlined in our current state plan for the first quarter of the year based on the CMS regulations explained above.

Non-Emergency Medical Transportation Services

1) Please provide FY 2020 final expenses and FY 2021 and FY 2022 estimates by program.

   See testimony.

2) The legislature has not yet approved a contract amendment to maintain FY 2021 ambulance rates at the levels that were increased in FY 2020. Have ambulance rates been reduced to the prior rates of $71.50 for BLS and ALS, accordingly?

   No, the NEMT broker has maintained the higher ambulance rates, and EOHHS has maintained the higher NEMT capitation rates assuming this initiative will pass. If the initiative is not approved EOHHS will need to recoup some of its payments made to the broker.

3) Please provide a breakdown of types of transportation usage including ambulance, RIPTA, wheelchair van, ride share, and other allowable modes of transportation. Please also include information about the increase or decrease in each type of transportation as a result of COVID-19.

   A breakdown of CY 2020 transportation by mode is included in the spreadsheet below. Each month shows the current month usage compare to the prior month. From this information, you can infer how COVID-19 affected utilization.

CY2020 Trip Data by Modes 10.5.2020. (1)

4) Please provide most recent performance/complaint report.

- *Stakeholder complaints through August 2020:*

Stakeholder data thru August 2020..d

- *Destination complaints through August 2020:*

Destination Complaints thru Au(

- *Performance Standards Withhold Explanation Letter*

Att A_Withhold Explanation Letter A

5) Discuss the impact of COVID-19 on the program, including, but not limited to: utilization, ability to provide appropriate methods of transportation, and changes made by EOHHS and MTM to accommodate social distancing

a) Are the restrictions imposed by EOHHS still in effect?

MTM has followed the ReOpening RI website guidance for transportation since the onset of COVID. See file below.

2020-08-13-Phase-3 -Car-and-Van-Guida

b) Has the Executive Office provided additional guidance or limitations for transportation providers?

The only "addition" or modification was ensuring COVID testing sites were approved destinations. MTM has provided transportation to testing sites if warranted.

c) How many more individuals have taken advantage of the gas mileage reimbursement option? Is there a potential for this trend to continue in the future, post-pandemic?

As seen in the below data, gas mileage reimbursement (GMR) has had a minor increase since Jan. 2020 after a dip in utilization in March due to the onset of COVID. It is noteworthy to add that MTM offers gas mileage reimbursement to every member that calls to schedule transportation. Lastly, MTM and EOHHS expanded GMR to include the ETP population in April 2020.

Month	Gas Reimbursement	% change from Previous Month

January	1,989	N/A
February	1,572	-21.0%
March	1,661	5.7%
April	1,579	-4.9%
May	1,594	1.05%
June	1,653	3.7%
July	1,937	17.2%
August	2,013	3.9%
September	2,057	2.2%

Reconciliation Payments and Recoupments

1) Please fill out Tabs 3a-3d of the attached file to show the advances, recoupments and the outstanding balance by facility since the May conference. For each facility, how many applications does this balance represent?

See tabs in workbook below.

Tables 3A to 3D Combined.xlsx

Note that unique individual is by the facility they were in when the interim payment was requested, and there could be an individual in multiple facilities and they would be counted each time. Additionally, we may have missed certain individuals if we did not have a MID and "no MIDs" are all being counted as "1," though there may be several.

a. 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.

As stated in past testimonies, the typical two-year timely filing requirement from CMS is not a risk factor here. The contingency payments that we will not be able to leverage Medicaid match on are those for which there is ultimately no approved application, as the RIGL requires that the agency pay contingency payments after the facility has waited more than 90 days for approval, and then entitles the facility to retain the amount of the contingency payments made if the application is not approved. Since the application was not approved and no Medicaid eligible service was rendered, the state cannot obtain a federal match. The amount of these contingency payments to date is $3.2 M and we are working to review any outstanding cases without a complete application.

b. Please provide a 3-year history 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.

See above.

c. Please note the percentage of estimated advances that are assumed to be State-only. This assumption was reduced from 10.0 percent in previous conferences to 2.2 percent in May.

Our accrual of contingency payments made from SFY20 and prior assumes 10% will be state-only. The projection in this testimony for payments made in SFY21 and SFY22 assumes 0% in recognition of the declining amount of contingency payments being made and the non-material nature of this assumption.

d. At the May conference, EOHHS noted that collections on contingency payments were suspended through May 2020. Was this extended? Have collections resumed?

On March 16, 2020 EOHHS sent a communication to Nursing Home Providers that all contingency payment recoupment activity would be suspended through May 2020. EOHHS continued this suspension through June 2020, with recoupments restarting with the July 2020 financial cycle.

