QUESTIONS FROM EOHHS VERBAL/WRITTEN TESTIMONY

1. **Update Table** Error! No text of specified style in document.**-1. Summary of Variances Between Revised Enacted and Preliminary Close, FY 2022**

Original (from p. 9 of testimony):

	SFY 2022		
CEC Budget Line	Revised Enacted	Prelim Final	Surplus/ (Deficit)
Managed Care	$ 852,900,000	$ 852,621,018	$0.3 M
Rhody Health Partners	303,100,000	227,334,745	75.8 M
Rhody Health Options	133,800,000	132,508,958	1.3 M
Expansion	745,000,000	802,688,861	(57.7 M)
Hospitals - Regular	70,000,000	68,470,982	1.5 M
Hospitals - DSH	287,573,859	290,942,646	(3.4 M)
Nursing and Hospice Care	314,300,000	309,213,322	5.1 M
Home and Community Care	98,600,000	99,973,611	(1.4 M)
Pharmacy	100,000	1,923,137	(1.8 M)
Clawback	68,800,000	69,358,996	(0.6 M)
Other Services	146,500,000	149,996,281	(3.5 M)
Subtotal - CEC Benefits	**$ 3,020,673,859**	**$ 3,005,032,557**	**$15.6 M**
Health System Transformation Project	25,000,000	24,674,903	0.3 M
Special Education	19,538,580	19,836,866	(0.3 M)
ARPA HCBS Investments[1]	60,600,000	61,453,664	(0.9 M)
Total - Benefits	**$ 3,125,812,439**	**$ 3,110,997,990**	**$14.8 M**

Revised:

	SFY 2022		
CEC Budget Line	Revised Enacted	Prelim Final	Surplus/ (Deficit)
Managed Care	$ 852,900,000	$ 852,621,018	$0.3 M
Rhody Health Partners	303,100,000	296,086,628	7.0 M
Rhody Health Options	133,800,000	132,508,958	1.3 M
Expansion	745,000,000	736,304,719	8.7 M
Hospitals - Regular	70,000,000	68,470,982	1.5 M
Hospitals - DSH	287,573,859	290,942,646	(3.4 M)
Nursing and Hospice Care	314,300,000	309,213,322	5.1 M
Home and Community Care	98,600,000	99,973,611	(1.4 M)
Pharmacy	100,000	(444,604)	0.5 M
Clawback	68,800,000	69,358,996	(0.6 M)
Other Services	146,500,000	149,996,281	(3.5 M)
Subtotal - CEC Benefits	**$ 3,020,673,859**	**$ 3,005,032,557**	**$15.6 M**
Health System Transformation Project	25,000,000	24,674,903	0.3 M
Special Education	19,538,580	19,836,866	(0.3 M)
ARPA HCBS Investments[1]	60,600,000	61,453,664	(0.9 M)
Total - Benefits	**$ 3,125,812,439**	**$ 3,110,997,990**	**$14.8 M**

Please note that the above reflects technical corrections to two accruals that involved debiting the wrong line sequences. There will be additional adjustments proposed by EOHHS and the OAG as part of the annual review. of

the prior fiscal year. These additional adjustments are not reflected above but were discussed on page ten of the testimony and are part of active conversations between EOHHS and the OAG.

2. Please clarify which members are still being passively enrolled?

EOHHS has been passively enrolling members into RHO since January 2021. For CY 2021, EOHHS was passively enrolling approximately 100-150 members each month. These members were not nursing home residents. Beginning in January 2022, EOHHS began to passively enroll an additional 100 Nursing Home residents. The FY 2023 Enacted assumed significant volume of passive enrollment of nursing home residents through first half of FY 2023 (for a net increase of 50 members per month after churn/terminations).

EOHHS ceased passively enrolling nursing home members in October 2022 (and had very minimal passive enrollment between July and September; with less than 6 residents enrolled in September, for example). The reason for this change was that there is an insufficient volume of nursing home residents eligible for RHO (i.e., residents who are not in Hospice care, do have a Medicare Part C plan, or had previously opted out of passive enrollment).

While the timeline was correctly noted on page 40, EOHHS's testimony erroneously stated on page 14 that passive enrollment for nursing home members stopped in June 2022. Passive enrollment significantly declined in June and ceased in October.

