MAY 2021

CASELOAD ESTIMATING CONFERENCE

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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I. General Considerations

Medical Benefits			
		All Funds	**General Revenue**
FY 2019	Final	$2,448,125,822	$949,397,045
FY 2020	Final	$2,420,224,903	$871,590,802
FY 2021	Enacted	$2,763,433,407	$939,951,700
	Current	**$2,739,401,035**	**$897,552,916**
	Surplus over Enacted	*$24,032,372*	*$42,398,784*
FY 2022	November CEC	$2,733,814,580	$1,009,281,230
	Current	**$2,974,593,980**	**$1,012,581,344**
	Deficit over Nov CEC	*($240,779,400)*	*($3,300,115)*

For FY 2021, Rhode Island's Executive Office of Health and Human Services (EOHHS) anticipates expenditures of **$2,739,401,035** All Funds, a **$24.0 million surplus** compared to FY 2021 Enacted. EOHHS' revised estimate for FY 2021 includes **$897,552,916** from General Revenue (GR), reflecting a **$42.4 million surplus**, 4.5% less than Enacted.

Please note that the FY 2021 Enacted included three quarters of the 6.20 percentage point increase to the Federal Medical Assistance Percentage (FMAP) under Section 1905(b) of the Social Security Act, resulting from a continuation of the provisions included as part of the Families First Coronavirus Response Act. EOHHS' current forecast includes enhanced FMAP through December 31, 2021. The additional quarter of relief in FY 2021 accounts for approximately 60% of the current year's general revenue surplus.

For FY 2022, EOHHS projects expenditures of **$2,974,593,980 All Funds**, including **$1,012,581,344 GR**. This reflects a **$3.3 million GR deficit** compared to November CEC Adopted for FY 2022. Note the FY 2022 estimate includes two additional quarters beyond what was assumed in November CEC of the enhanced FMAP. Other key drivers are highlighted in Section II.

Table I-1 compares EOHHS' current FY 2021 forecast to the Enacted and FY 2022 forecast to Nov CEC Adopted. ***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 Final.

As shown in **Table I-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 **325,293**. Additional caseload metrics are summarized in **Table I-3**. The downward revisions to Rhode Island's Medicaid caseload are driven by reductions in the Fee-for-Service population and slower than anticipated enrollment growth across all eligibility groups except childless adults (i.e. Medicaid Expansion). Nonetheless, the still-significant average 8.9% caseload increase over FY 2020 reflects the enrollment growth due to the COVID-19 pandemic and termination moratorium.

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**. A summary of the relative import of changes in net caseload and unit costs within each fiscal year and across the fiscal years are summarized in **Table I-4**.

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

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Summary by Budget Line								
Hospitals - Regular	$ 47,109,165	$ 55,937,481	$ 53,900,000	$2.0 M	$ 49,000,000	$ 54,300,000	($5.3 M)	$0.4 M
Hospitals - DSH	142,083,257	142,301,035	142,301,035	0.0 M	71,564,276	142,493,980	(70.9 M)	0.2 M
Nursing and Hospice Care	344,084,010	363,000,000	330,300,000	32.7 M	373,500,000	359,700,000	13.8 M	29.4 M
Home and Community Care	82,506,503	85,000,000	90,600,000	(5.6 M)	86,000,000	92,700,000	(6.7 M)	2.1 M
Managed Care	692,537,418	795,200,000	802,800,000	(7.6 M)	806,300,000	859,600,000	(53.3 M)	56.8 M
Rhody Health Partners	259,995,219	285,600,000	288,800,000	(3.2 M)	294,300,000	296,500,000	(2.2 M)	7.7 M
Rhody Health Options	133,751,933	132,600,000	128,000,000	4.6 M	151,700,000	144,800,000	6.9 M	16.8 M
Expansion	487,344,918	640,790,064	665,900,000	(25.1 M)	642,000,000	767,400,000	(125.4 M)	101.5 M
Pharmacy	(2,611,387)	(791,566)	(100,000)	(0.7 M)	(822,420)	100,000	(0.9 M)	0.2 M
Clawback	64,978,689	65,723,517	58,100,000	7.6 M	75,772,723	69,100,000	6.7 M	11.0 M
Other Services	125,661,850	138,534,296	134,300,000	4.2 M	140,000,000	143,400,000	(3.4 M)	9.1 M
Subtotal CEC EOHHS Benefits	**$ 2,377,441,575**	**$ 2,703,894,827**	**$ 2,694,901,035**	$9.0 M	**$ 2,689,314,580**	**$ 2,930,093,980**	($240.8 M)	$235.2 M
Health System Transformation Project	26,427,934	40,000,000	25,000,000	15.0 M	25,000,000	25,000,000	0.0 M	0.0 M
Special Education	16,355,394	19,538,580	19,500,000	0.0 M	19,500,000	19,500,000	0.0 M	0.0 M
Total EOHHS Benefits	**$ 2,420,224,903**	**$ 2,763,433,407**	**$ 2,739,401,035**	$24.0 M	**$ 2,733,814,580**	**$ 2,974,593,980**	($240.8 M)	$235.2 M
change over prior SFY			*13.2%*			*8.6%*		
By Funding Source								
Federal Funds	$ 1,525,633,637	$ 1,800,266,707	$ 1,823,583,119	($23.3 M)	$ 1,714,518,350	$ 1,944,219,840	($229.7 M)	$120.6 M
General Revenue	871,590,802	939,951,700	897,552,916	42.4 M	1,009,281,230	1,012,581,344	(3.3 M)	115.0 M
Restricted Receipts	23,000,464	23,215,000	18,265,000	5.0 M	10,015,000	17,792,796	(7.8 M)	(0.5 M)
All Funds	**$ 2,420,224,903**	**$ 2,763,433,407**	**$ 2,739,401,035**	$24.0 M	**$ 2,733,814,580**	**$ 2,974,593,980**	($240.8 M)	$235.2 M

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

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	
Average Monthly Enrollment, by Delivery System:								
Managed Care	255,959	286,206	284,099	(2,107)	278,472	301,631	23,159	17,532
RIte Care Core	147,378	164,870	157,959	(6,911)	152,849	163,745	10,896	5,786
RIte Care CSHCN	9,564	10,598	9,859	(739)	9,908	9,753	(155)	(106)
Expansion	70,321	80,493	88,389	7,896	86,127	99,111	12,984	10,722
Rhody Health Partners	14,572	15,659	14,640	(1,019)	14,532	14,633	101	(7)
Rhody Health Options	13,785	14,225	12,900	(1,325)	14,706	14,029	(677)	1,129
PACE	339	361	352	(9)	350	360	10	8
RIte Share	3,044	3,005	2,622	(383)	2,544	2,544	0	(78)
Remaining in FFS	39,572	44,438	38,572	(5,866)	39,219	37,144	(2,075)	(1,428)
Children and Families	7,860	8,906	7,653	(1,253)	9,218	7,428	(1,790)	(225)
CSHCN	2,283	2,494	2,176	(318)	2,161	2,256	95	80
Expansion	5,141	7,183	3,602	(3,581)	3,914	3,383	(531)	(219)
Aged, Blind and Disabled	24,288	25,855	25,141	(714)	23,926	24,077	151	(1,064)
Total	298,575	333,649	325,293	(8,356)	320,235	341,319	21,084	16,026
change over prior fiscal year			*8.9%*			*4.9%*		

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

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	
EFP Only	1,783	1,771	1,693	(78)	1,713	1,596	(117)	(97)
Rite Smiles	111,347	125,065	121,267	(3,798)	134,051	131,788	(2,263)	10,521
Non-Emergency Transportation	287,023	322,708	319,334	(3,374)	315,150	334,659	19,509	15,325
SOBRA Births	4,612	4,683	4,469	(214)	4,559	4,496	(63)	27
NICU Stays	599	620	589	(31)	604	591	(13)	2

Table I-4. Overall Price-Volume Analysis, All Funds (excludes HSTP & Special Education)

	Price	Volume	Net
FY 2021: Current over Enacted	$60.2 M	($69.2 M)	($9.0 M)
	2.2%	-2.5%	-0.3%
FY 2022: Current over Nov CEC	$59.8 M	$181.0 M	$240.8 M
	2.2%	6.6%	9.0%
FY 2021 over FY 2020	$96.1 M	$221.3 M	$317.5 M
	4.0%	8.9%	13.4%
FY 2022 over FY 2021	$97.6 M	$137.6 M	$235.2 M
	3.6%	4.9%	8.7%

II. 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 since Enacted for FY 2021 and November CEC for FY 2022

With respect to FY 2021, the $9.0 million All Funds surplus and $42.4 million GR surplus represent favorable variances of 0.4% and 4.5%, respectively, against the Enacted.[1] **Table II-1** summarizes the components of this surplus—with about half of favorable GR change attributed to the enhanced FMAP.

For FY 2022, the $240.8 million All Funds deficit and $3.3 million GR deficit represent unfavorable variances of 8.8% and 0.3%, respectively, to Nov CEC. **Table II-2** summarizes the components of this FY 2022 deficit. Approximately half of the General Revenue deficit is attributed to higher than anticipated caseload due to extension of moratorium on regular termination activity through December 31, 2021. The favorable nursing facility/hospice variance is attributable to a slight reduction in price and reduced utilization. The unfavorable FFS Activity excluding nursing facility and hospice is largely due to higher HCBS and inpatient hospital utilization. This increase GR cost is largely offset by the continuation of the 6.2% increase to the FMAP rate through first half of FY 2022.

The discrete drivers of the relative variances against EOHHS' prior forecasts are explained in more detail below and throughout this document.

Table II-1. Summary of Changes to FY 2021 Fiscal Position Compared to Enacted

	FY 2021:	
	All Funds	General Revenue
Favorable Variance		
COVID-19 Enhanced FMAP	$0.0 M	$25.6 M
Non RIte Care/Expansion Capitation	$7.7 M	$3.1 M
SOBRA and NICU	$3.7 M	$1.4 M
Medicare Premium Payment	$7.8 M	$7.7 M
Nursing Home & Hopsice	$32.7 M	$15.1 M
FFS Activity excl. Nursing Home/Hospice	$16.6 M	$3.2 M
Risk Share/Stop Loss	$6.4 M	$2.4 M
Subtotal Favorable	**$74.8 M**	**$58.5 M**
Unfavorable Variance		
RIte Care Capitation	($20.1 M)	($8.0 M)
Expansion Capitation	($31.0 M)	($3.3 M)
Rebates	($14.0 M)	($4.2 M)
DSH/UPL/GME	($0.3 M)	($0.4 M)
All Other	($0.4 M)	($0.3 M)
Subtotal Unfavorable	**($65.8 M)**	**($16.1 M)**
Total	**$9.0 M**	**$42.4 M**

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

Table II-2. Summary of Changes to FY 2022 Fiscal Position Compared to November CEC Adopted

	FY 2022:	
	All Funds	General Revenue
Favorable Variance		
COVID-19 Enhanced FMAP	$0.0 M	$58.9 M
Non RIte Care/Expansion Capitation	$2.2 M	$1.3 M
SOBRA and NICU	$0.6 M	($0.1 M)
Medicare Premium Payment	$7.5 M	$7.0 M
Nursing Home & Hopsice	$13.8 M	$6.2 M
Rebates	$9.0 M	$1.8 M
Risk Share/Stop Loss	$1.0 M	$0.1 M
All Other	$0.5 M	$0.2 M
Subtotal Favorable	**$34.5 M**	**$75.5 M**
Unfavorable Variance		
RIte Care Capitation	($55.8 M)	($23.9 M)
Expansion Capitation	($128.6 M)	($13.7 M)
FFS Activity excl. Nursing Home/Hospice	($16.2 M)	($7.6 M)
DSH/UPL/GME	($74.7 M)	($33.6 M)
Subtotal Unfavorable	**($275.3 M)**	**($78.8 M)**
Total	**($240.8 M)**	**($3.3 M)**

B. Disproportionate Share Hospitals

With respect to FY 2022, the November CEC Adopted for FY 2022 included $71,564,276 All Funds, based on the reduced federal allotment of $38,709,117. The *Consolidated Appropriations Act for 2021*, however, delayed the Medicaid DSH allotment reductions at least to FFY 2024. As a result of the delayed reduction, EOHHS estimates its FY 2022 (DSH Plan Year FFY 2021) unreduced federal allotment to be $77,074,994.[2] Overall, this is a $70.9 million increase over November CEC Adopted for FY 2022, contributing to a $32.6 million GR deficit. The difference between this $32.6 million and the $33.6 million GR unfavorable variance in the Table II-2 above is due to a $1.1 million GR deficit in UPL.

For more information on the treatment of DSH in the current and subsequent fiscal year, including the implications of the enhanced FMAP on financing Rhode Island's DSH payment, please see **Section VIII Hospitals - DSH.**

C. 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 November CEC, EOHHS projected savings of $2.7 million in FY 2021 and $2.2 million in FY 2022 across Rhody Health Options and Fee-for-Service. The FY 2021 estimate was higher because it assumed $500,000 in recoupments for FY 2020 activity that were not reflected in EOHHS' accruals.

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[2] This federal allotment is based on CMS communication to EOHHS, received in October 2020, that provided its draft unreduced FFY 21 DSH allotment for information purposes. As in past years this preliminary amount is based on most currently available data and is subject to revision.

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

Consistent with EOHHS' earlier testimony, these saving are reflected in EOHHS' revised forecast. The savings were incorporated into the final certified rates for the CMS Demonstration that are effective, retroactively, to July 1, 2020, and the FFS experience used for deriving the estimates for BHDDH Medical Services within the **Other Services** budget line. EOHHS' FY 2022 estimates are derived from these adjusted baselines. Further, Gainwell implemented the necessary claims edits to the MMIS and recouped approximately $0.5 million against dates of service between January 2020 and June 2020. This one-time savings is included in EOHHS' FY 2021 revised forecast for Other Services.

D. HIF Moratorium and Repeal

On December 20, 2019, H.R.1865 (the Further Consolidated Appropriations Act 2020) repealed the Health Insurance Fee (HIF) for calendar years after December 31, 2020. This eliminated the fee for 2021 (which would have been an FY 2022 expense) based on calendar year 2020 premiums. Managed Care Organizations, however, made payments in September 2020 based on calendar year 2019 premiums. EOHHS treated this recent payment as a FY 2021 expenditure based on the date in which EOHHS financed the liability.

This approach was consistent with the health plans' approach: recognition of the liability in the year in which it is due. For example, most health plans recognized their HIF liability 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.[4] Because of the acceptance of such practices in the past, EOHHS utilized the enhanced COVID-19 FMAP rate where applicable (excluding the HIF charged against Expansion premium payments that was eligible for 90/10 financing).

The cost of the tax—totaling $12.8 million ($4.2 million GR)—is not an ongoing expenditure and therefore it is not factored into the calculation of our managed care PMPMs for FY 2021 or our trended premiums for FY 2022. The actual payment made varied from Enacted because EOHHS' original estimate of $11.1 included did not properly reflect the after-tax treatment of the Health Insurer Fee.

E. Nursing Home Interim Payments and Recoupments

In May 2019, EOHHS began to offset interim payments owed to the state from nursing facilities' ongoing fee-for-service claims activity. Through March 15, 2021 EOHHS collected $114,688,353 million in recoveries against the $149.02 million in interim payments. Since July 2020 there have been no interim payments made.

Table II-3. Nursing Home Interim Payments and Recoupments through March 15, 2021, by Case Status

	Interim Payments	Recovered Amount	Outstanding Amount	Individuals
TOTAL	$149.02M	$114.68M	$34.34M	4,451
Claims Paid	$98.99M	$81.29M	$17.69M	3,125
Claims Ready to Bill	$7.87M	$6.38M	$1.48M	729
Claims Pending Eligibility	$9.63M	$1.72M	$7.90M	533
Claims Denied	$3.64M	$0.40M	$3.24M	167
Contingency Payments Prior to Feb-17	$28.88M	$24.88M	$4.00M	1,093

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.

[4] The State's Controller and Auditor General are aware of this approach.

As a reminder, at FY 2020 fiscal close, EOHHS had paid out $148.9 million in interim 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.

Other LTSS provider types

EOHHS also made interim payments to Assisted Living, Hospice, and Home Care providers. As with Nursing Homes, EOHHS plans to recoup outstanding interim payments made to these providers by offsetting amounts payments owed from their ongoing fee-for-service claims activity. However, due to the public health emergency, EOHHS has delayed these recoupments.

Table II-4. Other Provider Interim Payments and Recoupments

	Interim Payments made through 3/31/21	Interim payments recouped through 3/31/21	Outstanding through 3/31/31	Fiscal Close Assumed Recoverable (based on 90% of outstanding at fiscal close)
Assisted Living	$2,424,504	$217,806	$2,206,699	1,964,248
Hospice	$3,124,322	$312,752	$2,811,570	2,530,412
Home Care	$1,407,340	$7,359	$1,399,981	1,259,983

F. Hepatitis C

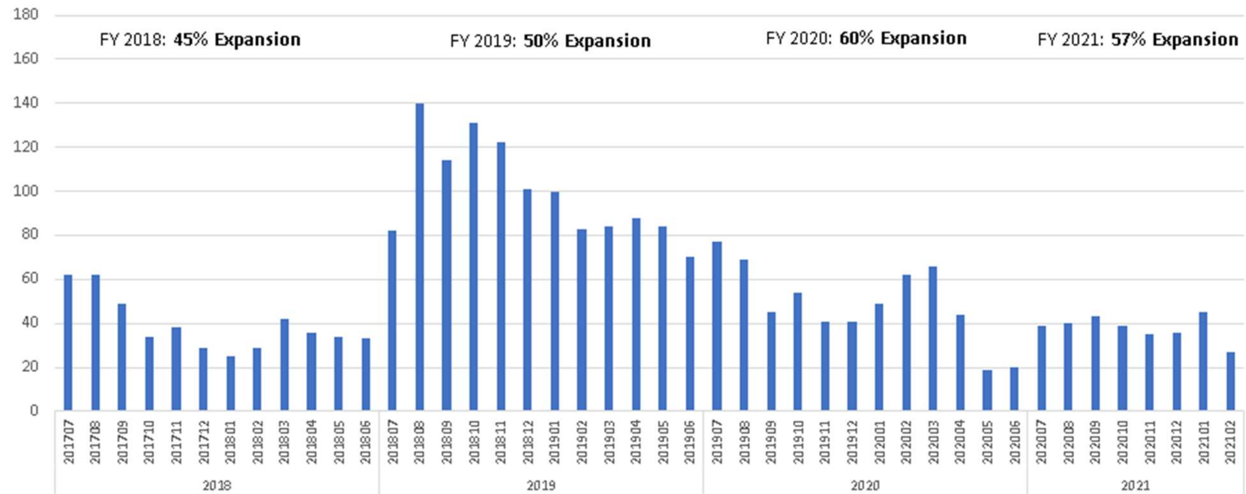
On July 1, 2018, EOHHS modified its pharmacy benefits policy to include all patients with documented Hepatitis C regardless of stage of disease. Of note, in FY 2022 EOHHS expects to fully finance the expected cost of this treatment within its capitation payments and therefore shift the funding from the separate Stop Loss program to the actuarially certified rates.

