May 2023 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 24, 2023. Please submit the answers no later than **close of business Wednesday, April 19, 2023**, 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.

PUBLIC HEALTH EMERGENCY

Given the cross-agency coordination necessary to respond to the Public Health Emergency and subsequent return to normal operations, the following questions may require input from multiple agencies. We assume that these responses will be included as part of the EOHHS testimony and that EOHHS will consult relevant agencies as needed. These themes should be covered in testimony during the session taking place at 1:00 PM on April 24.

1) **Please provide an updated summary of how the COVID-19 pandemic has impacted, and continues 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.**

    a. **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. Testimony should incorporate all impacts on expenditures of the State's COVID-19 public health emergency (PHE) response and now the Consolidated Appropriations Act, 2023 requirements including but not limited to timing of redeterminations and renewal strategy due to changes to the continuous enrollment condition (unwinding period) whereby the condition is now decoupled from the end of the COVID-19 PHE, as well as the availability of the temporary increase in the FMAP under FFCRA, new CMS enforcement authorities and reporting requirements, and policies for the continuity of coverage for children and families and the impact of redeterminations on rates. The testimony should describe the timelines and policies that EOHHS and other health and human service agencies intends to implement surrounding the unwinding period.**

        See section H, Public Health Emergency, Enhanced FMAP Rate and GR Savings, and section J, Caseload Growth and Trend Development, of EOHHS testimony.

    b. **Is the agency making any considerations for potential loss of enhanced FMAP for noncompliance with the unwinding requirements?**

        See section H, Public Health Emergency, Enhanced FMAP Rate and GR Savings, and section J, Caseload Growth and Trend Development, of EOHHS testimony.

    c. **Please provide information on the Medicaid's responsibility for financing any COVID-19-related costs that will no longer by covered by the federal government once the PHE ends including vaccines, treatment, etc. for FY 2023, FY 2024, and future years.**

Under section 6008(b)(4) of the FFCRA, to receive the temporary FMAP increase, a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies, for Medicaid enrollees without cost sharing.[1] The coverage requirements and cost-sharing prohibitions generally end on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. If the PHE ends on May 11, 2023, this provision will end on September 30, 2024.There is no additive cost to continuing this once the requirement ends, given the expenditures are built into base utilization. Although, the State Plan Amendment (SPA) will expire at this time. The State would have to permanently add the benefit to continue coverage.

Section 9811 and section 9821 of the American Rescue Plan Act required (and provided 100% federal financing to the States for the cost of) COVID-19 vaccine administration.[2] In December 2021, CMS clarified that this included visits for COVID vaccine counseling at which no vaccine is administered after counseling.[3] This 100% federal matching funds also ends on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. If the PHE ends on May 11, 2023, this enhanced funding will end on September 30, 2024. As with the above, the State would have to permanently add the benefit to continue coverage for vaccine counseling.

Sections 9811 and 9821 of the American Rescue Plan Act mandated insurance coverage for COVID-19 testing and SHO Letter #21-003 released in August 2021 further clarified that this included at-home tests.[4] In Rhode Island, most lab-based tests are funded from other sources. Coverage for at-home tests is included in EOHHS' Medicaid managed care contracts and paid by Medicare for those dually covered by Medicare. For the small number of Medicaid-only members remaining in FFS who do not have TPL, EOHHS implemented payment for at-home testing in March 2022. Any associated costs, if any, should be reflected in EOHHS' base data.

Sections 9811 and 9821 of the American Rescue Plan Act mandated coverage for treatment for COVID-19 as clarified in SHO #21-006 from October 2021.[5] EOHHS estimates include monoclonal antibody treatments which are reflected in claims data. Unlike the Covid-19 vaccination and vaccine administration costs, Covid-19 testing and treatment are subject to Rhode Island's usual federal financial participation provisions (i.e., either Regular FMAP or 90/10 Expansion FMAP depending on beneficiary's eligibility category).

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[1] CMS (2022, February 11) "Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration and Cost Sharing under Medicaid, CHIP, and Basic Health Program" Retrieved on April 20, 2022, from https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf.

[2] CMS (2021, August 30) "SHO #21-004 Re. Temporary increase to FMAP under sections 9811, 9814, 9815, and 9821 of ARP and administrative claiming for vaccine incentives." Retrieved on April 20, 2022, from: https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf.

