State of Rhode Island Office of the Health Insurance Commissioner
Social and Human Service Programs Review Advisory Council
Meeting Minutes
June 21, 2023
10:00 A.M. to 11:30 A.M.

Attendance

Members:
Co-Chair Commissioner Cory King, Co-Chair Elena Nicolella, Co-Chair Sam Salganik, Beth Bixby, Margaret Holland McDuff, Tanja Kubas-Meyer, Maureen Maigret, Carrie Miranda, Nicholas Oliver, Laurie-Marie Pisciotta, Lisa Tomasso (on behalf of Teresa Paiva Weed), John Tassoni

Rhode Island Office of the Health Insurance Commissioner Staff:
Molly McCloskey

Unable to attend:
James Nyberg, Garry Bliss, Linda Katz

Minutes

1. Call to Order

Co-Chair Sam Salganik called the meeting to order.

2. Review of April 18 Meeting Minutes

Co-Chair Elena Nicolella summarized the April 18, 2023 meeting. The council approved the April 18, 2023 meeting minutes.

3. OHIC Social and Human Service Programs Review Updates

Molly McCloskey provided updates. Phase 1 of Reports 2-9 were submitted to the Governor and the General Assembly on May 29, 2023. This concluded Phase 1 Reports and OHIC is working on Phase 2. The next meeting date was discussed.

The Commissioner stated that OHIC is taking stock of changes in the new state budget that affect the social and human service programs review. For example, we need to understand how adjustments to I/DD provider rates fit into this process. He asked the council members to let OHIC know if there are any other rate adjustments or items that were requested but were not included in the budget.

Carrie Miranda commented that the I/DD rates in the state budget are related to the consent decree. She said that she wants to make sure that, going forward, those rates would be considered in the social and human service programs review. The Commissioner agreed that I/DD rates are in scope but since there was a court ordered rate review of I/DD rates, and there was legislative action taken on those rates, we are going to focus our resources on the remaining universe of services. In a future iteration of this project, the I/DD rates will be prioritized. Carrie commented that the consent decree is slated to end 2024.

Maureen Maigret said that she read that FMAP increases for home and community-based services (HCBS) would be extended into 2024, but what she read did not provide a detailed explanation on this. She said that she wanted to know more about the extension of FMAP for HCBS providers. A

conversation around the FMAP ensued and Marti Rosenberg from EOHHS said that she would follow-up with an update on this.

Tanja Kubas-Meyer stated that, regarding enhancements in the budget, the Governor put in a 7% or $7+M increase for the new DCYF procurement although RICCF estimate needing approximately $19.5M. Due to process delays, the procurement won't be completed until later in the year but spending of these new funds began July 1s. The general assembly also continued the wage stabilization until the new procurement goes into effect, and we are grateful for both investments. More funds will be needed to complete the procurement so it will be interesting to see where we are at the end of the year even though it feels like a win at the beginning of the year.

Sam Salganik asked if OHIC would be updating its reports based on any relevant changes in the FY 2024 budget. The Commissioner responded that it depends on when EOHHS updates the Medicaid fee schedule. If it takes 2-3 months for the fee schedule to be promulgated with the revised rates, then OHIC will not be able to update the reports. Sam wanted it noted that his preference would be to include the updated rates. The Commissioner agreed.

4. Access Study Overview

Angela Sherwin from Faulkner Consulting Group (FCG) provided a presentation on the Access Study that FCG is working on for Phase 2 of Task 7. The presentation slides can be viewed here.

While Angela was presenting slide 2, Nicholas Oliver asked that FCG include individuals who are homebound as a separate population that experience equity barriers because they are unable to physically integrate into the community.

Maureen Maigret stated that when looking at access issues through an aging population lens, one barrier is that there are different Medicaid asset requirements for people aged 65 and older and adults with disabilities as compared to most other populations. This can create access issues.

Elena Nicolella said that she understands that we are looking at access within the universe of services that are in scope of the rates review but asked about whether it might make sense to recognize that access to primary care, hospital services, and nursing homes will impact access to the in-scope services. Angela stated that Elena's point made sense, and an example could be that access challenges in primary care might lead to a lack of behavioral health screening and therefore that demand is not being captured or is exacerbating the acuity of the demand.

Nicholas Oliver said that he recommended adding skilled nursing and therapeutic services at home, which is different than private duty nursing (as seen on slide 3). He stated that many of the individuals receiving skilled nursing and therapeutic nursing at home are otherwise nursing home eligible but remain at home whether it is through the desire of the individual patient, the family, or because there is a capacity issue and they're sitting on a waiting list to go into a nursing home. Angela thanked him and said she'd check to see if and how that feedback could be incorporate.

Margaret Holland McDuff talked about how there are capacity issues in specialized LEA school placements for children with behavioral health and psychiatric conditions. Sam Salganik said he has been thinking about that too and suggested that, though schools are and important part of this conversation, they may not fall within the scope of this project. Margaret agreed and suggested that

they should be mentioned in the report. Angela acknowledged that it might make sense to include for contextual purposes.

5. Vendor Presentation

Milliman provided a presentation on finance and programmatic report updates. Presentation slides can be viewed here.