Independent Provider Model

1) Please provide an update for the Independent Provider Model, including any relevant impacts due to COVID-19 and any potential costs outside of the conference estimate.

- *COVID 19 delayed the training of prospective PCAs due CCRI forced closure. As closure continued, training had to be developed and moved to a live, on-line (synchronous) format. This required CCRI to choose a platform for delivery of Mandatory Orientation (MO).*
- *COVID 19 further delayed the delivery of the IP Registry listing of fully trained PCAs as the CPR and 13-Hour training required in-person deliveries. These trainings have begun as of October 2020 which will result in the ability to post a registry of fully trained PCAs.*
- *There is one beneficiary utilizing the program currently with one additional approved for LTSS and the IP Program who is starting shortly with the newly onboarded Fiscal Intermediary (FI), Public Partnerships LLC (PPL) (This beneficiary requested to wait until the new FI started because he did not want to register twice with the FIs. – this was his choice).*
- *There are 40 applicants currently applying through the Service Advisory (SA), Seven Hills, in various stages of the process.*
- *One PCA completed all course requirements and National Criminal Background Check (NCBC) screening and is about to be listed on the IP Registry. She had completed the MO and 13-Hour ADL/IADL course before COVID but just completed her CPR.*
- *Ten perspective PCAs are scheduled to take the next 13-Hour ADL/IADL course this month.*
- *Nine prospective PCAs have taken the MO and are CNAs. Once all have verified their CPR and NCBC screening, they will be invited to join the registry.*
- *109 people have been interested in providing care. Of this, 31 have fallen out of interest, did not qualify, or are no longer responding. The remaining 78 make up various stages of activity as described above.*
- *Administrative costs involve:*
    - *The IP Administrator's salary. In EOHHS' Central Management program budget, there is $30,366 all funds/$3,037 general revenue for HCH contract support.*
    - *Translation fees total $13,338 and include:*
        - *the consumer and PCA manuals were translated to Spanish ($6,528);*
        - *all advertising flyers for consumers and PCAs were translated to Spanish, Portuguese, Haitian-Creole and Vietnamese, as recommended by DHS case workers. ($1,142); and,*

- *the manuals have recently been ordered to be translated to Portuguese since there are beneficiaries entering the stream who are Portuguese-speaking only. ($5,668)*

2) Testimony at the May conference noted that DLT would support training costs through October 2020. Has this timeline been impacted by COVID-19? If so, how?

   The timeline was not impacted. DLT funded the training costs through October 31st. A new contract funded by DLT began November 1.

Hepatitis C

1) Please provide actual expenses incurred to date since the change in policy. Please also provide a detailed comparison of the FY 2021 and FY 2022 estimates for Hepatitis C coverage. If any of the underlying assumptions have changed since May (utilization, price, case mix, State share, etc.), please explain why. Note any lag in data, where appropriate.

   *See **Major Developments** of testimony.*

   a. How many individuals have utilized the treatment through October 2020 (or the latest month for which the health plans have reported this information)?

      *See **Major Developments** of testimony.*

   b. Has there been an overall reduction in the number of beneficiaries diagnosed with Hepatitis C? Or another way to quantify the impact of the policy change?

      *See **Major Developments** of testimony.*

2) Please provide the Hepatitis C workbook that has been used to derive the estimates by program in previous conferences.

   EOHHS' estimate relies on its Stop Loss payments to the MCOs, annualizing the utilization in the nine months prior to March. As such, no additional workbook was developed. EOHHS can model revised assumptions at the conferees' request.

Behavioral Healthcare Services

1) How many individuals are receiving treatment through either IHH or ACT?

   Monthly authorizations for behavioral health health-home services are presented below:

Sum of MEMBERS	SFY20					SFY21					% in Managed Care
	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	
Assertive Community Treatment	**1,220**	**1,238**	**1,271**	**1,282**	**1,298**	**1,317**	**1,335**	**1,344**	**1,342**	**1,341**	**69%**
Medicaid Only	657	672	704	707	718	729	738	745	747	745	89%
Dual Eligible	563	566	567	575	580	588	597	599	595	596	44%
Integrated Health Home	**6,613**	**6,578**	**6,669**	**6,717**	**6,714**	**6,814**	**6,863**	**6,932**	**6,987**	**6,986**	**74%**
Medicaid Only	3,879	3,867	3,945	3,975	3,976	4,042	4,075	4,114	4,145	4,138	90%
Dual Eligible	2,734	2,711	2,724	2,742	2,738	2,772	2,788	2,818	2,842	2,848	51%
Opiod Treatment Health Home	**2,849**	**2,823**	**2,866**	**2,910**	**2,911**	**2,927**	**2,898**	**2,920**	**2,990**	**2,991**	**90%**
Medicaid Only	2,543	2,522	2,564	2,610	2,609	2,612	2,587	2,608	2,666	2,665	95%
Dual Eligible	306	301	302	300	302	315	311	312	324	326	45%
Centers of Excellence	**140**	**134**	**141**	**147**	**152**	**141**	**146**	**144**	**144**	**143**	**90%**
Medicaid Only	128	123	127	129	131	118	124	124	125	125	93%
Dual Eligible	12	11	14	18	21	23	22	20	19	18	72%
Grand Total	**10,822**	**10,773**	**10,947**	**11,056**	**11,075**	**11,199**	**11,242**	**11,340**	**11,463**	**11,461**	**78%**

