May 2025 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services

RI Bridges Data Breach

See **Temporary Impact of Cyber Attack on Caseload** within the **Major Developments** section.

Tables and Federal Changes

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 2025 and FY 2026. Please update FY 2024 final as necessary.

See **Attachment 7** for capitation rates and summary by product line. Additional details on caseload are included in **Attachment 5a-d,** and throughout testimony.

3) Please provide, where possible, detail on the risks to federal funding.

The entire CMS team working on the dual program for Rhode Island, the Contract Management Team within the Medicare-Medicaid Coordination Office, was laid off as of 4/1/2025. A new contact was assigned to Rhode Island for this work on 4/7/2025.

See also **Federal Changes** in the **Major Developments** section.

FY 2024 Closing -Audited

1) **Please provide a FY 2024 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 FY 2024 Final in the **Major Developments** section of the testimony.

   b. **Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2024 final budget.**

      Transportation Broker expenditures for Aged, Blind, and Disabled clients are initially reported against Funding Source 10. This funding source is assigned to **Other Services**. As part of year-end close, Medicaid reallocates spending from **Other Services** to **Rhody Health Partners** and **Rhody Health Options**, assuming one month of Transportation Broker premium for every member month of enrollment in the respective managed care products.

      The FY 2024 Final is consistent with this reallocation.

2) **Please include a column for FY 2024 audited closing figures in the summary tables within each section of your testimony.**

Each summary table includes the FY 2024 Final reflective of audit adjustments.

FY 2025 Budget

1) **Please include a status update on budget initiatives as outlined in "Tab 2" which retains the November 2024 data and has new columns for May 2025. Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate and any known barriers to approval.**

   See **Attachment 2a** and the **FY 2025 Budget Initiative Implementation** section within the **Major Developments** section of testimony for a detailed description of the status of pending submissions to CMS.

   a. **Include all relevant details regarding the status of pending submissions to CMS, including the 1115 demonstration waiver.**

      See the **1115 Waiver Update** in the **Major Developments** section of Medicaid's testimony file.

2) **Please provide an update on progress toward receiving authority for certain programs while the State waits for its delayed 1115 demonstration waiver approval.**

   See the **1115 Waiver Update** in the **Major Developments** section of Medicaid's testimony file**.**

   CMS Authority

   1) **Please provide an update on the proposed changes to CMS rules will impact projected caseload and programming. This may include recently proposed rules impacting Medicaid through 2030 including how the April 2, 2024, CMS Final Rule will impact projected caseload: Streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Applications, Eligibility Determination, Enrollment and Renewal Processes (including but not limited to impacts on eligibility (including justice-involved youth deadline of January 1, 2025); FFS Rate Transparency & Rate Restructuring; State Directed Payments; In Lieu of Services; HCBS Payment Adequacy; HCBS Quality Measure Set; and Nursing Facility Minimum Staff Ratios and Cost Reporting).**

      <u>Consolidated Appropriations Act of 2023</u>

      The Consolidated Appropriations Act of 2023 requires states to provide screening and diagnostic services and targeted case management services to Medicaid-eligible incarcerated individuals who are either under age 21 or eligible for Medicaid as former foster youth (under age 26) who are in the final 30 days before their scheduled release. The state must also ensure that this population receives targeted case management for 30 days after release. This rule applies only to individuals who have been sentenced; there is a state option to provide the full range of Medicaid services to youth who are in a pre-trial status, but RI has not yet elected to implement that. States are required to implement this by January 1, 2025, although CMS offered flexibility so long as states are underway and have an operational plan in place on that date, which Medicaid has done. Medicaid is working closely with DOC and DCYF to become compliant. This work includes:

      - Systems changes to ensure bidirectional information sharing between Medicaid and each agency that operates correctional facilities';
      - Changes to the Medicaid Management Information System (MMIS) to identify individuals who are entitled to these services while incarcerated and ensure that payment can be made.
      - Working with correctional service providers and community service providers to arrange for the CAA population to receive services;
      - Developing processes and procedures to ensure "warm hand-offs" to community providers after release;

- Working with DOC and DCYF to maximize these agencies' ability to support new Medicaid applications for incarcerated individuals not already enrolled in Medicaid; and,
- Developing processes and procedures for billing/claiming for services delivered while an individual is incarcerated.

The additional Medicaid spending on screening, diagnosis, and targeted case management services is likely to be small, and—at the—earliest will occur in early CY 2026. For example, in the past 12 months, approximately 110 individuals who fall into the CAA youth population were released from the ACI and RITS combined. In many cases, these individuals will have already received their required annual screening and diagnostic services before their 30-day pre-release period. DCYF currently incurs expenses for the screening and diagnostic services that are part of initial physicals that youth receive at RITS, and the CAA will not change that spending. It is unusual for youth to be at the RITS for a full year, so the expected volume of pre-release exams will be low – CMS does not expect the exams to happen more often than annually. The same is true at the ACI, where inmates receive an annual physical and therefore CAA youth at the ACI are likely to have received their screening/diagnostic services before their 30-day pre-release period.

