November CEC: EOHHS Follow Up Questions from Testimony

1. **Provide age breakout for the aged, blind, disabled (ABD) population from February 2020 through May 2023.**

Overall, the **ABD** population increased from 52,927 to 58,555 between February 2020 and May 2023. An increase of 5,628 (10.6% or 3.25% per annum). Two features of that growth:

- It occurred near-exclusively in FFS:
  - RHP fell by 491 members,
  - RHO II increased by just 21 members despite continued passive enrollment; and,
  - PACE increased by 64 (albeit a significant increase for this program).
- The growth was weighted disproportionately to the aged:
  - Adults aged 64 or younger decreased 212 (-0.5%),
  - Aged between 65 and 84 increased by 5,130 (30%); and,
  - Elders aged 85+ increased by 710 (15%).
- The magnitude of growth among men (2,801) and women (2,827) was near-equivalent, but the former represented a 13% increase for men compared to a 9% increase for women.
- A long-term growth rate of 3.25% is significant. However, it is unclear how much of this growth is attributed to the continuous coverage requirement. Or demographic shifts within the state. Specifically, according to the Census Bureau:
  - The 65+ group was the fastest growing between 2011 and 2021 in RI with its population increasing 29.3%. In comparison, the 35 to 49 age group declined the most, dropping 6.5% between 2011 and 2021 and overall RI population grew 4.0%. See usafacts.org.

FULL_MA_IND	Y								
Eligibility Group	ABD								
Month-End Snapshot									
	Feb-20		Feb-20 Total	May-23		May-23 Total	Change		
	FFS	Managed Care		FFS	Managed Care		Count	% Change	% of Total Change
00-18	1		1	1		1	0	0%	0%
19-20	1		1				-1	-100%	0%
21-30	1,538	3,066	4,604	1,316	3,120	4,436	-168	-4%	-3%
31-40	1,442	3,622	5,064	1,560	3,707	5,267	203	4%	4%
41-50	1,790	4,277	6,067	1,835	3,889	5,724	-343	-6%	-6%
51-60	3,096	7,657	10,753	3,469	6,790	10,259	-494	-5%	-9%
61-64	1,507	2,981	4,488	1,998	3,081	5,079	591	13%	11%
65-84	11,349	5,856	17,205	16,119	6,216	22,335	5,130	30%	91%
85+	3,778	966	4,744	4,359	1,095	5,454	710	15%	13%
Grand Total	**24,502**	**28,425**	**52,927**	**30,657**	**27,898**	**58,555**	5,628	11%	100%

Aged in Expansion

- It is noteworthy that the aged population within **Expansion** also increased, from 94 in February 2020 to 3,545 in June 2023.
  - As 64 years of age, is the upper-bound eligibility criteria threshold for Expansion, EOHHS assumes that these aged members will be eliminated from Expansion during the return-to-normal operations.
  - However, it is unclear if they will shift to ABD or lose coverage all together. Regardless, most of them will likely continue to receive Medicare Premium Payment supports even if as a Limited Benefits program. Or if they move to full benefits ABD, they will likely be in FFS with minimal expenditures.

Given the demographic trends and the shift between Expansion to ABD, EOHHS is not assuming reduction in ABD population:

- Demographics appear to sustain a above-average growth rate for this subpopulation; and,
- If the Expansion members shift to ABD and there could be a step-wise increase in ABD that would offset any unanticipated closures.

Any additional information on changes between EOHHS' pre- and post-Covid Medicaid eligibility and the demographics (including age and gender) and delivery system and Medicare status, by Eligibility Group, is included in the accompanying workbook "Nov 2023 CEC pre and post Covid snapshot."

2. Provide age breakout for expansion population, pre- and post-public health emergency (PHE).

Attachment 5 includes a breakdown of Expansion enrollment (in managed care) by the different age/gender-based rating categories. Below is a snapshot between February 2020 and May 2023 by age and then by gender.

A few observations:

- Overall Medicaid eligibility increased by 43,807 (64%) between February 2020 and May 2023, from 72,784 to 116,591.
- 56% of this growth occurred among those between 19 and 40 years old.
- Expansion is weighted more heavily toward men than women—55% to 45%—and this ratio did not meaningfully change during the PHE.