[3] CMS (2021, December 2) "Press Release: Biden-Harris Administration Makes 100% Federal Medicaid Matching Funds Available for State Expenditures on Certain COVID-19 Vaccine Counseling Visits for Children and Youth" Retrieved on April 20, 2022, from: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-makes-100-federal-medicaid-matching-funds-available-state-expenditures

[4] CMS (2021, August 30) "CMS SHO #21-003 Re: Medicaid and CHIP Coverage and Reimbursement of COVID-19 Testing under the American Rescue Plan Act of 2021 and Medicaid Coverage of Habilitation" Retrieved on April 20, 2022, from: https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-003.pdf

[5] CMS (2021, October 22) "SHO #21-006 Re. Mandatory Medicaid and CHIP Coverage of COVID-19-Related Treatment under the American Rescue Plan Act of 2021" Retrieved on April 20, 2022, from: https://www.medicaid.gov/federal-policy-guidance/downloads/sho102221.pdf

Regarding statutory flexibilities made possible by the PHE:

- Section 1135 waivers expire at the end of the PHE (May 11, 2023).
- Medicaid Disaster Relief SPAs expire at the end of the PHE (May 11, 2023), or an earlier date elected by the state.
- Section 1915(c) Appendix K or Section 1115 Attachment K termination dates vary but will be no later than six months after the end of the PHE. Rhode Island's Attachment K authorities will terminate six months after the end of the PHE.

2) Please provide a hiring update for DHS personnel since the last Staffing Report submission and also provide the plan for meeting the unwinding requirements. Please highlight how the agency is doing since the April 1st redetermination go live date.

DHS's most recent 60-Day Staffing and Operations report was submitted as of March 29, 2023 for the reporting period of January 17, 2023 through March 16, 2023. Between the submission of the last 60-Day Staffing and Operations report, up to April 8, 2023, which is the most recent payroll period, DHS has filled an additional seven vacancies, bringing its total positions filled to 663 out of 773.

In preparation and planning for the Medicaid recertification period, DHS has developed a comprehensive staffing projection model for the duration of the 12-month recertification period. DHS's model takes into account the time for task completion of each Medicaid category to project how many staff are needed on a monthly basis that is aligned with the Medicaid population redetermination schedule. This comprehensive projection modeling tool breaks out the total tasks associated within each Medicaid category and provides total average projected staff that will be needed to complete the monthly tasks. Additionally, DHS has included projections for other human service programs so the agency can be best prepared for the work ahead and the necessary staffing levels needed. This tool assists leadership in providing a look at the entirety of work that will take place between May 1, 2023, and April 30, 2024.

The Medicaid recertification process officially kicked off on April 1, 2023, with Group 1 letters being sent out. DHS, in coordination with EOHHS and HSRI, continue to host community education forums promoting awareness, readiness, and support.

Activities and highlights for Group 1 – 9,398 renewals were sent out; 33% (3118) active renewals and 67% (6280) passive renewals. Of the 3118 active renewals in Group 1, DHS has received and worked 419 renewals and processed 80 returned verifications from ADRs. The workforce is in place with assignments and keeping up with renewals as they are returned.

The size of Group 1 was considered very manageable, and being 10 weeks into our Processing Wednesday pilot, DHS continues to tackle the undetermined medical backlog. Week-over-week data reviews highlight a consistent, steady decline.

DHS continues to work with DOA/HR on its hiring activities. Highlights include: posting and promoting a new ETI Civil Service exam (4/2/2023 to 4/28/2023), implementation of another 6 month lateral freeze for ETI, execution of a special purpose agreement allowing for ET's with 12 months of experience to apply for customer facing positions vs. 18 months, pilot of 'PAR speed pass' allowing for an increased number of PAR's to be filed for vacant positions in hopes of generating an increased candidate pool leading to faster recruitment to increase our 'net new' FTE counts; and completion of a proactive outreach effort that entailed sending letters to all those on the current 580 Social Caseworker Civil Service list to determine who remains interested in state employment in hopes of increasing our efforts in reaching candidates that are interested in joining the DHS social caseworker team.

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 2023 and FY 2024. Please update FY 2022 final and FY 2023 November adopted figures as necessary.**

   See Attachment 5d.