Please note that EOHHS continues to passively enroll 100-150 non-Nursing Home members into RHO each month. However, as noted above, EOHHS has been passively enrolling this group since January 2021, so the net impact of this passive enrollment less any terminations during the month is already reflected in the historical experience/trends so no further below-the-line adjustments were applied to EOHHS' forecast. With respect to this group of non-Nursing Home residents, this is the same approach taken by EOHHS in May.

Post-CEC Update:

EOHHS finance staff learned on October 27, that a total of 412 members have been identified for passive enrollment effectively January 1, 2023. Over 75% of these members are in the IC70 (Community Non-LTSS) pay level. Some portion of these selected members will opt out prior to January. The remaining members are SPMI, DD Community, or Community LTSS. Further, this sweep of members could reduce the number who may be available for passive enrollment in subsequent months (i.e., the cadence of 100-150 per month may be less in February and onward), therefore it will not materially impact the overall member months. Further, if this sweep of members results in a meaningful increase in RHO enrollment there would likely be some corresponding reduction in FFS spending.

Being conservative, one could add a $1.0 million to FY 2023 and $2.0 million to FY 2024 to the RHO estimates to finance the potential increase in member months. However, given the uncertainty in overall impact to RHO and any offsetting FFS reductions, the conferees may see it as unnecessary to revise its estimates at this time.

3. How does the correction to risk share in FY 2022 close impact FY 2023 and FY 2024 estimates discussed on page 10 of Testimony?

There is no impact of the accrual adjustments for EOHHS FY 2022 Risk Share reporting on FY 2023 or FY 2024. This is because EOHHS does not prospectively assume any risk/gain share payments/recoupments in the current or future year. The rates are certified as actuarially sound and so the rates are assumed to be adequate. As of October 2022, EOHHS has received no reporting from the MCOs with respect to their current year performance to suggest otherwise. EOHHS risk share liabilities, if any, will be updated in May based on reporting through December.

4. **Conferees requested an update to Table II-2 to account for the shifts in "Other FFS" to the appropriate Line Sequences.**

The FY 2023 Enacted appropriated the entirety of $36 million in investments associated with the Perry Sullivan appropriation to the **Home and Community Care** budget line. EOHHS revised forecast reflects the spending where it will occur.

Please note that **Table II-2** is not organized around line sequences but rather spending categories (e.g., NEMT Broker crosses several budget lines; the is true also of changes in Drug Rebates). The summary is intended to help describe the primary drivers of variances with the Enacted. Each of the subsequent sections within EOHHS' testimony considers the drivers from a perspective of the budget line.

In **Table II-2**, "Other FFS" includes all the non-NICU fee-for-service spending that falls within **Managed Care**, **Hospitals – Regular**, and **Other Medical Services**, so it is not specific to line sequences. The intent of this table is to summarize spending by spending category in a manner that helped EOHHS fiscal staff consider overall changes in its benefits spend and not necessarily at budget line (although the two overlap in certain instances). With respect to Other FFS, the take-away is that overall FFS spending that is falling outside of our various managed care products is less than previously forecast for reasons discussed through testimony (e.g.., lower FFS caseload as people are not churning, offset savings from Medicare Part A Buy In).

5. **How old are the hospice and HCBS interim payments?**

EOHHS anticipates recoupments of hospice and HCBS interim payments to begin in FY 2023 Q2. EOHHS FY 2022 accruals reflect these collections so there is no impact to the FY 2023 estimate. The earliest interim payments to HCBS providers date back to April 2017. No interim payments have been made to HCBS providers since March 2019. The earliest interim payments to hospice providers were made in June 2017. No interim payments have been made to hospice providers since April 2020.

6. **Please send conferees information on SOBRA implementation. What did EOHHS implement? What are the alternative approaches?**

Overall, SOBRA payments are expected to be up 25% compared to last year. This increase reflects adjustments to the SOBRA rate development that EOHHS thought consistent with the intent of the legislation. The net increase is the result of an 18.3% increase in the price of each SOBRA payment and a 5.8% increase in the expected number of births in FY 2023 compared to FY 2022.