Targeted case management in the 30 days pre- and post-release will add some additional Medicaid spending but is unlikely to have a meaningful impact on caseload. At both RITS and the ACI, the targeted case management work is expected to be done by existing staff and embedded contractors who will provide this service as part of their existing work. There may be some new case management work conducted to comply with the CAA, but the volume relative to the status quo is expected to be low.

In the short term, neither DCYF nor DOC will submit Medicaid claims for exams or targeted case management provided pursuant to the CAA. In the longer term, DOC may be able to do so. In both cases, major changes to systems would be required. DOC is exploring the possibility of building capacity for Medicaid billing but will not have anything in place for the next year at least.

<u>Medicaid Access Rule and Medicaid Managed Care Rule</u>

In May 2024, CMS finalized its Medicaid Access Rule and Medicaid Managed Care Rule, which represent significant changes to the Medicaid program, imposing new requirements to enhance and standardize reporting, monitoring, and evaluation of Medicaid access to services. RI Medicaid completed an in-depth review of these new rules and requirements and has mapped out initial plan of resources to implement the work, which is phased in starting July 2024.

The following slides present an overview of these two rules, including major programmatic changes.

Attachment_Medica
id New Rules.pdf

Medicaid has eight working groups developing implementation plans. The implementation is occurring based on the federal deadline. As such, any new requirement to be implemented by 7/1/2025 is taking precedence over the remaining new requirements that are to be implemented in 2026 and beyond.

- One of the first CMS requirement due for implementation on 7/1/25 is the establishment of a Medicaid Advisory Committee and Beneficiary Advisory Council. Medicaid developed all the necessary structure and requires rules such as Charter, by-laws, committee application and process etc. and has posted and begun outreach for participants to apply to both committees. See link for details. Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) | Executive Office of Health and Human Services
- As part of the CMS managed care rule the internal group is working on new requirements regarding medical loss ratio and in lieu of services (ILOS) as part of the current managed care contract underway for 7/1/2025. Medicaid submitted to CMS the identified ILOS and relevant information pertaining to the allowable and waiver services that each ILOS would support. Medicaid is awaiting feedback from CMS on this submission and is continuing to work with Milliman on these new requirements as part of the rate setting process.

While a complete assessment of the direct impact on caseload projections is not known at this time, non-compliance with the final rules will lead to federal corrective action plans, holds on approval of federal authority requests, and future impact to Federal Financial Participation (FFP) for Rhode Island Medicaid benefit programs.

Nursing Facility Minimum Staff Ratios and Cost Reporting

In May 2024, CMS published the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting final rule, effective June 2024 with phased-in implementation over four years. The rule largely impacts survey and certification requirements overseen by CMS and the Rhode Island Department of Health. It should be noted, the overall 3.48-hour standard required in this rule is lower than Rhode Island's minimum staffing requirement of 3.81 hours of direct care per resident per day under R.I. Gen. Laws § 23-17.5-32. Although the Rhode Island minimum staffing standard is not currently being enforced, staffing levels are notably higher and Rhode Island nursing homes are better positioned to meet the new federal requirements compared to other states. CMS data included in the final rule publication suggests that Rhode Island nursing facilities are largely meeting the new federal requirements already, although an estimated 53 facilities will need to hire at least some additional staff.

The rule also implements new transparency reporting for Medicaid institutional payments to spend on direct care worker compensation. While this reporting requirement is similar to one included in the Access rule, it does not require a minimum percentage of payments be passed through to direct care workers.

On April 7, 2025, the US District Court for Northern Texas ruled to overturn two components of this rule:

- Facilities must have a registered nurse (RN) on duty 24 hours a day, 7 days a week (24/7 requirement); and,
- Facilities must have a minimum of 3.48 hours per resident per day of total nursing care, including at least 0.55 hours of RN care and 2.45 hours of nurse aide care[1]

2) Please also include a timeline for all changes.

[1] KFF, https://www.kff.org/policy-watch/texas-judge-overturns-controversial-nursing-facility-staffing-rule/, April 11, 2025.

The embedded slides provided in response to question 2.1 include the effective date for changes under the Access and Managed Care rules. Please note, this is not a comprehensive list of all specific changes in the Final Rules as new requirements are phased-in through 2030. The timelines for other rules discussed are noted earlier in the narrative.

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 8**.

2) **For the Governor's recommended budget, "Tab 4" includes the proposals to include and exclude from the EOHHS estimate when providing current law caseload estimates. Please provide the updated value of each initiative based on the updated May testimony.**

   See **Attachment 2b**.

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 nursing home and hospice days from FY 2024 to date.**

   See **Attachment 4.**

3) **Please provide the enrollment and capitation rate information for the PACE program and where applicable for all the monthly Medicaid reporting of the categories of Assisted Living, PACE, A&D, Waiver, Personal Choice/HAB Waiver, Habilitation Community Services, Habilitation Group Home, Preventative Community Services, and Core Community Services.**

   See **Table X-2** in **Home and Community Care** section of the testimony for a summary of authorizations for specific home-based services.

   See **Table X-5** in **Home and Community Care** section for PACE enrollment and rate information.

