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CORRECTED PAGES

NOVEMBER 2020

CASELOAD ESTIMATING CONFERENCE

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

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General Considerations

Medical Benefits			
		All Funds	**General Revenue**
FY 2019	Final	$2,448,125,822	$949,397,045
FY 2020	Final	$2,435,912,279	$885,588,163
FY 2021	May CEC Adopted	$2,836,568,525	$1,067,786,630
	Current	**$2,740,378,112**	**$937,013,833**
	Surplus over May CEC	*$96,190,414*	*$130,772,796*
FY 2022	Current	**$2,729,531,704**	**$1,007,999,054**

For FY 2021, Rhode Island's Executive Office of Health and Human Services (EOHHS) anticipates expenditures of **$2,740,378,112** from all sources, a **$96.2 million surplus** compared to the estimate adopted at the May 2020 Caseload Estimating Conference (May CEC). EOHHS' revised estimate for FY 2021 includes $937,013,833 from general revenue (GR), reflecting a **$130.8 million GR surplus**, 12.5% less than May CEC.

Please note that the FY 2021 estimate includes three quarters of the 6.20 percentage point increase resulting from the Federal Medical Assistance Percentage (FMAP) under Section 1905(b) of the Social Security Act, an increase that was passed as part of the Families First Coronavirus Response Act on March 18, 2020. The May CEC estimate for FY 2021 did not include this increase to Rhode Island's FMAP; it accounts for approximately 60% of the current year's general revenue surplus.

For FY 2022, EOHHS projects expenditures of **$2,729,531,704 All Funds**, including **$1,007,999,054 GR**. This reflects a **$56.7 million GR** surplus compared to the Budget Office's Current Service Level (CSL) in FY 2022.

Table 0-1 compares EOHHS' current FY 2021 forecast to the May CEC. ***Attachment 1a*** and ***Attachment 1b*** provide summaries of EOHHS' current forecast by budget program/category and funding source and include a comparison against FY 2020 closing and FY 2021 May CEC.

As shown in **Table 0-2**, with respect to FY 2021, EOHHS has revised the May CEC estimate of the average number of Medicaid clients with full benefits from **333,649** to **327,029**. Additional caseload metrics are summarized in **Table 0-3**. The downward revisions to Rhode Island's Medicaid caseload is driven by slower than anticipated enrollment growth across all eligibility groups except childless adults (i.e. Medicaid Expansion) compared to the May forecast; overall, 2.0% of the current year (All Funds) savings, over May Adopted, is attributed to caseload reductions, as summarized in **Table 0-4**. Nonetheless, the still-significant caseload increases over FY 2020 reflect realized and anticipated continued enrollment growth due to the COVID-19 pandemic and general cessation of all termination activity.

Details of EOHHS' revised caseload forecast for FY 2021 and FY 2022 are included in ***Attachment 5a*** and ***Attachment 5b***, respectively. A discussion of the trend assumptions is included in **Major Developments**.

Table 0-1. Summary of Rhode Island Medicaid – Medical Benefits

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Summary by Budget Line						
Hospitals - Regular	$ 46,066,642	$ 50,300,000	$ 51,522,943	($1.2 M)	$ 47,437,825	($4.1 M)
Hospitals - DSH	142,083,257	142,301,035	142,301,035	0.0 M	71,564,276	(70.7 M)
Nursing and Hospice Care	350,577,089	368,000,000	357,933,406	10.1 M	368,585,695	10.7 M
Home and Community Care	79,837,678	87,300,000	83,968,044	3.3 M	84,184,176	0.2 M
Managed Care	712,143,803	838,000,000	794,763,840	43.2 M	805,946,055	11.2 M
Rhody Health Partners	256,399,002	309,500,000	285,608,533	23.9 M	294,252,671	8.6 M
Rhody Health Options	132,600,805	140,800,000	133,493,291	7.3 M	153,545,257	20.1 M
Expansion	477,599,125	623,000,000	643,402,904	(20.4 M)	643,235,452	(0.2 M)
Pharmacy	(2,557,764)	428,110	(791,566)	1.2 M	(822,420)	(0.0 M)
Clawback	64,978,689	74,439,380	65,723,517	8.7 M	75,772,723	10.0 M
Other Services	132,525,103	143,500,000	137,952,165	5.5 M	141,329,994	3.4 M
Subtotal CEC EOHHS Benefits	**$ 2,392,253,428**	**$ 2,777,568,525**	**$ 2,695,878,112**	$81.7 M	**$ 2,685,031,704**	($10.8 M)
Health System Transformation Project	$ 26,427,935	$ 40,000,000	$ 25,000,000	$15.0 M	$ 25,000,000	$0.0 M
Special Education	17,230,917	19,000,000	19,500,000	($0.5 M)	19,500,000	$0.0 M
Total EOHHS Benefits	**$ 2,435,912,279**	**$ 2,836,568,525**	**$ 2,740,378,112**	$96.2 M	**$ 2,729,531,704**	($10.8 M)
change over prior SFY			*12.5%*		*-0.4%*	
By Funding Source						
Federal Funds	$ 1,527,323,652	$ 1,745,250,746	$ 1,785,099,278	($39.8 M)	$ 1,703,267,650	($81.8 M)
General Revenue	885,588,163	1,067,786,630	937,013,833	130.8 M	1,007,999,054	71.0 M
Restricted Receipts	23,000,464	23,531,150	18,265,000	5.3 M	18,265,000	0.0 M
All Funds	**$ 2,435,912,279**	**$ 2,836,568,525**	**$ 2,740,378,112**	$96.2 M	**$ 2,729,531,704**	($10.8 M)

Table 0-2. Summary of Rhode Island Medicaid Caseload (Full Medical Assistance Only)

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
Average Monthly Enrollment, by Delivery System:						
Managed Care	256,012	286,206	283,340	(2,866)	278,472	(4,868)
RIte Care Core	147,393	164,870	156,584	(8,286)	152,849	(3,735)
RIte Care CSHCN	9,580	10,598	9,942	(656)	9,908	(34)
Expansion	70,333	80,493	88,528	8,035	86,127	(2,401)
Rhody Health Partners	14,588	15,659	14,688	(971)	14,532	(156)
Rhody Health Options	13,780	14,225	13,245	(980)	14,706	1,461
PACE	338	361	353	(8)	350	(3)
RIte Share	3,141	3,005	2,582	(423)	2,544	(38)
Remaining in FFS	39,378	44,438	41,107	(3,331)	39,219	(1,888)
Children and Families	7,591	8,906	9,314	408	9,218	(96)
CSHCN	2,225	2,494	2,226	(268)	2,161	(65)
Expansion	5,109	7,183	3,955	(3,228)	3,914	(41)
Aged, Blind and Disabled	24,453	25,855	25,612	(243)	23,926	(1,686)
Total	298,531	333,649	327,029	(6,620)	320,235	(6,794)
change over prior fiscal year			*9.5%*		*-2.1%*	

Table 0-3. Summary of Other Rhode Island Medicaid Caseload Metrics (Limited Benefits)

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
EFP Only	1,783	2,098	1,771	(327)	1,713	(58)
Rite Smiles	111,351	130,544	125,065	(5,479)	134,051	8,986
Non-Emergency Transportation	287,280	318,921	322,708	3,787	315,150	(7,558)
SOBRA Births	4,711	5,513	4,683	(830)	4,559	(124)
NICU Stays	625	666	620	(46)	604	(16)

Table 0-4. Overall Price-Volume Analysis (excludes HSTP & Special Education)

	Price	Volume	Net
FY 2021 over FY 2020	$68.7 M	$234.9 M	$303.6 M
	2.9%	9.5%	12.7%
FY 2021: Nov 2020 over May 2020	($27.1 M)	($54.6 M)	($81.7 M)
	-1.0%	-2.0%	-2.9%
FY 2022 over FY 2021	$46.1 M	($57.0 M)	($10.8 M)
	1.7%	-2.1%	-0.4%

I. Major Developments

EOHHS' revised caseload and medical benefits budget updates for FY 2021 and FY 2022 are reflected in the subsequent sections and attachments. This section highlights major developments that contribute to variations in the current fiscal year against the prior consensus estimates and/or represent a meaningful fiscal or policy change anticipated for FY 2022.

A. Summary of Changes in Forecast

With respect to FY 2021, the $81.7 million All Funds surplus and $130.8 million GR surplus represent variances of 3.4% and 12.2%, respectively, against May CEC.[1]. **Table I-1** summarizes the components of this surplus—with over 60% of the GR savings attributed to the enhanced FMAP—that are explained in more detail below and throughout this document.

Table I-1. Summary of Changes to FY 2020 Fiscal Position Compared to November CEC Adopted

	FY 2021:	
	All Funds	**General Revenue**
Favorable Variance		
COVID-19 Enhanced FMAP	$0.0 M	$84.7 M
Non-Expansion Capitation	$47.2 M	$22.9 M
Health Insurer Fee	$5.8 M	$2.0 M
SOBRA	$8.8 M	$4.2 M
Medicare Premium Payment	$11.2 M	$9.9 M
Nursing Home & Hopsice	$10.1 M	$4.8 M
FFS Activity excl. Nursing Home/Hospice	$16.2 M	$7.3 M
Rebates	$9.0 M	$1.7 M
Risk Share/Stop Loss	$2.7 M	$1.2 M
Subtotal Favorable	**$110.9 M**	**$138.6 M**
Unfavorable Variance		
Expansion	($26.3 M)	($6.7 M)
All Other	($2.9 M)	($1.1 M)
Subtotal Unfavorable	**($29.2 M)**	**($7.8 M)**
Total	**$81.7 M**	**$130.8 M**

B. Disproportionate Share Hospitals

EOHHS' FY 2022 forecast includes funding for DSH at the federal fiscal year 2021 reduced allotment for Rhode Island of $71,564,276 (federal allotment of $38,709,117). Federally mandated DSH reductions, originally scheduled to impact the SFY 2021 DSH payment have been postponed an additional year under the Coronavirus Aid, Relief, and Economic Security Act; the tenth such law to amend the timing and/or magnitude of reductions.[2] Should the DSH reductions be postponed again, the FFY 2021 (paid by EOHHS in SFY 2022) unreduced allotment amount for Rhode Island totals $142,493,980 (federal allotment of $77,074,994).

[1] Unless otherwise noted expenditures are presented in All Funds.

[2] Congressional Research Service. April 1, 2020. "Medicaid Disproportionate Share Hospital (DSH) Reductions." Internet: https://crsreports.congress.gov/product/pdf/IF/IF10422. (Accessed October 19, 2020)

Table I-2. SFY 2021 DSH payments (FFY 2020 Plan Year), by Hospital

	SFY 2021[1]	SFY 2022[2]
Kent Hospital	$ 5,046,909	
Landmark Hospital	12,214,445	
Miriam Hospital	9,710,633	
Newport Hospital	5,783,504	
Rhode Island Hospital	63,083,982	
Roger Williams Medical Center	10,435,385	
St Joseph Hospital	9,257,707	
South County Hospital	3,819,582	
Westerly Hospital	2,468,222	
Women & Infants Hospital	20,480,666	
	$ 142,301,035	$ 71,564,276

Notes:

1. FFY 2020 Plan Year, paid in Jul-20 (SFY 2021).
2. FFY 2021 Plan Year, paid by Jul-21 (SFY 2022). Distribution by hospital is not final.

C. Nursing Home Interim Payments and Recoupments

In May 2019, EOHHS began to offset contingency payments owed to the state from nursing facilities' ongoing fee-for-service claims activity. Through September 15, 2020 EOHHS collected $94.3 million in recoveries against the $149.0 million in contingency payments. **Table I-3** summarizes the total contingency payments and any recoveries against those payments.

Table I-3. Nursing Home Contingency Payments and Recoupments through September 15, 2020, by Case Status

	Interim Payments	Recovered Amount	Outstanding Amount	Individuals
TOTAL	$149.02M	$94.25M	$54.77M	4,388
Claims Paid	$96.70M	$66.45M	$30.25M	2,929
Ready to Bill	$9.42M	$1.49M	$7.92M	775
Pending Eligibility	$10.16M	$1.57M	$8.58M	651
Denied	$3.59M	$0.32M	$3.27M	177
Prior to February 2017	$29.13M	$24.40M	$4.73M	1,055

In addition, an increasing number of contingency payment cases are recoverable consistent with R.I.G.L. §40-8-6.1, as the applications are no longer pending an eligibility determination, have had a claim paid for the applicant, or, the providers can bill for the applicant.

As a reminder, at FY 2020 fiscal close, EOHHS had paid out $148.9 million in contingency payments, assumed 10% of those would not be recovered (i.e. $14.9 million), and had already recovered $85.4 million. As a result of these assumptions, EOHHS accrued an outstanding receivable of $48.6 million.

COVID-19 and Temporary Suspension of Recoupments

On March 16, 2020 EOHHS communicated to nursing home providers that all contingency payment recoupment activity would be suspended through May 2020. EOHHS continued this suspension through June 2020, restarting recoupments with the July 2020 financial cycle.

D. Modification to Hepatitis C Policy

On July 1, 2018, EOHHS modified its pharmacy benefits policy to include all patients with documented Hepatitis C regardless of stage of disease.

For FY 2021, EOHHS estimates stop loss payments totaling $8.6 million from all funds, a decrease of $0.6 million compared to May, but marginally higher than the actual stop loss payments reported in FY 2020.

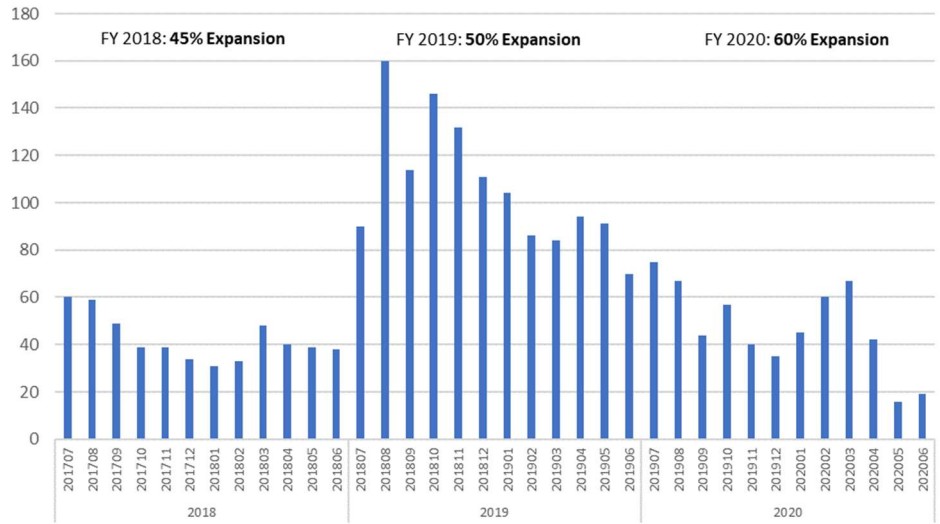
Just over 1,000 members have completed treatment or are in the process of being treated with the anti-viral pharmaceutical treatment since the change in policy. However, based on an analysis primary diagnoses present on the health plans claims data, there remain at least 2,500 members in Medicaid who have a Hepatitis C diagnosis and have not received the anti-viral curative treatment.

Overall, utilization of the Hepatitis C continues to remain well below EOHHS' original forecast (from FY 2019 and revised in FY 2020) of the impact of the change in the State's treatment protocols. While there remain a significant number of members who are Medicaid eligible and have had a diagnosis of Hepatitis C in the past 12 months, utilization remains steady.

EOHHS continues to monitor the MCOs' Stop Loss reporting; but is not forecasting a surge in the number of members being treated. However, it is worth noting from a budgetary perspective, an increasing percentage of the members receiving the anti-viral treatment—and presumably of those who are untreated or not diagnosed—are Expansion-eligible. Therefore, this utilization pattern across eligibility groups should mitigate the general revenue cost of any unanticipated surge in utilization.