For FY 2021, EOHHS estimates stop loss payments totaling $7.0 million, a decrease of $1.6 million compared to Enacted and a reduction of $0.8 million compared to actual stop loss payments reported in FY 2020. EOHHS' FY 2022 estimate reflects a 10 percent increase to factor potential for a price increase and potential that current utilization is depressed due to patients not seeking treatment during the pandemic.

Just under 1,100 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 of primary diagnoses present on the health plans claims data performed in October 2020, 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. As such, EOHHS plans to move payment for Hepatitis C in-plan starting in FY 2022. For purposes of the caseload estimate we continue to show this funding separately, but once it moves in-plan this funding will be included in the capitation rates and will no longer be estimated separately.

Figure II-1. Members Receiving Anti-Viral Hepatitis Treatment each Month, FY 2018 - FY 2021 YTD



Given that Hepatitis C expenditures impact multiple budget lines, **Table II-4** summarizes the comparison of the enacted (and November adopted for FY 2022) to EOHHS' revised May CEC estimate, by product line.

Table II-4. Hepatitis C Stop Loss Payments

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
Stop Loss Payments by Product	**Final**	**Enacted**	**Current**	**Surplus/ (Deficit)**	**Nov CEC**	**Current**	**Surplus/ (Deficit)**	
RIte Care	$ 771,272	$ 800,000	$ 1,100,000	($0.3 M)	$ 750,000	$ 1,210,000	($0.5 M)	$0.1 M
Expansion	4,609,793	5,250,000	3,900,000	1.4 M	5,250,000	4,290,000	1.0 M	0.4 M
Rhody Health Partners	2,500,000	2,500,000	2,000,000	0.5 M	2,500,000	2,200,000	0.3 M	0.2 M
Stop Loss - Hepatitis C	**$ 7,881,065**	**$ 8,550,000**	**$ 7,000,000**	**$1.6 M**	**$ 8,500,000**	**$ 7,700,000**	**$0.8 M**	**$0.7 M**

G. 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 II-5** 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 come in lower than expected, based on invoicing through March 31, 2021 based on claims activity through December 31, 2020 (i.e., the first two quarters of FY 2021). However, rebates are expected to be higher in FY 2022 compared to prior estimate, mitigating the decline over the combined two years. The shift is primarily attributed to: (a) EOHHS' improved understanding of how prior period rebate collections are to be treated on a go-forward basis, and; (b) a modest reduction in the effective PMPM value of our rebates.

Table II-5. Summary of Drug Rebate Collections

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
DRE								
Managed Care	$ 33,731,124	$ 36,446,112	$ 37,267,279	$0.8 M	$ 35,649,495	$ 38,506,281	$2.9 M	$1.2 M
Rhody Health Partners	34,542,652	34,371,502	34,089,326	($0.3 M)	34,005,041	34,073,605	$0.1 M	($0.0 M)
Rhody Health Options	42,134	39,719	60,533	$0.0 M	44,100	65,811	$0.0 M	$0.0 M
Expansion	48,551,638	62,025,237	58,940,650	($3.1 M)	60,433,924	65,908,137	$5.5 M	$7.0 M
Fee-for-Service	6,786,897	4,715,649	4,404,289	($0.3 M)	4,842,972	4,404,289	($0.4 M)	$0.0 M
Subtotal DRE	$ 123,654,445	$ 137,598,219	$ 134,762,077	($2.8 M)	$ 134,975,532	$ 142,958,123	$8.0 M	$8.2 M
J-Code								
Managed Care	$ 3,025,979	$ 2,913,663	$ 3,307,887	$0.4 M	$ 2,847,218	$ 3,420,905	$0.6 M	$0.1 M
Rhody Health Partners	1,184,477	1,069,759	1,180,755	$0.1 M	1,058,353	1,180,210	$0.1 M	($0.0 M)
Rhody Health Options	-	-	-	$0.0 M		-	$0.0 M	$0.0 M
Expansion	2,145,500	2,411,289	2,842,416	$0.4 M	2,345,938	3,187,330	$0.8 M	$0.3 M
Fee-for-Service	2,046,345	2,097,457	1,592,648	($0.5 M)	2,154,089	1,592,648	($0.6 M)	$0.0 M
Subtotal J-Code	$ 8,402,301	$ 8,492,168	$ 8,923,706	$0.4 M	$ 8,405,598	$ 9,381,093	$1.0 M	$0.5 M
Prior Period Rebate Collections[1]	$ 21,786,629	$ 11,579,941						
Total Rebates	**$ 153,843,375**	**$ 157,670,328**	**$ 143,685,783**	**($14.0 M)**	**$ 143,381,130**	**$ 152,339,216**	**$9.0 M**	**$8.7 M**
Quarterly Rebate Offset	$ (2,014,473)	$ (2,000,000)	$ (2,110,000)	($0.1 M)	$ (2,000,000)	$ (2,110,000)	($0.1 M)	$0.0 M
General Revenue	*$ (47,346,956)*	*$ (45,527,926)*	*$ (41,305,392)*	*$4.2 M*	*$ (40,282,400)*	*$ (42,040,776)*	*($1.8 M)*	*($0.7 M)*

With respect to its current estimates, EOHHS derived its rebate forecast by dividing the average quarterly rebate amounts invoiced to the drug manufacturers between July 2020 and December 2020 by the average managed care enrollment for the same period. 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.

Additionally, EOHHS's revised forecast changes its treatment of prior period claiming based on an its improved understanding of the ongoing practice by EOHHS' fiscal intermediary now that the backlog of historical invoices has been addressed. For example, during the most recent quarter (i.e. Jan-Mar 2021), Gainwell sent out invoices to the pharmaceutical manufacturers for claims activity in the quarter ending December 31, 2020 as well as for any "new" claims activity for the quarter ending December 31, 2019. This 12-month lag will persist. Rather than including "below the line" adjustments for this prior period activity, this activity is included in the overall total invoices issued during the July to December 2020 period used to develop the PMPM multiplier.

As a result of this steady cadence in invoicing, instead of having a windfall in the current fiscal year, EOHHS anticipates collections over FY 2021 and FY 2022 will smooth out; with the increase in FY 2022 over FY 2021 reflecting increase enrollment and pharmaceutical expenditures (and not increased rebate percentage).

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.

H. 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 2021 Enacted maintained the $0.67 PMPM, or 9.0%, increase to the composite rates paid to MTM through FY 2020. The continuation of this rate increase was necessary to maintain the existing non-emergency ambulance

rates provided by MTM. This rate increase is carried forward into EOHHS' revised forecast for FY 2022 and assumed to be current law.

The overall forecast for the budget for the MTM contract is reflected in **Table II-6**.

Table II-6. Non-Emergency Transportation – Premium and Other Payments

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	Increase/ (Decrease) over SFY21
Capitation								
Managed Care	$ 7,589,336	$ 8,311,149	$ 8,182,567	$0.1 M	$ 8,361,069	$ 8,654,922	($0.3 M)	$0.5 M
Expansion	8,244,739	10,843,768	10,099,435	$0.7 M	10,129,922	11,646,247	($1.5 M)	$1.5 M
Rhody Health Partners	3,309,816	3,247,956	3,237,100	$0.0 M	3,326,827	3,339,189	($0.0 M)	$0.1 M
Rhody Health Options	3,130,587	2,928,140	2,852,946	$0.1 M	3,365,712	3,200,933	$0.2 M	$0.3 M
Other FFS	4,940,389	7,245,656	5,204,134	$2.0 M	5,126,682	5,159,936	($0.0 M)	($0.0 M)
Subtotal Medicaid Premiums	$ 27,214,866	$ 32,576,669	$ 29,576,182	$3.0 M	$ 30,310,212	$ 32,001,226	($1.7 M)	$2.4 M
TANF Charge Back	$ (1,242,710)	$ (797,326)	$ (556,841)	$0.0 M	$ (889,680)	$ (940,119)	$0.0 M	$0.0 M
Total Medicaid	**$ 25,972,156**	**$ 31,779,343**	**$ 29,019,341**	**$2.8 M**	**$ 29,420,532**	**$ 31,061,107**	**($1.6 M)**	**$2.0 M**
General Revenue				*$0.0 M*			*$0.0 M*	*$0.0 M*
Information Only (Not Included in EOHHS' Medicaid Benefits' Caseload Testimony):								
DEA Copay	$ 614,557	$ 646,243	$ 599,893	$0.0 M	$ 654,055	$ 637,609	$0.0 M	$0.0 M
Elderly Transportation Program	3,768,000	3,840,000	3,960,000	($0.1 M)	3,840,000	4,080,000	($0.2 M)	$0.1 M
Total DHS	**$ 4,382,557**	**$ 4,486,243**	**$ 4,559,893**	**($0.1 M)**	**$ 654,055**	**$ 4,717,609**	**($4.1 M)**	**$0.2 M**
Grand Total Transportation	**$ 30,354,713**	**$ 33,088,552**	**$ 33,579,234**	**($0.5 M)**	**$ 29,714,266**	**$ 35,778,716**	**($6.1 M)**	**$2.2 M**

Table II-7. Non-Emergency Transportation - Average Monthly Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	Increase/ (Decrease) over SFY21
Medicaid:								
Managed Care	164,271	179,896	177,113	-2,783	175,064	181,674	6,610	4,561
Expansion	71,052	89,128	89,535	407	86,759	100,054	13,295	10,519
Rhody Health Partners	14,570	14,686	14,636	-50	14,531	14,630	99	-6
Rhody Health Options	13,783	13,239	12,902	-337	14,699	14,028	-671	1,126
Other FFS	21,750	24,016	23,530	-486	22,392	22,607	215	-923
Subtotal Medicaid Enrollment	285,426	320,965	317,716	-3,249	313,445	332,993	19,548	15,277
Department of Human Services								
OHA Copay	1,597	1,743	1,618	-125	1,705	1,666	-39	48
Elderly Transportation Program	$260k per month	$320k per month	$330k per month	+$10k per month	$320k per month	$340k per month	+$10k per month	+$10k per month

I. Public Health Emergency, Enhanced FMAP Rate and General Revenue Savings

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA; Pub. L. 116-127) was enacted. 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, if states meet the requirements set out in that law. The requirements for receiving the enhanced FMAP that are included in the FFCRA are summarized in **Table II-8**.

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

FFCRA 6008(b) Condition	Termination Date of Condition	Nov CEC	May CEC
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.	March 31, 2021	December 31, 2021

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.	March 31, 2021	December 31, 2021
6008(b)(3): **Continuous Coverage**[5] this prevents most terminations	Expires the last day of the **month** in which the PHE ends.	January 31, 2021	December 31, 2021
6008(b)(4): **Cost sharing exemption for Testing and Treatment**	Expires the last day of the **quarter** in which the PHE ends.	March 31, 2021	December 31, 2021
Enhanced FMAP	Expires the last day of the **quarter** in which the PHE ends.	March 31, 2021	December 31, 2021

At the end of January 2021, the Biden Administration sent a letter to Governors indicating their intent to continually renew the COVID-19 Public Health Emergency (PHE) through the end of Calendar Year 2021, and that HHS will provide states with 60 days' notice prior to its expiration. The Administration hopes that this will assist states in planning for the availability of ongoing federal resources and flexibilities. We should note, however, that the last guidance for how states could re-start terminations following the conclusion of the PHE was promulgated under the previous administration. The Biden Administration has not stated whether the previous administration's guidance will remain.

EOHHS' revised estimates assume the public health emergency will be in effect through December 31, 2021. This will allow Rhode Island to claim enhanced FMAP and provides general revenue relief through December 31, 2021. In November CEC, the enhanced FMAP was only available through the March 31, 2021.

The enhanced rate does not apply to the Expansion FMAP rate or the Family Planning FMAP (presently at 90%). Nor does EOHHS assume any GR savings against its DSH payments, pending CMS clarification on the American Rescue Plan enacted in 2021. However, the increased FMAP 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.

While EOHHS' forecast for FY 2022 does not assume the enhanced FMAP for second half of the fiscal year, 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 will need to be weighed against the likely additional cost associated with not terminating any individuals if that remains as a continued requirement for accessing the higher FMAP.

Estimating Net General Revenue Savings from the Enhanced FMAP Rate

Table II-9 summarizes EOHHS' estimate of the additional federal support from the temporary increase to Rhode Island's FMAP. Overall, Rhode Island's Medicaid program anticipates approximately $122.4 million in General Revenue relief in FY 2021 and $65.9 million in FY 2022. Not included here are any savings for DCYF and BHDDH and DHS for those agency's Medicaid spending. If the Public Health Emergency continues beyond December 31, 2021, EOHHS would receive an additional $30-35 million per quarter, all else equal.

This federal relief, however, comes with the costs from increased caseload due to the combination of the pandemic's impact on the economy and the federal moratorium on terminations for the duration of the PHE. Fortunately, the direct costs to Rhode Island taxpayers will be more than offset by the additional federal relief.

Overall, EOHHS estimates the direct cost attributed to the premium payments for the added caseload to be approximately $203 million in FY 2021. Without any increase to its FMAP these additional premium payments would cost EOHHS around $38 million GR. Noteworthy, the state will also receive an additional $4.1 million in premium tax collections as a direct consequence of the higher payments by EOHHS; thereby reducing EOHHS' new

[5] Note that in regards to the continuous coverage requirement in Error! Reference source not found., CMS clarified in an Interim Final Rule released in late October 2020 and further in follow-up CMS All State Calls in November 2020 that if "the state has determined that a beneficiary one, is no longer eligible for the group in which he or she is currently enrolled and two, is eligible for another group providing the same tier of coverage, the state must transition the beneficiary to that new eligibility group." Previously, in November CEC, beneficiaries were not moved within eligibility groups.

expenditure to $34 million GR. This compares favorably to the anticipated $122.4 million in fiscal relief from the enhanced FMAP.

Overall, over the three fiscal years—FY 2020 through FY 2022—combined, Rhode Island can anticipate net general revenue relief of approximately $165 million against its Medicaid program after factoring in the new state-financed costs for its increased Medicaid caseload. (Additional Medicaid-related savings would have accrued to BHDDH, DCYF, and DHS.)

The derivation of this estimate is summarized in **Table II-10**, with estimates for FY 2020 and FY 2021 also included.

To calculate these estimates of the gross cost, EOHHS compared Medicaid's current and anticipated caseload for FY 2020 through FY 2022 to the hypothetical counterfactual of what Rhode Island's expenditures would have been over that same period absent the pandemic's impact on the economy and the moratorium on terminations. For simplicity, the estimate considers only the change in capitated payments and does not factor in additional savings and/or costs attributed to fee-for-service which remain marginal and exhibit less correlation to changes in Rhode Island's aggregate caseload.

Significantly, Rhode Island's Medicaid caseload had been trending downward through February 2020 prior to the onset of the Public Health Emergency. Therefore, as a counterfactual EOHHS assumes that absent the pandemic enrollment would have remained flat from March 2020 through the end of FY 2022. The relative change in member months compared to baseline was then considered by population group, with the more expensive Children and Special Healthcare Needs and Aged, Blind, and Disabled populations experiencing almost no growth over the past 13 months.

Table II-9. Enhanced Federal Financial Participation available under Families First Coronavirus Response Act (EOHHS Medicaid Only)

	FY 2020	FY 2021	FY 2022[1]	FY 2022 per Quarter[2]
Hospitals - Regular	$ (2,228,540)	$ (3,233,300)	$ (1,614,548)	$ (807,274)
Hospitals - DSH[3]	n/a	n/a	n/a	n/a
Nursing and Hospice Care	(20,934,648)	(20,478,600)	(11,150,700)	(5,575,350)
Home and Community Care	(3,549,580)	(5,617,200)	(2,873,700)	(1,436,850)
Managed Care				
Regular	(21,048,035)	(42,199,124)	(22,701,352)	(11,350,676)
CHIP	(1,908,598)	(4,854,663)	(2,530,700)	(1,265,350)
Rhody Health Partners	(6,288,961)	(17,658,400)	(9,064,735)	(4,532,368)
Rhody Health Options	(3,650,392)	(7,930,730)	(4,486,165)	(2,243,083)
Expansion	n/a	n/a	n/a	n/a
Pharmacy	261,050	6,200	(3,100)	(1,550)
Clawback[4]	(4,698,142)	(11,995,889)	(7,018,789)	(3,509,395)
Other Services	(4,331,464)	(8,450,600)	(4,488,800)	(2,244,400)
Subtotal CEC EOHHS Benefits	**$ (68,377,310)**	**$(122,412,306)**	**$ (65,932,589)**	**$ (32,966,294)**

1. EOHHS assumes enhanced FMAP through end of FY 2022 Q2
2. As enrollment is expected to decline in second half of FY 2022 the monthly savings will be less if PHE extended.
3. Potential COVID-19 savings replaced with General Revenue.
4. Clawback is "state only." The enhanced FMAP is reflected through a reduced Part D Multiplier.

Table II-10. Estimating Cost Associated with Moratorium on Terminations during Public Health Emergency

		Additional Member Months by Fiscal Year:		
Product:	**Feb-20 Snapshot**	**FY 2020**	**FY 2021**	**FY 2022**
RIte Care Core	145,700	17,618	171,243	239,834
RIte Care CSHCN	9,975	57	3,313	1,765
Expansion	67,697	19,316	249,784	378,652
RHP/RHO/PACE	28,232	(747)	(3,236)	10,231
Total Member Months	**251,604**	**36,244**	**421,104**	**630,482**
Average Monthly Increase in Caseload		*9,061*	*35,092*	*52,540*
Average PMPM (Managed Care Only)				
Children and Families		$266	$291	$302
Children with Special Healthcare Needs		$958	$1,078	$1,120
Expansion		$549	$617	$638
Aged, Blind, and Disabled		$1,258	$1,364	$1,391
Composite PMPM		**$398**	**$482**	**$524**
Composite PMPM (GR Only)		***$79***	***$90***	***$102***
Additional Capitation Paid by EOHHS		**$14.4 M**	**$203.0 M**	**$330.3 M**
Additional Capitation Paid by EOHHS (GR Only)		$2.9 M	$38.0 M	$64.3 M
Additional State Premium Tax Collected (2%)		$0.3 M	$4.1 M	$6.6 M
Total - GR Impact of Additional Enrollment		**$2.6 M**	**$33.9 M**	**$57.7 M**
Gross COVID-19 Relief due to Increased FMAP[1]		***$68.4 M***	***$122.4 M***	***$65.9 M***

1. Gross COVID-19 Relief reflects EOHHS Medicaid savings only. Does not include BHDDH/DCYF/DHS savings.

J. Caseload Growth and Trend Development

EOHHS' revised caseload forecasts for FY 2021 and FY 2022 are higher than prior forecasts. The overall variance in EOHHS current projections versus November CEC are presented in **Figure II-2.** This change is primarily attributed to the continued Public Health Emergency and the general moratorium on termination activity.

