May 2022 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services;
the Department of Human Services; and, the Department of Behavioral Healthcare,
Developmental Disabilities, and Hospitals

The members of the Caseload Estimating Conference request that the Executive Office of Health and Human Services, the Department of Human Services, and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals provide written answers to the following questions in addition to the presentation of their estimates on Monday, April 25, 2022. Please submit the answers no later than close of business Thursday, April 21, 2022 so that staff can have the opportunity to review the material prior to the meeting. We ask that you bring 20 hard copies of any responsive materials to the Conference.

In addition to the caseload and expenditure estimates, the testimony should include back ground 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 PHE response.

Please include enrollment/utilization projections for both the Medical Assistance programs (including hospitals, nursing homes, pharmacy, in addition to the capitated programs) and the Private Community Developmental Disability programs (including Residential Habilitation, Day Program, Employment, Transportation, Case Management and Other Support Services, L9 Supplemental Funding, and Non-Medicaid Funding). Please provide a separate copy of any information that is requested as an Excel workbook.

CASH ASSISTANCE

Rhode Island Works

***Supplemental Security* Income**

All responses provided to EOHHS from DHS.

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

   Please see spreadsheet:

   DHS Info.xlsx

2) The FY 2022 Enacted Budget eliminated Category F payments. What impact has this had on the total SSI budget in FY 2022 and FY 2023?

   Since the elimination of Category F on 11/1/21, Category D payments have increased by an average of $28,000 per month. This represents an average monthly savings of $75,000 per month, or $900,000 per year

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

      There are approximately 136 individuals receiving the state-only payment after November 1, 2021.

3) Please provide the number of individuals receiving the additional $206 payment because they reside in a non-Medicaid funded assisted living facility and the total cost for FY 2022 and FY 2023.

DHS Projection of non-Medicaid Assisted Living Payments (Monthly Count of Residents and Amount)

	FY 2022		FY 2023	
	Counts	Payments	Counts	Payments
A Better Day	0	$0	0	$0
Bristol Assisted Living	4	$9,888	4	$9,888
Charlesgate	4	$10,986	4	$10,986
Community Care Alliance	12	$29,389	12	$29,389
Forest Farm	3	$6,180	0	$0
Franciscan Missionaries	16	$39,276	16	$39,276
St. Elizabeth	1	$2,678	0	$0
Total	**40**	**$98,397**	**36**	**$89,539**

MEDICAL ASSISTANCE

All tables requested by these questions are consolidated into one Excel workbook (emailed as an excel 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, rate changes and methodology for projections. Please include notes/comments on any related adjustments or factors that are relevant to the estimate.

See testimony and accompany Excel workbook.

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 2022 and FY 2023. Please update FY 2021 final and FY 2022 November adopted figures as necessary.

*See **Attachment 7a** of testimony and "1 – Caseload + PMPM" tab of workbook.*

3) Please provide a list of any state only medical assistance payments to be made in FY 2022 or anticipated in FY 2023 and the reason why the payments are being made. Also provide backup documentation that shows the services provided and payment(s) requested.

There remains one non-material, recurring state-only expense:

***Rite Start Program.** In FY 2020 there were approx. $170,000 in expenditures for this program. In FY 2021 and FY 2022 on the Managed Care – State Only account EOHHS includes $200,000 for this program.*

The program is described at http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-12.3/42-12.3-3.HTM and covers extended family planning benefits for women who do not have qualified immigrant status for Medicaid.

Additional State-only Expenses:

EOHHS revised forecast includes three one-time State-only expenses, this include:

***[1] Fogarty Center** There is a reclassification of a $135,960 overpayment to Fogarty Center from Regular FMAP to a State-only payment**. EOHHS returned the federal-share of $71,406 to CMS in FY 2022**. This repayment followed an investigation by the Office of the Inspector General into*

certain providers in the network. Program Integrity concluded that the Fogarty Center did its due diligence and should be held harmless. Therefore, instead of recouping the full amount from the center, Medicaid returned the federal share and reclassified the expenditure as non-Medicaid.

***[2] Reclassification of Refugee Payments**. During the third quarter of the fiscal year, EOHHS policy and fiscal staff discerned that the State was incorrectly interpreting federal law around the treatment of refugees receiving Medicaid. Federal law allows states to claim 100% match on refugees who would not otherwise be eligible for Medicaid. This match is available for 8 months following entry into the United States.*

Previously EOHHS interpreted this language to mean all refugees were eligible for 100% match.

However, refugees are exempted from the five-year bar and so the only refugees eligible for the 100% match are those whose income exceeds the FPL thresholds of Medicaid. As all of our refugees qualified under an existing aid category group, none of the refugees would be eligible for 100% match. They qualify for regular FMAP or expansion FMAP depending on their income and household situation.

*As a result of this**, EOHHS anticipates returning the federal-share of $3,562,708 to CMS.** This State-only amount is included in **Other Services**.*

[3] IMD Exclusion

The IMD exclusion was part of the Social Security Act of 1965 (SSA). It prevents states from claiming FMAP on certain inpatient/residential mental health services with more than 16 beds that are predominately for psychiatric services. There are several exemptions to this IMD exclusion (e.g., it does not apply to children or elders, SUD treatment services are allowed pursuant to EOHHS' 1115 waiver, and IMD services provided in managed care are eligible so long as the treatment does not exceed 15 days in a month).

Because of staffing shortages during pandemic, Community Care Alliance temporarily merged two MHPRR facilities between November 2021 and February 2022. As a result, for non-SUD related FFS residential services EOHHS cannot claim Medicaid funds.

