November 2022 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services

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 Wednesday, October 26, 2022. Please submit the answers no later than close of business Friday, October 21, 2022 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 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 requested as an Excel workbook.

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 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 2023 and FY 2024. Please update FY 2022 final as necessary.

   *See **Attachment 7a** of testimony and "Tab 1" of the attached workbook.*

   *Additional details on caseload are included in **Attachments 5** and throughout testimony.*

COVID-19/PHE Unwinding

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 and throughout the testimony. However, aside from the general impact on Rite Care and Expansion caseload (and therefore their premium payments), Covid-19 and the PHE is not assumed to have any impact on caseload beyond what is captured in historical trends. And aside from a 2.5% utilization adjustment to the FY 2022 baseline for Nursing Home spending being applied in both FY 2023 and FY 2024, no other utilization assumption is applied against the FY 2022 experience.*

   Below the line adjustments are included for:

- ***COVID-19 Federally Required SPAs -*** *Vaccine Administration ($5.0 million in FY 2023; $2.5 million in FY 2024). Vaccine counseling for kids and COVID testing and treatment are captured in our base claims data.*
- ***Enhanced FMAP related to the Public Health Emergency (PHE) –*** *For three quarters of FY 2023 EOHHS assumes an additional 6.20% for regular Medicaid activity and 4.34% for CHIP activity. No adjustment is applied to Expansion.*
- ***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.*

2) ARPA - Home and Community Based Support - 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 approved plan, any potential changes to the approved plan and any updates to the plan and the timeline for expected CMS response/approval.

EOHHS submits quarterly spending plan updates to CMS for their review and approval. On May 16th, Medicaid received notice from CMS that Rhode Island's FFY 2022, Q4 spending plan and narrative continue to meet the requirements set forth in the May 13, 2021, CMS State Medicaid Director Letter (SMDL) #21-003. Since this approval, EOHHS has submitted two subsequent reports, one in July and the latest in October. Based on the most recently submitted spending plan (FFY 2023 Q2, submitted October 18, 2022) and assumptions outlined in the plan about eligible federal match rates, EOHHS currently projects spending $147 million All Funds on new investments. This plan, posted on EOHHS' website (https://eohhs.ri.gov/initiatives/hcbs-enhancement), highlights changes since the plan submitted in July.

It is important to note that CMS' approval of the spending plan and narrative solely addresses the state's compliance with the applicable requirements set forth under section 9817 and fulfillment of the requirements as stated in SMDL # 21-003. Spending plan approval does not constitute approval for purposes of claiming federal financial participation (FFP). Approval of any activity in the state's spending plan does not provide approval to claim FFP for any expenditures that are not eligible for FFP. States must continue to comply with all existing federal requirements for allowable claims. As such, changes to the approved plan are expected as program teams work with the HCBS finance lead to finalize implementation plans for the approved projects, including assumptions on whether activities are eligible for a Medicaid administrative or benefits match.

EOHHS is committed to distributing funding in line with our core values of choice, equity, and community engagement. EOHHS will continue to provide regular updates throughout the budget process as it receives clarification and final approvals from CMS. See Major Development section of testimony for additional background.

   a. For "Tab 2", please include any temporary rate increases or other funding that is being provided through these funds.

      i. As an example, changes to the PACE program and First Connections.

      *See **Tab 2**.*

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?

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 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.

Table 1. Average terminations per month, by period and eligibility group

	Core	CSHCN	Expansion	ABD	Total
FY 2019	2,494	116	2,251	569	5,430
FY 2020 (Q1-Q3 only; i.e., pre-Covid)	3,128	84	2,470	554	6,236
FY 2021	384	20	324	323	1,051
FY 2022	678	61	509	231	1,479
FY 2021 (Q1 only)	489	64	313	211	1,077

Table 2. Reason for Termination as a Percentage of Total Terminations (based on activity between May 2021 and March 2022)

Reason for Terminations	Percentage (%)
Deceased	17%
Residency	23%
Voluntary Withdrawal	60%
Total	100%

e. What is the agency's plan for the pace, timeline, and strategy for redeterminations?

In accordance with CMS guidance, EOHHS has chosen to begin initiating its 12-month redetermination period beginning the month the PHE is officially ended by HHS. EOHHS developed its redetermination plan to observe the recommendation from CMS to keep monthly redeterminations below a threshold of 9 percent total caseload per month. For the first two months of redeterminations, EOHHS has opted to take a conservative approach with a slightly reduced volume in order to allow DHS and HSRI operations to adjust to the restart of normal operations.