4) **Please provide explanations of how the categories included in the testimony, including Self-Directed, Home Care, Adult Day, Home Care, Shared Living, and Assisted Living. 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.**

   The monthly Medicaid Expenditure Reports produced by Gainwell and provided to fiscal staff by Medicaid reflect FFS claims on a paid basis. Medicaid's 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 Medicaid's testimony. The "All Other HCBS" reported by Gainwell also includes expenditures for Targeted Case Management and DME for members in wavier categories; these expenditures as classified among the "Other HCBS" in Medicaid's testimony. Note that most Case Management and DME expenditures are reflected in the Other Services budget line.

   After receipt of the CEC questions, OMB requested that Medicaid "please provide explanations of how the categories included in the testimony, namely Self-Directed, Home Care, Adult Day, Shared Living and Assisted Living translate to the names in the caseload indicator data in the monthly reports."

Crosswalk

Caseload Name	Attachment 6D – MA Caseload
Self-Directed	Choice/HAB Waiver
Home Care	A&D Waiver, Personal Core Community Service Preventive Community Svc*
Adult Day	Not distinctly reported**
Shared Living	Shared Living***
Assisted Living	Assisted Living Core Community Service

*Expenditures included in the Home Care FFS activity, but members are not counted in the HCBS authorizations

**Adult Day is not an authorization grouping, rather it is a service available across HCBS categories. (For example, expenditures related to this service could be included across multiple Attachment 6D categories)

***It appears this is reported under managed care, but not as a distinct line under HCBS.

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

See an overview of LTSS initiatives and activities in the below slide deck. Also see **Attachment 2** for revised estimates for fiscal impact of the different initiatives.

LTSS 4-8-25 Final.pdf

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

Information on LTSS applications is available on the transparency portal.[2] As of April 11, 2025, the chart below shows a total of 145 overdue LTSS applications.

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	143	92	235	113	75	188	423
SNAP Non-Expedited	484	177	661	157	64	221	882
CCAP	42	114	156	16	63	79	235
GPA Burial	0	18	18	0	2	2	20
SSP	0	52	52	0	1	1	53
GPA	50	79	129	2	0	2	131
RIW*	129	75	204	25	25	50	254
Undetermined Medical	43	265	308	93	282	375	683
Medicaid-MAGI	30	19	49	58	34	92	141
Medicare Premium Payments	24	262	286	23	118	141	427
Medicaid Complex	12	496	508	25	492	517	1,025
LTSS	29	288	317	7	138	145	462
Grand Total	986	1,937	**2,923**	519	1,294	**1,813**	4,736

[2] https://transparency.ri.gov/uhip/documents/legislative-reports/2025/April%202025%20House%20Oversight%20RIBridges%20Report%20-final.pdf.

7) 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. From 2013 through 9/30/2024, when the average was set, this component had been adjusted by an inflationary index set by the General Assembly. The FY 2024 Rate Review rebased this component. Effective 10/1/2024, the Direct Care based was increased by 13.9% to $143.16 for all facilities. 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 reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities. As a result of the FY 2024 Rate Review, this component was increased 25.5% to $84.09. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
    - Indirect care reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities. As a result of the FY 2024 Rate Review, this component was increased 3.3% to $30.70. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
    - Fair rental value 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 Medicaid to use the IHS Markit Healthcare Cost Review. The 10/1/2024 increase was 2.9%.
    - A per diem tax 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, Medicaid determines if it should gross up the fiscal impact of its annual inflationary rate change for nursing facility and hospice payments to capture the true cost to the state of the rate increase. In general, patient share is expected to increase following cost of living adjustments under the Social Security supplemental security income programs. When rates paid to nursing facilities increase at a faster rate than changes to recipient income, the state can expect to bear a greater proportion of nursing facility costs.

With nursing facility rates increasing by 14.5% in FFY 2025 and a projected 4.2% increase in FFY 2026, Medicaid does not expect current patient share collections will keep pace with these increases.

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 the price increase.

Over the past five years, the average patient share amount per day has gone up about $2 annually. This represents an increase of between 4 and 5%. (Please see Table IX-2 in Nursing and Hospice Care section of testimony.) In comparison, the overall nursing home cost per day (i.e., prior to patient share) has generally increased by a greater percentage amount. If the base nursing home rate goes up faster than patient share this means that patient share will account for a smaller proportion of the total revenues collected by the nursing home and the State will need to make up the proportional shortfall from this mixed funding stream. For example, in FY 2025, the average nursing home per diem increased 14.5%. However, if the increase in patient share contribution remains steady at just $2—i.e., increasing collections from $47 per day to $49 per day—this is equivalent to just a 4.25% increase in the proportion of nursing facility's net revenue funded by patient share. As a result, the state will need to further increase its direct payments to the nursing home by $5 to keep the nursing facility whole and make up for the inability of patient share to keep pace with the overall price inflation of a nursing home stay (i.e., $47 × 14.5% - $2 = $4.82 shortfall). The result is that the effective increase for the state of a 14.5% increase to the nursing facility per diem becomes 16.6%.

Patient share accounts for about 15% of total nursing home charges. If a resident's income increases by 3.2% in January 2025 and 2.5% in January 2026 (a total of 5.5%), but total charges increase significantly faster, by the end of FY 2026, the patient share will account for only 15% of charges, and rates have increased (14.5% + 4.2%, or 18.7%) An increase to the direct reimbursement by Medicaid is needed to make up for this differential.