FULL_MA_IND	Y								
Eligibility Group	Expansion								
Month-End Snapshot									
	Feb-20		**Feb-20 Total**	**May-23**		**May-23 Total**	**Change**		
	FFS	**Managed Care**		**FFS**	**Managed Care**		**Count**	**% Change**	**% of Total Change**
00-18		2	2		1	1	-1	-50%	0%
19-20	609	5,985	6,594	265	6,960	7,225	631	10%	1%
21-30	1,975	20,265	22,240	971	35,546	36,517	14,277	64%	33%
31-40	1,076	11,704	12,780	718	21,510	22,228	9,448	74%	22%
41-50	779	10,019	10,798	482	15,657	16,139	5,341	49%	12%
51-60	996	13,662	14,658	498	21,257	21,755	7,097	48%	16%
61-64	327	5,291	5,618	216	8,878	9,094	3,476	62%	8%
65-84	26	67	93	224	3,408	3,632	3,539	3805%	8%
85+		1	1				-1	-100%	0%
Grand Total	**5,788**	**66,996**	**72,784**	**3,374**	**113,217**	**116,591**	43,807	60%	100%

FULL_MA_IND	Y								
Eligibility Group	Expansion								
Month-End Snapshot									
	Feb-20		**Feb-20 Total**	**May-23**		**May-23 Total**	**Change**		
	FFS	**Managed Care**		**FFS**	**Managed Care**		**Count**	**% Change**	**% of Total Change**
Female	2,385	30,082	32,467	1,206	51,182	52,388	19,921	61%	45%
Male	3,403	36,914	40,317	2,168	62,035	64,203	23,886	59%	55%
Grand Total	**5,788**	**66,996**	**72,784**	**3,374**	**113,217**	**116,591**	43,807	60%	100%

3. Fiscal Close: Variances likely to hold through work with Office of the Auditor General (OAG).

Attachment 1a has been updated to include a column that includes "FY 2023 Preliminary – Adjusted" that includes the impact of anticipated changes to EOHHS' year-end accruals.

EOHHS is actively working with RI OAG on the auditors final closing adjustments for FY 2024. Although that process is not completed, and the RI OAG may not accept all of EOHHS' recommendation and/or may make its recommendation, the following are consistent with our anticipations and past practices.

Overall, the impact is marginal, an $8.0 million improvement in the All Funds position and $0.2 million worsening of general revenue (GR) position.

Generally, the three most significant year-end accruals (that also include the most uncertainty) include: FFS IBNR, outstanding drug rebate collections, and risk share. We anticipate adjustments to two of these: rebates and risk share.

FFS IBNR

Rhode Island budgets on an accrual-basis. As such, EOHHS estimates the amount of claims payments that remain outstanding for activities that incurred within the fiscal year. Charges for such items as NICU and other inpatient hospital charges can exhibit meaningful variation and delays as claims are adjudicated for certain high acuity stays. Additionally, nursing home charges are significant in magnitude and timing of initial LTSS authorization can lead to delays in claims receipt and payments.

On total paid FFS spending of $649.5 million in SFY 2023, EOHHS accrued $102.2 million for IBNR across the various FFS items. Comparatively, of that FY 2023 total, $95.4 million was for prior period activity.

As of the end of September, total FY 2024 payments for prior period activity was $76.0 million, with $26.2 million still outstanding.

We currently do not anticipate a significant, if any, accrual adjustment for IBNR.

Drug Rebates

At preliminary close, EOHHS estimated outstanding collections based on initial invoices to manufactures on dates of service through March 2023 and actual collections against invoices for dates of service through December 2022.

We included an estimate of $95.8 million. While total rebate collections for FY 2023 activity remains consistent, **RI OAG has recommended a downward adjustment of approximately $3 million** (i.e., unfavorable) for collections that occurred in the last cycle of FY 2023 and were unintentionally excluded from EOHHS' calculation. We are reviewing the year-to-date collections and do not have the precise recommendation; approximately half of the rebates hit the Expansion line, so the overall impact of the unfavorable shift, if accepted, is likely to be less than $1.0 million GR. Given this uncertainty, EOHHS did not update its figures in Attachment 1a to reflect this potential change.

Risk Share

EOHHS included total risk share payables and gain share receivables of $28.8 million and $98.1 million, respectively, in its FY 2023 close. This net receivable of $69.3 million reflected outstanding estimates for FY 2022 Final and FY 2023 Preliminary.

EOHHS' adjusted gross accrual for Risk Share is a $87.0 million receivable, including payables of $15.8 million and receivables of $102.8 million.

The primary drivers for the change are a correction for EOHHS inadvertently understating revenues paid due to the re-adjudication of the SOBRA payments that led an overstatement of losses/understatement of gains. Additionally, the misallocation by a health plan of its AE shared savings' payments (an expense to the state) required a re-allocation of gains and losses across the budget line.

Overall, EOHHS expects that its proposed adjustments to FY 2022 and FY 2023 will have a favorable impact of $16.5 million All Funds including $5.6 million GR.