Through March 2021, EOHHS has observed annualized enrollment trends below the November Adopted trends. Rhode Island's recent experience during the public health emergency has been consistent with regional trends per CMS data. From February 2020 through September 2020, Rhode Island enrollment increased 8.8% while among other northeastern states (CT, MA, NH, VT, and ME) enrollment increased an average of 8.2% (ranging from 6.6% to 11.1%). Nonetheless, the increase to Rhode Island's caseload has been significant.

Figure II-3 summarizes the net change in Medicaid enrollment between February 2020, prior to the moratorium on terminations and the temporary closure of many businesses within the State, and March 2021. **Table II-11** summarizes Rhode Island's annualized trends observed from February 2020 through March 2021, by managed care program and by population group. Overall, the 40,578 increase in the Rhode Island's Medicaid enrollment between February 2020 and March 2021 reflects a gross increase of 13.9% or 12.8% annualized. But the increase has been uneven across EOHHS' different eligibility groups and its various managed care products. Eligibility among the adults in Medicaid Expansion has increased over 30% since February 2020, with enrollment expected to approach 100,000 (99,909 as of June 30, 2021, or nearly 10% of the State) by the end of the current fiscal year. Eligibility among Children and Families has increased 10%. Comparatively, eligibility for the Aged, Blind, and Disabled, and Children with Special Healthcare Needs has remained remarkably stable in the aggregate.

Figure II-2. Current Forecast compared to November CEC Adopted

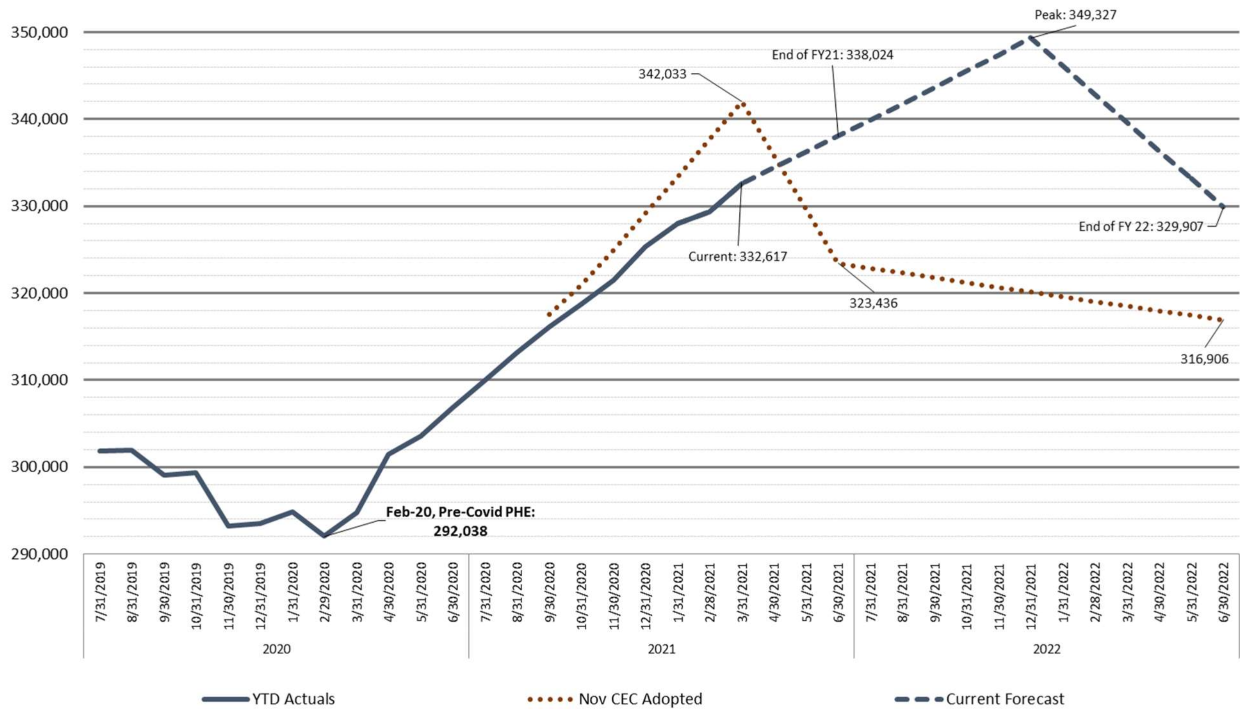


Figure II-3. Change in Full Medicaid Caseload since February 2020

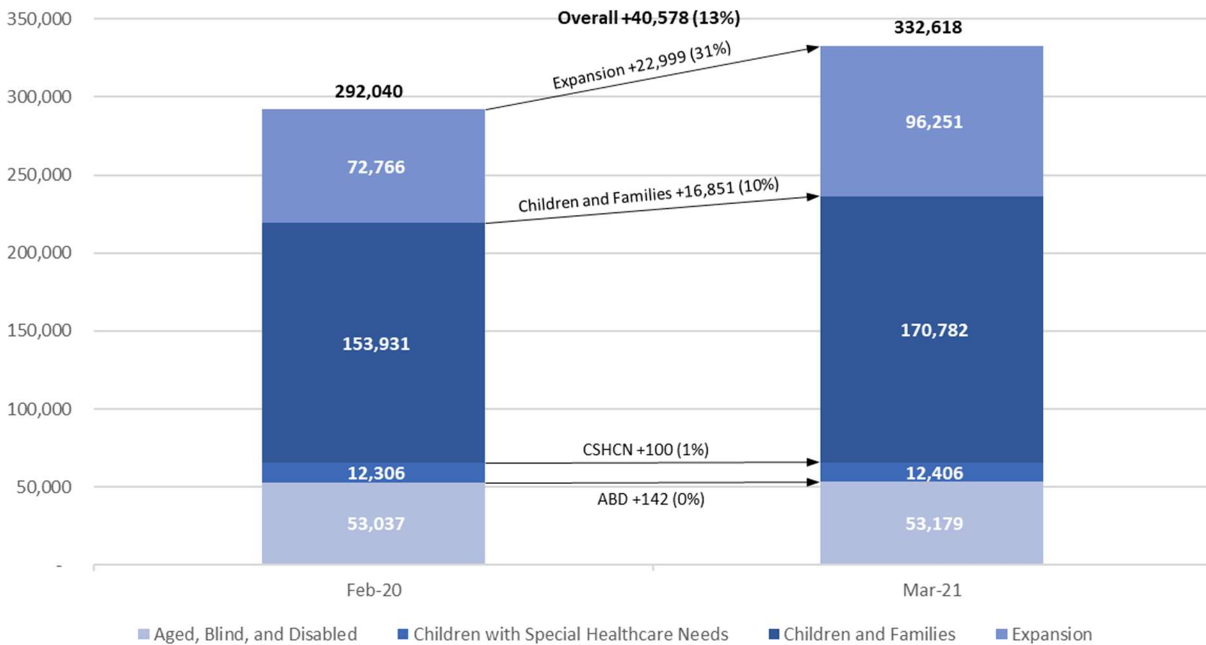


Table II-11. Current Annualized Trends for Enrollment Activity through March 31, 2021

Managed Care	Historical 2-Year Trend through Feb-20	Trend between Feb-20 and Mar-21	Trend between Dec-20 and Mar-21	Forecast Trend through Dec-21 (end of PHE)
RIte Care Core	-4.2%	11.2%	7.3%	5.4%
RIte Care CSHCN	-3.1%	2.2%	-11.2%	0.0%
Expansion	-4.6%	34.0%	25.1%	19.0%
Rhody Health Partners	-1.8%	0.5%	0.2%	0.5%
Rhody Health Options Phase II	-1.2%	-4.3%	-7.9%	16.4%
PACE	7.9%	2.4%	3.5%	3.9%
Rite Share	-26.2%	-8.4%	-21.7%	0.0%
All Managed Care (excl. RHO I)	-4.3%	15.4%	10.4%	9.6%
Overall:				
Children and Families	-4.4%	10.1%	8.2%	4.6%
Children with Special Healthcare Needs	-2.5%	0.7%	-4.1%	0.0%
Expansion	-3.5%	29.5%	18.7%	18.3%
Aged, Blind, and Disabled	-1.0%	0.2%	0.3%	0.1%
All Eligibility Groups	-3.5%	12.8%	9.2%	7.6%

Note.
1. All trends are annualized.
2. RHO Phase II trend reflects passive enrollment of 150 members per month.

The same limitations presented in November CEC still exist regarding the use of macro-economic indicators, such as unemployment and economic conditions, to predict trends in Rhode Island Medicaid enrollment. Specifically, this recession is more greatly impacting lower-income earners than prior recessions and that the maintenance of effort requirements (notably the prohibition on terminations) to maintain the enhanced FMAP during the PHE was not in place during prior recessions.

However, we now have several more months of enrollment data that EOHHS can use to derive more credible Rhode Island specific trends.

In **Table II-11,** the right-most column summarizes the trends that EOHHS is applying prospectively through the end of the Public Health Emergency. Reading the table left to right demonstrates that the annualized trend observed over the pandemic has been moderating: for example, for All Managed Care, the annualized trend between February 2020 and March 2021 is 15.4%;However, between December 2020 and March 2021 that trend has declined by about a third to 10.4%. Overall, EOHHS projects its net trend will continue to moderate, to a composite trend of 9.6%, as the economy continues to recover, vaccinations increase, and provisions of the ARP outlined below are implemented:

- ACA Marketplace Subsidy Enhancements for those currently eligible for Exchange subsidies and elimination of the 400 percent federal poverty level cap on subsidy eligibility.
- Subsidization of COBRA costs for six months for individuals becoming unemployed or facing reduced hours due to the pandemic.
- Unemployment Insurance Enhancements: All unemployment insurance provisions in the Families First Coronavirus Response Act and the CARES Act are extended through September 6, 2021.
- Federal unemployment enhancements are reduced from $400 to $300 for this period.
- Direct Stimulus Payments

Specifically, EOHHS' projection reflected in **Attachment 5a** and **Attachment 5b**, assumes that:

- Through the end of the PHE:
    - Managed Care Products experiencing a positive trend between December and March (i.e. Rite Care Core, Medicaid Expansion, PACE, and RHP) will see their three-month trend exhibited during that period reduced by one-third and applied to April 2021 through the end of the Public Health Emergency
        - Managed Care Products that have exhibited a negative trend between February 2020 and March 2021 or between December 2020 and March 2021 (Rite Care CSHCN and Rite Share) are assumed to be flat through the end of Public Health Emergency as the populations are generally stable and some of observed decline is likely attributed to higher mortality of this group prior to broader distribution of vaccine compared to Rite Care and Expansion. However, an increase of 150 members per month is assumed for CMS Demonstration (Rhody Health Options Phase II) due to passive enrollment and shift from FFS to Managed Care. This shift is not related to economy and/or public health emergency.
- The PHE will extend through December 2021, and terminations will begin to take effect 1/1/2022.
    - The Biden Administration has stated it will give States a 60-day notice before it ends the Public Health Emergency. As such, EOHHS expects DHS and EOHHS will be able to effectuate terminations in a timely manner effective January 1, 2022.
    - In November, EOHHS built in a 60-day lag between the end of the PHE and the declines in its caseload resulting from resumption of termination activity. This lag was due to the termination notice process, which takes approximately 60 days. However, the Biden administration's intent to give States a 60-day notice should allow EOHHS to align its resumption of terminations with the end of the PHE.
- Once the PHE ends, EOHHS and DHS will have to process renewals for all individuals who have had their renewal dates extended forward. CMS is allowing states 12 months to complete those renewals[6] and EOHHS' projects the full 12 months is needed.
    - EOHHS is currently doing renewals of MAGI individuals for individuals who can be passively renewed without client intervention.[7]
    - Overall, EOHHS forecast assumes that during the second half of the FY 2022 for those population groups that experienced growth, aggregate caseload will decline by one-third of the growth experienced through the entire PHE period (i.e. between March 2020 and December 2021)
        - For example, between February 2020 and March 31, Expansion (enrolled in Managed Care) increased from 67,644 to 92,880. EOHHS forecasts continued growth to 104,279 by December 2021, for a net increase 36,635 additional enrollees in Expansion over the entire PHE. Between January 2022 and June 2022, EOHHS' forecast assumes a net

[6] See page 29 https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf

[7] CMCS Informational Bulletin dated December 4, 2020 and CMS All-State Call on January 19, 2021 provided states with guidance that would enable them to restart the PEV and renewals process as a means to reduce the backlog of overdue renewals accumulating over the course of the PHE. EOHHS modified the PEV and passive renewal process to allow renewals of approximately 20,000 eligible customers per month, beginning with March 31st renewals. To date, approximately 90,000 customers have been passively renewed using this modified process. Of note, members that do not meet criteria for passive renewal will not be terminated; rather, they will have their renewal dates extended forward by 6-12 months. Similarly, customers with complex Medicaid, LTSS, or MPP were and will continue to have their renewal dates extended forward by 6-12 months. Once the PHE ends, and we run PEV, we will likely see several individuals that are over income and will receive an ADR.

decline of 2,020 members per month, equivalent to 12,120 reduction in caseload over the 6 months, or approximately one-third of the gross increase over the PHE.

- This decline is an abstraction and not equivalent to the gross number of terminations as new members will gain eligibility at the same time. Further, the decline will continue as EOHHS continues to finalize the delayed termination activities in FY 2023.
- Overall, based on current assessment of RI Bridges data, EOHHS expects that it will terminate approximately 60% of the members gaining eligibility during the PHE during a 12-month period following the cessation of the PHE. Changes to the economic forecast for Rhode Island could increase or decrease the likelihood of this volume and/or pace of these terminations.

- EOHHS currently estimates the number of terminations to be completed over this 12-month period is 69,000, as outlined below. However, because this assumes economic conditions are at pre-COVID levels, this likely overstates the actual number of terminations that will occur over the 12 months following the end of the PHE. That said, it may also understate the total volume of delayed terminations for the PHE if, as the moratorium on terminations continues, the count of potential terminations continues to grow. Furthermore, this number of terminations represents the potential reduction over a 12-month period, with only half of the redeterminations and subsequent terminations, where applicable, occurring within FY 2022.
  - By suppressing nearly all terminations, the Medicaid program has explicitly shielded just over 25,000 members from being terminated through early March. Approx. 5,000 have since regained eligibility, for a net impact of **20,000** members who remain on the Medicaid program who would have otherwise been terminated.
  - Additionally, through March 2021, EOHHS has extended the renewal date of 266,000 members (including 38,000 Complex and 228,000 MAGI) due to the PHE. This number will grow with the extension of the PHE.
    - Once the PHE ends, these members will be moved through the redetermination process. In terms of the share of redeterminations that may result in a termination, historically, an average of 16% of Complex/MPP/LTSS members and 7% of MAGI-based members are terminated. The termination rate is higher for Complex Medicaid than MAGI because the former requires every recertification packet to be signed and returned by the member. Comparatively, the MAGI population goes through Passive Renewal and most individuals are passively renewed. If historic termination rates apply, this would result in another **26,000** terminations (i.e., 38,000 × 16% + 228,000 × 7%). In the current environment where individuals are experiencing higher unemployment or under employment, the totals may end up being lower.
  - 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, between February 2019 and February 2020 about **23,000** members, or approximately 10% of the MAGI population, were flagged as over-income through the PEV process and sent termination notices (including an opportunity to dispute the findings and retain eligibility). In the current environment where individuals are experiencing higher unemployment or under employment, the totals may end up being lower.

	Potential Terminations over 12 Months
Shielded since March 2020	20,000
MAGI from renewals	20,000
Complex/LTSS from renewals	6,000
Post Eligibility Verification (PEV)	23,000
Total	**69,000**

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 II-12** 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 as outlined in response to a question in **Attachment 8**. EOHHS experience suggests these expenditures are less correlated with changes in aggregate trends due to either the nature of the expenditures and/or the small number of members driving the costs. For example, most of the FFS spending within Managed Care and Expansion is tied to the interim period prior to enrollment in managed care. These expenditures could increase as terminations increases if the result is additional churn. Additionally, FFS spending on Nursing Home, Hospitals, and Other Services are generally tied to the Aged, Blind, and Disabled or Children with Special Healthcare Needs eligibility groups that experience less overall variance in caseload.

The FY 2021 rates have been certified as final by the State's actuary; 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 an applied trend factor of 3.5% across all rating categories. Exceptions include the transportation broker rates for FY 2022 that assume an approximate 3.3% rate increase consistent with original cost proposal and the Medicare Premium Payments that reflect latest information reported in the Federal Funds Information for States (FFIS) and impact of COVID FMAP Increase (for Clawback multiplier).

In general, the 3.5 percentage point price factor incorporates potential changes in price and utilization. The composite price trends summarized in **Table II-12,** by product, may deviate from 3.5% as a result of change in enrollment mix; for example, the caseload increase in Rite Care Core through the pandemic has increased the relative proportion of members in the 14-44 years old and 45+ years old rating categories that have a higher PMPM.

Table II-12. 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	147,378	157,959	163,745	$270	$294	$305	7.2%	3.7%	8.9%	3.8%
Rite Care CSHCN	9,564	9,859	9,753	$1,000	$1,119	$1,160	3.1%	-1.1%	11.8%	3.7%
Expansion	70,321	88,389	99,111	$550	$618	$639	25.7%	12.1%	12.4%	3.5%
Rhody Health Partners	14,572	14,640	14,633	$1,610	$1,798	$1,858	0.5%	0.0%	11.7%	3.3%
Rhody Health Options (Phase II)	13,785	12,900	14,029	$829	$808	$842	-6.4%	8.8%	-2.5%	4.1%
PACE	339	352	360	$3,881	$3,992	$4,132	3.8%	2.3%	2.9%	3.5%
RIte Share[3]	3,044	2,622	2,544	$60	$63	$65	-13.9%	-3.0%	4.3%	3.5%
Subtotal	259,003	286,721	304,175	$480	$524	$543	10.7%	6.1%	9.2%	3.6%
Other Capitated Arrangements:										
Rite Smiles	111,347	121,267	131,788	$19	$20	$21	8.9%	8.7%	3.4%	3.3%
Rite Care EFP	1,777	1,693	1,596	$16	$20	$21	-4.7%	-5.7%	24.6%	3.5%
SOBRA Payments[4]	4,612	4,469	4,496	$12,469	$13,304	$13,770	-3.1%	0.6%	6.7%	3.5%
Non-Emergency Transportation[5]	287,023	319,334	334,659	$8	$8	$8	11.3%	4.8%	-2.6%	3.3%
Medicare Premium Payment:										
Part A (Hospital)	1,101	1,179	1,264	$445	$457	$468	7.1%	7.2%	2.6%	2.5%
Part B (Professional Services)	39,282	39,685	39,729	$144	$148	$153	1.0%	0.1%	3.3%	2.9%
Part D (Prescription Drugs)	36,864	37,784	37,727	$148	$140	$152	2.5%	-0.2%	-5.4%	8.9%

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 <u>only</u> 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.