Terminations will also align to the redetermination distribution plan; valid terminations will occur within the 12-month initiation period, as well as the last two months allowed by CMS to complete those redeterminations already started. EOHHS estimates an even distribution across the 12 months, although we recognize that in reality there will be fluctuations in the terminations that occur by month.

Once the PHE ends, EOHHS and DHS will process renewals for all individuals by extending forward the member's original renewal date. Terminations will be spread across the 12 months as allowed by CMS. Conducting renewal activity over 12 months will distribute renewals on a normal 12-month cycle, and thereby effectively allow for workload distribution and operational management with our DHS and HSRI partners. As noted in EOHHS'

testimony, given our current PHE assumptions, we estimate redeterminations will recommence in March 2023, impacting the April caseload census.

i. Are there any estimates of certain categories of individuals likely to be terminated due to presumptive factors (e.g., identified as enrolled in private insurance, known to be above income eligibility threshold) and will such groups be scheduled for redetermination early in process?

EOHHS is not intending to schedule members suspected of ineligibility early in the process. Further, consistent with CMS guidance, EOHHS cannot perform Post-Eligibility Validation on members who have not yet been regularly redetermined.

EOHHS anticipates a number of current beneficiaries to have reported income above the eligibility threshold once redeterminations are conducted. Individuals in this group could have reported high income at any time during the PHE, dating back to March 2020. EOHHS plans to align Medicaid and SNAP renewal dates so members can renew both programs at the same time. This will result in an alignment of renewal dates across programs for future years as well.

ii. What kind of eligibility screening is currently occurring or will be happening prior to the end of the PHE?

Eligibility screening prior to the end of the PHE is not advisable for two primary reasons: any negative findings from screening prior to the end of the PHE cannot be acted upon; and states are required by CMS to perform a renewal post-PHE with the most recent information received from external sources. That said, EOHHS did manage passively renew (or ex parte) 88% of the MAGI population during the PHE. EOHHS also made enhancements to RI Bridges to allow for ex parte renewal of non-MAGI beneficiaries, though that will not be effective until PHE ends.

iii. How likely is it that of known ineligible enrollees will be terminated early in the process?

Individuals determined ineligible during the PHE must undergo a renewal during the unwinding period. Per CMS guidance, States are not allowed to terminate eligibility based on changes reported during the PHE, even if those changes resulted in a member being determined ineligible. EOHHS adopted CMS' prescribed hybrid approach to redeterminations, retaining the renewal month where possible, but prioritizing alignment of SNAP and Medicaid renewal dates to improve efficiencies and reduce the renewal burden on members and State staff in years following PHE unwinding.

4) During the public health emergency, EOHHS received federal approval to extend certain program changes that were made available to respond to the COVID-19 public health emergency. The Executive Office is allowed to seek approval to continue some of the temporary authority it was given during the public health emergency for up to 14 months after it ends, and other measures minimize the adverse impact on beneficiaries at that time.

a. Please update the information provided at the May Caseload Estimating Conference in "Tab 7", "Tab 8" and "Tab 9"and indicate which authority it would seek to extend at the end of the emergency.

*See **Tabs** 7, **8**, and **9**.*

FY 2022 Closing

1) Please provide a FY 2022 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.

   *See general analysis in **Major Developments** of testimony.*

   EOHHS will be working with the auditors to make corrections to errors in its initial accrual submissions (i.e., incorrect application of Expansion gain share to Rhody Health Partners (and vice versa) and incorrect application of Pharmacy FFS rebates to Expansion (and vice versa)) as well as updates to its original accruals based on more complete information (e.g., higher drug rebates and improved gain share positions)

   The summary tables in each section reflect an improved accounting of current year spending against FY 2022 Revised as well as serving as a comparison point for FY 2023.

   Overall, EOHHS anticipates an improvement in the agency's All Funds position relative to close but a modest decline in its GR surplus due primarily to the incorrect application of the gainshare to be recouped in Expansion (and eligible for only 10% general revenue) to Rhody Health Partners.

   b. Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2022 final budget.