EOHHS recognizes that this significant growth in expenditures is less than what was included in Enacted. However, nearly half of the decline is attributed to fewer expected births and unrelated to pricing considerations.

Below is a summary of the Price-Volume comparison of SOBRA rates currently implemented for FY 2023 compared to FY 2022, as well as compared to FY 2023 Enacted. (And compared to FY 2024.)

Price-Volume Comparison – SOBRA Payments only.

	Price	Volume	Net
FY 2023 over FY 2022 (Current)	$11.3 M	$4.3 M	$15.6 M
	18.3%	5.8%	25.2%
FY 2023: Current over Enacted	($5.3 M)	($4.0 M)	($9.4 M)
	-6.1%	-4.9%	-10.8%
FY 2024 over FY 2023 (Current)	$3.9 M	($4.2 M)	($3.5 M)
	5.0%	-5.1%	-0.4%

To get to the 18.3% price increase, EOHHS applied the enacted 20% increase to the projected hospital experience (on top of the 5.0% underlying hospital rate increase also passed by the legislature) for select SOBRA line items that included inpatient labor and delivery DRGs. This adjustment was based on EOHHS' interpretation of the budget language that was specific to managed care and hospital-based payments for maternity care. It was also the agency's understanding that the estimate in the Enacted was specific to SOBRA payments.

Overall, a significant portion of services funded under the SOBRA rate cell do not go to the hospitals. Further a large share of hospital charges is for pathology/laboratory services, radiology, anesthesia, emergency room visits, and other non-delivery medical/surgical procedures. EOHHS did not think it was the intent of the language to increase non-hospital services, nor those hospital charges not explicitly for maternity-related services but that happen to be included in the SOBRA payment due to an associated diagnosis.

The table below illustrates the projected benefit expenses per delivery included in the SF 2023 certified rates. Note that of the total expenditures, 33% are attributable to outpatient hospital services, of which the majority is for emergency room visits and pathology, laboratory, and radiology services.

For purposes of the rate adjustment specific to the FY 2023 budget initiative, the State's actuary, in consultation with EOHHS, applied the additional 20% rate increase (on top of the general 5.0% rate increase for all hospital charges) to the following APR-DRG codes classified under the "Inpatient Maternity Delivery" service category: 540, 541, 542 and 560.

Category		Projected Benefit Expense (Per Delivery)	%
Inpatient Hospital	$	7,592.03	50%
Inpatient Maternity Delivery	$	6,728.64	45%
Inpatient Medical/Surgical/Non-Delivery	$	700.44	5%
All Other Inpatient	$	162.95	1%
Outpatient Hospital	$	4,920.41	33%
Outpatient Emergency Room	$	1,849.45	12%
Outpatient Pathology/Lab&Outpatient Radiology	$	2,106.81	14%
All Other Outpatient	$	964.15	6%
Professional	$	2,458.75	16%
Maternity	$	1,449.78	10%
Pathology/Lab&Radiology	$	333.55	2%
Anesthesia	$	323.04	2%
All Other Professional	$	352.38	2%
Ancillary	$	90.56	1%
LTSS	$	6.43	0%
Projected Benefit Expense	$	15,068.18	100%

Given recent conversations about how this initiative was implemented, EOHHS considered an alternative approach, which would affect the "SOBRA" rate cell, as well as other managed care rate cells, most notably the "MF <1" newborn rate cell in Rite Care Core, which was not previously considered. This approach captures non-NICU based neonatal services provided to newborns and high-risk pregnancy services. This would add between $2.5-3.0 million in new costs not reflected in EOHHS' testimony. However, it is worth caveating this estimate that if such an adjustment is required of the conferees, the actual amount could be more or less based on actuarial certification and a more comprehensive review of data and associated trends.

See below for additional background on the SOBRA rate cell.

SOBRA Rate Cell Background

It is worth highlighting how the SOBRA rate cell is used by the actuaries and how costs get assigned to that rate cell for separate payment to the plans.

The SOBRA rate cell serves as a risk adjustment mechanism that works by removing all costs for certain services, or where a diagnosis on the claim meets certain criteria, from the regular monthly payment to the health plan for a particular member. By removing pregnancy-related costs or services provided to pregnant members, we remove a source of volatility and risk for the plans. In any given year, total costs on behalf of pregnant members are materially influenced by the number of pregnancies (and the degree of complication thereof), which can vary significantly from year-to-year.

