May 2024 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services

PUBLIC HEALTH EMERGENCY

1. **Please provide an updated summary on return to normal operations, how that is factored into your caseload estimates, and how projections have changed since the November 2023 testimony.**

   See section B, Public Health Emergency, Enhanced FMAP Rate, and Return to Normal Operations, and Section C, Caseload Growth and Trend Development, of EOHHS testimony.

   For timely information on renewal information please refer to dashboard from Stay Covered RI, available here: https://staycovered.ri.gov/data-dashboard

   a. **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.**

   Please note that data presented in this section may have variances with caseload information included in testimony and supporting EOHHS' forecast; the summary data can vary based on date of analysis and its parameters (e.g., gross terminations compared to net change).

   Below is a summary of terminations from May 2023 through March 2024, by type of renewal.

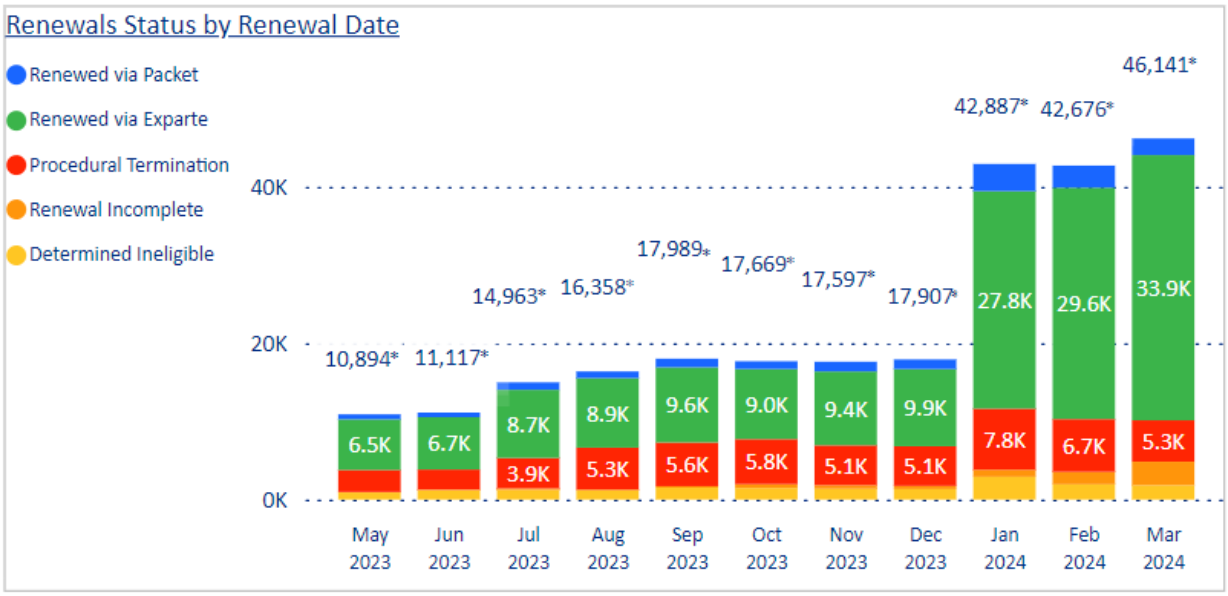
	May 2023- Mar 2024	All as of 4/4/24
Procedural Termination	55,865	56,050
Determined Ineligible	16,773	19,874
Total	72,464	75,738

   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 3,470 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 Month, by Product

Count of Clients	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Grand Total
Clients who were not eligible as of 30-Apr-2023		**35**	**109**	**149**	**231**	**223**	**293**	**334**	**430**	**929**	**619**	**911**	**4,263**
Expansion		14	54	75	89	90	129	148	239	575	293	502	2,208
MAGI		19	49	57	127	123	149	164	166	333	312	363	1,862
Non-MAGI		2	6	17	15	10	15	22	25	21	14	46	193
Clients who were eligible as of 30-Apr-2023	**1,190**	**3,435**	**2,475**	**4,088**	**5,774**	**8,184**	**9,781**	**7,981**	**6,875**	**10,579**	**8,380**	**10,722**	**79,464**
Expansion	478	2,576	1,779	2,996	4,589	6,275	7,829	6,181	4,761	3,259	2,202	2,343	45,268
MAGI	596	739	538	599	856	960	1,008	899	1,046	6,787	5,783	6,742	26,553
Non-MAGI	116	120	158	493	329	949	944	901	1,068	533	395	1,637	7,643
Grand Total	**1,190**	**3,470**	**2,584**	**4,237**	**6,005**	**8,407**	**10,074**	**8,315**	**7,305**	**11,508**	**8,999**	**11,633**	**83,727**

   Below is a summary of renewal status by month from the Stay Covered RI dashboard.