III. Managed Care

Managed Care			
		All Funds	**General Revenue**
FY 2019	Final	$707,261,206	$300,052,866
FY 2020	Final	$692,537,418	$276,766,454
FY 2021	Enacted	$795,200,000	$311,503,420
	Current	**$802,800,000**	**$303,315,112**
	Deficit over Enacted	*($7,600,000)*	*$8,188,308*
FY 2022	November CEC	$806,300,000	$347,879,341
FY 2022	Current	**$859,600,000**	**$346,795,778**
	Deficit over Nov CEC	*($53,300,000)*	*$1,083,564*

The revised forecast of $802.8 million for FY 2021 reflects a $7.6 million deficit over Enacted.

Overall, EOHHS forecasts an average fiscal year enrollment of 180,048 RIte Care eligible members in FY 2021, a reduction of 600 members compared to the Enacted. This includes: 157,959 members enrolled in RIte Care Core, 9,859 in Rite Care CSHCN, 2,622 enrolled in RIte Share, and an average of 9,828 remaining in fee-for-service each month.

For FY 2022, EOHHS forecasts spending of $859.6 million from all sources, a $56.8 million, or 7.1%, increase over FY 2021 and a $53.3 million deficit compared to November CEC Adopted for the same period. EOHHS forecasts its caseload to continue to increase through December 2021 before regular terminations resumes, leading to a monthly average of 185,498, including 163,745 enrolled in Rite Care Core, 9,753 in Rite Care CSHCN, 2,544 in Rite Share, and 9,6858 remaining in FFS each month.

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** and the forecast for the number of births and NICU stays are presented in **Table III-3**.

Table III-4 reflects a variance analysis of the changes between EOHHS' current forecasts and the FY 2020 Final, FY 2021 Enacted, and FY 2022 November CEC The average monthly RIte Care and RIte Smiles capitation rates paid to the health plans are summarized in **Table III-5** and **Table III-6**, with the FY 2022 rates reflecting a 3.5% price increase.

Table III-7 and **Table III-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 $7.6 million increase compared to Enacted. This increase consists of a deficit of $11.2 million for plan payments and an overall surplus of $3.6 million for other expenses.
- The primary drivers of the deficit over the Enacted are:
  - Shift of members from FFS to managed care enrollment:

    - Although overall eligibility was 600 average member months less than assumed in Enacted, enrollment in Rite Care Core is up 1,375, or 0.9%, compared to EOHHS' November forecast
  - Final certified capitation rates included an acuity adjustment that raised composite rate for Rite Care Core from $286 PMPM in November testimony to $294 PMPM
- Offsetting savings include:
  - a likely gain share recoupment of $4.6 million for reduced utilization in Rite Smiles
  - lower fee-for-service expenditures for Rite Care Core eligible members that reflects the reduced churn and shift of increase proportion of members enrolled in managed care
  - reduction of 216 SOBRA births and estimated NICU stays, as the number of births has not increased proportional to the number of women enrolled
- Overall, the enhanced FMAP associated with the COVID-19 emergency period provides $47.1 million in GR relief against this budget line in FY 2021, including $4.9 million GR in additional CHIP relief. Overall, this is $11.6 million in additional GR relief than assumed in the Enacted.

Managed Care Highlights – FY 2022

- Overall, the managed care forecast reflects an $56.8 million increase over the current year estimate and a $53.3 deficit over November CEC Adopted.
- The primary driver of the increases in spending over FY 2021, as summarized in **Table III-4**, include:
  - a 3.5% trend assumption for the capitation rates
  - a 0.5% price increase due to a change in enrollment mix
  - the Rite Smiles' gain share in FY 2021 also impacts the relative change in overall PMPM for the budget line between the two fiscal years, and
  - an additional 5,450 members per month eligible for Medicaid due to the continued moratorium on terminations through December 2021.
- Overall, the enhanced FMAP associated with the COVID-19 emergency period provides $425.2 million in GR relief in FY 2022, including $2.5 million GR in additional CHIP relief.

Rite Share – FY 2021 and FY 2022

Due to the public health emergency (PHE) and the provisions contained in the Families First Coronavirus Response Act (FFCRA), EOHHS is prohibited from "sanctioning" individuals who are eligible for RIte Share and have not enrolled in Employer Sponsored Insurance (ESI). Sanctioning means suspending Medicaid coverage. As such, it serves as an important prompt for individuals to enroll in ESI. EOHHS's inability to sanction is leading to depressed RIte Share enrollment during the PHE. We currently have 1,777 individuals who would be sanctioned but for the restrictions due to the PHE.

EOHHS' projections conservatively assume that these 1,777 individuals will not transition to Rite Share January 1, 2021 as Rite Share enrollment for those sanctioned will be processed over time with appropriate notification post PHE, and in the interim these individuals may have lost access to cost-effective ESI. If the conferees would like to adopt a different assumption regarding the timeline for these transitions, as stated in the Rite Share budget initiative, the savings per member per month transitioned would be $58.

Table III-1. Summary of Managed Care Expenditures

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Surplus/ (Deficit)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Surplus/ (Deficit)	SFY22 Increase/ (Decrease) over SFY21
Payments to Plans								
RIte Care Core	$ 474,423,677	$ 534,237,287	$ 553,647,667	($19.4 M)	$ 539,853,960	$ 595,618,954	($55.8 M)	$42.0 M
EFP Only	349,828	434,207	414,912	0.0 M	434,986	405,256	0.0 M	(0.0 M)
SOBRA	50,138,935	54,559,212	51,885,132	2.7 M	54,954,154	53,990,288	1.0 M	2.1 M
RIte Care CSHCN	114,210,049	131,247,617	131,683,633	(0.4 M)	135,311,479	135,086,312	0.2 M	3.4 M
RIte Smiles	25,752,670	29,833,617	27,997,790	1.8 M	32,975,509	30,538,743	2.4 M	2.5 M
Risk Share	(1,423,089)	-	(4,600,000)	4.6 M	-	-	0.0 M	4.6 M
Stop Loss	2,362,481	3,300,000	3,400,000	(0.1 M)	3,250,000	3,510,000	(0.3 M)	0.1 M
Health Insurer Fee	-	4,575,114	4,902,087	(0.3 M)	-	-	0.0 M	(4.9 M)
Withhold and Incentives	2,958,986	3,339,303	3,439,579	(0.1 M)	3,387,579	3,664,913	(0.3 M)	0.2 M
Subtotal Payments to Plans	$ 668,773,537	$ 761,526,357	$ 772,770,799	($11.2 M)	$ 770,167,667	$ 822,814,466	($52.6 M)	$50.0 M
Other Payments:								
RIte Share	$ 2,199,354	$ 1,943,958	$ 1,974,357	($0.0 M)	$ 1,981,908	$ 1,978,016	$0.0 M	$0.0 M
Premium Assistance Program	74,939	57,176	68,068	(0.0 M)	54,708	160,598	(0.1 M)	0.1 M
Non-Emergency Transportation	7,589,336	8,311,149	8,182,567	0.1 M	8,361,069	8,654,922	(0.3 M)	0.5 M
TANF Charge Back	(1,242,710)	(797,326)	(556,841)	(0.2 M)	(889,680)	(940,119)	0.1 M	(0.4 M)
NICU	25,712,115	28,336,907	27,526,608	0.8 M	28,323,751	28,624,686	(0.3 M)	1.1 M
Core FFS	30,472,382	34,183,323	27,101,913	7.1 M	30,875,745	33,491,472	(2.6 M)	6.4 M
CSHCN FFS	3,160,529	3,194,563	4,035,561	(0.8 M)	3,279,171	4,200,767	(0.9 M)	0.2 M
Early Intervention	2,736,103	2,942,374	2,436,393	0.5 M	2,942,374	2,842,378	0.1 M	0.4 M
Rebates	(46,412,921)	(44,194,677)	(40,575,166)	(3.6 M)	(38,496,713)	(41,927,186)	3.4 M	(1.4 M)
Other/Miscellaneous	(303,803)	(303,803)	(164,259)	(0.1 M)	(300,000)	(300,000)	0.0 M	(0.1 M)
Subtotal Other Payments	$ 23,985,324	$ 33,673,643	$ 30,029,201	$3.6 M	$ 36,132,333	$ 36,785,534	($0.7 M)	$6.8 M
Accruals/Adjustments	*(221,443)*							
Grand Total Managed Care	**$ 692,537,418**	**$ 795,200,000**	**$ 802,800,000**	($7.6 M)	**$ 806,300,000**	**$ 859,600,000**	($53.3 M)	$56.8 M
General Revenue	*$ 276,766,454*	*$ 311,503,420*	*$ 303,315,112*	*$8.2 M*	*$ 347,879,341*	*$ 346,795,778*	*$1.1 M*	*$43.5 M*

Table III-2. Average Managed Care Caseload

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Increase/ (Decrease)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Increase/ (Decrease)	SFY22 Increase/ (Decrease) over SFY21
Full Benefits, by Delivery System								
RIte Care Core	147,378	156,584	157,959	1,375	152,849	163,745	10,896	5,786
RIte Care CSHCN	9,564	9,942	9,859	(83)	9,908	9,753	(155)	(106)
RIte Share	3,044	2,582	2,622	40	2,544	2,544	0	(78)
Remaining in FFS - Core	7,860	9,314	7,653	(1,661)	9,218	7,428	(1,790)	(225)
Remaining in FFS - CSHCN	2,283	2,226	2,176	(50)	2,161	2,256	95	80
Total	170,129	180,648	180,048	(600)	176,476	185,498	9,022	5,450
PMPM	$339	$367	$371		$381	$386		
% Enrolled in Managed Care	*92%*	*92%*	*93%*		*92%*	*94%*		
Other Caseload Factors								
EFP Only	1,777	1,771	1,693	(78)	1,713	1,596	(117)	(97)
RIte Smiles	111,347	125,065	121,267	(3,798)	134,051	131,788	(2,263)	10,521

Table III-3. Medicaid Births and NICU Stays

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Increase/ (Decrease)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Increase/ (Decrease)	SFY22 Increase/ (Decrease) over SFY21
SOBRA Births	4,612	4,683	4,469	(214)	4,559	4,496	(63)	27
RIte Care	4,021	4,101	3,900	(201)	3,991	3,921	(70)	21
Expansion	591	582	569	(13)	568	575	7	6
Percent of Births Expansion	*12.8%*	*12.4%*	*12.7%*		*12.5%*	*12.8%*		
Cost per SOBRA Birth	$12,469	$13,304	$13,304	$0	$13,770	$13,770	($0)	$466
NICU Stays[1]	599	620	589	(31)	604	591	(13)	2
Cost per NICU Stay	$42,195	$44,952	$45,285	$333	$46,121	$46,462	$341	$1,177

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

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

	Price	Volume	Net
FY 2021: Current over Enacted	$10.3 M	($2.7 M)	$7.6 M
	1.3%	-0.3%	1.0%
FY 2022: Current over Nov CEC	$11.5 M	$41.8 M	$53.3 M
	1.4%	5.1%	6.6%
FY 2021 over FY 2020	$66.0 M	$44.2 M	$110.3 M
	9.5%	5.8%	15.9%
FY 2022 over FY 2021	$31.5 M	$25.3 M	$56.8 M
	3.9%	3.0%	7.1%

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

	SFY 2020	SFY 2021	SFY 2022 *Estimate*	FY21→FY22 Trend
RIte Care Core				
MF < 1 y.o.	*$583*	*$640*	*$662*	*3.5%*
MF 1-4 y.o.	*$175*	*$190*	*$197*	*3.5%*
MF 5-14 y.o.	*$165*	*$177*	*$183*	*3.5%*
M 15-44 y.o.	*$237*	*$243*	*$251*	*3.5%*
F 15-44 y.o.	*$370*	*$402*	*$416*	*3.5%*
MF 45+ y.o.	*$540*	*$572*	*$592*	*3.5%*
Composite	*$270*	*$294*	*$305*	*3.8%*
Average Member Months	*147,378*	*157,959*	*163,745*	*3.7%*
RIte Care CSHCN				
Substitute Care	*$744*	*$848*	*$878*	*3.5%*
SSI <15	*$1,461*	*$1,580*	*$1,635*	*3.5%*
SSI 15-20	*$1,030*	*$1,222*	*$1,265*	*3.5%*
Katie Beckett	*$3,283*	*$3,587*	*$3,712*	*3.5%*
Adoption Subsidy	*$543*	*$635*	*$657*	*3.5%*
Composite	*$1,000*	*$1,119*	*$1,160*	*3.7%*
Average Member Months	*9,564*	*9,859*	*9,753*	*-1.1%*
SOBRA Payment	*$12,469*	*$13,304*	*$13,770*	*3.5%*
EFP Only	*$16*	*$20*	*$21*	*3.5%*

Note 1. SFY 2020 PMPM does not include the HIF liability paid as capitation to the UHC and Tufts.

Table III-6. Summary of RIte Smiles Monthly Premiums

RIte Smiles	SFY 2020	SFY 2021	SFY 2022 *Estimate*	FY21→FY22 Trend
MF 0-2	*$5*	*$5*	*$5*	*3.6%*
MF 3-5	*$17*	*$17*	*$18*	*3.5%*
MF 6-10	*$23*	*$25*	*$25*	*3.5%*
MF 11-15	*$25*	*$26*	*$27*	*3.5%*
MF 16-19	*$21*	*$19*	*$20*	*3.5%*
MF 20+	*$21*	*$19*	*$20*	*3.5%*
Composite	*$19*	*$20*	*$21*	*3.2%*
Average Member Months	*111,349*	*121,259*	*131,784*	*8.7%*

Note 1. SFY 2020 PMPM does not include the HIF liability paid as capitation to the UHC Dental.

Enhanced Claiming: CHIP and EFP Activity

Table III-7 and **Table III-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.

The 6.2 percentage point FMAP increase applies to the Children's Health Insurance Program, but only indirectly. The Enhanced FMAP for CHIP is calculated using a State's Regular FMAP as its base. Therefore, as a State's Regular FMAP increases so does its Enhanced (CHIP) FMAP rate. For Rhode Island, the increase to the Enhanced (CHIP) FMAP is 4.34 percentage points according to the formula used for its derivation. Overall, EOHHS forecasts an increase in expenditures that are eligible for CHIP claim (resulting from caseload and price increases in FY 2022 compared to FY 2021); however, due to reduction in effective Enhanced (CHIP) FMAP rate for the entire state fiscal year and the elimination of the COVID-19 increase in December 2021, total GR relief from CHIP claiming is expected to decline in by $2.9 million GR.

Table III-7. CHIP Claiming

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	Increase/ (Decrease) over SFY21
CHIP Offset	**$ 104,484,019**	**$ 105,825,238**	**$ 111,858,604**	**$6.0 M**	**$ 106,996,485**	**$ 116,622,106**	**$9.6 M**	**$4.8 M**
Additional GR Relief	*$ 29,798,842*	*$ 17,707,208*	*$ 18,713,944*		*$ 14,099,462*	*$ 15,860,606*		*($2.9 M)*

Table III-8. EFP Claiming

	SFY 2020:	SFY 2021:			SFY 2022:			FY22 Increase/
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	(Decrease) over FY21
Extended Family Planning	**$ 8,301,973**	**$ 8,972,724**	**$ 9,110,361**	**$0.1 M**	**$ 8,773,252**	**$ 9,476,213**	**$0.7 M**	**$0.4 M**
Additional GR Relief	*$ 3,083,353*	*$ 3,247,678*	*$ 3,297,040*		*$ 3,098,493*	*$ 3,346,998*		*$0.0 M*

IV. Rhody Health Partners

Rhody Health Partners			
		All Funds	**General Revenue**
FY 2019	Final	$239,753,270	$115,465,870
FY 2020	Final	$259,995,219	$116,717,432
FY 2021	Enacted	$285,600,000	$119,564,936
	Current	**$288,800,000**	**$116,488,320**
	Deficit over Enacted	*($3,200,000)*	*$3,076,616*
FY 2022	November CEC	$294,300,000	$134,169,403
FY 2022	Current	**$296,500,000**	**$126,059,065**
	Deficit over Nov CEC	*($2,200,000)*	*$8,110,338*

EOHHS' revised FY 2021 forecast for Rhody Health Partners (RHP) reflects a deficit of $3.2 million over the Enacted for total expenditures of $288.8 million. Overall, EOHHS forecasts an average fiscal year enrollment of 14,460 members in RHP in FY 2021, a reduction of 48 average member months over the Enacted.

EOHHS' revised FY 2022 budget of $296.5 million for RHP reflects a stable enrollment forecast over current year forecast and a slight increase of 101 average member months compared to EOHHS' prior forecast. This revised budget reflects a 2.7% increase over FY 2021 which is primarily driven by an assumed 3.5% trend factor that is mitigated in the composite due to a favorable shift in the case mix.

Consistent with the forecast adjustments made in November, the Aged, Blind, and Disabled eligibility groups have exhibited considerable stability through the duration of the pandemic. This assumption is carried forward into FY 2022 that assumes a modest 0.5% annualized growth rate through end of PHE with overall average monthly enrollment being flat between FY 2021 and FY 2022.

The primary drivers for the General Revenue surpluses each fiscal year are due to the additional quarter of Enhanced FMAP in FY 2021 and two quarters of Enhanced FMAP relief in FY 2022.

The following tables summarize EOHHS' revised forecasts for Rhody Health Partners for FY 2021 and FY 2022. **Table IV-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 IV-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**. **Table IV-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 IV-4**.

Rhody Health Partners Highlights – FY 2021

- The Rhody Health Partners forecast reflects $3.2 million deficit compared to the Enacted.
- This increase is primarily attributed to a reduction in rebate collections and an acuity-adjustment to the capitation payments that increased the final certified rates for FY 2021 relative to what EOHHS reflected in its November testimony
- Overall, total payments to the managed care plans are otherwise on target:
    - Hepatitis C Stop Loss payments are expected to be $0.5 million less than in Enacted due to reduced utilization.

- The actual Health Insurer Fee liability was $0.6 million above EOHHS' original estimate due to EOHHS underestimating the tax implications of the fee to the MCOs that CMS recognized as a legitimate expenditure and was not originally incorporated into the liability.

- The enhanced FMAP associated with the COVID-19 emergency period provides $17.7 million in GR relief against this budget line in FY 2021, including an $4.4 million more than assumed in Enacted.