For purposes of rate setting, all services meeting the following criteria are included in the SOBRA rate cell:

- Professional services with the following CPT Code Ranges:

CPT Range	Description of Services
59400 through 59430	Vaginal Delivery, Antepartum and Postpartum Care Procedures
59500 through 59530	Cesarean Delivery Procedures
59600 through 59630	Delivery Procedures After Previous Cesarean Delivery

- Claims with a primary diagnosis with the following ICD-10 codes:

ICD-10 Codes	Description of Diagnosis
Starts with "O"	Pregnancy, childbirth and the puerperium ICD-10-CM Code range O00-O9A
Starts with "Z31" - 'Z37"	Persons encountering health services in circumstances related to reproduction

- Claims with any diagnosis with the following ICD-10 code:

ICD-10 Codes	Description of Diagnosis
Starts with 'Z39"	Encounter for maternal postpartum care and examination

7. Please explain the effective date assumed for implementation of the biomarking legislation.

EOHHS shifted the implementation of the biomarker testing from FY 2023 to FY 2024 based on language included in 2022 H-7587 Sub A, specifically section b, which specified a 1/2024 start date (see below). EOHHS initially assumed that the Medicaid coverage would align with the start of commercial coverage. As-is, EOHHS can prepare contract amendments with its managed care partners and adjust its FFS rate schedule for an effective date of July 1, 2022. The cost of the change is expected to be less than $25,000, as such no adjustment to EOHHS' estimate is needed given that EOHHS rounds all budget lines to the nearest $100k.

(b) Every individual or group health insurance contract, or every individual or group hospital or medical expense insurance policy, plan, or group policy delivered, issued for delivery, or renewed in this state on or after January 1, 2024, shall provide coverage for the services of biomarker testing in accordance with each health insurer's respective principles and mechanisms of reimbursement, credentialing, and contracting. Biomarker testing must be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions, when the test provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to:

8. Please provide general context on changes that occur in managed care capitation rates between May CEC and November CEC (apart from budget initiatives that impact rates).

As of the May CEC in April 2022 (with preparation in March), EOHHS had not completed the rates for FY 2023. As such, for the May testimony, EOHHS continued to use the same 5.0% price factor it used in November 2021 CEC. This remained a reasonable placeholder for a composite price factor in the absence of finalized rates and uncertainty around how the PHE and Covid-19 would impact the base experience used in rate development and trend factors (price and utilization) that the actuary would ultimately deem reasonable and adequate for the contracted services.

Milliman provided a preliminary certification of the FY 2023 rates in June 22, 2022. These rates were subsequently updated with inclusions for the FY 2023 budget initiatives impacting the rates in August 15, 2022. The rates were uploaded to MMIS in the first week of October after the health plans signed their contract amendments.

EOHHS current revised forecast for FY 2023 replaces these estimated PMPMs with the actual certified rates for FY 2023 after adjustments for any initiatives.

In general, the process by which rates are set for Medicaid managed care is outlined in 42 CFR 438.5 and certifying actuaries are subject to this regulation along with their own professional standards set forth in the Actuarial Standards of Practice (ASOP) (especially ASOP 49) and the managed care rate setting guidelines for Medicaid that are annually released by CMS.

The continued use of a 5.0% placeholder in May was deemed reasonable by EOHHS fiscal staff and our actuary confirmed this to be an adequate assumption (when viewed across all products and in the aggregate and granting a reasonable confidence interval of ± 2 percent). Given the rates remained under development in April, the actuary was unable to provide a more precise estimate/confirmation prior to their review and certification.

9. Please confirm whether the post-partum expansion impacts the GR/FF splits in FY 2023 as a result of state-only payments identified in verbal testimony and not included in written testimony.

For both years, the All Funds cost of the postpartum group is reflected in EOHHS' estimate (as we have been effectively providing for this coverage group for the past 2.5 years). The only change, relative to current spending, will be that some portion of these mothers will be State only if their underlying eligibility determination was due to Separate CHIP criteria that either allows coverage for undocumented mothers (i.e., CHIP Unborn) or higher income mothers who would not otherwise be eligible for Medicaid.

No state only cost is assumed in FY 2023 due to continued PHE and the fact that Rhode Island is not disenrolling these CHIP-eligible mothers. Technically, if the PHE ends in March and EOHHS begins redetermining these mothers some of them could be moved to a new State-only postpartum coverage group before the end of the current fiscal year. However, as the approximately 500 CHIP-eligible mothers will be terminated over 12 months the number of potential mothers who would transition in the last quarter of FY 2023 would be minimal as too any needed state-only adjustment.

For FY 2024, EOHHS assumes a total of $2.7 million in state-only payments for the post-partum extension. EOHHS written testimony did not include this as a state-only expenditure. The fiscal impact of FY 2024 adjustment is a $1.5 million increase in GR outlays.

The backup model provided to the conferees reflected the correct splits.

10. Please provide updated figures related to the final Enhanced FMAP (i.e., CHIP) for FY 2024

Although **Attachment 1d** reflected the correct FMAP rates for FFY 2024, the EOHHS underlying model that staff uses to determine the agency's GR/FF splits applied the preliminary Enhanced FMAP rate of 69.84% for FFY 2024 that was published in the Spring. The correct Enhanced FMAP rate for FFY 2024 will be 68.51% as published in the FFIS Issue brief released in October 2022.

Correcting for this error does not impact All Funds estimates. However, it results in an increase of $1.0 million GR compared to EOHHS original testimony.

The FMAP rates included in the **Attachment 1d** should be used by the conferees when determining the splits related to their consensus estimate.

The backup model provided to the conferees reflected the correct Enhanced FMAP.

Table III-7. CHIP Offsets on p. 36 of **Testimony**.

Original:

	SFY 2022			SFY 2023			SFY 2024
	Revised Enacted	Prelim Final	Surplus/ (Deficit)	Enacted	Current	Surplus/ (Deficit)	Current
CHIP Offset	$ 124,549,379	$ 127,658,575	$3.1 M	$ 136,253,019	$ 138,247,846	$2.0 M	$ 135,663,177
Additional GR Relief	*$ 16,938,716*	*$ 17,361,566*	*$0.4 M*	*$ 18,721,165*	*$ 18,995,254*	*$0.3 M*	*$ 19,467,666*

Revised:

	SFY 2022			SFY 2023			SFY 2024
	Revised Enacted	Prelim Final	Surplus/ (Deficit)	Enacted	Current	Surplus/ (Deficit)	Current
CHIP Offset	$ 124,549,379	$ 127,658,575	$3.1 M	$ 136,253,019	$ 138,247,846	$2.0 M	$ 135,663,177
Additional GR Relief	*$ 16,938,716*	*$ 17,361,566*	*$0.4 M*	*$ 18,721,165*	*$ 18,995,254*	*$0.3 M*	*$ 18,423,059*

11. Please provide more information on how EOHHS treats resident share in nursing facility rate setting.

Prior to each testimony, EOHHS determines if it should gross up the fiscal impact of its annual inflationary rate change used in its nursing facility and hospice estimates to capture the true cost to the state of the rate increase. For the past two Caseloads, EOHHS has not included any such adjustment. Staff now mention this in our testimony for transparency and for conferee awareness in case conferees would like to make different assumptions.

Typically, the resident's share of a nursing facility is around 17% (We can see this in claims data by analyzing the amount billed vs. the amount paid by Medicaid.) A resident's contribution to cost of care is affected by their available assets, income, and whether there a spouse remains living in the community. EOHHS total resident share is, in turn, affected by changes in the average contribution to care across all residents.

Holding all else equal, if the state implemented a price increase and patient share amount remained flat, the effective cost of the rate increase would be greater than the price increase paid to the provider as outlined in Example 1 below.

If the conferees believe that the patient share should be held constant at FY 2022 collections (in absolute terms on a per person basis), then the effective increase of any rate increase will be greater than the increase paid to the nursing facilities. In such a case, the conferees may want to add upwards of an additional $3.5 million (1.0%) in FY 2023 and $9.5 million (2.6%) in FY 2024 to the **Nursing and Hospice Care** budget line in order to effectuate the 5.0% rate increase in FY 2023 and a 6.9% rate increases assumed in FY 2024, (ie.,5.4% market basket + 1.5% for minimum staffing requirement) while holding patient share constant.