While discussing slide 9, which summarizes utilization trends, Elena Nicolella asked what we should be gleaning from the utilization trends report. Ian McCulla, from Milliman, said that the utilization report is a representation of the service delivery system for the in-scope services provided by the Medicaid program. Although rate recommendations apply to the fee-for-service (FFS) delivery system and rates, there may be implications for the managed care system as well. It is important to understand if rates are adjusted in the FFS system, how many utilizers in the managed care program may be affected. The easiest example is EI services. MCOs are required to pay at least what FFS is paying. We know any rate changes in EI would potentially have a corresponding impact to the managed care delivery system.

The Commissioner added that this report is also responsive to the council's request to understand how managed care fits into this work. He said that he wants to have a holistic perspective because rate recommendations could have a down stream impact on managed care reimbursement. The Commissioner said that he wants to understand whether we are looking at enough codes to impact the system more broadly because FFS doesn't exist in a silo. As you can see from the chart on slide 9, some services are largely funded outside of managed care, some are largely funded within managed care, and some are in between.

Sam Salganik shared an example of how this utilization report can be helpful. Licensed therapists primarily receive Medicaid reimbursements through managed care. If we identify that there are major access challenges there, and it is something the legislature decided they wanted to work on, this report lets them know that the FFS rate probably isn't the right lever because it is almost all managed care. Different levers might be needed to address that issue.

Margaret Holland McDuff asked if the FFS rate schedule is the minimum that the managed care plans have to recognize for all in-plan services? Or just for certain services like EI? The Commissioner stated that there is a statutory requirement for EI, which applies to commercial as well. For the rest of the services, OHIC will elucidate that issue in the final report.

In reference to slide 11, Medicaid rate benchmarks, Sam Salganik asked if in other states there are some services that are almost all managed care like there are in RI. He said that he thought that Connecticut doesn't use managed care in the same way that other states do. He asked if it was accurate to say the fee schedule from CT really does represent the fee that's being paid for all or almost all of the utilization. Whereas Massachusetts is a managed care state, and it may be more like RI where the fee schedule is meaningful for some codes and not so meaningful for others. He asked if that is a reasonable way to think about the benchmark states? Ian McCulla said that that is appropriate context to think about when reviewing the Medicaid rate benchmarks. Ian added that in many states the MCO reimbursement does follow the Medicaid reimbursement.

Nicholas Oliver asked about the composite rates listed on slide 11. Ian explained that Milliman normalized for differences in fee schedules across states. For example, the home care services in RI have

various shift differentials and acuity enhancements. When we observed multiple RI rates but a single rate in another state, we composite the RI rate to a single rate based on the utilization of those services. Sam Salganik asked if it is like a weighted average? Ian said yes.

During the review of Independent Rate Models (IRM) (slides 15-18), Elena commented that she wanted to make sure that everyone is aware that independent rate modeling is really important work. It presents a potential alternative to setting a rate for a service. John Kasey, from Milliman, stated that the general IRM methodology is to build up a rate on a cost basis. We look at the independent components of what is done to deliver a service and price each one of those from a cost perspective. We look at wages, costs of materials, time, credentials of the people delivering that service, and other factors and deliver an independent rate recommendation. That is what we are doing here for each one of these codes (slides 15-18). Of all the different things we are doing, including benchmarking, this is probably the most intricate and most dependable way to develop a rate recommendation. The Commissioner added that he has been calling IRMs "ground-up rate builds". He will use this methodology as a basis for rate recommendations. For services that we can't apply an IRM to, we will be looking at relevant benchmarks, and we will be looking at inflation adjustments as an alternative method. I want to make sure that IRMs cover a substantial percentage of the total expenditures within each service classification. I have had Milliman produce information to show what percentage of the total expenditure within each classification is actually covered by these codes, so that I can feel confident that we are applying this across a diverse set of services and that it is comprehensive enough.

Tanja Kubas Meyer asked why SUD residential services are included in the IRM list, but behavioral health residential services are not. The Commissioner stated that there are still some codes that are under evaluation that are not included on the slides. Tanja said that for adult residential it might be Medicaid codes but for children's residential it's back-billed. The Commissioner asked if the back-billing Tanja referred to is pursuant to a contract with DCYF where the provider presents a bid or cost proposal and there is an exchange based on a rate that's agreed to in the contract, and then Medicaid pays a portion of that. Tanja said yes. She then said that at least adult residential should be included. The Commissioner said he would take that under advisement.

The Commissioner asked that members look at the IRM list and follow up with OHIC within the next week to share any concerns or requests and he will see if the resources are available to make changes.

Natalie Angel, from Milliman, reviewed programmatic report updates on slides 19-24.

6. Public Comment

Tina Spears stated that she wanted to challenge everyone to remember that a waitlist is a waitlist and even though our state is under an agreement with the federal government to not have waitlists, we do have them. From CPNRI's perspective, we are comfortable saying the word waitlist because that is what it is. Tina also clarified that the statute governing this process is currently a biennial rate review, so unless the law changes, this process will occur again in two years. The commissioner agreed.

7. Adjourn