November 2024 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services

MEDICAL ASSISTANCE

All tables requested by these questions are consolidated into one Excel workbook. 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 2025 and FY 2026. Please update FY 2023 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.

FY 2024 Closing

1) **Please provide a FY 2024 preliminary closing analysis by program. Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position. Please note and explain if any of these adjustments are unusual or non-recurring (e.g., risk-share adjustments related to prior periods). If prior period adjustments relate to multiple prior periods, please provide documentation showing the specific adjustment amounts by fiscal year.**

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

   Please restate the closing position and note any discrepancies identified after the preliminary report was released that may need to be reversed in the audit period including any impacts on the General Fund and explanations of how they occurred. (e.g. incorrect FMAP rate applied to UPL payments, incorrect year-end journals).

   See **Section B**, Summary of FY 2024 Close, in the Major Developments section of testimony.

   
   closing analysis_final_summ

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

   Each summary table includes the FY 2024 baseline reflective of the activities that incurred within the fiscal year. These baselines use the latest data available to EOHHS and therefore reflect the adjustments noted in the Fiscal Close section of testimony.

FY 2025 Budget

Public Health Emergency

1) **Please provide an updated summary on return to normal operations, how that is factored into your caseload estimates, and how actual experience has compared to the May 2024 testimony. Please provide data indicating how the May 2024 CEC projections compare to actual experience.**

   See **Section C**, Caseload Growth and Trend Development in the Major Developments of testimony.

2) **Please provide an update on member appeals activity and its impact on projected caseload.**

   The following table shows the total number of appeals received by month from calendar year 2019 through September 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	516	925	864	805	645	728
Jan	520	537	479	706	665	662
Feb	676	528	402	606	957	911
Mar	535	488	418	689	565	679
Apr	602	321	269	495	654	784
May	452	237	283	516	699	530
Jun	462	347	408	615	593	553
Jul	600	444	298	462	712	612
Aug	471	616	455	868	1127	610
Sep	549	670	821	696	778	76
Oct	594	497	606	600	649	
Nov	535	428	815	888	927	
Dec	531	420	806	874	926	
Grand Total	**5351**	**5254**	**5033**	**6810**	**7585**	**5930**

CMS Authority

1) **Please outline how 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:**

   a. **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 as well as 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. Note that 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 has offered flexibility so long as states are well underway and have an operational plan in place on that date. EOHHS is working closely with RIDOC and DCYF to work towards full compliance. This work includes systems changes to ensure bidirectional information sharing between EOHHS 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; in collaboration if RIDOC and DCYF, working with both 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 RIDOC 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. 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. 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. To the extent that DCYF would have incurred costs for exams in the 30 days pre-release (e.g., if a youth were due for an annual physical exam at a time that happened to align with their release month), then the cost of those exams would be billed to Medicaid by the community provider instead of to DCYF. However, this is expected to be very minor because the length of stay at RITS is typically less than a year and these services are not required more than once a year, so the volume in those last 30 days before release is expected to be low.

In the case of the ACI, it is not currently clear whether it will be feasible for RIDOC to submit claims to Medicaid for exams conducted by RIDOC staff in the 30-day pre-release period, given that this would require establishment of a whole new billing system. 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. EOHHS expects that a community provider will do in-reach case management at RITS and submit the claims to EOHHS; there will be no impact on the DCYF budget as a result of the targeted case management work being done and billed to Medicaid. At the ACI, the targeted case management work is expected to be done by contracted medical discharge planners embedded at RIDOC who will provide this service as part of their existing contract, and it is likely that RIDOC will not bill Medicaid for it because the billed amount would probably not cover the cost of setting up the billing system and submitting claims.

<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. Our initial assessment of resource needs, including staffing and vendor expenses, was submitted as a budget initiative request in EOHHS' FY 2026 budget submission.

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

Attachment_Medicaid New Rules.pdf

Medicaid has implemented working groups of existing staff to create detailed implementation plans over the next 6 months. These workgroups will also work through fiscal implications to the agency, including additional detail on how provisions may impact caseload projections for requirements taking effect in FY 2026 and later.

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.[1] EOHHS' budget initiative was developed to support compliance with the rules and prevent negative action. Absent additional resources, current staff or vendor resources would be deferred from other critical work with similar implications. EOHHS acknowledges that current planning is at risk due to limited resources along with unfilled positions.

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.

[1] Per Federal Register 42 CFR Parts 431, 438, 441, and 447 https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf: "Among other responsibilities, CMS approves State plans, State plan amendments (SPAs), demonstration projects authorized under section 1115 of the Act, and waivers authorized under section 1915 of the Act; and reviews expenditures for compliance with Federal Medicaid law, including the requirements of section 1902(a)(30)(A) of the Act relating to efficiency, economy, quality of care, and access to ensure that all applicable Federal requirements are met." *"Noncompliance with the provisions of this final rule could result in a State plan compliance action in accordance with §430.35."* https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-430.35

b. Please also include a timeline for all changes.

The embedded slides above 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 rules as new requirements are phased-in through 2030. Detailed implementation plans from the active workgroups may be available for the Spring CEC. The current timelines for other rules discussed are noted in the narrative above.

2) Please include a status update on budget initiatives as outlined in "Tab 2" Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate and any known barriers to approval. Include all relevant details regarding the status of pending submission to CMS.

See **Attachment 2** and **Section E** of the Major Development section of testimony for a detailed description of the status of pending submissions to CMS.

3) 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 8**.

2) How is the home care BH rate enhancement projected in caseloads in order for the $0.35 cent difference to be consistent with current law?

For background, RIGL 40-8.9-9(g)(2) requires that the value of BH enhancement ($0.39) be passed through to direct care workers. The FY 2025 Enacted Budget enacted the OHIC recommendation, which estimated the cost for providers to participate in this program to be less than $0.05 per claims. Absent a change to RIGL 40-8.9, agencies are required to pass through $0.39 to direct care workers, even though the new base rates of $10.07 and $10.40 do not include $0.39. Therefore, in its testimony, EOHHS added $0.35 cents to the base rates, bringing the rates to $10.42 and $10.75, respectively, for home care agencies approved for this enhancement.

The BH rate enhancement was communicated to the managed care organizations and included in managed care rate setting, so the capitation rates account for the providers approved for participation. For the FFS estimate, EOHHS added $0.9M all funds in FY 25 and $1.4M all funds in FY 2026. The estimate's methodology is detailed below.

1. EOHHS pulled FFS claims for the 2024 providers certified to receive this enhancement as of 9/27/2024.
2. For each claim, EOHHS added at additional $0.35 since this amount would not have been included in the base rates assumed in the FY 2025 enacted budget for the rate increase effective 10/1/2024.
3. EOHHS then assumed an additional four providers might receive the enhancement by the end of FY 2025, based on the four providers who received the enhancement last FY. EOHHS took the average amount of yearly claims for each providing receiving the

enhancement, multiplied that by $.35, and then discounted by 50% to account for providers receiving the enhancement in the second half of FY 2025.

4. For FY 26, EOHHS annualized the FY 2025 estimate, and assumed four additional providers would be approved to bill the enhancement and included a 10% increase for additional utilization.

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 7.**

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 10-15-2024 final.pptx

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.

As of September 9, 2024, the chart below shows a total of 102 overdue LTSS applications, up 70% from March's 60 overdue applications, while the number of applications (not overdue) is down 27% to 177, from March's 241.2

The aggregate number of all LTSS applications is down by 7.3%, since March 2024, as DHS continues to incorporate Medicaid renewals into the regular workflow.

As of October 15, 2024, DHS reported the following:

- DHS receives an average about 430 applications monthly
  - 170 (40%) are nursing home
- LTSS has approximately 1,100 applications pending processing in a variety of stages.
  - Average time for determination is within 70 days.
  - 90% of applications are receiving an initial review within 45 days to evaluate what is needed to determine the application including clinical review or missing documents.
  - Backlog/overdue: 227 applications of which 50% are pending financial complex reviews (the agency is in the recruiting process to increase resources to process complex cases).

[2] Internet: http://www.transparency.ri.gov/uhip/documents/legislative-reports/2024/September%202024%20House%20Oversight%20RIBridges%20Report-final.pdf. Accessed 10/16/24.

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	166	188	354	275	113	388	742
SNAP Non-Expedited	494	380	874	83	125	208	1082
CCAP	11	274	285	9	66	75	360
GPA Burial	1	31	32	0	1	1	33
SSP	0	75	75	0	6	6	81
GPA	40	80	120	1	2	3	123
RIW	156	132	288	25	25	50	338
Undetermined Medical	31	584	615	89	550	639	1254
Medicaid-MAGI	54	25	79	62	52	114	193
Medicare Premium Payments	0	385	385	29	150	179	564
Medicaid Complex	9	190	199	16	248	264	463
LTSS	7	170	177	1	101	102	279
Grand Total	969	2514	**3483**	590	1439	**2029**	5512

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 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. 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 EOHHS 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, 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. 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 25 and a projected 4.2% in FFY 2026, 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.