Rhody Health Partners Highlights – FY 2022

- The Rhody Health Partners forecast reflects an increase of $7.7 million over FY 2021. This increase consists of $7.5 million for a 3.5% price increase (leading to an overall composite rate increase of 3.3% after taking into consideration of changes in enrollment mix; see **Table IV-4**) and $0.2 million for other payments.

Table IV-1. Summary of RHP Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Payments to Plans								
Rhody Health Partners	$ 280,018,589	$ 314,300,316	$ 314,203,620	$0.1 M	$ 321,860,263	$ 324,538,411	($2.7 M)	$10.3 M
Risk Share	12,389,218	-	-	0.0 M	-	-	0.0 M	0.0 M
Stop Loss - Hepatitis C	2,500,000	2,500,000	2,000,000	0.5 M	2,500,000	2,200,000	0.3 M	0.2 M
Health Insurer Fee	-	2,491,247	3,047,892	(0.6 M)	-	-	0.0 M	(3.0 M)
Withhold and Incentives	1,406,801	1,579,413	1,578,057	0.0 M	1,617,070	1,630,127	(0.0 M)	0.1 M
Subtotal Payments to Plans	$ 296,314,608	$ 320,870,976	$ 320,829,569	$0.0 M	$ 325,977,333	$ 328,368,538	($2.4 M)	$7.5 M
Other Payments:								
Non-Emergency Transportation	$ 3,309,816	$ 3,247,956	$ 3,237,100	$0.0 M	$ 3,326,827	$ 3,339,189	($0.0 M)	$0.1 M
RHP FFS	37,990	59,234	3,412	0.1 M	59,234	46,088	0.0 M	0.0 M
Rebates	(41,460,478)	(38,578,166)	(35,270,081)	(3.3 M)	(35,063,394)	(35,253,815)	0.2 M	0.0 M
DRE	$ (40,276,001)	$ (37,508,407)	$ (34,089,326)	(3.4 M)	$ (34,005,041)	$ (34,073,605)	0.1 M	$0.0 M
J-Code	$ (1,184,477)	$ (1,069,759)	$ (1,180,755)	0.1 M	$ (1,058,353)	$ (1,180,210)	0.1 M	$0.0 M
Subtotal Other Payments	$ (38,112,672)	$ (35,270,976)	$ (32,029,569)	($3.2 M)	$ (31,677,333)	$ (31,868,538)	$0.2 M	$0.2 M
Accruals/Adjustments	*1,793,283*							
Grand Total	**$ 259,995,219**	**$ 285,600,000**	**$ 288,800,000**	($3.2 M)	**$ 294,300,000**	**$ 296,500,000**	($2.2 M)	$7.7 M
General Revenue	*$ 116,717,432*	*$ 119,564,936*	*$ 116,488,320*	*$3.1 M*	*$ 134,169,403*	*$ 126,059,065*	*$8.1 M*	*$9.6 M*

Table IV-2. RHP Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	
Enrollment by Pay Level								
SSI 21-44 y.o.	3,670	3,742	3,763	21	3,708	3,805	97	42
SSI 45+ y.o.	7,237	7,310	7,249	(61)	7,228	7,217	(11)	(32)
SPMI	2,722	2,686	2,677	(9)	2,658	2,663	5	(14)
ID/DD	943	950	951	1	938	948	10	(3)
Total RHP	14,572	14,688	14,640	(48)	14,532	14,633	101	(7)
Overall PMPM	*$1,487*	*$1,620*	*$1,644*	*$24*	*$1,688*	*$1,689*	*$1*	*$45*

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

	Price	Volume	Net
FY 2021: Current over Enacted	$4.1 M	($0.9 M)	$3.2 M
	1.5%	-0.3%	1.1%
FY 2022: Current over Nov CEC	$0.2 M	$2.0 M	$2.2 M
	0.1%	0.7%	0.7%
FY 2021 over FY 2020	$27.5 M	$1.3 M	$28.8 M
	10.6%	0.5%	11.1%
FY 2022 over FY 2021	$7.8 M	($0.1 M)	$7.7 M
	2.7%	0.0%	2.7%

Table IV-4. RHP Monthly Premiums

Rhody Health Partners	SFY 2020	SFY 2021	SFY 2022 *Estimate*	FY21→FY22 Trend
SSI 21-44 y.o.	$994	$1,129	$1,169	3.5%
SSI 45+ y.o.	$1,593	$1,783	$1,845	3.5%
SPMI	$2,626	$2,948	$3,051	3.5%
ID/DD	$1,199	$1,318	$1,364	3.5%
Composite	**$1,610**	**$1,798**	**$1,858**	**3.3%**
Average Member Months	*14,572*	*14,640*	*14,633*	*0.0%*

Note:

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

V. Rhody Health Options

Rhody Health Options			
		All Funds	**General Revenue**
FY 2019	Final	$200,503,385	$96,179,681
FY 2020	Final	$133,751,933	$59,363,164
FY 2021	Enacted	$132,600,000	$55,163,670
	Current	**$128,000,000**	**$51,277,470**
	Surplus over Enacted	*$4,600,000*	*$3,886,200*
FY 2022	November CEC	$151,700,000	$68,821,648
FY 2022	Current	**$144,800,000**	**$61,222,195**
	Surplus over Nov CEC	*$6,900,000*	*$7,599,453*

The revised FY 2021 forecast of $128.0 million for Rhody Health Options reflects a surplus of $4.6 million over the Enacted with average monthly caseload in the CMS Demonstration of 12,900 reflecting a decrease of 345, or 2.6%, over Enacted.

Although EOHHS assumes the negative caseload trend experienced in FY 2021 over FY 2020 reverses in FY 2022 as EOHHS continues its passive enrollment of members (that began in January 2021), EOHHS' revised forecast for FY 2022 of an average 14,029 members per month, is 677 members, or 4.6%, less than in November CEC.

EOHHS' revised forecast reflects the enrollment of 150 additional members per month.

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 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 between FY 2021 and FY 2022.

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

Rhody Health Options Highlights – FY 2021

- The Rhody Health Options forecast reflects an overall surplus of $4.6 million compared to the Enacted.
- The primary drivers of this surplus are:
    - lower enrollments in the CMS Demonstration than forecasted in November
    - a reduced composite rate as the proportion of Nursing Home members enrolled
- Beginning January 2021, EOHHS began passively enrolling FFS members meeting specific criteria into the CMS Demonstration. The number has varied by month, but EOHHS anticipates continuing to enroll approximately 150 members per month distributed across the pay levels. Currently, EOHHS is not enrolling members currently in a Nursing Home.
    - 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.
- As discussed in **Section C Opioid Treatment Program – Medicare Coverage for Duals** of the **Major Developments**, the certified rates now reflect the full savings for the fact that the Medicare rate paid toward members enrolled in the CMS Demonstration fully finance the cost of providing SUD health

home treatment to these Duals. This savings is no longer "below-the-line" as they were in EOHHS' November testimony as they are reflected in the final certified rates.
- The enhanced FMAP associated with the COVID-19 emergency period provides $7.9 million in GR relief against this budget line in FY 2021 and increase of $2.0M over Enacted.

Rhody Health Options Highlights – FY 2022

- The Rhody Health Options forecast of $144.8 million reflects a $16.8 million increase over FY 2021, but a $2.1 million surplus relative to EOHHS prior forecast for FY 2022.
- 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 average enrollees per month for the year)
  - the SUD savings are carried forward into EOHHS' FY 2022 estimate.
  - The enhanced FMAP associated with the COVID-19 emergency period provides $4.9 million in GR relief against this budget line in FY 2022.

Table V-1. Summary of Rhody Health Options Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Payments to Plans								
RHO Phase II	$ 133,015,795	$ 125,277,543	$ 120,815,578	$4.5 M	$ 138,353,938	$ 137,385,842	$1.0 M	$16.6 M
Risk Share	-	-	-	0.0 M	-	-	0.0 M	0.0 M
Withholds	4,113,624	5,568,829	4,392,009	1.2 M	6,388,993	4,279,036	2.1 M	(0.1 M)
Other - OTP/SUD Savings	-	(1,134,793)	-	(1.1 M)	(1,134,793)	-	(1.1 M)	0.0 M
Subtotal Payments to Plans	$ 137,129,419	$ 129,711,579	$ 125,207,587	$4.5 M	$ 143,608,138	$ 141,664,878	$1.9 M	$16.5 M
Other Payments:								
Non-Emergency Transportation	$ 3,130,587	$ 2,928,140	$ 2,852,946	$0.1 M	$ 3,365,712	$ 3,200,933	$0.2 M	$0.3 M
Rebates	(42,134)	(39,719)	(60,533)	0.0 M	(44,100)	(65,811)	0.0 M	(0.0 M)
Subtotal Other Payments	$ 3,088,453	$ 2,888,421	$ 2,792,413	$0.1 M	$ 3,321,612	$ 3,135,122	$0.2 M	$0.3 M
Prior Period Activity/Accruals	*(6,465,938)*							
Grand Total	**$ 133,751,933**	**$ 132,600,000**	**$ 128,000,000**	$4.6 M	**$ 146,929,750**	**$ 144,800,000**	$2.1 M	$16.8 M
General Revenue	*$ 59,363,164*	*$ 55,163,670*	*$ 51,277,470*	*$3.9 M*	*$ 66,659,889*	*$ 61,222,195*	*$5.4 M*	*$9.9 M*

Table V-2. Rhody Health Options Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	
MMP SPMI	1,258	1,195	1,159	(36)	1,326	1,251	(75)	92
MMP ID/DD	1,363	1,381	1,358	(23)	1,533	1,478	(55)	120
MMP Community LTSS	1,626	1,604	1,604	0	1,777	1,781	4	177
MMP NH >90 days	391	381	354	(27)	426	375	(51)	21
MMP Community Non-LTSS	9,147	8,684	8,425	(259)	9,644	9,144	(500)	719
Total	13,785	13,245	12,900	(345)	14,706	14,029	(677)	1,129
Overall PMPM	$809	$834	$827	($7)	$833	*$860*	$28	$33

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

	Price	Volume	Net
FY 2021: Current over Enacted	($1.2 M)	($3.4 M)	($4.6 M)
	-0.9%	-2.6%	-3.5%
FY 2022: Current over Nov CEC	$4.9 M	($7.0 M)	($2.1 M)
	3.3%	-4.6%	-1.4%
FY 2021 over FY 2020	$3.0 M	($8.8 M)	($5.8 M)
	2.3%	-6.4%	-4.3%
FY 2022 over FY 2021	$5.1 M	$11.7 M	$16.8 M
	4.0%	8.8%	13.1%

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

	SFY 2020	SFY 2021	SFY 2022 *Estimate*	FY21→FY22 Trend
CMS Demonstratino (RHO Phase II)				
MMP SPMI	$1,159	$1,180	$1,222	3.6%
MMP ID/DD	$209	$213	$220	3.5%
MMP Community LTSS	$3,457	$3,195	$3,307	3.5%
MMP NH > 90 days	$3,457	$3,195	$3,307	3.5%
MMP Community Non-LTSS	$297	$299	$309	3.5%
Composite	***$829***	***$808***	***$842***	***4.1%***
Average Member Months	*13,785*	*12,900*	*14,029*	*8.8%*

VI. Medicaid Expansion

Medicaid Expansion		All Funds	General Revenue
FY 2019	Final	$474,972,127	$29,877,910
FY 2020	Final	$487,344,918	$42,855,710
FY 2021	Enacted	$640,790,064	$68,508,350
	Current	**$665,900,000**	**$71,362,396**
	Deficit over Enacted	*($25,109,936)*	*($2,854,046)*
FY 2022	November CEC	$642,000,000	$68,562,743
FY 2022	Current	**$767,400,000**	**$82,106,892**
	Deficit over Nov CEC	*($125,400,000)*	*($13,544,150)*

EOHHS' revised forecast for Expansion of $665.9 million for FY 2021 reflects a deficit of $25.1 million compared to the Enacted. Overall, EOHHS forecasts an average fiscal year enrollment of 92,120 members in Expansion in FY 2021, a decrease of 472 members compared to the caseload assumed in the Enacted.

For FY 2022, EOHHS forecasts total expenditures to increase by 15% over FY 2021 to $767.4 million, reflecting a $125.4 million deficit over prior forecast for FY 2022. This revised forecast includes an average enrollment of 102,638, an increase of 12,489, or 11.4%, over current FY and a 13.9% increase over prior estimate for FY 2022. The cause for this significant change in estimates is EOHHS current assumption for the continued moratorium on regular termination activities through December 2021.

The following tables summarize EOHHS' revised forecasts for Expansion for FY 2021 and FY 2022. **Table VI-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 VI-2** with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**. **Table VI-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 VI-4**

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

Medicaid Expansion Highlights – FY 2021

- The Medicaid Expansion forecast reflects an overall deficit of $25.1 million when compared to the Enacted.
- The primary drivers of the deficit are:
    - An increase of $30.4 million in payments to the health plans that is largely attributed to a significant acuity-adjustment to the capitation payments that increased the final certified rates for FY 2021 relative to what EOHHS reflected in its November testimony
        - The composite $618 PMPM for FY 2021 reflects a 4.4% increase over the composite $592 PMPM assumed in November's forecast for the same period
    - Lower-than-anticipated rebate collections: primarily resulting from an improved understanding by EOHHS of how its fiscal intermediary is administering prior period collections

- This deficit is offset by $5.3 million in other savings, that is made up of a $10.9 million reduction in FFS activity likely attributed to the reduced level of churn in Expansion that has greatly reduced the number of people remaining in FFS
- The enhanced FMAP associated with the COVID-19 emergency period does not impact the Medicaid Expansion budget line

Medicaid Expansion Highlights – FY 2022

- The 15.2% increase in expenditures in FY 2022 over FY 2021 is primarily attributed to the trend observed over the past quarter, which is carried forward through December 2021 with a partial "clean-up" occurring over the second half of the FY.
- Another driver is the 3.5 percent price increase to capitation rates
- 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.

Previously Eligible Expansion-Eligible Members

Both FY 2021 and FY 2022 include an adjustment for Expansion members who would have been previously eligible for Medicaid under criteria in place prior to January 1, 2014 (e.g., individuals who meet specific disability standards but otherwise meet Expansion eligibility criteria). These members are not eligible for the enhanced 90% federal financial participation. EOHHS' estimate includes $12.4 million and $14.4 million in FY 2021 and FY 2022, respectively, of Expansion capitation and fee-for-service activity that is not eligible for 90/10 match and so included at the regular FMAP.

Rite Smiles Adjustment

EOHHS' projections include spending on Rite Smiles for Expansion-eligible members in the Expansion budget line. EOHHS' estimate includes $1.0 million and $2.0 million in FY 2021 and FY 2022, respectively, based on current Rite Smiles spending allocated to the Expansion funding source. Please note that the FY 2021 figure is depressed relative to FY 2022 because the enrollment system was not properly enrolling Expansion-eligible members into Rite Smiles. The system was updated in November 2020.

This adjustment is modeled as a shift in funding sources for EOHHS' overall Rite Smiles enrollment.

Table VI-1. Summary of Medicaid Expansion Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	Increase/ (Decrease) over SFY21
Payments to Plans								
Expansion	$ 461,534,588	$ 621,979,532	$ 652,021,828	($30.0 M)	$ 628,389,337	$ 756,382,332	($128.0 M)	$104.4 M
SOBRA	7,369,339	7,742,858	7,569,908	0.2 M	7,821,087	7,917,474	(0.1 M)	0.3 M
Risk Share	14,192,491	-	-	0.0 M	-	-	0.0 M	0.0 M
Stop Loss - Hepatitis C	4,609,793	5,250,000	3,900,000	1.4 M	5,250,000	4,290,000	1.0 M	0.4 M
Health Insurer Fee	-	4,005,598	4,804,696	(0.8 M)	-		0.0 M	(4.8 M)
Withhold and Incentives	2,318,599	3,142,578	3,273,241	(0.1 M)	3,163,926	3,799,007	(0.6 M)	0.5 M
RIte Smiles	-	-	1,000,000	(1.0 M)	-	2,000,000	(2.0 M)	1.0 M
Subtotal Payments to Plans	$ 490,024,810	$ 642,120,566	$ 672,569,673	($30.4 M)	$ 644,624,350	$ 774,388,813	($129.8 M)	$101.8 M
Other Payments:								
Non-Emergency Transportation	$ 8,244,739	$ 10,843,768	$ 10,099,435	$0.7 M	$ 10,129,922	$ 11,646,247	($1.5 M)	$1.5 M
Expansion FFS	45,040,861	55,870,390	45,013,958	10.9 M	50,025,589	50,460,407	(0.4 M)	5.4 M
Rebates	(57,094,600)	(68,044,660)	(61,783,066)	(6.3 M)	(62,779,862)	(69,095,467)	6.3 M	(7.3 M)
Subtotal Other Payments	$ (3,809,000)	$ (1,330,502)	$ (6,669,673)	$5.3 M	$ (2,624,350)	$ (6,988,813)	$4.4 M	($0.3 M)
Accruals/Adjustments	*1,129,108*							
Grand Total	**$ 487,344,918**	**$ 640,790,064**	**$ 665,900,000**	($25.1 M)	**$ 642,000,000**	**$ 767,400,000**	($125.4 M)	$101.5 M
General Revenue	*$ 42,855,710*	*$ 68,962,375*	*$ 71,362,396*	*($2.4 M)*	*$ 68,562,743*	*$ 82,106,892*	*($13.5 M)*	*$10.7 M*

Table VI-2. Summary Medicaid Expansion Average Enrollment

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	(Decrease) over SFY21
Enrollment by Delivery System:								
Expansion	70,321	88,528	88,389	(139)	86,127	99,111	12,984	10,722
RIte Share	119	109	129	20	108	144	36	15
Remaining in FFS	5,141	3,955	3,602	(353)	3,914	3,383	(531)	(219)
Total	75,581	92,592	92,120	(472)	90,149	102,638	12,489	10,518
Overall PMPM	$537	$581	$602		$593	*$623*		$21
% Enrolled in Managed Care	*93%*	*96%*	*96%*		*96%*	*97%*		

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

	Price	Volume	Net
FY 2021: Current over Enacted	$28.5 M	($3.4 M)	$25.1 M
	4.5%	-0.5%	3.9%
FY 2022: Current over Nov CEC	$32.0 M	$93.4 M	$125.4 M
	5.0%	13.9%	19.5%
FY 2021 over FY 2020	$59.0 M	$119.6 M	$178.6 M
	12.1%	21.9%	36.6%
FY 2022 over FY 2021	$22.9 M	$78.6 M	$101.5 M
	3.4%	11.4%	15.2%

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

Expansion	SFY 2020	SFY 2021	SFY 2022 *Estimate*	FY21→FY22 Trend
F 19-24 y.o.	*$265*	*$322*	*$333*	*3.5%*
F 25-29 y.o.	*$415*	*$461*	*$477*	*3.5%*
F 30-39 y.o.	*$580*	*$686*	*$710*	*3.5%*
F 40-49 y.o.	*$759*	*$894*	*$926*	*3.5%*
F 50-64 y.o.	*$726*	*$831*	*$860*	*3.5%*
M 19-24 y.o.	*$205*	*$221*	*$229*	*3.5%*
M 25-29 y.o.	*$360*	*$410*	*$424*	*3.5%*
M 30-39 y.o.	*$539*	*$603*	*$624*	*3.5%*
M 40-49 y.o.	*$736*	*$788*	*$816*	*3.5%*
M 50-64 y.o.	*$821*	*$883*	*$914*	*3.5%*
Composite	***$550***	***$618***	***$639***	***3.5%***
Average Member Months	*70,321*	*88,389*	*99,111*	*12.1%*
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 15.0 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 VI-5. Medicaid Expansion FY 2020 + Extended 5-Year Fiscal Year Forecast

	Eligible	PMPM	All Funds	FMAP	General Revenue
FY 2020 - Final	75,581	$537	$487.3 M	9%	$43.9 M
FY 2021 - Current	92,120	$602	$665.9 M	10%	$66.6 M
FY 2022 - Current	102,638	$623	$767.4 M	10%	$78.1 M
FY 2023	87,242	$645	$675.1 M	10%	$67.5 M
FY 2024	89,423	$667	$716.2 M	10%	$71.6 M
FY 2025	90,765	$691	$752.4 M	10%	$75.2 M

VII. Hospitals - Regular

Hospitals - Regular			
		All Funds	**General Revenue**
FY 2019	Final	$66,805,603	$32,144,027
FY 2020	Final	$47,109,165	$20,116,400
FY 2021	Enacted	$55,937,481	$22,478,338
	Current	**$53,900,000**	**$20,866,514**
	Surplus over Enacted	*$2,037,481*	*$1,611,824*
FY 2022	November CEC	$49,000,000	$22,044,615
FY 2022	Current	**$54,300,000**	**$22,210,879**
	Deficit over Nov CEC	*($5,300,000)*	*($166,264)*

EOHHS' Hospital expenditure estimate of $53.9 million for FY 2021 reflects a $2.0 million surplus against Enacted. The FY 2021 estimates annualize the July 2020 through December 2020 monthly average. EOHHS increased this amount by two percent to account for increased utilization expected over the second half of the year. The estimates include the FY 2021 enacted inflationary increase of 2.6% for inpatient and outpatient hospitals.