   a. How many are dual eligible?

See above table. Overall, 45% of ACT and 40% of IHH are Dual-eligible.

b. Are the PMPM rates consistent at $420 for IHH and $1,267 for ACT?

EOHHS' payment does not distinguish between a Medicaid Only or Dual-Eligible member.

2) Please note any savings included in the estimates attributable to dual eligible beneficiaries in Opioid Treatment Programs whose services are now Medicare-eligible. *See testimony.*

Housing Stabilization Program

Please provide the following information regarding the housing stabilization program:

1) What are the estimated costs for the program for FY 2021 and FY 2022?

   FY 2021: $285,000 AF

   FY 2022: $1,140,000 AF

2) What is the projected enrollment in both years?

   The estimate assumes that 651 members will receive three member months of service in FY 2021. This increases to 1,302 receiving six months of service each in FY 2022. Since this is a new program, actuals will likely be different from what is assumed here. With additional experience, we will be able to more accurately estimate the impact of the benefit.

3) The benefit was expanded to provide services to those in IHH or ACT programs. What is the cost of that expansion?

   The cost of the expansion is included in the estimate above. The May CEC included $575,000 from all funds for the program on an annual basis. That estimate has since been revised using the assumptions above to capture the expanded population of eligible members. The reduction in FY 2020 reflects a delayed start of the program.

All Programs – Rate and Caseload Changes

1) Please fill out the table for the specific rate and caseload changes that impact the separate programs, as has been included in testimony in the past (example in Tab 4 of the attached file), so that the totals can be shown in the aggregate and by program.

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

Item	%	Program	FY 2021 Estimate All Funds	FY 2022 Estimate All Funds	Rate Increase Only [1]: All Funds	General Revenue
Nursing Home and Hospice[2]	3.00%	Fee-for Service	$355,026,691	$355,992,574	$7,833,577	3,549,981
		Managed Care	$224,628	$228,580	$5,030	2,279
		RHP	$1,654,652	$1,694,156	$37,280	16,894
		RHO II	$44,361,492	$50,951,508	$1,121,182	508,092
		Expansion	$8,647,276	$8,790,370	$193,431	19,343
		Total	**$409,914,739**	**$417,657,188**	**$9,190,500**	**4,096,590**
Personal Care Services [3]	3.38%	Fee-for Service	$38,571,573	$38,245,355	$1,250,429	566,663
		RHO II	$14,358,136	$16,309,622	$533,242	241,652
		Total	**$52,929,709**	**$54,554,977**	**$1,783,670**	**808,315**
Hospital Inpatient Rates	2.75%	Fee-for Service	$39,010,890	$34,543,487	$924,522	418,970
		Managed Care	$186,774,869	$186,775,451	$4,998,856	2,265,357
		RHP	$67,739,693	$69,356,959	$1,856,269	841,215
		RHO II	$5,918,174	$6,797,334	$181,924	82,443
		Expansion	$159,329,697	$154,270,153	$4,128,885	412,888
		Total	**$458,773,322**	**$451,743,384**	**$12,090,456**	**4,020,873**
Hospital Outpatient Rates	2.60%	Fee-for Service	$6,328,751	$6,493,299	$164,548	74,569
		Managed Care	$166,638,003	$169,594,837	$4,297,725	1,947,621
		RHP	$53,358,132	$54,632,042	$1,384,438	627,393
		RHO II	$4,011,816	$4,607,782	$116,766	52,916
		Expansion	$135,702,910	$136,717,581	$3,464,578	346,458
		Total	**$366,039,612**	**$372,045,541**	**$9,428,055**	**3,048,956**
Managed Care Administrative Rates [4]		Managed Care	$59,837,364	$60,890,125	$1,052,761	477,085
		RHP	$23,145,429	$23,698,020	$552,591	250,420
		RHO II	$5,194,772	$5,966,468	$771,697	349,714
		Expansion	$52,626,146	$52,985,270	$359,124	35,912
		Total	**$140,803,712**	**$143,539,884**	**$2,736,172**	**1,113,131**

Notes:

[1] Impact of price change only, except Managed Care Admin, which is the change attributable to caseload changes.
[2] Excludes Medicare days. Nursing and Hospice Care rate increase reflect 3/4 of year, adjusted for impact of patient share.
[3] Home Care Codes subject to statutory increase. RHO II based on HCBS capitation proxied to Personal Care as a % of total HCBS in FFS.
[4] Includes MCO Admin & Risk Margin. Change in revenue attributable to caseload changes. No change in the admin portion of cap rates.