   *All non-emergency transportation service premiums for EOHHS' Aged, Blind, and Disabled members are initially charged to **Other Medical Services** line sequences. Subsequently, EOHHS prepares journal entries to transfer the cost of enrollment for members enrolled in **Rhody Health Options** and **Rhody Health Partners** to their respective budget lines.*

   *However, while EOHHS correctly transferred the amounts from **Other Medical Services**, it did not transfer the any amount from within the "Other Services" line sequences (i.e., 2004101.01, 2010101.02, 4628411.2) to the "Other Services – Non-Emergency Transportation" line sequences (i.e., 2004103.01, 2010102,02, 4628409.02) that roll up to the same general budget line.*

   Overall, the Final reflected a deficit of $100,000 compared to Revised Enacted (i.e., May CEC).

Budget Line	*Line Seq*	*Source*	*Revised Enacted*	*Final*
Other Services – ABD Non-Emergency Transportation	2004103	GR	$1,911,641	
	2010102	FF	$2,671,999	
	4628409	FF	$302,970	
Other Services	2004101	GR		$2,014,983
	2010101	FF		$2,816,445
	4628411	FF		$319,348
Rhody Health Options	2006103	GR	$1,239,626	$1,239,673
	2012104	FF	$1,732,688	$1,732,753
	4628414	FF	$196,464	$196,472
Rhody Health Partners	2006101	GR	$1,405,006	$1,404,155
	2012101	FF	$1,963,848	$1,962,658
	4628415	FF	$222,675	$222,540
Total			**$11,646,917**	**$11,909,027**
GR Total			**$4,556,273**	**$4,658,811**

2) Please include a column for FY 2022 closing figures in the summary tables within each section of your testimony.

Each summary table includes the FY 2022 Preliminary Fiscal Close.

Please note that an attempt was made to reflect incurred data above the line with the necessary prior-period activity reflected as below-the-line adjustments to balance to the preliminarily close in RIFANs.

FY 2023 Budget

1) Please include a status update on budget initiatives as outlined in "Tab 3". Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate and any known barriers to approval.

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

    *See **Tab 3** or **Attachment 2.***

2) Please include an update to the status of the expansion of Medicaid for children regardless of immigration status. **(**The enacted budget assumed the proposal would be operational on October 1 and includes $1.3 million from general revenues).

    a. When did the program start?

    EOHHS is providing retroactive coverage for children determined eligible prior to the necessary system upgrades being completed back to July 1, 2022. Any services provided by a Medicaid-certified provider would be reimbursed in FFS. This is not expected to increase costs in a meaningful manner beyond the revised Enacted amount. EOHHS updated the original estimate to reflect the updated Rite Care and RIte smiles composite PMPM but made no change to the total covered member months.

    b. What is the enrollment as of October 1, 2022? What is the projected enrollment and expenses for FY 2023 and FY 2024?

    190 children were enrolled as of 10/1/2022. EOHHS utilized OMB's estimated enrollment and kept it at 434 in FY 2023 and 868 for FY 2024. The only changes to the estimate were updated PMPMs for the managed care plans and FMAPs. Estimated Medicaid expenditures are $1.3 million in FY 2023 and $4.1 million in FY 2024.

3) Please include an update to the status of the expansion of Medicaid for postpartum women regardless of immigration status. (The enacted budget assumed the proposal would be operational on October 1 and includes $2.0 million from general revenues).

    a. When did the program start?

    The eligibility change is effective of October 1, 2022; however, due to the current PHE it is as if the eligibility criteria been in effect since March 2020.

    b. What is the enrollment as of October 1, 2022? What is the projected enrollment and expenses for FY 2023 and FY 2024?

    This information is not available. EOHHS staff is working to estimate how impact of the PHE and unwinding may impact this estimate and what proportion of these women will not be eligible for Regular FMAP (and therefore must be paid with State only funds due to their immigration status). While EOHHS' estimate should reflect the total spending (given EOHHS is not actively terminating any woman after two months of postnatal), compared to FY 2023 and FY 2024 there may be a modest increase in state only expenditures if some members are undocumented or do not have five years of residency).

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 7a** of testimony and "4 - Rate Changes" tab of workbook.*

Long-Term Care

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

   *See **Nursing Home** section of testimony.*

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 an overview of LTSS redesign initiatives and activities in the below slide deck. Also see "Tab 3."