Over the past 5 years, the average patient share amount per day has gone up $2. 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.

7) 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. Please provide the nursing home and hospice days needed for the long-term care financing adjustment (Sullivan-Perry).

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

Overall, there was an increase in the number of nursing home and hospice stays in FY 2024 over FY 2023 negating the need for a long-term care financing adjustment under the parameters of Perry-Sullivan law. **Figure IX-1** summarizes change in average daily Medicaid census at nursing facilities over the course of the public health emergency through the end of FY 2024. Although the census has steadily increased over the past months (and the deficit in FY 2024 and FY 2025 reflect this increase), the average census remains well below its pre-Covid peaks.

8) Please provide an update on the implementation of CFCM, including what was changed from the enacted plan and why are the changes being made. Please also provide 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.

The FY 2025 enacted financial model assumed:

- 11,709 people eligible for CFCM services with staggered population start dates.
    - 965 IDD clients receiving case management under the new rate by June 2025.
    - 4,552 non-DD clients receiving case management under the new rate by June 2025.
- FMAP of 55.99%
- Rate of $170.87 per member per month
- Timeline
    - 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
    - January 2024: EOHHS began 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.

The FY 2025 revised estimate assumes:

- 11,585 people eligible for CFCM services with staggered start dates.
    - CFCM eligible individuals will be phased in based on available case management capacity each month. By December 2024, EOHHS estimates 2,054 people will be receiving CFCM services from a certified CFCM agency.
    - 979 IDD clients receiving case management under the new rate by June 2025.
        - Model excludes from CFCM $170 rate, 768 IDD clients who will be case managed by 16 BHDDH FTEs, and 986 clients being case managed by Independent Facilitators. (The Independent Facilitation (IF) 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)
        - There were many similarities between the Consent Decree and Medicaid rules, but there were also some differences. It took a lot of planning and discussion to merge the two programs. We now have a plan to use IF to supplement the CFCM roll out and align the required planning and monitoring activities.
        - IF Roles and Responsibilities:
            - Introduction, Pre-Planning, Planning Process, Writing the plan, Routine Check-ins
    - 7,706 non-DD clients receiving case management under the new rate by June 2025.
- FMAP of 55.99%
- Rate of $170.87 per member per month
- Timeline
    - 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
    - January 2024: EOHHS began accepting and reviewing applications on a rolling basis.
    - January 2024: 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.
    - May – December 2024: Medicaid HCBS participants transitioned to a certified CFCM entity.
    - December 2024: ~2,054 people receiving CFCM using new rate.
    - June 2025, 8,685 people receiving CFCM services at the new rates.

BHDDH identified the utilization of State staff and Independent Facilitators in response to limited case management capacity of I/DD participants in the community, and to ensure compliance with both the CMS Corrective Action Plan and the Court Monitor. BHDDH will utilize state staff and Independent Facilitators (IF) to support approximately 1,754 I/DD participants.

EOHHS continues to work closely with CMS on any changes.

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), 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.

Please see Tufts Health Plan's contract on page 62 as 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 II (CMS Demonstration), EOHHS will carve out the CCBHC benefit. The result is a reduction to the Rhody Health Options budget line of $5.6 million in FY 2025 and $8.0 million in FY 2026. There is a resulting 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. If FY 2025 is different from the rate assumed in the enacted budget, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.**

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

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.**

   Please see **Managed Care** section of testimony.

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 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 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.

[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)

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

Shared Savings is the main source of continued revenue for participating AEs. To the extent that providers do not earned 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. 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 rates are different from the prior capitation rate included in the enacted budget, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

   See the Rhody Health Partners 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) **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 **Hospitals – DSH** section of testimony.

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

   Total SDP Appropriation:

   - In FY 2025, the November CEC forecast is equal to the total all funds appropriation included in the SFY 2025 Enacted Budget, or $286.8 million. This methodology is consistent with last November's CEC for the current year (FY 2024).
   - In FY 2026, the November CEC forecast equates the enacted GR amount from the previous fiscal year ($90.1 million) and calculated the all funds amount by applying the anticipated federal Medicaid match received. This calculation produces an all-funds appropriation of $303.1 million. This methodology is consistent with last November's CEC for the budget year (FY 2025).