Long Term Care (including the Integrated Care Initiative)

1) Provide the number of pending applications and the backlog, including those past 90 days.

   As of 10/6/2020, there are:

   - *1,027 total applications pending;*
   - *311 cases pending more than 90 days since the initial application was filed; and,*
   - *141 complete applications pending more than 90 days (the backlog).*

2) Provide current and anticipated caseload trends for Rhody Health Options.

   See testimony.

   a. Provide a table of FY 2021 and FY 2022 Neighborhood capitation rates for Rhody Health Options. Please include FY 2020 final rates as a point of comparison.

   See testimony.

   b. If the rates for FY 2021 have changed since May, please provide an explanation.

   See testimony.

3) How are the estimates 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? May testimony assumed a continuation at least through the end of FY 2021.

The contract is being extended until December 2023.

The following table summarizes the FFS budget line reductions to account for the passive enrollment into Rhody Health Options (Phase II):

	FY 2021	FY 2022
Hospitals	$ 101,494	$ 376,977
Pharmacy	$ 3,528	$ 13,104
Other Services	$ 387,251	$ 1,438,362
Overall	$ 492,273	$ 1,828,444

a. Provide an estimate of the net impact if the contract is not extended and RHO members move to fee-for-service.

Following an extensive stakeholder engagement process, the contract is being extended, so this question is not applicable.

4) Please provide the enrollment and capitation rate information for the PACE program (Tab 1). *See testimony.*

5) Please note the impact of prior period hospice activity on your estimates.

The FY 2020 Closing included an accrual of $13,092,825 attributable to incurred by not reported hospice claims.

The EOHHS estimate assumes that this level of prior period activity occurs and thus the reversal for this accrual has no impact on the EOHHS estimate.

Between July - September of 2019, EOHHS had paid about $6M in SFY 2019 claims. During the same time period in 2020, EOHHS paid just over $5M in SFY20 claims.

The hospice estimate uses the same methodology employed during fiscal close.

6) During the peak of COVID-19 in Rhode Island, many nursing homes implemented procedures that limited the number of residents (for example, no double-occupancy rooms, no new admissions from hospitals, etc.). Are there procedures in place now that will continue to limit the number of residents?

Per the Department of Health, there is not a blanket policy that prevents the homes from utilizing their beds. In general, many homes still are utilizing double occupancy rooms. Most are also not accepting patients who are positive for COVID-19 and admissions are also being paused when there is an outbreak. Many facilities are reporting a large number of unfilled beds; this is consistent with EOHHS' analysis of the facilities' Minimum Data Set (MDS) submissions to CMS (see response to question #7 below).

7) Please provide a breakdown of nursing home census fluctuation during the pandemic, including the number of deaths, new admissions, and discharges by month.

See table below. Claims and hospice data traditionally have an extended lag in payments. As a result, a few percentage points change in claims expenditures is not unexpected when reviewing the most current data even after the application of historical IBNR factors. This is particularly true for Medicaid nursing home claims because the surge in contingency payments in FY 2017 and FY 2018 make the use of more recent IBNR factors unreliable.

Separate from the Caseload estimating process, EOHHS is analyzing nursing home census data. This work is based on the MDS which is a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified homes. This data is intended for clinical purposes and must be significantly manipulated to make census estimates and cannot be used to infer direct correlation to Medicaid expenditures.

- *Pre-COVID, this MDS data leads to an estimate of approximately 1,200 monthly admissions. In total the facilities experienced approximately 240 deaths per month. Average census was stable at approximately 95% occupancy, with about 8,100 residents.*
- *Since the pandemic, admissions have declined significantly in April through June, but have since begun increasing. However, the number of discharges is also down considerably over this time as are facility deaths.*

This suggests that much of the decline in nursing home stays is due to short-term or rehabilitative stays and may not translate into Medicaid savings within one fiscal year without additional action to promote nursing home diversions or transitions.

The average census appears to be down by at least 15% for an average occupancy rate of 78%. The data suggest significant variation in occupancy rates however, ranging from 53% to 100%.