8) Please include the projected cost of rate changes for both FY 2025 and FY 2026 including the amount of the rate increase and the index upon which it is based.

See **Table IX-3** in the **Nursing and Hospice Care** section of testimony.

9) Please provide an update on the implementation of CFCM, including an update on the implementation of CFCM specific to the IDD population. Please consult with BHDDH so that testimony regarding the status of CFCM for the IDD population is consistent across all agencies.

a. Please identify specific caseloads and how the services are being delivered to each.

CFCM Implementation Timeline

Date	Item
October 2023	Certification standards available for public comment.
November – December 2023	State updated and finalized certification standards.
January 2024	Final certification standards and application open to any willing provider Medicaid began accepting and reviewing applications on a rolling basis. DHS began conducting all initial functional needs assessments for LTSS eligibility determination for the EAD population.
April 2024	CFCM code and rate go live.
May 2024	First fully certified vendors.
July 2024	OHA no longer overseeing case management of Medicaid EAD participants aged 60 and older.

December 2024	2,746 people receiving CFCM using new rate with eight certified CFCM agencies.

SFY 25 Nov. Adopted vs. SFY 25 May Estimate

Item	Nov. CEC	May CEC
Total Eligible	11,585 eligible with staggered start dates based on available monthly case management.	12,234 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	8,685 (7,706 non-DD clients; 979 DD clients)	3,530 (2,829 non-DD clients; 701 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators*	CFCM model excludes 986 managed by Independent Facilitators	CFCM model excludes 433 DD clients managed by Independent Facilitators
FMAP	55.99%	55.99%
Rate	$170.87 Per Month	$170.87 Per Month
Amount in Medicaid Budget	$6,421,368	$5,651,013

SFY 26 Nov. Adopted vs. SFY 26 May Estimate

Item	Nov. CEC	May CEC
Total Eligible	11,585 eligible with staggered start dates based on available monthly case management.	12,672 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	11,290 (8,091 non-DD clients; 3,199 DD clients)	10,367 (8,266 non-DD clients; 2,101 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators (IFs)	0	We assume 200 people will shift from Independent Facilitators each month from Feb. 2026 through May 2026. (IFs will begin to decrease by 8, beginning in Feb so there will be none by June-end 2026.)
FMAP	57.20%	57.20%
Rate	$170.87 Per Month	$170.87 Per Month
Amount in Medicaid Budget	$20,312,560	$13,450,888

***The Ifs originated from a Consent Decree court order for DD services. More information is available at BHDDH's website: https://bhddh.ri.gov/developmental-disabilities/services-adults/independent-facilitation). IFs are responsible for introduction, pre-planning, planning process, writing the plan, and routine check-ins.

10) Please provide an update on the Patient-Driven Payment Model that will be in effect as of October 1, 2025

a. What are the policy choices that EOHHS must make as part of this model?

The Patient-Driven Payment Model (PDPM) is comprised of five components, of which one, multiple or all could be used. Medicaid must determine which, if not all, components of PDPM will be used in the state's PDPM calculation.

b. What Assembly input is required to make these changes?

Article 9 of 2024-H 5200, Sub a, as amended, includes the statutorily required authorization for Medicaid to seek a state plan amendment to codify the change in payment methodology from RUG to PDPM. No further action is required by the Assembly.

11) Please confirm that the statutorily required behavioral health care enhancement for certified nursing assistants and homemakers who have completed the necessary training is included in the FY 2025 and FY 2026 estimates.

Confirmed, managed care and FFS spending assumes payment of BH enhancement for eligible home care agencies. Medicaid's testimony includes $3.5 million in FY 25 and $3.6 million in FY 26.

Managed Care

1) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2025 and FY 2026.

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) and NICU. 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 the 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 found in the SFY 2025 final rate certification dated June 21, 2024, and is consolidated from **Attachment A** "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

Figure 3: Medicaid 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

Covered services are consistent with the SFY 2024 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.

Please see **Attachment A** on page 240 of Tufts Health Plan's contract for an example for a more in-depth description of in-plan services, available on EOHHS' website.[3] All MCO contracts have the same structure so there is no differentiation between Tuft's contract compared to Neighborhood or United. Please refer to Amendment 16 of the health plans for the most up to date MCO contract.

For Rhody Heath Options (CMS Demonstration), Medicaid carved out the CCBHC benefit for current contract effective October 1, 2024. While Medicaid anticipates moving this benefit in-plan effective January 1, 2026, it has not yet modeled this transition back into managed care and so the costs associated with CCBHC clients enrolled in RHO II remain in **Other Services**.

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

   a. **If FY 2025 or FY 2026 is different from the rate assumed in November 2024, 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.**

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

      In January 2025, the state reissued its capitation rates for the fiscal year that incorporated adjustments for the emerging experience and the resulting increase in average acuity, with the composite PMPMs exceeding those assumed in the prior testimony. The impact on RIte Care Core was 2.0% and on RIte Care CSHCN was 0.2%.