Other Adjustments:

Hospitals - DSH and Nursing & Hospice Care

EOHHS fiscal has already completed a recommended adjustment associated with the DSH FY 2019 recoupment. EOHHS collected $3.4 million from Lifespan in FY 2023 and (temporarily) deposited these funds into a state only funding source assigned to the Nursing and Hospice Care budget lines. Although EOHHS accrued for the outstanding $5.0 million receivable, it did not accrue for full $8 million payable including the payable associated with the $3.4 million already collected.

With the correcting journal entries, EOHHS' **Nursing and Hospice Care** will increase by $3,402,485 GR, reducing the FY 2023 surplus to $2.5 million. The **Hospitals – DSH** budget line will decrease by $5,103,727 and become consistent with the Enacted.

4. **Certified Community Behavioral Health Clinics (CCBHC) Initiative**

a. *Provide table of assumptions used to develop CCBHC cost estimates for SFYs 2024 and 2025.*

b. Assumption	SFY 2024*	SFY 2025*
Start Date	February 1, 2024 (5 Months)	July 1, 2024 (12 months)
Participating Providers	Contingently certified (3 sites)	All seeking certification (10 sites)
Rate/Cost Estimate	Uses current PPS rates for the 3 contingently certified providers and assumes baseline visits (i.e., no major expansion in visits as providers ramp up)	Uses current average of the PPS rates for the 3 contingently certified providers and uses anticipated visits reported by each CCBHC in their cost reports^
New SAMSHA Guidance	NA	Not yet reflected in cost reports

*As documented in EOHHS' "Nov2023 CEC Questions 10.25.23" file, several factors continue to leave considerable uncertainty in the fiscal estimates for both SFY 2024 and SFY 2025. ^EOHHS made one manual adjustment to reflect a difference in the average PPS rate used for SFY 2025 compared to SFY 2024, as the unaudited submission for one site suggests a lower PPS rate than those of the others, bringing down the average.

c. *Provide break down of existing vs new expenses.*

The CCBHC PPS rating methodology will replace existing expenditures at Rhode Island's Community Mental Health Organizations (CMHOs), but not all their expenditures. Residential treatments, including Mental Health (i.e., MHPRR) and SUD residential services will remain out of the PPS.

In total, the CMHOs had $98.5 million of expenditures in SFY 2023. This is not adjusted for IBNR, so total spending may exceed $100.0 million. To account for this and potential utilization changes, a 2.5% factor was applied to the FY 2024 and FY 2025 baselines. The following table shows the change in revenues for the existing community behavioral health providers. Please note that the providers will see an increase attributed to their MHPRR activities as well as the CCBHC certification and shift to the PPS-2 payment methodology. These are differentiated as PPS and non-PPS revenue changes.

	FY 2023	FY 2024	FY 2025
Non-PPS CMHO	$ 27,250,926	$ 27,932,200	$ 28,630,504
Non-PSS MHPRR Increase	$ -	$ 2,954,700	$ 6,752,025
PPS CMHO	$ 71,205,878	$ 63,081,878	$ -
PPS CCBHC	$ -	$ 19,140,802	$ 189,956,044
Total	**$ 98,456,804**	**$ 113,109,580**	**$ 225,338,573**
	Net Change over FY 2023:	**FY23 → FY24**	**FY23 → FY25**
	Non-PSS	$ 3,635,973	$ 8,131,603
	PPS	$ 11,016,802	$ 118,750,166
	Total	**$ 14,652,775**	**$ 126,881,769**

A model of EOHHS' estimate for FY 2024 and FY 2025 is included in the "adjst – ccbhc" tab within the workbook provided. In the current FY, EOHHS does not anticipate a significant uptick of attribution and so applied no utilization changes. Further, with the three conditionally certified provided representing 32.5% of payments and with implementation delayed until February 2024, we estimate $19.1 million in total PPS payments. This is offset by the $9.9 million in PPS-related CMHO spending that is already included in our base.

For FY 2025 we assume all providers are active as of July 1, 2024. While not all cost reports are completed and the rates can vary by CCBHC, EOHHS assume the three conditionally certified CCBHCs are representative of the PPS rate that would be paid to the other CCBHCs.