   Determination of Medicaid Matching Rates:

   Below are the primary factors which 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 (preliminary). For CHIP (Children's Health Insurance Program), the federal match received was 68.51% in FFY 2024, 69.42% FFY 2025, and 70.25% FFY 2026 (preliminary). For the Expansion population, the federal match received is unchanged at 90.0%.
- *Rate Certification*. The State's actuary, Milliman, certifies a PMPM (per-member per month) 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 vs Expansion, and each bring in varying magnitude of Medicaid match (#1 above).
- *Enrollment*. EOHHS uses the forecasted enrollment for FY 2025 and FY 2026 and multiplies it by the appropriate rate cell (#2) 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** 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 2025 and FY 2026.**

   See **Other Services** section of testimony.

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

   The state-only costs in the **Managed Care** budget line include:
   - Cover all Kids: provision of managed care coverage to children under 19 eligible who due to their immigration status are not otherwise eligible for Medicaid.
   - Equality in Abortion Coverage: covers the cost of providing for abortion treatments in certain circumstances not covered by the Hyde amendment. These costs are excluded from the actuarially certified payments to the health plans and EOHHS will directly reimburse the health plans for any expenses incurred.
   - Rite Start Program: provides extended family planning benefit 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 2025 and FY 2026 for the ACA-based Medicaid expansion population.**

   See **Expansion** section testimony.

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

   The rates differ from the Enacted for multiple reasons. Please see the **Expansion** section of the testimony for discussion of changes as well as the actuarially certified rates effective July 1 and draft rates effective October 1.

Behavioral Health

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

   Rhode Island was selected as one of ten additional states to participate in the next cohort of CCBHC Demonstration Program participants as of June 4th, 2024. Implementation of the program started on October 1, 2024.

   To determine the rates for Demonstration Year (DY) 1 of the CCBHC Program, providers estimated their CCBHC-allowable costs and expected visits using the CMS PPS Cost Report template. The CCBHC Interagency Team, with assistance from its actuarial consultant Milliman, then reviewed each provider's Cost Report submissions, provided feedback on the reasonableness of the estimates, and approved final Cost Reports and rates per provider.

   Below are the final State approved CCBHC PPS-2 rates by provider for DY 1. These rates are effective October 1, 2024 through September 30, 2025.

CCBHC	High Acuity Adult	High Acuity Child	SUD	Standard Population
Community Care Alliance	$ 1,336	$ 2,515	$ 1,528	$ 770
Family Service of Rhode Island	$ 2,226	$ 2,769	$ 1,154	$ 871
Gateway Healthcare - Johnston	$ 1,194	$ 820	$ 897	$ 626
Gateway Healthcare - Pawtucket	$ 1,206	$ 753	$ 948	$ 481
Gateway Healthcare - Washington County	$ 1,404	$ 664	$ 878	$ 436
Newport Mental Health	$ 1,367	$ 2,748	$ 2,121	$ 762
The Providence Center	$ 1,432	$ 661	$ 483	$ 351
Thrive Behavioral Health	$ 1,535	$ 1,967	$ 993	$ 722

   As demonstrated above, the rates for each CCBHC can vary considerably, as they are based on the CCBHC's own reported estimated costs and expected service volume. Each provider's cost profile depends on many different variables, including: the size of the organization (and whether it is part of a larger health system), the acuity of the populations it serves, its proposed staffing ratios for critical services, desired salary compositions, expected ramp-up costs, anticipated monthly encounters, and its federally approved indirect rate. For example:

   - The number of monthly encounters per provider organization varies considerably, from approximately 750 clients to nearly 5,500 clients. This impacts the distribution of fixed costs, such as the minimum staffing needed to provide emergency services.

- In addition, the CMS PPS Cost Report requires EOHHS/Medicaid to apply each provider's indirect rate. The indirect rates of our CCBHC providers vary from a federal minimum of 15.0%, to as high as a federally approved rate of 41.5%.
- The Providence Center's rates reflect cost efficiencies associated with being part of a larger health system and having a broad patient base. In contrast, Family Service of Rhode Island's rates reflect a higher federally approved indirect rate and a smaller patient base (with a more specialized focus on provision of behavioral health services and supports for children and families).

Moving forward, the State will monitor actual CCBHC staffing costs and service utilization throughout Demonstration Year (DY) 1 to determine if it is appropriate to rebase rates in DY 2. Rates in future Demonstration Years are anticipated to change – potentially in either direction, thus resulting in either higher or lower rates. However, we anticipate less variability amongst the providers' rates in subsequent years for three reasons: i) an increase in overall CCBHC service utilization; ii) better alignment in population-specific service utilization across providers; and iii) stabilization of salaries to reflect market conditions.