Overall, the EOHHS's estimate—consistent with relatively low utilization over the past two fiscal year—assumes only 600 member months of treatment in the current and subsequent fiscal years, equivalent to approximately 300 members being treat each year. The cost per month of treatment is $13,500.

Figure I-1. Members Receiving Anti-Viral Hepatitis Treatment each Month, FY 2018 - FY 2020



Given that Hepatitis C expenditures impact multiple budget lines, **Table I-4** summarizes the comparison of the May adopted to EOHHS' revised Nov CEC estimate, by product line.

Table I-4. Hepatitis C Stop Loss Payments

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Stop Loss Payments by Product						
RIte Care	$ 771,272	$ 738,982	$ 800,000	($0.1 M)	$ 750,000	($0.1 M)
Expansion	4,609,793	5,346,287	5,250,000	$0.1 M	5,250,000	$0.0 M
Rhody Health Partners	2,500,000	3,041,597	2,500,000	$0.5 M	2,500,000	$0.0 M
Stop Loss - Hepatitis C	**$ 7,881,065**	**$ 9,126,866**	**$ 8,550,000**	$0.6 M	**$ 8,500,000**	($0.1 M)

E. Non-Emergency Medical Transportation – Ambulance Rates

In January 2019, EOHHS transitioned vendors for the State's Non-Emergency Medical Transportation (NEMT) services. EOHHS' new NEMT broker, Medical Transportation Management, Inc. (MTM) provides services to Medicaid members and seniors using the State's Elderly Transportation Program. Additionally, MTM issues RIPTA bus passes to TANF recipients.

The FY 2020 closing expenditures included an additional $2.30 million ($0.77 million GR) to finance a $0.67 PMPM, or 9.0%, increase in the composite rates paid to MTM. The rate increase was necessary to finance non-emergency ambulance rates provided by MTM that had not been funded in the originally contracted rates.

In her FY 2021 Recommended Budget, the Governor extended this non-emergency ambulance rate increase. While EOHHS recommends funding this rate increase to maintain the current level of service, EOHHS has not reflected this additional expense of $2.72 million ($0.85 million GR) in its estimate; rather it is included as a FY 2021 budget initiative.

The overall forecast for the budget for the MTM contract is reflected in **Table I-5**.

Table I-5. Non-Emergency Transportation – Premium and Other Payments

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Capitation						
Managed Care	$ 7,589,613	$ 8,428,140	$ 8,311,149	$0.1 M	$ 8,361,069	$0.0 M
Expansion	8,246,257	9,016,125	10,053,704	($1.0 M)	10,129,922	$0.1 M
Rhody Health Partners	3,312,201	3,496,315	3,247,956	$0.2 M	3,326,827	$0.1 M
Rhody Health Options	3,128,921	3,185,414	2,928,140	$0.3 M	3,365,712	$0.4 M
Other FFS	4,989,267	5,464,347	5,311,360	$0.2 M	5,126,682	($0.2 M)
Subtotal Medicaid Premiums	**$ 27,266,258**	**$ 29,590,342**	**$ 29,852,309**	**($0.3 M)**	**$ 30,310,212**	**$0.5 M**
TANF and Other Adjustments	**$ (1,242,710)**	**$ (1,500,000)**	**$ (1,250,000)**	**($0.3 M)**	**$ (1,250,000)**	**$0.0 M**
Total Medicaid	**$ 26,023,548**	**$ 28,090,342**	**$ 28,602,309**	**($0.5 M)**	**$ 29,060,212**	**$0.5 M**
Information Only (Not Included in EOHHS' Medicaid Benefits' Caseload Testimony):						
DEA Copay	$ 622,801	$ 633,637	$ 646,243	($0.0 M)	$ 654,055	$0.0 M
Elderly Transportation Program		3,840,000	3,840,000	$0.0 M		($3.8 M)
Total DHS	**$ 622,801**	**$ 4,473,637**	**$ 4,486,243**	($0.0 M)	**$ 654,055**	($3.8 M)
Grand Total Transportation	**$ 26,646,349**	**$ 32,563,978**	**$ 33,088,552**	($0.5 M)	**$ 29,714,266**	($3.4 M)

F. Drug Rebate and J-Code Collections

Rebates on prescriptions provided in a pharmacy (i.e. DRE) and in an outpatient setting (i.e. J-Code) significantly offset the federal and state costs of most prescription drugs dispensed to Medicaid patients. EOHHS' Medicaid rebate collections reduce the program's gross pharmacy spend by over 40%. **Table I-6** summarizes EOHHS' current DRE and J-Code invoices for FY 2020 and provides forecasts for FY 2021 and FY 2022.

Overall, total rebates for FY 2021 are expected to increase $9.0 million, including $1.7 million GR over the May CEC. The increase is attributable to estimated prior year collections and additional rebates for the expansion population, offset by lower than anticipated rebates associated with families and children and aged, blind, and disabled populations. This is consistent with EOHHS's caseload forecast for these groups which are lower than anticipated.

Table I-6. Summary of Drug Rebate Collections

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
DRE						
Managed Care	$ 33,717,139	$ 41,667,752	$ 36,446,112	$5.2 M	$ 35,649,495	($0.8 M)
Rhody Health Partners	34,124,594	35,554,116	34,371,502	$1.2 M	34,005,041	($0.4 M)
Rhody Health Options	41,322	-	39,719	($0.0 M)	44,100	$0.0 M
Expansion	47,962,531	58,137,451	62,025,237	($3.9 M)	60,433,924	($1.6 M)
Fee-for-Service	6,899,096	4,883,399	4,715,649	$0.2 M	4,842,972	$0.1 M
Subtotal DRE	**$ 122,744,682**	**$ 140,242,718**	**$ 137,598,219**	**$2.6 M**	**$ 134,975,532**	**($2.6 M)**
J-Code						
Managed Care	$ 2,745,901	$ 2,864,646	$ 2,913,663	($0.0 M)	$ 2,847,218	($0.1 M)
Rhody Health Partners	1,062,074	1,397,028	1,069,759	$0.3 M	1,058,353	($0.0 M)
Expansion	1,915,801	2,781,647	2,411,289	$0.4 M	2,345,938	($0.1 M)
Fee-for-Service	2,054,317	1,428,939	2,097,457	($0.7 M)	2,154,089	$0.1 M
Subtotal J-Code	**$ 7,778,093**	**$ 8,472,261**	**$ 8,492,168**	**($0.0 M)**	**$ 8,405,598**	**($0.1 M)**
Prior Period Rebate Collections[1]	$ 23,159,881		$ 11,579,941	($11.6 M)		($11.6 M)
Total Rebates	**$ 153,682,656**	**$ 148,714,979**	**$ 157,670,328**	**($9.0 M)**	**$ 143,381,130**	**($14.3 M)**
Quarterly Rebate Offset	$ (2,014,473)	$ (2,000,000)	$ (2,000,000)	$0.0 M	$ (2,000,000)	$0.0 M
General Revenue	*$ (47,285,346)*	*$ (43,873,332)*	*$ (45,527,926)*	*$1.7 M*	*$ (40,282,400)*	*$5.2 M*

With respect to its current estimates, EOHHS derived its rebate forecast by dividing the average quarterly rebate amounts invoiced to the drug manufacturers over the prior 12 months by the average managed care enrollment for the same periods. The resulting PMPM multiplier, calculated by product line, was then applied to EOHHS' revised enrollment forecast for FY 2021 and FY 2022. As such the increase in collections in FY 2021 over FY 2020 is tied to the caseload increase related to COVID-19. If actual caseload is significantly lower or higher than presently estimated, EOHHS would anticipate a marginal change in the volume of rebates collected.

EOHHS's revised forecast includes a below-the-line adjustment attributed to the processing of prior period claims. The amount reflects half of the activity from last year as EOHHS' pharmacy benefits management catches up on the backlog of billing that arose following the change in CMS regulations in October 2017. SFY 2022 reflects rebate collections on a strictly incurred basis.

In addition to the rebates that are directly collected by EOHHS' fiscal intermediary, the health plans also maintain their own financial arrangements with the pharmaceutical manufacturers. For example, in FY 2019 the health plans collected $13.5 million in supplemental rebates. These rebates are not included above and instead are reflected in the health plans' medical experience used to establish their capitation rates.

G. Opioid Treatment Program – Medicare Coverage for Duals

As of January 1, 2020, Medicare began reimbursement for Opioid Treatment Programs (OTP) through bundled payments for opioid use disorder treatment services, including medication-assisted treatment, toxicology testing, and counseling services for individuals enrolled in Medicare.[3]

In the May CEC, in recognition of this benefit change to Medicare, EOHHS took savings of $4.9 million in FY 2021 for the costs for these services provided to dually eligible members across Rhody Health Options and Fee-for-Service. This November estimate reduces these savings to $2.7 million in FY 2021 and $2.2 million in FY 2022 because the earlier estimate erroneously included savings for a code (H0037) used for health home services which cannot be cost avoided to Medicare.

The implementation of this cost avoidance is still in progress in the MMIS but will be implemented retroactively to January 1, 2020 under FFS and retroactive to July 1, 2020 under RHO II. The FY 2021 savings is inflated because it includes savings from six months in FY 2020 (i.e. January through June 2020).

H. Accountable Entities and Health System Transformation Project

On July 11, 2018 EOHHS submitted a request to the CMS for an extension of the current Medicaid 1115 Waiver which took effect January 1, 2019 and will end on December 31, 2023. Approval of the Medicaid 1115 Waiver, granted on December 20, 2018, continued all current authorities with some changes essential to successfully transform the Medicaid program. The Medicaid 1115 Waiver extension also increased federal participation by an additional $100 million bringing the total spend available to at least $240 million. The Medicaid 1115 Waiver grants authority for the establishment of a Health Workforce Partnership with Rhode Island's public higher education institutions and restricts funding uses to the establishment of value-based payment models through provider networks called Accountable Entities (AE).

Transitioning the Medicaid program from fee-for-service to a value-based payment model is necessary to continue to improve quality and reduce cost. Value-based payment models reward quality, population health outcomes and cost efficiency and enable innovative and more holistic models of care delivery that encourage meaningful partnerships between payers and providers. The Health System Transformation Project (HSTP) seeks to achieve these goals with investments in workforce transformation through the three institutes of higher education and the Rhode Island Department of Labor and Training; through the establishment of AEs that are integrated provider networks responsible for the total cost of care as well as the healthcare quality and clinical outcomes of an attributed population; and through centralized infrastructure investments that seek to address and support interventions aimed at Behavioral Health and Social Determinants of Health.

Total Cost of Care & Incentive Funds

Participation in the program requires that our MCO partners enter into Total Cost of Care (TCOC) contracts with AEs that set benchmarks for performance. In the first two years of the program, AEs were in shared savings-only TCOC contracts with the MCOs and were insulated from financial losses through the incentive funds that supported the newly formed networks with financial incentives, if programmatic and outcome-based milestones were met. The incentives enabled infrastructure and capacity building so the AEs could better serve their attributed population and integrate operationally with the MCO's.

EOHHS had intended to require that eligible AEs enter into TCOC contracts that include both shared savings and downside risk starting in program year three (FY 2021). However, due to the COVID-19 pandemic and the uncertainty regarding impacts on utilization and provider financial stability, EOHHS allowed all AEs to continue in upside-only (shared savings only) contracts for program year three.

[3] Source: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf

Assumption of Downside Risk – Program Year 4 and Beyond

Beginning in program year four (FY 2022), AEs able to assume financial risk will be required to enter into TCOC contracts that include both shared savings and downside risk sharing with downside risk set at 1% of TCOC with a maximum of 3% provider revenue at risk; this will increase to a total of 4% downside risk by program year six. AEs in risk-based contracts will receive at least 60% of the Shared Savings Pool and will be responsible for at least 30% of Shared Losses. Failure to achieve quality benchmarks will reduce the amounts of shared savings that the AEs may earn.

Alternative to Downside Risk for FQHC-Based AEs – Program Year 4 and Beyond

AEs that are Federally Qualified Health Centers (FQHC) are unable to put their prospective payments at risk and can only enter into shared-savings contracts, eligible for 50% of the shared-savings pool. Therefore, EOHHS will propose via a formal public comment process in mid-October 2020 an alternative to downside risk for these AEs. EOHHS proposes to require that FQHC AEs and MCOs be eligible to earn 5% of their Incentive Fund Pool upon submitting a description of a targeted area of utilization and targeted amount of utilization reduction; a work plan to implement an intervention to achieve the targeted utilization reduction; and a budget for the intervention.

At the end of the Performance Year, EOHHS proposes that FQHCs and MCOs are eligible to receive Incentive Funds in the amount that their intervention saved by reducing the target utilization. FQHC AEs and MCOs would be eligible to earn up to 5% of their Incentive Fund Pool. Any difference between the amount saved and the amount equal to 5% of their Incentive Fund Pool will be considered unearned Incentive dollars.

Move Towards Outcomes – Program Year 4 and Beyond

For program year three, EOHHS had planned to tie incentive funds to specific milestone achievements aimed at supporting relationships with behavioral health providers, substance use disorder providers, and community-based organizations instead of milestones aimed at infrastructure and capacity building. Due to the COVID-19 pandemic, EOHHS made more limited changes to this portion of the incentive funding program. EOHHS allocated a portion of incentive funds for AEs that execute a qualified alternative payment methodology contracts with the managed care organization, a portion for development of a Pandemic Response Plan, and a smaller portion for executing an agreement with a social service organization, behavioral health provider, and/or substance use disorder provider.

In addition, EOHHS had planned to tie incentive funds to performance on outcome metrics, rather than to development of plans to address outcome metrics. Again, due to concerns about the very uncertain impact of COVID-19, EOHHS delayed the change to a pay-for-performance model for these incentive funds. Therefore, for FY 2021 AEs can continue to earn 35% of incentive funds through reporting on plans to improve performance on these metrics.

In program year four (FY 2022), EOHHS plans to require that AEs do the following to earn incentive funds:

- Require that AEs able to take on downside risk execute an agreement to take on “downside” risk;
- Require that FQHC-based AEs execute an agreement to implement a return on investment project;
- Require certain levels of performance or improvement on outcome measures;
- Require reporting on a new metric related to obtaining race/ethnicity/language data to support evaluation of efforts to reduce disparities; and,
- Continue to require joint MCO-AE project-based performance measures that focused on behavioral health integration and addressing social determinants of health.

I. FY 2021 Budget Initiatives

As outlined in **Attachment 2**, with the delay of the passage of the FY 2021 budget, increasing unemployment and uncertainty facing its MCOs, EOHHS does not expect to achieve all budget initiative savings targets.

Regarding the budget delay, if a FY 2021 budget passes that contains the proposals already posted for public comment, EOHHS will formally submit State Plan amendments to CMS. The effective date will be the first day of the quarter in which EOHHS submits the changes; therefore, EOHHS will not be able to achieve savings back to July

1, 2020. If the General Assembly passes a FY 2021 budget with different State Plan changes, EOHHS will post the specific amendments for public comment and submit them to CMS after the State's regulatory process completes. These changes will only be effective the day following the posting for public comment. If the State Plan changes are not posted for public comment within the applicable quarter, then the earliest effective date would be the first day of the quarter in which the requested changes are submitted to CMS.

J. HIF Moratorium and Repeal

On December 20, 2019, the President signed H.R.1865, the Further Consolidated Appropriations Act, 2020, that repealed the Health Insurance Fee (HIF) for calendar years beginning after December 31, 2020. This eliminated the fee for 2021 (which would have been an FY 2022 expense) based on calendar year 2020 premiums. MCOs must still make a payment in September 2020 based on calendar year 2019 premiums (which is an FY 2021 expense).

May CEC assumed the fee would be funded in FY 2021, and this testimony maintains that assumption. EOHHS' accounting is consistent with the health plans' approach: recognize this liability in the year in which it is due. For example, most health plans recognized the liability for the health insurer fee due on September 2018 in their 2018 NAIC filing, not as an accrual in 2017, although the fee was assessed against the plans' 2017 experience. The State's Controller and Auditor General are aware of this approach.