LTSS Slides for QA.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:

   http://www.transparency.ri.gov/uhip/#legislative-reports As of 8/9/22:

PENDING NEW APPLICATIONS

The State continues to prioritize access to benefits. As of **August 9, 2022**, the number of pending new applications across all programs was **7,148**. The total overdue, pending applications awaiting State action was **2,857.**

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	
SNAP Expedited	40	410	450	28	104	132	582
SNAP Non-Expedited	538	847	1,385	54	49	103	1488
CCAP	11	321	332	6	72	78	410
SSP	0	51	51	0	6	6	57
GPA	11	42	53	1	10	11	60
RIW	124	310	434	24	30	54	488
Undetermined Medical	23	455	478	161	2,028	2,189	2667
Medicaid-MAGI	38	46	84	132	139	271	355
Medicare Premium Payments	22	172	194	30	112	142	336
Medicaid Complex	10	57	67	25	337	290	357
LTSS	17	287	304	3	48	51	355
Grand Total	**834**	**3017**	**3,851**	**464**	**2,857**	**3,321**	7,148

Please note that some undetermined medical cases awaiting state action have already been resolved but were added to this reporting metric as part of broader system fixes in 2022 to ensure an accurate accounting of applications. A future update will archive pending applications that require no further action.

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.

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

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 2023 and FY 2024 including the amount of the rate increase and the index upon which it is based.

*See **Table IX-4** in **Nursing and Hospice Care** section and **Table X-4** in **Home and Community Care** section of testimony.*

*See also **Attachment 7**.*

8) Please provide the nursing home and hospice days needed for the long-term care financing adjustment (Sullivan-Perry).

*See "Perry Sullivan Appropriation" subsection the **Major Developments** section of testimony.*

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2023 and FY 2024.

*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 enacted budget, 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.

EOHHS assumed a 5.0% price factor for all managed care products in FY 2023 in its testimony.

The actuarially certified rates for FY 2023 for Rite Care Core, Rite Care CSHCN and SOBRA reflect a composite rate change of 8.0%, 16.3%, and 18.3%, respectively, based on updated claims experience. These rates include any FY 2023 initiatives impacting the rates, such as the Early Intervention rate increase, the Home-Based Therapeutic Services, and maternity delivery increase, which had material impacts on rates.

4) Please provide the projected CHIP funding for FY 2023 and FY 2024, as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed since the May Conference, please provide an explanation for the change.

*Please see **Table III-7** in **Managed Care** section of testimony for CHIP allocation.*

*The only anticipated state-only charges are for Cover-All-Kids (FY 2023: $1.4 million; FY 2024: $3.8 million) and, in FY 2024 only, extension of postpartum coverage for an additional 12 months for undocumented women (FY 2024: $2.7 million). These expenditures are in **Managed Care** section of testimony.*

Please note that no state only charges are assumed from a budgeting perspective for the postpartum extension in FY 2023 due to the PHE. Even if the PHE ends and terminations resume on March 30, 2023 these undocumented women will remain in their existing aid category code until they scheduled for redetermination and most may have had 12 months of postpartum coverage already.

Rhody Health Partners

1) Please provide estimates for Rhody Health Partners for FY 2023 and FY 2024. 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 **Table IV-4** in **Rhody Health Partners** section of testimony.*

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

EOHHS assumed a 5.0% price for all managed care products in May CEC. The actuarially certified rates for FY 2023 reflect a composite rate change of 3.8% based on updated claims experience.

*For monthly capitation rates, please see **Rhody Health Partners** section of testimony.*

Hospitals

1) Please provide separate inpatient and outpatient estimates for hospital services in FY 2023 and FY 2024.

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

2) What is the current DSH allotment reduction schedule over the next several federal fiscal years? Is there a DSH allotment reduction scheduled for FFY 2024?

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

Pharmacy

1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2023 and FY 2024.

   *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.

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

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2023 and FY 2024.

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

   Note that an error in May CEC testimony (with respect to the Part B multiplier) resulted in a deficit in the FY 2022 Preliminary Close that carries forward into FY 2023. This is error is corrected for here.

3) What are the state-only costs in FY 2023 and FY 2024?

   *The only anticipated state-only costs are in the **Managed Care** budget line.*

Medicaid Expansion

1) Please provide updated caseload and expenditure estimates for FY 2023 and FY 2024 for the ACA-based Medicaid expansion population.

   *See **Expansion** section testimony.*

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

   EOHHS assumed a 5.0% price for all managed care products in May CEC. The actuarially certified rates for FY 2023 reflect a composite rate change of 0.4%. For the past two fiscal years the health plans have made significant profits against the medical component of the rate and so this represents an adjustment attributed to updated base experience used in rate certification.