Significantly, there appears to be a decline among Medicare-paid residents. For example, as of March 31, 2020, 25% of facility residents were in for less than 90 days; in May that proportion was 18%, representing a decline of 725 members. This means that 80% of the decline in daily census is attributed to a reduction in the relatively short-stay nursing facility residents. These member-days are more likely to be Medicare-reimbursed and have a higher reimbursement rate and therefore the fiscal impact is potentially disproportionately significant to the homes. It also suggests that Medicaid-paid days may not have declined to the same extent. While a short-term post-acute stay may make a future dually eligible resident more likely to return to nursing home in the future based on personal choice, it is too early to tell whether this experience in short-term stays will translate in to Medicaid stays in the future.

			New Admissions[3]:		Month-End Census:				
	All Entries[1]	All Discharges[2]	Count	% Medicaid[4]	Count	% Medicaid[5]	Occupancy Rate	Distinct Residents[6]	Deaths in Facility
August 2020	1,307	1,258	884	31%	6,634	63%	77%	7,549	167
July 2020	1,244	1,222	832	31%	6,636	63%	77%	7,509	136
June 2020	1,079	1,098	698	33%	6,618	64%	77%	7,427	233
May 2020	845	1,296	530	32%	6,646	64%	77%	7,680	474
pre-COVID: February 2020	1,847	1,925	1,168	39%	8,119	62%	95%	9,583	276
January 2020	2,087	2,003	1,339	32%	8,188	62%	95%	9,624	294
Deecmber 2019	1,898	1,962	1,194	34%	8,033	63%	93%	9,511	249

Notes:

1. Entries are defined as any MDS segment that begins in the indicated month. This may be for a transition from Medicare to Short Term Stay, a readmission/reentry, or a short-term stay where an admission assessment was not completed.
2. Discharges are defined as any MDS segment that ends, either temporarily (as a result of short term stay in hospital) or permamently (as a result of death in facility or discharg out to community). Some discharges will have a resulting entry in the same month, at the same or as a different facility.
3. Admissions refer only to residents with a completed OBRA admission assessment for a stay that commenced in the indicated month.
4. Medicaid-eligible includes anyone with a full Medicaid, or MMP only, or in an OHA Copay Program eligibility on the date of entry.
5. Medicaid-eligible includes anyone with a full Medicaid, or MMP only, or OHA Copay Program eligibility as of the most recent assessment of any type.
6. Distinct residents reflect number of people who in nursing facility for at least one day in the indicated month.

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share, and fee-for-service for FY 2021 and FY 2022. Please delineate those aspects of managed care programs not covered under a payment capitation system.

   See testimony.

2) Please provide the monthly capitation rate(s) for RIte Care. If different from the rates assumed in the May 2020 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 cost impacts are also provided.

   See testimony.

3) Please discuss the reason for the steady decline in RIte Share enrollment, despite the enhanced focus on enrolling beneficiaries in the program.

   The pre-pandemic decline was driven by the State's inability to enroll and update employer's employer sponsored insurance information to run its cost-effectiveness calculation. In her SFY21 budget, the Governor proposed revising current law to require employers meeting certain requirements to provide this information to the State. Without timely and regular employer rate information, individuals cannot be enrolled in RIteShare

   The decline since COVID, however, can also be attributed to enrollee's loss of employer sponsored health insurance. The state can only enroll someone in RIte Share after running a cost-effectiveness test on a beneficiary's ESI. Additionally, the State decided to stop sending client enrollment notices to beneficiaries during the early months (March through July) of the Public Health Emergency to be sensitive to employees who may have lost employment or were working remotely as these notices require signature and action from the beneficiary's employer. Lastly, while the State has started re-sending client enrollment notices, if a beneficiary does not return the notice to enroll, there are no negative action taken against the beneficiary due to the PHE.

4) May 2020 testimony noted an 11-month delay in the submission of SOBRA claims. Does this remain an issue? What is the reason for the delay?

   This has been an historic delay that has to do with UHS's general billing practices.

5) Please provide the projected CHIP funding for FY 2021 and FY 2022.

   See testimony.

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

The testimony includes, $57,000 in FY 2021 and $55,000 in FY 2022 for 1115 policies.

a. Has the program now been automated through HSRI? If not, when is this expected?-*No.*

Rhody Health Partners

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

See testimony.

a. Please provide the monthly capitated payment for the different groups enrolled in RHP.

See testimony.

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

See testimony.

Hospitals

1) Please provide separate inpatient and outpatient hospital estimates for FY 2021 and FY 2022.

See testimony.

2) For the FY 2022 Disproportionate Share Payment to Hospitals, please include the current federal law amount available for FY 2022 and any insight on the potential for a further delay in the scheduled reduction in the uncompensated care payment cap to the states in CY 2021.

See testimony.

3) How much of the inpatient UPL was attributed to Expansion in FY 2020? What amount is included in the estimates for FY 2021 and FY 2022?