BHDDH is working with both CCA and EOHHS to assess its total liability that is not eligible for federal match. In total EOHHS anticipates that the total federal amount that may need to be returned to CMS to be less than $75,000.

EOHHS has not included this amount in its estimate at this time as we are still working to identify the relevant claims.

Please note that "Emergency Case Management Services" appears as a State-only based on RIFANS spending report. This service can be matched, and EOHHS' estimate reflects this fact. EOHHS will shift these expenditures as part of its fiscal close activities.

COVID-19 Impact and Expenses

1) Please provide an updated summary of how the COVID-19 pandemic has impacted, and is projected to impact, enrollment, rates, and expenditures across all programs (managed care and fee-for-service), how that is factored into your caseload estimates, and how projections have changed since the budget was enacted.

*The impact of the COVID-19 pandemic on EOHHS' caseload is presented in the **Major Developments** section of our testimony:*

- ***COVID-19 Federally Required SPAs -** Vaccine Administration, Vaccine counseling for kids, COVID Testing. COVID Treatment.*

- ***Enhanced FMAP for Home and Community Based Services.*** *EOHHS has identified an estimated $71.9 million in new federal match can be claimed against eligible HCBS expenditures (incurred between April 1, 2021, and March 31, 2022) and deposited into a Restricted Receipt account. The State can then use these funds to finance the state-share of new investments in HCBS-related services as outlined in Rhode Island's spending plan and approved by CMS. As these restricted receipts are spent, additional federal match will be drawn down per federal regulations, for HCBS initiatives through March 31, 2024.*
- ***Enhanced FMAP related to the Public Health Emergency (PHE)*** *– For entire FY 2022 EOHHS has received an additional 6.20% for regular Medicaid activity and 4.34% for CHIP activity. No adjustment is applied to Expansion.*

  The FY 2022 revised forecast also includes $143.0 million in GR relief including $8.1 million GR relief from the FY 2021 DSH payment and $10.8 million for the Pharmacy Clawback, the latter does not appear as in RIFANS Covid-19.
- ***Caseload trends during the COVID-19 pandemic due to moratorium on terminations.*** *Overall enrollment is anticipated to increase by 63,166 members, or 22%, compared to EOHHS' February 2020 caseload.*

FFS utilization*.*

FY 2022. *As vaccinations increase and people who have been delaying care begin to receive it, outpatient, professional, nursing facility/LTSS, and dental services might increase. Given this uncertainty, EOHHS FY 2022 continue to be conservative. EOHHS has six months of claims data therefore EOHHS' estimates use July 2021 through December 2021 actuals, adjusted by an IBNR as the base. To estimate the remaining six months, EOHHS used several methodologies depending on trends seen in service delivery claims data.*

  - ***Inpatient Hospitals.*** *EOHHS took the average monthly spend from March 2021 through December 2021, inflated by 2.4% to account for the July 1, 2021, hospital rate adjustment, and added it to July through December actuals. (Inpatient FFS utilization over the first half of the current fiscal year remains low (relative to the pre-Covid era) is not expected to rebound during the current fiscal year.*
  - ***Outpatient Hospitals.*** *To the base, EOHHS added a projection for the remaining six months based on March 2021 through December 2021, inflated by 2.4% to account for the July 1, 2021, hospital rate adjustment and a slight utilization adjustment to account for increased utilization seen in recent claim trends.*
  - ***Nursing Facilities and Hospice.*** *To the July to December 2021 spend, EOHHS utilized the average spend from October through December 2021, inflated by a 2.5% utilization increase for the remaining six months. EOHHS utilized the October through December time-period as it captures the 10/1/2021 rate increase of 2.2% as well as the increases to the RUG weights for ventilator per diems. The hospice estimate used the same methodology as above, except that no utilization increase was included.*
  - ***HCBS****. In general, EOHHS' continues to see increased HCBS utilization across its HCBS budget lines. Except for Adult Day Services the more recent experience (i.e., March 2021 through December 2021) is higher now than the pre-Covid 19 period (i.e., October 2019 through March 2020) claims experience. The current year methodology used in EOHHS' estimate is:*
    - *For the remaining six months of the FY, EOHHS used the recent experience for all service categories except for Adult Day Services that reflect the higher of pre-COVID monthly average*

- *For Adult Day Services, EOHHS has seen average monthly spending fluctuate throughout the pandemic: from a low of less than $0.1 million at its onset to $0.29 million in early Summer 2021. Claims data show increased expenditures since September 2021 and therefore, EOHHS used the pre-Covid period of $0.35 million per month as it appears members behavior is moving toward pre-COVID utilization.*

▪ *The exception to the above periodization of the data is the Shared Living budget line. Because EOHHS increased these rates by 10% on July 1, 2021, the current experience period was derived using average monthly experience from July 2021 through December 2021 so to fully reflect price adjustment.*

- ***Pharmacy.*** *For the remaining six months of the fiscal year, EOHHS used the more recent monthly average (i.e., March 2021 through December 2021).*
- ***Other Services****. EOHHS' revised fee-for-service estimates used the higher of the pre-COVID (October 2019 to March 2020) or current trend (March 2021 to December 2021) average monthly spend, adjusted for INBR and annualized. BHDDH Medical Services and Other Practitioners reflect current spending trends; all other spending types DME, physician services, refugee program, rehab and TCM, and Tavares, reflect pre-COVID spending trends.*

Once baseline estimates were complete, below the line adjustment for various FY 22 enacted initiatives and items were added when not already present in claims data.