EOHHS includes $11.1 million, including $3.3 million GR, for the Health Insurer Fee in SFY 2021. This reflects a $5.8 million reduction from the amount that EOHHS had calculated in May and reflects the actual amounts included by the MCOs on Form 8963 for the 2020 fee year that was due to the IRS on April 15, 2020. Operationally, EOHHS will revise its FY 2020 rates to incorporate this HIF liability and make a lump sum payment to MCOs in late October or early November. Due to the timing of the HIF payment and the allowance by CMS' actuarial to recognize the expenditure at the time it was incurred (i.e. CY 2019) or when it would come due to the IRS (i.e. on September 30, 2020). EOHHS assumes that this payment is eligible for the enhanced COVID-19 FMAP rate, providing $0.4 million in GR relief relative to the regular FMAP. Rhode Island has asked for confirmation from CMS and CMS has advised a national FAQ is forthcoming.

K. Federal Public Health Emergency and Enhanced FMAP Rate

On March 18, 2020, the President signed into law the Families First Coronavirus Response Act (FFCRA; Pub. L. 116-127). Section 6008 of the law provides a temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act, effective January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services terminates, as long as states meet the requirements set out in that law.

EOHHS' estimates assume the public health emergency as extended by Secretary Azar on October 5, 2020 will remain in effect for another 90 days through January 2021. This will allow Rhode Island to claim enhanced FMAP and provides general revenue relief through at least March 31, 2021. In May CEC, the enhanced FMAP was only available through the end of the June 30, 2020 quarter.

The enhanced rate does not apply to the Expansion FMAP rate or the Family Planning FMAP (presently at 90%). However, it does apply to CHIP expenditures. Based on the formulary for calculating the states' CHIP Enhanced FMAP, Rhode Island will get an additional 4.34% general revenue relief for CHIP expenditures claimed during the emergency period.

Table I-7 summarizes EOHHS' estimate of the additional federal support in FY 2021 from the temporary increase to Rhode Island's FMAP. Rhode Island's Medicaid program receives approximately $10.2 million per month in additional federal relief through the increase to its FMAP (not including additional monies received at BHDDH or DCYF for their Medicaid-eligible expenditures).

EOHHS assumes no enhanced FMAP for the final quarter of FY 2021 or the entirety of FY 2022. However, if the emergency period extends into a single day within the subsequent quarter, Rhode Island would be eligible for the enhanced rate for the entire quarter. This increase would need to be weighed against the likely additional cost

associated with not terminating any individuals as a continued requirement for accessing the higher FMAP and the other requirements in the FFCRA as summarized in **Table I-8**, some of which conflict with FY 2021 budget initiatives as well as EOHHS's budget initiatives submitted in early October for FY 2022.

Additionally, even if the COVID-19-related public health emergency period is terminated, it is not unreasonable to expect that the federal government will pass some other form of an enhanced FMAP to compensate states during a potential recession and depressed revenues. For example, between October 2008 and June 2011, Congress appropriated an additional $100 billion for Medicaid (P.L. 111-5 §5001, as amended by P.L. 111-226 §201). During these eight quarters, all states received a hold harmless to prevent any decline in regular FMAP rates and an across-the-board increase of 6.2 percentage points until the last two quarters of the period, at which point the across-the-board percentage point increase phased down to 3.2 and then 1.2, with certain qualifying states receiving an additional unemployment-related increase.

Table I-7. Enhanced Federal Financial Participation available under Families First Coronavirus Response Act

Summary by Budget Line	Monthly All Funds[1]	Enhanced FMAP	FY 2021 GR Relief[2]	Monthly GR Relief
Hospitals - Regular	$ 4,293,579	6.20%	$ (2,395,817)	($0.3 M)
Hospitals - DSH[3]	n/a	n/a	n/a	n/a
Nursing and Hospice Care	29,827,784	6.20%	(16,643,903)	($1.8 M)
Home and Community Care	6,997,337	6.20%	(3,904,514)	($0.4 M)
Managed Care				
Regular	57,521,970	6.20%	(32,097,259)	($3.6 M)
CHIP	8,818,770	4.34%	(3,444,611)	($0.4 M)
Rhody Health Partners	23,599,249	6.20%	(13,168,381)	($1.5 M)
Rhody Health Options	10,660,390	6.20%	(5,948,498)	($0.7 M)
Expansion	n/a	n/a	n/a	n/a
Pharmacy	4,090	6.20%	36,808	$0.0 M
Clawback[4]		6.20%	(6,930,360)	($0.8 M)
Other Services	12,330,597	6.20%	(6,880,473)	($0.8 M)
Subtotal CEC EOHHS Benefits			**$ (91,377,009)**	**($10.2 M)**

Notes:

1. Amounts reflects All Funds **eligible** for enhanced FMAP(e.g. excludes Expansion, Family Planning, etc.)
2. EOHHS assumes enhanced FMAP through end of quarter in which PHE is currently set to expire (i.e. SFY21 Q3)
3. DSH is eligible for enhanced FMAP; however, the State's DSH allotment was not increased.
4. Clawback is a "state only" expenditure with the enhanced FMAP reflected through reduced Part D Multiplier.
5. As enrollment declines monthly savings may be marginally less as All Funds expenditures also declines.

Table I-8. Section 6008(b) Conditions of Family First Coronavirus Relief Act for 6.2 Percentage Point FMAP Increase

FFCRA 6008(b) Condition	Termination Date of Condition
6008(b)(1): **Maintenance of Effort** i.e. maintain eligibility standards, methodologies, procedures	Expires the last day of the **quarter** in which the PHE ends.
6008(b)(2): **Premium Restrictions** Rhode Island does not presently charge any premiums	Expires the last day of the **quarter** in which the PHE ends.
6008(b)(3): **Continuous Coverage** this prevents most terminations, but also prevents RI from eliminating optional services and/or implementing copays	Expires the last day of the **month** in which the PHE ends.
6008(b)(4): **Cost sharing exemption for Testing and Treatment**	Expires the last day of the **quarter** in which the PHE ends.

L. Caseload Growth and Trend Development

Through September 2020, EOHHS has observed annualized enrollment trends below the trend adopted by the conferees in May. Rhode Island's recent experience during the public health emergency has been consistent with regional trends per CMS data. From February 2020 through June 2020, Rhode Island enrollment increased 5.3%

while enrollment increased an average of 4.8% among other northeastern states (CT, MA, NH, VT, DE, NY, MD and ME).

Overall Medicaid enrollment increased from 291,894 in February 2020 to 317,564 in September 2020.

Table I-9 summarizes Rhode Island's annualized trends observed from February 2020 through September 2020, by managed care program and by population group. The table also summarizes the trends that EOHHS is applying prospectively through the end of the Public Health Emergency.

Table I-9. Current Annual Trends for Enrollment Activity through March 31, 2020

Managed Care	Historical 2-Year Annualized Trend through Feb-20	Actual Annualized Trend between Feb-20 and Sep-20[1]	Forecast Trend[2]
RIte Care Core	-1.4%	12.0%	0.4%
RIte Care CSHCN	0.5%	5.3%	0.9%
Expansion	6.0%	40.6%	5.1%
Rhody Health Partners	-1.0%	1.0%	-0.2%
Rhody Health Options Phase II	-7.4%	-3.2%	8.0%
PACE	9.0%	4.1%	0.6%
Rite Share	-24.6%	-19.1%	0.0%
All Managed Care (excl. RHO I)	0.1%	17.3%	2.2%
Overall:			
Children and Families	-1.0%	12.1%	0.6%
Children with Special Healthcare Needs	0.1%	3.3%	-0.1%
Expansion	5.8%	36.0%	4.4%
Aged, Blind, and Disabled	-0.3%	1.6%	0.1%
All Eligibility Groups	0.9%	15.5%	1.5%

Note.

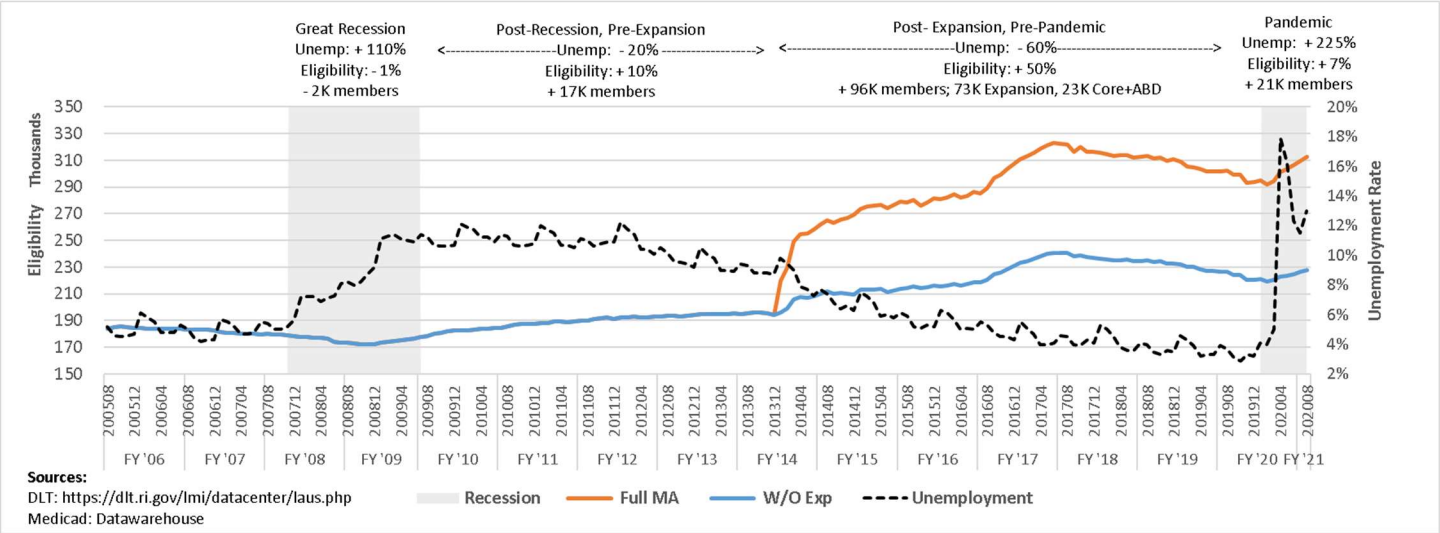
1. Reflects average annualized trend over 24 months through 9/30/2020.
2. Forecast reflects effective trend over next 12-months.

Estimating the Impact of COVID-19 on Medicaid

There is a lot of uncertainty over the impact of COVID-19 and the current recession on Medicaid enrollment. While May projections overstated the immediate impact of unemployment on Medicaid enrollment, there is now a growing consensus that a correlation exists in this recession.

Both nationally and regionally, the historical link between unemployment and Medicaid enrollment was not particularly strong or exhibited a long lag that may not be causal. For example, during the 2008 Recession, when unemployment increased 110% from its start in FY 2008 to its end in FY 2009, Rhode Island's Medicaid enrollment declined. As unemployment hovered around 12% through FY 2012, enrollment increased by 17,000 through FY 2014. Medicaid enrollment subsequently increased dramatically through end of FY 2017 as all employment metrics in the State significantly improved; even after controlling for the introduction of the new Medicaid Expansion group.

Figure I-2. Historical Comparison of Medicaid Eligibility compared to Unemployment Rate in Rhode Island



While Rhode Island exhibits a positive correlation between the State's high unemployment rate and its increasing Medicaid caseload, the contribution of the cessation of nearly all termination activities to the continued caseload growth is likely considerable. **Figure I-2** above shows the historical comparison of Medicaid eligibility compared to the Rhode Island unemployment rate.

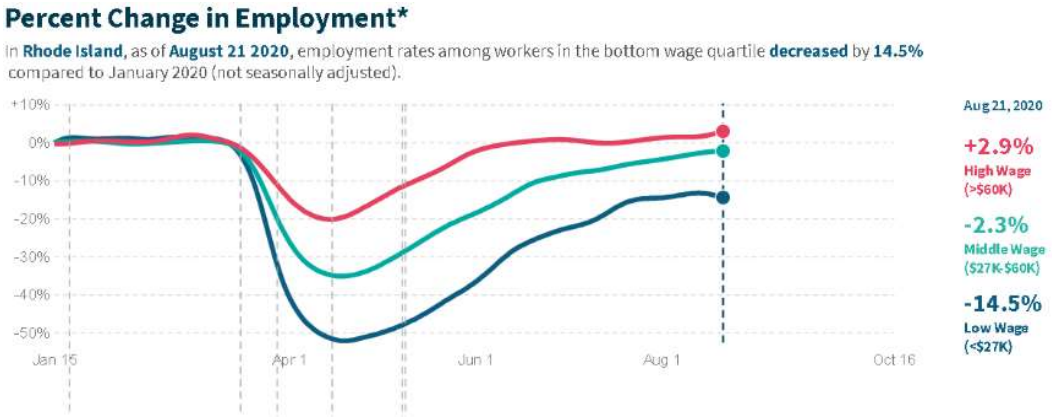
Regardless, there is little doubt that the unprecedented increase in unemployment contributed greatly to the more than 20,000 increase to the Medicaid caseload since February. Significantly, nearly two-thirds of the observed increase is within the Expansion population which did not exist during the 2008 Recession. This could indicate that these individuals are more likely to lose access to other forms of insurance when they experience a job loss and therefore are more likely to subsequently enroll in Medicaid.

In addition to the existence of the Expansion population, there are several other factors unique to the current period that make it inappropriate to apply the trends observed in the 2008 recession to today's forecasts.

First, in the current recession, those experiencing job loss are more likely to be lower income (as illustrated in **Figure I-3** below); in prior recessions, unemployment was more evenly distributed across all income-earners. Consequently, many of the Rhode Islanders who lost their jobs over the past six months may have already been enrolled in Medicaid thereby mitigating new growth. So long as the economy does not continue to worsen, enrollment might eventually reach a peak at a maximum threshold.

Second, the moratorium on terminations might suggest enrollment is overstated relative to what the economic indicators would otherwise predict and will continue to increase as those experiencing job loss continue to enroll, but those returning to the work force do not churn out of the program as they normally would when they obtain new employment. Relatedly, although in Rhode Island overall unemployment is currently below its April peak, non-temporary layoffs are up from 6,200 in April to 22,800 in August based on DLT data, suggesting that loss of insurance may still be increasing.

Figure I-3. Percent Change in Employment by Wage Group, January - August 2020

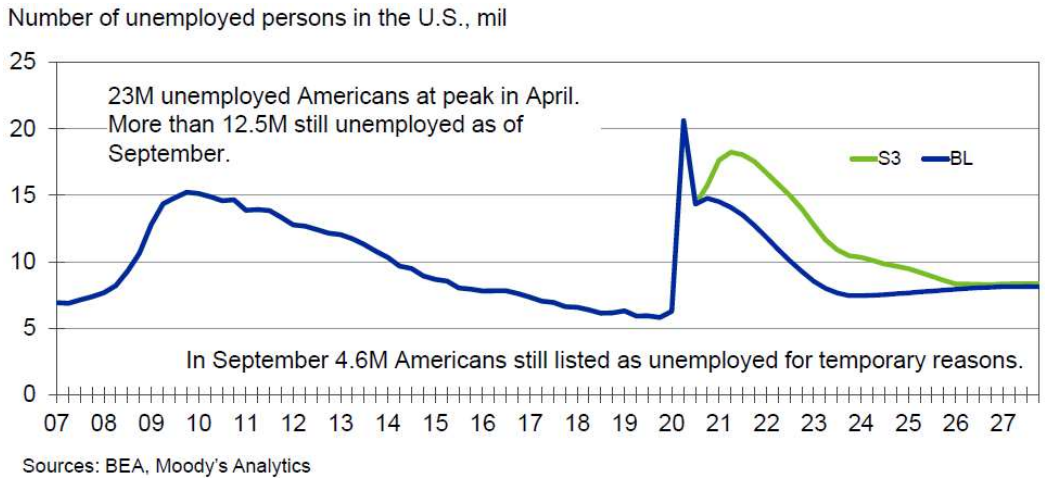


Source: https://tracktherecovery.org/. Accessed 10/16/2020

Lastly, there remains a wide band of uncertainty regarding anticipated unemployment trends among respected analysts. In October 2020, Moody's Analytics prepared two forecasts of United States' unemployment levels over the next six years (**Figure I-4** below). Their baseline (blue) forecast assumes that the worst of the pandemic is over from an economic perspective and that employment will reach pre-pandemic levels by the end of FY 2022.

The alternate forecast (green) assumes that the lack of federal stimulus and/or a resurgence in COVID in the winter months would lead to another increase in unemployment, and that employment will not reach pre-pandemic levels until FY 2027.

Figure I-4. Number of unemployed Persons in the United States



Source: Moody's Analytics. The Pandemic Economy and State Budgets, October 2020

Enrollment Magnitude Trend, and Shape of Economic Recovery Determine the Fiscal Impact of COVID-19

EOHHS modeled low, medium, and high enrollment scenarios. The low and high scenarios correspond in narrative to the two scenarios projected by Moody's and assume that enrollment will correlate with unemployment trends once the Public Health Emergency Ends. The low enrollment scenario assumes that the ability to resume terminations plus a federal stimulus passes with a rapid recovery and results in enrollment returning to pre-pandemic levels by the end of FY 2022. In the high enrollment scenario, the growth trend assumed after the State is able to resume terminations moderates such that peak enrollment is below the peak previously assumed in May and the growth rate is just below that projected by the CBO prior to the pandemic.

For its testimony, EOHHS selected the medium enrollment scenario which assumes a federal stimulus, with a more lagged recovery in terms of enrollment reduction.

All models assume that the 6.20% and 4.34% increases to regular Medicaid and CHIP expenditures will end March 31, 2021, and that the federal regulation preventing the termination of any Medicaid members (except in the case of death, moving out of state, or self-attestation) will be lifted January 31, 2021.

The significant variance in assumptions underlying the scenarios and underlying fiscal impact are summarized in **Table I-10** with a visual representation of the overall caseload variance presented in **Figure I-5**.

EOHHS' selected scenario assumes that

1. The annualized trend observed since February 2020 will continue until the state can resume terminations after the end of the PHE. If the PHE ends in January 2021, the state can resume termination activity after January 31, 2021, but April will be the first month in which declines in caseload resulting from terminations will occur. This is due to the termination notice process, which takes approximately 60 days.

2. Our testimony assumes that 1/3 of the members who became Medicaid-eligible between February and March (or approximately 35,000) will be terminated over a three-month period (April, May, and July).

   This magnitude of termination activity is reasonable based on the following.

   By suppressing nearly all terminations, the Medicaid program has shielded just under 17,000 members from being terminated through early October. Approximately 3,000 have since regained eligibility for a net 14,000 members who remain on the Medicaid program.

   Additionally, through September, there are 62,000 members who have had their renewal date pushed (53,000 MAGI/9,000 complex) back because of the PHE. This number will continue to grow now that the PHE has been extended. Once the PHE ends, these members will be moved through the renewal process. In terms of the share of those renewals that may result in termination, on average approximately 16% of Complex/MPP/LTSS renewals end up being terminated. For MAGI, roughly 7% of renewals are terminated. In the current environment those totals may end up being lower. For Complex Medicaid renewals, the termination rate is higher than MAGI because EOHHS require every recertification packet to be signed and returned. The MAGI population goes through Passive Renewal and most individuals are passively renewed.

   Lastly, Post Eligibility Verification (PEV) runs the entire MAGI population every month, excluding cases that have recertifications due within 90 days. Once the PHE ends, the entire MAGI population will be run through the PEV process. For comparison purposes, from March through November 2019, just over 21,000 members (or approximately 10%) were flagged as over-income through the PEV process and sent termination notices (including an opportunity to dispute the findings and retain eligibility).

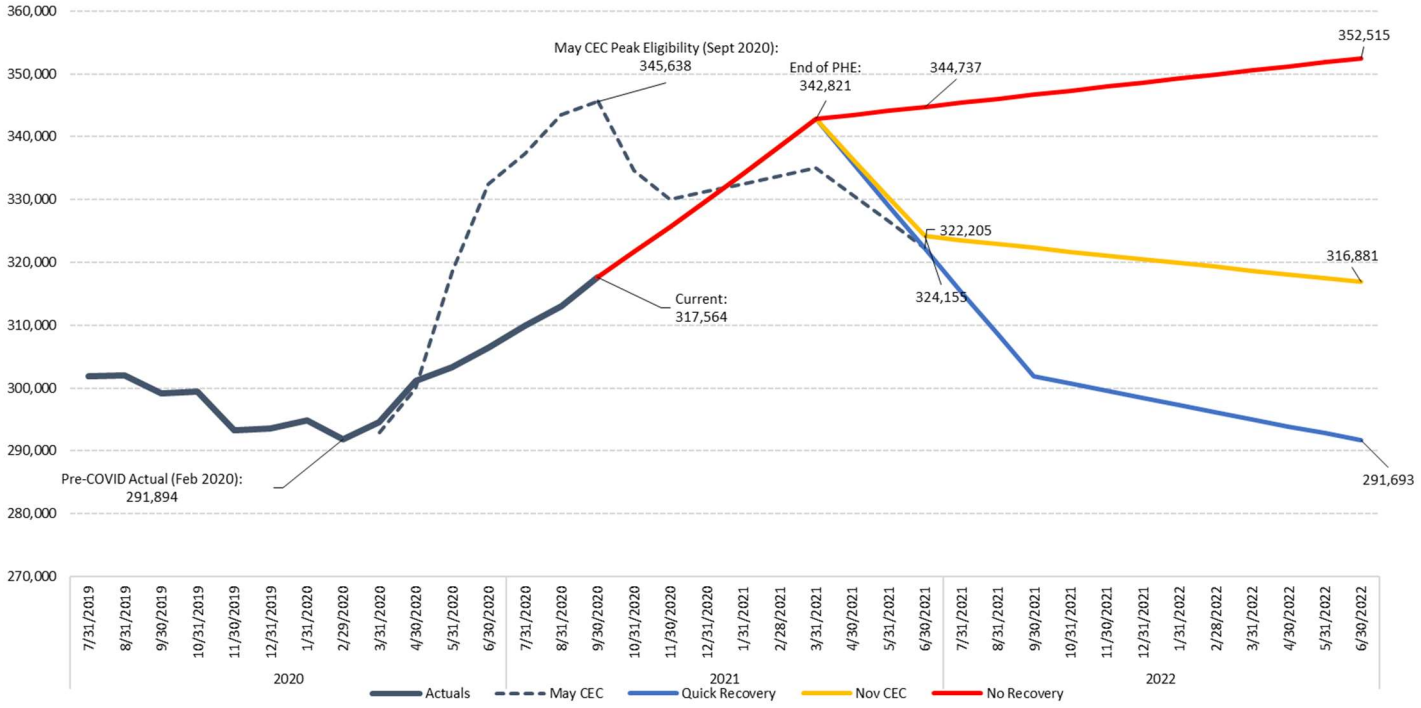
3. The three-month period of determination backlog processing will be followed by a more moderate decline in caseload which is carried through the end of the FY 2022. EOHHS applies annualized reductions of 5.0 percent for the MAGI population and 2.5% for Aged, Blind, and Disabled population.

   While a more rapid recovery scenario (blue) could assume that caseload would return to pre-COVID levels by the end of FY22, based on the Moody's projections that unemployment levels could return to pre-COVID levels by the end of FY22, EOHHS' projections instead assume that terminations will lag behind the economic improvement.

Table I-10. Comparison of COVID-19 Scenarios

	Baseline	Quick Recovery	No Recovery
Clean-Up Period	1/3rd over 3-months	2/3rd over 6-months	no clean-up
Post Clean-Up Growth Factor	-5.0% MAGI -2.5% Complex	-2.5% MAGI -1.25% Complex	2.5% MAGI 1.25% Complex
FY 2021 Average	327,000	326,500	330,500
Peak Enrollment	342,821	342,821	351,859
(Month)	Mar-21	Mar-21	Jun-22
FY 2022 Average	320,503	299,975	348,609
Jun-22 Enrollment	316,881	291,693	352,515
FY21 - Increase/(Decrease) Relative to Baseline		-$1.9M AF -$9.1M GR	+$5.5M AF +$1.1M GR
FY22 - Increase/(Decrease) Relative to Baseline		-$124.4M AF -$28.7M GR	+73.7M AF +16.2M AF

Figure I-5. Current Forecast compared to alternative scenarios



Estimating an Alternative to EOHHS' Forecast

The conferees can manually estimate the fiscal impact on EOHHS' forecast by calculating the costs associated with a marginal increase or decrease in the number of member months paid for by Medicaid. To assist the conferees, **Table I-11** consolidates discrete information included in multiple tables within the subsequent sections. The PMPM in the table reflects the composite monthly premium for each product line. These estimates do not include the members remaining in FFS nor the non-capitated costs budgeted against each program.

The FY 2021 rates have been actuarially certified; as such, these rates cannot be reasonably amended by the conferees without assuming a significant change in the mix of enrollees within a product for the remaining months

of the fiscal year. The FY 2022 rates, however, remain estimates based upon the current enrollment mix and a preliminary review of the trends exhibited in the base experience that will be used to develop the rates.

Table I-11. FY 2020 Actuals Compared to May Forecasts for FY 2021 and FY 2022, with Caseload and Price Trends

	Caseload:			Price:			Caseload Trend:		Price Trend:	
	2020	2021	2022	2020	2021	2022	20→21	21→22	20→21	21→22
Full Benefits:										
Rite Care Core	147,393	156,584	152,849	$ 269.63	$ 285.75	$ 295.81	6.2%	-2.4%	6.0%	3.5%
Rite Care CSHCN	9,580	9,942	9,908	$ 1,001.17	$ 1,105.68	$ 1,143.81	3.8%	-0.3%	10.4%	3.4%
Expansion	70,333	88,528	86,127	$ 549.74	$ 591.70	$ 612.31	25.9%	-2.7%	7.6%	3.5%
Rhody Health Partners	14,588	14,688	14,532	$ 1,609.58	$ 1,792.41	$ 1,854.98	0.7%	-1.1%	11.4%	3.5%
Rhody Health Options (Phase II)	13,780	13,245	14,706	$ 829.44	$ 829.19	$ 858.04	-3.9%	11.0%	0.0%	3.5%
PACE	338	353	350	$ 3,874.59	$ 3,969.46	$ 4,103.25	4.4%	-0.8%	2.4%	3.4%
RIte Share[3]	3,141	2,582	2,544	$ 60.09	$ 62.68	$ 64.87	-17.8%	-1.5%	4.3%	3.5%
Subtotal	259,153	285,922	281,016	$ 480.05	$ 514.10	$ 535.41	10.3%	-1.7%	7.1%	4.1%
Other Capitated Arrangements:										
Rite Smiles	111,351	125,065	134,051	$ 19.27	$ 19.88	$ 20.50	12.3%	7.2%	3.2%	3.1%
Rite Care EFP	1,777	1,771	1,713	$ 16.41	$ 20.44	$ 21.16	-0.3%	-3.3%	24.6%	3.5%
SOBRA Payments[4]	4,711	4,683	4,559	$ 12,469	$ 13,304	$ 13,770	-0.6%	-2.6%	6.7%	3.5%
Non-Emergency Transportation[5]	287,280	322,708	315,150	$ 8.09	$ 7.88	$ 8.19	12.3%	-2.3%	-2.6%	3.9%
Medicare Premium Payment:										
Part A (Hospital)	1,101	1,170	1,204	$ 445.22	$ 457.36	$ 463.53	6.3%	2.9%	2.7%	1.3%
Part B (Professional Services)	39,282	40,056	41,043	$ 143.69	$ 147.51	$ 150.26	2.0%	2.5%	2.7%	1.9%
Part D (Prescription Drugs)	36,814	37,613	38,587	$ 147.97	$ 145.61	$ 163.64	2.2%	2.6%	-1.6%	12.4%

Notes:

1. FY 2021 rates do not include the Health Insurance Fee (HIF). That payment is budgeted seperately.
2. Rite Share PMPM includes employee premium payments only and does not include wrap-around payments.
3. One of the Medicaid Managed Care health plans is 11-months behind in submitting SOBRA claims and so FY 2020 remains an estimate.
4. SOBRA Payments reflect annual estimate and not monthly average.
5.. Non-Emergency Medical Transportation includes enrollment of DEA Copay clients funded by the Office of Healthy Aging.

II. Managed Care

Managed Care			
		All Funds	**General Revenue**
FY 2019	Final	$707,261,206	$300,052,866
FY 2020	Final	$712,143,803	$286,513,247
FY 2021	May CEC Adopted	$838,000,000	$367,175,074
	Current	**$794,763,840**	**$311,426,928**
	Surplus over May CEC	*$43,236,160*	*$55,748,146*
FY 2022	Current	**$805,946,055**	**$348,813,990**

The revised forecast of $794.7 million for FY 2021 reflects a $43.2 million surplus over the May CEC.

Overall, EOHHS forecasts an average fiscal year enrollment of 166,526 RIte Care eligible members in FY 2021, a reduction of 8,942 members compared to the May adopted. This includes: 156,584 members enrolled in RIte Care Core, 9,942 in Rite Care CSHCN, 2,582 enrolled in RIte Share, and an average of 11,540 remaining in fee-for-service each month.

For FY 2022, EOHHS forecasts spending of $805.9 million from all sources, a $11.2 million, or 1.4%, increase over FY 2021. EOHHS forecasts its caseload to decline to a monthly average of 176,476, including 152,849 enrolled in Rite Care Core, 9,908 in Rite Care CSHCN, 2,544 in Rite Share, and 11,379 remaining in FFS each month.

Table II-1 summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments. EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table II-2** and the forecast for the number of births and NICU stays are presented in **Table II-3**.

Table II-4 reflects a variance analysis of the changes between EOHHS' current forecast and the SFY 2020 preliminary close and the current forecast compared to May CEC. The average monthly RIte Care and RIte Smiles capitation rates paid to the health plans are summarized in **Table II-5** and **Table II-6**, with the FY 2022 rates reflecting a 3.5% price increase.

Table II-7 and **Table II-8** identify changes to total CHIP and EFP claiming activities that provide general revenue savings through enhanced federal claiming.

Additional month-by-month detail is provided in **Attachment 5a** and **Attachment 5b**.

Managed Care Highlights – FY 2021

- Overall, the managed care forecast reflects a $43.2 million reduction compared to the May CEC. This increase consists of a total decrease of $35.1 million for plan payments and an overall decrease of $8.1 million for other plan expenses.
- The primary drivers of the increase over the May CEC are:
    - the 5.1% and 6.2% reductions to the average monthly enrollment in Rite Care Core and Rite Care CSHCN, respectively, contribute savings of $23.1 million;
    - a reduction of 760 SOBRA payments during the fiscal year—such that the total Rite Care funded births are consistent with the number of births in SFY 2020—provides $8.2 million in savings,
    - a $7.3 million favorable variance against Core and CSHCN fee-for-service activity, and;
    - a $2.8 million reduction to estimated health insurer fee.

- Overall, the enhanced FMAP associated with the COVID-19 emergency period provides $35.7 million in GR relief against this budget line in FY 2021, including $3.4 million GR in additional CHIP relief.

Managed Care Highlights – FY 2022

- Overall, the managed care forecast reflects an $11.2 million increase in spending over the current year estimate.
- The primary driver of the increases in spending is price, as summarized in **Table II-4**, and includes:
  - a 3.5% assumed price increase in capitation rates, and
  - a change in the general mix of members enrolled in managed care (that increases the proportion of parents and members enrolled in Rite Smiles) that slightly increases the overall PMPM.
- Partially offsetting the price factor is the reduction in anticipated enrollment.

Table II-1. Summary of Managed Care Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Payments to Plans						
RIte Care Core	$ 474,498,138	$ 550,152,379	$ 534,253,802	$15.9 M	$ 539,860,337	$5.6 M
EFP Only	349,828	425,526	434,207	($0.0 M)	434,986	$0.0 M
SOBRA	51,510,554	62,734,581	54,559,212	$8.2 M	54,954,154	$0.4 M
RIte Care CSHCN	114,469,742	138,446,208	131,247,617	$7.2 M	135,311,479	$4.1 M
RIte Smiles	25,752,996	30,754,318	29,833,617	$0.9 M	32,975,509	$3.1 M
Risk Share	(1,423,089)	-	-	$0.0 M	-	$0.0 M
Stop Loss	2,362,481	3,238,982	3,300,000	($0.1 M)	3,250,000	($0.1 M)
Health Insurer Fee	-	7,369,409	4,575,114	$2.8 M	-	($4.6 M)
Withhold and Incentives	2,960,663	3,529,026	3,339,303	$0.2 M	3,387,579	$0.0 M
Subtotal Payments to Plans	$ 670,481,314	$ 796,650,429	$ 761,542,871	$35.1 M	$ 770,174,044	$8.6 M
Other Payments:						
RIte Share	$ 2,264,672	$ 2,079,465	$ 1,943,958	$0.1 M	$ 1,981,908	$0.0 M
Premium Assistance Program	74,939	61,370	57,176	$0.0 M	54,708	($0.0 M)
Non-Emergency Transportation	7,589,613	8,428,140	8,311,149	$0.1 M	8,361,069	$0.0 M
TANF Charge Back	(1,242,710)	(1,500,000)	(1,250,000)	($0.3 M)	(1,250,000)	$0.0 M
NICU	26,444,185	29,266,482	28,336,907	$0.9 M	28,323,751	($0.0 M)
Core FFS	30,270,430	40,486,100	34,183,323	$6.3 M	30,875,745	($3.3 M)
CSHCN FFS	3,110,075	4,206,354	3,194,563	$1.0 M	3,279,171	$0.1 M
Early Intervention	2,804,329	3,229,058	2,942,374	$0.3 M	2,942,374	$0.0 M
Rebates	(46,132,843)	(44,532,399)	(44,194,677)	($0.3 M)	(38,496,713)	$5.7 M
Other/Miscellaneous	1,278,364	(375,000)	(303,803)	($0.1 M)	(300,000)	$0.0 M
Subtotal Other Payments	$ 26,461,054	$ 41,349,571	$ 33,220,969	$8.1 M	$ 35,772,011	$2.6 M
FQHC PPS Wrap Accrual	*13,080,770*					
Accruals/Adjustments	*2,120,665*					
Grand Total Managed Care	**$ 712,143,803**	**$ 838,000,000**	**$ 794,763,840**	$43.2 M	**$ 805,946,055**	$11.2 M
General Revenue	*$ 286,513,247*	*$ 367,175,074*	*$ 311,426,928*	*$55.7 M*	*$ 348,813,990*	*$37.4 M*

Table II-2. Average Managed Care Caseload

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
Full Benefits, by Delivery System						
RIte Care Core	147,393	164,870	156,584	(8,286)	152,849	(3,735)
RIte Care CSHCN	9,580	10,598	9,942	(656)	9,908	(34)
RIte Share	3,141	3,005	2,582	(423)	2,544	(38)
Remaining in FFS - Core	7,591	6,343	9,314	2,971	9,218	(96)
Remaining in FFS - CSHCN	2,225	2,494	2,226	(268)	2,161	(65)
Total	169,930	187,310	180,443	(6,867)	176,476	(3,967)
PMPM	$349	$373	$368		$381	
% Enrolled in Managed Care	*92%*	*94%*	*92%*		*92%*	
Other Caseload Factors						
EFP Only	1,777	2,088	1,771	(317)	1,713	(58)
RIte Smiles	111,351	130,544	125,065	(5,479)	134,051	8,986

Table II-3. Medicaid Births and NICU Stays

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
SOBRA Births	4,711	5,513	4,683	(830)	4,559	(124)
RIte Care	4,131	4,861	4,101	(760)	3,991	(110)
Expansion	580	652	582	(70)	568	(14)
Percent of Births Expansion	*12.3%*	*11.8%*	*12.4%*		*12.5%*	
Cost per SOBRA Birth	$12,469	$12,906	$13,304	$398	$13,770	$466
NICU Stays[1]	625	666	620	(46)	604	(16)
Cost per NICU Stay	$41,611	$43,962	$44,952	$990	$46,121	$1,169

Note 1. NICU stays have a long completion factor and so a significant portion of SFY 2020 remain outstanding.

Table II-4. Managed Care Price-Volume Comparison to May CEC and Prior SFY

	Price	Volume	Net
FY 2021 over FY 2020	$36.3 M	$46.3 M	$82.6 M
	5.1%	6.2%	11.6%
FY 2021: Nov 2020 over May 2020	($13.0 M)	($30.2 M)	($43.2 M)
	-1.6%	-3.7%	-5.2%
FY 2022 over FY 2021	$29.3 M	($18.1 M)	$11.2 M
	3.7%	-2.2%	1.4%

Table II-5. Summary of RIte Care Core and CSHCN Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
RIte Care Core				
MF < 1 y.o.	*$582.84*	*$636.71*	*$658.99*	*3.5%*
MF 1-4 y.o.	*$174.59*	*$186.95*	*$193.49*	*3.5%*
MF 5-14 y.o.	*$165.39*	*$174.26*	*$180.36*	*3.5%*
M 15-44 y.o.	*$237.00*	*$235.96*	*$244.22*	*3.5%*
F 15-44 y.o.	*$370.13*	*$390.96*	*$404.65*	*3.5%*
MF 45+ y.o.	*$540.31*	*$553.71*	*$573.09*	*3.5%*
Composite	*$269.63*	*$285.75*	*$295.81*	*3.5%*
RIte Care CSHCN				
Substitute Care	*$743.92*	*$829.44*	*$858.48*	*3.5%*
SSI <15	*$1,460.74*	*$1,566.10*	*$1,620.91*	*3.5%*
SSI 15-20	*$1,029.66*	*$1,211.51*	*$1,253.91*	*3.5%*
Katie Beckett	*$3,282.90*	*$3,548.79*	*$3,673.00*	*3.5%*
Adoption Subsidy	*$543.13*	*$628.31*	*$650.30*	*3.5%*
Composite	*$1,001.17*	*$1,105.68*	*$1,143.81*	*3.4%*
SOBRA Payment	*$12,469.27*	*$13,303.88*	*$13,769.52*	*3.5%*
EFP Only	*$16.41*	*$20.44*	*$21.16*	*3.5%*

Note 1. SFY 20201 PMPM does not include the HIF liability paid as capitation to the UHC and Tufts.
The September 2020 liability for Rite Care Core/CSHCN is estimated to be $6.7 million.

Table II-6. Summary of RIte Smiles Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
RIte Smiles				
MF 0-2	*$4.62*	*$4.73*	*$4.90*	*3.6%*
MF 3-5	*$16.53*	*$17.35*	*$17.96*	*3.5%*
MF 6-10	*$22.83*	*$24.57*	*$25.43*	*3.5%*
MF 11-15	*$24.92*	*$25.97*	*$26.88*	*3.5%*
MF 16-19	*$20.56*	*$18.85*	*$19.51*	*3.5%*
MF 20+	*$20.56*	*$18.85*	*$19.51*	*3.5%*
Composite	*$19.27*	*$19.88*	*$20.50*	*3.1%*

Note 1. SFY 20201 PMPM does not include the HIF liability paid as capitation to the UHC Dental.
The September 2020 liability for Rite Smiles is estimated to be $0.8 million.

Enhanced Claiming: CHIP and EFP Activity

Table II-7 and **Table II-8** summarize the enhanced federal financial participation that Rhode Island claims against medical benefits for overall CHIP activity and Family Planning Services.

EOHHS continues to make manual retroactive adjustments to its CHIP claiming 45 days after the close of each quarter to capture the enhanced rate as it applies to children between the age of one and 18 in households with incomes between 138% and 155% of the FPL. With respect to its family planning claiming, EOHHS makes a year-end adjustment to its prior period claiming based on overall capitation payments and an allocation methodology based on enrollment and the certified managed care rates. Any adjustment that is not completed within the fiscal year will be included in EOHHS' accrual and the amounts budgeted reflect this accrual basis accounting.

Table II-7. CHIP Claiming

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Increase/ (Decrease)	Current	Increase/ (Decrease) over FY21
CHIP Offset	**$ 104,533,668**	**$ 103,830,525**	**$ 105,825,238**	**$2.0 M**	**$ 106,996,485**	**$1.2 M**
Additional GR Relief	*$ 29,815,615*	*$ 17,373,443*	*$ 17,707,208*		*$ 14,099,462*	*($3.6 M)*

Table II-8. EFP Claiming

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Increase/ (Decrease)	Current	Increase/ (Decrease) over FY21
Extended Family Planning	**$ 8,313,186**	**$ 8,863,030**	**$ 8,972,724**	**$0.1 M**	**$ 8,773,252**	**($0.2 M)**
Additional GR Relief	*$ 3,087,933*	*$ 3,207,974*	*$ 3,247,678*		*$ 3,098,493*	*($0.1 M)*

III. Rhody Health Partners

Rhody Health Partners			
		All Funds	**General Revenue**
FY 2019	Final	$239,753,270	$115,465,870
FY 2020	Final	$256,399,002	$115,246,674
FY 2021	May CEC Adopted	$309,500,000	$143,773,525
	Current	**$285,608,533**	**$119,568,480**
	Surplus over May CEC	*$23,891,467*	*$24,205,045*
FY 2022	Current	**$294,252,671**	**$134,147,954**

EOHHS' revised FY 2021 forecast for Rhody Health Partners (RHP) reflects a surplus of $23.9 million over the May CEC for total expenditures of $285.6 million. Overall, EOHHS forecasts an average fiscal year enrollment of 14,688 members in RHP in FY 2021, a reduction of 971 over the May CEC.

EOHHS' revised FY 2022 budget of $294.3 million for RHP reflects a decline of 156 full-time equivalent members over current year forecast. This revised budget reflects a 3.0% increase over FY 2021 which is primarily driven by a 4.1% price factor offset by the -1.1% annual caseload reduction.

The primary drivers for the surplus are lower than anticipated enrollment increases resulting from the COVID-19 crises.

The following tables summarize EOHHS' revised forecasts for Rhody Health Partners for FY 2021 and FY 2022. **Table III-1** summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments. EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table III-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**. **Table III-3** considers the changes in spending and caseload to summarize the price and volume variances for FY 2021 over FY 2020 and across the May and November estimates. The average monthly RHP capitation rate, by pay level, is summarized in **Table III-4**.

Rhody Health Partners Highlights – FY 2021

- The Rhody Health Partners forecast reflects lower spending of $23.9 million compared to the May CEC. This reduction consists of $21.8 million savings in plan payments and $2.1 million savings from non-MCO related payments including higher rebate collections.
- The primary driver for the savings is lower than anticipated caseload, with the RHP population experiencing very little growth since February 2020 and EOHHS assuming the continuation of this trend going forward.
- The Health Insurer Fee liability is $1.2 million below EOHHS' previous estimate.
- Noteworthy is a 9.7% price increase, excluding the HIF payment, in FY 2021 over FY 2020, which may reflect an increasing acuity amongst the enrolled membership.
    - This price increase does not incorporate the $2.5 million for the health insurer fee as it was not levied in FY 2020.
- The enhanced FMAP associated with the COVID-19 emergency period provides $13.2 million in GR relief against this budget line in FY 2021.

Rhody Health Partners Highlights – FY 2022

- The Rhody Health Partners forecast reflects an increase of $8.6 million over FY 2021. This increase consists of $5.1 million for plan payments and $3.6 million for other payments.
- The primary drivers of the increase are:
  - A $7.5 million increase in capitation payments that reflects a more modest 3.5% price increase, offset by the elimination of the Health Insurer Fee.
  - A reduction of $3.5 million in drug rebates as the backlog of prior period rebates is eliminated.

Table III-1. Summary of RHP Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Payments to Plans						
Rhody Health Partners	$ 280,222,863	$ 334,325,194	$ 314,308,848	$20.0 M	$ 321,812,933	$7.5 M
Risk Share	12,389,218	-	-	$0.0 M	-	$0.0 M
Stop Loss - Hepatitis C	2,500,000	3,041,597	2,500,000	$0.5 M	2,500,000	$0.0 M
Health Insurer Fee	-	3,674,729	2,491,247	$1.2 M	-	($2.5 M)
Withhold and Incentives	1,407,827	1,678,821	1,579,413	$0.1 M	1,617,070	$0.0 M
Subtotal Payments to Plans	$ 296,519,907	$ 342,720,341	$ 320,879,508	$21.8 M	$ 325,930,004	$5.1 M
Other Payments:						
Non-Emergency Transportation	$ 3,312,201	$ 3,496,315	$ 3,247,956	$0.2 M	$ 3,326,827	$0.1 M
RHP FFS	38,341	234,488	59,234	$0.2 M	59,234	$0.0 M
Rebates	(41,460,478)	(36,951,144)	(38,578,166)	$1.6 M	(35,063,394)	$3.5 M
Subtotal Other Payments	$ (38,109,936)	$ (33,220,341)	$ (35,270,976)	$2.1 M	$ (31,677,333)	$3.6 M
FQHC PPS Wrap Accrual	-$3,632,937					
Accruals/Adjustments	$1,621,968					
Grand Total	**$ 256,399,002**	**$ 309,500,000**	**$ 285,608,533**	$23.9 M	**$ 294,252,671**	$8.6 M
General Revenue	*$ 115,246,674*	*$ 143,773,525*	*$ 119,568,480*	*$24.2 M*	*$ 134,147,954*	*$14.6 M*

Table III-2. RHP Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
Enrollment by Pay Level						
SSI 21-44 y.o.	3,672	3,959	3,742	(217)	3,708	(34)
SSI 45+ y.o.	7,247	7,793	7,310	(483)	7,228	(82)
SPMI	2,724	2,894	2,686	(208)	2,658	(28)
ID/DD	945	1,013	950	(63)	938	(12)
Total RHP	14,588	15,659	14,688	(971)	14,532	(156)
Overall PMPM	$1,465	$1,647	$1,627	($20)	*$1,687*	$60

Table III-3. RHP Price-Volume Comparison to May CEC and Prior SFY

	Price	Volume	Net
FY 2021 over FY 2020	$27.3 M	$1.9 M	$29.2 M
	10.6%	0.7%	11.4%
FY 2021: Nov 2020 over May 2020	($5.0 M)	($18.9 M)	($23.9 M)
	-1.6%	-6.2%	-7.7%
FY 2022 over FY 2021	$11.8 M	($3.2 M)	$8.6 M
	4.1%	-1.1%	3.0%

Table III-4. RHP Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
Rhody Health Partners				
SSI 21-44 y.o.	$994.05	$1,122.94	$1,162.25	3.5%
SSI 45+ y.o.	$1,592.92	$1,775.72	$1,837.87	3.5%
SPMI	$2,625.73	$2,939.29	$3,042.16	3.5%
ID/DD	$1,199.29	$1,314.96	$1,360.98	3.5%
Composite	$1,609.58	$1,792.41	$1,854.98	3.5%

Note:

1. SFY 2021 PMPM does not reflect HIF liability estimated to be $3.7 million and is included in SFY 2021 forecast.

IV. Rhody Health Options

Rhody Health Options			
		All Funds	**General Revenue**
FY 2019	Final	$200,503,385	$96,179,681
FY 2020	Final	$132,600,805	$58,817,184
FY 2021	May CEC Adopted	$140,800,000	$65,117,560
	Current	**$133,493,291**	**$55,534,788**
	Surplus over May CEC	*$7,306,709*	*$9,582,772*
FY 2022	November CEC	**$153,545,257**	**$69,657,872**

The revised FY 2021 forecast of $133.5 million for Rhody Health Options reflects a surplus of $7.3 million over the May CEC with average monthly caseload down 980 over May 's forecast. This negative caseload trend reverses in FY 2022 as EOHHS anticipates the resumption of passive enrollment in January 2021. EOHHS' revised forecast for FY 2021 and FY 2022 reflects the enrollment of 150 additional members per month. The overall 11.0% increase caseload combined with a 3.6% effective price increase contributes to a forecast of $$153.5 million in FY 2022.