   However, it is worth noting that after accounting for anticipated recoupments against the MCOs by EOHHS the effective increase between FY 2022 and FY 2023, on a composite per member basis is approximately 9.0% ($585 overall PMPM in FY 2022 versus $640 overall PMPM in FY 2023).

   *For monthly capitation rates, please see **Medicaid Expansion** section of testimony.*

Behavioral Health

1) Please provide an estimate for FY 2023 and FY 2024 of Medicaid expenditures for behavioral health services, including overall BH spending over that time (e.g., Medicaid spend on primary BH diagnoses).

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. Further, among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of total 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*

Table 3. Claims with a Primary BH diagnoses, by provider type

	FY 2020	FY 2021	FY 2022
CMHO	$90,643,756	$96,081,952	$105,281,925
SUD/MAT	$27,902,947	$27,624,659	$24,265,833
Other Professional	$112,216,497	$117,700,836	$122,640,601
Bradley	$31,870,462	$35,807,028	$35,495,577
Butler	$29,200,576	$31,775,656	$32,900,896
Tavares	$7,276,094	$7,171,481	$7,149,501
Inpatient	$65,938,700	$73,882,177	$68,675,340
Outpatient	$19,244,756	$20,848,028	$21,724,928
NH/Hospice	$111,657,315	$86,220,700	$84,526,824
Subtotal – Medicaid	**$495,951,103**	**$497,112,518**	**$502,661,425**
BHDDH Providers (excl. Eleanor Slater)	$260,259,234	$255,490,665	$302,033,868
DCYF Providers	$5,097,773	$5,123,902	$4,673,589
OHA Providers	$673,236	$603,646	$799,492
Special Education	$10,315,359	$9,983,887	$11,217,802
Grand Total – EOHHS	**$772,296,705**	**$768,314,618**	**$821,386,177**

Note 1. Spending includes MMIS paid or submitted MCO claims only. Any manual payments are not reflected herein. Claims do not reflect any accounting for IBNR.
Note 2. BHDDH does not include Eleanor Slater.

Table 4. Total Medicaid EOHHS spending on behalf of members with a BH diagnoses

	FY 2020	FY 2021	FY 2022
Mental Health Dx Claims	$363,061,106	$357,715,742	$360,215,964
Substance Abuse Dx Claims	$87,541,368	$90,981,766	$88,049,339
I/DD Dx Claims	$34,425,308	$37,182,435	$39,384,266
Non-BH Claims	$532,298,053	$569,539,792	$582,364,298
Pharmacy Claims	$166,327,947	$178,093,106	$196,544,891
Total Claims Activity - Medicaid	**$1,183,653,782**	**$1,233,512,841**	**$1,266,558,758**
Distinct Members (with Primary BH Dx in FY)	98,378	101,819	104,479
Member Months	1,103,397	1,177,356	1,216,740
PMPM	$1,073	$1,048	$1,041

Note 1. Spending includes MMIS paid or submitted MCO claims only for Medicaid EOHHS. Does not include any administrative payments to MCOs. BHDDH or DCYF claims activity not included. Claims do not reflect any accounting for IBNR.

a. What are the projected expenses for the MHPRR services for FY 2023 and FY 2024? In what program or programs do these expenses occur? How many individuals are enrolled in the program for FY 2023 and projected for FY 2024?

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:

- U*1- $85- supervised apartment*
- U3- $125- apart*ment, moderate acuity*
- U4- $125- group home, *moderate acuity*
- U5- $175, high intensity

A U6 modifier has been created in the MMIS for $525 related to the enhanced MHPRR. Costs associated with the $525 are available in **Attachment 2.**

MCO rates appear comparable.

Presented in **Table 6** *and* **Table 7** *below is the total spending for FY 2022 and estimates for FY 2023 and FY 2024. 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. These costs have not been adjusted for missing data and/or IBNR.

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

See **Table 5** *below.*

c. What costs are projected for the opioid treatment health home program in FY 2023 and FY 2024? 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 three programs:

Table 5. September 2022 Snapshot of Health Home Authorizations by eligibility category

	Regular	Expansion	SSI-like	Medically Needy	Total
Integrated Health Home (IHH)	4,556	1,301	942	189	6,988
Assertive Community Treatment (ACT)	903	228	202	69	1,402
Opioid Treatment Program (OTP)	1,153	1,661	143	9	2,966
Total	**6,612**	**3,190**	**1,287**	**267**	**11,356**

2) Please provide enrollment and costs expected to be incurred in FY 2023 and FY 2024, for the following programs. Please indicate the costs to programs individually.

   a. IHH, ACT, OTP Programs

   b. Behavioral Health Link Program

   c. Peer Supports Programs

   d. Housing Stabilization Program

See following tables for (a) a breakdown of spending by service type in FY 2022 in Managed Care and FFS, and (b) estimate of spending for these select services in FY 2023 and FY 2024.