The FY 2022 estimate utilized is the higher of the Pre-COVID monthly average (July 2019 to March 2020) or the monthly average of the FY 2021 projection, given continued uncertainty regarding the pace and impact of a post-COVID recovery. The time periods used for each hospital service type are shown in **Table VII-2**. The FY 2022 estimate applies the price change of 2.4% shown in **Table VII-3**.

A summary of the FY 2021 and FY 2022 hospital expenditure forecasts are shown in **Table VII-1**.

Table VII-1. Summary of Hospital – Regular Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
Hospitals - Regular	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Total FFS	**$ 39,832,771**	**$ 45,816,698**	**$ 43,460,961**	**$2.4 M**	**$ 41,036,786**	**$ 44,172,687**	**($3.1 M)**	**$0.7 M**
Inpatient	34,314,610	39,487,947	37,559,314	1.9 M	34,543,487	38,054,394	(3.5 M)	0.5 M
Outpatient	5,518,161	6,328,751	5,901,647	0.4 M	6,493,299	6,118,293	0.4 M	0.2 M
Upper Payment Limit	**$ 4,642,402**	**$ 7,920,782**	**$ 7,920,782**	**$0.0 M**	**$ 4,852,239**	**$ 7,920,782**	**($3.1 M)**	**$0.0 M**
Inpatient UPL	-	-	-	0.0 M	-	-	0.0 M	0.0 M
Outpatient UPL	4,642,402	7,920,782	7,920,782	0.0 M	4,852,239	7,920,782	(3.1 M)	0.0 M
Graduate Medical Education	**$ 1,591,500**	**$ 2,200,001**	**$ 2,518,257**	**($0.3 M)**	**$ 1,548,800**	**$ 2,206,531**	**($0.7 M)**	**($0.3 M)**
Prior Period Activity/Accruals	*1,042,492*							
Grand Total	**$ 47,109,165**	**$ 55,937,481**	**$ 53,900,000**	$2.0 M	**$ 47,437,825**	**$ 54,300,000**	($6.9 M)	$0.4 M
General Revenue	*$ 20,116,400*	*$ 22,478,338*	*$ 20,866,514*	*$1.6 M*	*$ 22,044,615*	*$ 22,210,879*	*($0.2 M)*	*$1.3 M*

Table VII-2. SFY 22 Hospital Service Type Estimate Basis

Service Type	Time Period Monthly Average Used
Hospitals Inpatient	**FY21**: Jul-20 thru Dec-2020
Hospitals Outpatient	**Pre-COVID** FY20: Jul-19 thru Mar-20

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

	Percent	Dollar Impact	Comments
Price			
Inpatient	2.40%	$ 1,731,470	CMS FY 2021 IPPS Less Productivity Adjustment
Outpatient	2.40%	$ 317,780	CMS CY 2021 OPPS Less Productivity Adjustment
		$ 2,049,250	
Utilization			
Inpatient	0.00%	$ -	EOHHS
Outpatient	0.00%	$ -	EOHHS
		$ -	
Total, Price/Volume		**$ 2,049,250**	

Market Basket Background

Inpatient Hospital

R.I.G.L § 40-8-13.4(b)(1)(i) mandates annual inflationary increases using the "CMS Prospective Payment System (IPPS) Hospital Input Price index," which is consistent with our State Plan language. The State Plan and current law do not detail (1) the issue date of the inflation index, (2) if EOHHS should use the CMS actual market basket or the forecast, and (3) if we should apply the productivity adjustment. EOHHS intends to submit a SPA to CMS to clarify the language to improve transparency and to **document current practice** as summarized below:

> Effective July 1, 2020 the DRG will be increased by the change in the "actual regulation market basket" as reflected in the CMS ~~national Prospective Payment System (IPPS) Hospital Input Price Index~~ Inpatient Hospital Prospective Payment System Market Basket Update Less Productivity Adjustment for the current federal fiscal year.

Therefore, because July 1, 2021 is in FFY 2021, EOHHS will use the FFY 2021 market basket for its FY 2022 projections.

Outpatient Hospital

RIGL § 40-8-13.4(b)(2) stipulates that EOHHS use the "CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index" to determine the inflationary increase amount. The current State Plan does not specify which inflationary index to use: "For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change to the Centers for Medicaid and Medicaid Service OPPS fee schedule posted January of the current calendar year." RIGL and our State Plan do not specify if EOHHS should (1) use the CMS actual market basket or the future forecast posted January of the current calendar year, and (2) if we should apply a productivity adjustment. EOHHS intends to submit a SPA to CMS to clarify the language to improve transparency and to document current practice as summarized below:

> For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change in the "actual regulation market basket" as reflected in the CMS Outpatient Hospital Prospective Payment System Market Basket Update Less Productivity Adjustment for the calendar year that contains the start of the current state fiscal year. ~~to the Centers for Medicaid and Medicaid Service OPPS fee schedule posted January of the current calendar year~~

In the FY 2022 estimate, EOHHS utilized the most recently available market baskets, less productivity adjustment, which totaled 2.4% for both inpatient and outpatient. These were accessed on March 8, 2021 from the CMS' Market Basket Data website (Actual Regulation Market Basket Updates, "Summary Web Table – Actual 2020Q3").

Inpatient Hospital PPS	SFY 2022 Proposed *Based on FFY 2021*
Market Basket Update	2.4%
Productivity Adjustment	0.0%
Market Basket Update less Productive Adjustment	**2.4%**

Outpatient Hospital PPS	SFY 2022 Proposed *Based on CY 2021*
Market Basket Update	2.4%
Productivity Adjustment	0.0%
Market Basket Update less Productive Adjustment	**2.4%**

Hospital Supplemental Payments – Upper Payment Limit (UPL)

FY 2021 UPL Payment

The FY 2021 enacted budgeted included $7.9 million in outpatient UPL payments. At the time of testimony, EOHHS paid all eligible hospitals the total enacted amount. Should the Governor's recommended hospital license fee increase pass, EOHHS will need to recoup previous FY 2021 payments.

FY 2022 UPL Payment

The FY 2022 estimated outpatient UPL payment amount is a placeholder and remains at the FY 2021 enacted budget amount. A of April 21, 2020 EOHHS received some of the Medicare Cost reports from the Hospital Association of Rhode Island, which are needed to complete the UPL demonstration from which the UPL payment is derived. Due to the public health emergency, CMS extended the due dates for the Medicare Cost reports. Due to this delay, EOHHS has not yet received updated cost reports from Landmark, St. Joseph, and Roger Williams Medical Center. It is unlikely that EOHHS will know its exact UPL payment amount unless these hospitals submit their Medicare cost reports before July 1, 2021. (Alternatively, EOHHS could use these hospitals' most recent cost reports which provide data from January 2018 to December 2019, as opposed to using January 2019 to December 2020, which would be the most recent data.) EOHHS is working with the Hospital Association of Rhode Island to obtain the remaining cost reports as they are submitted.

- Four of the 11 hospitals typically eligible for outpatient UPL payments have fiscal years aligned with the calendar year.
  - Their reports are typically due by May 31, but CMS extended this deadline to July 31.
  - Hospitals: Roger Williams, St. Joseph, Landmark, and Rehabilitation Hospital of Rhode Island.
- The remaining seven hospitals have fiscal years aligned with the FFY.
  - Their reports are typically due March 1, but CMS extended the deadline to April 30.
  - Hospitals: Newport, Rhode Island Hospital, South County, Kent County, Women and Infants, Miriam, and Westerly. On April 20, EOHHS received updated cost reports from these facilities with October 2019 to September 30, 2021 data.

Based on EOHHS' analysis of the proportion of hospital fee-for-service expenditures attributed to Expansion-eligible members, one third of EOHHS outpatient UPL payments are eligible for 90% federal financial participation.

Table VII-4. shows the FY 2021 Outpatient UPL payments made by hospital.

Table VII-4. Upper Payment Limit (UPL) Spending by Hospital, FY 2021 Actual and FY 2022 Estimate

	Outpatient	Inpatient	Total
Rehab Hospital	$ 8,295	$ -	$ 8,295
Kent Hospital	842,336	-	842,336
Landmark Hospital	441,649	-	441,649
Miriam Hospital	1,057,804	-	1,057,804
Newport Hospital	271,314	-	271,314
Rhode Island Hospital	3,228,832	-	3,228,832
Roger Williams Medical Center	572,208	-	572,208
St Joseph Hospital	339,232	-	339,232
South County Hospital	176,231	-	176,231
Westerly Hospital	111,521	-	111,521
Women & Infants Hospital	871,360	-	871,360
Total	$ 7,920,782	$ -	$ 7,920,782

Note. Payments made quarterly in July, October, January, and April.

Hospital Supplemental Payments – Graduate Medical Education (GME)

Background

FY 2020 was the first year EOHHS received a federal match on its GME payment. The FY 2020 Enacted included $1.0 million GR for GME; but it did authorize EOHHS to submit a SPA to seek federal authority to receive an additional federal match. EOHHS utilized the $1.0 million All Funds pool available in the existent 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.

For FY 2021, EOHHS is unclear how to interpret "current law," and seeks clarification from the conferees on whether we have the General Assembly's authorization to submit a SPA to CMS to increase the all funds pool:

- RIGL authorizes a total maximum GME pool of $4.0 M; the State Plan has $1M all funds pool
- The SFY 21 Gov. Rec. proposed a SPA to increase the All Funds pool from $1M to $2.2M to better leverage the $1 M GR used in FY 2020.
- The FY 2021 enacted budget did not remove the federal funds added in the Gov Rec, implying EOHHS should seek a SPA, but did not include any resolution language enabling EOHHS to seek a SPA
- EOHHS posted for public comment a potential SPA and is budgeting the necessary federal funds in these projections to fund that SPA, but will not submit it to CMS without the Legislature's endorsement via the conferee's adopted estimates
    - To secure the June 1, 2021 effective date, EOHHS must submit the SPA to CMS by June 30th. Waiting to post the public notice until after the May CEC would significantly reduce the amount of time that EOHHS had to review and respond to public comments and secure signatures for the formal SPA submission to meet the June 30th deadline.

FY 2021 Payment

Our caseload testimony assumes we should submit a SPA, and therefore budgets $1.0M GR / $2.5 AF, based making the payment for FY 2021 in June 2021 using the enhanced FMAP of 60.29%. If the legislature does not want us to submit a SPA, the estimate should instead use a $1M all funds pool ($397,100 GR/ $602,900 FF) GME payment plus an additional $602,900 state only payment, for an all funds payment of $1,602,900 based on the approach taken in FY 2020.

FY 2022 Payment

Our caseload testimony assumes we again submit a SPA (meaning “current law” is a $1M GR appropriation), so EOHHS projects a GME payment totaling $1 M GR/$2.2 million AF, assuming a June 2022 payment using the FFY 2022 FMAP of 54.88% because the enhanced FMAP is currently projected to end December 31, 2021.

VIII. 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	Enacted	$142,301,035	$66,290,193
	Current	**$142,301,035**	**$66,290,193**
	Deficit over Enacted	*$0*	*$0*
FY 2022	November CEC	$71,564,276	$32,855,159
FY 2022	Current	**$142,493,980**	**$65,418,986**
	Deficit over Nov CEC	*($70,929,704)*	*($32,563,827)*

The FY 2021 Enacted included $142,301,035 All Funds including a federal DSH allotment (DSH Plan Year FFY 2020) of $76,010,842.

The Nov CEC Adopted included $71,564,276 All Funds for FY 2022, based on the reduced federal allotment of $38,709,117 and Rhode Island's anticipated effective FMAP rate for July 1, 2021 (which at the time did not assume the continuation of the 6.2% increase beyond March 2021). The *Consolidated Appropriations Act for 2021*, however, delayed the Medicaid DSH allotment reductions at least to FFY 2024, and CMS has stated that the enhanced FMAP will likely continue through December 31, 2021.

As a result of the delayed reduction, EOHHS estimates its FY 2022 (DSH Plan Year FFY 2021) unreduced federal allotment to be $77,074,994. This federal allotment is based on CMS communication to EOHHS, received in October 2020, that provided its draft unreduced FFY 21 DSH allotment for informational purposes. As in past years, this preliminary amount is based on most currently available data and is subject to revision. Overall, these changes result int a $70.9 million All Funds increase over the November CEC SFY 22 estimate, contributing to a $32.6 million GR deficit. EOHHS compares its current estimates to Enacted and Nov CEC in Error! Reference source not found..

The anticipated distribution by hospital for FY 2021 is shown in Error! Reference source not found.. The distribution by hospital for FY 2022 is pending completion of uncompensated care attestations and will be finalized after the May CEC.

Table VIII-1. Summary of DSH

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Hospitals - DSH								
Regular	$ 142,083,257	$ 142,301,035	$ 128,505,227	$13.8 M	$ 71,564,276	$ 127,840,428	($56.3 M)	($0.7 M)
State Only		-	13,795,808	(13.8 M)		14,653,552	(14.7 M)	0.9 M
Grand Total	**$ 142,083,257**	**$ 142,301,035**	**$ 142,301,035**	$0.0 M	**$ 71,564,276**	**$ 142,493,980**	($70.9 M)	$0.2 M
General Revenue	*$ 67,489,693*	*$ 66,952,637*	*$ 66,290,193*	*$0.7 M*	*$ 32,855,159*	*$ 65,418,986*	*($32.6 M)*	*($0.9 M)*

Table VIII-2. SFY 2021 DSH Payments by Hospital (FFY 2020 DSH Plan Year)

	SFY 2021[1]	SFY 2022[2]
Kent Hospital	$ 5,046,908.83	
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	$ 142,493,980

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

CMS' DSH policy

In CMS' "Families First Coronavirus Response Act – Increased FMAP FAQs" issued on January 6, 2021, CMS clarified that: (a) the DSH payments are eligible for the enhanced 6.2% FMAP during the duration of the Public Health Emergency (p. 118), and (b) each state's federal allotment would not change (p. 129). This effectively made it less costly for the states to access their full federal DSH allotments but would reduce the All Funds amount of DSH paid to state hospitals without an additional state contribution.

See **Table VIII-3** for DSH allotments and resulting All Funds payments assuming prevailing FMAPs apply.

Table VIII-3. Current and Historical DSH Allotments by SFY and FFY Plan Year

	Federal DSH Allotment	FMAP	State Share	DSH Eligible for FFP
				= Max Federal Allotment ÷ FMAP
SFY 2019 (FFY18 DSH Allotment)	$71,268,126	51.45%	$67,251,070	$138,519,196
SFY 2020 (FFY19 DSH Allotment)	$74,593,564	52.57%	$67,300,223	$141,893,787
SFY 2021 (FFY20 DSH Allotment)[1]	$76,010,842	59.15%	$52,494,385	$128,505,227
SFY 2022 (FFY21 DSH Allotment)[2]	$77,074,994	60.29%	$50,765,434	$127,840,428

Note 1. CMS FFY20 Unreduced.
Note 2. CMS Preliminary Unreduced.

Therefore, under this policy interpretation, EOHHS made a state-only payment to maintain the previously assumed All Funds payment, and makes a similar assumption in FY 2022 as shown in **Table VIII-4**. In FY 2021, EOHHS made a $128.5 million All Funds DSH payment at the prevailing FMAP rate (i.e., 59.15% including the 6.2% increase attributed to the PHE) and an additional State-only "DSH" payment of $13.8 million. The gross outlays by EOHHS, however, remained consistent with the FY 2021 Enacted that assumed Rhode Island's Regular FMAP (i.e., 52.95%).

EOHHS' current FY 2022 estimate reflects making a $127.9 million DSH payment and a $14.7 million State-only "DSH" payment.

Table VIII-4. Breakdown of All Funds DSH payments in EOHHS' testimony

		DSH Payments in CMS Reporting						
SFY	FFY	Federal Payment	GR Payment	Computed Total	eFMAP	Additional GR Payment	Total AF	Total GR
SFY 2021	FFY 2020	$ 76,010,842	$52,494,385	$ 128,505,227	59.15%	$ 13,795,808	$142,301,035	$66,290,193
SFY 2022	FFY 2021	$ 77,074,994	$50,765,432	$ 127,840,426	60.29%	$ 14,653,554	$142,493,980	$65,418,986

American Rescue Plan Act of 2021 and Potential Increase to Federal Allotment

The *American Rescue Plan Act of 2021* includes a section on DSH payments, Sec. 9819(a)(1)(2)(F), that states

> *"The Secretary shall recalculate the annual DSH allotment, including the DSH allotment specified under paragraph (6)(A)(vi), to ensure that the total DSH payments (including both Federal and State shares) that a State may make related to a fiscal year is equal to the total DSH payments that the State could have made for such fiscal year without such increase to the Federal medical assistance percentage"*

CMS has not increased the federal allotment; however, CMS informed EOHHS that guidance on interpreting the above is forthcoming. EOHHS and other states are unclear whether the above language was meant to codify states' ability to make an additional state-only payment to keep the All Funds and General Revenue contributions the same as they would have been without the enhanced FMAP (see **Table VIII-5** scenario B), or whether the federal allotment will actually increase (scenario C).