The following tables summarize EOHHS' revised forecasts for Rhody Health Options for FY 2021 and FY 2022. **Table IV-1** summarizes Rhody Health Options expenditures. EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table IV-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**. **Table IV-3** calculates the price and volume related changes between FY 2021 and FY 2022.

The average monthly Rhody Health Option capitation rates, by pay level, are summarized in **Table IV-4.**

Rhody Health Options Highlights – FY 2021

- The Rhody Health Options forecast reflects an overall surplus of $7.3 million compared to the May CEC.
- The primary drivers of this surplus are lower enrollments in FY 2021 than forecasted in May.
- However, offsetting the lower-than-anticipated number of enrollments resulting from the public health emergency, EOHHS expects a surge in enrollment into the CMS Demonstration as it resumes passive enrollment.
    - Beginning January 2021, EOHHS anticipates a shift of 150 members per month from FFS to the CMS Demonstration, for a total of an additional 3,150 member months or the equivalent of 263 members eligible for the entire fiscal year.
    - Please note that the additional cost of this enrollment is partially offset by a reduction in the FFS spending in Hospital, Pharmacy, and Other Services. (At this time, members receiving long term care services and supports in an institutional setting are not expected to be passively enrolled.)
- As discussed in **Section G** of the **Major Developments**, the forecast reflects a $1.1M reduction to the current year rates attributed to the expectation that Medicare now fully finances the cost of providing SUD health home treatment to Duals. This reduction will be retroactive to July 1, 2020.
- The enhanced FMAP associated with the COVID-19 emergency period provides $5.9 million in GR relief against this budget line in FY 2021.

Rhody Health Options Highlights – FY 2022

- The Rhody Health Options forecast of $146.9 million in FY 2022 reflects a $20.1 million increase over FY 2021.
- The primary drivers of the increase are:
    - the 3.5% price increase assumed for the PMPMs
        - the continued passive enrollment of an additional 150 members per month, for a total of an additional 11,700 member months (the equivalent of 975 additional enrollees per month for the entire year).
    - the SUD savings are carried forward into EOHHS' FY 2022 estimate.

Table IV-1. Summary of Rhody Health Options Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Payments to Plans						
RHO Phase II	$ 132,983,917	$ 130,923,357	$ 126,170,834	$4.8 M	$ 144,959,842	$18.8 M
Risk Share	-	2,100,687	-	$2.1 M	-	$0.0 M
Withholds	4,112,638	4,590,542	5,568,829	($1.0 M)	6,398,596	$0.8 M
Other - OTP/SUD Savings	-		(1,134,793)	$1.1 M	(1,134,793)	$0.0 M
Subtotal Payments to Plans	$ 137,096,555	$ 137,614,586	$ 130,604,870	$7.0 M	$ 150,223,645	$19.6 M
Other Payments:						
Non-Emergency Transportation	3,128,921	3,185,414	2,928,140	$0.3 M	3,365,712	$0.4 M
Rebates	(41,322)		(39,719)	$0.0 M	(44,100)	($0.0 M)
Subtotal Other Payments	$ 3,087,599	$ 3,185,414	$ 2,888,421	$0.3 M	$ 3,321,612	$0.4 M
Prior Period Activity/Accruals	*(7,583,349)*					
Grand Total	**$ 132,600,805**	**$ 140,800,000**	**$ 133,493,291**	$7.3 M	**$ 153,545,257**	$20.1 M
General Revenue	*$ 58,817,184*	*$ 65,117,560*	*$ 55,534,788*	*$9.6 M*	*$ 69,657,872*	*$14.1 M*

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Payments to Plans						
RHO Phase II	$ 132,983,917	$ 130,923,357	$ 120,602,227	$10.3 M	$ 138,353,938	$17.8 M
Risk Share	-	2,100,687	-	$2.1 M	-	$0.0 M
Withholds	4,112,638	4,590,542	5,568,829	($1.0 M)	6,388,993	$0.8 M
Other - OTP/SUD Savings	-		(1,134,793)	$1.1 M	(1,134,793)	$0.0 M
Subtotal Payments to Plans	$ 137,096,555	$ 137,614,586	$ 125,036,263	$12.6 M	$ 143,608,138	$18.6 M
Other Payments:						
Non-Emergency Transportation	3,128,921	3,185,414	2,928,140	$0.3 M	3,365,712	$0.4 M
Rebates	(41,322)		(39,719)	$0.0 M	(44,100)	($0.0 M)
Subtotal Other Payments	$ 3,087,599	$ 3,185,414	$ 2,888,421	$0.3 M	$ 3,321,612	$0.4 M
Prior Period Activity/Accruals	*(7,583,349)*					
Grand Total	**$ 132,600,805**	**$ 140,800,000**	**$ 127,924,684**	$12.9 M	**$ 146,929,750**	$19.0 M
General Revenue	*$ 58,817,184*	*$ 65,117,560*	*$ 53,221,310*	*$11.9 M*	*$ 66,659,889*	*$13.4 M*

Table IV-2. Rhody Health Options Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
MMP SPMI	1,257	1,263	1,195	(68)	1,326	131
MMP ID/DD	1,363	1,466	1,381	(85)	1,533	152
MMP Community LTSS	1,626	1,737	1,604	(133)	1,777	173
MMP NH > 90 days	392	445	381	(64)	426	45
MMP Community Non-LTSS	9,142	9,314	8,684	(630)	9,644	960
Total	13,780	14,225	13,245	(980)	14,706	1,461
Overall PMPM	$802	$825	$805	($20)	*$833*	$28

Table IV-3. RHO Price-Volume Comparison to May CEC and Prior SFY

	Price	Volume	Net
FY 2021 over FY 2020	$6.3 M	($5.4 M)	$0.9 M
	4.7%	-3.9%	0.7%
FY 2021: Nov 2020 over May 2020	$2.6 M	($9.9 M)	($7.3 M)
	1.8%	-6.9%	-5.2%
FY 2022 over FY 2021	$4.8 M	$15.3 M	$20.1 M
	3.6%	11.0%	15.0%

Table IV-4. Summary of Rhody Health Options Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
MMP SPMI	$1,159.04	$1,179.16	$1,220.40	3.5%
MMP ID/DD	$208.79	$212.33	$219.75	3.5%
MMP Community LTSS	$3,456.90	$3,284.26	$3,399.12	3.5%
MMP NH > 90 days	$3,456.90	$3,284.33	$3,399.17	3.5%
MMP Community Non-LTSS	$297.41	$318.62	$329.76	3.5%
Composite	*$829.44*	*$829.19*	*$858.04*	*3.5%*

V. Medicaid Expansion

Medicaid Expansion			
		All Funds	**General Revenue**
FY 2019	Final	$474,972,127	$29,877,910
FY 2020	Final	$477,599,125	$43,252,026
FY 2021	May CEC Adopted	$623,000,000	$62,663,603
	Current	**$643,402,904**	**$68,779,061**
	Deficit over May CEC	*($20,402,904)*	*($6,115,458)*
FY 2022	Current	**$643,235,452**	**$68,686,288**

EOHHS' revised forecast for Expansion of $643.4 million for FY 2021 reflects a deficit of $20.4 million compared to the May CEC. Overall, EOHHS forecasts an average fiscal year enrollment of 92,592 members in Expansion in FY 2021, an increase of 5,205 over the May estimate. The increase in the Expansion members enrolled in managed care reflects a 25% increase between February and September 2020: from 67,656 in February to 82,529 in September.

For FY 2022, EOHHS forecasts total expenditures to be effectively flat at $643.2 million. This revised forecast includes an average enrollment of 90,149, a decline of 2,443 members over the current year forecast as EOHHS assumes the resumption of termination activity and improvements in the local economy will further reduce caseload over the subsequent months.

The following tables summarize EOHHS' revised forecasts for Expansion for FY 2021 and FY 2022. **Table V-1** summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments. EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table V-2** with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**. **Table V-3** calculates the price and volume related changes for FY 2021 and FY 2022. The average monthly Expansion capitation rates, by pay level, is summarized in **Table V-4**

A five-year forecast that takes into consideration the impact of the changing FMAP rate for the Expansion population is presented in **Table V-5**.

Medicaid Expansion Highlights – FY 2021

- The Medicaid Expansion forecast reflects an overall deficit of $20.4 million when compared to the May CEC. This deficit consists of an increase of $26.2 million in net payments to the health plans offset by $5.8 million in other savings.
- The cessation of termination has reduced the level of churn in Medicaid and thereby greatly reduced the number of people remaining in FFS.
- The primary driver of the deficit is an increase of $28.7 million in increased premium payments for the additional 8,398 additional enrollees in the fiscal year compared to the May forecast.
    - As of September 2020, enrollment was up nearly 15,000 since February 2020 with enrollment expected to further increase another 12,000 to 97,142 in March 2021 before it begins to decline.
- Favorable changes include:
    - A decrease of $0.7 million in SOBRA payments due to fewer births;
    - A reduction of $1.8 million to the Health Insurer Fee liability; and,
    - Improved rebate collections of $7.1 million, although this increase may be largely attributed to collections against the backlog of prior period rebates.

- The enhanced FMAP associated with the COVID-19 emergency period does not impact the Medicaid Expansion budget line

Medicaid Expansion Highlights – FY 2022

- The Medicaid Expansion for FY 2022 is even with FY 2021. The drivers consist of:
  - a positive 3.5 percent price increase to capitation rates;
  - a continued negative 5.0 percent annualized caseload trend; and,
  - a 10% reduction to FFS expenditures that reflects expectation for a decline in the volume of inpatient hospital utilization as number of newly eligible members declines after the end of public health emergency
- Note that there are two interim adjustments in FY 2021 that do not carry-forward into FY 2022, including the elimination of the $4.0 million health insurer fee liability that is largely offset by the $5.3 million reduction to drug rebate attributed to the accounting fully catching up to the incurred basis.

Table V-1. Summary of Medicaid Expansion Expenditures

	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Payments to Plans						
Expansion	$ 461,638,687	$ 596,679,813	$ 625,382,436	($28.7 M)	$ 629,624,789	$4.2 M
SOBRA	$ 7,232,177	8,414,513	7,742,858	$0.7 M	7,821,087	$0.1 M
Risk Share	14,192,491	-	-	$0.0 M	-	$0.0 M
Stop Loss - Hepatitis C	4,609,793	5,346,287	5,250,000	$0.1 M	5,250,000	$0.0 M
Health Insurer Fee	-	5,838,738	4,005,598	$1.8 M		($4.0 M)
Withhold and Incentives	2,319,122	3,001,087	3,142,578	($0.1 M)	3,163,926	$0.0 M
Subtotal Payments to Plans	$ 489,992,270	$ 619,280,437	$ 645,523,470	($26.2 M)	$ 645,859,802	$0.3 M
Other Payments:						
Non-Emergency Transportation	$ 8,246,257	$ 9,016,125	$ 10,053,704	($1.0 M)	$ 10,129,922	$0.1 M
Expansion FFS	47,744,544	55,622,536	55,870,390	($0.2 M)	50,025,589	($5.8 M)
Rebates	(57,094,600)	(60,919,098)	(68,044,660)	$7.1 M	(62,779,862)	$5.3 M
Subtotal Other Payments	$ (1,103,799)	$ 3,719,563	$ (2,120,566)	$5.8 M	$ (2,624,350)	($0.5 M)
FQHC PPS Wrap Accrual	*(8,996,365)*					
Accruals/Adjustments	*(2,292,981)*					
Grand Total	**$ 477,599,125**	**$ 623,000,000**	**$ 643,402,904**	($20.4 M)	**$ 643,235,452**	($0.2 M)
General Revenue	*$ 43,252,026*	*$ 62,663,603*	*$ 68,779,061*	*($6.1 M)*	*$ 68,686,288*	*($0.1 M)*

Table V-2. Summary Medicaid Expansion Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
Enrollment by Delivery System:						
Expansion	70,333	80,130	88,528	8,398	86,127	(2,401)
RIte Share	126	74	109	35	108	(1)
Remaining in FFS	5,109	7,183	3,955	(3,228)	3,914	(41)
Total	75,568	87,387	92,592	5,205	90,149	15,168
Overall PMPM	$527	$594	$580		*$600*	$19
% Enrolled in Managed Care	*93%*		*96%*		*96%*	

Table V-3. Expansion Price-Volume Comparison to May CEC and Prior SFY

	Price	Volume	Net
FY 2021 over FY 2020	$47.5 M	$118.3 M	$165.8 M
	9.9%	22.5%	34.7%
FY 2021: Nov 2020 over May 2020	($15.8 M)	$36.2 M	$20.4 M
	-2.5%	6.0%	3.3%
FY 2022 over FY 2021	$17.3 M	($17.4 M)	($0.2 M)
	2.7%	-2.6%	0.0%

Table V-4. Summary of Medicaid Expansion Effective Monthly Premiums

Expansion	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
F 19-24 y.o.	*$265.40*	*$303.13*	*$313.74*	*3.5%*
F 25-29 y.o.	*$415.08*	*$434.14*	*$449.34*	*3.5%*
F 30-39 y.o.	*$580.33*	*$655.22*	*$678.15*	*3.5%*
F 40-49 y.o.	*$758.70*	*$855.52*	*$885.46*	*3.5%*
F 50-64 y.o.	*$725.72*	*$795.77*	*$823.62*	*3.5%*
M 19-24 y.o.	*$204.67*	*$208.45*	*$215.75*	*3.5%*
M 25-29 y.o.	*$360.06*	*$389.55*	*$403.19*	*3.5%*
M 30-39 y.o.	*$538.93*	*$580.61*	*$600.93*	*3.5%*
M 40-49 y.o.	*$735.51*	*$760.84*	*$787.47*	*3.5%*
M 50-64 y.o.	*$820.73*	*$850.39*	*$880.15*	*3.5%*
Composite	*$549.74*	*$591.70*	*$612.31*	*3.5%*
SOBRA Payment	*$12,469*	*$13,304*	*$13,770*	*3.5%*

Note 1. SFY 20201 PMPM does not include the HIF liability estimated to be $5.9 million in SFY 2021.

5-Year Extended Forecast

- EOHHS' extended five-year forecast assumes a further 5.0 percent caseload decline in FY 2023 followed by moderate growth of 2.5% and 1.5% in FY 2024 and FY 2025, respectively.
- In January 2020, the FMAP rate transitioned to 90 percent for this population.

Table V-5. Medicaid Expansion FY 2019 + Extended 5-Year Fiscal Year Forecast

	Eligible	PMPM	All Funds	FMAP	General Revenue
FY 2020 - Final	75,568	$527	$477.6 M	9%	$43.0 M
FY 2021 - Current	92,592	$579	$643.4 M	10%	$64.3 M
FY 2022 - Current	90,149	$595	$643.2 M	10%	$65.4 M
FY 2023	85,642	$615	$632.5 M	10%	$63.2 M
FY 2024	87,783	$637	$671.0 M	10%	$67.1 M
FY 2025	89,099	$659	$704.9 M	10%	$70.5 M

VI. Hospitals - Regular

Hospitals - Regular			
		All Funds	**General Revenue**
FY 2019	Final	$66,805,603	$32,144,027
FY 2020	Final	$46,066,642	$20,055,913
FY 2021	May CEC Adopted	$50,300,000	$23,140,723
	Current	**$51,522,943**	**$21,059,976**
	Deficit over May CEC	*($1,222,943)*	*$2,080,747*
FY 2022	Current	**$47,437,825**	**$21,336,676**

EOHHS' Hospital expenditure estimate of $51.5 million for FY 2021 reflects a $1.2 million deficit against May CEC. A summary of the FY 2021 and FY 2022 hospital expenditure forecasts are shown in **Table VI-1**. The price and utilization factors used in the calculation of the FY 2022 forecast are presented in **Table VI-3**.