Impact of Transition to CCBHC PPS-2 by Budget Line, FY 2024 and FY 2025:

	FY 2024		
	Reduced CMHO	**CCBHC PPS Payments**	**Net Change**
Managed Care	$ (2,020,673)	$ 4,093,611	$ 2,100,000
Expansion	$ (1,960,931)	$ 3,972,581	$ 2,100,000
Rhody Health Partners	$ (1,882,117)	$ 3,812,915	$ 2,000,000
Rhody Health Options			$ -
Other Services	$ (2,655,322)	$ 7,808,549	$ 5,200,000
Total	$ (8,519,042)	$ 19,687,656	$ 11,400,000
State Share	*$ (3,163,638)*	*$ 7,508,329*	*$ 4,418,250*

	FY 2025		
	Reduced CMHO	**CCBHC PPS Payments**	**Net Change**
Managed Care	$ (15,840,057)	$ 42,658,423	$ 26,900,000
Expansion	$ (15,311,931)	$ 41,236,143	$ 26,000,000
Rhody Health Partners	$ (15,743,149)	$ 42,397,443	$ 26,700,000
Rhody Health Options	$ (9,598,995)	$ -	$ (9,500,000)
Other Services	$ (18,316,544)	$ 70,881,932	$ 52,600,000
Total	$ (74,810,676)	$ 197,173,941	$ 122,700,000
State Share	*$ (23,492,073)*	*$ 72,751,839*	*$ 49,338,620*

Interaction with OHIC Rate Review

Please note that the OHIC rate review made recommendations for certain services that will be included within the PPS rate, such as psychotherapy services or health home services, as well as for CMHO services not included within the PPS rate, such MHPRR and SUD residentials. EOHHS' budget submission for the OHIC rate review excludes any costs for increasing rates on those services as it pertains to the CCBHC. In other words, there is no double counting of the rate increases between EOHHS' November testimony and the OHIC rate review. However, EOHHS' OHIC rate review estimate does include the recommended increases for MHPPR and SUD residentials as well for certain services included in the PPS but provided by non-CCBHC providers (such as psychotherapy).

5. **Please provide the timeline to finalize manual updates for the SFY 2024 Personal Needs Assessment (PNA) initiative.**

   The original PNA-impacted population was 6,374; 20%, or 1,244, required manual work. Of that 20%, DHS has manually processed 795. These cases are now going through the automated batch process to be authorized. The remaining 449 cases are still pending staff manual processing. It can take from 20 minutes to 1.5 hour to process a case depending on the system exception reason. DHS anticipates completion of those cases over the next two weeks.

   Please note that EOHHS' model includes a below-the-line cost of $1,050,000 in Nursing and Hospice Care to reflect the change in PNA as it would not have been reflected in the base data. This cost reflects the actual number of members who had a non-zero patient share (i.e., 3500 x $25 increase in PNA x 12 months). For LTSS members without any patient share, increasing the PNA will not have an impact on EOHHS' costs.

   This change also impacts Rhody Health Options. The impact of the change was taken into consideration in the rate setting and therefore is reflected in the certified rates. As such n below-the-line adjustment was needed.

6. **Medicare premium pmpm – will share if available**

   This remains the most current information available, posted in April 2023.
   https://ffis.org/PUBS/issue-brief/23/06

   EOHHS continues to monitor federal communications and FFIS and will promptly communicate any updated information. (As of October 31, no update available.)

7. **Reports such as [Medicaid Utilization and Spending on New Drugs Used for Weight Loss | KFF [kff.org]]() suggest that GLP-1 agonist drugs are contributing to Medicaid cost trends in some states. Under which qualifying diagnoses and circumstances, if any, does Rhode Island Medicaid cover GLP-1 agonist drugs? Please provide data or discussion on the extent to which GLP-1 agonist drugs are contributing to cost trends in state Medicaid programs.**

   Rhode Island Medicaid generally covers GLP-1 agonist drugs approved for diabetes, except for Qsymia (which is not covered because its manufacturer, Vivus, does not participate in the CMS Drug Rebate Program). A listing of Rhode Island's FFS preferred drug list (PDL) is available here: https://eohhs.ri.gov/providers-partners/provider-directories/pharmacy. Note, EOHHS' Pharmacy & Therapeutics Committee, which reviews all drug-related coverage decisions, made the determination to cover these drugs after review of clinical studies and clinician input.

   In covering these drugs, the RI FFS program follows FDA approved guidelines. Note that Phentermine and the non-preferred drugs on the PDL require a prior authorization to be covered. Our Managed Care Organizations (MCOs) cover these medications in compliance with what is allowable under the FDA and what is medically necessary. The plans cover fully for diabetes and require prior authorizations for drugs approved for weight management. MCOs have not established any "fail first" policies for these drugs. Between October 2022 and September 2023, there were 4,920 unique beneficiaries on GLP-1s across FFS and managed care.

   This class of drugs does represent a significant advance in diabetes care, particularly among diabetic patients who are obese. Presumably, cost savings may be realized through a reduction of in chronic disease care spending. While we don't have any current data to speak to how these drugs will contribute to cost trends locally, Medicaid will continue to explore the cost implications, as well as discuss with our actuary when beginning rate setting for SFY 2025.