4) **Please provide the projected CHIP funding for FY 2025 and FY 2026, 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.**

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

[3] Internet: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-11/THPP_Amendment_13_fully%20executed_20231024.pdf (Last Accessed October 20, 2024)

5) **Please discuss any program changes that may occur in the Medicaid program with the expiration of funding that supported the Accountable Entity Program. How will Medicaid beneficiaries be affected by this change to services? Given the expiration of Health System Transformation funds, will any direct service costs be shifted to managed care plans in the Medical Assistance Program?**

Medicaid beneficiaries are not directly impacted by the depletion of Health System Transformation funds as they still receive all Medicaid covered services necessary from the Accountable Entities (AEs). Sustainability of the program is updated annually in the program's "roadmap" file; the latest version is available on EOHHS' website.[4] The sustainability plan, which begins on page 20, details the framework and strategies for sustainability post-depletion of the time-limited funding provided through the HSTP program. The strategies include the following:

a) Centralize key investments to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.

b) Support achievement of shared savings through the Total Cost of Care (TCOC) arrangements that AEs have with MCOs to provide some support for AE costs.

c) Obtain the authorities needed to provide reimbursement for high value services that require consistent support (e.g., Community Health Workers).

d) Leverage contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities.

e) Leverage multi-payer statewide policies to support AEs.

Shared Savings is the main source of continued revenue for participating AEs. To the extent that providers do not earn shared savings at levels that cover future expenses for AE-related programs, providers must make business decisions related to their operations, while still meeting the program's certification requirements if they wish to continue participation.

The AE program's one-time infrastructure funding infused over $86 million directly to the accountable entities to build their internal capacities to manage long-term participation and sustainability. It is not the agency's intention to shift costs to managed care plans in the Medical Assistance program. The TCOC model provides a major incentive to AEs to implement strategies to efficiently coordinate and manage their patient's care.

Rhody Health Partners

1) **Please provide estimates for Rhody Health Partners for FY 2025 and FY 2026. Please delineate those aspects of managed care programs not covered under a payment capitation system.**

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

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

2) **If FY 2025 or FY 2026 rates are different from the prior capitation rate included in the November 2024 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

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

[4] https://eohhs.ri.gov/media/43411/download?language=en

In January 2025, the State reissued its capitation rates for the fiscal year that incorporated adjustments for the emerging experience and the resulting increase in average acuity, with the composite PMPMs exceeding those assumed in the prior testimony. The impact on RHP was less than 0.5%.

Rhody Health Options

3) Please provide estimates for Rhody Health Options for FY 2025 and FY 2026. Please delineate those aspects of managed care programs not covered under a payment capitation system.

See the **Rhody Health Options** section of the testimony.

Rhody Health Options budget line represents the CMS Demonstration program for Dual eligible clients. It covers LTSS benefits, excluding BHDDH I/DD services. Regarding acute care services, Medicare is generally the primary payer with Medicaid only covering a portion of the marginal cost—up to the Medicaid fee schedule—of such services not covered by Medicare.

Beginning October 1, 2024, CCBHC services were moved out of plan and therefore not covered in plan.

4) Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Options.

See the **Rhody Health Options** section of the testimony

5) Please begin including Rhody Health Options enrollment data on the caseload indicators tab of the monthly Medicaid Report submission.

Please see **Attachment 5d** as well as the detailed pay level information included in **Attachment 5a** through **Attachment 5c**.

6) If FY 2025 or FY 2026 rates are different from the prior capitation rate included in the November 2024 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

See the **Rhody Health Options** section of the testimony.

The rates have not changed since November testimony; however, for FY 2026, the application of Medicaid's' price assumption was updated. The current rates are effective October 1, 2024, are valid through December 31, 2025 (controlling for no legislative changes). Previously Medicaid applied its standard 5.0% price increase effective July 1, 2025. This was in error. The price increase should have been applied effective January 1, 2026.

7) Please provide an update on the progress being made to move this population to a Fully Integrated Dual Eligible Special Needs Plan. A final rule by the Centers for Medicare and Medicaid Services phased out these demonstration programs nationwide, but states were able to extend them until December 31, 2025, and RI did that. How is this change reflected in the FY 2026 estimate for this program?

See also the **Rhody Health Options** section of the testimony.

Hospitals

1) Please provide separate inpatient and outpatient estimates for hospital services in FY 2025 and FY 2026.

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

2) Please provide inpatient and outpatient days from FY 2024 to date.

Please see **Attachment 6d** for count of Inpatient Hospital Discharges and Inpatient Days. This is a Gainwell report that reflects activity on a paid basis. As such, it is not directly used for caseload projections that reflect accrual or incurred basis.

Please also see **Attachment 3b** for additional details on hospital FFS claims activity for SFY 2024 and SFY 2025, paid through April 15, 2025. This data includes hospital claims' activity by Budget Line (Managed Care FFS, Expansion FFS, and Hospital – Regular). It presents the data on a paid basis as well as an incurred basis. Data based on incurred basis reflects the first date (or admission) of service for a specific claim—i.e., an IP claim that spans June 29, 2024 through July 21, 2025 would be treated as SFY 2024 expenditure.