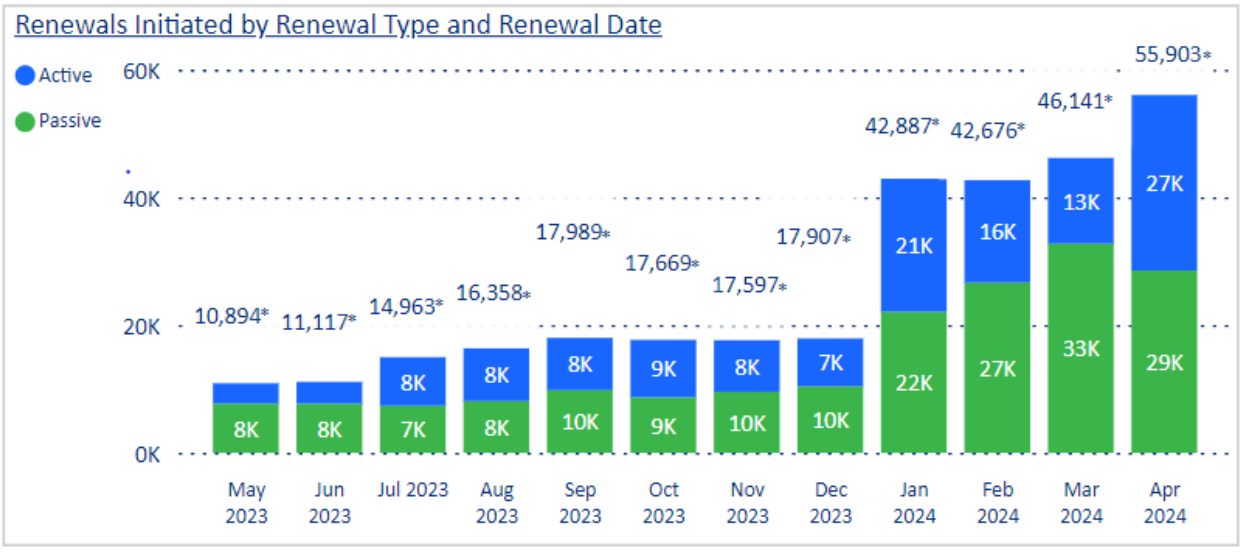


ii. Please provide data indicating how the November 2023 CEC projections compare to actual experience and the updated May 2024 projections.

See **Major Developments** and **Attachment 5** for comparison of current to prior forecasts.

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

Note, EOHHS does not track and report renewals by week. The number of renewals issued each month increased substantially in January as the state began redeterminations of households with children. The number of renewals initiated each month is presented below.



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

As shown in the previous chart from the Stay Covered RI dashboard, 46,000 and 56,000 renewals were initiated during March and April. Following the planned unwinding period, we anticipate there will be approximately 10,000 clients who are in in an incomplete status.

In general, these are clients that were either missed or that provided some form of documentation that needs to be reviewed to complete a determination. Those in incomplete status will be addressed via both manual work and automated system related activities.

b. 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?

Efforts in Progress: Department of Human Services Call Center Strategies

Vision for Call Center Transformation: DHS emphasizes collaborative efforts for call center transformation, aiming for improved customer service, one-touch resolution, decreased wait times, and lower abandonment rates.

Key Collaborative Support: Critical support from the Department of Administration's Human Resources, Contract Management, and Enterprise Technology Strategy and Services staff is pivotal for achieving a fully functional call center. The goal is to elevate the customer experience through collaboration.

Specific Support Requested: DHS seeks assistance in acquiring workforce management and CRM tools, enhancing Verizon contract management, and obtaining flexibilities in labor contracts for eligibility technician assignments and utilizing Health Source Rhode Island (HSRI) for MAGI Medicaid Calls.

Strategies and Actions in Process: Efforts include workforce enhancements through FTE increase requests, compensation adjustments, active vacancy management, contractor deployment, and leveraging sister agencies like HSRI. Training and education are being optimized, along with process improvements and technological innovations such as IVR enhancements and chat bots.

Conclusion and Future Steps: DHS's strategies aim to enhance workforce capabilities, streamline processes, optimize training, and leverage technological innovations for improved customer service. Continuous assessment and adjustments are prioritized to achieve service delivery excellence.

Please see EOHHS' August 2023 response to CMS' letter regarding redetermination wait times.

Sousa Response
CMS Letter 8_22_23 I

c. Provide an update on member appeals activity and its impacted on projected caseload.

The following table shows the total number of appeals received by month from calendar year 2016 through March of 2024. The appeals activity is not expected to have a meaningful impact on EOHHS' projections.

	Appeals Received, by Year (CY 2019 through CY 2024 to date)					
Row Labels	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Jan	513	894	855	802	622	723
Feb	523	530	479	694	660	631
Mar	675	527	402	597	953	901
Apr	532	482	419	682	563	

May	599	316	269	495	656	
Jun	450	236	281	510	702	
Jul	462	348	406	612	592	
Aug	596	444	296	459	709	
Sep	468	610	452	864	1120	
Oct	548	666	811	694	779	
Nov	591	490	607	595	649	
Dec	531	420	806	874	926	
Grand Total	**5329**	**5186**	**5002**	**6751**	**7542**	**2547**

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 the end of March 2024, DHS's internal staff tracking based on payroll reports indicate that the agency had 680 of 770 FTE positions filled, for an 88% filled rate. This data excludes the Office of Healthy Aging and Office of Veterans Services and mirrors the data that is reported in the agency's 60-day Staffing and Operations reports.