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 for this limited period. As of April 1, the rate returned to $1,267.

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 6. Select Behavioral Health Spending, FY 2022 (Managed Care and FFS)

	FFS	Managed Care	Total
MHPRR (H0019)	$7,223,075	$9,910,366	$17,133,441
Integrated Health Home (H0037)	$8,587,720	$27,105,060	$35,692,780
Assertive Community Treatment (H0040)	$5,922,572	$12,310,318	$18,232,890
Opioid Treatment Program (H0037 - Provider Type 060)	$467,171	$940,138	$1,407,309
BH Link (H2011/S9485)	$743,381	$1,653,197	$2,396,578
Housing Stabilization (H0044)	$20,563		$20,563
Peer Support Program (H0038)	$190,671	$157,097	$347,767
Subtotal	**$23,155,154**	**$52,076,175**	**$75,231,329**

Table 7. FY 2022 and FY 2023/2024 Estimate for Select Behavioral Health Spending

	FY 2022	FY 2023 Est.	FY 2024 Est.
MHPRR (H0019)	$17,133,441	$21,936,688	$26,460,105
Integrated Health Home (H0037)	$35,692,780	$37,274,445	$38,206,306
Assertive Community Treatment (H0040)	$347,767	$278,973	$285,947
Opioid Treatment Program (H0037 - Provider Type 060)	$18,232,890	$22,406,540	$22,966,704
BH Link (H2011/S9485)	$20,563	$203,701	$208,794
Peer Support Program (H0038)	$2,396,578	$2,588,405	$2,653,115
Housing Stabilization (H0044)	$1,407,309	$901,239	$2,373,770
Subtotal	**$75,231,329**	**$85,589,991**	**$93,154,741**

Note 1. For MHPRR activity, FY 2023 and FY 2024 include $1.0 million and $5.0 million, respectively, added to the FFS totals for purposes of the MHPRR $525 enhanced rate.

Certified Community Behavioral Health Clinics

1) Please provide an update on the implementation of the federal model for Certified Behavioral Health Clinics included in "Tab 5".

Responses provided below.

Date	CCBHC Model Implementation	Progress/Update
8/1/2022	EOHHS will issue the appropriate purchasing process and vehicle for organizations who want to participate in the CCBHC model program.	
12/1/2022	Organizations will submit a detailed cost report developed by the Department of Behavioral Healthcare, Developmental Disabilities Hospitals, with approval from EOHHS, that includes the cost for the organization to provide the required services.	
1/15/2023	The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, in coordination with EOHHS, will prepare an analysis of proposals, determine how many behavioral health clinics can be certified in FY 2024 and the costs for each one. Funding will be included in the FY 2024 Governor's recommended budget.	

August 1, 2022:

On 7/29/22, EOHHS' CCBHC Infrastructure Grant RFP, to prepare community providers to carry out CCBHC planning was posted to the state purchasing website. The full RFP is also available on EOHHS'website:https://eohhs.ri.gov/Certified-Community-Behavioral-Health-Clinics-Infrastructure-Grant-Program. Section C of the RFP, Applicant Information Form and Technical Proposal, required respondents to provide their formal intent to participate in the Certified Community Behavioral Health Clinic model program. The RFP closed on September 7. EOHHS received 12 CCBHC site responses and is in the process of establishing contracts for 10 sites. EOHHS received 32 Designated Collaborating Organization (DCO) site responses and is in the process of establishing contracts for 20 sites. EOHHS also received Letters of Intent for an additional 7 organizations seeking to become Designated Collaborating Organizations but who did not apply for infrastructure funding to support their preparation.

All CCBHC planning work, for both the ARPA SFRF infrastructure program and CCBHC model implementation, is being implemented by an interagency team of EOHHS/Medicaid, BHDDH and DCYF staff. This 8/1/2022 timeline was met due to the significant interagency planning team work that occurred across FY 2022 and incorporated significant provider engagement.