In contrast, despite year-over-year inflation in the per diem, the effective patient share has remained generally consistent at 17% of total costs. This suggests that patient share is trending with the change in per diem. This consistency could be due to (a) overall improvements in patient share collections, (b) reduction in average per diem cost (i.e., due to a greater proportion of lower acuity stays or stays at lower costing facilities), (c) higher patient share amounts among newly determined residents, or some combination of the these. Given the significant increase to Social Security for CY 2022 and CY 2023, EOHHS assumed the all resident will have income that they will be required to put toward the cost of care.

In this scenario, the members patient share is assumed to increase in comparable fashion to the provider rate increase. The result is an increase in state costs that mirrors the overall price increase. Such a case is outlined in Example 2 below.

<u>Example 1: No change in Resident Share Dollar Amount</u>

In this example, we assume the resident's share of total cost of care remains at a steady dollar amount, and that the resident can't contribute more, despite the rising cost of care. When the per diem paid to nursing facilities increases, resident share remains the same, which means the State absorbs more of the cost of the increase. To account for this, EOHHS structures its modeling to include the 3.6% shown in the table below.

	Per Diem "Rate" Facility Receives	Patient Share	State Cost
Year 1	$100	$17	$83
Year 2	$103	$17	$86
% Change	3.0%	0.0%	**3.6%**

Example 2: Resident Share $ Amount Increases

In this example, we assume that because the resident receives an increase in social security payments that the resident can still maintain a 17% share for total cost of care, despite the rise in the cost of care. The State does not have to cover more of the nursing facility per diem rate increase, because this is covered by the resident. EOHHS would model the 3.0% shown in the table below and incorporate that into its estimates.

	Per Diem "Rate" Facility Receives	Patient Share	State Cost
Year 1	$100	$17.00	$83.00
Year 2	$103	$17.50	$85.50
% Change	**3.0%**	3.0%	**3.0%**

12. Please provide additional information on the Previously Eligible Adult group.

Previously Eligible Adults are Medicaid-eligible people who enter through the Modified Adjusted Gross Income (MAGI) eligibility pathway and are childless (16-64) with household income below 133% FPL. However, some of these individuals have SSI or RSDI or a disability that would have made them eligible in Rhode Island for an Aged, Blind, and Disabled eligibility group that existed prior to January 1, 2014.

While these so-called "previously eligible" members are determined in RI Bridges to be Expansion eligible (based on income), their expenditures are not entitled to 90% federal financing (based on the presence of a disability).

To avoid overclaiming for the Previously Eligible Adults group, EOHHS must retroactively adjust its federal claiming at the end of the fiscal year. To do this, EOHHS relies upon a supplementary data extract from Deloitte that identifies Expansion-eligible members who have a disability. EOHHS fiscal staff uses this individual level data extract to identify all capitation payments and FFS claim not eligible for 90/10 match. EOHHS does this comprehensive reconciliation at the end of the fiscal year. For FY 2022, EOHHS did its analysis and prepared its journal entry in July 2022.

In May CEC (and therefore for the FY 2023 Enacted), EOHHS applied an amount for the previously eligible group that was comparable to the amount identified in FY 2021. The actual reallocation for FY 2022 was higher than the prior year, therefore this higher amount is carried forward into EOHHS' FY 2023 and FY 2024 assumptions.

It is worth noting that some of the stagnation in Rhody Health Partners enrollment is attributed to the increasing number of previously eligible adults in Expansion. Therefore, the increased spending on this group does not necessarily represent a new GR expense; rather it is likely a transfer of regular Medicaid spending from Rhody Health Partners to Expansion budget line.

This should only impact Rhody Health Partners since Rhody Health Options members would never be eligible for expansion (as they have Medicare coverage) and Rite Care eligible members already are determined through the MAGI eligibility pathway.

13. Please provide additional information the Part A Buy-In deficit.

Medicare Part A covers hospital coverage. Most elders are automatically eligible for Part A coverage at no charge, since they contributed to its costs through the FICA (Federal Insurance Contributions Act) taxes that are both withheld and paid on behalf of each employee.