   RTNO (Return to Normal Operations) is set to conclude on May 31, 2024, marking a significant milestone in Medicaid operations. Despite its completion, Medicaid annual redeterminations will seamlessly continue as part of routine operations in the subsequent months. Key data points indicate comprehensive efforts in Medicaid operations, including 309,665 renewals, 73,742 terminations, and 8,649 appeals since April 1, 2023. SFY 24 accomplishments include implementing 12-month continuous coverage for children, improving renewal processes, and initiating all Medicaid redeterminations by March 1, 2024. Communications and outreach initiatives leverage lessons from RTNO, focusing on promoting Medicaid eligibility, enhancing community engagement, and optimizing messaging coherence. Noteworthy efforts include Staycovered.ri.gov, Medicaid Renewal Lookup Portal, quarterly mini grants, and targeted paid media campaigns.

   Rhode Island's commitment to improving Medicaid services is evident in its proactive measures. The state's ex-parte rate, initially ranked 5th in the nation at 55% per CMS reporting, has increased to 74% in recent months. Rhode Island has leveraged multiple e14 waiver authorities to enhance ex parte for vulnerable residents, including those in nursing homes. Notably, Rhode Island was among the minority of states with individualized ex parte in place prior to CMS's updated guidance. Furthermore, Rhode Island ranks in the top 10 in the nation for Medicaid application timeliness, as reported by CMS. Surge support is concluding by the end of April, and state teams are prepared to manage the 2-month cleanup period post 12-month RTNO redistribution. These initiatives reflect a proactive approach to maintaining program integrity, ensuring eligibility verification, and enhancing access to essential healthcare services for Rhode Islanders.

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

   On February 8, 2023, DHS launched the Processing Wednesdays pilot initiative to enhance operational efficiency and customer service. This initiative allocates Call Center staff to focus on case processing every Wednesday, addressing backlogs effectively.

   Since its launch, call center staff have consistently prioritized processing applications, updating customer files, and completing operational tasks on Processing Wednesdays. Notably, only incoming

calls are deferred to the IVR system on Wednesdays, while all regional offices remain open for regular in-person services.

The impact of Processing Wednesdays on task completion is evident in the data. Comparing tasks completed on Wednesdays to regular processing days, there's a noticeable increase, reflecting the initiative's effectiveness. For example, in the week beginning March 10, an average of 18.1 tasks per worker were completed, totaling 507 tasks completed by 28 staff members.

Despite the intensified focus on processing tasks, Processing Wednesdays have not significantly affected call center wait times or enrollment. DHS closely monitors call center dashboards for any spikes in call volume, particularly on Thursdays, but anticipated spikes have not occurred. Similarly, HSRI has observed no increase in call volume on Wednesdays. Instead, DHS call center workers have exceeded typical task processing levels, ensuring the agency keeps up with incoming work.

DHS offices and HSRI remain open on Wednesdays, providing alternative access points for individuals to receive services and support. This collaborative effort underscores DHS's commitment to maintaining service excellence while effectively managing workload demands.

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-d,** and throughout testimony.

FY 2023 Closing -Audited

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.**

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

   By CEC/Non-CEC & Source:

		Preliminary			Final	
Row Labels	**FY 2023 Revised**	**FY 2023 Prelim**	**Surplus/ (Deficit)**	**Audit Period Adj**	**FY 2023 Final**	**Surplus/ (Deficit)**
CEC Medical Benefits						
General Revenue	$ 1,032,625,473	$ 1,038,020,679	$ (5,395,206)	$ (7,522,329)	$ 1,030,498,350	$ 2,127,123
Federal Funds	$ 2,088,160,888	$ 2,073,612,524	$ 14,548,364	$ (22,075,793)	$ 2,051,536,731	$ 36,624,157
Restricted	$ 9,310,000	$ 9,871,442	$ (561,442)	$ -	$ 9,871,442	$ (561,442)
CEC Medical Benefits Total	**$ 3,130,096,361**	**$ 3,121,504,644**	**$ 8,591,717**	**$ (29,598,122)**	**$ 3,091,906,522**	**$ 38,189,839**
Non-CEC Medical Benefits	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Federal Funds	$ 33,615,248	$ 33,534,824	$ 80,424	$ -	$ 33,534,824	$ 80,424
Restricted	$ 11,142,127	$ (995,335)	$ 12,137,462	$ 10,000,000	$ 9,004,665	$ 2,137,462
Non-CEC Medical Benefits Total	**$ 44,757,375**	**$ 32,539,490**	**$ 12,217,886**	**$ 10,000,000**	**$ 42,539,490**	**$ 2,217,885**
Grand Total	**$ 3,174,853,736**	**$ 3,154,044,134**	**$ 20,809,602**	**$ (19,598,122)**	**$ 3,134,446,012**	**$ 40,407,724**

Detailed Adjustments by Funding Source:

		Preliminary		*Audit Period Adjustments -->*							Final	
	FY 2023 Revised	**FY 2023 Prelim**	**Surplus/ (Deficit)**	**Adj # 10-16 DSH**	**LTC Advances Reverse Accruals**	**Risk Share Net Adjustment**	**Adj # 10-17 Rx Rebates Overstated**	**Adj # 10-20 FFS IBNR SOBRA**	**Adj. # 10-27 RHO Quality Withhold**	**Adj# 10-39 Duplicate Revenues**	**Adj# 10-07 HSTP**	**FY 2023 Final**	**Surplus/ (Deficit)**
CEC Medical Benefits													
General Revenue	$ 1,032,625,473	$ 1,038,020,679	$ (5,395,206)	$ 5,823,182	$ 600,576	$ (12,874,141)	$ 689,165	$ (585,400)	$ (1,175,711)			$ 1,030,498,350	$ 2,127,123
Federal Funds	$ 2,088,160,888	$ 2,073,612,524	$ 14,548,364	$ 2,683,030	$ (4,948,313)	$ (10,395,483)	$ 1,810,835	$ (2,164,600)	$ (2,033,548)	$ (7,027,714)		$ 2,051,536,731	$ 36,624,157
Restricted	$ 9,310,000	$ 9,871,442	$ (561,442)									$ 9,871,442	$ (561,442)
CEC Medical Benefits Total	**$ 3,130,096,361**	**$ 3,121,504,644**	**$ 8,591,717**	**$ 8,506,212**	**$ (4,347,737)**	**$ (23,269,624)**	**$ 2,500,000**	**$ (2,750,000)**	**$ (3,209,259)**	**$ (7,027,714)**	**$ -**	**$ 3,091,906,522**	**$ 38,189,839**
Non-CEC Medical Benefits													
Federal Funds	$ 33,615,248	$ 33,534,824	$ 80,424									$ 33,534,824	$ 80,424
Restricted	$ 11,142,127	$ (995,335)	$ 12,137,462								$ 10,000,000	$ 9,004,665	$ 2,137,462
Non-CEC Medical Benefits Total	**$ 44,757,375**	**$ 32,539,490**	**$ 12,217,886**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 10,000,000**	**$ 42,539,490**	**$ 2,217,885**
Grand Total	**$ 3,174,853,736**	**$ 3,154,044,134**	**$ 20,809,602**	**$ 8,506,212**	**$ (4,347,737)**	**$ (23,269,624)**	**$ 2,500,000**	**$ (2,750,000)**	**$ (3,209,259)**	**$ (7,027,714)**	**$ 10,000,000**	**$ 3,091,906,522**	**$ 40,407,724**

See embedded workbook for a version of the above that includes adjustments by budget line:

FY 2023 Final Close vs. FY 2023 Prelimina

Audit Adjustments:

Adj # 10-16 DSH. This adjustment records a redistribution of fiscal 2019 DSH payments pursuant to independent DSH audit results. One hospital owed the State $8.5 million. The State established a monthly repayment schedule through December 2023. Through June 30, 2023, the State had received $3.4 million, which was credited to a nursing facility state only account to track the repayments. In July 2023, EOHHS accrued for the remaining $5.1 million that would be received through December 2023. However, EOHHS did not book the accrual shifting the money that was in the nursing facility state only account to the DSH accounts for redistribution. This resulted in an unintended $3.4 million surplus in the nursing facility line at the end of the year, which was corrected through this entry.

LTC Advances Reverse Accruals. This adjustment reverses accruals included in the preliminary close (claim liability and provider receivables) relating to advances dating back to 2017-2020. There are currently no active recoveries (via recoupment) nor identified outstanding claims by reconciliation efforts. EOHHS will not be accruing further claims liabilities for this period.

Risk Share Net Adjustment. This adjustment reverses the original risk share accrual by EOHHS at June 30, 2023 and records revised amounts based upon updated plan reporting.

Adj # 10-17 Rx Rebates Overstated. This adjustment revises anticipated rebate collections downward to reflect partial receipt of March 31 quarter-end rebates prior to June 30, 2023. The original accrual did not account for rebates that were received prior to June 30, 2023 and thus should have been removed from the estimate.

Adj # 10-20 FFS IBNR SOBRA. Reduces IBNR liability accrual for SOBRA claims by $2.75 million.

Adj. # 10-27 RHO Quality Withhold. This adjustment is comprised of the following components:

a) Reverses the original recording of RHO Quality withhold due to NHP-RI at June 30, 2023 recorded by EOHHS.

b) Records recoupment of DY5 Quality Withhold from NHP-RI for a QW payment not earned and erroneously paid; and

c) Records a corrected RHO Quality withhold due to RINHP at June 30, 2023 recorded by EOHHS.

Adj#10-39 Duplicate Revenues. This adjustment includes two audit adjustments related to the HCBS enhanced FMAP accounts. The first adjustment reverses the prior year cost recovery scoop in the HCBS Admin restricted revenue account, and the second reverses the duplicate posting of revenue in the prior fiscal year.

Adj#10-07 HSTP. This adjustment corrects an erroneous entry made to the HSTP restricted receipt account when A&C meant to adjust the HCBS restricted account. The entry had caused total expenditures on the HSTP line sequence to be understated by $10.0 million.

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

The FY 2023 column in summary tables within each section of testimony reflects the audited close.

FY 2024 Budget

1) **Please include a status update on budget initiatives as outlined in "Tab 2" which retains the November 2023 data and has new columns for May 2024. Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate and any known barriers to approval.**

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

See **Attachment 2**.

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

See section G, "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**.

2) For the Governor's recommended budget, "Tab 4" includes the proposals to 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 2.b**.

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 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 April 2024

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

Information on LTSS applications is available monthly on the transparency portal here: http://www.transparency.ri.gov/uhip/#legislative-reports.

The response to this question was prepared on 4/8/24, using the most recent report available (March 2024).[1] The following chart shows a total of 60 overdue LTSS applications. 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. In the current report DHS noted that "...call center staff continue to prioritize processing applications, updating customer files, completing reports and other operational tasks on Processing Wednesdays…Importantly, since the launch of the initiative, only incoming calls were deferred to the IVR system on Wednesdays, with all regional offices remaining open for regular in-person services available according to their posted schedule. With regards to the work by call center staff on Processing Wednesdays, DHS continues to see more cases completed or worked on Processing Wednesdays when compared to cases worked on regular processing days (about 100 cases) prior to launch."

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	44	297	341	7	18	25	366
SNAP Non-Expedited	476	624	1100	55	70	125	1225
CCAP	11	237	248	11	56	67	315
GPA Burial	0	22	22	0	0	0	22
SSP	0	29	29	0	0	0	29
GPA	37	87	124	1	2	3	127
*RIW	152	165	317	29	23	52	369
Undetermined Medical	45	626	671	73	606	679	1350
Medicaid-MAGI	39	19	58	35	37	72	130
Medicare Premium Payments	5	434	439	12	75	87	526
Medicaid Complex	4	114	118	12	396	408	526
LTSS	14	227	241	3	57	60	301
Grand Total	827	2881	**3708**	238	1340	**1578**	5286

[1] Internet: http://www.transparency.ri.gov/uhip/documents/legislative-reports/2024/March%202024%20House%20Oversight%20RIBridges%20Report-final.pdf. Accessed 4/8/2024.

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 for nursing facility and hospice payments to capture the true cost to the state of the rate increase. While it is not an exact science, in general, patient share can be 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 6.9% in FY 2024 and 14.7% in FY 2025, EOHHS does not believe 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.

Specifically, in Q1 of FY 2024, patient share accounted for 18.1% of total nursing home charges. If a resident's 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, the patient share will account for only 14.8% of charges. An increase to the direct reimbursement by Medicaid is needed to make up for this differential.

For simplicity, EOHHS assumes that patient share is held constant on a dollar basis in both periods. This is illustrated in the table below:

	FY 2024 Eff 10-1-2023	FY 2025 Eff 10-1-2024	Change
Composite per Diem	$259.39	$297.61	14.7%
Patient Share	$44.10 (17.0%)	$44.10 (14.8%)	n/a
Paid per Diem	$215.29	$253.52	17.8%

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.

See Section E, Nursing Facility Rate Review in the Major Development section and **Table IX-3** in the Nursing and Hospice Care section of testimony.

8) Please provide an update on the implementation of CFCM, including

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 certification standards
- January 2024: Final certification standards and application open to any willing provider
- January 2024: EOHHS begins accepting and reviewing applications on a rolling basis
- April 2024: First fully certified vendors. CFCM services begin billing.
- May – December 2024: Medicaid HCBS participants transitioned to a certified CFCM entity
- December 2024: ~5,500 clients receiving CFCM services.

The updated SFY 24 and SFY 25 financial model assumes:

- 11,709 people eligible for CFCM services
    - Katie Becket population no longer in model as CFCM is covered in managed care.
    - Remaining CFCM eligible individuals will be phased in based on available case management compacity each month. By December 2024, EOHHS estimates ~5,500 people will be receiving CFCM services.
- 55.01% FMAP in SFY 24. SFY 2025 blended FMAP of 55.99%.
- Rate of $170.87 per member per month. For April 2024, ~1,500 clients will bill a partial month rate of $85.44

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 until 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.

For Rhody Heath Options II (CMS Demonstration) it EOHHS will carve out the CCBHC benefit. The result is a reduction to the Rhody Health Options budget line (of $ and an increase to Other Services for the associated reduction to the capitation rates and increased CCBHC costs.

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

   a. **If FY 2024 or FY 2025 is different from the rate assumed in November 2023, 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. No change to FY 2024 certified rates compared to November CEC. A 7.0% trend is applied for FY 2025—an increase of 2.0% over the November assumption for Rite Care Core. A 5.0% price trend was maintained for RC CSHCN as the Unwinding was less impactful for non-MAGI eligible members.

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

   Please see **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.**

   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. No change to FY 2024 certified rates compared to November CEC. A 6.0% trend is applied for FY 2025—an increase of 1.0% over November assumption.