The data includes Total Paid, IP Days, IP stays, (and Cost per IP Day and Cost per IP Stay) OP Visits (and Cost per OP Visit). No completion factor is applied to this data.

For purposes of Medicaid's various FFS forecast, however, the agency takes a simplified approach to estimate each fiscal year's expenditures. Except for NICU claims—that are treated differently given (a) their high cost per claim and (b) their correlation with SOBRA payments—Medicaid derives its hospital FFS estimates by trending <u>total</u> expenditures by month. Medicaid does explicitly take into consideration the cost per day/visit and/or the number of visits. (These metrics are used for considering reasonability and general trends but are generally not directly used for final estimate.)

Medicaid estimates its projections by completing historical monthly expenditures on an incurred/service basis. To complete its monthly expenditures, Medicaid estimates the value of Incurred But Not Reported (IBNR) for each of the historical months, ignoring the most recent experience. For example, based on historical experience, even after a full three months have lapsed, 33.59% of inpatient claims activity are likely to remain outstanding for the month. These percentages are calculated by looking at several years of claims lag.

For purposes of calculating IBNR, at least 60-90 days should be allowed to pass before applying historically imputed completion factors. For example, for this current reprojection, Medicaid evaluated activity incurred through December 31, 2024, and paid through March 31, 2025. Therefore, although it is April, Medicaid is basing its estimates on expenditures incurred only during the first half of the year.

The following two tables show the base data used for estimating **Hospitals – Regular** (Inpatient and Outpatient). In contrast, the third table below reflects hospital spending for SFY 2025 on a paid basis.

The Medicaid estimate uses the "**Paid@100%**" amounts between July and December (i.e., the highlighted figure in the second table below). As is evident, even claims activity going back as early as SFY 2024 is not yet presumed to be completed and therefore Medicaid's estimate includes a considerable amount of IBNR. Each year, Medicaid's accruals are intended to capture the still outstanding claims' activity.

Based on the comparison of Table 2 and Table 3, the calculated incurred amount (i.e., "Paid@100%") is less than the amount per month on a paid basis.

SFY 2024 - INCURRED BASIS (Table 1)

SVC_SFY 2024

	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
Hospitals													
Inpatient													
Sum of PAID@100%	$ 2,783,335	$ 3,059,248	$ 2,951,722	$ 2,852,458	$ 3,016,079	$ 2,767,215	$ 3,214,135	$ 2,419,624	$ 3,209,909	$ 2,785,959	$ 2,872,289	$ 2,865,766	$ 34,797,739
Sum of PAID	$ 2,776,695	$ 3,041,637	$ 2,914,542	$ 2,776,927	$ 2,921,231	$ 2,665,873	$ 3,061,690	$ 2,294,835	$ 3,012,150	$ 2,606,828	$ 2,662,900	$ 2,619,569	$ 33,354,879
Sum of IBNR	$ 6,640	$ 17,611	$ 37,180	$ 75,531	$ 94,848	$ 101,342	$ 152,445	$ 124,789	$ 197,758	$ 179,131	$ 209,389	$ 246,197	$ 1,442,860
Outpatient													
Sum of PAID@100%	$ 489,678	$ 590,477	$ 543,761	$ 631,009	$ 566,095	$ 523,711	$ 744,780	$ 620,500	$ 620,941	$ 621,973	$ 596,263	$ 593,636	$ 7,142,825
Sum of PAID	$ 489,659	$ 590,454	$ 543,124	$ 630,089	$ 565,259	$ 522,833	$ 743,577	$ 619,477	$ 619,745	$ 619,617	$ 590,112	$ 584,753	$ 7,118,699
Sum of IBNR	$ 19	$ 24	$ 638	$ 920	$ 836	$ 878	$ 1,203	$ 1,023	$ 1,196	$ 2,356	$ 6,151	$ 8,883	$ 24,126

SFY 2025 YTD - INCURRED BASIS (Table 2)

SVC_SFY 2025

	July	August	September	October	November	December	January	February	March	Grand Total
Hospitals										
Inpatient										
Sum of PAID@100%	$ 2,746,189	$ 2,448,086	$ 2,297,660	$ 2,502,014	$ 2,427,061	$ 1,919,391	$ 1,702,234	$ 1,301,442	$ 609,561	$ 17,953,639
Sum of PAID	$ 2,456,988	$ 2,153,257	$ 1,968,829	$ 2,026,584	$ 1,816,385	$ 1,331,143	$ 1,054,903	$ 477,201	$ 41,467	$ 13,326,758
Sum of IBNR	$ 289,201	$ 294,829	$ 328,831	$ 475,430	$ 610,676	$ 588,249	$ 647,331	$ 824,241	$ 568,094	$ 4,626,882
Outpatient										
Sum of PAID@100%	$ 595,316	$ 641,453	$ 539,022	$ 674,562	$ 644,869	$ 658,238	$ 727,109	$ 736,468	$ 1,122,679	$ 6,339,715
Sum of PAID	$ 582,860	$ 625,016	$ 519,634	$ 643,339	$ 601,389	$ 588,192	$ 584,929	$ 460,803	$ 138,918	$ 4,745,080
Sum of IBNR	$ 12,456	$ 16,438	$ 19,388	$ 31,222	$ 43,480	$ 70,045	$ 142,180	$ 275,665	$ 983,761	$ 1,594,635