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

3) **Please provide a list of any state only medical assistance payments to be made in FY 2023 or anticipated in FY 2024 and the reason why the payments are being made. Also provide backup documentation that shows the services provided and payment(s) requested. This should include recent expansions like "Cover All Kids".**

   The only anticipated state-only charges are for Cover-All-Kids (FY 2023: $3.0 million; FY 2024: $7.5 million). CMS approved EOHHS' request to implement a "Health Service Initiative" on April 19, 2023. With this approval, the State may claim CHIP matching funds for undocumented women during the 12-month post-partum period. Previously, EOHHS had assumed those individuals would be covered with state-only funds. The expenditures under the health service initiative count towards the 10% administrative cap on CHIP claiming. These expenditures are reflected in Managed Care section of testimony.

   Health Service Initiative Reference:

   https://www.macpac.gov/wp-content/uploads/2019/07/CHIP-Health-Services-Initiatives.pdf

FY 2023 Budget

1) **Please include a status update on budget initiatives as outlined in "Tab 2". 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 Attachment 2.

2) **Please provide an update on the status of the Long-term Care Rebalancing support initiative in FY 2023.**

   EOHHS distributed the funding associated with the Long-Term Care Rebalancing support initiative to providers via one-time supplemental payments in CY 2023, to support workforce-related activities.

   The majority of funds, $9.4 million ($4.5 million GR), were paid out to 34 Home Health agencies to help alleviate the current wait time for home care services while improving timely access to these

services. Participating provider agencies must spend the funds on staff recruitment, development, and retention efforts and are required to maintain detailed and complete financial and payroll records demonstrating that funds received through this Program are spent in accordance with guidance.[6] The disbursement of this one-time supplemental payment was contingent upon the agency's ongoing compliance with the terms of the Guidance Document, including submission of Workforce and Expenditure Reports.

A small portion, $311,290 (all GR), was paid to three (3) Medicaid Self-Directed Service Advisory agencies for workforce-related expenses, such as recruiting, supporting, and/or retaining employees who spend at least fifty percent (50%) of their hours on service advisory activities for Medicaid beneficiaries in the Independent Provider and/or Personal Choice program. Participating Agencies are required to maintain detailed and complete financial and payroll records demonstrating that funds received through this Program are spent in accordance with guidance. The agencies must expend these funds by December 31, 2023.

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 3" attached file), so that the totals can be shown in the aggregate and by program.**

   See Attachment 7b of testimony.

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.**

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 Attachment 2.

   LTSS Slides for caseload May23.ppt

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. The response to this question was prepared on 4/19, using the most recent report available (March 20, 2023) "As of March 8, 2023, the number of pending new applications across all programs was 7,262, representing an approximate 16 percent

[6] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-02/One-Time%20Supplemental%20Payment%20for%20HHA%20-%20Guidance%20Document_020323.pdf

decline from the same time period in February 2023. The total overdue, pending applications awaiting State action was 3,839. With the November Release intended to archive active pending cases already resolved, the Department [DHS] has seen progress in the way that erroneous, aged and duplicate applications are not being added to the overall pending Undetermined Medical backlog. Our IT vendor and state team are continuing analysis on the existing overdue undetermined medical (2,794 cases) and prioritizing recommendations for closure, purging and merging of duplicate cases. Data is also showing some cases in pending status and have already been worked with tasks needing to be disposed. Importantly, this system fix is only part of the solution to address the increase in pending cases. On February 8, 2023, DHS launched a pilot called Processing Wednesdays intended to prioritize call center staff to process applications, update customer files, reports and other operational tasks, which will support efforts to reduce the backlog. All regional offices remain open with regular services available according to their posted schedule. As of March 15, DHS has the initial data needed from the pilot and an assessment of the early findings will be provided in the next report."

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	38	281	319	4	8	12	331
SNAP Non-Expedited	581	319	900	74	112	186	1,086
CCAP	9	190	199	7	43	50	249
GPA Burial	0	5	5	0	4	4	9
SSP	0	32	32	0	23	23	55
GPA	28	51	79	12	24	36	115
RIW	113	123	236	27	24	51	287
Undetermined Medical	17	396	413	174	2,620	2,794	3,207
Medicaid-MAGI	27	45	72	175	169	344	416
Medicare Premium Payments	8	290	298	55	417	472	770
Medicaid Complex	5	68	73	54	347	401	474
LTSS	5	205	210	5	48	53	263
Grand Total	831	2,005	**2,836**	587	3839	**4,426**	7,262

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.

Prior to each testimony, EOHHS determines if it should gross up the fiscal impact of its annual inflationary rate change used in its nursing facility and hospice estimates to capture the true cost to the state of the rate increase. For the past two Caseloads and this Caseload, EOHHS has not included any such adjustment.