2) **If FY 2024 or FY 2025 rates are different from the prior capitation rate included in the November 2023 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. No change to FY 2024 certified rates compared to November CEC. A 5.0% trend is applied for FY 2025—no change from the November assumption.

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 In the Hospital State-Directed Payment Program.**

EOHHS received CMS approval of the New Hospital State Directed Payment (SDP) preprint on December 21, 2023. The below dated list outlines SDP specific updates post-CMS approval.

- February 29, 2024: Quarter 1 and 2 SDP payments were wired to the managed care organizations. (Please note that these amounts reflect the hospital payments only and do not include the additional premium tax that is included in the payment so that the MCOs can meet their associated tax liability with Rhode Island.) The MCOs are required to disburse the funding to the hospitals within 30 days of receipt.
    - Quarter 1: $74,191,628
    - Quarter 2: $69,267,484
- April 15, 2024: EOHHS is actively working on the Quarter 3 SDP payment. The Executive Office has 60 days after the close of the quarter to distribute the money to the MCOs.

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 as well as members enrolled in the Rite Start extended family planning benefit. This benefit provides family planning services for up to 24 months following pregnancy to all members regardless of 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 and FY 2025 capitation rates are different from the November 2023 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

See the Medicaid Expansion section of the testimony. No change to FY 2024 certified rates compared to November CEC.

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).

As of April 2024, the Interagency Team has contingently certified eight CCBHC sites (cohorts 1 and 2), Community Care Alliance (Woonsocket), Family Service of Rhode Island (Providence), Gateway (Pawtucket, Johnston, and South County), Newport Mental Health (Newport), The Providence Center (Providence), and Thrive Behavioral Health (Warwick).[2] Two additional providers continue to ready themselves to meet the CCBHC certification requirements to begin services in Year 2 of the CCBHC program (cohort 3).

EOHHS delayed the start for the first three prospective CCBHCs (cohort 1) to October 1st (moved from July 1, 2024 as of Governor's budget submission and from February 1, 2024 as of the November CEC) to ensure the largest coverage for the state (i.e., 91% with eight sites). Cohorts 1 and 2 are preparing for this October 1, 2024 start date.

- Guidance Interagency requires prospective CCBHCs to be added into the Demonstration at the start of each Demonstration year (i.e., not at any point during the year). See "Special Guidance- Addition of new CCBHCs" on page 3 for a description of this guidance.
- Absent this delay, only sites starting on July 1st would be eligible to provide CCBHC services under the demonstration in State Fiscal Year 2025. The remaining sites would be eligible to begin on July 1, 2025.

The CCBHC interagency team continues to work with the prospective CCBHCs to ensure readiness for the program start date. This includes supporting providers in meeting certification requirements and continuing revisions to CCBHC cost reports used to set reasonable and sustainable rates for the program. This also includes actively working with the plans and providers to support their

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

contracting process, system configurations, claims and quality reporting requirements, and provider education.

Authority Update:

EOHHS submitted the state's CCBHC Demonstration application on March 19th and expects to receive a response from SAMHSA in mid-June. Receipt of the Demonstration 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 a 13.55 percentage point increase over the FY 2025 base FMAP, which would provide savings of $12.8 million GR against EOHHS' current FY 2025 estimate.** Participating in the demonstration requires states to adhere to the prescribed payment methodologies to retain the enhanced federal dollars.

If Rhode Island is not awarded the Demonstration, EOHHS will need approval on its CCBHC State Plan to implement the program and receive regular federal financial participation. The State Plan pages are drafted and were posted for public comment. As such, the CCBHC State Plan is ready for submission in June, once EOHHS learns its Demonstration status.

Note, RIGL requires that EOHHS align the state's program with the Federal model; any change not in alignment with the Federal model (e.g., not following annual inflation or rebasing requirements set by the demonstration) would require statutory amendments.

Updated Fiscal Estimate:

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.

Significant progress has been made through collaboration between EOHHS, BHDDH, DCYF, our vendor Milliman, and providers. However, several factors continue to leave some uncertainty in the fiscal estimates for SFY 2025. That said, EOHHS' revised forecast reflects the CCBCHC's requested PPS-2 rates as of mid-March. These rates are derived from the provider's SFY 2022 costs and any anticipated costs they expect to incur during the first year of the demonstration. Their new costs will include those associated with the fulfillment of existing vacancies, new hires to meet the State's new CCBHC requirements, and higher salaries across existing and new staff positions, as well as the application of the provider's federally approved indirect rate or approved methodology to calculate appropriate level of indirect costs. EOHHS continued intent is to work with the contingently certified CCBHCs on reducing their anticipated costs and bring their requested rates in better alignment with comparable benchmarks, realistic staffing expectations, and efficient management while best assuring equity in rates across the state.

While EOHHS is actively working with each CCBHC to reduce their cost estimates and find efficiencies, the permissive nature of CMS and SAMHSA toward provider's cost estimates limit EOHHS' ability to reduce these rates and apply consistent rates across the state. On average, EOHHS estimates that the PPS-2 rates will reflect a more than doubling of current revenues from Medicaid to these providers and modest increase in utilization. As utilization of CCBHC services increases these costs will compound.