The SFY 2021 inpatient hospital estimates account for increased utilization in the first part of the fiscal year, with the regular hospital budget line expected to average $3.5 million per month from July through September, attributed to the COVID-19 emergency and the apparent increases observed in the last quarter of SFY 2020. Like the overall caseload trends, EOHHS projects these increases slow in the latter part of SFY 2021, declining each month until reaching the pre-COVID average of $2.8 million per month in June 2021. The SFY 2022 estimate takes this pre-COVID monthly average and applies the price changes shown in **Table VI-3**.

The enhanced FMAP associated with the public health emergency contributes $2.4 million in GR relief in FY 2021 relative to May.

Table VI-1. Summary of Hospital – Regular Expenditures

	SFY 2020:	**SFY 2021:**			**SFY 2022:**	
	Final	**May CEC**	**Current**	**Surplus/ (Deficit)**	**Current**	**Increase/ (Decrease) over FY21**
Hospitals - Regular						
Total FFS	**$ 43,847,499**	**$ 44,657,598**	**$ 45,339,641**	**($0.7 M)**	**$ 41,036,786**	**($4.3 M)**
Inpatient	38,050,018	37,508,180	39,010,890	($1.5 M)	34,543,487	($4.5 M)
Outpatient	5,797,481	7,149,418	6,328,751	$0.8 M	6,493,299	$0.2 M
Upper Payment Limit	**$ 4,642,402**	**$ 4,642,402**	**$ 4,642,402**	**$0.0 M**	**$ 4,852,239**	**$0.2 M**
Inpatient UPL	-	-	-	$0.0 M	-	$0.0 M
Outpatient UPL	4,642,402	4,642,402	4,642,402	$0.0 M	4,852,239	$0.2 M
Graduate Medical Education	**$ 1,591,500**	**$ 1,000,000**	**$ 1,540,900**	**($0.5 M)**	**$ 1,548,800**	**$0.0 M**
Prior Period Activity/Accruals	*(4,014,759)*					
Grand Total	**$ 46,066,642**	**$ 50,300,000**	**$ 51,522,943**	($1.2 M)	**$ 47,437,825**	($4.1 M)
General Revenue	*$ 20,055,913*	*$ 23,140,723*	*$ 21,059,976*	*$2.1 M*	*$ 21,336,676*	*$0.3 M*

Hospital Supplemental Payments – Upper Payment Limit (UPL)

UPL payments in FY 2021 total $4.6 million. No change in UPL payments is forecast for FY 2021 at this time, due to the absence of a FY 2021 Enacted Budget. Although UPL payments were to be issued in July and October, the Office of Management and Budget advised EOHHS to not make these payments until a FY 2021 Budget is enacted. EOHHS anticipates making these payments after the passage of a FY 2021 budget. Note that EOHHS is in the

process of finalizing its FY 2021 prospective inpatient UPL demonstration to CMS; therefore, these amounts may change pending the CMS' review of this demonstration and items included in a FY 2021 adopted budget.

The projected FY 2022 UPL payments is the same as the current amounts adjusted for OMB's current service level adjustment, which are based on NHE hospital FY 2022 inflation factors.

Based on EOHHS' analysis of the proportion of hospital fee-for-service expenditures attributed to Expansion-eligible members, 33.4 percent of outpatient UPL payments are assumed eligible for enhanced federal financial participation.

Please refer to **Table VI-2** for additional information on UPL payments. By hospital estimates for FY 2021 will be made once the data necessary to estimate this becomes available.

Table VI-2. Upper Payment Limit (UPL) Spending by Hospital, FY 2020 Actual and FY 2021 Estimate

	Outpatient	Inpatient	Total
Rehab Hospital	$ 6,382	-	$ 6,382
Bradley Hospital	-	-	-
Butler Hospital	-	-	-
Kent Hospital	467,307	-	467,307
Landmark Hospital	142,564	-	142,564
Miriam Hospital	526,739	-	526,739
Newport Hospital	153,358	-	153,358
Rhode Island Hospital	2,150,649	-	2,150,649
Roger Williams Medical Center	331,194	-	331,194
St Joseph Hospital	211,401	-	211,401
South County Hospital	114,418	-	114,418
Westerly Hospital	34,665	-	34,665
Women & Infants Hospital	503,725	-	503,725
Total	$ 4,642,402	-	$ 4,642,402

Note 1. Payments made quarterly: July 20, October 20, January 20, & April 20.

Hospital Supplemental Payments – Graduate Medical Education (GME)

A Graduate Medical Education (GME) payment of $1.5 million all funds, including $1.0 million GR, is included in both the FY 2021 and FY 2022 forecasts. This is based on "current law" being equivalent to the May CEC adopted estimate.

In FY 2020, we utilized the $1.0 million pool available in the state plan ($408,500 GR/$591,500 FF) and supplemented this with additional $591,500 State-Only payment for a total payment of $1,591,500. A similar approach is assumed for FY 2021 and FY 2022 with marginal changes to the All Funds amount reflecting the different FMAP rates each year.

The FY 2021 budget initiative before the General Assembly would increase the pool in the state plan to $2.2 million all funds so that, if approved by CMS, the $1.0 million GR could be better leveraged. The FY 2022 amount assumes the same level of GR would be spent, with the all the funds adjusted for the FY 2022 federal match rate.

Table VI-3. FY 2022 Hospital Trend Assumptions (includes Managed Care and Expansion FFS)

	Percent		Dollar Impact	Comments
Price				
Inpatient	2.75%	$	2,542,405	CMS Inpatient Market Basket less productivity
Outpatient	2.60%	$	360,420	CMS OPPS Hospital Input Price Index less productivity
		$	**2,902,824**	
Utilization				
Inpatient	0.00%	$	-	EOHHS
Outpatient	0.00%	$	-	EOHHS
		$	**-**	
Total, Price/Volume		**$**	**2,902,824**	

VII. Hospitals - DSH

Hospitals - DSH Payments			
		All Funds	**General Revenue**
FY 2019	Final	$138,519,196	$67,251,069
FY 2020	Final	$142,083,257	$67,489,693
FY 2021	May CEC Adopted	$142,301,035	$66,952,637
	Current	**$142,301,035**	**$66,952,637**
	Deficit over May CEC	*$0*	*$0*
FY 2022	Current	**$71,564,276**	**$32,855,159**

Projected DSH payments total $142.3 million for FY 2021, consistent with the May CEC. This includes a $67.0 million general revenue payment, reflecting the FFY 20 FMAP rate.

EOHHS' FY 2022 forecast includes funding for the maximum DSH allotment under current law, at $71,564,276, including $32.9 million in general revenue. This reduction was originally scheduled to impact FY 2021, but the federally mandated DSH reductions have been postponed an additional year under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) to FY 2022.

Should the DSH reductions be postponed again, the federal fiscal year 2021 unreduced allotment amount for Rhode Island is equal to $142,493,980 (federal share of $77,074,994). The CARES Act also lowered the scheduled reduction from $8 billion to $4 billion. The $8 billion per year reductions are set to take effect in each federal fiscal year 2022 through 2025 and will affect Rhode Island's FY 2023 DSH payments.

The current fiscal year disbursement by hospital is presented in **Table VII-1**. The maximum amount in current State law, the reduced and unreduced amounts from CMS for FY 2022 are presented in **Table VII-2**.

Note that in FY 2021, EOHHS made the $142.3 million using the enhanced FMAP. Contrary to EOHHS' original assumption, CMS confirmed that the federal allotment will not change due to the enhanced FMAP; therefore, EOHHS overspent its federal allotment by $8.2 million. EOHHS shifted the $8.2 million to a State-Only payment to not exceed the federal allotment.

Table VII-1. SFY 2021 DSH Payments by Hospital (FFY 2020 DSH Plan Year)

	SFY 2021[1]	SFY 2022[2]
Kent Hospital	$ 5,046,909	
Landmark Hospital	12,214,445	
Miriam Hospital	9,710,633	
Newport Hospital	5,783,504	
Rhode Island Hospital	63,083,982	
Roger Williams Medical Center	10,435,385	
St Joseph Hospital	9,257,707	
South County Hospital	3,819,582	
Westerly Hospital	2,468,222	
Women & Infants Hospital	20,480,666	
	$ 142,301,035	$ 71,564,276

Notes:

1. FFY 2020 Plan Year, paid in Jul-20 (SFY 2021).
2. FFY 2021 Plan Year, paid by Jul-21 (SFY 2022). Distribution by hospital is not final.

Table VII-2. SFY 2022 DSH Allotment (based upon FFY 2021 Plan Year)

	SFY21 *based on FFY20 Unreduced*	SFY22 *based on CMS estimate*	SFY22 Unreduced *based on FFY21 Unreduced*
All Funds	$ 142,301,035	$ 71,564,276	$ 142,493,980
Federal Funds	75,348,398	38,709,117	77,074,994
General Revenue	66,952,637	32,855,159	65,418,986
FMAP	*59.15%*	*54.09%*	*54.09%*

VIII. Nursing and Hospice Care

Nursing and Hospice Care			
		All Funds	**General Revenue**
FY 2019	Final	$316,748,108	$154,022,945
FY 2020	Final	$350,577,089	$150,609,446
FY 2021	May CEC Adopted	$368,000,000	$170,139,645
	Current	**$357,933,406**	**$148,703,433**
	Surplus over May CEC	*$10,066,594*	*$21,436,212*
FY 2022	Current	**$368,585,695**	**$167,033,822**

EOHHS' estimate of $357.9 million for FY 2021 reflects a $10.1 million surplus against the May CEC. The enhanced FMAP associated with the public health emergency contributes $16.8 million in GR relief in FY 2021.

In FY 2022, EOHHS is forecasting $368.6 million, a 3.0% increase above the current fiscal year. The increase is driven almost exclusively by the inflationary rate increase set to occur in October 2021, estimated to be $8.4 million.

Note that the FY 2021 and FY 2022 estimates include an adjustment for hospice due to CMS' Medicare minimum hospice rates effective October 1, 2020. The adjustment contributes less than $10,000 over the two-year period.

A delineation of the nursing home and hospice expenditure forecasts, and associated trend assumptions are presented in **Table VIII-1**, **Table VIII-2** and **Table VIII-3**, respectively. Additional information on paid days is presented in **Attachments 4a**, **4b,** and **4c**.

Information on total nursing home days as required for reporting purposes under the Perry-Sullivan law will be furnished to the conferees under separate cover.

For information specific to EOHHS' interim payments and reconciliation process please see **Major Developments** and responses provided in **Attachment 8**.

Table VIII-1. Summary of Nursing Home and Hospice Expenditures

	SFY 2020:	**SFY 2021:**			**SFY 2022:**	
	Final	**May CEC**	**Current**	**Over/ (Under)**	**Current**	**Increase/ (Decrease) over FY21**
Nursing Home Days	$ 317,049,049	$ 341,493,320	$ 322,604,634	$18.9 M	$ 332,203,838	$9.6 M
Hospice	34,063,426	26,506,680	32,422,057	($5.9 M)	33,387,940	$1.0 M
Advances[1]	$ 5,317,697		$ 2,906,715		$ 2,993,917	
Prior Period Activity/Accruals	*(5,853,085)*					
Grand Total	**$ 350,577,089**	**$ 368,000,000**	**$ 357,933,406**	$10.1 M	**$ 368,585,695**	$10.7 M
General Revenue	*$ 150,609,446*	*$ 170,139,645*	*$ 148,703,433*	*$21.4 M*	*$ 167,033,822*	*$18.3 M*

Note 1. Advances do not reflect total advances made in SFY. It represents outstanding advances for incurred services without offsetting claim.

Table VIII-2. Nursing Home Medicaid Per Diem before Patient Share (Average)

Rate Effective	Avg Per Diem[1]
1-Oct-19	$230.00
1-Apr-20[2]	$250.69
1-Jul-20	$230.00
1-Oct-20	$235.52
1-Oct-21	$242.59

[1] Rate is prior to patient share.
[2] 10% increase to Direct Care, Indirect Care, Other Direct Care. No adjustment to FRV, Policy Adj, Taxes.

Table VIII-3. FY 2022 Nursing and Hospice Care Trend Assumptions (inc. Expansion FFS)

	Percent	Dollar Impact	Comments
Price	3.00%	$ 8,361,609	CMS Market Basket Forecast Skilled Nursing Facility (SFY21)
Utilization	0.00%	$ -	EOHHS
Total		**$ 8,361,609**	

Derivation of FY 2021 and FY 2022 Forecast

In a "normal" fiscal year, given stability in caseload and utilization, the average paid expenditures in a month is a reasonable proxy of the anticipated level of fee-for-service activity likely to be incurred in that same month. However, with the fluctuations in nursing home claims payments as well in contingency payments and recoupments, in addition to potential COVID impacts and the transition of members from Rhody Health Options to fee-for-service, it is unlikely that this assumption holds true.

Therefore, as in previous CEC testimonies for this budget line, to derive a monthly baseline from which to forecast its nursing home expenditures for FY 2021 and FY 2022 estimate, EOHHS considered both its historical nursing home claims data and its contingency payment data. Instead of relying upon what EOHHS *paid* each month, EOHHS estimated what its members *incurred* each month. To do so, EOHHS employed an approach that it used for estimating its year-end accruals and that is widely utilized by actuaries in rate development to calculate any outstanding liability of activity that is incurred but not reported (IBNR).

This approach is necessary because providers can generally submit claims up to 12-months after the date of service. While a significant proportion of claims are submitted well before this deadline, it is not uncommon for claims to be paid many months after the date of service for cases where there is an LTSS application pending. Given the large volume of claims impacting this budget line, even with a relatively fast "completion factor" or minimal "lag," there are millions of dollars in liability that remain outstanding even several months after the date of service.

This application of an IBNR methodology that considers the average lag between when a service was provided and when the provider was paid for that service, however, is complicated in the case of nursing home payments due to the interaction of the advances and claims that would lead to an overstating of the typical lag. EOHHS' approach addresses this concern.

Specifically, EOHHS:

1. Estimated the monthly average amount spent on dates of service from July 2019 through February 2020 (adjusted for October 1, 2019 rate increase, but pre-COVID impact) which was $25.8 million per month.
2. EOHHS subsequently applied the appropriate price factors based on R.I.G.L and applied a 2% utilization/acuity increase to derive the FY 2021 estimate. No further utilization adjustment was made for FY 2022.

3. Finally, EOHHS made an adjustment for the activity incurred by the facilities but not yet submitted to MMIS due to contingency payments and eligibility delays. *Please note that this is different than the total amount of spending on contingency payments made each month.* EOHHS added $2.9 million each year because there are $2.9 million in contingency payments (after adjusting for rate increases) for FY2020 dates of service that do not yet have a claim paid.

Of note, the above methodology does not distinguish between Medicare Days or Medicaid Days.

IX. Home and Community Care

Home and Community Care			
		All Funds	**General Revenue**
FY 2019	Final	$70,243,474	$32,624,518
FY 2020	Final	$79,837,678	$33,247,145
FY 2021	May CEC Adopted	$87,300,000	$40,328,235
	Current	**$83,968,044**	**$34,884,524**
	Surplus over May CEC	*$3,331,956*	*$5,443,711*
FY 2022	Current	**$84,184,176**	**$38,150,164**

EOHHS is projecting Home and Community Based Services (HCBS) expenditures in FY 2021 to total $83.9 million, or $3.3 million less than the May CEC. The enhanced FMAP associated with the COVID-19 emergency period contributes $3.9 million in GR relief in FY 2021.

The FY 2022 forecast of $84.2 million is marginally higher than the SFY 2021 estimate.

