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To: Caseload Conferees
Subject: Response to April 26th Testimony Questions

This document includes EOHHS's response to questions received during caseload testimony on April 26th, 2024.

Cover All Kids – Enrollment By Month & Age Cohort

Please find attached a summary of the Cover-All-Kids population through May 2024 by age cohort. Note that enrollment for May does not yet include members who gain eligibility for a partial month in May, which may modestly reduce the month/month decline in caseload. As we noted in our testimony, our modeling reflected data through March 31, 2024.

Reviewing this refreshed data, it is worth noting:

1. Enrollment in CAK declined in April and May. This reduction is associated with both the Unwinding (people losing coverage) and transition of children from state only Cover-all-Kids eligibility group to full Medicaid. The latter is the primary reason for the reduction to CAK. While some members may enroll during the month of May and receive partial coverage,
2. There are some older children who should be cleaned up through the RTNO. CAK is for children under 19 and so those who are 19+ are likely included in error and should be cleaned up during redeterminations.

As a result of these transitions/cleanup, EOHHS is comfortable shifting $1.4 million from our State-Only to Medicaid matching accounts. This results in savings of **$0.6M from general revenue** in FY 2025. While there could be a modest impact on the All Funds estimate (i.e., for those who lose all coverage), most of the savings are primarily from a shift from State-Only to Regular funding sources.

		Reductions
April/May Reduction over March	$	(71,519)
19+ y.o. savings	$	(14,731)
Reduced premium payments per month	$	(86,249)
7% price factor for SFY 2025	$	(6,037)
SFY 2025 Savings - Reduction to State Only	**$**	**(1,107,440)**
FMAP		55.99%
Increase to Medicaid Matching		
State	$	487,384
Federal	$	620,055
All Funds	**$**	**1,107,440**
Net State	*$*	*(620,055)*

May 2024 CEC - follow-up CAK.xlsx

The Work Number

This does not affect EOHHS testimony or forecast for FY 2025 and is provided for rebasing the Governor's budget initiative. Below is EOHHS' model for The Work Number (TWN) budget initiative that was updated to reflect the latest enrollment data. As discussed, this also impacts the non-CEC budget lines (Central Management accounts). The Medicaid finance team is working with Central Management on the update and will provide a full rebased estimate for both Medical Assistance and Central Management programs post-CEC conference.

twn_final_may cec rebase.xlsx

Disproportionate Share Hospitals (DSH)

As discussed during testimony, there are federal and state definitions of uncompensated care. Please see below.

Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule

- CMS issued a final rule in 2021 to clarify how uncompensated care is calculated. The information in the "Uncompensated Care Cost Detail" below applies to each hospital unless the hospital meets the 97th percentile exemption. The 97th percentile exemption applies to hospitals that are at or above the 97th percentile of all hospitals nationwide with respect to the number of Medicare supplemental security income (SSI) days or the percentage of Medicare SSI days to total inpatient days.
    - CMS will publish the 97th percentile list annually prior to October 1 of each year. No commitment as to an exact date except for after March 31st and before October 1st.
    - The calculation is prospective. The October 1 list will be published for use in the subsequent year's DSH payment calculation (state plan rate year beginning on or after October 1).
    - CMS will not require the identification or reporting of any separate information on hospitals that meet the 97th percentile exception or that benefit from the exception. However, CMS suggests that auditors provide this information as part of their independent certified audit.
- Uncompensated Care Cost Detail: Uncompensated Care Costs only include costs and payments for services for which the Medicaid State Plan or waiver is the primary payer for such services. This includes:
    - Medicaid individuals with no source of third-party coverage for the specific inpatient hospital or outpatient hospital services.
    - Uninsured individuals (no health insurance or other source of third-party coverage for the specific inpatient hospital or outpatient hospital services).

R.I. Gen. Laws § 40-8.3-2

- (4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred by the hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any, received directly from such patients; and (ii) The cost incurred by the hospital during the base year for inpatient or outpatient services attributable to Medicaid

beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated-care index.

- (5) "Uncompensated-care index" means the annual percentage increase for hospitals established pursuant to § 27-19-14 [repealed] for each year after the base year, up to and including the payment year; provided, however, that the uncompensated-care index for the payment year ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment year ending September 30, 2008, shall be deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018, September 30, 2019, September 30, 2020, September 30, 2021, September 30, 2022, September 30, 2023, and September 30, 2024, shall be deemed to be five and thirty hundredths percent (5.30%).

Updated Certified Community Behavioral Health Clinics (CCBHC) Timeline/Workplan

Please see updated version of the CCBHC workplan below.

Cohort 1 and 2 High Level Timeline 4.30.24

CMS Final Rule

On April 22, 2024, CMS finalized three rules related to Medicaid managed care, access standards, and minimum staffing requirements. The rules are:

- Managed Care Access, Finance, and Quality Final Rule
- Access Rule
- Minimum Staffing Rule

Concurrently, CMS released guidance on health care-related tax programs with hold harmless arrangements involving the redistribution of Medicaid payments.

EOHHS is currently evaluating impact across programs and awaiting summaries from the National Association of Medicaid Directors and our actuarial vendor. We will share those as they become available. In the interim, EOHHS has included some additional information specific to the Managed Care Access, Finance, and Quality Final Rule that was referenced during testimony below.

Significantly, the rule prohibits the use of separate payment terms as well as post-payment reconciliation processes. As a result, the state will no longer be permitted to direct specific dollar amounts to specific providers or groups of providers. Instead, any additional funding the state wishes to direct to providers will need to be based on adjustments to fee schedules for specific services rendered. Under the rule, those adjustments cannot result in rates that exceed the average commercial rate for a service.

Because post-payment reconciliation processes will also be prohibited, health plans will be required to revise their fee schedules and submit claims to EOHHS that include all costs associated with any state-directed payment for a service and cannot issue separate payments outside of claims to providers. The

State will also be required to submit, via T-MSIS, claims-level information that includes the full cost of any state-directed payment.

For a CMS Summary, including a table of major provisions by topic area, see: https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule