November 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 Friday, October 27, 2023. **Please submit the answers no later than close of business Monday, October 23, 2023** 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.

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 October 27.***

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 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 include updated timelines and policies that EOHHS and other health and human service agencies intends to implement surrounding the unwinding period.**

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

b. Please provide data regarding whether the Department is still on track for compliance with the unwinding process. Please provide the following in an excel spread sheet (attached in this email).

i. Provide data which summarizes actual monthly renewal activities since the end of the PHE and projected monthly renewal activity for the remainder of the PHE unwinding. Organize data by eligibility group, delivery group, renewal type, renewal status, and other appropriate categories where possible.

See Nov 2023 CEC PHE Question 1 Part B file and Section C and D of EOHHS testimony.

Below is a summary of total terminations by month. Please note that the month represents the month in which the member was no longer eligible; the member would have lost eligibility on the last day of the prior month. For example, the 3,454 terminated in June 2023 would have been part of the first post-continuous coverage renewal cohort whose renewal process began in April 2023 and their last day of eligibility was May 31, 2023.

Gross Terminations by Delivery System, by Month

	June	July	August	September	October Preliminary
RC Core	687	516	569	891	976
RC CSHCN	26	8	29	41	124
Expansion	2,516	1,764	3,008	4,613	5,885
RHP	37	48	49	37	292
RHO II	15	13	34	30	121
PACE			3	1	3
FFS	173	223	588	397	1,545
Total Terminations	**3,454**	**2,572**	**4,280**	**6,010**	**8,946**

Gross Terminations by Eligibility Group, by Month

	June	July	August	September	October Preliminary
Children and Families	741	568	653	970	1,096
Children with Special Healthcare Needs	18	12	30	35	47
Expansion	2,587	1,846	3,098	4,698	6,499
Aged. Blind, and Disabled	108	146	499	307	1,304
Total Terminations	**3,454**	**2,572**	**4,280**	**6,010**	**8,946**

ii. Please provide data indicating how the May 2023 CEC projections compare to actual experience and the updated projections.

As noted in Section D, Caseload Growth and Trend Development, of EOHHS testimony, EOHHS' revised caseload forecast for FY 2024 is generally consistent with May CEC: with a current average enrollment of 359,444 compared to 359,898 in EOHHS' May estimate.

iii. On average, how many active renewals does the Department process weekly. Monthly?

See "PHE – FY2024" tab of "Nov 2023 CEC - PHE Question 1.B" file.

Note, EOHHS does not track and report renewals by week. Through October, DHS has processed an average of 14,599 redeterminations per month.

Renewals by Cohort

		Individuals			Cases		
CY	**Cohort**	**MAGI**	**Non-MAGI**	**Total**	**MAGI**	**Non-MAGI**	**Total**
2023	May	10,895	-	10,895	9,391	-	9,391
	June	11,117	-	11,117	9,919	-	9,919
	July	10,425	4,550	14,975	9,642	4,467	14,109
	August	13,817	2,555	16,372	13,104	2,505	15,609
	September	13,612	4,388	18,000	12,316	4,297	16,613
	October	12,172	4,064	16,236	10,516	3,982	14,498
	November	12,842	3,928	16,770	10,940	3,846	14,786
	December	13,175	5,740	18,915	12,031	5,551	17,582
2024	January	43,282	2,581	45,863	17,091	2,542	19,633
	February	43,700	2,255	45,955	17,476	2,220	19,696
	March	48,202	2,556	50,758	18,443	2,521	20,964
	April	53,853	2,131	55,984	20,519	2,089	22,608
	May*	9,764	366	10,130	8,004	363	8,367
	June*	9,764	357	10,121	8,271	353	8,624
	July*	9,421	3,672	13,093	8,010	3,619	11,629
	August*	10,619	2,092	12,711	9,345	2,052	11,397
Grand Total		**296,962**	**34,915**	**331,877**	**166,715**	**34,382**	**201,097**

*Redeterminations after April 2024 represent members who were newly eligible (post-unwinding) or already renewed during the first few months of the unwinding and are approaching their regularly scheduled annual review.

iv. How many more active renewals need to be processed until the end of the redetermination period.

See "PHE – FY2024" tab of "Nov 2023 CEC - PHE Question 1.B" file.

There remain at least 280,300 individuals (across 155,286 cases) that need to be renewed for redetermination dates after October.

Separately, EOHHS is working with RI Bridges to identify all individuals known internally as "**Category I**"—these are individuals with an active MMIS enrollment segment but appear inactive within RI Bridges and therefore may not be fully included in the 280,300-figure identified above (although the vast majority, if not all, have been identified and are included in the renewal schedule above). During the continuous coverage period, EOHHS interpreted federal regulations as not permitting DHS to close these clients' case; that moratorium is no longer in place. Prior to closure, however, these clients must be identified within RI Bridges and processed for re-redetermination (even though they had previously been determined ineligible). For the most part these clients are known to RI Bridges and EOHHS finance staff routinely audits its MMIS records to best assure that RI Bridges is identifying the complete universe of these clients are including them in the ongoing redetermination cycles. In general, these clients are expected to have a higher closure rate than other clients.

Sensitivity of CEC Model

Please note that the refinement of the RI Bridges' list of "Category 1" members will impact EOHHS' caseload model used for projecting overall member months (and therefore expenditures). In general, there is insufficient information, currently, to make informed adjustments to our a priori assumptions that through September data generally align with our prior forecast.

For example, using rounded numbers, assume 120,000 Expansion members at the end of the continuous coverage period (actual figure was 117,050). This reflects a net increase of 40,000 from pre-Covid. However, while caseload grew 40,000, the number of new members was closer to 60,000 as 20,000 members lost or forfeited coverage during the intervening years for some reason. Within the 120,000 enrolled in MMIS, approximately 10% are identified as Category I. Whether the actual number of Category I members is 10,000 or 12,000 or 15,000, however, does not impact our modeling assumptions. (Again, at this time, absent information that would meaningfully shift assumptions in terms of net closures, one way or the other.)

Ultimately, our estimate assumes that 75% of the 40,000—not the 60,000—will lose coverage during the unwinding. Already included in these 40,000 clients are any unidentified Category I members. And regardless of the specific number of Category I (who are expected to have a higher closure rate) or, conversely, the number of unanticipated appeals (that are expected to depress the closure rate), the number of the total net closure should remain at approximately 30,000 members. It is likely that a greater proportion of the 30,000 closures will come from the Category 1, but the forecast of net closures, would not meaningfully change if we learned there were 15,000 Category I members instead of 12,000 presently identified.

Having determined the volume of closures, the distribution of these closures is then determined by the volume of closure activities per month based on the current renewal schedules for non-Category I clients. Any delays will shift this, but our current forecast in line with expectations and no mixed households—where most non-Expansion closures and thereby GR savings—having yet been initiated there is no reason to adjust at this time.

c. Please provide the Department's strategy to shorten call center wait times.

i. How does the Department plan to respond to the Medicaid letter regarding redetermination wait times and concerns for equitable access to programs?

DHS has been working on a multi-pronged approach to reduce wait times and provide better access to services and programs in the call center. The department is focusing efforts to 1) increase call center staffing resources 2) partner with other state agencies to handle calls and 3) utilize technology available to improve call handling.

DHS is currently working with a vendor to add staff resources to the call center's existing medical queues. In the month of October, an additional 10 contracted resources will be trained in MAGI and Complex Medicaid to be able to handle inbound calls. Adding additional staff to the medical queues will significantly increase the resources available which, in turn, will lower the wait time and decrease the abandonment rate on those queues. DHS anticipates the contracted staff will be ready to begin taking calls in early November.

Additionally, DHS has submitted a request to the Food and Nutrition Service (FNS) seeking approval to allow non-merit staff to handle SNAP related calls. In doing so, DHS anticipates that not only will the added staff help to lower the wait time on SNAP queues, but it will also make available state merit employees to be able to handle other calls, including Medicaid related inquiries.

DHS also continues to post positions for Eligibility Technicians in the call center to fill FTE vacancies. Currently, there are only 2 vacancies for Eligibility Technicians remaining.

DHS is partnering with our sister agency, HealthSource RI, to transfer MAGI customer calls to the HSRI Contact Center, where they can be handled more rapidly and with the same level of service. Beginning in mid-August, DHS triage staff (who are the first point of contact and act as call center operators) identify MAGI-related calls and seamlessly transfer them out of the DHS call center and into the HSRI contact center via a direct line. As HSRI has greater bandwidth to handle calls at this time, transferring MAGI calls has not only lowered the volume of MAGI calls coming to DHS, but it has also lowered the wait time for the few MAGI calls that are transferred to DHS workers. Moreover, for the calls that are transferred to HSRI, they are picked up within minutes. This has provided an increased level of access to

many MAGI members. If the call transferred to HSRI does, in fact, need further assistance from DHS (for complex Medicaid household members or other DHS programs) a direct line has been set up to transfer the caller back to DHS without having to go through the IVR prompts and triage queues.

Finally, DHS is also focused on utilizing active dashboard management and queue prioritization to move call volume as expeditiously as possible. Supervisors and call center management monitor the dashboards daily to watch call wait times and prioritize queues where wait times are growing. The supervisory team also manages worker queue assignments to put staffing resources where they are needed most.

Please see the response to CMS' letter regarding redetermination wait times.

Sousa Response CMS Letter 8_22_23

d. **Provide an update on member appeals activity and its impact on projected caseload.**

The following table shows the total number of appeals received by month from SFY 2016 through September of SFY 2023.

The appeals activity is not expected to have a meaningful impact on EOHHS' projections at this time. For additional consideration on sensitivity of modeling to such consideration, please see response above to **Question. 1 b. iv**.

Months	2019	2020	2021	2022	2023
Jan	374	716	511	570	453
Feb	394	396	292	529	461
Mar	532	491	232	437	611
Apr	349	373	284	518	358
May	388	250	178	311	438
Jun	280	199	193	320	531
Jul	307	297	266	438	428
Aug	422	364	199	344	478
Sep	319	430	297	632	593
Oct	365	522	509	490	
Nov	438	355	377	441	
Dec	376	309	537	617	
Grand Total	**4466**	**4613**	**3793**	**5597**	**4279**

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.**

As of payroll period 8 (end date of 10/7 and paid date of 10/13), 675 of 770 positions are filled. Of the 95 vacancies, 92 are in progress/various stages of recruitment.

In preparation for the Medicaid Recertification period, also referred to as the Return to Normal Operations (RTNO), EOHHS and DHS developed a comprehensive workforce projection model to

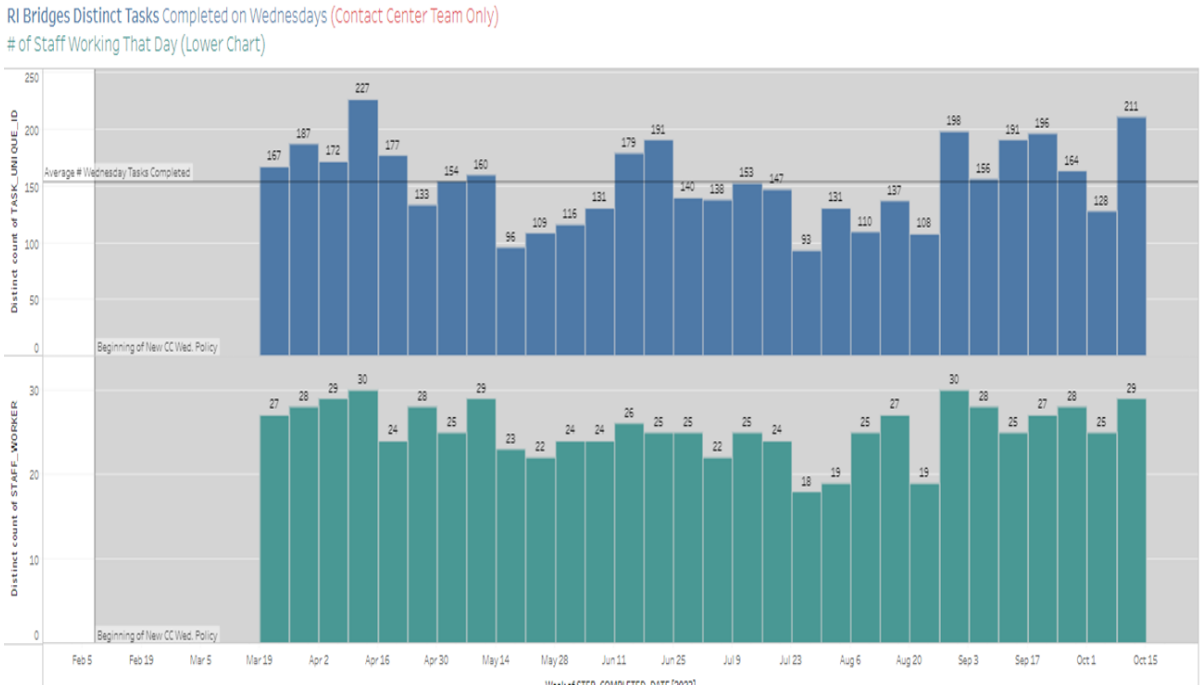
meet the monthly recertifications based on the redistribution model that was sent to CMS. This workforce projection model considered the monthly task processing for each category of Medicaid, in additional to other DHS human service monthly processing. The model then projects how many staff are needed by task, which has been the basis for monitoring the processing of redeterminations throughout the RTNO period.

Medicaid recertifications began on April 1, 2023, with a cohort of approximately 9,400 recertifications sent to customers. For the month of October, DHS is processing a total of 15,731 case renewals, with approximately 7,600 case renewals requiring action from the customer. Medicaid renewal cases are anticipated to steadily increase in alignment with the increase of passive renewals, which require no action from customers. DHS continues to work with numerous state agencies, managed care organizations, advocates, and community-based organizations to reach and inform as many affected Rhode Islanders as possible. Outreach also continues to inform families with children that their renewals will not start until January 2024.

The Executive Office of Health and Human Services awarded mini grants to enlist the support of community partners to reach the broadest group of Rhode Islanders, with special attention paid to those most at risk in the renewal process. Some of these groups include individuals who may have barriers to obtaining this information, and those that may need assistance to complete the process. In addition, the state has continued to update the staycovered.ri.gov website with notices, marketing collateral, and other resources such as a data dashboard to help support the Medicaid renewal process. In May 2023, DOA awarded a contract to Deloitte to provide data processing support so that DHS eligibility technicians can focus on Medicaid redeterminations through July 2024. Currently, all temporary support staff have been recruited and onboarded to provide data processing support to the DHS Eligibility Technicians working on Medicaid Redeterminations.

3. **Please provide an update regarding *Processing Wednesdays*, challenges, and impact on call center wait times and enrollment.**

On February 8, 2023, DHS launched a pilot initiative called Processing Wednesdays. With the goal of improving operational efficiency and customer service, the strategy shifts call center staff to prioritize case processing one day a week, deemed crucial for addressing any backlogs.



As of September 16, 2023, DHS has seen an approximate 62 percent increase in the number of tasks completed, or an increase from 101.5 to 164 cases completed on average, when comparing the last four Wednesdays prior to launch, to the most recent four Wednesdays. While this only examines the tasks completed, Processing Wednesdays has also increased the number of tasks worked and helped reduce the backlog, which directly helps reduce the need for customers seeking additional support services either by phone or in-person. The blue bars show the number of tasks completed on Wednesdays. The green bars show the number of available staff on for the date listed, which impacts the number of cases that can be worked on Processing Wednesdays.

Processing Wednesdays have not had a negative impact on call center wait times or enrollment. Since the inception of Processing Wednesdays, DHS has monitored call center dashboards to track any spikes in call volume, particularly on Thursdays. These anticipated spikes have not come to fruition, nor has the community at-large expressed any major concerns or dissatisfaction. Moreover, HSRI has monitored the amount of calls their contact center receives on Wednesdays (anticipating a spike due to DHS being closed to inbound calls), and also reports no adverse impact. Instead, the data has shown that DHS call center workers are able to surpass the typical task processing levels on Wednesdays, which has contributed to the agency as a whole being able to keep up with incoming work. DHS offices and HSRI continue to be open on Wednesdays to provides other access points for individuals to receive services and support.

4. **Please provide an update and final estimate regarding temporarily increased FMAP under FFCRA, as compared to the May 2023 estimate.**

   See section C, Public Health Emergency, Enhanced FMAP Rate and GR Savings. The May CEC estimate assumed that the enhanced FMAP would provide general revenue relief through December 31, 2023. This is still accurate and the updated estimate of the value of the enhanced FMAP in FY 2024 is $23.6 million relief in FY 2024, consistent with assumptions in May CEC. Overall, Rhode Island received an additional $490.9 million in federal financial participation over the course of the public health emergency.

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 accompanying 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 2024 and FY 2025. Please update FY 2023 final as necessary.**

   See **Attachment 7a** for capitation rates and summary by Product Line.

   Additional details on caseload are included in **Attachment 5a, 5b, 5c,** and throughout testimony.

FY 2023 Closing

1) **Please provide a FY 2023 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.

b. **Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2023 final budget.**

   Year-end adjustments for NEMT reflect assumptions incorporated into FY 2023 Revised.

2) **Please include a column for FY 2023 closing figures in the summary tables within each section of your testimony.**

   Each summary table includes the Preliminary Fiscal Close for FY 2023.

   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 2024 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) **In July, the Secretary raised concern about CMS potentially needing a year to approve the 1115 Demonstration Waiver to replace the current waiver as of January 1, 2024. What, if any, progress has been made toward receiving authority for certain programs while the State waits for waiver approval?**

   See section I, "1115 Waiver Update" in **Major Developments** of EOHHS' testimony file.

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**.

Long-Term Care

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

   See **Nursing and Hospice Care** section of testimony.

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

   See **Home and Community Care** section to testimony as well as **Attachment 7a.**

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** for revised estimates for fiscal impact of the different initiatives.

LTSS Slides for caseload OCT 23.pp

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 10/14, using the most recent report available (September 2023).[1] The following chart shows a total of 50 overdue LTSS applications. In the report, DHS offered updates on all applications processing:

- On February 8, 2023, DHS launched a pilot called Processing Wednesdays intended to prioritize call center staff to process applications, update customer files, complete reports and other operational tasks, which supports efforts to reduce the backlog. All regional offices remain open with regular services available according to their posted schedule. As of September 11, 2023, DHS continues to see more cases completed or worked on Processing Wednesdays when compared to cases worked on regular Wednesdays (about 100 cases) prior to launch. The increased number of tasks completed on average, aided with the support of Processing Wednesdays, have helped reduce the backlog and directly reduced the need for customers to seek additional support by phone or in-person. DHS's operational adjustments and initiatives have contributed to an overall 43% reduction in overdue pending applications awaiting state action since January 2023 (Jan 2023: 4,274 vs Sept 2023: 2,404).

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	60	551	611	13	45	58	**669**
SNAP Non-Expedited	614	546	1,160	43	47	90	**1,250**
CCAP	10	380	390	13	46	59	**449**
GPA Burial	0	18	18	0	0	0	**18**
SSP	0	31	31	0	0	0	**31**
GPA	42	83	125	8	4	12	**137**
*RIW	198	228	426	26	31	57	**483**
Undetermined Medical	31	425	456	56	1877	1933	**2,389**
Medicaid-MAGI	20	42	62	13	19	32	**94**
Medicare Premium Payments	8	192	200	8	8	16	**216**
Medicaid Complex	5	108	113	9	279	288	**401**
LTSS	11	173	184	2	48	50	**234**
Grand Total	999	2,777	**3,776**	191	2,404	**2,595**	**6,371**

[1] Internet: http://www.transparency.ri.gov/uhip/documents/legislative-reports/2023/September%202023%20House%20Oversight%20RI%20Bridges%20Report-FINAL-amended.pdf. Accessed 10/14/2023.

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 Care** 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.

Patient Share Adjustment

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 three Caseloads and this Caseload, EOHHS has not included any such adjustment. In part due to the significant COLA increases to Social Security as well as changes in the composite rate of members residing in nursing facilities. (Relatedly, the nursing facility population is not static, and rates can vary from less than $200 per diem to well-over $300. The change in composite rate and average patient share will vary year-over-year based on combination of the acuity of those residing in the facilities and how much those members are able to contribute to their cost of care. If the average member has a lower acuity, and therefore lower cost, then the average patient share would likely pay for a greater proportion of the total cost of care.)

However, with the nursing facility rates increasing 6.9% and 6.6% in FY 2024 and FY 2025, respectively, with a further 11.0% increase expected in FY 2025 for the underlying review of base rates, EOHHS does not believe current patient share collections will keep pace with these increases. For example, the Social Security Administration announced that Americans will get a 3.2% COLA increase in January 2024 and the Federal Reserve targets a long-term inflation rate of 2.0%. If Social Security is the primary source of income for nursing facility resident such modest increases will be insufficient to capture the increasing cost of a nursing stay. As such the percentage of the per diem paid by the resident will decrease and the effective increase of Medicaid's costs will exceed that of price increase. Specifically, in Q1 of FY 2024, patient share accounted for 18.1% of total nursing home charges. If a residents income increases by 3.2% in January 2024 and 2.0% in January 2025, but total charges increase significantly faster, by the end of FY 2025, patient share would account for only 14.9% of charges. An increase to the direct reimbursement by Medicaid is needed to make up for this differential.

For FY 2024, the result is an additional increase of **0.8%** or $2.6 million. For FY 2025, the adjustment is equivalent to **2.3%** or $9.1 million This includes $2.4 million (0.6%) associated with impact of the 6.6% legislatively mandated rate increase (and partial current year 6.9% increase) and $6.7 million (1.7%) to account for the approximate 11.0% increase for EOHHS' nursing home rate review. Below is the derivation of these percentages :

FY 2024 Rate Increase - 6.90% effective Oct 1, 2023											
	Q1 per diem	**Oct-23 Increase**		**Q2 per diem**	**Jan-24 COLA**		**Q3-Q4 per diem**	**Average Q2-Q4 per diem**			
CHARGE per diem	$260	6.90%	→	$278			$278	$278			
patient share per diem	$47			$47	3.20%	→	$49	$48			
PAID per diem	$213			$231			$229	$230			
Effective Increase				8.4%			7.7%	8.0%			
Patient Share Shortfall				1.5%			0.8%	1.1%			
								× 0.75			
Effective SFY impact								0.8%			
FY 2025 Rate Increases - compound of 6.60% + 11.0%, effective Oct 1, 2023 (total incrase of 18.3%)											
Includes impact of prior year imapct on Q1 + variable impact in Q2 through Q4 due to change in COLA											
	Q1	**Sept-24 per Diem (est.)**	**Oct-23 Increase**		**Rate Review**		**Q2 per diem**	**Jan-24 COLA**		**Q3-Q4 per diem**	**Average Q2-Q4 per diem**
CHARGE per diem	**$278**	$278	6.60%	→	11.0%	→	$329			$329	$329
patient share per diem	**$49**	$49					$49	2.0%	→	$49	$49
PAID per diem	**$229**	$229					$280			$279	$280
Effective Increase	**7.7%**	7.7%					22.2%			21.8%	21.9%
Patient Share Shortfall	**0.8%**						3.9%				3.6%
	× 0.25										× 0.75
Annualized Impact	0.2%										2.7%
Potential Underfunding	2.9%										
Discount applied	80%										
	2.3%										

7) Please include the projected cost of rate changes for both FY 2024 and FY 2025 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 7b includes a summary of all rate changes.

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 **Home and Community Care** section of testimony. Based on Rhode Island's increasing nursing home census no supplemental appropriation required for FY 2025.

9) Please provide an update on the implementation of Conflict Free Case Management (CFCM):

What was the original plan for implementation?

RI EOHHS's original anticipated timeline was as follows:

- November 2022: RI EOHHS releases a CFCM/Person Centered Planning (PCP) strategic plan and roadmap to stakeholders for public comment.
- January 2023: RI EOHHS finalizes its CFCM/PCP strategic plan based on stakeholder input.
- November 2022-June 2023: Implement an IT system that will support CFCM/PCP activities.
- July 2023: Pilot launch of CFCM/PCP for a select population.
- Late 2023: RI EOHHS issues an RFP for 1 or more vendors to provide CFCM/PCP. It will take approximately six (6) months to execute contracts and prepare vendors to begin the gradual transition of new and existing participants.
- January 1, 2024: The State begins to enroll Medicaid HCBS participants into CFCM according to its participant transition plan. By January 1, 2025, all Medicaid HCBS participants have access to high quality CFCM from a conflict-free case manager that has met the minimum standards established by the State.

What assumptions were included in the plan provided in the enacted budget?

Assumptions in the plan that was provided in the enacted budget included, a successful Request for Information (RFI) and Request for Proposals (RFP) would find adequate capacity, that Wellsky functionality would be on track and in the correct phase. That Wellsky and InterRAI functionality would be ready by fall 2023. Additionally, BHDDH originally had intentions to start a pilot program.

The FY 2024 enacted financial model assumed:

- 11,968 people eligible for CFCM services with staggered population start dates
    - Entirety of BHDDH DD population to start 7/1/2023.
    - Katie Beckett population to start 7/1/2024.
    - All others to start 1/1/2024.
- FMAP of 55.75%
- Rate of $170.87 per member per month

What is the current plan?

RI EOHHS's revised timeline is as follows:

- October 2023: Certification standards were made available for public comment
- November – December 2023: State updates and finalizes certifications standards
- January 2024: Application open to any willing provider
- January – March 2024: EOHHS begins accepting and review of applications
- April 2024: Expected time of first fully certified vendors
- December 2024: All Medicaid HCBS populations transitioned to appropriate conflict free case management providers.

The updated SFY 24 financial model assumes:

- 10,335 people eligible for CFCM services with staggered start dates.
    - Katie Becket population no longer in model as CFCM is covered in managed care.
    - OHA populations to start 4/1/2024.
    - Remaining CFCM eligible individuals will be phased in based on available compacity each month until entire population is fully compliant by 12/31/2024.
- 55.01% FMAP
- Rate of $170.87 per member per month

What was changed from the original plan to the current plan?'

Based on a review of responses from the RFI, decision to move LTSS into Managed Care, and change in management of CFCM it was decided to move away from the RFP route, in favor of a certification standards for any willing provider. This was done to allow a continuous opportunity for providers to enroll rather than a fixed transition which would arise through using an RFP.

The BHDDH pilot was unable to get off the ground thus it was decided that BHDDH would come into the timeline EOHHS is currently on.

Why were these changes made?

Moving away from an RFP was proactively made based on the belief that a certification standards model would give greater opportunity to reach CFCM desired capacity by December of 2024. Further the new timeline takes into consideration slowdowns in the Wellsky timeline. Including factors such as the billing code through Gainwell/MMIS would not be available till April 2024. These complicating factors led to adoption of a more flexible approach and timeline which better fits the practical realities of the project now that we have moved from the theoretical phase into the implementation of CFCM.

EOHHS has worked closely with CMS on the changes.

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2024 and FY 2025.

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 2024 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.

The Enacted reflected a 5.0% price factor for all managed care products in SFY 2024 based on EOHHS' May testimony. Actual rate certifications reflect a 0.6% composite increase.

Rite Care CSHCN exhibited a composite change of 2.3% (excluding the new Katie Beckett case management rating category). While SOBRA reflect a 11.1% increase.

See **Managed Care** section of testimony for additional detail.

4) Please provide the projected CHIP funding for FY 2024 and FY 2025, 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.

Rhody Health Partners

1) **Please provide estimates for Rhody Health Partners for FY 2024 and FY 2025. 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 2024 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.**

   The actuarially certified rates for FY 2024 reflect a composite rate change of 1.9% based on updated claims experience, compared to the 5.0% assumed in May.

   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 2024 and FY 2025.**

   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 2025?**

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

3) **Please provide an update on the Hospital State-Directed Payment Program.**

   As of October 19, 2023, CMS is still conducting its review of the Hospital State Directed Payment (SDP). Please see the below timeline regarding updates to the hospital SDP program review process.

   - June 2, 2023: The Executive Office submitted the hospital SDP specific preprint to CMS.
   - June 8, 2023: CMS confirmed receipt of the preprint and engaged EOHHS with clarifying questions regarding the hospital SDP.
   - June 9, 2023: CMS acknowledges that the hospital SDP proposal has begun the review stage.
   - September 14, 2023: EOHHS requested a status update regarding the submitted pre-print. This request was sent approximately 90-days post last hospital SDP specific correspondence with CMS. CMS indicated the review is ongoing and questions will be sent to EOHHS as soon as possible.
   - October 17, 2023: EOHHS received first round of review questions from CMS and is in process of drafting a response.

   Once the hospital SDP is approved by CMS, it is EOHHS intention to make the payments in the next applicable quarter, including any missed quarters associated to the approval delay.

Pharmacy

1) **Please provide separate estimates of pharmacy expenditures and rebates for FY 2024 and FY 2025.**

   See **Pharmacy** section of testimony and **Major Developments** for consolidation of pharmacy rebates and J-code collections.

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 Services** section of testimony.

2) **Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2024 and FY 2025.**

   See **Other Services** section of testimony.

3) **What are the state-only costs in FY 2024 and FY 2025?**

   The only anticipated state-only costs are in the **Managed Care** budget line, attributable to the population of members children under 19 eligible for state only medical assistance due to their immigration status.

Medicaid Expansion

1) **Please provide updated caseload and expenditure estimates for FY 2024 and FY 2025 for the ACA-based Medicaid expansion population.**

   See **Expansion** section testimony.

2) **If the FY 2024 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.**

   The actuarially certified rates for FY 2024 reflect a composite rate decrease of 3.1%, instead of increasing by 5.0% as assumed in May. 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 update on the implementation of the federal model for Certified Community Behavioral Health Clinics (CCBHC).**

   CCBHC Project Development & Certification: Throughout the CCBHC program design and implementation process, the state's top priority has been the creation of high-quality services for Rhode Islanders who seek behavioral health supports. As of October, the Interagency Team has contingently certified three CCBHCs, Community Care Alliance, Newport Mental Health, and Thrive Behavioral Health.[2] Eight additional providers continue to ready themselves to meet the CCBHC certification requirements to begin services after the anticipated Year 1 start date. Note: To date, 11 organizations have applied for certification. This includes all Infrastructure Grantees, plus one additional provider who did not receive a grant.

[2] https://eohhs.ri.gov/initiatives/behavioral-health-system-review

Implementation of the $30 million CCBHC / Designated Collaborating Organizations (DCO) Infrastructure Grants:

The $30 million legislative allocation of ARPA dollars has three separate elements of work: i) Direct Grants; ii) Operations; and iii) Administration.

1. Direct Grants to potential CCBHCs and DCOs

EOHHS funded 10 potential CCBHC organizations at $300,000 each for Phase 1 and $760,000 for Phase 2, and 20 potential DCOs at $30,000 each for Phase 1 and $370,000 for Phase 2. We have encumbered a total of $10.6 million for the 10 potential CCBHC organizations and anticipate all $10.6 million to be spent by the end of FY 2024. We have encumbered a total of $8 million for the 20 potential DCO organizations and anticipate all of these dollars to be spent by the end of SFY24.

EOHHS intends to finish planning for Phase 3 Grant Dollars in October 2023. We plan to encumber at least 75% of the Phase 3 dollars by the end of FY 2024 (June 30, 2024), and all remaining Phase 3 dollars before the encumbrance deadline of December 31, 2024.

CCBHC and DCO grantees have spent the dollars to prepare for certification and to close program gaps that both they and the State have identified in their CCBHC planning. Expenditures in Phase 2 include staff recruitment, development, and training (including on evidence-based practices and diversity and inclusion); Electronic Health Record system enhancements, data gathering, and information technology implementation activities; staff hiring (including for general services, veteran's services, and Substance Use Disorder programming); quality enhancement; and marketing and outreach.

2. Operations & Program Development: The Operations component of the CCBHC Project includes two major areas of work:

- Program Development, with vendor and staff support for major state CCBHC certification and program implementation activities. The state is working with Milliman as its cost reporting vendor, Gainwell as its Medicaid Management Information System (MMIS) technical implementation vendor, and Faulkner Consulting Group as its program design and development technical assistance vendor. BHDDH has also received $400,000 for certification staff, to help with the ongoing CCBHC certification and oversight process.
- Provider Technical Assistance, which includes a group Learning Collaborative and significant 1:1 support for all grantee provider organizations. The state carried out a competitive RFP to choose the Brandeis Behavioral Health Institute to serve as the technical assistance vendor for this provider support program.

3. Administration – Staffing: Our program staff have been crucial to the design and implementation of the CCBHC program. We were able to fill allocated positions approximately midway through SFY23. Right now, our budget will allow us to keep staff through SFY25.

Pursuit of the Federal Demonstration Project/expanded FMAP: As directed by the General Assembly in the SFY23 budget, BHDDH and EOHHS applied successfully for the SAMHSA CCBHC Planning Grant. The $1 million dollar award is being used on spending not covered by the State Fiscal Recovery Funds dollars – and thus we are braiding the funding together. Receipt of this grant also means the state is eligible to apply for the federal CCBHC Demonstration Project that would allow Medicaid to claim an enhanced federal Medicaid match for CCBHC services that is based on a state's enhanced CHIP FMAP. This represents an approximate 13 percentage point increase over the FY 2025 base FMAP. Note, the demonstration guidance and application for FY 2025 has not been released; this is based on the current demonstration. EOHHS and BHDDH anticipate the application will be released in December 2023, with a March 2024 due date.

Application results are expected to be released prior to July 1, 2024, however SAMSHA has not provided a definitive date.

State Plan Amendment:

As directed by the General Assembly, EOHHS is submitting a State Plan Amendment (SPA) for CCBHCs based on program requirements for Year 1 with PPS-2 (monthly bundle) as the payment mechanism. The SPA was posted for public comment on 10/23/2023 and then submitted to CMS for review with a 2/1/2024 effective date. CMS has 90 days to approve or deny the SPA, which can also include 'pausing the clock' for a Request for Additional Information. If Rhode Island becomes a CCBHC Demonstration state, the SPA will be rescinded as the demonstration becomes the authority for Medicaid to claim Federal dollars for the program.

Concurrently, EOHHS will prepare an updated SPA for CCBHC Program Requirements for Year 2, with an effective date of July 1, 2024. The updated SPA is needed should Rhode Island not become a Demonstration state to ensure Medicaid coverage for the services included in the CCBHC model for Year 2 (based on changes to the Federal model effective July 1, 2024).

SFY 2024 and SFY 2025 Medical Assistance Fiscal Estimates

Generally, CCBHC costs and visits are highly uncertain in the first year of the program, as it is unknown the extent to which providers will be able to hire more staff and to what extent behavioral health service utilization will increase with the new program. Further, redeterminations resulting from the 'Return to Normal' operations may impact the percentage of Medicaid recipients receiving CCBHC services. The second full year of the program, SFY 2026, is the first year that rates and estimates will be based on actual experience.

SFY 2024 Estimates:

- Assume the three contingently certified providers are participating and billing for CCBHC services starting on the anticipated start date of February 1, 2024.
- Reflect cost report materials received as of October 3rd for the three contingently certified providers. Note, additional providers could become certified between the anticipated start date and the end of FY 2024.

SFY 2025 Estimates:

- Assume all providers seeking CCBHC certification are participating as of July 1, 2024.
- Reflect annualized, statewide fiscal impact estimates calculated by utilizing the composite PPS rates for the three contingently certified providers with reported visits for all providers, with adjustments where applicable.
- Do not reflect new cost reports that will include program requirement changes associated with the updated March 2023 Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC certification criteria.

While significant progress has been made through collaboration between EOHHS, BHDDH, DCYF, our vendor Milliman, and providers, several factors continue to leave considerable uncertainty in the fiscal estimates for both SFY 2024 and SFY 2025. We continue to work with the contingently certified CCBHCs on their cost report submissions. As such, the estimates are anticipated to change as updated CCBHC cost report information is obtained, and discussions continue with state subject matter experts. EOHHS also has outstanding questions with CMS that could impact the estimates.

There are implementation risks that may delay the anticipated SFY 2024 start date, and subsequently the fiscal estimates, including approval of the state plan amendment by CMS, continued release of new guidance from SAMHSA and CMS, system readiness for billing (for both fee-for-service through the MMIS and for the MCOs), and MCO/provider readiness.