FY 2023. *The FY 2023 estimate takes the selected FY 22 monthly average; annualizes the monthly average spend; and applies applicable rate increases. Like FY 2022, EOHHS add, below the line adjustment for various items when not already present in claims data.*

The only variation to this methodology is Nursing Facilities, which included a 5% utilization increase and use the average spend from October 2021 through December 2021 as a baseline.

Managed Care Utilization

FY 2022. *The actuarially certified rates for FY 2022 utilize experience from FY 2019. In terms of actuarial standards this is the longest lag allowed for purposes of establishing credible baselines. In typical years, Rhode Island would be leveraging its FY 2020 experience to set its FY 2022 rates. However, due to COVID-19 utilization patterns that period is not considered credible experience for purposes of forecasting future utilization. The use of FY 2019 as a baseline is not unique to Rhode Island.*

Adjustments were subsequently made to account for potential changes in general acuity between FY 2019 and anticipated for FY 2022 due to continued enrollment growth as well as subsequent termination schedule in the latter part of the fiscal year.

Preliminary Risk/(Gain) Share reporting by the MCOs suggest utilization has yet to normalize. Combined with the increased enrollment from the extension of the PHE and continued moratorium on terminations has resulted in significant gain share recoupments across the product lines.

EOHHS estimate for FY 2022 calculates a gain share PMPM based on reporting through December 31, 2021 and annualizes the impact by multiplying these savings against forecast for the entire year. If utilization picks up in the second half of the year (i.e., beginning January 2022) then this approach could overstate savings; however, continued enrollment of members who have a lower average acuity than the base should offset this increase.

FY 2023. *EOHHS continues to apply a 5.0% trend assumption against the current FY 2022 rates. As of April 20, 2022, EOHHS' consulting actuary has not completed rating for FY 2023. Preliminary reports suggest that the 5.0% trend may be overstated. However, EOHHS' actuary cautions that their*

preliminary estimates have yet to be adjusted for the impact of the unwinding of the PHE. Regardless of when the PHE ends, there will be an upward revision of some or all the rating categories. The magnitude of that revision will depend on actual timing and revised enrollment forecast.

In general, EOHHS believes maintaining the 5.0% trend assumption is appropriate. It may be marginally conservative (i.e., the final rates are more likely than not to be less than assumed in May testimony), however, we are not sufficiently confident in this assessment given uncertainty around the timing of PHE and necessary adjustments to account for changes in average acuity of enrolled population.

a. Please delineate COVID-19 expenses relevant to the Medicaid program. Please include any/all federal funding from the Coronavirus Relief Fund (CRF), and expenditures to date of State Fiscal Recovery Funds (SFRF) that were enacted in January 2022 as part of "RI Rebounds," ncluding funds that may be encumbered or planned but have not yet been spent. [Note: these expenses may be incurred in other programs but impact Medicaid providers, such as HAPP.] Please provide additional details for the LTSS Resiliency Fund and HAPP, including the amounts paid to each provider.

   i. *Please see spreadsheet below from the DOA that details all CRF expenditures in the health agencies through March 31, 2022. Note that Project Status on the Summaries Tab is the status reported by the agency as of 3/31/22 and has not yet been validated by Pandemic Recovery Office.*

EOHHS CRF Report Summary 2022-03-3

   ii. *Please see spreadsheet below which details HAPP DOA expenditures through 4/12/2022.*

HAPP as of 4_12_2022.xls.xlsx

   iii. *Please see spreadsheet below which details expenditures from the LTSS Resiliency Fund.*

LTSS Spending-caseload

   vi. Please see spreadsheet below which details expenditures from the SFRF enacted as part of RI Rebounds in January

HHS RI Rebounds FY22 status 4_13_22.

b. Please identify any specific program changes funded by the LTSS Resiliency Fund that have affected the Medicaid program. For example, any programs that expand capacity, such as shared living.

   See the list of programs in (1)(a)(iii).

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.

Of the 14 programs funded by the Resiliency Fund, 12 have been for HCBS services, and $6.6 million has been invested through these initiatives. EOHHS believes that these investments and any observed impact are included in our SFY 22 and SFY 23 estimates. It is unclear to EOHHS how much of the increased utilization is due to COVID or to the investments, or a combination of both. EOHHS's estimate are conservative—increasing HCBS spend in both years to capture increased utilization that is a current trend for most HCBS services, and budgeting nursing facility spend with anticipated LTSS package savings.

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

Workforce Stabilization Loan Program (WSLP). *The WSLP audit report was included in EOHHS' April 2021 testimony therefore it is not included here. Since the publication of the audit report, EOHHS has participated in several appeal hearings and referred cases to the Department of Revenue's Collections Unit. Collections are on-going and one appeal hearing remains.*

LTSS Resiliency Reporting. *All programs were closed as of 9/1/2021. There are no additional program metrics and outcomes to report since our November 2021 testimony.*

2) Please identify any programs available through the American Rescue Plan not accounted for in the FY 2022 Enacted Budget.

a. Regarding the temporary 10 percent FMAP increase for home and community-based services (April 1, 2021 through March 31, 2022), please provide information on the submitted plan and an update on the timeline for expected CMS response/approval.

All communications with CMS, including spending plan updates, are online here:https://eohhs.ri.gov/initiatives/american-rescue-plan-act/home-and-community-based-services-hcbs-enhancement

3) Please provide an updated impact of the current delay in terminations associated with the enhanced FMAP compared to the November estimate including any updated guidance regarding terminations provided by CMS.