The Part A Buy In program is for those American and permanent residents who did not work 40 quarters and are therefore are not automatically enrolled in Medicare Part A; however, they are eligible to "buy-in" for this insurance coverage at a cost of either $274 or $499 each month ($278 or $506 in 2023), depending on how long an individual or their spouse worked and paid Medicare taxes.

Medicaid is required to pay for the Part A coverage for Medicare-eligible members with full Medicaid benefits who do not yet have Part A coverage. Rhode Island was out of compliance of this regulation. Overall, EOHHS has approximately 40,000 members for who it fully subsidizes the cost of the Part B (professional services) and Part D (pharmacy) coverage. Comparatively, there are 2,930 Rhode Islanders for whom the State is also paying for Part A coverage including the 1,766 newly enrolled in October.

EOHHS fiscal recognizes that enrolling additional Part A members is generally not cost-effective. We had previously (back in 2017 and 2019) looked at enrolling a significant portion of these Partial Duals (i.e., those who have Part B coverage but have no Part A coverage) into the Part A Buy-In program and we always concluded the Medicaid cost savings were less than the additional premium payments. However, the need to get into compliance with CMS regulations outweighed such fiscal considerations. To our knowledge, we did not receive an official notice from CMS about this issue, but In July 2023, Medicaid programmatic and fiscal staff began to evaluate implementation timing and assess the fiscal impact.

14. Please provide your approach to modeling Part A spending.

EOHHS receives monthly Part A invoices from CMS on a prospective basis. Each invoice has adjustments for prior periods. For example, in early October, EOHHS received its bill for November enrollment. This bill showed a significant increase for November and additional payment to enroll these members effective as of October 1.

Details on the monthly caseload estimate is included in **Attachment 5** as well as in the "forecast" tab in the backup workbook provided to the conferees. Even prior to this stepwise increase of 1,766 new enrollees in October EOHHS was experiencing a 10% annualized trend rate. This underlying trend was carried forward. To the member months count EOHHS applied the Part A composite PMPM of $489.47 for FY 2023 and $504.89 for FY 2024.

Overall member months and PMPM by period are summarized in **Table XIII-4** on p. 68 of EOHHS written testimony.

As an offset to the increase for the newly enrolled Part A members, EOHHS fiscal staff audited the historical inpatient hospital spending of these 1,766 members. This hospital spending paid for by Rhode Island Medicaid will now be paid for by Medicare and their average annual charges are assumed to be a partial savings offset to the new Part A expenditure.

15. Please correct links on page 54.

The links provided in testimony on page 54 appear to be correct and working. Please retry:

- Actual Regulation Market Basket Updates, Summary Web Table – Actual 2022 Q2. Internet: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData (Accessed 9/15/2022)
- 87 FR 47502. Internet: https://www.federalregister.gov/documents/2022/08/03/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities (Accessed 10/14/2022)

16. Please update the LTSS application backlog vs. the number of applications.

Since EOHHS completed its responses to the conferee's questions an update (with data as of October 12, 2022) was posted to Rhode Island's transparency website.

As of October 12, 2022, the number of pending new applications across all programs was 9,125. The most current information on LTSS applications is available monthly on the transparency portal here: http://www.transparency.ri.gov/uhip/#legislative-reports.

Reporting as of 10/12/22:

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	
SNAP Expedited	54	459	513	34	467	501	**1,014**
SNAP Non-Expedited	536	1,053	1,589	104	238	342	**1,931**
CCAP	17	398	415	20	149	169	**584**
GPA Burial	0	2	2	0	0	0	**2**
SSP	0	86	86	1	27	28	**114**
GPA	25	64	89	5	13	18	**107**
RIW	117	318	435	34	86	120	**555**
Undetermined Medical	21	614	635	168	2,402	2,570	**3,205**
Medicaid-MAGI	22	41	63	140	159	299	**362**
Medicare Premium Payments	9	341	350	28	125	153	**503**
Medicaid Complex	7	82	89	35	276	311	**400**
LTSS	16	266	282	3	63	66	**348**
Grand Total	824	3724	**4,548**	572	4,005	**4,577**	**9,125**

17. **Note, DHS is providing information on the number of staff needed for PHE unwinding, including assignment of new work and existing backlogs, within their CEC response.**