- EOHHS has proactively engaged CMS over the past few months on SPA development. Despite these ongoing conversations, EOHHS anticipates constructive dialogue during the formal review process as CMS is actively working with their Federal counterparts at SAMHSA to align the demonstration requirements with traditional Medicaid authority pathways. The SPA is currently posted for public comment and will be formally submitted after public comment is received and addressed.
- Concurrently, the CCBHC Interagency Team is working with our MMIS vendor to finalize the technical/business specifications. These specifications are next used to deploy system build in the MMIS and then used by the MCOs to develop their internal billing processes. This outstanding build is a risk to timing that is undetermined at the time of this testimony.

The CCBHC Interagency Team is also actively working with the plans and providers to support their contracting process, system configurations, claims and quality reporting requirements, and provider education.

2) Please provide an estimate for FY 2024 and FY 2025 of Medicaid expenditures for behavioral health services, including overall BH spending over that time (e.g. Medicaid spend on primary BH diagnoses).

Table 1. Claims with a Primary BH diagnoses, by provider type

	2020	2021	2022	2023
Medicaid	**507,890,000**	**510,890,000**	**532,680,000**	**547,940,000**
Other Professional	110,850,000	116,440,000	122,820,000	150,200,000
CMHO	91,040,000	97,600,000	109,290,000	99,310,000
NH/Hospice	111,690,000	86,380,000	86,280,000	77,500,000
Inpatient	66,150,000	74,670,000	74,180,000	75,760,000
Bradley	32,100,000	36,610,000	38,700,000	38,940,000
Butler	29,310,000	31,800,000	34,150,000	39,900,000
SUD/MAT	28,190,000	27,800,000	24,710,000	21,770,000
Outpatient	19,420,000	21,040,000	22,240,000	24,510,000
Special Education	11,860,000	11,380,000	13,310,000	13,540,000
Tavares	7,280,000	7,170,000	7,000,000	6,510,000
BHDDH Providers, Excl Slater	**260,260,000**	**255,500,000**	**304,330,000**	**342,080,000**
DCYF	**5,100,000**	**5,120,000**	**4,810,000**	**5,300,000**
DHS	**670,000**	**600,000**	**800,000**	**520,000**
Grand Total	**773,920,000**	**772,110,000**	**842,620,000**	**895,840,000**

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. Rounded to the nearest multiple of ten thousand.

a. What are the projected expenses for the MHPRR services for FY 2024 and FY 2025? In what program or programs do these expenses occur? How many individuals are enrolled in the program for FY 2024 and projected for FY 2025?

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*
- *U6- $525, enhanced*

MCO rates appear comparable.

Presented in

Table 3 and **Table 4** below is the total spending for FY 2023 and estimates for FY 2024 and FY 2025. 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 2024 and FY 2025? 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 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 2. October 2023 Snapshot of Health Home Authorizations by eligibility category

	Regular	Expansion	SSI-like	Medically Needy	Total
Integrated Health Home (IHH)	4,433	1,154	947	170	6,704
Assertive Community Treatment (ACT)	889	276	188	57	1,410
Opioid Treatment Program (OTP)	1,066	1,498	119	10	2,693
Total	**6,388**	**2,928**	**1,254**	**237**	**10,807**

3) Please provide enrollment and costs expected to be incurred in FY 2024 and FY 2025, 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 3. Select Behavioral Health Spending, FY 2023 (Managed Care and FFS)

	FFS	Managed Care	Total
MHPRR (H0019)	$5,990,000	$11,540,000	$17,530,000
Integrated Health Home (H0037)	$8,720,000	$25,240,000	$33,960,000
Assertive Community Treatment (H0040)	$5,620,000	$13,600,000	$19,220,000
Opioid Treatment Program (H0037 - Provider Type 060)	$300,000	$50,000	$350,000
BH Link (H2011/S9485)	$750,000	$1,960,000	$2,710,000
Housing Stabilization (H0044)	$430,000	$-	$430,000
Peer Support Program (H0038)	$300,000	$180,000	$480,000
Subtotal	$22,110,000	$52,570,000	$74,680,000

Table 4. FY 2023 and FY 2024/2025 Estimate for Select Behavioral Health Spending

	FY 2023	FY 2024 Est.	FY 2025 Est.
MHPRR (H0019)	$17,530,000	$20,950,000	$25,330,000
Integrated Health Home (H0037)	$33,960,000	$34,660,000	$35,920,000
Assertive Community Treatment (H0040)	$19,220,000	$19,670,000	$20,350,000
Opioid Treatment Program (H0037 - Provider Type 060)	$350,000	$370,000	$370,000
BH Link (H2011/S9485)	$2,710,000	$2,770,000	$2,870,000
Peer Support Program (H0038)	$430,000	$710,000	$1,960,000
Housing Stabilization (H0044)	$480,000	$500,000	$510,000
Subtotal	$74,680,000	$79,630,000	$87,310,000

Note 1. Rounded to the nearest multiple of ten thousand. For MHPRR activity, FY 2024 and FY 2025 include $2.9 million and $6.7 million, respectively, added to the FFS totals for purposes of the MHPRR $525 enhanced rate.

Note 2. Values are not adjusted for incurred but not paid claims.