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

By suppressing nearly all terminations, the Medicaid program has shielded just about 28,000 members from being terminated through early April 2022. This number has decreased as system modifications were made to effectuate terminations for individuals no longer living in Rhode Island or had withdrawn their request for Medicaid coverage.

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 the PHE ends, EOHHS and DHS will have to process renewals for all individuals who have had their renewal dates extended forward. CMS is now allowing states 12 months to complete those renewals once the PHE ends (as opposed to starting the renewals during the 60 days' notice period). EOHHS' projections assume that full 12 months is needed; EOHHS is currently doing renewals of MAGI individuals and planning to begin renewals for non-MAGI groups when the PHE ends.

c. How many individuals have voluntarily terminated Medicaid enrollment?

Terminations have been completed for being deceased, changing residency or withdrawal. See below.

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

Termination Reason	5/31/21	6/30/21	7/31/21	8/31/21	9/30/21	10/31/21	11/30/21	12/31/21	1/31/22	2/28/22	3/31/22
Deceased	220	173	158	147	86	37	208	181	211	130	92
Residency	209	206	235	256	253	208	150	124	158	271	200
Withdrawal	498	504	495	608	668	606	493	419	422	555	528
Grand Total	927	883	888	1011	1007	851	851	724	791	956	820

4) Please separately identify the general revenue savings from the enhanced FMAP rate and the increased expenses from a delay in redeterminations for FY 2022. Note if there is an impact from the redetermination delay in FY 2023.

*Please refer to **Major Developments** for additional discussion.*

5) During the public health emergency, EOHHS applied for, and received, federal approval that allows the state to extend certain program changes that were made available to respond to the COVID-19 public health emergency for another six months after the emergency ends. Please update the information provided during the May 2021 Conference on the status of these changes.

Please see spreadsheet below which shows there are two (2) 1135 waivers EOHHS would like legislative authorization to pursue permanently, and one (1) temporary waiver we would like legislative authorization to pursue permanently. In addition, there are two (2) items BHDDH would like legislative authorization to pursue permanently. These rows are highlighted in green.

Waiver and PHE

In addition to the above, EOHHS is going to seek legislative authorization in pursuing a new authority to support the PHE unwinding to allow extended Timeframe to Take Final Administrative Action on Fair Hearing Requests: CMS may grant states authority under section 1902(e)(14)(A) to temporarily extend the timeframe to take final administrative action on fair hearing requests. In order to use this option in a manner that protects beneficiaries, states would be required to provide benefits pending the outcome of a fair hearing decision (including reinstating benefits pursuant to 42 C.F.R. § 431.231), regardless of whether or not a beneficiary has requested a fair hearing prior to the date of the adverse action, and to forgo recoupment from beneficiaries if the fair hearing ultimately upheld the agency's determination.

FY 2022 Budget

1) Please include a status update on FY 2022 budget initiatives as outlined in "Tab 2". Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate.

*See **Attachment 2** to testimony and "FY22 Budget Initiative" tab of workbook.*

a. Include all relevant details regarding the status of pending submission to CMS.

- *Items in Tab 2 with SPAs pending CMS approval due to HLF issue are: HCBS shift differential, HCBS behavioral health enhancements, community health workers, doulas, nursing facility minimum staffing rate increase*
- *MHPRR and $175 NF Add-On are delayed due to certification standard and shareholder review. SPAs are drafted and awaiting certification standard review. Additionally, it appears the MHPRR $525 rate requires a RICR change. BHDDH is working with OMB to prepare RICR changes.*

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 ("Tab 4" attached file), so that the totals can be shown in the aggregate and by program.

   *See **Attachment 7b** of testimony and "4 - Rate Changes" tab of workbook.*

2) Please include the hospital July 1 increase, nursing home October 1 increases, home care rate increase, and policy adjustor as well as managed care plan changes. Consistent with the current law interpretation in recent Caseload Estimating Conference reports, the provided estimate should not include a productivity adjustment.

FFS Service Type	***FY 2022***	***FY 2023***
Inpatient Hospital	*2.40%*	*2.70%*
Outpatient Hospital	*2.40%*	*2.40%*
Nursing Facilities	*2.20%*	*1.90%*
HCBS	*0.00%*	*2.34%*
Managed Care*	***SFY 22***	***SFY 23***
*Inpatient Hospital***	*2.40%*	*2.00%*
*Outpatient Hospital***	*2.40%*	*2.40%*
Nursing Facilities	*2.20%*	*1.90%*

*[***]** Note that the composite rate increase used for all the capitated payments was 5.0% and so EOHHS did not separately apply a price factor to the discrete components of the rates. The 5.0% rate increase therefore reflects composite changes in price, utilization, and acuity across all types of services. Additionally, RIGL 40-8.9-9(f)(3)(iv) which mandates annual adjustments to personal care and attendant services delivered under Medicaid FFS does not apply to managed care. As a result, the specific price factor utilized for purposes of rate development is at the discretion of the certifying actuary and is therefore removed from the table above.*

However, any adjustment to the price factor that the legislature enacts can be mandated by EOHHS and passed through to the health plans. Therefore, marginal savings or costs associated with relative changes to these rate factors can be estimated by using the "Spending by Type of Service" (by product/budget line) that is included in the Excel workbook.

[**] Per RIGL 40-8-13.4 hospital rates reimbursed under managed care are adjusted each July 1st, based on the change in the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment[1].

[1] http://webserver.rilin.state.ri.us/Statutes/TITLE40/40-8/40-8-13.4.HTM

Consistent with the interpretation of current law made in the May 2021 Caseload Estimating Conference Report, the market basket applied under Medicaid fee-for-service does not include the productivity adjustment.