Table IX-1 delineates the FY 2021 and FY 2022 expenditures compared to FY 2020 close. The caseload and price trend assumptions used for the FY 2022 estimate are shown in **Table IX-2**. Enrollment projections are presented in **Table IX-3**.

Table IX-1. Summary of Home and Community Care Expenditures

	SFY 2020:	**SFY 2021:**			**SFY 2022:**	
	Final	**May CEC**	**Current**	**Surplus/ (Deficit)**	**Current**	**Increase/ (Decrease) over FY21**
Capitation						
PACE	$ 15,630,090	$ 17,273,219	$ 16,699,509	$0.6 M	$ 17,241,859	$0.5 M
FFS Claims						
Assisted Living	$ 9,803,312	$ 8,731,392	$ 8,832,773	($0.1 M)	$ 8,832,773	$0.0 M
Shared Living	3,788,011	4,018,398	3,628,622	$0.4 M	3,628,622	$0.0 M
Adult Day	3,441,353	5,035,901	4,654,089	$0.4 M	4,654,089	$0.0 M
Personal Choice	9,570,789	10,261,637	9,203,282	$1.1 M	9,203,282	$0.0 M
Home Care	38,902,946	39,517,889	38,571,573	$0.9 M	38,245,355	($0.3 M)
Other HCBS	1,754,479	2,461,564	2,378,196	$0.1 M	2,378,196	$0.0 M
Subtotal FFS	**$ 67,260,890**	**$ 70,026,781**	**$ 67,268,535**	$2.8 M	**$ 66,942,317**	($0.3 M)
Prior Period Activity/Accruals	*(3,053,302)*					
Grand Total	**$ 79,837,678**	**$ 87,300,000**	**$ 83,968,044**	$3.3 M	**$ 84,184,176**	$0.2 M
General Revenue	*$ 33,247,145*	*$ 40,328,235*	*$ 34,884,524*	*$5.4 M*	*$ 38,150,164*	*$3.3 M*

Table IX-2. FY 2022 Home and Community Care Trend Assumptions

	Percent	Dollar Impact	Comments
Price			
PACE	3.37%	$ 561,930	EOHHS
Assisted Living	0.00%	$ -	N/A. These rates are not changed annually
Personal Care	3.40%	$ 1,332,112	NE Consumer Price Index
Other HCBS	0.00%	$ -	N/A. These rates are not changed annually
		$ 1,894,042	
Utilization			
PACE	-0.85%	$ (142,900)	EOHHS
Assisted Living	0.00%	$ -	EOHHS
Personal Care	0.00%	$ -	EOHHS
Other HCBS	0.00%	$ -	EOHHS
		$ (142,900)	
Total, Price/Volume		**$ 1,751,141**	

Table IX-3. Home and Community Based Services Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Over/ (Under)	Current	Increase/ (Decrease) over FY21
PACE	338	361	353	(8)	350	(3)
Remaining in FFS:						
Assisted Living	507	586	537	-49	540	3
Shared Living	152	185	179	-6	180	1
Personal Choice	352	404	368	-36	372	4
Home Care	2,051	2,264	2,253	-11	2,280	27
Core Community Services	1,503	1,668	1,616	-52	1,632	16
Other HCBS	35	30	24	-6	24	0
Subtotal HCBS	**3,097**	**3,468**	**3,361**	**-107**	**3,396**	**35**

Table IX-4. Summary of PACE Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
Medicaid Only	$6,730	$6,887	$7,128	3.5%
Dual, 55-64 y.o.	$3,739	$3,831	$3,965	*3.5%*
Dual, 65+ y.o.	$3,589	$3,677	$3,806	*3.5%*
Composite	*$3,875*	*$3,969*	*$4,103*	*3.4%*

Note.

1. Rates are net of average patient share.

X. Pharmacy

Pharmacy			
		All Funds	**General Revenue**
FY 2019	Final	($462,718)	$6,333
FY 2020	Final	($2,557,764)	($798,257)
FY 2021	May CEC Adopted	$428,110	$447,766
	Current	**($791,566)**	**($78,856)**
	Surplus over May CEC	*$1,219,676*	*$526,621*
FY 2022	Current	**($822,420)**	**($122,700)**

EOHHS' revised forecast for FY 2021 is $1.2 million less than the May CEC, with the net credit to the budget line attributed to higher than anticipated rebates.

The FY 2022 estimate remains relatively flat compared to the current year.

FY 2021 and FY 2022 Pharmacy expenditures and rebates are presented in **Table X-1** as well as in **Major Developments**. The trend assumptions used for these forecasts are shown in **Table X-2**. (Note the 0% on the rebates line indicates that EOHHS did not adjust rebates for utilization or enrollment.)

As previously explained, this minimal appropriation, in this instance a net savings, is due to:

(1) CMS' rebate formula, which, for certain drugs, can compensate for significant price increases;
(2) Medicaid being entitled to the full rebate amount even if it only pays a portion of a drug claim; and
(3) the Pharmacy budget line reflecting J-Code rebates collected against pharmaceuticals delivered in an outpatient hospital setting.

Also, the Quarterly Rebate Offset Amount (QROA) is a state remittance to CMS that is a reduction to the general revenue savings attributed to drug rebate collections and is also budgeted to this line.

Table X-1. Summary of Pharmacy Expenditures

	SFY 2020:	**SFY 2021:**			**SFY 2022:**	
	Final	**May CEC**	**Current**	**Surplus/ (Deficit)**	**Current**	**Increase/ (Decrease) over FY21**
FFS Claims						
Pharmacy	$ 6,130,827	$ 6,740,448	$ 6,021,540	$0.7 M	$ 6,174,641	$0.2 M
DRE	(6,899,096)	(4,883,399)	(4,715,649)	($0.2 M)	(4,842,972)	($0.2 M)
J-Code	(2,054,317)	(1,428,939)	(2,097,457)	($0.1 M)	(2,154,089)	($0.1 M)
Subtotal Pharmacy	**$ (2,822,586)**	**$ 428,110**	**$ (791,566)**	($0.0 M)	**$ (822,420)**	($0.2 M)
Prior Period Activity/Accruals	*264,822*					
Grand Total	**$ (2,557,764)**	**$ 428,110**	**$ (791,566)**	$1.2 M	**$ (822,420)**	($0.0 M)
General Revenue	*$ (798,257)*	*$ 447,766*	*$ (78,856)*	*$0.5 M*	*$ (122,700)*	*($0.0 M)*

Table X-2. FY 2022 Pharmacy Trend Assumptions (includes Managed Care and Expansion FFS)

	Percent	Dollar Impact	Comments
Price	2.70%	$ 244,382	Average IHS inflation factors
Utilization	0.00%	$ -	EOHHS
Rebates	0.00%	$ -	EOHHS
		$ 244,382	

XI. Pharmacy Claw Back (Medicare Part D)

Pharmacy Claw Back (Medicare Part D)			
		All Funds	**General Revenue**
FY 2019	Final	$72,001,485	$72,001,485
FY 2020	Final	$64,978,689	$64,978,689
FY 2021	May CEC Adopted	$74,439,380	$74,439,380
	Current	**$65,723,517**	**$65,723,517**
	Surplus over May CEC	*$8,715,863*	*$8,715,863*
FY 2022	Current	**$75,772,723**	**$75,772,723**

EOHHS' revised FY 2021 estimate of $65.7 million for Pharmacy Claw Black is $8.7 million less than the May CEC. The improved position reflects reductions due to the enhanced FMAP reducing the states' multiplier for the duration of the public health emergency through March 2021. This revised forecast is based on actual caseload and Part D payments made through August 2020 as reflected in the monthly invoices from CMS to Rhode Island. The increase in FY 2022 over FY 2021 is attributed to the increase in the multiplier following the assumed elimination of the enhanced FMAP in the last quarter of FY 2021.

Table XI-1. Summary of Pharmacy Claw Back Expenditures

	SFY 2020:	**SFY 2021:**			**SFY 2022:**	
	Final	**May CEC**	**Current**	**Surplus/ (Deficit)**	**Current**	**Increase/ (Decrease) over FY21**
Medicare Premiums - Part D	$ 65,366,171	$ 74,439,380	$ 65,723,517	$8.7 M	$ 75,772,723	$10.0 M
Prior Period Activity/Accruals	*(387,483)*					
				Change		**Change**
PMPM	$147.97	$165.17	$145.62	($19.55)	$163.64	$18.02
Jul-Sept	$155.52	$162.31	$140.92	($21.39)	$162.89	$21.97
Oct-Dec	$154.27	$161.24	$136.99	($24.25)	$160.98	$23.99
Jan-Mar	$140.92	$168.50	$141.42	($27.08)	$165.33	$23.91
Mar-Jun	$140.92	$168.50	$162.89	($5.61)	$165.33	$2.44
Average Enrollment	**36,813**	**37,557**	**37,612**	**55**	**38,587**	**975**

Table XI-2. Pharmacy Claw Back Price-Volume Comparison to May CEC and Prior SFY

	Price	**Volume**	**Net**
FY 2021 over FY 2020	-$1,038,834	$1,396,179	$357,345
	-1.6%	2.2%	0.5%
FY 2021: Nov 2020 over May 2020	-$8,811,243	$95,379	-$8,715,863
	-11.8%	0.1%	-11.7%
FY 2022 over FY 2021	$8,134,614	$1,914,593	$10,049,207
	12.4%	2.6%	15.3%

XII. Other Medical Services

Other Medical Services			
		All Funds	**General Revenue**
FY 2019	Final	$124,318,646	$49,770,341
FY 2020	Final	$132,525,103	$46,176,404
FY 2021	May CEC Adopted	$143,500,000	$53,608,483
	Current	**$137,952,165**	**$44,459,345**
	Surplus over May CEC	*$5,547,835*	*$9,149,137*
FY 2022	Current	**$141,329,994**	**$51,667,106**

EOHHS' FY 2021 revised forecast for Other Medical Services is a $5.5 million surplus over the May CEC. The enhanced FMAP associated with the COVID-19 emergency period contributes $6.9 million in GR relief in FY 2021.

The All Funds surplus is driven by a reduction in Medicare Premium Payments and lower fee-for-service expenditures, in part attributed to the assumed transfer of members into the CMS Demonstration beginning in January.

The FY 2022 forecast reflects a $3.4 million, or 2.4 percent, increase above projected FY 2021 expenditures.

A summary of expenditures for both FY 2021 and FY 2022, by type of service, is presented in **Table XII-1**. **Table XII-2** summarizes all Other Medical Services expenditures subject to a non-regular matching rate. The pricing and caseload assumptions used for the FY 2022 forecasts are shown in **Table XII-4**.

Medicare Part A/B Premium Payments

Expenditures for FY 2021 are projected to total $77.3 million which is $2.5 million less than the May adopted estimate. The decrease is due to exclusively to a lower average monthly PMPM than EOHHS had previously estimated. For Part A, EOHHS' revised forecast assumes average Part A enrollment of 1,101 in FY 2021, increasing to an average of 1,155 in FY 2022. For Part B, EOHHS' forecast assumes average Part B enrollment of 39,265 in FY 2021 and 40,051 in FY 2022.

Both forecasts reflect an annualized growth rate of 2.5%, the same trend assumed in May, with EOHHS having received preliminary invoices from CMS through November 2020.

Recoveries

The FY 2020 forecast for recoveries is $11.0 million or $2.0 million less than the May CEC. EOHHS has revised this projection downward based on monthly collections to-date that average $856 thousand per month since July.

Table XII-1. Summary of Other Medical Services Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Medicare Premium Payments - Part A	$ 5,880,455	$ 6,327,815	$ 6,419,530	($0.1 M)	$ 6,697,143	$0.3 M
Medicare Premium Payments - Part B	$ 67,732,870	$ 73,454,578	$ 70,904,741	$2.5 M	$ 74,004,948	$3.1 M
Subtotal MPP	**$ 73,613,325**	**$ 79,782,393**	**$ 77,324,271**	$2.5 M	**$ 80,702,091**	$3.4 M
NEMT Capitation	$ 4,989,267	$ 5,464,347	$ 5,311,360	$0.2 M	$ 5,126,682	($0.2 M)
Other Medical Services						
Tavares	$ 7,318,788	$ 7,501,098	$ 7,496,179	$0.0 M	$ 7,599,251	$0.1 M
Rehabilitation & TCM	16,179,075	19,400,262	17,639,307	$1.8 M	17,639,307	$0.0 M
BHDDH Medicaid Program	22,457,981	23,913,108	22,203,137	$1.7 M	22,203,137	$0.0 M
Physician Services	10,765,529	15,143,797	12,552,844	$2.6 M	11,501,733	($1.1 M)
Durable Medical Equipment	3,411,764	3,486,522	3,392,373	$0.1 M	3,392,373	$0.0 M
Other Practitioners	3,210,795	3,384,813	3,245,550	$0.1 M	3,245,550	$0.0 M
Refugee Program	577,369	758,074	805,680	($0.0 M)	805,680	$0.0 M
Home Stabilization	-		570,000	($0.6 M)	1,140,000	$0.6 M
TPL Cost Avoidance (SUD Treatment)	-	(2,334,414)	(1,588,537)	($0.7 M)	(1,025,810)	$0.6 M
Subtotal Other Medical Services	**$ 63,921,301**	**$ 71,253,260**	**$ 66,316,533**	$4.9 M	**$ 66,501,222**	$0.2 M
Recoveries	$ (12,504,220)	$ (13,000,000)	$ (11,000,000)	($2.0 M)	$ (11,000,000)	($0.0 M)
Prior Period Activity/Accruals	*$2,505,430*					
Grand Total	**$ 132,525,103**	**$ 143,500,000**	**$ 137,952,165**	$5.5 M	**$ 141,329,994**	$3.4 M
General Revenue	*$ 46,176,404*	*$ 53,608,483*	*$ 44,459,345*	*$9.1 M*	*$ 51,667,106*	*$7.2 M*

Table XII-2. General Impact of Non-Regular FMAP Sources of Funds Applied to Other Medical Services

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Surplus/ (Deficit)	Current	Increase/ (Decrease) over FY21
Restricted - Children's Health Account	$ 9,981,985	$ 10,316,150	$ 10,000,000	$0.3 M	$ 10,000,000	$0.0 M
Restricted - Organ Transplant Fund	1,538	15,000	15,000	$0.0 M	15,000	$0.0 M
100% Federal - QI Medicare	(1,529,061)	(1,750,000)	(1,750,000)	$0.0 M	(1,750,000)	$0.0 M
100% Federal - Refugee Program	577,369	758,074	805,680	($0.0 M)	805,680	$0.0 M
100% State - BCCP	(220,671)	(250,000)	(250,000)	$0.0 M	(250,000)	$0.0 M

Table XII-3. Medicare Monthly Part A and Part B Premiums

	SFY 2020:	SFY 2021:			SFY 2022:	
	Final	May CEC	Current	Change	Current	Increase/ (Decrease) over FY21
Part A PMPM	$ 445.22	$ 456.55	$ 457.36	$ 0.81	$ 463.53	$ 6.17
Part A Enrollment	1,101	1,155	1,170	15	1,204	34
Part B PMPM	$ 143.69	$ 152.83	$ 147.51	$ (5.32)	$ 150.26	$ 2.75
Part B Enrollment	39,282	40,051	40,056	5	41,043	986

Table XII-4. FY 2022 Other Medical Services Trend Assumptions

	Percent	Dollar Impact	Comments
Price			
Medical & BHDDH	0.00%	$ -	N/A
Rehab & TCM	0.00%	$ -	N/A
Tavares	2.75%	$ 103,072	CMS Inpatient Market Basket Forecast less productivity adjustment. Effective January 2022.
		$ 103,072	
Utilization			
Medical & BHDDH	0.00%	$ -	EOHHS
Rehab & TCM	0.00%	$ -	EOHHS
Tavares	0.00%	$ -	EOHHS
		$ -	
Subtotal, Price/Volume		**$ 103,072**	

XIII. Attachments