2) **Please provide enrollment and costs expected to be incurred in FY 2025 and FY 2026, for the following programs. Please indicate the costs to programs individually and the extent to which these are covered by the CCBHCs**.

   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 FY 2024 with share of total spending in Managed Care.

   Both the OHIC rate review and the CCBHC program will have a significant impact on these costs by program and within FFS versus managed care.

   For FY 2025, the total CCBHC spending is estimated to be $113.2 million for 9 months, increasing to $187.9 million in FY 2026 (this figure includes the assumption that EBCAP will begin participation on October 1, 2025) and additional utilization. Please note that these costs include an additional 10% for additional MCO-related charges for administration and taxes, related to the proportion of the CCBHC clients who are enrolled in managed care.

   Additionally, the OHIC rate review impacted rates for many different behavioral health and SUD services. These increases are estimated to total $40.1 million in FY 2025, annualizing to $53.4 million in FY 2026, across both managed care and FFS. Please note that this amount excludes increases related to those CCBHC activities that are subsumed within the PPS-2 rates.

Paid Amount Grouping	SERVICE_TYPE	SFY: 2023	2024	% Managed Care
CCBHC	Integrated Health Home (H0037)	$ 30,739,893	$ 29,018,282	74%
	Assertive Community Treatment (H0040)	$ 17,979,815	$ 16,191,138	70%
	BH Link (H2011/S9485)	$ 1,392,330	$ 835,037	97%
	Peer Support_Program(H0038)	$ 148,436	$ 154,179	1%
	Opioid Treatment Program (H0037 - Provider Type 060)	$ 44,929		n/a
	Housing_Stabilization (H0044)	$ 192,973	$ 387,932	0%
	Other BH/SUD Services	$ 11,122,516	$ 11,123,648	88%
CCBHC Total		**$ 61,620,892**	**$ 57,710,216**	**75%**
OHIC Review	Integrated Health Home (H0037)	$ 2,480,441	$ 2,469,432	66%
	Assertive Community Treatment (H0040)	$ 1,433,388	$ 1,366,136	69%
	MHPRR (H0019)	$ 17,656,508	$ 18,212,731	32%
	BH Link (H2011/S9485)	$ 1,377,584	$ 1,075,438	66%
	Peer Support_Program(H0038)	$ 399,421	$ 411,626	48%
	Opioid Treatment Program (H0037 - Provider Type 060)	$ 1,128,586	$ 536,331	59%
	Other BH/SUD Services	$ 137,938,071	$ 134,158,942	95%
OHIC Review Total		**$ 162,413,998**	**$ 158,230,635**	**90%**
Other	Housing_Stabilization (H0044)	$ 241,961	$ 484,253	0%
	Other BH/SUD Services	$ 5,572,589	$ 5,424,722	95%
Other Total		**$ 5,814,550**	**$ 5,908,975**	**89%**
Grand Total		**$ 229,849,440**	**$ 221,849,826**	**86%**

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

		Managed Care		FFS		Total Distinct Users	Total Monthly Users
Grouping	Service Type	Distinct Users	Monthly Users	Distinct Users	Monthly Users		
CCBHC	Integrated Health Home (H0037)	6,837	4,232	2,724	1,586	9,561	5,818
	Assertive Community Treatment (H0040)	1,517	763	674	343	2,191	1,106
	BH Link (H2011/S9485)	2,134	207	1,297	141	3,431	349
	Other BH/SUD Services	16,298	5,453	9,503	2,848	25,801	8,301
	Peer Support_Program(H0038)	56	14	1,285	298	1,341	312
	Housing_Stabilization (H0044)			211	98	211	98
OHIC Review	Integrated Health Home (H0037)	526	321	272	171	798	492
	Assertive Community Treatment (H0040)	145	65	52	29	197	94
	MHPRR (H0019)	442	268	231	130	673	398
	BH Link (H2011/S9485)	222	19	935	111	1,157	130
	Other BH/SUD Services	329,948	79,942	38,996	7,651	368,944	87,593
	Peer Support_Program(H0038)	66	19	772	202	838	222
	Opioid Treatment Program (H0037 - Provider Type 060)	179	55	454	137	633	192
Other	Other BH/SUD Services	2,754	531	4,440	1,166	7,194	1,697
	Housing_Stabilization (H0044)	3	0	424	110	427	110