April 26, 2021: May CEC Follow-Up Items

Q: Did all interim payment accruals use the assumption that 10% were not recoverable, after adjustments?

Yes, EOHHS' accrual for FY 2020 reflects the 10% of all interim payments not being recoverable. Most of the contingency payments were made prior to FY 2020.

Related but not specific to the 10% non-recoverable assumption of our receivable, the Nursing Home adjustment that RIOAG recommended in December 2020 reduced EOHHS' outstanding payable for claims associated with the earliest contingency payments made by EOHHS. In reviewing the claims' data with the auditors, EOHHS agreed to a reduction to the payable. This contributed to a $8,148,892 All Funds ($3,763,973 GR) favorable change to EOHHS' FY 2020 position.

In FY 2021 Enacted and FY 2022 Nov Adopted, EOHHS did not need to make any assumptions regarding recovery of ongoing payments as no interim payments have been made since July 2020.

Q: Run prior period rebate treatment by auditors.

Annually, EOHHS waits until mid-August to complete its DRE accruals to align when it receives a summary of invoice by Gainwell. This is generally for the Q3 period (i.e., Jan-Mar 2021). This year, we will receive prior period invoicing for Q3 of the prior year (i.e., Jan-Mar 2020).

EOHHS will discuss the treatment of other prior period DRE/J-Code collections with the auditors and keep the conferees aware of any direction given. We have sent an initial communication to begin these conversations.

Q: Why isn't difference in the size of the decline between November and May (I.e., 823 in the table below) equal to 1/3 of the difference in the growth between the two scenarios (I.e.,7,294*1/3=2,431)?

*In November, EOHHS assumed a negative underlying trend beginning in April 2021. The negative slope in **Figure 11-2** that carries through FY 2022 started in April 2021. This trend increased the number of terminations that were anticipated to occur during the initial "clean-up" period of November's enrollment numbers. In its revised May forecast, EOHHS replaced this negative trend with a flat trend. This means that the row labeled "After 1/3 Decline" is actually showing a decline larger than 1/3 for the November Adopted. If the decline in November had only been 1/3 of the growth seen between February 2020 and peak enrollment, the decline would have been 16,665, and the difference between the two projections would be approximately equal to the expected figure.*

Additionally, in this May testimony, the addition of 150 per members per month being passively enrolled into RHO was not offset with a reduction to the "Remaining in FFS" figure. This member count does not impact the FFS estimate as the actual expenditures are used to calculate FFS

expenditures (and EOHHS made a below-the-line reduction for the members shifting to RHO). Over the 6 months, however, the overall eligible count may be overstated by 900 members.

*Summary of Overall Eligible from **Figure 11-2**:*

	Nov Adopted	May CEC	Difference
Caseload at Feb 2020	292,038	292,038	0
Peak	342,033	349,327	7,294
Growth between Feb 2020 and Peak	49,995	57,289	7,294
After 1/3 Decline*	323,436	329,907	6,471
Total Decline	18,597	19,420	**823**

Q: Please provide details on hospitals cost reports and potential recoupment if hospital licensing fee changes?

EOHHS improperly stated "recoup" in its testimony on page 41 in the following sentence, "Should the Governor's recommended hospital license fee increase pass, EOHHS will need to recoup previous FY 2021 payments."

This was intended to read "adjust" as in: "Should the Governor's recommended hospital license fee increase pass, EOHHS will need to adjust previous FY 2021 payments."

A Hospital License Fee below the enacted of 5.0% would generate a recoupment, while an increase generates additional SFY 21 payment to the hospitals. The SFY 21 Gov. Rec. increases the Hospital License Fee from 5% to 6%. Doing so would increase UPL Gap by $95,045 from $7.9 million to $8.0 million.

CMS' Outpatient UPL Demonstration requires EOHHS to include Hospital License Fee (Medicaid Provider Tax) in the derivation of the Upper Payment Limit (See Model-Outpatient, Column T) The UPL model below shows the derivation of the SFY 21 UPL payments, which totaled $7.9 million and incorporated a hospital license fee of 5%.

UPL Model_HLF 5 percent_Enacted.xlsx

The SFY 21 Gov. Rec. recommended increasing the Hospital License Fee from 5% to 6%. Doing so would increase UPL Gap by $95,045 from $7.9 million to $8.0 million. The model below shows the impact by hospital.

SFY 21 Outpatient UPL_Gov Rec..xlsx

Also, in our testimony noted we do not yet have updated cost reports for three hospitals, but it is actually four hospitals: Landmark, Our Lady of Fatima, Roger Williams, and the Rehabilitation Hospital of Rhode Island. We anticipate receiving these in late summer.

Q: Please provide a monthly break-out of items in HCBS table x-1.

The spreadsheet below includes the backup for EOHHS' SFY 21 and SFY 22 projected spend in each of the items in this table. The spreadsheet includes tabs for the SFY 21 and 22 estimates, monthly spend for each line item (July 2019 to December 2020), and the estimate for the assisted living technical correction needed to tie out Table x-1.