Long-Term Care

1) Please provide fee-for-service nursing home expenses and methodology.

*See **Nursing Home** section of testimony and response to **COVID-19 Impact and Expenses (1)***

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

*See **Home and Community Services** section to testimony.*

3) Please provide an update on all current LTSS activities including most current initiatives.

See Attachment "Tab 2" for all initiatives, except the three below.

LTSS Activity Name	***Status Update***
Category F Elimination (DHS Budget)	*Implemented 11/1/2022.*
No Wrong Door	*Please see PowerPoint below for recent updates* NWD.pptx

4) Please provide details on the LTSS application backlog vs. the number of applications.

Information on LTSS applications is available monthly on the transparency portal here: State of Rhode Island: Transparency: UHIP (ri.gov). As of 3/18/22:

PENDING NEW APPLICATIONS

The State continues to prioritize access to benefits. As of **March 14, 2022**, the number of pending new applications across all programs was **4,355**. The total of overdue, pending applications awaiting State action was **1,895**

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	
SNAP Expedited	62	46	108	5	33	38	146
SNAP Non-Expedited	534	314	848	53	27	80	928
CCAP	9	165	174	6	44	50	224
GPA Burial	0	16	16	0	2	2	18
SSP	0	17	17	0	3	3	20
GPA	9	51	60	1	1	2	62
RIW	113	92	205	13	14	27	232
Undetermined Medical	16	189	205	121	1335	1456	1661
Medicaid-MAGI	39	43	82	94	88	182	264
MPP	13	109	122	13	115	128	250
Complex Medicaid	4	48	52	21	198	219	271
LTSS	22	218	240	4	35	39	279
Totals	821	1308	2129	331	1895	2226	4355

5) Please provide a breakdown of type of service for home and community care expenses identified as "All Other HCBS" in the monthly Medicaid Expenditure report.

Please note that the monthly Medicaid Expenditure Reports produced by Gainwell and provided to fiscal staff by EOHHS reflect FFS claims on a paid basis. EOHHS' testimony reflects claims on an incurred basis completed for IBNR and forecasted current and subsequent fiscal year.

The "All Other HCBS" as defined by Gainwell consists primarily of home care, shared living, and adult day. These expenditures are separated into explicit subcategories within ***Home and Community Care*** *budget line in EOHHS' testimony. The "All Other HCBS" reported by Gainwell also includes some expenditures for Targeted Case Management and DME for members in wavier categories; these expenditures as classified among the "Other HCBS" in EOHHS' testimony. (Note that most Case Management and DME expenditures are reflected in the Other Services budget line.)*

6) Please provide an explanation for the separate components of the nursing home rate increase, including the adjustment for patient share.

Nursing home per diems are comprised of the following components:

- *Direct care. Reimburses for nursing salaries (RNs, LPNs, and CNAs) and fringe benefits. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility's costs and then setting an average for the state. Since 2013 when the average was set, this component has been adjusted by an inflationary index set by the General Assembly. The Direct Care component is adjusted by a RUG weight, to account for patient acuity. (For example, a patient on a ventilator would receive a higher rate than someone not on a ventilator). The RUG weight acts as a multiplier on the base rate. This rate is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.*
- *A Provider Base Rate which is the sum of the components below*
    - *Other direct care which reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility's costs and then setting an average for the state. Updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.*
    - *Indirect care which reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility's costs and then setting an average for the state. Updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.*
    - *Fair rental value which is facility specific and was determined as of 7/1/2012 based on a formula included in the current Principles of Reimbursement. Updated annually, pursuant to the State Plan which requires EOHHS to use the IHS Markit Healthcare Cost Review.*
    - *A per diem tax that is facility specific and based on real estate, property taxes, and fire tax paid, and the Medicaid census days. Updated annually based on information from the BM-64 Cost Reports.*

The Direct Care and Provider Base Rates are grossed up by 5.82% to make the provider's whole after the required 5.5% nursing facility provider tax (RIGL 44-51-3)

The cost to the state is not the full per diem, as there is a patient share contribution deducted from the amount paid to the providers.

7) Please include the projected cost of rate changes for both FY 2022 and FY 2023 including the amount of the rate increase and the index upon which it is based.

See testimony for cost of FFS FY 2023 rate adjustments. The cost of the FFS FY 2022 estimates for hospitals and nursing facilities is below. Like our testimony rate change tables, Expansion and MCO budget lines are not included. Please note the FY 20222 enacted budget included no increases for HCBS providers.

SFY 22 Rate Change Impact by Service Type (Excludes Expansion and MCO lines)

Price	Percent		Dollar Impact	Source
Inpatient Hospital	2.4%	$	722,160	CMS FFY 2021 Inpatient Hospital PPS Market Basket Update
Outpatient Hospital	2.4%	$	139,353	CMS CY 2021 Outpatient Hospital PPS Market Basket Update
Nursing Facility	2.2%	$	4,874,424	CMS FFY 2022 Skilled Nursing Facility PPS Market Basket Update
		$	**5,735,937**	

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2022 and FY 2023.

*See **Managed Care** section of testimony.*

2) Please delineate those aspects of managed care programs not covered under a payment capitation system.

All acute services are included in capitation payments, except for dental services (dental services for children are provided in Rite Smiles), NICU, and Covid-19 vaccine administration. Prior to FY 2022, costs associated with organ transplants and Hepatitis C pharmaceuticals were subject to stop loss programs and not included in the rates. These are now included in capitation.