SFY 2024 Estimates: EOHHS reduced SFY 2024 expenditures to zero given the delayed start date.

SFY 2025 Estimates: For FY 2025, EOHHS' budget reflects three-quarters of the year. Additionally, not all prospective CCBCHCs will begin operations in FY 2025 nor will those that are starting will be fully staffed in FY 2025. We have told the CCBHC's to reflect vacancies in their cost assumptions in Year 1 with the expectation that we will reflect these costs in Year 2 when they are more likely to be incurred. As such, the cost increases for FY 2025 do not represent the fully annualized cost of the state's investment into its behavioral health safety net.

For determining the increase in costs for SFY 2025, EOHHS compared to the status quo spending for the Cohort 1 and Cohort 2 applicants for CCBHC-like activities over a 9-month period and compared that to their requested PPS-2 and utilization over the first 9 months of the program. The base spending includes the CMHO spending on those services that will be subsumed within the CCBHC demonstration as well as approximately $500,000 in spending on certain outpatient behavioral health services by FSRI. Not all CMHO services are covered under the CCBHC program. Excluded services include MHPRR and SUD residential.

By Budget Line:	Status Quo CMHO Spending 3/4 Year	FY 2025 CCBHC Spending (Nov-24 - Jun-25)	New Spending
Managed Care	$6,586,514	*$20,386,514*	$13,800,000
Expansion	$9,460,615	*$29,360,615*	$19,900,000
Rhody Health Partners	$12,633,959	*$39,133,959*	$26,500,000
Rhody Health Options	$7,782,090		-$7,700,000
Other Services	$10,999,316	*$35,199,316*	$24,200,000
Total	$47,462,495	*$124,162,495*	$76,700,000
State Share	*$18,103,910*	*$45,739,110*	*$27,635,200*
Potential GR Savings from Demonstration			-$12,834,531

Please note that EOHHS' cost estimate assumes the cost reductions reflected in the Governor's Recommend.

SFY 2026 Estimates:

SFY 2026 annualizes the experience in 2025 and assumes participation of East Bay Community Action Program and Amos House as prospective CCBHCs. Neither of these providers are contingently certified at present.

By Budget Line:	Status Quo CMHO Spending Full Year (inc. EBCAP)	FY 2026 CCBHC Spending	New Spending
Managed Care	$9,309,529	*$35,009,529*	$25,700,000
Expansion	$13,371,850	*$50,471,850*	$37,100,000
Rhody Health Partners	$17,857,127	*$67,257,127*	$49,400,000
Rhody Health Options	$10,199,384		-$10,200,000
Other Services	$16,346,686	*$61,446,686*	$45,100,000
Total	$67,084,576	*$214,184,576*	$147,100,000
State Share	*$25,588,481*	*$78,963,481*	*$53,375,000*
Potential GR Savings from Demonstration			-$22,183,158

Out year costs/savings

EOHHS' SFY 2025 estimate does not assume any offsetting savings from lower utilization of other services such as emergency room visits and reduced inpatient hospitalizations. As a reminder, EOHHS has risk-based contracts with its health plans and given the lack of experience in the state and the continuity between the CCBHC and pre-existing IHH and ACT programs to serve Medicaid's highest acuity BH clients, as well as the complicating factor of the Unwinding on overall acuity, it

would be imprudent to impose an arbitrary liability on the health plans through assumed savings target.

However, over time, EOHHS expects savings through averted behavioral health emergency department visits and inpatient stays. Among adults with disabilities, the average cost of an ED visit was $775 in FY 2022 and the average cost of an inpatient stay was $7,262. The Medicaid cost for such services for Duals—who account for approximately 30% of our CCBHC users—is substantially less as Medicare is the primary payer of hospitalizations.

For additional costs: EOHHS' FY 2022 Medicaid Expenditure Report at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-11/FY%202022%20-%20RI%20Medicaid%20Expenditure%20Report%20-%20FINAL.pdf

CCBHC Implementation Timeline:

For reference, below is an updated project timeline – this reflects the adjusted program go-live date of October 1, 2024.