Gross federal DSH appropriations are determined by separate legislation. Not all states utilize their full federal allotment, so how CMS would modify the allotments consistently under the latter interpretation to ensure all states' All Funds payments would remain unchanged is unclear. For states that have not historically used their full federal allotment, there already may be no reduction in total DSH payments. There is no consensus among EOHHS' colleagues within the National Association of Medicaid Directors (NAMD) as to how to interpret the language. Presently, Rhode Island's DSH federal DSH allotment and total computable amount included in the Medicaid Budget and Expenditure System (MBES) remain unchanged as of April 22, 2021.

EOHHS believes that the most favorable interpretation for SFY 2022 would be for CMS to increase our federal DSH allotment to $85.9 million such that EOHHS could make its full $142.5 million DSH payment at the enhanced FMAP of 60.29%. Under this scenario, EOHHS would see GR savings of $8.8 million in FY 2022 compared to its current forecast, shown in Scenario C below. However, due to the above considerations and previous guidance, EOHHS has not revised its previous interpretation.

Further, if CMS were to retroactively adjust its DSH allotments for FFY 2020, EOHHS could save an additional $9.3 million GR in SFY 2021, as shown in **Table VIII-6** scenario D. Note that the SFY 2020 DSH payment was made in July 2019, FFY 2019, prior to the declaration of the PHE so EOHHS does not anticipate any FY 2020 GR savings.

Table VIII-5. SFY 2022 DSH Summary

DSH SFY 22 Options						
Scenario	FF Payment	GR Payment	Additional GR Payment	Total AF	Total GR	Imputed FMAP
A DSH at regular FMAP	$ 77,074,994	$ 65,418,986	$ -	$142,493,980	$ 65,418,986	54.09%
B Interpretation of ARP: State share reduced for eFMAP. Add'l GR payment is made.	$ 77,074,994	$ 50,765,432	$ 14,653,554	$142,493,980	$ 65,418,986	54.09%
C Alternative interpretation: Federal allotment increases	$ 85,909,621	$ 56,584,360	$ -	$142,493,980	$ 56,584,360	60.29%
			Variance Scenario C vs. B (GR Savings):		*$ (8,834,627)*	

Table VIII-6. SFY 2021 DSH Summary

DSH SFY 21 Options						
Scenario	FF Payment	GR Payment	Additional GR Payment	Total AF	Total GR	Imputed FMAP
A Actual SFY 21 Payment	$ 76,010,842	$ 52,494,385	$ 13,795,808	$142,301,035	$ 66,290,193	53.42%
B DSH at regular FMAP	$ 76,010,842	$ 67,541,268	$ -	$143,552,110	$ 67,541,268	52.95%
C Interpretation of ARP: State share reduced for eFMAP. Add'l GR payment is made.	$ 76,010,842	$ 52,494,385	$ 15,046,883	$143,552,110	$ 67,541,268	52.95%
D Alternative interpretation: Federal allotment increases	$ 86,547,567	$ 57,004,543	$ -	$143,552,110	$ 57,004,543	60.29%
			Variance Scenario D vs. A (GR Savings):		*$ (9,285,650)*	

IX. Nursing and Hospice Care

Nursing and Hospice Care			
		All Funds	**General Revenue**
FY 2019	Final	$316,748,108	$154,022,945
FY 2020	Final	$344,084,010	$146,519,287
FY 2021	Enacted	$363,000,000	$150,808,350
	Current	**$330,300,000**	**$132,103,485**
	Surplus over Enacted	*$32,700,000*	*$18,704,865*
FY 2022	November CEC	$373,500,000	$169,260,863
FY 2022	Current	**$359,700,000**	**$151,865,340**
	Surplus over Nov CEC	*$13,800,000*	*$17,395,523*

For FY 221, EOHHS' estimate of $330.3 million reflects a $32.7 million surplus against Enacted. In FY 2022, EOHHS is forecasting $359.7 million, an 8.9% increase above the current fiscal year due to the price adjustment as well as projected utilization increase expected to occur absent policy intervention. The components of this estimate are summarized in **Table IX-1**. Additional information on paid days is presented in **Attachments 4**.

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

	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*

For FY 2021, EOHHS estimated average monthly spend, by using July to December 2020 actuals, and a blended average for the remaining 6 months that adjusted for the rate increase implemented on 10/1/2020 by inflating the first 3 months of the year by the FY 2021 rate increase. The surplus reflects nursing facility census that is below the census estimate implied by the November CEC estimate Adopted by the conferees as shown in

Table IX-2. Of note, the methodology for estimating total FFS spending on nursing facilities does not distinguish between Medicare Coinsurance Days or Medicaid Days.

In FY 2022, EOHHS projects that under "current law", nursing home census will return to Pre-COVID levels; EOHHS' anticipates that its LTSS resiliency budget initiatives will mitigate this growth, which is why that initiative has a savings component. The favorable nursing facility/hospice variance compared to November is also due to a slightly lower price factor (2.65% vs. 3.0%)

The FY 2022 estimate is the higher of the Pre-COVID monthly average (July 2019 to March 2020) or the monthly average of the FY 2021 projection adjusted for rate increases, given continued uncertainty regarding the pace and impact of a post-COVID recovery. The time period used is shown in **Table IX-3**, as well as the rate and utilization assumptions used as presented in **Table IX-5**. **Table IX-4** shows the average nursing facility per diem.

Table IX-2. Proxy of Average Full-Time Equivalent Nursing Home Census: Nov CEC Estimate for FY 2021 versus "Actuals" for Selected Time Periods (i.e., completed for IBNR)

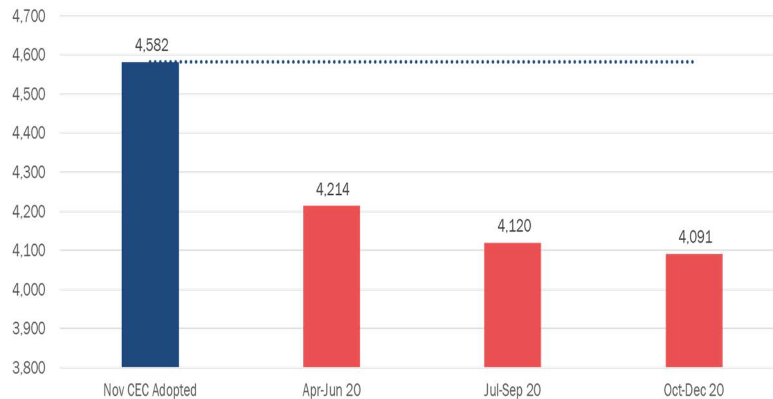


Table IX-3. Baselines Used for Deriving FY 2022 FFS Forecast

Service Type	Time Period Monthly Average Used
Hospice	**FY21**: Jul-20 thru Dec-2020
Nursing Facility	**Pre-COVID** FY20: Jul-19 thru Mar-20

Table IX-4. Nursing Home Medicaid Per Diem (Average)

Rate Effective Date	Average NF Per Diem[1]	Average NF Per Diem Less Resident Contribution [2]
1-Oct-19	$230	$191
1-Apr-20[3]	$251	$208
1-Jul-20	$230	$191
1-Oct-20	$236	$195
1-Oct-21	$241	$200

[1] Rate is prior to resident's share.
[2] Average Cost of Medicaid Day to EOHHS
[3] 10% increase to Direct Care, Indirect Care, Other Direct Care. No adjustment to FRV, Policy Adj, Taxes.

Table IX-5. FY 2022 Nursing and Hospice Care Trend Assumptions (Excludes Expansion FFS)

	Percent	Dollar Impact	Comments
Price	2.65%	$ 7,011,269	FFY 2021 Skilled Nursing Facility PPS Less Productivity Adjustment
Utilization	0.00%	$ -	EOHHS
Total		**$ 7,011,269**	

Note. "Price" in this table is meant to show the impact of the rate increase above to the State. All else equal, the component of the rate paid by Medicaid (i.e., not paid by the beneficiary) will increase by a larger percentage than the rate increase seen by the facility. In FY 2022, the 2.65% price increase to the state results from a 2.2% market basket rate increase.

In our FY 2022 estimate, EOHHS utilized the most recently available market basket, less productivity adjustment, which totaled 2.2% as shown below. The market basked was accessed on March 8, 2021 from the CMS Market Basket Data website (Actual Regulation Market Basket Updates, Summary Web Table – Actual 2020Q3).

Skilled Nursing Facility PPS	SFY 2022 Proposed *Based on FFY 2021*
Market Basket Update	2.2%
Productivity Adjustment	0.0%
Market Basket Update less Productive Adjustment	**2.2%**

The 2.2% represents the effective price increase that providers will see; however, EOHHS used a 2.65% increase in state spending to account for the 17% patient share.

In the House Finance Committee's recent legislative hearing on the Medicaid Resolution, the House Fiscal presentation noted a 3.0% increase to nursing facilities. This aligned with the November 2020 adopted estimate, which reflected a 2.5% market basket increase to the nursing facilities, but a 3.0% cost to the State to account for 17% patient share. The table below shows the comparison of EOHHS inflationary projections between November 2020 CEC and May 2021.

Table IX-6. Changes to October 1, 2021 Rate Increase, Comparison of Nov CEC and May CEC Indices

Nov CEC 2020		May 2021		
Factor	**Index**	**Factor**	**Index**	**Change**
2.5% (3.0% state cost)	CMS Skilled Nursing Forecast. Applied average of last four actual productivity adjustments.	2.20% (2.65% state cost)	CMS Actual Regulation Market Basket -FFY 21 Skilled Nursing Facility PPS Market Basket Update Less Productivity Adjustment	Changed to actual regulation market basket so conferees will not adopt an inflationary increase that could change prior to implementation of rate increase on 10/1/21. (Forecasts updated quarterly)

Nursing Home Market Basket Background

RIGL § 40-8-19(2)(vi) mandates an "adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1 of each year, beginning October 1, 2012" The State Plan language further requires that "Direct Nursing, Other Direct Care, and Indirect Care" be increased annually with the "Global Insight/CMS Skilled Nursing Facility Market Basket."

Current law and State Plan language do not clarify: (1) if EOHHS should use forecasted or actual market basket regulation, (2) if EOHHS should include a productivity adjustment, and (3) what issue date of the inflationary index to use. To improve clarity and transparency, EOHHS plans to submit clarifying language in a State Plan Amendment to identify a consistent market basket to use. Proposed language is below:

> "The components of the base per diem rate will be increased annually, effective October 1 of each year, as follows:
>
> 1. Direct Nursing, Other Direct Care, and Indirect Care:
>   - ~~Global Insight/CMS Skilled Nursing Facility Market Basket.~~ Center for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Prospective Payment System Market Basket Update Less Productivity Adjustment. The adjustment will be applied annually on October 1 (the start of a new federal fiscal year), using the CMS' actual regulatory market basket update for the previous federal fiscal year.

The October 1, 2021 rate increase (the start of FFY 2022) would rely on the CMS FFY 2021 actual regulatory market basket update – this is available for the May CEC testimony and actual implementation, ensuring that the May CEC aligns with what is enacted if the legislature adopts this market basket as current law.

Note that in the past, as discussed in Attachment 8, EOHHS' out year projections referenced CMS market basket *forecasts*; however, these are updated quarterly, do not contain productivity adjustments; and do not include outpatient hospitals. To ensure that conferees adopt a number that will be consistent with what EOHHS implements should the market baskets be enacted, EOHHS used the most recently available market basket (FFY

2021) less productivity adjustment. CMS updates the actual regulation market baskets annually. EOHHS utilizes the productivity adjustment—for both hospital and nursing home market basket adjustments—to incentivize appropriate care and ensure that the Rhode Island taxpayer is not overpaying for these services.

X. Home and Community Care

Home and Community Care			
		All Funds	**General Revenue**
FY 2019	Final	$70,243,474	$32,624,518
FY 2020	Final	$82,506,503	$34,704,126
FY 2021	Enacted	$85,000,000	$35,313,250
	Current	**$90,600,000**	**$36,230,940**
	Deficit over Enacted	*($5,600,000)*	*($917,690)*
FY 2022	November CEC	$86,000,000	$38,973,050
FY 2022	Current	**$92,700,000**	**$39,137,940**
	Deficit over Nov CEC	*($6,700,000)*	*($164,890)*

EOHHS is projecting Home and Community Based Services (HCBS) expenditures in FY 2021 to total $90.6 million, or $5.6 million more than the Enacted.

The FY 2022 forecast of $92.7 million is $2.1 million higher than the FY 2021 estimate, and $6.7 million over the November CEC Adopted.

Table X-1 below shows the summary of Home and Community Care Expenditures over FY 2021 and FY 2022 versus Enacted and November CEC. **Table X-2** summarizes changes in authorizations for HCBS services. Please note that the count of people authorized for HCBS and is not equivalent to number of members utilizing LTSS services. EOHHS derives its fee-for-service estimates from actual utilization and spending with prospective adjustments applied in the aggregate—as opposed to on a PMPM basis as EOHHS does for its managed care estimates—for any anticipated changes in price and/or utilization.

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

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Capitation								
PACE	$ 15,683,629	$ 16,699,509	$ 16,718,362	($0.0 M)	$ 17,241,859	$ 17,697,341	($0.5 M)	$1.0 M
FFS Claims								
Assisted Living	$ 8,495,281	$ 8,832,773	$ 10,995,525	($2.2 M)	$ 8,832,773	$ 11,694,890	($2.9 M)	$0.7 M
Shared Living	3,642,983	3,628,622	4,492,936	(0.9 M)	3,628,622	4,492,936	(0.9 M)	0.0 M
Adult Day	3,483,583	4,654,089	2,305,942	2.3 M	4,654,089	4,326,172	0.3 M	2.0 M
Personal Choice	9,502,678	9,203,282	9,703,566	(0.5 M)	9,203,282	9,239,727	(0.0 M)	(0.5 M)
Home Care	37,699,303	39,603,529	44,732,244	(5.1 M)	38,245,355	42,473,249	(4.2 M)	(2.3 M)
Other HCBS	1,754,276	2,378,196	1,651,425	0.7 M	2,378,196	2,775,685	(0.4 M)	1.1 M
Subtotal FFS	**$ 64,578,104**	**$ 68,300,491**	**$ 73,881,638**	($5.6 M)	**$ 66,942,317**	**$ 75,002,659**	($8.1 M)	$1.1 M
Prior Period Activity/Accruals	*2,244,770*							
Grand Total	**$ 82,506,503**	**$ 85,000,000**	**$ 90,600,000**	($5.6 M)	**$ 86,000,000**	**$ 92,700,000**	($6.7 M)	$2.1 M
General Revenue	*$ 34,704,126*	*$ 35,313,250*	*$ 36,230,940*	*($0.9 M)*	*$ 38,973,050*	*$ 39,137,940*	*($0.2 M)*	*$2.9 M*

Table X-2. PACE and FFS Home and Community Based Services Authorizations

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	
PACE	339	353	352	-1	350	360	10	8
Remaining in FFS:								
Assisted Living	489	537	519	-18	540	587	47	68
Shared Living	149	179	192	13	180	234	54	42
Personal Choice	349	368	332	-36	372	342	-30	10
Home Care	2,022	2,253	2,483	230	2,280	3,134	854	651
Other HCBS	36	24	29	5	24	24	0	-5
Subtotal HCBS	**3,045**	**3,361**	**3,555**	**194**	**3,396**	**4,321**	**925**	**766**

Note 1. In July 2020, Preventive Services Only changed from a waiver group to a program indicator for authorization purposes.

SFY 21 Estimate and Methodology

EOHHS' projections for all HCBS categories are above Enacted levels due to increased utilization, except Adult Day and Other HCBS.

For all HCBS categories, except for Adult Day Services and Personal Choice, EOHHS' FY 2021 projections are based on the average paid for services dates from July 2020 through December 2020, adjusted for services incurred but not reported (IBNR), annualized and adjusted for places where our data did not yet reflect the FY 2021 rate adjustments per RIGL. The estimate assumed a 2% utilization rate increase to capture possible utilization increases that may occur in the remaining months of the current fiscal year as more people become vaccinated

Additional adjustments or deviations from the above were made as outlined below:

- **Adult Day Services**. Pre-pandemic, average monthly spending was approximately $300,000. Since the pandemic, EOHHS has seen some months with spending below $100,000. EOHHS' projection uses actuals for July through December and then assumes average monthly spend of $192,000 (pre-COVID monthly average) for the remainder of FY 2021. No utilization multiplier was used in this estimate as the pre-COVID monthly average captures higher utilization.
- **Personal Choice**. EOHHS used the July 2020 through November 2020 monthly average, as the December 2020 average was below $100,000, and monthly spend typically ranges from between $500,000 to $990,000, assuming there is a lag in our data.
- **Assisted Living added costs of $349,682 for Revised Regulation 210-RICR-50-00-8**, effective March 1, 2021 which increased the Personal Needs Allowance to $120 for all and the room and board allowance to $1,590 minus the PNA.[8]
    - This has a financial impact to the state as less income will be available to be paid toward cost of care, potentially by $791 per month for non-SSP residents. There are 273 current AL resident without SSP; this estimate assumes the full patient share amount is forfeit as a result of these changes; average patient share today is $10.52 per diem per utilizer.
    - This was done to comply with 42 CFR 435.735 (c)(1) (ii) which mandates that the state cannot have different maximum maintenance of needs amounts for Assisted Living residents.

FY 2022 Estimate and Methodology

For FY 2022, all HCBS items are projected to be above November Adopted except Adult Day. As shown in **Table X-3**, EOHHS projections rely on the higher of the Pre-COVID monthly average (July 2019 to March 2020) or FY 2021 monthly average (July to December 2020 completed @100%) due to continued uncertainty regarding the pace and impact of a post-COVID recovery. The estimate also adjusts for statutorily required increases, as shown in **Table X-4**.

[8] Category F recipients not included because they already receive the $120

EOHHS also added $1.0 million in FY 2021 to account for the projected cost of the change to 210-RICR-50-00-8, effective March 1, 2021, detailed above.