Additionally, while short-term nursing services where medically necessary are a covered benefit on all products, only the CMS Demonstration (i.e., RHO Phase II) includes comprehensive coverage for long-term care services and supports. Relatedly, community and residential services for Rhode Island's Medicaid-eligible I/DD population is generally paid on a fee-for-service basis and included in BHDDH budget. Enrolled members in Expansion and Rhody Health Partners may utilize LTSS services not covered under a payment capitation system.

The Managed Care FFS line captures costs incurred in the pre-enrollment period, FQHC wrap payment for dental services not included in the Rite Smiles contract and wrap services for Rite Share, and adult dental services.

The table below provides a brief schedule of in-plan services. The exhibit is taken from Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

FIGURE 3: MANAGED CARE BENEFIT PACKAGE

Inpatient and Outpatient Hospital	School-Based Clinic Services
Therapies	Services of Other Practitioners
Physician Services	Court Ordered Mental Health and Substance Use Services
Family Planning Services	Court Ordered Treatment for Children
Prescription and Non-Prescription Drugs	Podiatry Services
Laboratory, Radiology, and Diagnostic Services	Optometry Services
Mental Health and Substance Use Inpatient and Outpatient Services	Oral Health
Home Health and Home Care Services	Hospice Services
Preventive Services	Durable Medical Equipment
EPSDT Services	Case Management
Emergency Room Services	Transplant Services
Emergency Transportation	Rehabilitation services
Nursing Home and Skilled Nursing Facility Care	Other Miscellaneous Services

Note: Hepatitis C drugs and COVID-19 vaccine administration professional charges are covered under a non-risk payment from EOHHS to the MCOs.

Covered services are consistent with the SFY 2020 benefit package. Detailed benefit coverage information for all benefits listed in this figure can be found within Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts. In-lieu-of services may also be provided with written approval from EOHHS.

3) Please provide the monthly capitation rate(s) for RIte Care.

   a. If FY 2023 is different from the rate assumed in the November estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.

      FY 2023 is unchanged from November. For monthly capitation rates, please see testimony.

4) Please provide the projected CHIP funding for FY 2022 and FY 2023, as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed since the November Conference, please provide an explanation for the change.

   *Please see **Managed Care** section of testimony.*

Rhody Health Partners

1) Please provide estimates for Rhody Health Partners for FY 2022 and FY 2023. Please delineate those aspects of managed care programs not covered under a payment capitation system.

   *See above response under **Managed Care** questions.*

   RHP members who have a long-term care authorization are eligible for LTSS services not covered under a payment capitation system. These expenditures would appear in Home and Community Care or Nursing and Hospice Care budget lines.

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

      *See **Rhody Health Partners** section of testimony*

2) If FY 2023 rates are different from the prior capitation rate adopted in November, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

   FY 2023 is unchanged from November. For monthly capitation rates, please see testimony.

Hospitals

1) Please provide separate inpatient and outpatient estimates for hospital services in FY 2022 and FY 2023.

*See **Hospitals – Regular** section of testimony.*

2) For the DSH payment, please provide an update on the recent federal update that allows the enhanced FMAP rate to be applied to this payment for FY 2022 and FY 2023. Please provide a specific update as to whether CMS has given formal notice of their intent to allow application of the PHE enhanced FMAP to the DSH payment, such as publishing final allotments for impacted federal fiscal years in the Federal Register. Please provide the total applicable general revenue savings for each state fiscal year separately.

See testimony.

The DSH allotment for FFY 2021 (SFY 22) already includes the additional 6.2% in the allotment. The table below illustrates the savings to the State assuming the 6.2% were not in effect and the state's federal share was not increased.

FFY 2021/SFY 22 DSH Payment

Paid in RIFANS

Allowable Federal Amount	State Amount	Enacted	FMAP
$ 85,909,621	$ 56,584,359	$ 142,493,981	60.29%

Savings Calculation - Assume FMAP is 54.09% and State Maximized Federal Match

Allowable Federal Amount [1]	State Amount	Computed Total	FMAP
$ 77,151,005	$ 65,483,502	$ 142,634,507	54.09%

Total Saviings: $ 8,899,143

[1] Federal Register, Vol. 87, No. 51, March 16, 2022.
https://www.federalregister.gov/documents/2022/03/16/2022-

See testimony for consideration of FFY 2022 / SFY 2023 DSH payment.

Pharmacy

1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2022 and FY 2023.

*See **Pharmacy** section of testimony and **Major Developments** for consolidation of rebates and J-codes.*

Other Medical Services

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

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2022 and FY 2023.

*See **Other Services** section of testimony.*

3) What are the state-only costs in FY 2022 and FY 2023?

Please see response to question 3 under Medical Assistance question above.

Medicaid Expansion

1) Please provide updated caseload and expenditure estimates for FY 2022 and FY 2023 for the ACA-based Medicaid expansion population.

   *See **Expansion** section testimony.*

2) If the FY 2023 capitation rates are different from the prior capitation rate adopted at the November Conference, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

   FY 2023 is unchanged from November. For monthly capitation rates, please see testimony.

Behavioral Health

1) Please provide an estimate for FY 2022 and FY 2023 of Medicaid expenditures for behavioral health services, including overall BH spending over that time (e.g., Medicaid spend on primary BH diagnoses).

   See the exhibit below, which is taken from page 55 of the SFY 2020 Medicaid Expenditure Report.