December 1, 2022:

BHDDH and EOHHS (and the entire interagency planning team) are doing what they can to meet the General Assembly's stated timeframe and are committed to working in close partnership with OMB, the House and Senate fiscal, and the Governor's Office over the course of the next year.

The FY 2023 final Budget Language as written by the General Assembly requires EOHHS to "amend its state plan to cover all required services for persons with mental health and substance use disorders at a certified community behavioral health clinic through a daily or monthly bundled payment methodology that is specific to each organization's anticipated costs and inclusive of all required services. Such certified community behavioral health clinics shall adhere to the federal model, including payment structures and rates."

Under the Section 223 Demonstration Program for CCBHCs (the Federal model), CMS established a prospective payment system (PPS) for CCBHCs. The CCBHC PPS is a Medicaid per-encounter rate set based on provider cost reporting that applies to services delivered either directly by a CCBHC or through a formal relationship with a Direct Care Organization (DCO). There are two types of PPS: PPS-1, a per clinic daily encounter-based rate, and PPS-2, a per clinic monthly rate for attributed members.

Given the shift to the Federal model per the FY 2023 enacted budget, EOHHS had to modify planning that occurred over the course of FY 2022, specifically around this payment methodology. All

planning through June 2022 was directed to implementing a statewide capitated payment model (that is, not a provider-specific PPS rate).

EOHHS has worked towards and intends to implement the PPS-2 methodology. Each participating CCBHC will submit a cost report including all allowable costs (both actuals and anticipated), by population and according to additional guidance developed by the interagency planning team. The cost reports are then used to build rates by participating provider. The interagency planning team is designing the programatic aspects of the state's CCBHC model, Medicaid is overseeing the rate development component, and Milliman is providing guidance to Medicaid on technical specifications required for cost reporting. Milliman will also lead the cost report review and validation process, and subsequent rate build up for the first year.

The interagency team is currently finalizing programatic decisions and working through technical specifications to inform the technical guidance that is critical for cost report completion. These include decisions on population definitions, identification of all FFS and MCO procedure codes for the services covered under the model, and the complex technical process for attributing costs and populations to providers. Once the technical guidance is final, the providers will need a minimum of two months to accurately complete the reports. Through the infrastructure project, the participating providers will also have funding to pay for financial/accounting expertise to support completion of their reports. The infrastructure program contracts were established on October 15. Providing two months to complete once the technical guidance document is finalized will also allow the providers time to secure these support services.

Given this ongoing work and need to provide technical guidance to the providers for them to accurately complete the cost reports, EOHHS proposes February 15th as a reasonable alternative for cost-report submission.

January 15, 2023:

Based on progress that occurs through December on the infrastructure project, BHDDH will determine home many clinics can likely be certified in FY 2024. Working with EOHHS, BHDDH intends to certify providers in the Spring 2023.

There is significant risk that analysis of the costs reports, and subsequent rate build up to determine the projected costs for each clinic that may be ready for certification in FY 2024, will not occur by January 15th. Even if cost reports were received by December 1, completing the review and validation process is not reasonable in six weeks, which the Assembly would not have necessarily known when finalizing the FY 2023 budget. Medicaid's actuarial consultant suggested 2-3 months is a reasonable timeframe for this process. For context, this process includes a detailed review that crosswalks the report with a provider's financial statements, uses encounter data to validate expenditures and visits reported, reviews each cost report in relation to others to ensure consistency between costs, and includes considerable back and forth between providers and the state to request more granular explanation of variances and revisions and resubmissions where necessary. The collaboration with the providers at this stage can take significant time.

As such, EOHHS proposes April 30th as a reasonable alternative for completion of report validation, build-up of provider specific rates, and to complete development of the budget estimate using the rates and estimates of providers who will be certified as CCBHSs in SFY 2024. This timeframe allows for provider specific rates and overall budget estimate to be complete by end of April, in time for either a Governor's budget amendment or for tdebhe General Assembly's consideration

EOHHS has also modeled estimated costs using a service-based rate as a proxy. If desired, the interagency planning team is committed to working with OMB and the Governor's office on an estimate developed using this alternative process and assumptions, recognizing the cost report process reflects a different methodology.

2) Please identify in more detail the specific assumptions on behavioral health expenses in the Executive Office's FY 2024 overall caseload estimate including the expenses for each of the services that are required under the federal model that must be in place by FY 2024 in "Tab 6". Because expenses under the federal model will differ from the current practice reflected in the FY 2024 estimate; baseline spending need to be established. If the estimate contains no expenses for a particular service, the value should be zero.