Pursuant to current law, no inpatient UPL payments were made in SFY 20. However, outpatient UPL payments were made. In SFY 20, 29.8 percent, or $1.4 million, was attributed to Expansion. No payments have been made in SFY 21 due to the absence of a SFY 21 Enacted Budget. The SFY 21 and SFY 22 amounts will be reallocated, consistent with CMS approved methodology, based on Expansion-related hospital payments, FFS hospital claims only, within the quarter aligning with the UPL payment. Current estimates for SFY 21 and 22 include 33.4% for Expansion, or $1.5 million in SFY 21 and $1.6 million in SFY 22.

4) Please describe the impact of the temporary delay in voluntary and elective procedures on Medicaid hospital expenditures. Have the number procedures returned to pre-pandemic levels, or are there an unusually high/low number occurring due to an influx in rescheduled appointments, indefinite cancellations, or otherwise?

It is too early to assess the change in utilization and claims volume attributed to COVID. Providers have up to 12 months to submit claims and, in some cases, claims may be submitted and/or re-adjudicated beyond 12 months after the date of service. Additionally, the health plans have their own internal data managed processes which create a lag between when the plan pays a claim and when it is submitted to EOHHS' data warehouse for analytics.

The number of claims paid to-date for elective procedures for dates of service since February 2020, under both FFS and Managed Care, is 30% lower than the number of claims paid per month pre-COVID. Claims' activity is down by a similar amount across the board, including for emergency and urgent care. The true magnitude of the reduction in elective procedures (and other services) can only

be assessed after additional time has passed. We would expect this decline in claims volume in more recent months even without COVID due to the above-mentioned claims lag.

However, with respect to the FFS estimates, after applying historical completion factors, total inpatient expenditures appear to be trending higher. This may be attributed to increased enrollment and does not eliminate the likelihood of a negative trend of a utilization metric such as claims per 1,000 member-months. Consequently, EOHHS estimates assume higher-than-typical monthly inpatient expenditures (gradually tapering back down to the pre-COVID monthly average by the end of the current fiscal year) and about-average monthly outpatient expenditures based on the pre-COVID monthly average (adjusted for rate increases).

With respect to the managed care lines, the health plans have reported significant reductions in utilization and this has been reflected in the improved risk share performance of the MCOs for SFY 2020. Relatedly, the rates for SFY 2021 reflect an adjustment for overall acuity (and therefore utilization) that take into consideration the impact of COVID on enrollments and expenditures.

Pharmacy

1) Please provide separate estimates for pharmacy expenditures and rebates for FY 2021 and FY 2022.

   See testimony.

2) Discuss the potential DRE impact from recent attempts by drug manufacturers to restrict access to the 340(b) program.

   State Medicaid agencies are required by federal law at Section 1927(a)(1) of the SSA to cover all drugs that have been approved by the United States Food and Drug Administration (FDA) and are from manufacturers that have signed a Medicaid drug rebate agreement. In return, state Medicaid agencies receive Medicaid drug rebates that allow the state agency to pay the "best price" (which is equal to the lowest price for which the manufacturer sold the drug for that year).

   The 340B Program allows covered entities (such as FQHCs and certain hospitals) to purchase drugs at a discounted price. If a drug was sold to a covered entity at a discounted price, the state Medicaid agency is not eligible to receive the Medicaid drug rebate for that drug (to avoid the manufacturer from having to pay duplicative discounts for the same drug).

   In RI, covered entities are currently paid by EOHHS in general the wholesale acquisition cost for a drug that is dispensed to a Medicaid member, whether it was through the 340B program or not. The covered entity gets as net revenue to cover the expenses of their programs, the delta between the whole sale acquisition cost of the drug that it receives from Medicaid and the discounted price that it paid for the drug.

   If the 340B program were to go away, EOHHS could receive Medicaid drug rebates on all of its drugs, but the covered entities would lose their current revenue stream and take a significant financial loss and would likely advocate for a Medicaid rate increase.

   Drug manufacturers suspect that they are paying duplicate discounts to Medicaid agencies and 340B covered entities. Duplicate discounts are when a covered entity purchases the drug with a 340B discount, and then Medicaid also claims rebates on those same drugs.

   They suspect this because most covered entities have contracted pharmacies (versus in-house pharmacies) and most of the identification of 340B-eligible people and drugs is done on the back end as the pharmacists do not perform this task, and therefore communication to the state Medicaid agency on which drugs were purchased at the 340B discount may not be as strong as it

should. If this concern of manufacturers is accurate, the elimination of the 340B program would not actually result in an increase in Medicaid drug rebates as the agencies are already claiming these rebates incorrectly.