SFY 2025 YTD - PAID BASIS (Table 3)

PD_SFY 2025

Sum of PAID	202407	202408	202409	202410	202411	202412	202501	202502	202503	Grand Total
Hospitals										
Inpatient	$ 2,579,322	$ 3,957,712	$ 3,651,044	$ 2,539,384	$ 2,910,849	$ 1,898,646	$ 2,970,639	$ 2,789,109	$ 2,365,416	$ 25,662,121
Outpatient	$ 717,973	$ 523,006	$ 673,429	$ 622,065	$ 698,626	$ 527,914	$ 774,004	$ 620,395	$ 719,177	$ 5,876,589

3) What is the current DSH allotment reduction schedule over the next several federal fiscal years? Is there a DSH allotment reduction scheduled for FFY 2026?

See **Disproportionate Share Hospital Payments** section in **Major Developments** of the testimony.

4) Please provide an update ln the Hospital State-Directed Payment Program, including any changes to assumptions about Medicaid match rates.

Total SDP Appropriation:

- In SFY 2025, the May CEC forecast of $286.8 million in all funds financing is equal to the both the SFY 2025 Enacted Budget and the adopted November CEC. Compared to the November CEC, this represents a general revenue increase of $671,894, which still represents an overall general revenue savings of $2.5 million compared to the enacted budget.
- In FY 2026, the May CEC forecast equates the enacted general revenue amount from the previous fiscal year ($90.1 million) and calculates all funds amount by applying the anticipated federal Medicaid match received. This calculation produces an all funds appropriation of $300.3 million, a reduction of $2.9 million. This methodology is consistent with last May's CEC for the budget year (FY 2025).

Determination of Medicaid Matching Rates:
The following are the primary factors that impact the forecasted splits for the hospital state directed payment.

- *FMAP*. Rhode Island has received more favorable FMAP allocations over the past three fiscal years. Therefore, holding all things equal, GR would be making up a lower percentage of the SDP each fiscal year.

- For the traditional FMAP, i.e. RIte Care, the federal match received was 55.01% in FFY 2024, 56.31% FFY 2025, and 57.50% FFY 2026. For CHIP (Children's Health Insurance Program), the federal match received is 68.51% in FFY 2024, 69.42% FFY 2025, and 70.25% FFY 2026. For the Expansion population, the federal match received is unchanged at 90.0%.

- *Rate Certification*. The State's actuary, Milliman, certifies a per-member per month (PMPM) capitation rate by pay level. Pay level, also known as a rate cell, groups members by like characteristics, for example expansion female between specific ages, and develops a monthly rate based on historical enrollment/expenditures. These capitation rates vary for types of coverage, i.e. RIte Care v. Expansion, and each bring in varying magnitude of Medicaid match. Note, both the FY 2025 and FY 2026 estimates utilize the PMPMs from the FY 2025 certified rates to allocate the budgeted amount across product lines.
- *Enrollment*. Medicaid uses the forecasted enrollment for FY 2025 and FY 2026 and multiplies it by the appropriate rate cell to forecast the fiscal impact.

Pharmacy

1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2025 and FY 2026 as well as the funding source breakout for the separate estimates.

See **Pharmacy** and **Major Developments** sections of testimony 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.

Medicaid recently provided KidsVax with its accounting of the Children's Health Account for FY 2026. While this has amount has not been promulgated it is included in Medicaid's testimony.

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2025 and FY 2026.

Forecast for Medicare Buy In (Part A/B) is based on invoices received through April 2024 for enrollment through May 2025.

See **Other Services** section of testimony.

3) What are the state-only costs in FY 2025 and FY 2026?

State only expenditures are shown below.

Budget Line	Description	FY 2025	FY 2026
Managed Care	Cover all Kids	$16,100,000	$16,905,000
Managed Care	Abortion Coverage	$1,000,000	$1,000,000
Rhody Health Options	Retroactive Enrollment	$1,600,000	-
Nursing Facility	TBI Payment	$134,000	-

Medicaid Expansion

1) Please provide updated caseload and expenditure estimates for FY 2025 and FY 2026 for the ACA-based Medicaid expansion population.

See **Expansion** section of testimony.

2) If the FY 2025 or FY 2026 capitation rates are different from the November 2024 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

See the **Expansion** section of testimony.

In January 2025, the State reissued its capitation rates for the fiscal year that incorporated adjustments for the emerging experience and the resulting increase in average acuity, with the composite PMPMs exceeding those assumed in the prior testimony. The impact on Expansion was 4.5%.

Behavioral Health

1) Please provide an update on the implementation of the federal model for Certified Community Behavioral Health Clinics (CCBHC).

a. Please include any information on third party liability billings and payment collections.

Medicaid is the payer of last resort and all CCBHCs are obligated to collect payment from clients with any third-party coverage, such as Medicare FFS or Medicare Advantage. Each CCBHC is responsible for billing and seeking maximum payment from these payers for any service covered through the insurance product. Although many services are not covered (i.e., case management services delivered to high acuity clients and not all credentialed staff are eligible for Medicare reimbursements), services such as psychotherapy sessions and outpatient services are generally covered by Medicare.

Year-to-date collections reported through March 2025 for reimbursements collected through December 31, 2024, have been minimal. Medicaid continues to work with the CCBHCs to highlight potential shortfalls in collections and better understand the limits of their ability to collect from Medicare (as well as other Medicaid clients who may have commercial coverage as well).

Medicaid is currently recoupin from the CCBHCs for Q1 activity (i.e., Oct-Dec 2024) and will accrue for additional recoupment for the other two quarters in the fiscal year. Medicaid reduced its anticipated collections for FY 2025 and FY 2026—from $4.8 million to $1.0 million in FY 2025 and from $7.5 million to $3.0 million in FY 2026.

These TPL collections are included in the **Other Services** as an offset to the BHDDH Behavioral Health Services line item.

2) Please provide enrollment and costs expected to be incurred in FY 2025 and FY 2026, for the following programs and their relationship with the CCBHC payments. Please indicate the costs to programs individually.

a. MHPRR

b. IHH, ACT, OTP Programs

c. Behavioral Health Link Program

d. Peer Supports Programs

e. Housing Stabilization Program

The exhibit below shows expenditures by program in FY 2024 and for the first two quarters of FY 2025—along with estimates for the remainder of FY 2025 and FY 2026. The OHIC rate review and the CCBHC program have a significant impact on spending in FY 2025 and FY 2026 over FY 2024.

CCBHC expenditures are estimated to be $94 million for nine months in FY 2025 and increasing to at least $131 million in FY 2026. While the CCBHCs will continue to provide some non-CCBHC activities (such as SUD Residential and MHPRR), most revenues will transition from IHH/ACT and miscellaneous BH services for outpatient clients to the monthly PPS-2 payment.

This is lower than the amount assumed in November due to:

i. Medicaid does not assume East Bay Community Action Program (EBCAP) will begin participation the CCBHC Demonstration program on October 1, 2025,
ii. Utilization in Q1 is lower than anticipated

The following figures reflect provider payments only and do not include any associated costs for managed care administration. Please note that these costs are equivalent to an additional 10% for MCO-related charges for administration and taxes that are eligible for enhanced FMAP.

		2024	2025 1	2	2026 Est.	2026 Est.
CCBHC	CCBHC PPS-2 (T1041)		$0	$28,488,914	$94,013,415	$131,049,002
	Peer Support_Program(H0038)	$155,836	$25,737		$25,737	$0
	Other BH/SUD Services	$11,177,944	$2,683,175		$2,683,175	$0
	Housing_Stabilization (H0044)	$388,263	$111,216		$111,216	$0
	Assertive Community Treatment (H0040)	$16,160,567	$3,860,128		$3,860,128	$0
	Integrated Health Home (H0037)	$28,642,992	$6,904,113		$6,904,113	$0
CCBHC Total		**$56,525,601**	**$13,584,370**	**$28,488,914**	**$107,597,784**	**$131,049,002**
OHIC	Other BH/SUD Services	$134,919,433	$30,662,923	$37,581,525	$149,044,728	$165,358,711
	MHPRR (H0019)	$18,242,830	$5,187,136	$6,201,643	$24,722,310	$27,287,228
	Integrated Health Home (H0037)	$2,918,768	$727,269	$825,857	$3,328,719	$3,633,771
	Assertive Community Treatment (H0040)	$1,541,523	$410,804	$413,041	$1,711,881	$1,817,379
	BH Link (S9485)	$928,872	$274,712	$282,048	$1,163,162	$1,241,010
	Opioid Treatment Program (H0037 - Provider Type 060)	$561,069	$145,060	$280,386	$1,028,276	$1,233,699
	Peer Support_Program(H0038)	$409,731	$66,204	$53,029	$233,246	$233,330
OHIC Total		**$159,522,227**	**$37,474,106**	**$45,637,529**	**$181,232,322**	**$200,805,128**
Other	Other BH/SUD Services	$10,818,977	$2,481,880	$3,629,304	$13,914,186	$15,968,936
	Housing_Stabilization (H0044)	$486,570	$195,373	$367,245	$1,352,193	$1,615,876
Other Total		**$11,305,547**	**$2,677,253**	**$3,996,548**	**$15,266,379**	**$17,584,811**
Grand Total		**$227,353,375**	**$53,735,728**	**$78,122,991**	**$304,096,485**	**$349,438,941**
% Managed Care		**86.00%**	**85.50%**	**77.60%**	**77.00%**	**75.00%**

The table below represents distinct utilizers and average monthly users in FY 2024, grouped by service.

	Distinct Users	Monthly Users
Other BH/SUD Services	259,871	84,119
Integrated Health Home (H0037)	8,748	6,325
Peer Support_Program(H0038)	2,167	1,210
Assertive Community Treatment (H0040)	2,017	534
BH Link (S9485)	936	392
Housing_Stabilization (H0044)	640	208
Opioid Treatment Program (H0037 - Provider Type 060)	619	202
MHPRR (H0019)	504	111