The specific data is not yet available. EOHHS will provide to conferees when completed.

Total CMHO spending is approximately $95.0 million per year. In FY 2022, spending was higher, at $105.3 million (with some claims activity still outstanding); however, this higher amount was due, in part, to the ARPA HCBS investments embedded in the FY 2022 claims data.

For purposes of FY 2023 caseload, however, all current CMHO experience is either in the FFS data (falling within Other Medical Services or Expansion) or included in the actuarially certified managed care rates. For caseload, we do not separately trend discrete CMHO activities (with the exception, presently, of the MHPRR activities that requires a below-the-line adjustment for the new $525 per diem rate). Some spending, for example, the IHH bundled payment, may be redistributed to finance "target case management" or "primary care screening/monitoring" or some portion of "outpatient mental health services." Other spending, for example, medication-assisted treatment, may already be spent in an alternative setting and so not require additional investments (or just marginal investments).

Presently, EOHHS and BHDDH are finalizing cost reporting technical guidance, attribution methodology, and requirements for the CCBHCs. As part of that exercise EOHHS is creating a crosswalk between service types/categories specified in **Table 8** *and the specific procedure codes and billing practices of the various CMHOs and managed care organizations.*

In general, the CMHO spending includes four broad categories of services: residential treatment services, ACT bundled services, IHH care management services, and general outpatient services. Some of these services, such as MHPRR and related residential treatment services, may be explicitly excluded from the PPS rate development. Other services, such as medication-assisted treatment, are generally not provided within the CMHO (and so would not be included in the $95.0 million figure above but would not be considered "new" spending from a statewide perspective if included in the PPS). Whether or not that is included in the CCBHC PPS will depend on the prevalence of a formal relationship with a Direct Care Organization (e.g., Codac, Journey to Hope) and policy decisions to be made by EOHHS and BHDDH. Their inclusion in the PPS would not necessarily imply an overall cost increase for the State. Such a calculus is also true of other service categories.

EOHHS acknowledges that such a quantification is essential for establishing, as the conferees note, a baseline from which to assess if any additional funding is needed for implementing the federal model.

Over the course of last year, EOHHS had worked with various contractors to establish a state-wide cost-based reimbursement model that would be refined around the specific services to be included in the bundled rate (e.g., such policy decisions as those around whether to include medication-assisted treatment or assertive community treatment as part of the CCBHC model payment or keep such services separate). This prior work included careful consideration of standards of care, practice patterns, and labor requirements across the different services and various provider type (e.g., social workers, nurse practitioner, physician, psychiatrist, psychologist, etc.) with these labor needs and their costs pegged to regional benchmarks.

However, with the transition from a state-wide cost-based model to the provider-specific cost-based federal model based on the provider's own cost reporting (for both their existing and expected costs) much of this work has become academic in nature. EOHHS cannot establish an estimate of the additional costs needed to fund the new (nor existing) services without first receiving the cost reports.

Prior to revising its overall budgetary needs for the CCBHC program, EOHHS will need to assess and establish unique provider-specific payment arrangements: with each arrangement potentially having different payment rates for three or more distinct population groups (e.g., high acuity adult, high acuity child, general outpatient adult/child). While Rhode Island's common labor market would presuppose that there should not be significant variation in costs profiles across the potential CCBHCs, each facility will be submitting its own cost report that will include their own estimate of necessary investments. Although part of the report validation process is to explore major differences between providers, variation is likely.

In moving to the federal model and different payment structure, EOHHS needs to complete the review of the cost reports before stating exactly how much of the below service costs are baseline under the CCBHC model. As such, EOHHS is unable to provide a reasonable cost estimate prior to receiving the provider cost reports. Receipt and review of the cost reports will be necessary to establish what additional spending is being requested, what requests are reasonable, and what the federal model may cost given consideration to EOHHS' current spending.

Table 8. CCMHC Services Categories, historical baseline and estimate for FY 2024

	FY 2021	FY 2022	FY 2024 Est.
Outpatient mental health and substance abuse services			
24-hour mobile crisis response and hotline services			
Screening, assessment, and diagnosis, including risk assessments			
Person-centered treatment planning			
Primary care screening and monitoring key indicators of health risk			
Target case management			
Psychiatric rehabilitation services			
Peer support and family services			
Medication-assisted treatment			
Assertive Community Treatment			
Total			