	Date	Milestone
Infrastructure Grant Program	October 2022	Disbursement of Phase 1 Infrastructure Grant Awards
	Beginning May 2023	Disbursement of Phase 2 Infrastructure Grant Awards
	Beginning Spring/Summer 2024	Disbursement of Phase 3 Infrastructure Grant Awards
Year 1 Implementation/ Rollout (Go Live October 1, 2024, in FY25)	Dec 15, 2022	State release of RI CCBHC Cost Reporting Guidance
	Feb 1, 2022	State release of RI CCBHC Certification Standards
	Feb 15, 2023	State release of RI CCBHC Certification Application
	Apr 3, 2023	Year 1 CCBHC Certification Applications due to State
	Jun 16, 2023	State budget authority for the CCBHC rollout granted
	Oct 1, 2023	Contingent Certification of CCBHCs- • Cohort 1 Providers (3) – CCA, Newport, Thrive • Cohort 2 Providers (5) – FSRI, Gateway Pawtucket, Gateway Johnston, Gateway South County, TPC
	Oct 1, 2023	State release of CCBHC MCO Operations Manual, defining program and billing requirements
	Oct 2023 – May 2024	Cohort 1: Development of CCBHC specific staffing plans, DCO plans, and Cost Report reviews, refinements, and approval
	Feb 2024 – Jul 2024	Cohort 2: Development of CCBHC specific staffing plans, DCO plans, and Cost Report reviews, refinements, and approval
	Mar 20, 2024	SAMHSA Demonstration Program application submitted
	May – Aug 2024	MMIS, CCBHCs, and MCOs systems testing and readiness assessment
	Jun 17, 2024	SAMHSA Demonstration decisions to be released
	July 1, 2024 (if needed)	State submission of SPA to CMS for approval, to operate CCBHC program under SPA if State is not selected for the Demonstration program
	July 1, 2024	CCBHC Quality Program Manual to be released
	July 1, 2024	Finalization of BHDDH and Medicaid Interagency Service Agreement (ISA), and supporting BHDDH CCBHC regulations and billing/policy manuals.

	July – Sept 2024	MCO Contracting
	July 31, 2024	Full Certification of Year 1 CCBHCs with Approved PPS Rates
	Sept 1, 2024	State confirms provider staffing and systems readiness for go-live
	Oct 1, 2024	Start of Program Year 1 / Cohorts 1 & 2 Go-Live
	Ongoing	Provider engagement and training; State provision of technical assistance pre and post go-live
Year 2 Implementation/ Rollout (Go Live October 1, 2025, in FY26)	Spring/Summer 2024	State shares Year 2 guidance, including updated cost report and staffing templates. State provides individual feedback on Cohort 3 providers' submitted certification applications.
	Aug 15, 2024	Cohort 3 providers submit updated certification applications for their Go Live in Year 2
	Jan 1, 2025	Kickoff cost reporting/rate setting process
	Jun 2025	State posts final provider- specific PPS rates
	Jul 1 2025	Cohort 3 Provider attestation of system build complete and ready for testing with state and MCOs
	Jul/Aug 2025	MMIS, CCBHCs, and MCOs systems testing and readiness assessment
	Sep 1, 2025	State confirms provider staffing and systems readiness for go-live
	Oct 1, 2025	Start of Program Year 2 / Cohort 3 Go-Live

2) 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. MHPRR**
- **b. IHH, ACT, OTP Programs**
- **c. Behavioral Health Link Program**
- **d. Centers of Excellence**
- **e. Peer Supports Programs**
- **f. Housing Stabilization Program**

Below is an exhibit of expenditures by program in FY 2023 and estimates for FY 2024. The CCBHC program will replace some of this utilization.

Service	FY 2023	FY 2024	FY 2025
MHPRR(H0019)	$ 17,630,000	$18,810,000	$23,790,000
Integrated_Health_Home(H0037)	$ 34,000,000	$34,780,000	$36,810,000
Assertive_Community_Treatment(H0040)	$ 19,380,000	$19,600,000	$20,720,000
Opioid_Treatment_Program(H0037-Provider_Type_060)	$ 360,000	$ 420,000	$ 430,000
BH_Link(H2011/S9485)	$ 2,760,000	$ 2,890,000	$ 3,050,000
Housing_Stabilization(H0044)	$ 430,000	$ 1,480,000	$ 2,250,000
Peer_Support_Program(H0038)	$ 540,000	$ 780,000	$ 810,000
TOTAL	**$ 75,100,000**	**$78,760,000**	**$87,860,000**
Est. % MCO	*70%*	*68%*	*66%*
Below the Line Adjustments in EOHHS Forecast (reflected in totals above):			
MHPRR [1]		$1,000,000	$5,000,000
Home Stabilization [2]		$750,000	$1,500,000

Notes:

Adjustments for MHPRR and Home Stabilization b/c anticipated expenditures not reflected in FY 23 claims.
FFS activity trended to FY 2025 by 2.5% utilization factor, consistent with FFS methodology
MCO acticity trended to FY 2025 by the composite change in capitation rates from FY 2023 --> FY 2025.

The table below represents distinct utilizers in FY 2023 and FY 2024 YTD, grouped by delivery system and program.

Distinct Members By Program

Sum of USERS	Column Labels	
Row Labels	2023	2024 YTD (6 mo)
FFS		
Assertive_Community_Treatment(H0040)	655	547
BH_Link(H2011/S9485)	2,071	1,178
Housing_Stabilization(H0044)	342	352
Integrated_Health_Home(H0037)	2,571	2,346
MHPRR(H0019)	217	178
Peer_Support_Program(H0038)	1,307	1,388
Opioid_Treatment_Program(H0037-Provider_Type_060)	330	286
Managed Care		
Assertive_Community_Treatment(H0040)	1,734	1,218
BH_Link(H2011/S9485)	4,445	1,524
Integrated_Health_Home(H0037)	8,030	5,939
MHPRR(H0019)	501	300
Peer_Support_Program(H0038)	260	72
Opioid_Treatment_Program(H0037-Provider_Type_060)	92	15