Table X-1 Estimate Support and Backup.x

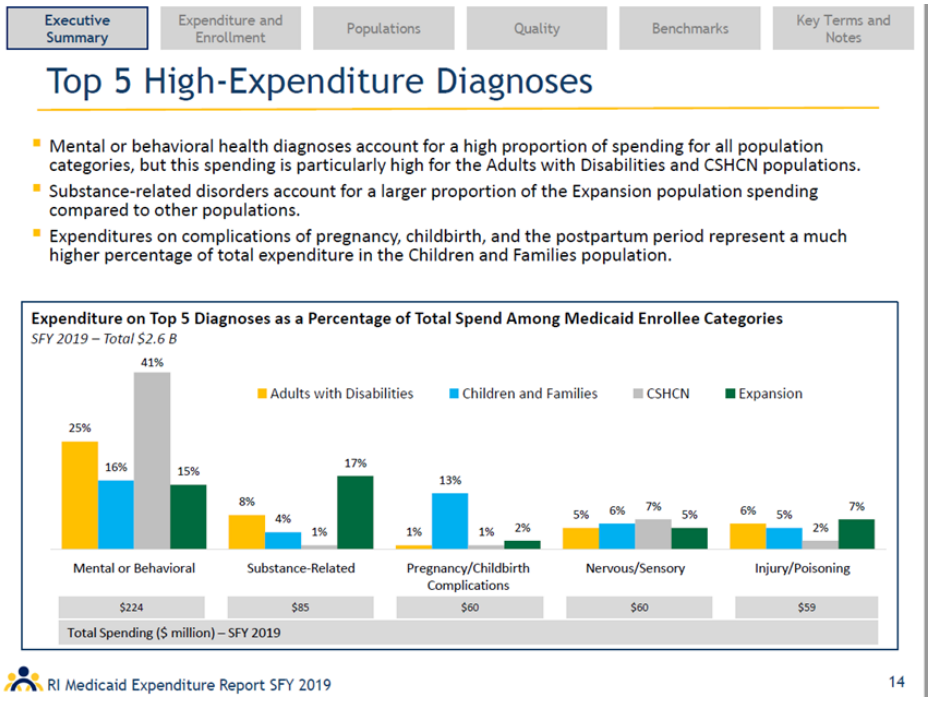
Q: Please provide details on the LTSS application backlog vs. number of applications.

	Applications	Overdue applications
April 2020	450	750
March 2021	350	100

Q: Please provide an estimate of Medicaid overall spending Behavioral Health?

In SFY 2019, Medicaid spent $224M on claims where a behavioral health condition was the primary diagnosis on the claim and $85M where substance use disorder was the primary diagnosis. Condition assignment to a behavioral health or substance use disorder classification was done using the clinical classification software (CCS) from the federal Agency for Healthcare Research and Quality.

Additionally, this exhibit is based on claims (both Managed Care and Fee For Service) present in the MMIS and is not adjusted to reflect missing managed care encounter data.



EOHHS is also providing the attached excel file as in prior years, with the tabs as described below:

May 2021 CEC - EOHHS & Principal E

1. *Principal estimates – if desired, this tab can be used to populate the adopted estimate and allocate changes made by the conferees to each budget line, with associated fund source splits calculated within the workbook on the "summary by budget line" tab.*
2. *Summary by budget line – this tab includes the full detail of expenditures reflected in EOHHS' caseload testimony.*
3. *Summary by line sequence – this tab rolls up expenditures to the applicable RIFANS line sequence account number.*
4. *Summary by type of service – SFY 2021/ SFY 2022 – These tabs allocate both FFS and MCO expenditures into broad service categories. For managed care expenditures, the amounts represented are allocated based on the share of expenditures by service category contained in the SFY 2021 managed care rate certification.*
5. *Forecast – this tab includes monthly enrollment and eligibility detail used in the caseload estimate. For managed care, the estimated liability for capitation payments used in the department's forecast is also included. For FFS, the values represent actual eligibility for members remaining in FFS, along with enrollment in various waiver programs. As mentioned in response to previous testimony, not all members*

enrolled in a particular waiver program are active users. EOHHS' estimates for FFS rely on actual FFS activity paid on behalf of eligible members.

6. *MPP: Includes actual and forecasted enrollment in the Medicare Premium Payment programs.*
7. *DRE + J-Code – Includes actual and invoiced DRE/J-Code rebates along with associated PMPMs used in EOHHS' rebate forecast*
8. *FFS Est – includes historical and projected FFS activity by budget line and service category (completed for IBNR) used in the FFS forecast*

EOHHS is working on rebasing FY22 initiatives, and will finalize those estimates as soon as the conferees adopted final estimates.

While working on this rebasing, EOHHS noticed that the Nursing Home Days SFY 22 Nov. CEC amount ($335,197,755) included in Table IX-1 on page 48 (shown below) was lower than the actual adopted CEC amount ($337,325,000) used in the initiatives in the Governor's budget and the forthcoming rebasing.

This has no impact on EOHHS forecast or the overall surplus of the budget line, only the relative surplus between the two components of the budget line. The total Nursing and Hospice line is consistent in either approach. The difference is due to treatment of the conferees "add" to the EOHHS November CEC testimony, and how much was allocated to Nursing Homes. In the May CEC testimony, the amount of the "add" to this line was allocated to hospice instead of nursing homes.

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Nursing Home Days	$ 315,423,306	$ 325,511,349	$ 297,094,118	$28.4 M	$ 335,197,755	$ 325,834,001	$9.4 M	$28.7 M
Hospice	31,241,630	37,488,651	33,205,882	4.3 M	38,302,245	33,865,999	4.4 M	0.7 M
Subtotal FFS	**$ 346,664,935**	**$ 363,000,000**	**$ 330,300,000**	$32.7 M	**$ 373,500,000**	**$ 359,700,000**	$13.8 M	$29.4 M
Prior Period Activity/Accruals	*(2,580,925)*							
Grand Total	**$ 344,084,010**	**$ 363,000,000**	**$ 330,300,000**	$32.7 M	**$ 373,500,000**	**$ 359,700,000**	$13.8 M	$29.4 M
General Revenue	*$ 146,519,287*	*$ 150,808,350*	*$ 132,103,485*	*$18.7 M*	*$ 169,260,863*	*$ 151,865,340*	*$17.4 M*	*$19.8 M*