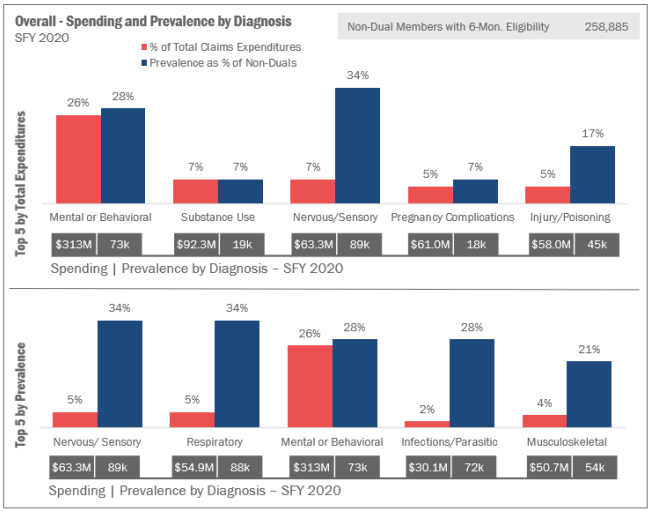
   Members with a diagnosis for a behavioral or mental health condition account for 75% of all high-cost users and have a PMPM that is, on average, more than three times greater than a member without such a condition.

   - *Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:*
     - *One-third of Medicaid Only members have a BH-related diagnosis and account for over two-thirds of expenditures*
     - *40% of Duals have a BH diagnosis and account for 60% of expenditures*
   - *Approximately three-quarters of members with $5,000 or more in claims per year had a BH-related diagnoses*

   In addition to the exhibit below, the Medicaid Expenditure Report includes separate exhibits illustrating the top 5 highest expenditure diagnoses for each the following populations: Adults with Disabilities, Children and Families, and Expansion Adults.

Executive Summary | Overview and Trends | Programs | Provider Type | Populations | Miscellaneous

Expenditures by Diagnoses



- The only diagnosis category that exceeds 10% of Medicaid expenditures is mental or behavioral health, which accounts for at least 25% of expenditures.
  - Prevalence data does not include the Dual population and may understate cost of treating certain conditions.
- Two diagnoses are in the top five in terms of both expenditure and prevalence:
  - Mental or behavioral health, and
  - Diseases of the nervous system and sense organs.
- **Notes**:
  - Prevalence is presented in this report as both a percentage of the CSHCN, Children and Families, Expansion and Disabled Adults populations with the diagnoses, and as the number of enrollees with the diagnoses.

An example of how to interpret the chart to the left:

- 28% "prevalence as a % of non-duals" means that among members within the overall population that have at least 6 months of eligibility during the year and do not have Medicare, 28% had claims where "Mental or Behavioral Health" was the primary diagnosis.
- Of the total claims for this population, 26% of their costs were for claims where "Mental or Behavioral Health" was the primary diagnosis.

RI Medicaid Expenditure Report SFY 2020 | 15 | RHODE ISLAND

High Cost Enrollees: Behavioral Health Diagnoses and Expenditures

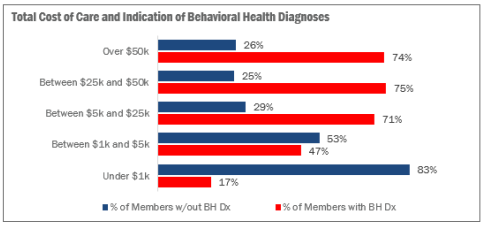
Members with a diagnoses for a behavioral or mental health condition account for 75% of all high-cost users and have a PMPM that is, on average, more than three times greater than a member without such a condition.

Enrollment and Expenditures among Members with a Behavioral Health Diagnosis
SFY 2020

Primary Payer and Diagnosis[1]	Average Enrollment	% of Enrollment	Overall PMPM	% of Expenditures
Medicaid Only				
I/DD Community (BHDDH)	1,190	<1%	$5,890	5%
Other Developmental Disability	12,417	5%	$1,069	9%
Substance Use Disorder	15,196	6%	$1,628	17%
Other Behavorial/Mental Health	60,269	23%	$869	37%
Subtotal - Any BH-Related Diagnoses	89,112	34%	$1,093	69%
No BH-Related Diagnosis	169,922	66%	$263	31%
Overall - Medicaid Only	259,034	100%	$548	100%
Duals				
I/DD Community (BHDDH)	2,532	6%	$6,561	20%
Other Developmental Disability	241	1%	$3,065	1%
Substance Use Disorder	2,163	6%	$1,304	3%
Other Behavorial/Mental Health	11,855	30%	$2,469	35%
Subtotal – Any BH-Related Diagnoses	16,908	43%	$2,928	60%
No BH-Related Diagnosis	22,362	57%	$1,492	40%
Overall - Duals	39,270	100%	$2,110	100%

[1] Members had a claim with an I/DD community provider or a primary diagnoses indicating specified behavioral health condition. If multiple BH categories applicable, member assignment based on prioritization: I/DD (BHDDH), Other DD, SUD, Other BH/MH.

- Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:
  - One-third of Medicaid Only members have a BH-related diagnosis and account for over two-thirds of expenditures
  - 40% of Duals have a BH diagnosis and account for 60% of expenditures
- Approximately three-quarters of members with $5,000 or more in claims per year had a BH-related diagnoses



RI Medicaid Expenditure Report SFY 2020 | 55 | RHODE ISLAND

a. What are the projected expenses for the MHPRR services for FY 2022 and FY 2023? In what program or programs do these expenses occur? How many individuals are enrolled in the program for FY 2022 and projected for FY 2023?