Typically, the resident's share of a nursing facility is around 17% (We can see this in claims data by analyzing the amount billed vs. the amount paid by Medicaid.) A resident's contribution to cost of care is affected by their available assets, income, and whether there a spouse remains living in the community. EOHHS total resident share is, in turn, affected by changes in the average contribution to care across all residents.

Holding all else equal, if the state implemented a price increase and patient share amount remained flat, the effective cost of the rate increase would be greater than the price increase paid to the provider as outlined in Example 1 below.

In contrast, despite year-over-year inflation in the per diem, the effective patient share has remained generally consistent at 17% of total costs. This suggests that patient share is trending with the change in per diem. This consistency could be due to (a) overall improvements in patient share collections, (b) reduction in average per diem cost (i.e., due to a greater proportion of lower acuity stays or stays at lower costing facilities), (c) higher patient share amounts among newly determined residents, or some combination of the these. Given the significant increase to Social Security for CY 2022 and CY 2023, EOHHS assumed the all resident will have income that they will be required to put toward the cost of care.

In this scenario, the members patient share is assumed to increase in comparable fashion to the provider rate increase. The result is an increase in state costs that mirrors the overall price increase. Such a case is outlined in Example 2 below.

Example 1: No change in Resident Share Dollar Amount

In this example, EOHHS assumes the resident's share of total cost of care remains at a steady dollar amount, and that the resident can't contribute more, despite the rising cost of care. When the per diem paid to nursing facilities increases, resident share remains the same, which means the State absorbs more of the cost of the increase. To account for this, EOHHS structures its modeling to include the 3.6% shown in the table below.

	Per Diem "Rate" Facility Receives	Patient Share	State Cost
Year 1	$100	$17	$83
Year 2	$103	$17	$86
% Change	3.0%	0.0%	**3.6%**

Example 2: Resident Share $ Amount Increases

In this example, EOHHS assumes that because the resident receives an increase in social security payments that the resident can still maintain a 17% share for total cost of care, despite the rise in the cost of care. The State does not have to cover more of the nursing facility per diem rate increase, because this is covered by the resident. EOHHS would model the 3.0% shown in the table below and incorporate that into its estimates.

	Per Diem "Rate" Facility Receives	Patient Share	State Cost
Year 1	$100	$17.00	$83.00
Year 2	$103	$17.50	$85.50
% Change	**3.0%**	3.0%	**3.0%**

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.

- Hospitals: See Table VII-2 in the Hospitals – Regular section of testimony.
- Nursing Facilities: See Tables IX-3 and IX-4 in the Nursing and Hospice Care section of testimony.
- HCBS: See Table X-4 in the Home and Community Care section of testimony.
- Attachment 7d includes a summary of all rate changes.

8) Please provide additional information on the rebound of the nursing home census from pandemic lows and any relevant and considerations for the FY 2023 and FY 2024 forecasts.

See Nursing and Hospice Care section, specifically the subsection "A review of Rhode Island's Nursing Home Census and Forecasts."

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 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.**

   The FY 2023 managed care rates are consistent with those used in November 2022.

   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 November Conference, please provide an explanation for the change.**

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

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 and/or FY 2024 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.**

   The FY 2023 managed care rates are consistent with those used in November 2022. 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) **Please provide the current DSH allotment reduction schedule over the next several federal fiscal years.**

   See Hospitals – DSH section of testimony.

3) **Please provide any updated estimates for the DSH allotment including an updated source allocation.**

See Hospitals – DSH section of testimony.

Pharmacy

1) **Please provide updated 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.

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 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.**

   The FY 2023 rates are consistent with those used in November 2022. 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.

   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 1. 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.
Note 3. Exhibit unchanged from November 2022.

Table 2. 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.
Note 2. Exhibit unchanged from November 2022.

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:

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

- U6- $525, enhanced (This new modifier was 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 Community Mental Health Center (CMHC) 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 mon*th. 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 3. 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. Centers of Excellence

d. Peer Supports Programs

e. 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 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 not been adjusted for missing data and/or IBNR.