One threat from manufacturers was that they would only service one contracted pharmacy for each covered entity. Given that people often go to the pharmacy that is most convenient for them (and not necessarily most convenient/preferred to their doctor), the number of drugs that a covered entity could purchase at a 340B discounted price would most likely be decreased significantly if manufacturers limited each covered entity to one contracted pharmacy. If covered entities are communicating the 340B discounted drugs fully and Medicaid is only claiming rebates on those with no such discount, this change in policy would result in an increase in rebates; however, if covered entities are not communicating the 340B discounted drugs fully, Medicaid may already be claiming those rebates in appropriately.

Other Medical Services

1) Please provide an updated estimate of receipts for the Children's Health Account for FY 2021 and FY 2022 and expenditures for all Other Medical Services by service.

   See testimony.

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2021 and FY 2022.

   See testimony.

3) Are there any costs with a non-regular FMAP (State-only or otherwise) in FY 2021 and FY 2022?

   There remains one non-material, recurring state-only expense: the Rite Start Program. *In FY 2020 there were ~$170K in expenditures for this program. The same amount is carried in FY 2021 and FY 2022 on the Managed Care – State Only account. The program is described at* http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-12.3/42-12.3-3.HTM.

   Settlement for certain NICU claims based on discharge DRG. *This is not federally reimbursable because federal rules require Medicaid only pay for conditions present on admission; we currently pay claims using admission DRG to satisfy this requirement. Although paying with discharge DRG may satisfy this requirement in this instance, it would require an alternative methodology be outlined in a SPA and therefore would require Assembly approval. EOHHS has been working with CMS regarding whether and how such a change could be implemented to make this expense reimbursable. See "general questions" below.*

4) How is Tavares different from other long-term care facilities and why is that payment made differently? What services are being provided at the facility?

   In 1995, the State transitioned all adult developmentally disabled (DD) group homes being ICF/MRs (now known as ICF/IIDs) to waiver-based group homes. However, ICF-MRs still fell under DOH licensing and required an RN at each facility. When the DD group homes became waiver-based group homes they fell under BHDDH licensing and DD rate structures. This left four Zambrano group homes and Tavares as the only ICF-MRs in the State.

   Because the Zambrano group homes were attached to Zambarano and Eleanor Slater Hospital, a cost-based funding rate was utilized as the rate reimbursement methodology. To be consistent, a similar rate structure was used for Tavares. Note that the two remaining Zambarano ICF/IID group homes converted to waiver-based group homes last year, leaving Tavares as the State's only remaining ICF/IID.

License Type. *Tavares Pediatric Center (Tavares) is licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Please see CMS' ICF/IDD Glossary for a full definition of an ICF/IID. 210-RICR 050-05-1 also provides a description of an ICF/IID. Information on ICF/IID services and coverage can also be found on the CMS website, and Section 1902 of the Social Security Act. Generally, an ICF/IID facility provides health and or rehabilitative services to individuals with intellectual disabilities. The facility is primarily for the diagnosis, treatment, or rehabilitation of the intellectually disabled or persons with related conditions; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.*

Tavares's Services. *According to a facility representative, as of October 2020, Tavares has a bed capacity of 30 and current census of 28. Approximately 98% of the residents "age-in-place", and stay to end-of-life, and the residents are currently between 2 and 42 years of age. The residents are medically fragile children who have life-long medical issues, very limited motor function and utilize specialized, customized wheelchairs. Residents require a hospital level of care, round-the-clock respiratory therapy, and extensive nursing and respiratory care, such as gastrostomy tube or jejunostomy tubes, respirators, and ventilators. Separately, through the Local Education Agency program, Tavares has an in-house school program for school-age children. For those who have aged-out of school, Tavares has an active treatment room staffed by an LPN because of the medical needs of the young adults.*

Expansion

1) Please provide updated caseload and expenditure estimates (with associated methodology) for FY 2021 and FY 2022 for the Medicaid expansion population.

   See testimony.

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

   See testimony.

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

      See testimony.

General Questions

1) The FY 2020 Revised Budget included a $1.0 million State-only payment to Care New England for outstanding claims. Are there other claims that may be an issue in the future?

   Yes. EOHHS and Care New England reached a settlement agreement to reimburse NICU fee-for-service inpatient hospital claims using DRGs at the time of discharge. EOHHS anticipates making a state only payment totaling $343,928.72 in SFY 21 for 36 NICU cases from July 1, 2019 to March 31, 2020. EOHHS annualized this expense to $466K and is budgeting this amount in SFY21 and SFY22.

2) Please ensure that written testimony clearly identifies if there are any new programs being implemented in either FY 2021 or FY 2022. For example, the housing stabilization program was included in the May estimate, but not identified as such.