Unlike most service areas, several HCBS services saw increased utilization during the pandemic. EOHHS' projections do not assume this utilization decreases as the threat of COVID declines because it is unclear to what extent this increase is related to the pandemic. First, these HCBS increases have occurred despite LTSS applications being down overall versus pre-pandemic: from 300 to 550 applications per month between April 2019 to March 2020 to 200 and 350 applications per month from April 2020 to March 2021. This suggests that actual HCBS utilization is inelastic to absolute volume of authorizations and utilization will remain elevated after the threat of COVID subsides. Second, there is evidence that the HCBS workforce has been limited due to the pandemic, and utilization could increase further or, at minimum, remain steady as this workforce returns to "normal." In addition, the fee-for-service estimate may be experiencing increased utilization from a marginal shift from Rhody Health Options to FFS. This is supported by the fact that enrollment in RHO's HCBS rate cell has declined by 2.5% since February 2020, from 1,651 to 1,609.

Table X-3. Baseline Used for Deriving FY 2022 FFS Forecast

HCBS Service Type	Time Period Monthly Average Used
Assisted Living	**FY21**: Jul-20 thru Dec-20
Shared Living	**FY21**: Jul-20 thru Dec-20
Adult Day	**Pre-COVID** FY20: Jul-19 thru Mar-20
Personal Choice	**Pre-COVID** FY20: Jul-19 thru Mar-20
Personal Care	**FY21**: Jul-20 thru Dec-20
Other HCBS	**Pre-COVID** FY20: Jul-19 thru Mar-20

Table X-4. FY 2022 Home and Community Care Trend Assumptions

	Percent	Dollar Impact	Comments
Price			
PACE	3.51%	$ 604,930	EOHHS
Assisted Living	0.00%	$ -	N/A. These rates are not changed annually
Personal Care	0.00%	$ -	CPI-U, Medical Care in New England, February 2021 Release
Other HCBS	0.00%	$ -	N/A. These rates are not changed annually
		$ 604,930	
Utilization			
PACE	2.27%	$ 383,229	EOHHS
Assisted Living	0.00%	$ -	EOHHS
Personal Care	0.00%	$ -	EOHHS
Other HCBS	0.00%	$ -	EOHHS
		$ 383,229	
Total, Price/Volume		**$ 988,159**	

Table X-5. Summary of PACE Monthly Premiums

	SFY 2020	SFY 2021	SFY 2022	FY21→FY22 Trend
Medicaid Only	$6,730	$6,907	$7,149	3.5%
Dual, 55-64 y.o.	$3,739	$3,864	$3,999	*3.5%*
Dual, 65+ y.o.	$3,589	$3,676	$3,805	*3.5%*
Composite	***$3,881***	***$3,992***	***$4,132***	***3.5%***
Average Member Months	*339*	*352*	*360*	*2.3%*

HCBS Market Basket Background

RIGL § 40-8.9-9(f)(7) mandates annual inflationary increases to certain HCBS rates on July 1st using the New England Consumer Price Index card as determined by the United States Department of Labor for medical care. This index is available online and updated monthly.

The state plan language for HCBS Hospice rates further specifies that "Each July 1, the rates effective October 1st of the previous calendar year will be trended by the **May** release of the New England Consumer Price index card, as determined by the United State Department of Labor for medical care." For non-hospice rates the State Plan does not specify which release of the New England Consumer Price index card to use; however, for consistency, if the market basket is enacted, EOHHS treats the non-hospice rates the same as the hospice rates given they relate to the state RIGL. For non-hospice rates the State Plan states:

> Effective July 1, 2019, and each July 1 thereafter, the base rates for personal care attendant services and skilled nursing and therapeutic services, provided by home care providers and home nursing care providers, will be increased by the New England Consumer Price Index card as determined by the United States Department of Labor for medical care.[9]

Because the May 2022 data is not yet available, EOHHS' May CEC projections refer to the February data. However, the February over February change was negative 0.2%. EOHHS assumes no negative adjustment is possible as RIGL § 40-8.9-9(f)(7) directs EOHHS to inflate the rates. Therefore, EOHHS is budgeting a 0% increase.

Of note, EOHHS acknowledges that use of this CPI-U data may not be reflective of the change in home care providers' costs in Rhode Island, particularly their labor costs over the last year during the PHE. The legislature can, of course, revise the inflation for FY 2022 to better align with the law's original policy intent to provide for an increase. However, based on our current state law and Medicaid State Plan, EOHHS is providing the specific market basket as required by law.

When the May release/data is available (in June), EOHHS will review the inflation and apply an increase, pursuant to current law, if applicable; if negative, we will use 0%. This assumes that the conferees or the General Assembly do not approve a more specific rate increase based on the concern above.

In the future, to allow the May CEC estimate to align with what would be enacted if the market basket were included in the RIGL, EOHHS requests the Assembly to clarify in RIGL or allow EOHHS to pursue a SPA to clarify which release of the New England Consumer Price Index to use:

- *Non-hospice. EOHHS suggests "increased by the February release/data," be added to the language so our May testimony includes the rates that will be enacted if the market basket is passed.*

- *Hospice Rates*: *EOHHS requests the Assembly allow EOHHS to pursue a SPA to change from the May to the February release/data, so our May testimony will include the rates that will be enacted if the market basket is passed.*

[9] Attachment 4.19B Pages 2a and 3, Rhode Island's State Plan. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Attach.%204.19-B%201%20to%20Attach.%204.19-C%20Pg.%203.pdf

Table X-6. CPI-U Data used for derivation of EOHHS' FY 2022 Home Care Market Basket

Series Title	Medical care in New England, all urban consumers, not seasonally adjusted			
Series ID	CUUR0110SAM			
Seasonality	Not Seasonally Adjusted			
Survey Name	CPI for All Urban Consumers (CPI-U)			
Measure Data Type	Medical care			
Area	New England			
Item	Medical care			
Year	Period	Label	Observation Value	
2020	M02	2020 Feb	110.484	
2020	M03	2020 Mar	110.965	
2020	M04	2020 Apr	110.971	
2020	M05	2020 May	110.512	
2020	M06	2020 Jun	110.989	
2020	M07	2020 Jul	111.009	
2020	M08	2020 Aug	111.420	
2020	M09	2020 Sep	110.557	
2020	M10	2020 Oct	110.212	
2020	M11	2020 Nov	109.874	
2020	M12	2020 Dec	108.985	
2021	M01	2021 Jan	110.309	
2021	M02	2021 Feb	110.291	-0.17469%

XI. Pharmacy

Pharmacy			
		All Funds	**General Revenue**
FY 2019	Final	($462,718)	$6,333
FY 2020	Final	($2,611,387)	($819,557)
FY 2021	Enacted	($791,566)	($78,856)
	Current	**($100,000)**	**($39,990)**
	Deficit over Enacted	*($691,566)*	*($38,866)*
FY 2022	November CEC	($822,420)	($122,700)
FY 2022	Current	**$100,000**	**$42,220**
	Deficit over Nov CEC	*($922,420)*	*($164,920)*

EOHHS' revised forecast for FY 2021 is $0.7 million over than the Enacted with the deficit attributed to lower than anticipated prior period rebates.

The FY 2022 estimate remains relatively flat compared to the current year but reflects a $1 million deficit over Nov CEC Adopted.

Although EOHHS is not statutorily required to apply an inflationary index, EOHHS has traditionally used an inflationary factor due to the fluctuation of drug costs. The SFY 21 Enacted Budget assumed a 2.2% increase, based on the IHS Markit 2020 Q2 forecast for pharmacy in CY21 Q2, which corresponds to the end of our SFY 21. EOHHS reduced the inflationary increase to 0.4%, based on IHS Markit's 2020-Q4 revised prescription forecast for CY21 Q2 The CY22 Q2 forecast is 2.4%, which EOHHS applied to its SFY 22 estimate, a reduction of 0.3% below Nov. CEC estimate.

FY 2021 and FY 2022 Pharmacy expenditures and rebates are presented in **Table XI-1** as well as in **Major Developments**. (Note 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 (excluding Part D drugs); and
(3) the Pharmacy budget line reflecting J-Code rebates collected against pharmaceuticals delivered in an outpatient hospital setting.

Table XI-1. Summary of Pharmacy Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
FFS Claims								
Pharmacy	$ 6,102,630	$ 6,021,540	$ 5,896,937	$0.1 M	$ 6,174,641	$ 6,096,937	$0.1 M	$0.2 M
DRE	(6,786,897)	(4,715,649)	(4,404,289)	(0.2 M)	(4,842,972)	(4,404,289)	(0.2 M)	(0.2 M)
J-Code	(2,046,345)	(2,097,457)	(1,592,648)	(0.1 M)	(2,154,089)	(1,592,648)	(0.1 M)	(0.1 M)
Subtotal Pharmacy	**$ (2,730,612)**	**$ (791,566)**	**$ (100,000)**	**($0.0 M)**	**$ (822,420)**	**$ 100,000**	**($0.0 M)**	**($0.2 M)**
Prior Period Activity/Accruals	*$119,225*							
Grand Total	**$ (2,611,387)**	**$ (791,566)**	**$ (100,000)**	**($0.7 M)**	**$ (822,420)**	**$ 100,000**	**($0.9 M)**	**$0.2 M**
General Revenue	*$ (819,557)*	*$ (78,856)*	*$ (39,990)*	*($0.0 M)*	*$ (122,700)*	*$ 42,220*	*($0.2 M)*	*$0.1 M*

XII. 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	Enacted	$65,723,517	$65,723,517
	Current	**$58,100,000**	**$58,100,000**
	Surplus over Enacted	*$7,623,517*	*$7,623,517*
FY 2022	November CEC	$75,772,723	$75,772,723
FY 2022	Current	**$69,100,000**	**$69,100,000**
	Surplus over Nov CEC	*$6,672,723*	*$6,672,723*

EOHHS' revised FY 2021 estimate of $58.1 million for Pharmacy Claw Black is $7.6 million less than the Enacted. The improved position reflects the continued reduction to the Part D Clawback multiplier in Q4 of SFY 2021 as well as a $5.4 million credit from CMS for its misallocation of Rhode Island's Medicare Premium Payments in a prior fiscal year. The price-volume comparisons presented in **Table XII-2** do not consider the impact of this credit. This revised forecast is based on actual invoices through March 2021.

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 December 2021. Like general enrollment among the Aged, Blind, and Disabled population, the caseload for Part D reimbursement has remained stable throughout the Public Health Emergency and this is expected to remain so through FY 2022.

Table XII-1. Summary of Pharmacy Claw Back Expenditures

	SFY 2020:	SFY 2021:			SFY 2022:			SFY22 Increase/ (Decrease) over SFY21
	Final	Enacted	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	
Medicare Premiums - Part D	$ 65,452,273	$ 65,723,517	$ 63,493,939	$2,229,578	$ 75,772,723	$ 69,100,000	$6.7 M	$5.6 M
CMS Adjustment for Prior Period			(5,393,939)	$5,393,939				
Prior Period Activity/Accrual	*(473,584)*			$0				
Grand Total	**$ 64,978,689**	**$ 65,723,517**	**$ 58,100,000**	**$7.6 M**	**$ 75,772,723**	**$ 69,100,000**	**$6.7 M**	**$11.0 M**
				Change			**Change**	**Change**
Part D PMPM	**$148**	**$146**	**$140**	**-$6**	**$164**	**$153**	**-$11**	**$13**
Jul-Sept	$156	$141	$141	$0	$163	$141	-$22	($0)
Oct-Dec	$154	$137	$137	$0	$161	$138	-$23	$1
Jan-Mar	$154	$141	$141	-$1	$161	$165	$4	$24
Apr-Jun	$141	$163	$141	-$22	$165	$165	$0	$24
Average Enrollment	**36,865**	**37,612**	**37,783**	**171**	**38,587**	**37,726**	**-861**	**-57**

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

	Price	Volume	Net
FY 2021: Current over Enacted	($2.6 M)	$0.3 M	($2.3 M)
	-3.9%	0.5%	-3.5%
FY 2022: Current over Nov CEC	($5.2 M)	($1.6 M)	($6.8 M)
	-6.9%	-2.2%	-8.9%
FY 2021 over FY 2020	($3.6 M)	$1.5 M	($2.0 M)
	-5.4%	2.5%	-3.1%
FY 2022 over FY 2021	$5.7 M	($0.1 M)	$5.6 M
	8.9%	-0.2%	8.8%

XIII. Other Medical Services

Other Medical Services			
		All Funds	**General Revenue**
FY 2019	Final	$124,318,646	$49,770,341
FY 2020	Final	$125,661,850	$42,899,404
FY 2021	Enacted	$138,534,296	$44,676,532
	Current	**$134,300,000**	**$41,558,476**
	Surplus over Enacted	*$4,234,296*	*$3,118,056*
FY 2022	November CEC	$140,000,000	$51,064,386
FY 2022	Current	**$143,400,000**	**$48,622,049**
	Deficit over Nov CEC	*($3,400,000)*	*$2,442,336*

EOHHS' FY 2021 revised forecast for Other Medical Services is a $4.2 million surplus over the Enacted budget. The enhanced FMAP associated with the COVID-19 emergency period contributes $8.5 million GR relief in FY 2021, an improvement of $1.6 million over Enacted.

The All Funds surplus is driven by a reduced fee-for-service expenditures for rehabilitation, targeted case management, and physician services.

The FY 2022 forecast of $143.4 million reflects a $9.1 million, or 6.8 percent, increase above projected FY 2021 expenditures and a $3.4 million deficit against November Adopted. However, due to the continuation of the Enhanced FMAP through first half of FY 2022 and $4.5 million GR relief, EOHHS forecasts a surplus of $2.4 million GR.

A summary of expenditures for both FY 2021 and FY 2022, by type of service, is presented in **Table XIII-1**. **Table XIII-2** summarizes all Other Medical Services expenditures subject to a non-regular matching rate.

Medicare Part A/B Premium Payments

See Table XIII-3. Medicare Monthly Part A and Part B Premiums. Expenditures for FY 2021 are projected to total $77.2 million which is $0.1 million less than the Enacted. For Part A, EOHHS' revised forecast assumes average Part A enrollment of 1,179 in FY 2021, increasing to an average of 1,264 in FY 2022. For Part B, EOHHS' forecast assumes average Part B enrollment of 39,685 in FY 2021 and 39,729 in FY 2022.

Both forecasts reflect an annualized growth rate of 2.5% over most recent invoices, the same trend assumed in May. EOHHS has received preliminary invoices from CMS through April 2021.

Recoveries

The FY 2021 forecast for recoveries is $12.4 million consistent with the revised figure adopted in November and reflected in Enacted. This figure was assessed against collections through March 2021.

Table XIII-1. Summary of Other Medical Services Expenditures

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Surplus/ (Deficit)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Surplus/ (Deficit)	SFY22 Increase/ (Decrease) over SFY21
Medicare Premiums - Part A	$ 5,880,455	$ 6,419,530	$ 6,459,106	($0.0 M)	$ 6,697,143	$ 7,098,369	($0.4 M)	$0.6 M
Medicare Premiums - Part B	67,732,870	70,904,741	70,715,563	0.2 M	74,004,948	72,810,903	1.2 M	2.1 M
Subtotal MPP	**$ 73,613,325**	**$ 77,324,271**	**$ 77,174,669**	**$0.1 M**	**$ 80,702,091**	**$ 79,909,271**	**$0.8 M**	**$2.7 M**
NEMT Capitation	**$ 4,940,389**	**$ 7,245,656**	**$ 5,204,134**	**$2.0 M**	**$ 5,126,682**	**$ 5,159,936**	**($0.0 M)**	**($0.0 M)**
Other Medical Services								
Tavares	$ 7,287,842	$ 7,496,179	$ 7,633,063	($0.1 M)	$ 7,599,251	$ 7,724,660	($0.1 M)	$0.1 M
Rehabilitation & TCM	16,082,030	17,639,307	15,560,254	2.1 M	17,639,307	16,842,592	0.8 M	1.3 M
BHDDH Medicaid Program	22,068,619	20,614,600	23,836,025	(3.2 M)	21,177,327	24,336,025	(3.2 M)	0.5 M
Physician Services	10,544,424	12,552,844	8,885,396	3.7 M	12,940,095	12,157,516	0.8 M	3.3 M
Durable Medical Equipment	3,374,812	3,392,373	3,152,518	0.2 M	3,392,373	3,366,670	0.0 M	0.2 M
All Other Services	3,088,734	3,863,385	5,234,252	(1.4 M)	3,017,194	5,604,666	(2.6 M)	0.4 M
Refugee Program	579,276	805,680	19,689	0.8 M	805,680	698,664	0.1 M	0.7 M
Subtotal Other Medical Services	**$ 63,025,737**	**$ 66,364,369**	**$ 64,321,197**	**$2.0 M**	**$ 66,571,227**	**$ 70,730,793**	**($4.2 M)**	**$6.4 M**
Recoveries	**$ (12,504,220)**	**$ (12,400,000)**	**$ (12,400,000)**	**$0.0 M**	**$ (12,400,000)**	**$ (12,400,000)**	**$0.0 M**	**($0.0 M)**
Prior Period Activity/Accruals	*-$3,413,381*							
Grand Total	**$ 125,661,850**	**$ 138,534,296**	**$ 134,300,000**	**$4.2 M**	**$ 140,000,000**	**$ 143,400,000**	**($3.4 M)**	**$9.1 M**
General Revenue	*$ 42,899,404*	*$ 44,676,532*	*$ 41,558,476*	*$3.1 M*	*$ 51,064,386*	*$ 48,622,049*	*$2.4 M*	*$7.1 M*

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

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Surplus/ (Deficit)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Surplus/ (Deficit)	SFY22 Increase/ (Decrease) over SFY21
Restricted - Children's Health Account	$ 9,981,985	$ 10,000,000	$ 10,000,000	$0.0 M	$ 10,000,000	$ 9,527,796	$0.5 M	($0.5 M)
Restricted - Organ Transplant Fund	1,538	15,000	15,000	0.0 M	15,000	15,000	0.0 M	0.0 M
100% Federal - QI Medicare	(1,529,061)	(1,750,000)	(1,750,000)	0.0 M	(1,750,000)	(1,750,000)	0.0 M	0.0 M
100% Federal - Refugee Program	579,276	805,680	19,689	0.8 M	805,680	698,664	0.1 M	0.7 M
100% State - BCCP	(220,671)	(250,000)	(250,000)	0.0 M	(250,000)	(250,000)	0.0 M	0.0 M

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

	SFY 2020: Final	SFY 2021: Enacted	SFY 2021: Current	SFY 2021: Increase/ (Decrease)	SFY 2022: Nov CEC	SFY 2022: Current	SFY 2022: Increase/ (Decrease)	SFY22 Increase/ (Decrease) over SFY21
Part A PMPM	$445.22	$456.55	$456.73	$0.18	$463.53	$468.11	$4.58	$11.37
Part A Enrollment	1,101	1,155	1,179	24	1,204	1,264	60	85
Part B PMPM	$143.69	$152.83	$148.49	-$4.34	$150.26	$152.73	$2.47	$4.23
Part B Enrollment	39,282	40,051	39,685	(366)	41,043	39,729	(1,314)	44

XIV. Attachments