Table 4. Select Behavioral Health Spending, FY 2022 (Managed Care and FFS)

	FFS	Managed Care	Total
MHPRR (H0019)	$11,870,000	$10,990,000	$22,860,000
Integrated Health Home (H0037)	$8,370,000	$24,310,000	$32,680,000
Assertive Community Treatment (H0040)	$10,750,000	$13,840,000	$24,590,000
Opioid Treatment Program (H0037 - Provider Type 060)	$310,000	$1,210,000	$1,520,000
BH Link (H2011/S9485)	$740,000	$1,860,000	$2,600,000
Housing Stabilization (H0044)	$280,000	$-	$280,000
Peer Support Program (H0038)	$150,000	$150,000	$300,000
Subtotal	$32,470,000	$52,360,000	$84,830,000

Table 5. FY 2022 and FY 2023/2024 Estimate for Select Behavioral Health Spending

	FY 2022	FY 2023 Est.	FY 2024 Est.
MHPRR (H0019)	$22,860,000	$23,600,000	$28,240,000
Integrated Health Home (H0037)	$32,680,000	$33,610,000	$34,860,000
Assertive Community Treatment (H0040)	$24,580,000	$25,280,000	$26,000,000
Opioid Treatment Program (H0037 - Provider Type 060)	$1,520,000	$1,560,000	$1,620,000
BH Link (H2011/S9485)	$2,610,000	$2,680,000	$2,780,000
Peer Support Program (H0038)	$280,000	$290,000	$290,000
Housing Stabilization (H0044)	$280,000	$540,000	$1,790,000
Subtotal	$84,830,000	$87,240,000	$89,940,000

Note 1. Rounded to the nearest multiple of ten thousand. For MHPRR activity, FY 2023 and FY 2024 include $0.1 million and $4.2 million, respectively, added to the FFS totals for purposes of the MHPRR $525 enhanced rate.

3) **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. 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.

CCBHC Services	FY 2024
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 of key indicators of health risks	-
Targeted case management	-
Psychiatric rehabilitation services	-
Peer support and family services	-
Medication-assisted treatment	-
Assertive Community Treatment	-
Total	**$ -**

EOHHS and BHDDH are presently working with our consulting actuary (Milliman) to review submitted cost reports from provider organizations interested in becoming certified under the program. To identify baseline spending, EOHHS identified existing CMHC spend less residential services and BH Link, along with applicable claims for providers that are not CMHCs (out of the nine submissions, three providers are not CMHC). In general, the CMHC spending includes four broad categories of services: residential treatment services, ACT bundled services, IHH care management services, and general outpatient services. Residential treatment services are explicitly excluded from the PPS rate development. Other costs may not be provided within the CMHC (and so would not be included in the estimate 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 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.

For caseload, we do not separately trend discrete CMHC 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). From the cost reports, we are also not able to isolate spend by service type. Given these factors, we present summary baseline expenditures below.

Total Spending @ CMHCs and Other Providers Applying for Certification, By Service Type

Excluding Residential Services	**2020**	**2021**	**2022**
CMHCs	$ 66,920,000	$70,600,000	$74,590,000
Integrated Health Home	$ 31,080,000	$33,370,000	$33,330,000
Assertive Community Treatment	$ 16,410,000	$18,770,000	$24,450,000
Other	$ 19,170,000	$18,130,000	$16,490,000
Peer Support Program	$ 260,000	$ 300,000	$ 160,000
Housing Stabilization	$ -	$ 20,000	$ 170,000
Non-CMHC	$ 4,300,000	$ 4,660,000	$ 4,800,000
Grand Total	**$ 71,220,000**	**$75,250,000**	**$79,400,000**

Note: Rounded to nearest multiple of ten thousand. Based upon claims paid and submitted to EOHHS as of 4/15/2023 for dates of service between 2020 and 2022, with no adjustment for IBNR. CMHCs identified based

upon billing provider tax id consistent with Table 3. CMHC services excludes MHPRR and related residential treatment services and BH Link, which are excluded from the PPS rate development. Non-CMHCs applying for certification include Amos House, CCAP, and FSRI. Categories of service included for purposes of the exhibit for non-CMHCs include case management, mental health/substance abuse, community psychiatric treatment, and office visits based upon managed care rate setting service classification methodology.

EOHHS and BHDDH aim to have an updated SFY24 budget estimate based on the Cost Report submissions by the end of the month. This estimate will likely include a refined baseline expenditure calculation. Note, the cost report review and validation process will continue beyond April 30th. The State is also currently reviewing and scoring certification applications. This process will also not be complete by the end of the month. As such, the estimate (and subsequent baseline expenditures) will assume all providers could be certified in SFY 2024 unless any applicants are explicity ruled out at that time. Future updates based on the total number of certified CCBHCs, finalized PPS rates, and any assumptions included in the enacted budget (e.g., start date) would be incorporated at the Nov. CEC.