   Besides items that are included as budget initiatives, Home Stabilization is the only program being implemented in FY 2021. No new programs are included in FY 2022.

3) Health System Transformation Project Social Determinants of Health Investment Strategy

   a. Please identify any new initiatives or programs included in the investment strategy that will have an impact on the Medicaid program.

All new initiatives identified in the SDOH investment strategy will have a positive impact on the care delivery for Medicaid members and contribute to HSTP's broader goal of reducing the overall reduction of total cost of care or Medicaid spending. A summary of each is provided below.

Rhode to Equity

EOHHS and RIDOH will collaborate to expand the Health Equity Challenge, so that all six AEs can participate. Teams will receive facilitation and coaching through Well-Being and Equity in the World via a Learning Collaborative structure. Limited financial support will be available to support organizations and individuals in spending time engaging in the Learning Collaborative. Teams will identify health outcomes on which to focus (e.g., diabetes in the current model), as well as the social needs/ risk factors that they will address to improve the focal health outcome and the communities where individuals live, work, and play. The Rhode to Equity creates a process for healthcare providers and community partners to come together and workshop an issue collaboratively. Through this approach, and with the help of a facilitator, the stakeholders can translate each other's respective languages and create working relationships that recognize the value that each group brings with the common goal of improving the health and wellbeing of the people that they mutually serve and support. EOHHS envisions the Rhode to Equity as a vehicle to foster meaningful, long term collaborative relationships between the HEZ, AEs/CHTs and MCOs by providing a starting point for that collaboration.

Sustain Community Health Teams

EOHHS will continue to sustain the existing network of CHTs with HSTP funds and make administrative changes to promote closer alignment with AE operations. Beginning in July 2021, EOHHS plans to integrate CHTs into the AE program, continuing to sustain CHTs with HSTP funds for the remainder of the HSTP program. Recognizing that HSTP funds are finite, EOHHS will pursue long-term sustainability for CHTs, such as 1115 Waivers, as outlined in the EOHHS FY22 budget submission.

Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP)

It is intended that with a patient's consent, the CIRP would allow a healthcare provider to send an electronic communication with relevant information about the client to the CBO, before the client arrives, allowing the CBO to spot issues that impact service delivery. If the client arrives and receives a service, the CBO can report back to the healthcare provider, closing the loop. If the CBO does not feel they can assist the patient, they can communicate this back to the provider or send the referral to another CBO. This may help reduce patients' experience of being shuffled across many different organizations that are not able to assist them. If the patient does not seek out the service, or if the CBO cannot immediately meet the patient's needs (for example if the patient is placed on a housing waiting list) the healthcare provider will also receive that information and know that the patient's problem could still exist.

Additionally, the platform would allow collection of data about the types of services that CBOs are not able to provide, whether due to limited staff capacity at the local CBOs or limited community resources (e.g., inadequate supply of affordable housing). This will facilitate advocacy by healthcare organizations and CBOs to increase resources for CBOs and the communities in which their patients live.

Participatory Budgeting

Participatory Budgeting is a democratic process in which a government agency funds a facilitator who assists members of the community to decide how to spend part of a public budget.

Participatory budgeting funds from HSTP will be focused on addressing upstream social determinants of health, while remaining consistent with the obligation to use HSTP funds towards "the establishment of AEs." EOHHS and RIDOH recognize that although the healthcare providers and social service providers play a very large role, there also need to be investments in the communities in which Medicaid members live, pray, and play to ensure the success of the AE program and the improvement of Medicaid members' health outcomes.

4) Nearly one-third of the State's population is covered by Medicaid. Please describe the estimated ceiling of Medicaid beneficiaries in Rhode Island and/or nationally.

The ceiling of Medicaid beneficiaries is a count of all people with incomes below the set federal poverty line eligibility thresholds by program, meaning they also meet the categorical eligibility criteria for that program. The "ceiling" therefore is changing as the number of people with low- or no-income increases. For example, without a federal stimulus, if permanent job loss increases, the number of people with low or no income will increase. This will increase the number of people potentially eligible for Medicaid.

The Kaiser Family Foundation estimated that 98,000 people would be eligible because of job loss between from March 1st through May 2nd. Of that amount, 25,490 have enrolled, leaving 72,510 individuals eligible for possible enrollment. If all these individuals would be added to current Medicaid enrollment, the projected enrollment over the RI population recorded in the US Census would be 37%.

5) Does EOHHS intend to expand the MFP program in light of the recent announcement that more funds will be made available by CMS?

EOHHS intends to apply for the additional $5M grant recently announced by CMS. However, as of this writing, CMS has not made available any additional information on the application process, deadlines etc. While we continue to work on ideas for the grant, we are unable to proceed without further information from CMS.