Mental Health Psychiatric Rehabilitative Residential (group home and supportive housing) or MHPRR services provide 24-hour staff having persistent and severe impairments resulting

from extreme persistent disabilities. This benefit is provided in FFS and in Managed Care. Both delivery systems use procedure code H0019 with modifiers to bill for this service. The current reimbursement is as follows:

Current FFS Rates for H0019 by modifier:

- *U1- $85- supervised apartment*
- *U3- $125- apartment, moderate acuity*
- *U4- $125- group home, moderate acuity*
- *U5- $175, high intensity*

MCO rates appear comparable.

*Total Medicaid spending is around $16.5 million per annum. Nearly all the FFS spending is included in the **Other Services** budget line.*

Presented below is the total spending for FY 2020 and FY 2021. Each month there are approximately 430-450 distinct users of the service.

Please note that this is based on actual claims submitted to MCO based on specified procedure codes. Because of nuances in billing practices by the MCOs this may understate total payments for these services that are nonetheless captured in the capitation payments paid to the health plans. Additionally, these costs have been adjusted for missing data and/or IBNR.

Table 1. MHPRRI (H0019) Expenditures in Managed Care and FFS, FY 2021 Actuals and Estimates for FY 2022/2023

	2021	FY 2022 Est	FY 2022 Est
FFS	$7,016,380	$6,592,431	$6,757,242
Managed Care	$9,455,403	$11,080,092	$11,357,094
Grand Total	**$16,471,783**	**$17,672,523**	**$18,114,336**
% Managed Care	57%	63%	63%

b. How many individuals receiving specialized, intensive services, such as ACT, are enrolled as "medically needy"?

c. What costs are projected for the opioid treatment health home program in FY 2022 and FY 2023? How many individuals receiving the service are part of the medically needy coverage group?

EOHHS has two health home programs that provide intensive care management services for the behavioral health needs of its Medicaid members. These include the Integrated Health Home (IHH) and Opioid Treatment Program (OTP). Additionally, members in Medicaid's Assertive Community Treatment (ACT) program are provided with IHH services as part of the bundled payment to the CMHO serving these members. These benefits are provided in FFS and in each of the managed care products.

The monthly health home cost for IHH and ACT is $420.55 per month. (Note that the monthly cost for ACT is $1,267, but *that* includes non-health home behavioral health services as well). The health home cost for OTP is $220 per month.

*Most of the FFS spending is included in the **Other Services** budget line. The managed care spending is included in the premium payments and spread across the entire enrolled population.*

Approximately 11,500 Medicaid members are currently authorized across these four programs:

Table 2. March 2022 Snapshot of Health Home Authorizations by eligibility category

	Regular	Expansion	SSI-like	Medically Needy	Grand Total
Integrated Health Home (IHH)	4,544	1,322	950	193	7,009
Assertive Community Treatment (ACT)	941	224	193	77	1,435
Opioid Treatment Program (OTP)	1,194	1,630	140	12	2,976
Grand Total	**6,679**	**3,176**	**1,283**	**282**	**11,420**

Note that EOHHS increased the ACT rate by 255% to improve access to care through direct care workforce recruitment and retention initiatives effective December 1, 2021, through March 2022. The effective rate was $4,498. As of April 1, the rate returned to $1,267.

2) Please provide enrollment and costs expected to be incurred in FY 2022 and FY 2023, for the following programs. Please indicate the costs to programs individually.

   a. IHH, ACT, OTP Programs

   b. Behavioral Health Link Program

   c. Centers of Excellence. *This program was discontinued.*

   d. Peer Supports Programs

   e. Housing Stabilization Program

See following tables for (a) a breakdown of spending by service type in FY 2021 in Managed Care and FFS, and (b) estimate of spending for these select services in FY 2022 and FY 2023.

Please note that this is based on actual claims submitted to MCO based on specified procedure codes. Because of nuances in billing practices by the MCOs this may understate total payments for these services that are nonetheless captured in the capitation payments paid to the health plans. Additionally, these costs have been adjusted for missing data and/or IBNR.

Table 3. Select Behavioral Health Spending, FY 2021 (Managed Care and FFS)

	FFS	Managed Care	Grand Total
Integrated Health Home (H0037)	$8,493,372	$19,690,291	$28,183,662
Assertive Community Treatment (H0040)	$5,921,323	$9,596,761	$15,518,084
BH Link (H2011/S9485)	$743,252	$1,627,250	$2,370,502
Opiod Treatment Program (H0037 - Provider Type 060)	$467,171	$855,967	$1,323,138
Peer Support Program (H0038)	$190,671	$157,097	$347,767
Housing Stabilization (H0044)	$20,563	$0	$20,563
Grand Total	**$15,836,351**	**$31,927,366**	**$47,763,717**

Table 4. FY 2021 and FY 2022/2023 Estimate for Select Behavioral Health Spending

	FY 2021	FY 2022 Est	FY 2023 Est
Integrated Health Home (H0037)	$28,183,662	$30,088,948	$30,841,172
Assertive Community Treatment (H0040)	$15,518,084	$16,824,180	$17,244,785
BH Link (H2011/S9485)	$2,370,502	$2,374,535	$2,433,899
Opiod Treatment Program (H0037 - Provider Type 060)	$1,323,138	$833,154	$853,983
Peer Support Program (H0038)	$347,767	$249,523	$255,761
Housing Stabilization (H0044)	$20,563	$200,228	$1,655,233
Grand Total	**$47,763,717**	**$50,570,568**	**$51,834,832**